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The Concept and Law on Medical Insurance in Armenia

TNO Prevention and Health

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1 Introduction

Several TNO-missions visited Armenia during the period of April - October 2000 to provide assistance to the development of a possible concept and draft Law "on Medical Insurance" in the country. The counterpart in Armenia was the Working Group on Health Insurance Development, established by the Ministry of Health in April 2000 with the aim to develop a concept and Law on introduction of Medical Insurance in Armenia. TNO became involved in this effort shortly after upon the specific request of the Ministry of Health and the State Health Agency, whose long-term wish it is to establish a Bismarckian-type of health care financing system in Armenia replacing the current budget-based system. In April, June and September 2000 TNO-consultants Serge Heijnen and Andre den Exter participated in detailed discussions on the (im)possibilities of health insurance development in the short- and long-term.

Upon a rapid assessment of the economy's and health system's preparedness in April 2000 (see "Mission Report 10-18 April 2000", Serge Heijnen) the consultant strongly advised 'not to opt for a fast introduction of health insurance in Armenia' as important 'basic pre-conditions for social insurance implementation are not met at this stage'. The basic pre-conditions being the current state of the economy with high levels of un-employment, improductivity and low wages/income of citizens, as well as the inefficient organisation and poor performance of the health system itself. Next to a needed path of economic growth it was suggested that if the MoH would like to pursue its goal of a sustainable health financing system based on health insurance it should ACHIEVE the following in the health sector: 1) real improvements in optimisation of the health system, 2) benefit package more in line with economic reality, and 3) development of a realistic concept of health financing based on health insurance, as well as Law development.

The Ministry of Health acknowledged the importance of these prerequisites and announced that it will give an impetus to the rationalisation of the health system and benefit package in addition to the ongoing work on the development of the health insurance concept and Law. As mentioned in the April report as well, TNO will be technically and financially supporting the rationalisation efforts as well as the work on the development of a concept and Law (see section 6).

During a mission in June 2000, the first draft concept of the Working Group was examined and detailed comments as well as suggestions for further study/analysis were provided to the Working Group. Also, a meeting was held with all important local and international stake-holders to inform them on the on-going activities and to discuss the preliminary ideas on the long-term model, the transition phase and the prerequisites. In addition, detailed legal comments and recommendations on the draft Health Insurance Law were given to the Ministry of Health and the Working Group by our health legislation expert (den Exter, Legal Review of the draft Law on Health Insurance).

During June-August 2000, the Working Group developed a second draft concept on Medical Insurance. This concept has been endorsed by the Government in August 2000. Despite, we were

informed that it should still be considered 'work in progress' and that a reaction to the document would be appreciated. Regarding the Law, we were informed by the Minister of Health that the Government has requested that the draft-Law on Medical Insurance incl. necessary sub-regulatory documents should be finalized on 15 November 2000 for Government discussion and, ultimately, submission to Parliament.

2 Content of the Report

This report compiles the results of the findings of the TNO-Consultants Andre den Exter and Serge Heijnen when assessing the possibilities for medical insurance introduction in Armenia and analysing the content of the draft "Concept on Medical Insurance" and the Draft "Law on Medical Insurance" developed by the Working Group and the Ministry of Health. The report starts with the comments to the latest draft of the Insurance Concept and then compiles the legal comments to the drafts of the Medical Insurance Law.

The latest version of the "Draft Concept on Medical Insurance", version of September 2000, is attached as Annex 1.

The latest version of the "Draft Law on Medical Insurance", version of September 2000, is attached as Annex 2.

The earlier comments to the first draft of the "Health Insurance Law (version June 2000)" are provided as Annex 3.

The earlier comments given to the first draft of the "Health Insurance Concept" (version June 2000) are provided as Annex 4.

3 Analysis of the Medical Insurance Concept

The discussion and recommendations on the concept are provided under 4 main 'lines' in this report:

- comments to the long-term concept;
- comments to the introduction strategy (excl. starting date);
- prerequisites and starting date;
- conclusions.

This part of the report will end with an explanation of TNO's further activities to support the development of a sustainable health financing system in Armenia. These activities are all very much related to the main findings in this report.

3.1 The long-term medical insurance concept

Important aims and principles of the long-term medical insurance model chosen are:

- the existence of compulsory and voluntary insurance in one model;
- the notion of social solidarity, health for all, and aiming to increase the level of protection of citizens from unpredicted cases of disease;
- to better manage the health financing sector and to increase the 'official' health economy;
- to improve the financial accessibility and utilisation of essential medical services.

There would be one state insurance company involved in the execution of the compulsory medical insurance. The statute of this insurance would be defined by the State. Coverage would ultimately be (close to) universal and contributions to this fund would largely come from employers and employees (through premiums) and state budget resources (that would cover for the contribution of some groups). The program (benefit package), contribution and premium rates are defined by the Government. The concept identifies all groups that should ultimately be covered by health insurance and identifies the ways in which contributions by or for individuals belonging to these groups will be transferred to the insurance fund. The concept mentions that the prices/tariffs to be paid by the health insurance fund to health care services, which fall under the insurance benefit package, should be based on actual costs and prices. No new administrative structure should be established to implement compulsory medical insurance and to collect premiums. The Law on Medical Insurance will define population groups, implementing and supervision structure, fund collection, basis for premium calculation (price list to become Tariff Act), benefit package (annually by Government/Parliament etc). The benefit package itself should contain the kinds of services which are considered necessary to maintain and promote good health of the Armenian population, services should be based on health policy goals and should be cost-effective. The health insurance system should protect the population against high and unpre-

dictable medical expenses but priority should also be given to stimulate utilisation of low cost-high effect services and technologies. Investing in the opposite can not be justified.

Voluntary insurance would be a commercial activity providing private and voluntary insurance for individuals and groups. It can be implemented by insurance companies of different property types and the statutes of this insurance is defined by the insurance companies. Sources of income will be personal income of citizens and profit of employers (?). The program and rates of contributions would be set by the contract between the insurer and insured. Legal barriers (part. in tax legislation) will be removed from RoA legislation so that voluntary insurance can be further developed and the population stimulated to additionally insure themselves outside of the compulsory package.

In general, the broad framework and mainstream characteristics of this model are acceptable and in fact bear most of the features of the insurance model and traditions prevailing in European countries (whose health financing systems are based on health insurance). There seems to be consensus that this model – the social insurance model - should be the long-term aim instead of a model which will be based largely on private financing and insurance. The arguments for this choice and the principles on which this social insurance model should be based are sufficiently described in the first two chapters.

However, it is more difficult at this stage to judge whether certain aspects of the concept are realistic long-term targets in economic terms, such as large/universal coverage and a substantial benefit package. Long-term problems can be expected in the collection of insurance contributions and expansion of the benefit package due to the structure of the economy, labour market and social security system (e.g. many unemployed or other groups who will need to be supported, large 'unofficial' economy) in combination with the low average wages, low pension/unemployment subsidies and the financial situation of the state (that is both a major employer and responsible to support most groups in the current concept). Reliable trend figures on the size and structure of the population (groups) and their income/wage characteristics are unavailable.

Technical and administrative problems can be expected in registration and income assessment of, particularly, the large group of self-employed and farmers in the Armenian economy. The long-term desired premium rate of 9% of the income is based on arbitrary figures (of hospital prices and utilisation) and methodology (weak relation to demographic/epidemiological situation, needs and benefit package and health system). In addition, at central level there is not yet a clear vision on the scope and content of the compulsory insurance package vis-a-vis the state (budget) scope and priorities, individual financial responsibility and private/voluntary insurance, the role of co-payments etc. All mentioned issues have been discussed with the Working Group during this and previous missions and suggestions for improvements were made. It is clear that the economic and labour market analysis and overall health financing strategic choices and priorities would still require substantial attention before any realistic long-term milestones and planning can be developed.

3.2 Comments to the introduction strategy (excl. starting-date)

The presented introduction strategy has the following features:

- contribution raising and insurance coverage at first only for the group of official workers and their relatives for which groups it is administratively most easy to start with while this group is likely to contain an acceptable risk profile;
- premiums for the group of official workers initially 3% (2% employer – 1% employee), financed by an additional and compulsory 'tax' on the payroll;
- covered services by medical insurance would include: primary care diagnostic and therapeutic services, specialist ambulatory-polyclinic diagnostic and therapeutic services, as well as ambulance services. This should be accompanied by a reorganisation of the State Order Programs;
- to minimize administrative costs, no new administrative structure will be created. The SHA will have separate accounts for state budget and medical insurance programs while the premiums itself will be collected through the Social Fund, which has all mechanisms in place, and then transferred to the SHA.

The choices and arguments with regard to the first and fourth bullets can be supported. However, there is one big obstacle related to the collection of contributions from the payroll of workers which will affect the financial stability of the medical insurance fund. This is the fact that a significant part of the official workers is paid by the Government. Due to the financial crisis of the Government salary levels are decreasing annually and are paid at very irregular times. Without proper payment of salaries and transfer of premiums to the Fund there cannot be a 'healthy' insurance fund and realistic insurance planning. The Fund would immediately run into the same problems and debts as the current State Order.

Collection of contributions through an extra 'tax' on the payroll is an acceptable mechanism in many countries to develop medical insurance but extra investments should only be asked from the contributing population if this will be accompanied by an increase in quantity or quality of services. However, given the very inefficient organization of health care provision (large overcapacity) and the absence of sound safe-guards that unofficial payments will not be possible under the insurance program (AND that this can and will be strictly controlled), this measure seems very controversial in the short-term. It is very likely that this would only lead to an extra financial burden on the working population and companies and that it would even give negative impetus to efforts to raise the efficiency of the health financing and health provision system.

On the other hand, the health sector's request for additional funds is justified given the current discrepancy between Government commitments and resource allocation and the very low part of GDP spent on health care (less than 3%).

As we understand that it is not advisable to decrease social premiums and payments for pensions/unemployment, the only remaining option would then be to introduce an earmarked premium on the payroll (to be collected by the Social Fund and then transferred to the SHA) for the

(partial) coverage of the working population accompanied by an equal reduction in tax for those subjects. At the same time, as indicated in the concept, budget resources for health care should not decrease in the first stage of introduction so as to ensure essential health needs coverage for the entire population (but better targeted at the poor/needy) until they can be covered by medical insurance. If the latter cannot be guaranteed, the introduction of medical insurance will have detrimental effects as it will weaken the position of the poor and vulnerable in society.

In any case, a significant reduction of the Government's declared responsibilities in health care guarantees (State Order) should take place in the coming years, starting in 2001, in order to bring the commitments more in line with the financial possibilities. This is also an important aspect for the development of compulsory medical insurance and voluntary insurance.

Therefore, the Working Group's concept is right to note that it is recommendable to take the issue of benefit package definition to include all state guaranteed medical services. Within the financial limits, a BBP should aim to deliver the kind of services people are accustomed to and which are considered necessary to maintain and promote good health. It should better prevent the population from falling into poverty because of high medical costs and it should continue to cover for certain 'uninsurable risks' (e.g. long-term psychiatric treatment). It should also promote the use of cost-effective services and should promote attainment of health policy goals (e.g. development of family medicine, stimulation of hospital outpatient treatment and rationalization of the quantity of facilities, specialties and human resources). So, to be more specific on the health needs to be covered by compulsory medical insurance specifically, more insight and consensus is needed on the organization of benefits coverage and the use of official co-payments under 1) Government programs (e.g. public health, health promotion, prevention, coverage of certain uninsurable risks), 2) compulsory medical insurance programs (e.g. necessary, essential and cost-effective emergency and non-emergency curative care delivered in PHC and hospitals for the insured population) and 3) individuals/groups by means of private risks/insurance. From there on, the desirable compulsory medical insurance package and the planning/development of coverage and benefits can be better designed.

In case the compulsory medical insurance will be introduced at a time where the current State Order Programs are basically the same, with no major differences, then the definition of benefits into the 3 main lines given (PHC-family medicine – specialist care – ambulance services) can certainly be preliminary supported with one important amendment regarding specialist care. To support health care policy and optimisation goals, it is advisable to change 'specialist *ambulatory-polyclinic* diagnostic and therapeutic services into: specialist diagnostic and therapeutic services in *outpatient hospital departments upon referral of PHC*.

As there is no information in the concept on the total expected amount of contributions to compulsory medical insurance in the introductory phase it is impossible to give any comments on the scope of any benefit package within any of these lines. It is recommended that the concept will give some estimates of expected contributions, while further analysis on incomes and costing of

benefits are essential activities in case the decision is taken (by Law) to introduce medical insurance at any given point in time.

Finally, one should be aware that in the transitional stage - before almost universal coverage and benefit package can be achieved - some population groups (e.g. workers) will have more entitlement to health care than others will. There is a clear tension between the fact that it is in the Government's interest to treat all citizens/groups equal under its own programs (in this concept compulsory medical insurance is implemented by the State) and the other fact that, to ensure an effective insurance system, there needs to be a good balance between 'people who pay more than they consume' and 'people who consume more than they pay'. The latter means that the Government should be very careful to extend coverage to other groups.

3.3 About pre-requisites and the starting-date

The concept recognises that there are significant pre-requisites related to medical insurance introduction as well as substantial preparations and investments. It mentions:

- acceptance of the Law on Medical Insurance;
- taking steps for complete and real provision of state guaranteed medical services and revision of the BBP;
- budget allocations to health care should not diminish while insurance premiums are introduced;
- optimisation of the health care system: reduce nr. of facilities, beds according to needs and actual volumes of medical care and services; privatisation of care provision and targeted investments;
- developing and adopting legislation/regulation to establish appropriate payment mechanisms;
- definition of an optimum basic health insurance program in accordance with the social-economic situation of the country and acceptable rates of insurance premiums;
- development of a Charter for the compulsory medical insurance fund;
- training of insurance staff, development of a system of individual registration and other insurance procedures for registration, claims processing and payment etc.

I would like to underline the notion of the Working Group that the introduction of medical insurance is a national matter of political and economic importance. There are three time factors influencing the date of introduction:

1. time needed for technical preparations before starting-date;
2. preparedness of the health system;
3. preparedness of the economy.

In the best case scenario, at least one year is needed for further concept development and technical preparations after the acceptance of the Law on Medical Insurance by Parliament. The needed further studies on compulsory medical insurance incomes and benefit package, the development and adoption of further legislation/regulation on payment mechanisms and pricing, as well as the

development of contribution collection mechanisms and registration systems prevent an earlier start.

