Measures on Administration of Health Insurance
健康保险管理办法

No.8 [2006]

Reviewed and adopted at the Chairmen Meeting of the China Insurance Regulatory Commission on June 12, 2006, *Measures on Administration of Health Insurance* is hereby promulgated and shall be effective as of September 1, 2006.

Chairman: WU Dingfu
August 7, 2006

Measures on Administration of Health Insurance

Chapter I General Provisions

Article 1
These Measures are formulated in accordance with the *Insurance Law of the People's Republic of China* (hereinafter referred to as *Insurance Law*) with a view to promoting development of health insurance, regulating operation activities of health insurance and safeguarding legitimate rights and interests of parties concerned in health insurance activities.

Article 2
"Health insurance" used in these Measures refers to the type of insurance under which an insurance company pays benefits for losses caused by health reasons in the form of disease insurance, medical insurance, disability income insurance and care insurance etc.

"Disease insurance" used in these Measures refers to the type of insurance under which payment of benefits depends upon occurrence of diseases specified in insurance contract.

"Medical insurance" used in these Measures refers to the type of insurance under which payment of benefits depends upon occurrence of medical treatment activities specified in insurance contract and which provides coverage for medical expenses incurred to the insured during medical treatment.

"Disability income insurance" used in these Measures refers to the type of insurance under which payment of benefits depends upon loss of working ability as a result of diseases or accidental injuries specified in insurance contract and which provides coverage for reduction or interruption of income of the insured in a certain period of time.

"Care insurance" used in these Measures refers to the type of insurance under which payment of benefits depends upon needs of care arising from impediment of daily life capability specified in insurance contracts and which provides coverage for care expenses of the insured.

Article 3
Health insurance is classified into long-term health insurance and short-term health insurance according to insurance term.

"Long-term health insurance" refers to such health insurance under which the insurance term is longer than one year or, the insurance term is not longer than one year but a guaranteed renewal is provided.

"Short-term health insurance" refers to health insurance under which insurance term is one year or below without containing a guaranteed renewal clause.

“Guaranteed renewal clause” refers to a clause in insurance contract providing that the insurance company must renew the policy according to the premium rate and original clauses specified in the contract upon renewal application of the applicants after expiration of the previous insurance term.

Article 4
Medical insurance is classified into medical insurance on a reimbursement basis and medical insurance on a fixed payment basis according to the nature of benefit payment.

“Medical insurance on a reimbursement basis” refers to medical insurance under which the amount of benefit is determined in accordance with the standard agreed upon on the basis of medical expenses actually incurred to the insured.

“Medical insurance on a fixed payment basis” refers to medical insurance under which benefits are paid in accordance with the amount agreed upon.

The amount of payment for medical insurance on a reimbursement basis shall not exceed the medical expenses actually incurred to the insured.

Article 5 China Insurance Regulatory Commission (hereinafter as “CIRC”) supervises and regulates insurance companies’ operation activities of health insurance pursuant to law.

Article 6 These Measures are not applicable to insurance companies’ entrustment management services in which no insurance risks are assumed by the insurance companies.

Chapter II Administration of Operation

Article 7
Life insurance companies and health insurance companies established according to the law can undertake business of health insurance with approval of CIRC.

Insurance companies not covered by the preceding paragraph can undertake business of short-term health insurance with approval of CIRC.

Article 8
In order to undertake business of health insurance, an insurance company shall meet the following requirements on a continual basis:

1) Having an independent accounting system for business of health insurance;
2) Having an actuarial system and risk management system for health insurance;
3) Having an underwriting and claims settlement system for health insurance;
4) Having a data management system for health insurance;
5) Having a relatively independent information management system with complete functions for health insurance;
6) Having actuaries, underwriting personnel and claim-verification personnel with relevant professional knowledge;
7) Other requirements specified by CIRC.

Article 9
Insurance companies shall offer professional training of health insurance to personnel engaged in underwriting, claim-verification and sales work of health insurance.

Article 10
Insurance companies undertaking business of medical insurance on a reimbursement basis shall enhance cooperation with medical service institutions and health management service institutions, strengthen administration on costs of medical service and supervise rationality and necessity of medical expenses.

