



EU-China Social Security Reform Co-operation  
Project

**Situational Analysis of the Medical  
Insurance System Hunan Province**

*Prepared by the*

Hubert Stueker - Medical Insurance Expert

Sylvia Xu – Medical Insurance Junior Expert

### **Abbreviations:**

MoLSS	Ministry of Labour and Social Security
MoH	Ministry of Health
MCA	Ministry of Civil Affairs
NDRC	National Development and Reform Commission
PLSSB	Provincial Labour and Social Security Bureau
LSSB	Labour and Social Security Bureau
SIA	Social Insurance Agency
NRCMS	New Rural Cooperative Medical System
PTF	Project Task Force
BMI	Basic Medical Insurance
DRG	Diagnosis Related Groups
TCM	Traditional Chinese Medicine
HIS	Hospital Information System
GIP	Golden Insurance Project - IT
HTA	Health Technology Assessment
SOEs	State Owned Enterprises
TORs	Terms of References

## Introduction

This report covers the period between 01<sup>st</sup> December 2008 and 28<sup>th</sup> February 2009. During the reporting period we accomplished three field visits to Hunan Province, Changsha Municipality, Xiangtan Municipality, Pingjiang County and Xiangxiang County. Several visits to the Medical Insurance Administration of the provincial, municipal and county level Labour and Social Security Bureaus were conducted. The Director General Mr. Ding Chunting prepared an additional report on the Medical Insurance Scheme related to cross catchments compensation issues within the province and the report has been included in this report.

However, the provincial bureau organized the field visits very well and the consultancy received almost the necessary information to set up the next steps for the project activities. Furthermore the provincial bureau agreed to continue the cooperation with our project and asked for an official confirmation on behalf of the project director Mr. Dai. The next project steps have been discussed both sides the consultancy and the DG agreed that it is feasible to continue the activities to provide a new model on rising the pooling level and solutions on cross catchments compensation.

Considerable major findings are:

- The introduction of the basic medical insurance urban dwellers on the municipal and county level causes a higher workload of the current medical insurance personnel they are heavily under staffed almost. The local government reacted inadequately through employing new staff on a temporary basis. Staffing numbers have to be revised as the administrative Labour and Social Security Bureaus requested already.
- The analysis of the provincial, municipal and county level medical insurance expenditure shows that on provincial level 10 – 15%, municipal level 5 – 10% and county level up to 20% needs to be spent on services outside of their catchments area. The insured have to pay higher co-payments due to the policies of the medical insurances regulation as well. Authorities of all levels are aware about the problem and willing to change their policies as well try to increase the coverage of service through the rising of pooling levels within the province.
- The co-payment system consists in three levels; the first level is defined as the general deductible and ceiling, the second is a deductible on the provider grade (A,B,C) which means a certain percentage on different hospital categories and the third on the three list. The co-payments vary from the different insurance coverage like employees, residents, public civil servant etc. The system is not transparent for the insured population although the MI schemes providing leaflets, difficult to handle for the hospitals and do not set up the right incentive related to the demand of patient and hospitals.

## Content:

1. General information Hunan province by the end of the year 2005 and Medical Insurance by the end of 2008 .....	5
Financial situation .....	5
Population .....	5
Employment and unemployment .....	5
Social insurance and healthcare .....	5
Social protection .....	6
2. Hunan provincial administration of Medical insurance .....	6
Benefit package and the “Three Lists” of the MI PLSSB .....	6
Reimbursement system of the services .....	7
Contracting procedures with providers .....	7
Co-payments of the MI PLSSB Hunan province .....	8
Organization of the MI PLSSB .....	9
IT system of the MI LSSB .....	10
3. Hunan municipal level administration of Medical insurance Changsha City .....	10
General Figures of the MI .....	10
Administration of the MI .....	11
4. Hunan county level administration of Medical insurance Pingjiang and Xiangxiang County .....	12
Pingjiang County .....	12
General Figures of the MI .....	12
Administration of the MI .....	14
Xiangxiang County .....	15
General Figures of the MI .....	15
Administration of the MI .....	18
5. Analysis of the Hunan provincial Bureau to improve medical insurance administration for cross catchment area health service .....	18
6. Recommendation .....	31

# 1. General information Hunan province by the end of the year 2005 and Medical Insurance by the end of 2008

## **Financial situation**

GDP for 2005 was 647.361 billion RMB, up 11.6% from the previous year. The per capita GDP stood at 10.366 RMB.