Important prerequisites regarding the preparedness of the health system are related to 1) the success of coming optimisation efforts in the health care delivery system and 2) the progress in a significant revision of the BBP on the health care financing side. The Ministry of Health is taking its responsibility in these areas very serious. TNO will whole-heartedly support this process. On the health care provision side it is recommendable to introduce medical insurance once there are clear signs that optimisation efforts have shown effects in terms of reduction of facilities, services, staff and other capacities and that the optimisation process can be described as 'irreversible' (important here is the acceptance by Government, (medical) society and population, as well as the adoption and implementation of a realistic and effective optimisation plan). In the best scenario, this could be achieved within a 2-3 years time period from now. The adoption and implementation of a new BBP (organisation) can and should be done within the period needed for technical preparations.

With regard to the economic preparedness decisions on the starting-date should be influenced by a number of indicators, the most important being:

- 'sustained' economic growth and relative and absolute growth of the 'official' economy;
- positive developments in the financial situation of the public sector, allowing a gradual (relative) increase in public spending on health;
- positive labour-market developments with prolonged growth of nr. of officially-paid jobs and better balance between economically active and inactive population;
- positive development in income and salary levels of employees in the public-private sectors and regular payment of salaries, particularly in the public sector.

In my view, the careful considerations made on 'prerequisites for health insurance introduction' in the concept are contrasting with the proposed date of introduction of medical insurance implementation in the year 2001, as also proposed in the current concept.

3.4 Concluding

On a conceptual basis, the long-term vision for medical insurance organisation in Armenia can be supported as well as the proposed introduction strategy. Suggestions and recommendations to further improve the structure and content of the document have been given in this report and earlier missions, notably that of June 2000. From the perspective of feasibility it is very difficult to give any argumented judgment given the fact that essential financial-economic data on e.g. workforce and salary levels, expected revenues /contributions and costs of the benefit package are not available. However, also without these figures it is clear that there are significant obstacles related to *fast* implementation of this introduction strategy while particularly the proposed financing of the compulsory medical insurance package is a very controversial issue. An extra and uncompensated 'tax' on the payroll seems undesirable in the Armenian context due to the

present inefficient health care organisation (giving little value for money for the contributing subjects) and the current State Order Programs. Also, in the short-term the financial stability of the Fund will be affected by the fact that the Government with its troubled financial situation would also be the main employer/contributor.

3.5 TNO involvement

As mentioned, TNO has a commitment to support the development of a sustainable financing system in Armenia. Between May – October 2000 TNO has financially supported the work of the MoH-established Working Group in the process of concept- and Law-development, we have given detailed advise on legal aspects of the first draft Medical Insurance Law developed by the Working Group and, by means of this document, have completed our advise on the concept of medical insurance introduction. Based on the outcomes of the April, June and October 2000 missions, TNO will continue our collaboration with the Ministry of Health in this area by means of the following activities:

- Final advise on the Law on Medical Insurance before 15 October, once the Working Group has elaborated a second draft. This should enable the Working Group to review them before the Government's deadline of 15 November. In this regard it is important to note that it is the expert's role only to *improve the legal quality of the Law*. This publicly available report "comments to the concept of medical insurance concept in Armenia" has sufficiently described our recommendations on further medical insurance development in Armenia. The next stages, the decision on whether to propose and adopt a Law on Medical Insurance, is the sole responsibility of the Government respectively the Parliament. TNO will continue to give its support to the Ministry of Health and the SHA in the elaboration of the concept and by-regulations once a go - no go decision (the Law) has been taken about the further development of medical insurance in Armenia. This also means that TNO's technical and financial support to the work of the Working Group on Health Insurance Development in this stage will be considered completed after submission of the final draft-concept and draft-Law to the Minister of Health in the coming weeks, but before 15 November.
- Financial and technical support to the establishment of a MoH/SHA Working Group on BBP development which would at first have the task to review and prepare proposals for the State Order 2001, incl. further introduction of targeted co-payments. The Working Group would then work on a conceptual paper on the role of the Government in health care financing and implications for future BBP development. The Working Group will be established initially for a period of 5.5 months between 15 October and 31 March. Terms of Reference for this Working Group are currently being developed.
- Increased financial and technical support to the Ministry of Health's optimisation efforts by sponsorship and technical assistance to 3 Working Groups (on human resource planning, national guidelines/regulatory framework development and development of the Giumri-pilot). Detailed information is given in the report of Jan Both (TNO, September 2000).

4 Final Comments on the Draft Law on Compulsory Medical Insurance of the Republic of Armenia and the List of Derived (Secondary) Legislation

4.1 General remarks

According to the legal consultant, prior remarks suggested by the team made during the mission in June 2000 have been adequately transposed into a framework of complementary regulations and or resulted in necessary amendments of the previous draft.

Hereafter, several detailed remarks that will be described. For this moment, analysis of the list of recommended additional acts and/or derived regulations revealed that one governmental regulation seems to be absent in the latest proposal, viz, 'to regulate the conditions of medical insurance of foreign citizens and persons with no citizenship, temporary staying in the country', (article 40 last sentence). It is questioned if this will be regulated in the near future. Apart from this detail the list of additional regulations seem to be adequate.

4.2 Substantive remarks

Concerning the latest amendments of the (draft) Law and the list of secondary legislation.[1]

- Article 5: '...its structure and charter will be approved by the Government...'

Remark: without having taken notice of the content of the Charter document, a substantive review is not possible.

Remark: the Charter should regulate the accountability and the supervisory dimension, which places the independent function of the Compulsory Medical Insurance Fund (CMIF) into perspective. Apart from the administrative independence, the Fund is financially accountable to the Founder Board, supervising the Fund (see also article 6). With regards to the supervisory function, in order to carry out this function adequately, it is crucial that the Charter clearly defines the nature and scope of supervisory functions of the Founder Board.

The final sentence 'legal body with a separate bank account', stresses the importance of CMHI 's independence from the State Health Agency. Since the CMIF is established by Public Law (and not by Civil Law), the following amendment is suggested: the CMIF of the republic of Armenia is a legal body *established by public law* with a separate bank account.

[1] Remarks will be focussed primarily on the latest amendments, respectively additional legal norms.

- article 8: no further comments

- article 9: no further comments

- article 10, Rights and duties of the CMIF:

Remark: a possible inconsistency in the English translation concerns the rights and duties mentioned in article 10(a). 'Rights' includes the right of the CMIF to contract selectively with (individual) providers and the 'duty' to conclude contracts with *selectively contracted* providers on the provisions that are covered by the CMI system. Otherwise, article 10(a) could be interpreted as both a right and a duty to contract providers which seems not logical.

Remark: selectively contracting, 'the procedure of selection and contracting is established by ...', article 10(a): The applicable selection criteria should be transparent, objective and enable review by (third) parties. Preferably, the procedure should also include a kind of complaint procedure in cause of denial of a contract, specifying the rights of the plaintiff.

- article 11, 'basic programme'. Despite prior (opposite) recommendations, the working group prefers a separate law on 'Compulsory Medical Insurance Annual Programme', ergo interpreted as a separate Parliamentary Act which yearly defined the personal and material scope of services covered. This being the case, it should be mentioned that procedure will take quite some time due to parliamentary discussions about the contents of the programme. This is why a governmental regulation (yearly reviewed) is easier to realise.

Remark: here, it states that 'other rights and duties of the fund are established by the government'. Likely, this phrase refers to article 10(h) 'rights and 10 (h) 'duties. It is assumed that these further rights and duties will not exclude the earlier mentioned rights and duties in 10 (b-g).

- article 12: no further comments

- article 27, *mutatis mutandis* article 34: 'Model contract'

Remark: given the English translation the precise link between the 'model contract' and the 'individual' contract is not very clear in this provision. Obviously individual contracts and its conditions are based on the model contract that enumerates the compulsory conditions. That being the case, would it not be better to start this article with the model contract, instead with the individual contract. From linguistic perspective, this seems more logical.

Question: the model contract is developed ... by the MoH, CMIF and providers'. What this provision does not foresee is a scenario in which there is no consensus within this tripartite gremium concerning the model contract and its contents. Probably the government of the MoH will have a decisive vote but it is recommended to regulate this since consensus is not always the case. This is even more the case when it concerns the prices of the basic package (article 28).

- article 28, no consensus about 'prices' : see remark article 27

- article 30, 'refusal of reimbursement'

Remark: the procedure of the order should foresee in a kind of complaint procedure, in case of disputes concerning reimbursement. Instead of a civil court procedure or a procedure mentioned in the June mission report, a kind of less complicated out of court, 'arbitration' procedure could be considered.

This being the case, its consistency with article 32 'all disputes occurring.... are regulated according to court procedures' should be assessed. Sometimes 'arbitration' procedure can be preferred above court procedures, particularly in case of 'overloaded' courts and possible lacking expertise in this specific field of judges.

- Article 37: confidentiality

Remark: relevant procedures and conditions can be derived from, inter alia, a Data Protection Law. Of further relevance is the European Data protection Convention No 108, describing the conditions on disclosure of sensitive (medical) data.

4.3 Concluding remarks

Grosso mode, the latest revisions of the (draft) Law on Compulsory Medical Insurance, including the suggested additional regulations provide the necessary legal 'tools' to establish a compulsory health insurance system in the republic of Armenia based on prior recommendations set in TNO's mission reports. Apart from some specific remarks or recommendations concerning technical-legal aspects, some critical aspects concern the enforcement and realisation of individual complaint procedures by this draft Law. A final critical consideration of the applicable Government regulations regulating this area is therefore recommended.

Appendix A Draft Law on Medical Insurance (Version September 2000) Prepared by the Working Group on Health Insurance Development

Draft (unofficial translation, version September 2000)

THE LAW OF THE REPUBLIC OF ARMENIA "ON MEDICAL INSURANCE"

This present law establishes the organizational-legal bases of the medical insurance implementation in the Republic of Armenia, principles of regulation of medical insurance activities, rights and duties of the members and regulates public relations in the medical insurance field.

CHAPTER 1. GENERAL PROVISIONS

Article 1: The Legal Regulation of the Relations in the Medical Insurance Field

The relations in the medical insurance field in the Republic of Armenia are regulated by the Constitution of the Republic of Armenia, this present law and other legal acts.
The norms defined in the International Agreements of the Republic of Armenia shall be applied if they are other than those stipulated by this present law.

Article 2: Main definitions used in this law

Medical insurance-an insurance directed towards the health protection of the population and carried out through compulsory and voluntary types.

Compulsory medical insurance /hereinafter referred to as CMI/ - a type of national social insurance set in this present law and other legal acts to guarantee the right of the insured persons of receiving medical care and services in the scope of the CMI insurance programs.
The CMI is being performed by the principle of universality.

Voluntary medical insurance /hereinafter referred to as VMI/ - a type of medical insurance of population which is carried out by the principle of voluntarism and ensures the provision of the medical services not covered by the CMI programs according to the procedure and volumes established by the contracts of VMI.
VMI is performed by group and individual principles.

Insurance risk – Probability of complete or partial damage to health of the insured person.

Insurance case – A case of referral to medical providers, provision and reimbursement of care for the insured person in the scope of the health insurance programs.

Health insurance policy – the main individual document to confirm the right of the insured person to receive insurance medical care.

Insured person- is considered the physical person, for who the medical insurance contract is concluded either by him or another insuring.

The insuring – are considered physical persons and the organizations stipulated by the Chapter 5 of the Civil Code of the Republic of Armenia, irrespective of the organizational and property type of the organization.
The insuring in the CMI system are:

- for the unemployed population- regional structures of state administration at the expense of the budget of the Republic of Armenia,
- for the working population- organizations registered in the territory of the Republic of Armenia according to the established procedure /irrespective of the organizational and property type/, the individual businessmen, persons engaged in science and creative activities, agriculture /hereinafter referred to as organization/.

The insuring in the VMI system are:
Physical persons, organizations /irrespective of the organizational and property type/ for the citizens.

The insurer in case of the CMI is the CMI fund of the Republic of Armenia and its regional /marz/ divisions.
In case of VMI the insurers are medical insurance companies, licensed by the state for carrying out voluntary medical insurance activities according to the established procedure.

Insurance premium – insurance contributions paid by the insuring.

Medical care provider in the CMI system /hereinafter referred to as medical care provider/ - individual entrepreneurs and juridical persons licensed according to the established procedure by the legislation of the Republic of Armenia who are contracted by the insurers for medical care and services.

Article 3: The Medical Insurance Subjects

a/ insured person
b/ the insuring
c/ the insurer
d/ medical care provider

Article 4: The Medical Insurance Object

The object of the Medical Insurance is the insurance risk related to the reimbursement against medical care provided in the insurance case.

CHAPTER 2. COMPULSORY MEDICAL INSURANCE

Article 5: The Compulsory Medical Insurance Fund

The compulsory medical insurance in the Republic of Armenia is implemented by the Compulsory Medical Insurance Fund of the Republic of Armenia and its regional /marz/ divisions.
The Compulsory Medical Insurance is established and its structure and charter are approved by the Government of the Republic of Armenia.
The Compulsory Medical Insurance Fund of the Republic of Armenia is an independent state financial-credit organization.
The Compulsory Medical Insurance Fund is accountable to the founder board is supervised by the latter.
The Compulsory Medical Insurance Fund of the Republic of Armenia is a legal body with separate bank account.

Article 6: The Founder Board of the Compulsory Medical Insurance Fund

The management and control of the activities of the Compulsory Medical Insurance Fund is carried out by the Founder Board.
The Founder Board is in an independent structure with the status of state regulatory body.
The establishment, rights and responsibilities of the Founder Board are set by charter approved by the Government of the Republic of Armenia.

Article 7: The Financial Basis of the Compulsory Medical Insurance

The financial basis of the compulsory health insurance serves the independent budget of the Compulsory Medical Insurance Fund.

Article 8: The Sources of Formation of the Compulsory Medical Insurance Fund Budget

The budget of the Compulsory Medical Insurance Fund is generated from
a/ the compulsory insurance contributions exacted for the implementation of the CHI programs,
b/ funds from the state budget of the Republic of Armenia allocated according to the established procedure by this present law and other legislative acts of the Republic of Armenia,
c/ funds generated from the independent financial-credit activities of the Compulsory Medical Insurance Fund of the Republic of Armenia,
d/ charity donations,
e/ credits of banks and other financial-credit organizations,
f/ state budget subsidies.
The Government of the Republic of Armenia allocates additional funds to the Compulsory Medical Insurance Fund according to the established procedure if during the formation of the latter budget the expenditures grow or the receipts decrease for unexpected reasons, bringing to the inability of the compulsory medical insurance to carry out its duties.

The charter of the Compulsory Medical Insurance Fund of the Republic of Armenia, procedure of the funds collection and main directions of their spending are approved by the Government of the Republic of Armenia.
The financial-credit activities of the Compulsory Medical Insurance Fund of the Republic of Armenia is exempt from taxes.