Cooperation between insurance companies and medical service institutions and health management service institutes shall not harm the legitimate rights and interests of the insured.

Article 11
Insurance companies shall attach high importance to privacy protection of the insured and establish information management and confidentiality system for the clients of health insurance.

Chapter III Administration of Products

Article 12
Insurance companies shall submit drafted insurance clauses and premium rates for health insurance to CIRC for examination and approval or filing according to relevant stipulations of CIRC.

Article 13
When a health insurance product designed by an insurance company contain more than two types of health protection liabilities, the responsible actuary of the company shall determine the main liability according to general actuarial principles and the product type shall be determined based on the main liability of the product.

Article 14
Disease insurance products of long-term health insurance can contain death liabilities, but the amount of death benefits shall not exceed the maximum amount of disease benefits.

Health insurance products other than those specified in the preceding paragraph shall not contain death liabilities, except death liabilities arising from disease.

Medical insurance products and disease insurance products shall not contain living benefits liabilities.

Article 15 Long-term health insurance products shall have contract hesitation period and the rights of the applicant in such period shall be specified in insurance clauses. Hesitation period for long-term health insurance products shall be no less than 10 days.

Article 16

Premium rates of short-term individual health insurance products can be adjusted.

“Adjustment of premium rates” refers to insurance companies’ act of determining specific insurance premium rates reasonably within adjustment scope on the basis of benchmark premium rates in product selling.

Article 17
Materials submitted by insurance companies for application of examination and approval or filing of short-term individual health insurance products with adjusted premium rates shall contain benchmark premium rates, the method and scope of premium adjustment; and the materials shall be confirmed and signed by the responsible actuary of the company following the principle of prudence.

Article 18
Parameters of short-term group health insurance products can be subject to adjustment.

“Parameters” herein refer to insured amount, minimum indemnities, payment percentage, exclusions and elimination period etc. specified in insurance clauses, which can be reasonably adjusted based on specific situations of the group applicant.

Article 19
Materials submitted by insurance companies for application of examination and approval or filing of short-term group health insurance products with adjustable product parameters shall contain adjustment method of the

product parameters and shall be confirmed and signed by the responsible actuary of the company following the principle of prudence.

When selling short-term group health insurance products with adjustable product parameters, insurance companies shall calculate corresponding premium rates based on the adjustment method of product parameters. Premium rating method and basic data required for calculation of premium rate shall not be changed in the adjustment of product parameters.

Where premium rating method or basic data required need to be changed in the selling of short-term group health insurance products with adjustable product parameters, insurance companies shall go through the examination and approval or filing procedures for such products again.

Article 20
For health insurance products containing a guaranteed renewable clause, time for such clause to take effect shall be specified.

No specification providing that insurance companies have the right to adjust insurance liabilities and scope of exclusions at the time of renewal shall be made for health insurance products containing a guaranteed renewable clause.

When applying for examination and approval or filing of health insurance products with a guaranteed renewable clause, insurance companies shall provide an explanation of the pricing method and calculation method of liability reserves for guaranteed renewal in product actuarial report.

Article 21
When drafting clauses of medical insurance products, insurance companies shall respect the rights of the insured to accept reasonable medical services, and shall not set unreasonable requirements or requirements against general medical standards in clauses as conditions for payment of benefits.

Diagnosis standards for diseases specified in the clauses of health insurance products shall conform to generally accepted medical diagnosis standards and shall take into consideration the development trend of medical technology and conditions. After health insurance contract takes effect, if the insured has been diagnosed to have disease based on generally accepted medical diagnosis standards, the insurance company shall not decline payment of benefits with inconsistency between such diagnosis standards and the stipulation in insurance contract as the excuse.

Article 22
When designing medical insurance products on a reimbursement basis, insurance companies must differentiate between different situations of the insured such as whether they enjoy public health services or social medical insurance, and shall treat them differently regarding insurance clauses, premium rates and indemnity amounts.

Article 23
In the contract of medical insurance products, insurance companies can specify that medical treatment of the insured in designated medical service institution network is the condition for payment of benefits.

Medical service institution networks designated by the insurance companies shall follow the principle of “convenient for the insured and reasonable management of medical expenses”, guide the insured to reasonably use medical resources and save medical expenses and properly publicize and explain to the applicant and the insured.