Article 9: The Budget of the Compulsory Medical Insurance Fund

The budget of the Compulsory Medical Insurance Fund and the annual reports on its realization are approved by the Government of the Republic of Armenia.
The budget of the Compulsory Medical Insurance Fund is approved per each calendar year. The budget and the report on its realization is announced according to the procedure established by the Government of the Republic of Armenia.
The draft budget of the Compulsory Medical Insurance Fund and the annual report on its realization is developed and submitted to the Government of the Republic of Armenia for approval by the Board of Founders of the Compulsory Medical Insurance Fund.
The procedure of development and realization of the budget of the Compulsory Medical Insurance Fund and its transactions are established by the Government of the Republic of Armenia.

Article 10: The rights and duties of the Compulsory Medical Insurance Fund

The Compulsory Medical Insurance Fund of the Republic of Armenia has the rights to
a/ selectively contract the medical care & services providers. The procedure of selection and contracting of the medical care providers is established by the Government of the Republic of Armenia,
b/ participate in the process of licensing and accreditation of the medical care and services providers,
c/ create a reserve fund to provide for the performance of duties in the system of compulsory medical insurance,
d/ submit lawsuit to claim reimbursement in case of the damage to the life and health of the insured person caused by the medical provider
e/ submit lawsuit to claim reimbursement of incurred by the insured person costs of medical care by the responsible person /persons/ for the damage to the his/her life and health by the medical provider /subrogation/,
f/ implement financial-credit activities,
g/ receive free of charge information from the ministries, other governmental facilities, marz administration structures of the Republic of Armenia required for the implementation of the Compulsory Medical Insurance Fund. The list of the above information is defined by the Order on the Compulsory Medical Insurance Fund,
h/ the Compulsory Medical Insurance Fund has other rights set in the laws, orders and legal acts relevant to the Compulsory Medical Insurance Fund.

The Compulsory Medical Insurance Fund of the Republic of Armenia has the duties to

a/ conclude contracts with the medical care providers on the provision of medical care and services to the insured in covered by the CMI system,
b/ provide the insured persons with insurance policies from the moment signing of medical insurance contracts,
c/ reimburse incurred by the insured persons costs of the medical care provided to them in the order and time-period stipulated by medical insurance contracts,
d/ control the volumes, quality and terms of the provided medical care,
e/ protect the interests of the insuring /insured persons/,
f/ register and report the insurance funds,
g/ carry out other duties defined by the legislation of the Republic of Armenia,
h/ get free of charge information from state administration republican, regional structures and bodies of local self- administration required for the implementation of the Compulsory Medical Insurance Fund charter activities.

Other rights and duties of the Compulsory Medical Insurance Fund are established by the Government of the Republic of Armenia.

Article 11: The Basic Program of the Compulsory Medical Insurance and the Population Coverage

The basic program of the compulsory medical insurance and the population coverage is established by the law "On Compulsory Medical Insurance Annual Program" of the Republic of Armenia.

CHAPTER 3. THE COMPULSORY MEDICAL INSURANCE PREMIUMS

Article 12: The Concept of the Compulsory Medical Insurance Premiums and the Performers

The rates of the CMI premiums for organizations and managing subjects are defined as a proportion of calculated salary regardless of the property type.

1. The CMI contributions are the compulsory payments for the financing of the CMI programs made by the insuring.
2. The CMI premiums are paid in Armenian drams. The currency funds are exchanged to Armenian drams at the rate established by the Central Bank of the Republic of Armenia on the day of the payment.
3. The juridical persons, organizations without juridical status included in the CMI system of the Republic of Armenia, as well as the citizens of the Republic of Armenia (CMI system participants) should pay the CMI premiums.
4. The CMI premiums are paid by

a/ employers,
b/ hired workers,

c/ individual businessmen,
d/ persons engaged in scientific and creative or free activities,
e/ persons engaged in agriculture,
f/ territorial structures of state administration.

The CMI premiums for the non-working population are transferred by the state and republican budgets.
The rate of the CMI contributions is annually set by the Government and approved by the Parliament of the Republic of Armenia.

Article 13. Calculation Objects of the CMI Premiums

Objects of calculation of the CMI premiums are as follows:
a/ the salary funds of the employers and the incomes equated with them,
b/ the salary of the hired working physical persons and the incomes equated with it,
c/ the annual income of the individual businessmen , persons engaged in scientific and creative activities as well as persons not mentioned in this article, after deductions (of CMI premiums) set in the law "On the Income Tax" of the Republic of Armenia,
d/ the net cadastre income of the land considered as property the agricultural farms.

Article 14: The CMI Premium Rates

1. The employers make the CMI contributions at the rate of 2% of the total salary and equated with them funds, but not less than drams for each hired worker monthly.
2. The hired workers pay the CMI contributions at the rate of 1% of salary and equated with it income, which deductions and transfer to the CMI Fund are done by the employers.
3. The agricultural farms pay the CMI premiums during one year at the rate of 3% of the net cadastre income of land considered as property and calculated by the established order for that year. The agricultural farms employing hired workers pay CMI premiums at the rates also set for employers and hired workers.
4. The individual businessmen, persons engaged in scientific and creative activities, as well as persons not mentioned in this article pay the CMI premiums at the rate of 3% of their annual income but not less than ----- drams monthly.
5. The duties of calculation of the CMI premiums, their deductions and transfers to the CMI Fund according to this present law are laid on the insuring.

Article 15: The Order of Calculation and Payment of the CMI Premiums

1. The employers have the duty to calculate and transfer the CMI premiums to the CMI Fund monthly on the day of salary funds expense registration from the bank or cash register.
2. The CMI premiums of the agricultural farms are calculated by the CMI Fund.

3. The agricultural farms, individual businessmen, persons engaged in scientific or creative work pay the CMI premiums calculated for year on monthly basis till the 7th day of the following month.
4. The employer submits quarterly report to the CMI Fund till the 25th day of the month following the quarter.
5. In case of delays in CMI payments a penalty at the rate of 0,2% daily is exacted from the insuring from the first to the 365th day of the delay.
6. In case of concealing the object of CMI premiums or showing it less the above amount of CMI premiums calculated against the object of the CMI premiums /by the CMI Fund/ as well as penalty of 50% of that amount is exacted from the insuring according to the procedure established by this law, but 100 % is exacted if another act of concealing occurs during one year after the registration of the first.
7. The insuring pay the CMI premiums calculated against the object of concealed CMI premiums as well as penalties set in this law to the CMI Fund in 10 days' time after submission of the act by CMI Fund.
8. In case of delays in payments of the CMI premiums the CMI Fund has the right to submit lawsuit to confiscate the inventory of the insuring. The CMI Fund lays a ban on and ensures realization of the inventory of the insuring as a means of coercive performance of the court verdict.

Article 16: The Structures Providing for the Collection and Exaction of the Medical Insurance Premiums

1. Collection and exaction of the CMI premiums is carried out by the CMI Fund, which directs the collected funds to the implementation of the CMI programs and the CMI fund activities.
2. Collection and exaction of the VMI premiums is ensured by the voluntary health insurance organizations.

Article 17: The Order of Registration of the Payers of Medical Insurance Premiums

1. The state registered employers, agricultural farms, individual businessmen, persons engaged in scientific and creative activities or the non-registered in 10 days' time from the first day of state registration should get registered in the CMI Fund according to the procedure established by the Government of the Republic of Armenia.
2. The employers, agricultural farms, individual businessmen are registered according to the state registered place of activities.
3. The persons involved in scientific and creative work are registered according to the place of residence.

Article 18: The Departmental Normative Documents on Medical Insurance Premiums

The departmental normative documents on the application of compulsory health insurance premiums are adopted by the CMI Fund according to the procedure established by the Republic of Armenia.

CHAPTER 4. VOLUNTARY MEDICAL INSURANCE

Article 19: The Organization of the Voluntary Medical Insurance

The voluntary medical insurance (VMI) of the population of the Republic of Armenia is organized by this present Law, the Law " On Insurance" of the Republic of Armenia, other legal acts.
The organization of the VMI includes:
a/ concluding of VMI contract between the insuring and insurer,
b/ collection of insurance contributions by the VMI companies,
c/ registration of the insured persons of the insuring,
d/ concluding of contracts between the VMI companies and medical care providers for the organization of medical care,
e/ Organization of medical care and reimbursement according to the order and conditions established by the VMI medical care contracts beyond the CMI programs.

Article 20: Medical Insurance Company

Medical insurance companies are considered to be the juridical persons carrying out independent economic activities regardless of the property type licensed by the state to perform voluntary health insurance activities and having the necessary means of regulations.
The activities of the medical insurance company is regulated by this present law, the law "On Insurance" of the Republic of Armenia and other legal acts.
The medical Insurance companies are not included in the health care system of the Republic of Armenia.
The health care administrative bodies and the medical care providing organizations can not be a founder of the medical insurance companies.
The health care administrative bodies and the medical care providing organizations of the Republic of Armenia are not entitled to obtain /own/ stocks of the medical insurance companies.

Article 21: The Rights and Duties of the Medical Insurance Companies

1. The Medical Insurance Company is eligible to
a/ select medical care provider to provide medical care and services by the VMI contracts,
b/ participate in the process of licensing of the medical facilities,
c/ define VMI premium rates,
d/ participate in the definition of the prices of VMI medical services,

e/ submit lawsuit to the medical care provider or/and health worker for financial reimbursement in case of causing of physical or/and moral damage to the insured,
f/ submit lawsuit to claim reimbursement for the damage to the life and health of the insured person caused by the provider of medical care and services,
g/ submit lawsuit to claim reimbursement of the costs /subrogation/ incurred by the insured person for the damage to his/her life and health from the person /persons/ responsible for that case.

2. The medical insurance company has the duty to
a/ conclude contracts with the providers on the provision of medical care to the insured in the system of VMI,
b/ provide the insuring or the insured with insurance policies from the moment of signing of the voluntary medical insurance contract,
c/ partially return the contributions to the insuring or insured as stipulated by the VMI contract,
d/ control the terms, volumes and quality of the provided medical care according to the requirements of the VMI contract,
e/ represent the interests of the insuring and/or insured and protect their rights,
f/ create a reserve fund to smoothly carry out insurance activities.

Article 22: The Premiums of the Voluntary Medical Insurance

The VMI is implemented at the expense of incomes of the organizations and personal funds of the citizens.
The rates of the VMI premiums, order, conditions and terms of the contributions are set in the VMI contact signed between the insuring and VMI company.

Article 23: The State Control of the Voluntary Medical Insurance Activities

The state control of the VMI activities in the territory of the Republic of Armenia is performed by this present law, the law "On Insurance" of the Republic of Armenia and other legal acts according to the established procedure.

Article 24: The taxation of the Activities of the Medical Insurance Companies

The taxation of the activities of the medical insurance companies is performed according to the acting legislation in the territory of the Republic of Armenia.

Article 25: The Organization and Elimination of Medical Insurance Companies

The Medical Insurance Companies are reorganized and eliminated according to the procedure established by the Legislation of the Republic of Armenia.

CHAPTER 5. THE ACTIVITIES OF THE MEDICAL CARE PROVIDERS IN THE MEDICAL INSURANCE SYSTEM

Article 26: The Rights and Duties of the Medical Care Providers

The provision of medical care in the health insurance system by the order set in this law is organized according to this law, other legal acts of the Republic of Armenia, based on the contracts signed between the CMI Fund of the Republic of Armenia and the medical providers in case of CMI and between the health insurance companies and medical care providers in case of VMI.
According to the order established by the legislation of the Republic of Armenia the medical care providers are entitled to
a/ provide medical care in the system of medical insurance,
b/ be paid against the performed work and services.

The medical care providers have the obligation to
a/ submit the necessary documents on the quantitative and qualitative characteristics of the medical care provided to the insured, substantiation of the incurring costs upon the demand of the insurer and insuring,
b/ ensure the performance of the duties laid on them by the contract signed with the insurer on the provision of medical care and pharmaceuticals.

Article 27: The Contract on the Provision of Medical Care in the System of Medical Insurance

A contract is signed between the insurer /CMI Fund of the Republic of Armenia, medical insurance companies/ and medical care provider on the organization of medical care in the medical insurance system.
According to the contract the medical care provider is committed to provide medical care and services to the insured in the established volumes and quality.
The relations of the parties are regulated by the contract.
The contract includes:
a/ requisites of the parties,
b/ the types of the medical care and services,
c/ the prices and order of reimbursement of the performed works,
d/ the order of the control of the medical care quality and usage of insurance funds,
e/ the duration of the contract,
f/ the responsibilities of the parties and other conditions set in the legislation of the Republic of Armenia.
The model contract on the provision of medical care in the CMI system, the order and conditions of its signing is developed by the Ministry of Health, Compulsory Medical Insurance Fund of the Republic of Armenia together with representatives of medical care providers and is approved by the Government of the Republic of Armenia.

Article 28: The Prices of the Medical Care

The prices of the basic program of the compulsory medical insurance system of the Republic of Armenia are set by the law "On the Annual Program of Compulsory Medical Insurance" of the Republic of Armenia.
The prices of the medical care provided to the insured by the medical care provider in the scope of the CMI programs, being a component of the CMI programs are established by the Ministry of Health, CMI Fund of the Republic of Armenia and medical professional associations and approved by the Government of the Republic of Armenia.
The indexing of prices of medical care provided in the scope of the CMI programs to the insured is performed according to the procedure and conditions established by the Government of the Republic of Armenia.
The prices of the medical care provided in the scope of the VMI programs are established by the contract between the health insurance company and medical provider.

Article 29: The Order and Conditions of Reimbursement of Medical Care

The reimbursement of the medical care by the insurer is made according to the contract- based on the report submitted by the medical care provider.
The model report of the CMI system is elaborated and approved jointly by the Ministry of Health and the CMI Fund of the Republic of Armenia.
The reimbursement of the medical care provided to the population in the scope of the VMI programs is made according to the contract signed between the parties.

Article 30: The Right of the Insurer to Refuse Reimbursement of Medical Care

The order of refusal of medical care reimbursement by the insurer in the CMI system is established by the Government of the Republic of Armenia.
The conditions of refusal of medical care reimbursement by the insurer in the system of the VMI are set in the contract.

Article 31: Taxation of Medical Care Providers

The medical insurance system part of the activities of the medical care providers is exempted from taxes.

CHAPTER 6. THE REGULATION OF THE RELATIONSHIP OF THE PARTIES IN THE MEDICAL INSURANCE SYSTEM

Article 32: The Regulation of the Relationship of the Parties in the Medical Insurance System

The relations between the health insurance subjects are regulated by this present law, legislation of the Republic of Armenia, other legal acts, as well as contracts signed between the medical insurance subjects.
All the disputes occurring between the parties are resolved according to the Republic of Armenia legislation and court procedures.

Article 33: The Responsibility of the Parties in the Medical Insurance System

In case of the delays or refusals of payment of insurance premiums by the insuring in the CMI system penalties and sanctions are applied to the latter according to the legislative order.
In case of avoiding to conclude the CMI contract by the insuring the latter is fined the amount liable to transfer at the established rate of insurance premium.
The funds generated from fines and penalties are directed to the CMI Fund of the Republic of Armenia.
The medical care providers are responsible for the volumes and quality of the care provided to the insured and for the refusal to provide services according to the procedure established by the legislation of the Republic of Armenia and contract requirements. In case of violations of the contract provisions by the medical care providers the medical insurance company is entitled to reimburse the costs medical service-related costs partially or not reimburse them at all, unless otherwise stipulated by the contract.
In case of non-fulfillment of the contract requirements by the medical insurance company the latter bears legal and material responsibility in front of the insured or insuring. The material responsibility is stipulated by the contract signed between the medical insurer and insuring.
The reimbursement of the medical services provided by the medical care providers in the MI system is carried out according to the order and terms set in the contract concluded between the parties.

Article 34: The Medical Insurance Contract

The medical insurance is implemented according to the contracts signed between the medical insurance subjects. The medical insurance subjects carry out their responsibilities set in the contract according to the code of the Republic of Armenia.
The Compulsory medical insurance contract is an agreement between the CMI Fund of the Republic of Armenia, its regional divisions and the insurer on the organization and reimbursement of medical care of established volume and quality to the insured by the CMI Fund of the Republic of Armenia and its regional divisions.
The contract of the voluntary medical insurance is an agreement between the insuring and voluntary health insurance company, according to which the latter must organize and reimburse

medical care of established volume and quality or other services in the scope of the VMI programs to the insured.
The medical insurance contract should include:
a/ the names of the parties /requisites/,
b/ the duration of the contract,
c/ number of the insuring,
d/ the rate of insurance premiums and payment terms,
e/ the list of services to be provided in the scope of the CMI/VMI programs,
f/ the order of making amendments to the contract and its denunciation,
g/ the rights , obligations of the parties and other conditions set in the legislation of the Republic of Armenia.

The CMI model contract, order and conditions of its signing are established by the Government of the Republic of Armenia.
The medical insurance contract enters into force from the moment of the payment of the first premium unless otherwise stipulated by the contract.
In case of re-organization of the insuring organization during the action of the CMI contract, the contract duties are passed on to its successor. In case of the elimination the legislative procedure of the Republic of Armenia is being followed.
If the insuring is found incapacitated or of limited activities by the court during the action of VMI contract, the rights and duties set in the contract are carried out according to the Law "On Insurance" and other legal acts of the Republic of Armenia.

Article 35: The Medical Insurance Policy

The medical insurance policy is the document certifying the act of the contract conclusion
Each insured person gets medical insurance policy. The medical insurance policy is being kept with and considered the property of the insured person.
The medical insurance policy is active throughout the territory of the Republic of Armenia, as well as in those countries with which the Republic of Armenia has concluded contracts on the medical insurance of citizens.
The form and order of usage of the medical insurance policy issued in the CMI system is defined by the Government of the Republic of Armenia.

Article 36: The Rights of Citizens of the Republic of Armenia in the Medical Insurance System

The citizens of the Republic of Armenia are eligible to
a/ be engaged in the compulsory and voluntary medical insurance systems,
b/ select the medical insurance company in the system of voluntary health insurance,
c/ select the medical care provider,
d/ receive medical care in the scope of the insurance programs throughout the territory of the Republic of Armenia regardless of the place of permanent residency,

e/ receive information on his/her health, anticipated examinations, treatment procedures, selected mode of treatment and its effects, volumes of the services offered in the scope of CMI and VMI programs, the place and conditions of their provision from the medical care providing facility contracted with the CMI Fund of the Republic of Armenia or medical insurance company. Similar information on the disabled persons are entitled to get their close relatives and legal representatives,
f/ submit a law-suit to the insurer, the medical insurance company, CMI Fund of the Republic of Armenia, medical care provider for the reimbursement /material too/ of the damage caused by the above even if not stipulated by the medical insurance contract. The amount and order of reimbursement is defined by the legislation and other legal acts of the Republic of Armenia,
g/ be partially returned the premiums in the VMI system if stipulated by the contract.
The rights of the citizens in the medical insurance system are also protected by the public structures according to the procedure set in the legislation of the Republic of Armenia.

Article 37: Confidentiality (Secrecy) of Medical Data of the Insured Persons

Personal information on the insured persons is kept inaccessible. Familiarization with the data of the insured persons in special cases is regulated through the procedure established by the Government of the Republic of Armenia.

Article 38: Settlement of Disputes between the Subjects in the Compulsory Medical Insurance System and Discussion of Complaints

The procedure of settling of disputes between the subjects in the compulsory medical insurance system and discussing of complaints is developed and submitted for the approval of Government of the Republic of Armenia by the Compulsory Medical Insurance Fund of the Republic of Armenia.

Article 39: The Rights and Obligations of the Insuring

The insuring has the right to
a/ participate in all kinds of medical insurance
b/ select the insurance company acting in the system of VMI,
c/ carry out control of the implementation of conditions set in the medical insurance contract,
d/ be partially returned the insurance premiums in the VMI system if stipulated by the contract,
e/ decrease the insurance premium rates in case of stable level or reduction of morbidity /health/ of the workers of the organization in three years,
f/ attract additional funds from the profit of the facility to insure the workers in the VMI system.

The insuring is committed to
a/ conclude contract with the CMI Fund of the republic of Armenia or its regional divisions on entering the CMI system,

b/ pay insurance contributions according to this law and the procedure set in the CMI and VMI contracts,
c/ eliminate the impact of health damaging factors on the citizens in the limits of its authorities,
d/ provide information to the insurer on the health condition of the persons to be insured.

Article 40: Medical Insurance of the Citizens of the Republic of Armenia in Other Countries or Foreign Citizens or Persons with no Citizenship Living in the Territory of the Republic of Armenia

The medical insurance of the citizens of the Republic of Armenia in other countries is realized according to the legislation of that country and intergovernmental agreements between it and the Republic of Armenia.
The reimbursement of costs of medical care and services in the scope of CMI programs incurred by the citizens of the Republic of Armenia in other countries is done according to the procedure established by the Government of the Republic of Armenia.
The reimbursement of costs of medical care and services in the scope of VMI contract programs incurred by the citizens of the Republic of Armenia in other countries is done according to the procedure established by the contract signed between the insuring and medical insurance companies of the Republic of Armenia.
The foreign citizens and persons with no citizenship having obtained the right of permanent residency in the territory of the Republic of Armenia have equal rights and duties to use the medical insurance services for the citizens of the Republic of Armenia, unless otherwise stipulated by the international agreements of the Republic of Armenia.
The medical insurance of the foreign citizens and persons with no citizenship temporarily staying in the Republic of Armenia and without the right of permanent residency is implemented according to the order established by the Government of the Republic of Armenia.

Article 41: Entering into Force

This present law enters into force from the moment of its publication.

The List of Sub-legislative Documents to be Approved by the Decrees of the Government of the Republic of Armenia

Article 5. The Compulsory Medical Insurance Fund

The Compulsory Medical Insurance is established and its structure and charter are approved by the Government of the Republic of Armenia.

Article 6. The Founder Board of the Compulsory Medical Insurance Fund

The establishment, rights and responsibilities of the Founder Board are set by charter approved by the Government of the Republic of Armenia.

Article 8. The Sources of Formation of the Compulsory Medical Insurance Fund Budget

The charter of the Compulsory Medical Insurance Fund of the Republic of Armenia, procedure of the funds collection and main directions of their spending are approved by the Government of the Republic of Armenia.
The financial-credit activities of the Compulsory Medical Insurance Fund of the Republic of Armenia is exempt from taxes.

Article 9. The Budget of the Compulsory Medical Insurance Fund

The budget of the Compulsory Medical Insurance Fund and the annual reports on its realization are approved by the Government of the Republic of Armenia.
The budget and the report on its realization is announced according to the procedure established by the Government of the Republic of Armenia.
The procedure of development and realization of the budget of the Compulsory Medical Insurance Fund and its transactions are established by the Government of the Republic of Armenia.

Article 10: The rights and duties of the Compulsory Medical Insurance Fund

The Compulsory Medical Insurance Fund of the Republic of Armenia has the rights to:
a/ selectively contract the medical care & services providers. The procedure of selection and contracting of the medical care providers is established by the Government of the Republic of Armenia,

Other rights and duties of the Compulsory Medical Insurance Fund are established by the Government of the Republic of Armenia.

Article 11: The Basic Program of the Compulsory Medical Insurance and the Population Coverage

The basic program of the compulsory medical insurance and the population coverage is established by the law "On Compulsory Medical Insurance Annual Program" of the Republic of Armenia.

CHAPTER 3. THE COMPULSORY MEDICAL INSURANCE PREMIUMS

Article 12: The Concept of the Compulsory Medical Insurance Premiums and the Performers

The rate of the CMI contributions is annually set by the Government and approved by the Parliament of the Republic of Armenia.

Article 27: The Contract on the Provision of Medical Care in the System of Medical Insurance

The model contract on the provision of medical care in the CMI system, the order and conditions of its signing is developed by the Ministry of Health, Compulsory Medical Insurance Fund of the Republic of Armenia together with representatives of medical care providers and is approved by the Government of the Republic of Armenia.

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The prices of the basic program of the compulsory medical insurance system of the Republic of Armenia are set by the law "On the Annual Program of Compulsory Medical Insurance" of the Republic of Armenia.
The prices of the medical care provided to the insured by the medical care provider in the scope of the CMI programs, being a component of the CMI programs are established by the Ministry of Health, CMI Fund of the Republic of Armenia and medical professional associations and approved by the Government of the Republic of Armenia.
The indexing of prices of medical care provided in the scope of the CMI programs to the insured is performed according to the procedure and conditions established by the Government of the Republic of Armenia.

Article 30: The Right of the Insurer to Refuse Reimbursement of Medical Care

The order of refusal of medical care reimbursement by the insurer in the CMI system is established by the Government of the Republic of Armenia.

Article 35: The Medical Insurance Policy

The form and order of usage of the medical insurance policy issued in the CMI system is defined by the Government of the Republic of Armenia.

Article 37: Confidentiality (Secrecy) of Medical Data of the Insured Persons

Familiarization with the data of the insured persons in special cases is regulated through the procedure established by the Government of the Republic of Armenia.

Article 38: Settlement of Disputes between the Subjects in the Compulsory Medical Insurance System and Discussion of Complaints

The procedure of settling of disputes between the subjects in the compulsory medical insurance system and discussing of complaints is developed and submitted for the approval of Government of the Republic of Armenia by the Compulsory Medical Insurance Fund of the Republic of Armenia.

Appendix B Draft Medical Insurance Concept (Version September 2000) Prepared by the Working Group on Health Insurance Development

DRAFT, unofficial translation, version September 2000

THE MINISTRY OF HEALTH OF THE REPUBLIC OF ARMENIA

THE STATE HEALTH AGENCY ATTACHED TO THE GOVERNMENT OF THE REPUBLIC OF ARMENIA

CONCEPT
of Introduction of Health Insurance in the Republic of Armenia

Yerevan-2000

CONTENTS

1. Basic Problems of the Health Care System and the Present Situation of the Field of the Health Care Financing

The reforms of the health care system in Armenia started some time after the break up of Soviet Union and gaining of independence in 1992-1993. The economic crisis of that years aggravated the problems caused by the centralized planning of the health care system. In 1993-1998 several measures were undertaken towards structural, managerial and financial reforming of the health care system, which led to only partial improvements but to unexpected results in some cases. For example the changing of the status of medical facilities /to economically independent state enterprises and to state closed joint-stock companies afterwards/ and the new administrative-territorial division of the republic resulted in substantial weakening of the mechanisms of quality control and management of the health care system. A major split between different levels /republican, regional, rural/ of health care has been created. Accessibility of services has become a most serious problem mainly for the socially vulnerable groups of population, having resulted in increase of morbidity and decrease of timely referrals for medical care. The present system of free medical care / state order/ is mainly declarative and not trusted by the population and health care workers. There is not enough emphasize on the priority of primary /out-patient-polyclinic/ medical care. There is excess of number of beds which do not conform to the real requirements and possibilities of the system. There is also accumulation of problems and issues in need of strategic clarification.

The health care financing is in quite difficult situation. With the background of debts created in 1997-1998, the budget under-financing of chronic character continued in 1999. Proceeding on the present social-economic situation it's also clear that an essential increase in the budget financing of the health care can not be expected in near future. An important source of the payment in the health care system continue to be direct expenditures by the population for the medical care. The investigations done with the World bank support show that the real financial flows to the hospital sector /including direct expends by the population to pay for drugs, food, medical personnel services, etc./ 3,5-4 times exceed the funds allocated from state budget. It was expected that the above situation could be avoided through introduction of the system of officially paid medical care and services from 1997, which resulted in other things. The proportion of the funds generated from the officially paid medical care and services was estimated as only 10-12% of the total income of the medical facilities, whereas the shortness of state funds and introduction of paid services created serious psychological barriers for majority of population in seeking medical care. However with all its drawbacks the introduction of paid services should be considered as one of the important phases of the health care financing reform, which experience is essential for taking strategic decisions in future.

Thus the results of the reform process initiated in the health care system do not meet the main objectives of the health care policy- they did not contribute to the decrease of morbidity levels of population, increase of accessibility of the medical care, ensuring transparency, improvement of the activities of health care providing facilities. Some of the contributing factors to the actual situation are the following:

- the rate and deepness of the economic changes in the health care system /in particular structural changes, including privatization of the state inventory/ falls behind those in the whole economy,
- the knowledge and skills of the medical providers to manage under new economic conditions are unsatisfactory,
- the inferiority and non-transparency of the state guarantied free medical care and services provision mechanisms. Under conditions of incomplete financing of the above programs it was necessary and expedient to parallel implement some health care programs through compulsory health insurance system, which would allow to provide medical care and services to a big number of insolvent population not included in the national health target programs.
- Disparities between the actual network of the medical care providers, existing capacities, volumes and quality of the provided medical care and the needs and financial feasibility of separate regions and the republic as a whole. The under-financed medical care providers have no possibility to provide for appropriate volumes and quality of medical care, apply modern technologies, equipment, pharmaceuticals and medical devices.