Article 24
Insurance companies shall make timely amendment to the premium rates of new health insurance products based on actual indemnity experience and apply for examination and approval or filing of the new premium rates according to relevant requirements of CIRC.

Chapter IV Administration of Sales

Article 25
When selling health insurance products, insurance companies shall strictly adhere to insurance clauses and premium rates examined and approved or filed.

Article 26
When selling health insurance products, insurance companies shall not have any of the following acts:

1) Selling health insurance products at the premises of medical institutions;
2) Authorizing medical institutions or medical practitioners to sell health insurance products.

Article 27
When selling health insurance products, insurance companies shall explain the contents of insurance contract to the applicant and make written representations on the following matters, which are to be acknowledged by the applicant through signing:

1) Insurance liabilities;
2) Exclusions;
3) Elimination period;
4) Hesitation period of insurance contract and relevant rights and obligations of the applicant;
5) Whether to provide guaranteed renewal and valid time of renewal;
6) Claim procedure and document requirements for claim;
7) Insurance term of each product in package health insurance;
8) Other matters specified by CIRC.

Article 28
When selling health insurance products, insurance companies shall not exaggerate scope of insurance coverage, shall not conceal exclusions or mislead the applicant or the insured.

Where the applicant and the insured raise inquiries on technical terms of insurance, medical treatment or diseases in the insurance clauses, insurance companies shall explain in clear and easy language.

Article 29
When selling medical insurance on a reimbursement basis, insurance companies shall ask the insured whether the latter has public health services, social medical insurance or other medical insurance on a reimbursement basis.

Insurance companies shall not induce the insured to purchase medical insurance products on a reimbursement basis with identical or similar protections.

Article 30
When selling medical insurance specified in article 23 hereof, insurance companies shall disclose the list of the medical service institutions or qualification requirements for such institutions to the applicant and provide service for information inquiry.

In case insurance companies adjust the medical service institution network, the applicant or the insured shall be notified in time.

Article 31
When insurance companies sell health insurance products without guaranteed renewal clauses in the form of additional insurance, the insurance term of such additional health insurance shall not be shorter than the insurance term of the basic insurance.

Article 32
When selling individual medical insurance product on a reimbursement basis, insurance companies shall seek feedback from the applicant during hesitation period.

Finding the applicant has been misled, insurance companies shall properly explain and clearly inform the applicant of the right to cancel the insurance contract during hesitation period.

Article 33
When underwriting group health insurance, insurance companies shall notify each insured of his/her insurance participation and relevant rights and interests in written forms such as notices etc.

Article 34
Where an applicant surrenders group health insurance contract, the insurance companies shall require the applicant to provide valid certification proving that the insured have been notified of the surrender, and the premiums shall be returned to the account of the organization to which the applicant belongs through bank transfer.

Chapter V Actuarial Requirements

Article 35
Insurance companies undertaking business of health insurance shall submit actuarial report or report on evaluation of reserves for the previous year according to relevant requirements of CIRC, in which the basis, method and result of calculation of reserves and impact of reserving on solvency shall be reported in detail, and which shall be confirmed and signed by the responsible actuary following the principle of prudence.

Article 36
Insurance companies shall draw reserves in respect of outstanding losses incurred and reported for cases in which the insured events have occurred and claims have been made but not settled.

Insurance companies shall use reasonable methods such as Case Estimate Method and Average Cost Per Claim Method etc. to prudently draw reserves in respect of outstanding losses incurred and reported.

In case insurance companies use an actuarial method other than Case Estimate Method to calculate and draw reserves in respect of outstanding losses incurred and reported, basic data, parameters setting and estimate method of such method shall be reported in detail, and resource of basic data, data quality and reliability of calculation results of the reserves shall be explained.

Where the responsible actuary of the insurance company is not able to confirm the reliability of the estimate method or experience data of relevant business is less than 3 years, reserves in respect of outstanding losses shall be drawn according to the amount claimed.

Article 37
Insurance companies shall draw reserve in respect of incurred but not reported losses for cases in which the insured events have occurred but claims have not been made.