Proceeding on the created situation the taking of practical steps towards the health insurance introduction becomes an actual problem. During the last years several discussions have taken place , different documents and often mutually exclusive approaches have been elaborated. In 1999 three documents were submitted to the Government by the Ministry of Health of the Republic of Armenia. These were "Conceptual approaches of the Ministry of Health to the compulsory health insurance introduction in the Republic of Armenia", "The introduction model of the compulsory health Insurance in Armenia" and "Proposal on introduction of compulsory health insurance in Armenia" as well as "Conceptual approaches to the introduction of health insurance" by the State Health Agency. At the same time, during the last months of 1999 the Parliament and Government considered and approved the document prepared by the MOH "Strategy of the health care system development in Armenia for the years 200-2003", which contents some principally new approaches related to the above issue. This present Concept in broad outline joined the suggestions made in the above-mentioned documents with the purpose of definition of legislative, financial and organizational approaches and mechanisms to be applied towards the health insurance introduction.

2. Main Principles of the Health Insurance System

The elaboration of this concept is based on the main values of the WHO policy "Health for all for the 21st century"- health as an important aspect of human rights; equity in health and its protection; each individual, family, local community, organization and sphere as active partners in designing and implementing health development strategies as well as the WHO fundamental principles of equity, solidarity, accessibility and quality control.

The problem of the health insurance is one of the important elements of the health care system development and reform process, here it should not be considered solely as a means of attraction of additional funds into the health care system, but as a major step of national importance to-

wards making the health care most accessible for population. From this standpoint the introduction of the health insurance is closely connected both with general trends of the country's social-economic development and the process of reforms in the field of health care.
The problem of the health insurance is considered in the context of the social insurance policy.
The development and introduction of a functional health insurance system shall allow to:

- create a system of financing of medical services based on the principle of social solidarity, where the "healthy pays for the sick, the rich for the poor, the young for the old and the working for the unemployed",
- through civilized measures gradually make legal and manageable the today's "shade" medical expenditures directly paid by population for their more efficient usage,
- overcome the deepening psychological barrier at population connected with the need to pay for the medical care at the moment of the illness treatment,
- increase the level of protection of citizens from unpredictable cases of diseases, at the same time making the payments for medical care predictable, soft and individual, which creates a perfectly new quality of public consciousness in terms of financial duties and psychology.
- collect additional funds for the health care system.

It is important to note that the introduction of health insurance should be a major but not the only direction of the health care financing reform. Starting from the year 2000 certain steps will be taken for complete and real provision of state guarantied medical services. Also approaches towards regulation of the paid medical care are being elaborated.
It is crucial that in the initial stage of the introduction of health insurance system the present state budget allocations to the health care will principally remain the same. In other words the obligations of the state in the health care area should not diminish right after the introduction of health insurance / which may lead to social shocks too/, but be kept at the same level for a while thereby letting for the health insurance system to establish and function efficiently. Along with the health insurance introduction the state should continue to cover the primary health care and hospital care priorities as defined by the annual state health target programs according to the country's legislation. This will allow to fluently replace a part of the above state budget covered programs with health insurance programs while gradually increasing the total amount of the state guarantied health funds.
Proceeding on the above-said and considering the currently planned improvements in the primary health care level / towards family medicine introduction as well/, the anticipated gradual increase of budget funds allocations to that field in the coming years, it is suggested to introduce the health insurance initially for covering a part of hospital services whereas the whole primary healthcare system /including the ambulatory-polyclinic level/ will continue to be financed by the mechanisms presently in place. So and thus the insurance /compulsory and voluntary/ shall be directed mainly to the hospital, while the budget -to primary care services which mostly conforms to the international practice and the essences of insurance and budget.

3. Introduction of the Health Insurance

Taking into consideration the present social-economic situation of Armenia and the broad range of problems connected with the introduction of health insurance it is suggested to start it from the year 2001 after adoption of the law "On the Health Insurance of the Republic of Armenia".
The introduction of compulsory health insurance system entails a number of serious problems of political, economic and organizational character. In particular
it is obvious that the compulsory health insurance premiums will be an additional social tax for managing subjects and the domestic manpower may become more expensive. Realizing the importance of the related economic problems /goods and services may go up in prices, etc./ nevertheless we think that in this case the priority should be given to the need of making worth its full value the role of the state in the health protection of population. Such an approach issues directly from the basic Constitutional statute on the Republic of Armenia being a social state.
The introduction of compulsory medical insurance starting from the year 2001 will allow to collect additional funds for the provision of hospital care and reorient the state budget health expenditures more and more towards the primary health care /family medicine/ and ambulatory-polyclinic system. It is expected that a comparatively long time will be needed to involve the majority of population in the compulsory health insurance system the process will be implemented gradually. Such a prediction is based on the social-economic situation of Armenia and trends of development as well as on the analysis of experience of other countries, which shows that even after legalization of compulsory health insurance principles its introduction process takes time and is associated with certain difficulties.
At the same time it is necessary to encourage the development of voluntary insurance in the coming years, which will contribute to and reinforce the public awareness of the need of medical insurance.
We forecast that in case of encouraging and support of voluntary health insurance by the state the health insurance coverage will be about 5-7 % in the years 2000-2001 and about 20% by the 2005. These calculations are based on the situation which is anticipated after the new national hospital care policy implementation in the year 2000. The persons covered by voluntary health insurance may receive guarantied medical care in hospitals with mixed financing, which will slowly alleviate their maintenance burden on the budget, as well as stimulate development of paid services.
Thus the objective of the suggested approaches to health insurance introduction may be formulated as follows:
Without increasing the burden on the state budget and avoiding sharp increase in tax burdens on the managing subjects /economic management/ step by step introduction of a system addressed to the social protection, to cover significant number of population, allowing to substantially increase the accessibility of the most expensive health care level /the hospital care/ for the covered members and direct additional funds into the health care area.

4. Pre-conditions and Financial-Organizational Bases for the Introduction of Compulsory Health Insurance

The scope of problems related to the introduction of compulsory health insurance /CHI/ may be tentatively divided into 5 main groups:

1. Pre-conditions for the introduction of compulsory health insurance
2. Rates and mechanisms of collection of insurance contributions
3. Financial stability of the compulsory health insurance system
4. The compulsory health insurance basic program and mechanisms of premium calculation
5. Structures implementing health insurance

4.1. Pre-conditions for the introduction of compulsory health insurance

The introduction of CHI is a national problem of political and economic importance. In this sense a number of pre-conditions are necessary for it.
The first and important pre-condition is the taking of political decision about the introduction of CHI as the only realistic mechanism for future to provide accessible, transparent and quality medical care to each individual. In favor of such a decision speaks the chapter 1, where the factors influencing the results of the health care reform are stated.
The second important pre-condition is the optimization of the health care system. It is well-known that the present health system infrastructure /human, material and capital resources/ is excessively blown up, expensive and essentially surpasses the demand in medical care including that of the state guarantied programs. There are 181 hospitals in the country with 24470 beds. Their average occupancy rate is 40%, in some regions /marzes/ reaching only 10-15%. As a result, the state budget funds allocated /partially/ to the hospital programs are not being spent for the provision of quality care but to maintain the whole system. Here the funds are used to somehow cover the current costs of the medical providers and naturally are not enough for the improvement of technical and technological equipment and increasing the salaries of medical personnel. Additional investments in the health care system /which the health insurance provides for/ will not bring to the increase of efficiency. On the contrary, the additional funds will continue to be spent on the maintenance of huge, inefficient structures and the insured person /the patient/ will gain nothing. Therefore it is absolutely necessary to implement the following measures towards optimization of medical facilities in the beginning of CHI introduction:

- reduce the medical care and services providing facilities, especially the number of beds and personnel according to the expected demand and actual volumes of the medical care and services,
- speed up the process of privatization of medical facilities /mainly hospitals, health centres/, while preserving their profile and doing proper investments for some cases.

In parallel with the health system optimization before the introduction of CHI it is necessary to revise the Basic Benefits Package /especially the list of emergency medical care/ in the scope of the state guarantied free medical care and services in order to make substantial and realistic

reductions. Such a measure shall guarantee the success of CHI system, as the medical services to be provided against the insurance of individuals should be more transparent and compulsory by the law.
The financing of the national health care programs by the state should be divided into two parts: first- the programs of national priority to be covered completely by the state budget and second- the programs to be covered partially by the budget funds and co-payments /differentiated system of co-payments may be established/ of population. The introduction of the co-payment system will permit every citizen to share the responsibility in health protection. Such a measure could make it possible to overcome "shade" payments and legalize them on one hand, on the other - bring to the conviction that payment for the illness treatment is inevitable and it's more efficient and expedient if done through the CHI system.
The next important pre-condition is the definition of an optimum basis health insurance program in accordance with the social-economic situation of the country and acceptable rates of insurance premiums. Correct solutions to these problems predetermine provision of affordable, quality and sufficient volumes of medical care in the limits of the CHI system, its perspectives of future development. The above issues are more detailed in subsections 4.2, 4.3 and 4.4..
The training of the CHI system personnel as well as preparation and development of a system for individual registration are essential to ensure accessibility and transparency of medical care in the CHI system . Even though the resources and possibilities of already existing structures will be used the above measures require substantial funds before starting its introduction. Here we seek the involvement of international organizations/donor countries.

4.2 Rates and Mechanisms of Collection of Insurance Contributions

Taking into consideration the unemployment resulting from the present social-economic situation of the country, big proportion of "shade" economy and related problems, the mechanism of covering different population groups by CHI system is of principal importance.
In this sense the population may be divided into the following groups:

1. Hired workers, officially engaged in economy, including state servants and workers of the budget sphere
2. Individual businessmen and persons engaged in the field of agriculture
3. Children up to 18 years old
4. Retirees and socially vulnerable groups
5. Students
6. Officially registered unemployed

For each of the above 6 groups there should be a differentiated approach to insurance coverage and collection of contributions stated below:

1. The officially working population will be the basis of the CHI system, as main parts of the CHI funds will be collected here. The classic approaches of the CHI shall be applied to this group, which are individual registration system by work place, centralized calculation of

premiums and payment by the employer, etc.. The premium rate defined by the law is to be divided between the employer and employee in a correlation of 2/3 – 1/3 accordingly.

2. The coverage of individual businessmen in CHI system should be controlled by the appropriate state structures. The insurance premiums will be calculated from the declared income based on the rate stipulated by the law. For the persons involved in agriculture the approaches will be basically the same, with the difference that a basis for premium calculation will be the amount of cadastral net income of the land
3. Up to 18 years old children are covered by the CHI system at the expense of state budget funds in the minimum premium rate
4. The retirees and socially vulnerable groups are covered by the CHI system at the expense of state budget funds in the minimum premium rate
5. To students a differentiated approach should be applied as far as state order and paid courses. For the first category the insurer may be the state with corresponding premiums and for the second the premiums may be added to the tuition fee and be collected simultaneously. For the both categories minimum rate of premium should be applied.
6. The officially registered unemployed are also covered by the CHI system at the expense of state budget funds in the minimum premium rate.

It should be noted that there is a group of citizens who's work or unemployment are not officially registered. This group includes the persons engaged in "shade" economy, as well as the citizens having other sources of income and not imposed of taxes. Covering this group by the CHI system is a actual problem as it has a big proportion in Armenia. The mechanism of fixed premiums /proceeding on the annual volumes of the CHI basic program/ may be considered for this group. It is expedient to work out mechanisms to indirectly motivate the unofficially working citizens to be taken in the CHI system. With this regard the Government should define clear mechanisms, like the CHI membership must be considered compulsory to be able to perform civil-legal transactions requiring state registration.

4.3 Financial stability of the Compulsory Health Insurance system

To guarantee the financial stability of the CHI system it is necessary to ensure the timely, complete and constant collection of contributions as well as financially substantiate the volumes and types of the medical care programs in the scope of CHI.
The guaranties and control mechanisms of the collection of premiums will be dfined by the law and other legislative documents. That mechanism will be principally different from that of tax and other fees collection. The CHI has an addressed system with individual registration of each insured person, meaning that in case if the premiums are not paid properly the system provides for the possibility to cease the action of insurance temporarily, till the complete payment of premiums along with the fines accumulated during that time-period.
As to the financial substantiation of the insurance health programs which will be the basis of definition of the premium rate with its minimum and maximum limits, it proceeds on the available health statistics and average estimated prices of hospital care. For example according to the

statistic data of 1996-1998 annual number of people applied for hospital care in Armenia was 7-8 of 100 of population /the same indicator was 15-16 in 1985-1986/. The indicator decreased mainly because of the social hardships and it is anticipated that with introduction of health insurance, in other words with elimination of financial obstacles and establishing accessible and functional primary care system the above indicator will increase to 10% of population that will apply or be referred for hospital treatment. Thus the likelihood of the insurance summary risk is estimated as 10% in average.
The cost of one hospital case reimbursed by the state has been about 65 000 Drams during the last years, which is three times less than the real price /as mentioned above the difference is covered by direct expends of population as well as partially by humanitarian aid and other sources/. The calculations are based on 200 000 Drams- the average real cost of a hospital treatment case.
Here taking into consideration the 10% of insurance summary risk average probability, to insure from all the probable hospital cases, 20 000 drams must be collected annually from each insured person, or the average monthly premium must be 1700 Drams. To collect this premium from the income a 9% rate must be considered.
Proceeding on the present social-economic condition of the country it is advised to apply the above rate not in the first year of CHI introduction, but further on, when the stable growth of economy is achieved, function mechanisms of the system are in place, the insurance structures have the necessary expertise and the system accepted by the public.
Therefore to ensure financial stability of the CHI system it is recommended to apply 3% of premium rates in the first years to provide for full implementation of the basic program of the year. In this process, the initial program can not cover the all hospital care, but only a part of it, where the collected contributions will suffice for efficient performance.

4.4 The Compulsory Health Insurance Basic Program and Mechanisms of Premium Calculation

Taking into consideration the social-economic situation of Armenia and with the notion not to increase significantly the tax burden on the employers a step by step introduction of the CHI system is recommended. Here it is envisioned that the authority of the Government to yearly approve the CHI basic program will be stipulated by the law.
In the year 2001 - the initial year of the introduction of CHI system it is recommended to include in the CHI basic program the types of medical care and services involving major and common risk factors. For example emergency care, ambulance services. In doing so it is advisable to start with a relatively small program, which includes the emergency care partially /for example, cardiovascular, respiratory, gastrointestinal diseases/ or just ambulance services. This will allow to apply low rates of insurance premiums in the beginning.
Further on it is possible that the Government will take a decision on the expansion of the CHI basic program, which entails corresponding changes of the premium rate.
The problem of the calculation base of insurance premiums and the related questions of their rate and collection mechanisms are very important in the process of introduction of CHI system. It will be closely linked to the approved basic CHI program of that year. It is suggested to apply

approaches similar to the calculation and collection of social insurance fees. Based on the classification of the population groups in the chapter 4.2 we anticipate to apply the following mechanisms of premiums' calculation.

1. for the officially employed hired workers the rate of 3% of salary fund in the first years of CHI system introduction will be applied with setting a ceiling /as a preliminary option maximum 5000 Drams per worker per month/. It is suggested that 2/3 of this amount is paid by the employer and 1/3 by the employee. The calculation and transfer of contributions is done in centralized order by employers. After the adoption of the law the Government will define the order of calculation, collection of the CHI contributions and the system of sanctions.
2. For individual businessmen and persons engaged in agriculture two options are applicable: a/ fixed amount of premiums, which order of calculation and collection is defined by the Government, b/ for the individual businessmen a rate of 3% of the declared income will be applied as insurance deductions-minimum 150Drams and maximum 5000 Drams monthly and the agricultural area workers will be charged 3% of the cadastre net income, minimum 150 Drams per month per person / or per farm/
3. For up to 18 years old children the premiums will be paid from the state budget in the minimum amount of 150 Drams.
4. For the retirees and socially vulnerable groups the premiums are suggested to be paid from the state budget in the minimum amount of 150 Drams. Such an approach will emphasize the social orientation of the CHI system reflecting the social solidarity between the working part and indigent group of population
5. Differentiated approach to the students-for the state order students the insurance premiums will be paid from the state budget in the minimum amount of 150 Drams and for the paying ones- the premiums in minimum amount of 150 Drams will be added to the tuition.
6. For the officially registered unemployed the premiums will be paid from the state budget in the minimum amount of 150 Drams.

The minimum size of the insurance premiums is calculated as 3% of the minimum monthly salary. In future depending on the changes of the size of the minimum monthly salary the minimum of insurance premiums will be changed respectively.
In future it is anticipated to gradually expand the basic program which will require increase of insurance premiums, its minimum and maximum limits.

4.5 The Compulsory Health Insurance Implementing Structure

The compulsory health insurance will be implemented by the corresponding body authorized for that purpose by the Government of the Republic of Armenia.

5. Legislative Regulation of the Compulsory Health Insurance

The steps towards the introduction of health insurance should have proper legislative foundation. It should be noted that the presently active "Law on Insurance" provides for necessary /but not

satisfactory/ conditions to implement voluntary forms of insurance, nevertheless there should be developed a complete legislative package on health insurance which will be regulating legal relations of that area /both compulsory and voluntary types/. With this purpose it is suggested to submit to the Parliament the draft "Law on Health Insurance" by September 1, 2000 for consideration.

It should regulate the following issues.

- Clearly specify the notions of voluntary and compulsory health insurance, define the main concepts to be used in the field of health insurance.
- Define specific mechanisms to develop and encourage the voluntary health insurance / if necessary through amendments in the relevant laws of the taxation field/.
- Define the main subjects of the voluntary and compulsory health insurance, their rights and obligations.
- Regulate mechanisms of involvement of different population groups /citizens occupied in the field of economy, including workers in the field of agriculture, businessmen, hired workers, etc, state servants, retirees, under legal age children, students, officially registered unemployed, etc/.
- Regulate the procedure of confirming the programs and volumes of medical care to be reimbursed by the compulsory health insurance funds, etc.

The draft law will also contain the legislative bases to define the rates of insurance premiums, mechanisms of their calculation and collection.

The suggested policy of the compulsory health insurance implementation presumes revision of the statute of the Civil Code according to which " citizen's duty to insure his/her life and health may not be stipulated by the law" /article 991, paragraph 2/. The above provision impedes the introduction of the internationally accepted mechanism of compulsory health insurance according to which a part /usually a half or 2/3/ of the total rate of insurance contribution is paid by the employer and the remainder by the employee. As mentioned above a similar approach is suggested to apply in Armenia too.

It is important to achieve the adoption of the above legislative package /including the proposed amendments in the tax legislation/ not later than the third quarter of the 2000. It will allow to take the necessary steps towards the development of the voluntary health insurance, as well as preparation to introduce compulsory health insurance. It is necessary to emphasize that the latter process in particular will require joint, systemized efforts of state administrative bodies of all levels for the foundation of a principally new system of social and economic relations countrywide is planned in a rather limited time-period.

6. Basic problems of the Voluntary Health Insurance Development

The legislation now in force in Armenia has some "necessary but not satisfactory" provisions for implementing voluntary health insurance. For example the "Law on insurance" stipulates the main organizational-legal norms of insurance activities, the subjects acting in that field, their rights and duties. All the above norms are extended on to the voluntary health insurance companies as well, which number is very limited /only 20% of about twenty officially registered and

licensed insurance companies of the republic are engaged in voluntary health insurance/. The above fact is explained by a number of hindering factors, the main of which are as follows:

- the majority of population being well aware of the present situation of cost reimbursement of the medical facilities predominantly through unofficial payments does not trust the idea of insured medical care. There is no conviction that without additional payments it is possible to receive complete treatment,
- the active tax-legislation /especially the "Law on Income Tax"/ has provisions which do not arouse the interest of juridical persons to insure the health of their workers /see detailed below/,
- the majority of population is insolvent and prefers to spend money on every-day needs rather then insure themselves of possible risks in future, also because they have a poor notion about the meaning and advantages of health insurance.

Proceeding on the above it is necessary to implement complex measures towards voluntary health insurance stimulation and development. Among these an important place should be given to the improvement of tax legislation to eliminate the present obstacles for all the insurance subjects. In particular, the provision of the "Law on Income Tax" stipulating that the part of insurance contributions made by juridical persons for physical persons be included in the gross income of physical persons (article 6, chapter 2, subparagraph jd/) should be changed. The provision of the "Law on Profit tax" stipulating that insurance contributions are included in the enterprise expenditures should be stated more clearly with the following words added " including the premiums for life and health insurance of physical persons".
It is suggested to define some tax privileges for the voluntary health insurance companies too, and exempt from the profit tax in the amount to be allocated to the financing of additional medical and preventive measures for the insured persons.
It is also important to create proper mechanisms to interest the medical facilities to work with insurance companies, that is to say make the provision of medical care to the insured persons more profitable for the medical personnel and medical facilities. With this purpose it is suggested to exempt from income tax the salary of the medical personnel generated from the contributions of insurance companies and for the profit tax of medical facility apply the same privilege as that suggested for insurance companies.
Along with the above measures it is necessary to develop and implement a broad propaganda campaign to inform the public about the significance and advantages of health insurance with possible cooperation and support of various international organizations /USAID, UNDP, World, Bank, etc/. It should include dissemination of published materials /books, handouts, articles/ , electronic information, training courses for the stakeholders in the insurance field. The organization and implementation of the above campaign requires active involvement of different ministries, governmental and non-governmental organizations, for which reason it is expedient to create an inter-sector commission to systemize different measures in that field by the Resolution of Government of the Republic of Armenia.

Main differences between the Compulsory and Voluntary Health Insurance

	Compulsory Health Insurance	Voluntary Health Insurance
1.	Non-commercial	Commercial
2.	Is a form of social insurance	Is a form of private insurance
3.	Universal or mass	Individual or group
4.	Regulated by the Civil Code, the "Law on Health Insurance of Population" of the Republic of Armenia	Regulated by the Civil Code, the "Law on Insurance", the "Law on Health Insurance of Population" of the Republic of Armenia
5.	Implemented by the state	Implemented by insurance companies of different property types
6.	The statutes of insurance are defined by the state	The statutes of insurance are defined by the insurance companies
7.	The insured members- the state and employees	The insured members- the juridical and physical persons
8.	The sources of funds- state budget, contributions by employers and employees	The sources of funds- personal income of the citizens and profit of employers
9.	Program (the minimum needed /satisfactory/ from the state) is defined by the government bodies	Program is defined by the contract between the insurer and insured
10.	Rates of premiums are defined by generally established method	Rates of premiums are defined by the contract between the insurer and insured
11.	The Quality Control system is defined by the state bodies	The Quality Control system is defined by the contract between insurance subjects
12.	The income may be used only for the main activity-health insurance	The income may be used for any commercial and non-commercial purposes

Appendix C Legal Review of the First Draft "Law on Health Insurance" (Version June 2000) Prepared by Andre den Exter (June 2000)

Legal review of the draft Law on Health Insurance (Andre den Exter, June 2000)

1. Introduction

Armenia is switching its society to a more market driven system. Where health care is concerned, the current government is planning to introduce a social health insurance system. Therefore, a newly established health insurance fund will be authorised to contract with (privatised) health care institutions and individual providers. The underlying idea is a partially withdrawal by the state from both the financing and provision of health care.
From a legal perspective, the emerging purchaser-provider split requires major changes of the current legal framework. One of the main challenges is to draft a health insurance law that regulates the intended reforms. The project on 'Health Fund Development in Armenia' is focussed on supporting the Armenian government with the introduction of a new health insurance scheme and subsequent legislation. Therefore, the objective of this mission was: (i) a legal assessment of the current draft law on health insurance (ii) to identify missing elements, respectively major legal obstacles, and (iii) to propose recommendations to the Armenian Ministry of Health to solve these problems.
The following set of observations of the key elements of the health insurance scheme represents an evaluation of the proposed draft law on health insurance[2] in the light of the suggested early recommendations by TNO (hereafter, the TNO Notes)[3]. A conclusion section summarises the major findings.

2. Constitutional base Health Insurance Law

The legal base for the draft Law on Health Insurance is the constitutional right to health care, reading "Everyone has the right to maintain his health. The system for medical assistance and services is stipulated by law. The state executes programs for the preservation of the health of the population .." (Article 34 of the Armenian Constitution). As such, the future Health Insurance Act, in combination with the Health Care Facilities Act reflect the main legislative instruments implementing this constitutional right.

In the near future this Constitutional right is particularly relevant in case the Armenian government considers the introduction of patients' own payments. Experiences from other transition countries (e.g., Hungary, Czech Republic and Poland) show that Constitutional Courts have critised the government introducing own-payments which had no legal base in the Health Insurance Act itself. For

[2] English translation June 2000

[3] TNO, S. Heijnen, June 19th, 2000 Yerevan.

instance in 1996, the Czech Constitutional Court considered a Ministerial Decree - introducing patients co-payments - as unconstitutional since it had no legal base it the Health Insurance Act. Patients' co-payments mean a limitation of the insured's (financial) access to health care and according to the Czech Constitution such a measure requires an explicit legal base in the Health Insurance Act. Consequently, the Czech government had to repair this deficit in order to prevent its planned reform policy from being annuled by the Court. Such a situation could be prevented in Armenia by critical consideration of (i) the legal base of the Health Insurance Act, and (ii) future patients' own payments. More concrete, in case the legislature considers own payments for services covered by the compulsory health insurance scheme, the legislature should define the principle of patients' own payments in the Health Insurance Law and simultaneously delegate the competence of levying own payments to the government or Minister of Health.

3. Legal status of the Health Insurance Fund

Interpreting article 5, the Health Insurance Fund (HIF) is a public organisation with certain financial independency, that is, apart from budget approval (art. 8) not legally subject to the control and subordination of any ministry. The HIF is separate from the State Health Agency and established by law (Health insurance Law). Moreover, the HIF has also some managerial and administrative autonomy (e.g., monitoring health care transactions, contracting providers).

Recommendation 1. To clarify the legal and institutional setting of the HIF it is recommended to define the legal status of the HIF by law. For instance, the following additional statements could be added to article 5 on compulsory health insurance.

'The HIF is a legal person, that is, a subject of rights and obligations on its own. The HIF is established by the Health Insurance Law, seperate from the State Health Agency (SHA) with a seperate account within the SHA and a seperate basic benefit package (BBP) from the state order programmes. Mixture of funds or covered services between the BBP and SHA programmes are not allowed. Furthermore, a Charter - based on the draft Law - will define the structure, role and responsibilities of the national and regional offices implementing the health insurance law and will be approved by the Government of the Republic of Armenia.'

4. The insured persons.

Under the draft law, the insured persons are not explicitly defined (Article 2). According to the TNO concept document, the target group of insured and co-insured include: (i) employees and their first degree relatives, (ii) other population groups (e.g., self-employed, farmers, pensioners, students, unemployed). In the

initial stage, only employees and their first degree relatives are included in order to prevent the fund from serious financial-economic problems. From a legal perspective such a selection of beneficiaries might cause a problem in view of the equality principle. However, this can be legitimised by an explicit referral of a transitory period.

Recommendation 2. The draft Law should specify all the insured groups. Simultaneously, an additional provision should be included in the act reading, for instance,
'for a transitory period of -- years, other groups then the employed and their relatives are excluded from the insured'.
Preferably, this provision should be added in Chapter Two, defining the basic elements of compulsory insurance.

Recommendation 3. It is recommended to specify the temporary period in the act since an unspecified term may cause legal uncertainty among potential insured persons. Particularly when there are differences in entitled benefits between group (1) and (2), the judiciary will take into consideration the length of the temporary period. Any inequality due to such a temporary period will only be legitimised for a strictly defined period. Moreover, it will be likely that a temporary period of, for instance 20 years will be considered as unacceptable, whereas a period between 3 and 5 years seems to be more acceptable as a temporary period.

5. Registration of the insured

Despite the statutory nature of the scheme, to obtain benefits individuals must register with the HIF. This does not imply entering into an insurance contract, since insurance cover follow from the legislation itself; rather it is an administrative procedure which must be gone through if effect is to be given to the individual's statutory rights and obligations. Once an individual is registered the health insurance fund issues a certificate of registration for use as proof of entitlement to services (art. 33). Provisional certificates may be issued where the fund considers the individual's status to require further investigation.

Recommendation 4. In Chapter Two on Compulsory Health Insurance a provision on registration should be added in order to obtain benefits.

Moreover, where a change of circumstances means that an individual is no longer entitled to insurance or joint cover, s/he must inform the HIF directly. If this is not done, and the individual remains improperly registered as insured or jointly insured, the HIF has the right when this becomes known to terminate registration and require compensation for the period of improper registration.

This includes compensation for fees paid to individual practitioners, for administrative costs and for the risks born by the HIF.

Recommendation 5. Besides registration, an additional provision on change of circumstances should also be included.

6. Basic benefit package (BBP) or core health care entitlements.
A rather controversial issue is the 'basic benefit package' (BBP) or core health care entitlements to be covered by health insurance.[4] It is understandable that a newly developing social health insurance scheme may want to limit the medical care benefits in an initial stage. The problem with this approach comes from the weak financial base to cover all the available health care facilities and services. In Armenia, the dynamics of change in medical science is not the real problem although rigidity in defining a core package may ultimately lead to patients using the conventional measure in the health insurance system, and seeking the 'new, scientific and more sophisticated' measure in the private medical care system. Rather, the real issue in Armenia is the creation of a list of *essential* needs of health care explicitly defined within the compulsory health insurance scheme. The TNO concept document identifies 'cost-effectiveness' and 'medical necessity' as basic criteria for the subsequent definition of medical services as 'core health care entitlements'. If accepted by the Armenian government, the outcomes of these criteria should be stipulated in the draft law.