Based on factors such as risk nature and experience data of specific lines, insurance companies shall use at least two of the following methods: Chain-Ladder method, Average Cost Per Claim Method, Reserve Development Method and B-F method to evaluate reserve and select the maximum of the evaluation results to determine the best estimate.

Insurance companies shall report in detail the basic data, parameter setting and estimate method of the reserve in respect of incurred but not reported losses and explain resource of basic data, data quality and reliability of the calculation result of the reserve.

Where the responsible actuary of the insurance company is not able to confirm the reliability of the estimate method or experience data of relevant business is less than 3 years, the reserve for incurred but not reported claims shall be drawn according to the amount no less than 10% of actual payment of claims for such accounting year.

Article 38
For short-term health insurance business, insurance companies shall draw unearned premium reserve.
One of the following methods shall be adopted to draw unearned premium reserve for short-term health insurance:

1) "24ths" method (reserving on a monthly basis);
2) "365ths" method (reserving on a daily basis);
3) More prudent and more reasonable methods can be adopted based on distribution of the risk, but the unearned premium reserve drawn under such method shall not be lower than the lesser one of the results under method 1) and 2).

Article 39 The amount to be drawn for unearned premium reserve of short-term health insurance shall not be lower than the bigger one of the following:

1) Expected future indemnity and expenses minus relevant investment returns;
2) Surrender value of all policies, which are assumed to be surrendered on the date of reserve evaluation.

When unearned premium reserve is insufficient, premium deficiency reserve shall be drawn to make up for the gap between unearned premium reserve and the bigger one of the two values in the preceding paragraph.

Article 40
Reserving method for unearned premium reserve of long-term health insurance shall comply with relevant stipulations of CIRC.

Article 41
Insurance companies shall report to CIRC the reserving results prior to and after reinsurance respectively.

Chapter VI Administration of Reinsurance

Article 42
Insurance companies shall abide by relevant provisions of *Insurance Law* and *Measures on Administration of Reinsurance Business* in placement of reinsurance business of health insurance.

Article 43
Branches of insurance companies except branches of reinsurance companies and foreign insurance companies shall not be engaged in reinsurance business of health insurance.

Chapter VII Legal Liabilities

Article 44
Where insurance companies violate the stipulations of article 8 hereof, CIRC shall order the insurance companies to rectify the situation within a prescribed time limit; for failure to do so within the prescribed time limit, a warning shall be given and a fine of no more than RMB 30,000 shall be imposed by the CIRC.

Article 45
Where insurance companies violate relevant stipulations of articles 13 to 15 or articles 20 to 23 hereof, CIRC shall order the insurance companies to stop selling the product, impose a fine of no more than RMB 30,000 on the insurance companies and give a warning to the responsible actuary and the legally responsible person.

Article 46
Where insurance companies violate the stipulations of article 24 hereof, which might endanger their solvency, CIRC shall order the insurance companies to stop selling the product.

Article 47
Where insurance companies violate the stipulations of these Measures concerning administration of sales, CIRC shall give a warning and impose a fine of no more than RMB 30,000; for senior management personnel directly responsible and other people directly responsible, a warning shall be given and a fine of no more than RMB 5,000 shall be imposed.

Article 48
Where the responsible actuary violates relevant actuarial stipulations of these Measures, CIRC shall impose a punishment on him/her according to relevant laws and administrative regulations.

Article 49
Where the branches of an insurance company are engaged in reinsurance business of health insurance in violation of the stipulations of article 43 hereof, CIRC shall impose a fine of no more than RMB30,000; and another fine of no more than RMB5,000 shall also be imposed on senior management personnel and other people directly responsible.

Chapter VIII Supplementary Provisions

Article 50
In case of discrepancy between the rules promulgated by CIRC prior to the effectiveness of these Measures, these Measures shall prevail.

Article 51
Where insurance companies undertake business of health insurance prior to effectiveness of these Measures without complete fulfillment of the requirements as specified herein, they shall satisfy the requirements within a prescribed time limit. Specific measures will be stipulated by CIRC separately.

Article 52
CIRC shall be responsible for the interpretation of these Measures.

Article 53
These Measures shall take effect as of September 1, 2006.

End.