Recommendation 6. It is highly recommended that the legislature defines the three selected health benefits (primary health care diagnostic and therapeutic services in the community; specialist out-patient diagnostic and therapeutic services in polyclinics and out-patient hospital departments, and ambulance services) in the draft Law, preferably in Chapter Two on compulsory health insurance. In that case, the statutory base for receiving medical care to which the insured are entitled to will be provided by the Health Insurance Act. The details (what kind of primary health care, out-patient and ambulance services, etc.) should be set out in a derived Decree, e.g. the 'Health Insurance Treatment and Services Decree'. The advantage of this approach is that it enables the government to review periodically which medical services should be included, respectively excluded within the compulsory health insurance scheme.

Since the entitlements will be stipulated in the act and derived decree, the insured can claim these services from the health care provider, reimbursed by the fund. To obtain medical services individuals must apply to a practitioner with whom, the HIF has concluded a contract and who are therefore defined as asso-

[4] TNO Notes, p. 5.

ciated with it. They are free to choose whichever practitioner they wish from among this group (art. 34).

Apart from the contract condition, it is also likely that in certain circumstances the HIF may authorise treatment by a practitioner with whom, or institution with which, it does not have a contract. Secondly, in special cases the draft law may allow for reimbursement of the costs of medical care obtained other than by prescribed procedure, whether in Armenia or abroad. This could for instance be the case when the entitled services are not present.
Recommendation 7. If agreed, it is recommended to include both options in the draft law, e.g. under article 9 'the rights and duties of the HIF'.

7. Price list of covered services (Health Care Tariff Act).
Fixed tariffs based on a 'Health Care tariffs Act' are an essential part of cost containment policy. It is therefore crucial that in the initial stage of health insurance covered services will be reimbursed according to tariffs based on a 'price list'.[5] In a latter stage, the legal base of such a price list should be provided by a seperate act, e.g. an Act on Health Care Tariffs. Whereas a derived decree, e.g., Health Care Tariffs Decree specifies the tariffs. The advantage of such a decree is that is relatively easy for the Minister of Health to modify the tariffs. In the long term, such a Health Care Tariff Act may also include tariffs that are excluded from the the covered compulsory health insurance services.

recommendation 8. It is recommended to add an provision that covered services by the draft Law on Health Insurance will be reimbursed according to the price list, respectively Health Care Tariffs Act (article 27). Secondly, deviation of the legally binding tariffs should be forbidden by law. This should prevent providers from asking 'under the table' payments. Simultaneously, the Health Care Tariffs Act should specify the sanctions in case of irregularities.

8. Contracting health care providers
Under the draft Law, the HIF is entitled to contract health services provided by health providers (article 25). The core conditions of such individual contracts are set by law and stipulated in the so-called 'model contract' (article 25). According to the draft Law it is unclear who are the actors defining the 'model contract'. It is recommended to specify the key-players in developing the 'model contract'. For instance, instead of the Government respectively the Ministry of Health, a 'model contract' can be the result of a national consultation between representative organisations of health care providers and the HIF. If the consultation process is successful, the 'model contract' is drawn up, which then has to be approved by

[5] TNO Notes p.5.

the Ministry of Health or Health Insurance Fund Council (hereafter). If the parties cannot work anything out, a 'model contract' is drawn up by the Ministry of Health or Health Insurance Fund Council. Under the terms of the draft Law on Health insurance, the 'model contract' must contain certain contractual conditions (specified in art. 25). Any other agreements, for example concerning fees charged, are set down in the individual contracts with health care providers. Reviewing the contractual conditions it appeared that some conditions are missing, such as the starting date, ending and duration of the contract; nature and scope of mutual obligations; possible options in case of dispute. Moreover, the recommendation on (postponed?) selective contracting[6] should be combined with temporary contracts, periodically re-negotiated. Without specifying the duration of the contract, it would mean infinite contracts difficult to cancel. This seems not consistent with the underlying idea of selective contracting. Therefore, the following recommendation reads as follow:

Recommendation 9. It is recommended to add the missing elements in the contractual conditions (art. 25). Particularly, the starting date, ending and duration of the contract; nature and scope of mutual obligations, and finally possible options in case of dispute.

9. Voluntary health insurance

Under the Law on Insurance, voluntary health insurance is already allowed in Armenia (travel insurance insuring health care services in foreign countries). Therefore, the Health Insurance Law cannot prohibit this type of insurance since it has a legal base derived from this act. Otherwise, it is recommended that the government should not stimulate further voluntary health insurance (restricted licensing policy) *before* the provisions on voluntary health insurance mentioned in the draft Law on Health Insurance came into force. Since the draft Law is first of all focussed on compulsory health insurance, provisions on voluntary health insurance may only enter into force after a transition period of, for instance, 5 years. During that period, the legislature can focus on the introduction and modernisation of compulsory health insurance. In the meantime, private insurance companies that provide voluntary health insurance should restrict there activities to private travel insurance.

Recommendation 10. It is recommended to include an additional provision postponing the introduction of voluntary health insurance under the draft Law n Health Insurance.

10. Supervision, Complaints and Appeal

[6] TNO Notes, p.6.

Supervision
Under the draft law, the element of supervision of the HIF is largely missing. Although the government have an important role in budget approval (article 8), financial, managerial and administrative supervision are not mentioned.

Recommendation 11. Due to the public tasks performed by the fund, it is therefore highly recommended to define a supervisory body and specify its supervisory competences. There are two main options:
Option 1: a newly established council. Since the HIF is a independent statutory public body, supervision could be entrusted to a statutory public body, e.g. a 'Health Insurance Fund Council' (hereafter, the 'Council'). Supervision includes several aspects: (1) finanical supervision, (2) management and (3) administration.
(1) the financial supervision should include overseeing annual accounting audits, monitoring the reserve fund, ensuring sound financial planning and defining parameters on investment and financial management. To certain extent this kind of supervision ensures the financial vialbility of the HIF. This task could be performed by the Council or the Board of Founders (art. 8). However, under the draft law, the independency of the Board of Founders remains an open question.
(2) and (3) the tasks of ensuring that the HIF carries out his managerial and administrative functions in a proper manner can be entrusted to a 'Health Insurance Fund Council', whose other statutory duties may include advising the government at his request or on its own initiative, on all matters relating to health insurance under the act. If the advice relates to policy proposals or proposed statutory regulations, only the specific implementation aspects will be considered. The Council should have the power to issue instructions to the HIF regarding administrative procedures, the registration and insured persons, the collection of statistics, annual reports and the conditions of service of staff.
The Council should include -- members of whom -- are appointed by the Minister of Health, -- by the representative organisations of employers, employees, health care providers and the HIF, The chairman is appointed by the Minister from among the members, following consultations with the Council; deputy chairpersons are appointed by the Council from each of the other -- groups.
Furthermore, the Council is assisted by a secretariat headed by a general secretary appointed, similar as the rest of the secretariat's staff by the Council.
Whereas the Council is accountable to the MoH, to whom it reports annually on its work. The Minister may issue the Council with policy rules concerning the performance of its duties; the Minister may also influence its work by exercising his power to reverse its decisions.
Finally, the financial resources made up by a special fund are used to cover the costs of the Council.

Option 2: the Social Security Fund[7] will perform the supervisory tasks on the financing, administration and management of the HIF. The Social Security Fund already has some advisory and/or supervisory tasks related to other social security schemes. But this option depends on the tasks and competences of the Social Security Fund, and Ministries of Health and Finance concerning supervision.
The supervisory tasks could be divided among the Social Security Fund and the Board of Founders. Since it is unclear what should be the role of the Board of Founders, a clear separation of supervisory powers remains an open question. It is however clear that the draft Law and the derived Charter of the Compulsory HIF should specify the supervisory competences.

Remark. Option 1 has the advantage of a comprehensive approach where all the specific knowledge and experience with concern to health care are cumulated in one independent body. If necessary, the Council can divide its functions among several committees (e.g., complaints, supervision). The Council's specific tasks and competences should be stipulated in the draft Law and a 'Decree on the Health Insurance Fund Council'.

Complaints and Appeals
Under art. 34, the individual right to complain can only be realised by means of (civil) law-suits. In general, the constraints to initiate a court procedure are considerable. Instead, a more simple procedure could be included in the draft Law. Simultaneously, a complaint and appeal procedure should be initiated for health care providers complaining about the HIF.

Recommendation 12. It is recommended to define a relatively easy accessible complaint procedure by law, open for disputes between HIF-insured, respectively HIF-provider.
Further details may include the following elements: Appeals can be made in various manners against decisions made by the health insurance fund in applications of the draft Law. A distinction must be made here between (1) complaints relating to how the HIF treats insured persons, or to whether the insured persons are insured under the draft Law, (2) disputes about registration or contribution and (3) disputes concerning entitlement to benefits under the draft Law.

I. An insured person who has a complaint about his or her treatment by the HIF must first take the matter up with the HIF. If the insured and the HIF cannot resolve the matter satisfactorily, the person concerned can request for the opinion of the Complaint Committee of the Health Insurance Funds Council.

[7] TNO Notes p.7.

If an insured person disagrees with the decision of the HIF as to whether s/he is insured under the draft Law, s/he should first submit a formal objection to the HIF. If the HIF upholds the original decision, the person concerned can bring an appeal to the (administrative law section of the) district court, or if s/he wishes, seek the opinion of the Complaint Committee of the Health Insurance Fund Council.

2. Appeals by individuals against decisions regarding the contributions and registration with the health insurance fund may be made to the district court in the area where the person lives. Appeals by employers against decisions on contributions must be addressed to the district court named in the document setting out the decision. Appeals against rulings by a district court (other than rulings on benefits) may be made to a Final Appeal Tribunal. Anyone who disagrees with a decision by the HIF must first submit a (written) complaint to the HIF. If they still disagree, they can turn to the courts or, if they wish, seek the opinion of the 'Complaints Committee' of the Health Insurance Fund Council (Arbitration).

3. Different arrangements may apply for disputes relating to entitlement to benefits. The insured must submit a formal objection in writing to the HIF. Before considering the objection, the HIF must first request the advice of the Council. After obtaining the advice and sending a copy of it to the insured, the HIF issues a decision on the objection. If the insured does not agree with the decision, s/he can bring an appeal to the (administrative law section of the) district court.

In case of a dispute of a purely medical nature, the court may decide, at appeal or appeal to a higher court, to bring the case forward if it is urgent.

11. Privacy regulation

The protection of personal data requires legislative protection. Particularly in the field of health insurance personal data reflect sensitive information that requires protection from unauthorised access.

Recommendation 13. Under the draft law, data protection of the insured's records could be added to the Chapter 6 on 'the regulation of the relationship of the parties in the health insurance system. Apart from an additional provision in the draft Law, privacy rules could by further defined in a 'Decree on Privacy Rules'. Suggestions concerning the core content of such 'Privacy Rules', could include: - definitions (personal data, registration, provision of data, holder of the data, etc.); - type of registred data and the way personal data can be included in the register, by which institutions/organisations)*; - removal and distroyal; - access to personal data; - access to third persons; - linking of registered data; - information

of the insured concerning registration; - right to inspection and correction, and - organisation and management.

* differentation of type of data: (1) insurance technical data (name, address, etc.); (2) pure technical data (e.g., registration data, changes, data of the employer); (3) data concerning health benefits (e.g., admission, specialist); and (4) medical data.

12. Summary and Conclusions.

The draft law on health insurance can be considered as a landmark in the Armenian health care reforms. It will introduce an statutory social health insurance fund that will be responsible for contracting individual practitioners and outpatient clinics. Based on the Georgian experiences, the TNO concept recommends a careful approach starting with a limited group of benificieries and a restricted number of insured health benefits. In a latter stage, voluntary health insurance could be introduced covering supplementary health services.
This suggested incremental approach raises several legal questions to be answered. It appeared however that the suggested step-by-step period can be realised by adding a transitory period in the draft law or derived decree concerning the covered beneficiaries, nature of benefits and postponement of voluntary health insurance (recommendations 2, 3, 6, 10).
As concerns the content, *grosso modo*, the draft law can be characterised as a feasible and realistic document that includes the main elements necessary to introduce a social health insurance scheme. However, the evaluation of the draft law and TNO document showed that some major elements are missing, *viz* a defined package of health care entitlements, supervision of the HIF, an accessible complaint procedure and protection of personal data of the insured are missing (adequate) legislative support. To improve this situation several legislative (and regulatory) recommendations were made.

Appendix D Comments and Suggestions to First Draft "Health Insurance Concept" (Version June 2000) Prepared by Serge Heijnen, June 2000

Comments and Suggestions to "Health Insurance Concept" prepared by the Working Group on Health Insurance Development (Version June 2000)

Serge Heijnen, June 2000

SUGGESTIONS FOR PROPOSED STRUCTURE AND BUILDING-BLOCKS OF A MEDICAL INSURANCE CONCEPT

1. Current Situation

1.1 Health situation

- life expectancy at birth
- mortality rates, incl. infant mortality and maternal mortality and leading causes of death
- morbidity rates, incl. overall morbidity patterns and leading causes of morbidity / trends

1.2 Health care organization and utilization

- accessibility, utilization rates declining: this is in sharp contrast with:
- excess capacity, particularly in secondary care
- primary health care underdevelopment
- poor management of services and the system
- free medical care 'declarative', intransparant and inferior
- health services of bad quality and not in line with needs of the population

1.3 Financial situation

- real underfinancing due to poor economic situation and not giving priority to health sector (*find figure for 1995-1999*) health as % of GDP or Government budget
- BBP (state order) not in line with the financial situation of the sector and excess capacities in the hospital sector have not been reduced: this has resulted in debts for the SHA and health sector, prices in the official health sector which have lost touch with real economic prices
- financially, official sector in state of crisis as officially paid medical services are only 10-12% of income of medical facilities (*have we a figure for 1990 and 1995??*) and under-the-table payments are now estimated at 4* official payments. Investments in the sector are absent : the underfinanced medical care providers have no possibility to provide for appropriate quality of medical care, apply modern techniques, buildings and equipment, pharmaceuticals and medical devices..

Argument: Health in Armenia is in a bad situation, in real terms, even worse and declining if one considers that the denominator figures (official population statistics) are probably largely overstated. Part of the problematic health situation can be attributed to the poor performance of the health care organization and medical services, as well as the underfinancing of services and problems in priority-setting.

2. Objectives and Main Principles of Medical Insurance Development

2.1 Objectives
- Describe history and failures of reform process, contributing factors etc.
- The aim of the medical insurance development is to contribute to the main objectives of the Government Health Policy for the Republic of Armenia (which document). In particular it should contribute to:
- strengthening primary health care and increasing accessibility of basic and essential health services;
- better organization and transparency of health care financing, accountability to the clients of health insurance (population)
- stimulating efficiency, quality and competition among health care providers.

This should result in increased utilization rates, particularly in PHC and better quality of services. In the medium-term this should lead to real improvements in health, particular by a reduction of preventable causes of mortality and morbidity, such as declining rates of infant/maternal mortality and putting a halt to, or even reversing the trend of increasing mortality/morbidity from cardio-vascular diseases, cancers and some infectious diseases.

2.2 Principles
- HFA principles
- investment in health is investing in one's future
- medical insurance principles in line with context of social insurance policy and Armenia being a 'social state'. The principles on which MI system will be built are:
- social solidarity and equity
- new role for Government and individuals as to the responsibility of individual and population health and health care
- legalization and de-criminalization of grey circuit
- psychology of people and increase health protection of population;
- preserve and, if possible, attract additional funds for the health care system

The scheme will be mandatory for the target population because this option, as opposed to voluntary insurance, (1) will have the largest impact on reaching the health policy

goals, (2) improves 'risk pooling' and (3) will be more efficient, given the expected higher coverage in relation to the investments and administration needed to set-up and maintain the system.

The Armenia 'insurance market' is thought to be too small to justify the operation of more than one fund which administers the compulsory medical insurance, both in terms of efficiency and quality. To achieve 'economies of scale' (by reducing administration costs), as well as to stimulate transparency and accountability and to ensure solidarity among various groups with different risk profiles it will be proposed to establish 1 single fund.

The introduction of medical insurance principles in the health system will be accompanied by a review of the state order and gradual introduction of co-payments in the BBP, already in 2001 as well as real efforts (privatization, optimization) to reduce excess capacities in particular the hospital sector and to strengthen the quality and utilization of PHC services.

It is important to note that, due to the very low percentage of GDP spent on health, budget allocations to the health sector should NOT decrease because of the introduction of medical insurance, as this will seriously endanger the efficient implementation of the MI system and will widen and deepen the gap between actual population health needs and public services. Health insurance introduction should stimulate multi-source financing. Government (budget) resources should be released to develop health care and health promotion services for people not covered by the scheme, which thus will raise standards for the people worst off. At the same time the HI system will increasingly invest in health and (primary) health care for the working population and their relatives and, at a later stage, for other population groups as well. Over time and as coverage expands, medical insurance will become the largest method of funding basic health care, incl. primary, secondary and tertiary care.

To stimulate the future development of voluntary insurance next to the compulsory scheme, all legal obstacles will be taken away for commercial enterprises to engage in private medical insurance (INCLUDE HERE WHICH). Economically, a market will be created by streamlining the State Order and the Medical Insurance benefit package, as well as making the population more accustomed to insurance principles. The differences between compulsory medical insurance and voluntary medical insurance are summarized in the following table (INCLUDE TABLE of your paragraph 6: basic problems of the vol. Ins. Development)

3. Medical Insurance Revenues and Population Coverage

In the medium- to long-term, medical insurance should aim to cover for the health care needs of the majority of the Armenian population, including various groups of self-employed people and the non-working population. However, international experience shows that it is very difficult to create a system that covers the entire population right from the start. In Armenia, the financial-economic situation and labor market does not permit a large scale implementation, as insurance only works if there is a reasonable balance between people who pay more in contribution than they take out in services to compensate for those who cost the scheme more than they pay in. In addition, there are serious technical constraints related to the collection of funds from various self-employed groups (e.g. farmers, owners of small businesses) as well as problems in ability to pay by individuals and the Government for the coverage of the non-working population.

Therefore, in the first stage of medical insurance introduction, the target group could be restricted to employees and their relatives (husband/wife and children) that are officially engaged in economic activities, incl. state and private sectors. This initial set-up follows the international experience regarding the introduction of social health insurance for various technical reasons. This group is the biggest group with regular wages from which contributions can be deducted, while registration and monitoring of the collection of contributions is much easier and economic. Other population groups can be covered with the growing of the economy and the labor market (which will add more 'good risks') and when the medical insurance fund has established the administrative capacity to collect and administer funds efficiently.

Medical insurance will be funded by a deduction of the payroll of officially registered employees. At present, the deductions to the payroll (before taxes) include a 28% employer and 3% employee deduction to the social security fund with a minimum (total) of 2500 Drams per month and a maximum of 20.000 Drams monthly. A large majority of wages in the public and private sector are such that they fall within the minimum and maximum contribution levels (*any exact figures on this from the social funds??*). In addition, employees pay income taxes according to the following monthly scales:

0 – 28.000 Drams:	0%
28.001 – 120.000 Drams:	15%
120.001 – 320.000 Drams:	25%
320.001 - >>>	30%

It is suggested that, io order to place no new burden on the payroll of those workers who pay for social security, medical insurance will be funded out of the current resources for social security (28% + 3%). Each employee for whom contributions have been made to the social security and medical insurance system will receive an individual policy, aimed at him/herself and his/her relatives. It is important to note that, initially, only those work-

ers (as opposed to workers and their families who do not contribute to the social security system) will benefit from the medical insurance coverage. Therefore, it should also be considered an incentive for employers and (particularly) employees to be engaged in official economic activities.

In the initial stage, 3% of the payroll (2% employer contributions and 1% employee contributions) will be allocated to health insurance. In fact, this thus entails the earmarking of 9.68% of income of the social security fund (7.14% of employer contributions and 33.3% of employee contributions) to medical insurance. The minimum contribution will be (09.68% * 2500 Drams) 242 Drams monthly and the maximum will be 1936 Drams monthly.

INCLUDE TABLE WITH STATISTICS AND EXPECTED INCOMES FOR THIS TARGET GROUP. If not available, we should estimate and indicate that these are estimations only.

In the short-term, an assessment should be made regarding if and how it will be possible for other employers/employees (those who do not pay for social security) to contract separately with the medical insurance fund and thus to ensure additional health protection for more employees and their relatives. In addition, methodologies will be explored to include other working groups into the scheme (e.g. farmers, craftsmen).

4. Benefit Package and Costs

A benefit package should deliver the kind of services people are accustomed to and which are considered necessary to maintain and promote good health. In addition, the benefit package should be in line with the health policy and only those services should be included that are cost-effective. The medical insurance fund should plan the use of its scarce resources in order to avoid waste, duplication and inappropriate investment. Given the financial-economic situation of Armenia, this means that priority will be given to low cost – high (health) effect services and technologies, while investing in high-cost equipment and technologies cannot be justified.

Health Benefits for the target population could eventually include:
1) Primary care diagnostic and therapeutic services in the community
2) Specialist out-patient diagnostic and therapeutic services in polyclinics and out-patient hospital departments
3) Ambulance services
4) Catastrophic illnesses and exceptional medical expenses

In the period until the introduction of medical insurance, (1) a concept should be developed of the main directions and priorities of the Benefit Package and the diagnostic and

therapeutic procedures to be covered by medical insurance should be specifically defined following a positive list, (2) the utilization rates should be estimated (add here already the average nr. of people applying for hospital care and nr. of primary care consultantions per 1000 population) and (3) the costs per service and the total costs for the target group should be estimated on the basis of more realistic prices. For this, (4) a price list should be established and maintained. This is an essential part of medical insurance development, as it should enable health care organizations and physicians to provide essential services while not having to ask any more for unofficial payments. The success of medical insurance development will largely depend on its credibility towards clients and providers. Therefore, the benefit package can never go far outside the economic reality, which is the case with the current state order programs. Control over the cost of services could be achieved by putting initial ceilings on spending per facility, fixed at e.g. 80% of expected spending. When this ceiling has been reached, utilization and service delivery profiles would then need to be re-negotiation between the medical insurer and the health care provider.

5. Registration and Provider Payment Mechanisms

Clients should be individually registered and should receive a personal health insurance number. Both the client and the treating physician should sign an official form to be provided by the MI Fund to selected primary health care and hospitals, upon the delivery of services which will mark the specific diagnostic or therapeutic procedures(s), the name of the treating physician, insurance nr., the price (and the passport nr. to discourage fraud??). The medical insurance fund will pay directly to the health care provider based on the established price list. The price list / health care tariffs may include capitation payments (e.g. for primary health care and ambulance services) and fee-for-service payments (e.g. in for hospital-specialist care). It is recommendable that the price setting and payment mechanisms prevailing under the "State Order Programs" will be reformed to include better and more targeted budgeting practices plus payments based on a less rigid and more fair and simple methodology. This could be done either on case/activity-based, or based on a limited number of DRGs.

As, in any payment system, prices should be set that are more based on real costs than in the current situation, health care providers and physicians are NOT allowed to ask for under-the-table payments to insured patients, only official co-payments are allowed (if and where established within the scheme). This should be sharply monitored by the Medical Insurance Fund.

To make the scheme attractive to individual physicians, specific incentives need to be built in the contracts with hospitals and polyclinics to ensure that individual physicians are stimulated to provide quality care to the insured population. It should be explored whether it would be possible to introduce certain bonus-payments for the treating physi-

cian. If so, in fact this would create different income mechanisms for doctors within hospitals and polyclinics. For example, physicians' income would include a salary part and a fee-for-service part. Official nurses' income will continue to be salary-based only.

Until a good provider's licensing (and accreditation) system has been established in Armenia, the medical insurance fund would contract selectively with primary care and secondary care providers in order to control costs and to achieve quality and efficiency gains through competition.. In the period until its implementation (1) the criteria should be established, (2) then the list of to be contracted facilities will be published, and (3) contracts will be negotiated with each facility.

6. Medical Insurance Organization and Fund Management

Medical insurance is a mechanism for achieving health policy goals; it is not in itself a policy. It must be clearly understood that the Ministry of Health will continue to oversee the medical insurance organization and health care providers. The responsibilities of the Ministry of Health remain as follows:
- setting overall health policy goals;
- creating the policy framework for the operations and activities of the medical insurance fund and the providers;
- monitoring the performance of the medical insurance fund and providers;
- ensuring that mechanisms are in place to fund and provide staff training and development;
- ensuring that the overall costs of health services are kept under control.

The medical insurance fund must collect contributions from the insured population, and agree on contracts for the provision of health services to fulfill members' entitlements. As part of this process, they must be involved in setting priorities for health care, since it will not be possible to provide entitlements to all services which would benefit patients. The role of the providers of health services is to produce the quantity and quality of health care for the insured population that is specified in the agreements with the medical insurance fund.

The medical insurance fund could be a separate legal entity with a separate account within the State Health Agency. The MI fund will make use of existing structures and capacities of the SHA at national and regional level. The roles and responsibilities of the national and regional offices in the medical insurance implementation should be clarified before the introduction. A new Charter should be developed and adopted for the State Health Agency before the introduction of the Medical Insurance. In the MI Law it should be clear that the medical insurance fund has separate funds and a separate benefit package from the state order programmes and that there cannot be any pollution of the medical insurance package or mixture of funds. Specific texts need to direct to the (to be developed) Charter.

The medical insurance fund will need to contact and contract with the social security fund about the specifics of the transfer of funds to its account (periodic transfer) for the people registered as clients. Also, some personal information about the client should be available to the medical insurance fund (name, sex, date of birth, known relatives, address and tel. nr, employment status, salary, etc.). Another option might be direct transfer of funds from the employers/employer groups to the medical insurance fund. Over-time this might be the best option but in the short-term it has the disadvantage of duplication of social security and medical insurance procedures and higher administration, operation and monitoring costs. Also, it holds the risk that population coverage will be lower and less resources can be collected in the first year(s), as the medical insurance company has to enter into cont(r)act with each individual employer, which takes time.

7. Preparatory Stage of Medical Insurance Development

Substantial investments are needed in staff and procedures before the introduction of the medical insurance, e.g.
1) set-up of procedures and systems of registration, pricing, billing and, payment, accounting, financial audit, contracts and negotiations, budgeting, information requirements and reporting;
2) training of SHA staff in new procedures and systems;
3) training to health care providers on some new procedures and systems;
4) PR and information to clients, medical community, health care providers, general public.

In combination with the time and efforts needed to define the benefit package, selective contracting, the new SHA Charter etc. full implementation of the medical insurance should definately start not earlier than 1 January 2002 and preferably later.

In a first step, the basic concept and the draft-Law on Medical Insurance should be ready for discussion in Parliament and Parliament agreement should be sought. The Law on Medical Insurance should regulate the following issues:
- specifying notions and objectives of compulsory and voluntary medical insurance, population groups (introductory phase and long-term objectives), funding mechanisms, BBP definition, rights and obligations of stake-holders (incl. relation insurance fund – provider, insurance fund – client and client – provider), payment mechanisms, insurance organization, implementation schedule, pre-conditions and relation to other MoH policies and reforms (particularly privatisation and optimisation, BBP review of state order programmes).

In addition, all legal obstacles for the introduction of MI should be removed with the MI Law (articles in other Laws which impede MI introduction).

Upon Parliamental Approval of the Law and Concept, an Investment and PR Plan should be developed by the Ministry of Health and the SHA, in close coordination with other stake-holders and (inter)national partners. This Plan should further define the preparatory phase and deadlines, investments needed and costs, information and PR, and responsibilities of the several actors during the preparatory phase.

8. Main pre-conditions for the Introduction and Success of Compulsory Medical Insurance

1. **Political decision now and political commitment in the future to the principles of medical insurance development;**
2. **Protect the credibility of the medical insurance scheme among the population, clients and providers and protect the medical insurance against decisions which do not respect economic laws and financial reality of the Medical Insurance Fund. Basic articles in the MI Law should reflect this.**
3. **Medical Insurance must be part of a broader effort to strengthen the efficiency and quality of the medical services. In fact, without significant efforts to reduce the excess capacity within the next 10 years and reduction and review of the state order programs, its implementation will certainly fail. Therefore, the MI Law should address the main (intermediate) targets and plans for health services optimisation and BBP review (incl. co-payments).**
4. **The economic situation and labor market should not deteriorate further and, in fact, should show some signs of revitalization during the coming months/years.**
5. **Clarification of available resources and definition of the optimum basic health insurance program in the short- and medium-term.**
6. **Appropriate time reserved for the preparatory phase, securing funds and other resources for investment in staff and procedures before take-off.**

As can be seen, the pre-conditions and constraints are very serious. It is questionable whether a system reform is feasible and desirable given the present context.

Serge Heijnen, 19 June 2000.