Provincial revenue was 73.855 billion RMB, an increase of 20.6% over the previous year. Provincial expenditure was 86.565 billion RMB, an increase of 20.31%.

The disposable income of urban residents was 9.524 RMB per capita, up 8.2% from 2004. Rural residents' per capita net income was 3.118 RMB, a growth of 7.2% from the previous year.

## **Population**

The birth rate in 2005 was 11.9‰, while the mortality rate was 6.75‰. The natural growth rate of the population stood at 5.15‰. At the end of the year, the total population stood at 67.321 million, an increase of 344,000 from the 2004 figure. The total population reached 68.057 million by the end of 2007.

## **Employment and unemployment**

The employed population stood at 38.814 million at the end of 2005, an increase of 575,600 from the previous year-end. A total of 342,200 laid-off workers got reemployed during the year. The registered urban unemployment rate was 4.3%.

## **Social insurance and healthcare**

In 2008, the social insurance schemes covered the urban population for pension of 5.57 million, unemployment 3.89 million, medical treatment 6.82 million (employees) and 6.39 million (residents), work injuries 4.03 million and maternity 4.31 million respectively. There were a total of 15.331 medical and healthcare institutions equipped with 159.377 beds and staffed with 248.018 medical professionals and technicians at the end of 2006. By the end of 2006 the health personnel reached 204.011 heads which partly consists of 87.853

certified doctors and 58.187 registered nurses.

## **Social protection**

A special relief fund of 770 million RMB was spent and lifted 200.000 people out of poverty. A total of 1.157 billion RMB of minimum living allowances were distributed among the needy urban residents.

## **2. Hunan provincial administration of Medical insurance**

The Provincial Labour and Social Security Bureau of Hunan cover the administration of the Department of Medical Insurance, Work Injury Insurance and Maternity Insurance. The department has two functions: 1st to administer the provincial insurance bureau and 2nd to supervise the municipal administrative insurances.

The medical insurance department coverage of the MI PLSSB is 300.000 insured persons in the medical insurance for the urban employees and retirees. The contribution rates are 2% employees and 8% employers. 2% and 30% out of the employer's payments are allocated to the individual account of the employees. By nature the urban dwellers are not covered by the provincial bureau but the administration providing the policy guidelines for the implementing agencies at the municipal and county level. The department implemented the supplementary medical insurance "catastrophic disease" and accidents for the provincial level insured population.

Furthermore the administration is covering the retired higher civil servant (retirement before 1949) and the disabled servicemen's (Grade 2 and above). The bureau is responsible for 500.000 insured in the work injury insurance and 200.000 insured in the maternity insurance. The Rural Medical Community Scheme covers around 45 million populations in Hunan province but is not connected to the PLSSB and LSSB's.

### **Benefit package and the "Three Lists" of the MI PLSSB**

The provincial bureau implemented the national three lists of services, drugs/medicines and service items but they consolidated the list of services and service items. The service list consists of 3.996 plus 250 supplemented items. The list is divided into three groups of full payment services, co-payment service and non-covered services. Around 90% of the service should be fully reimbursed through the medical insurance minus the co-payments according to the provincial regulations. The drug list covers 450 category A and 1608 category B pharmaceuticals. The provincial bureau modified around 15% of the medicines

in category B. The category A list is subject to full reimbursement through the medical insurance fund whilst co-payments are foreseen for the category B on each product. Category C pharmaceuticals are not covered by the medical insurance.

## **Reimbursement system of the services**

The provincial bureau of health and the pricing bureau setting up the prices for services and drugs/medicines and the medical insurance adapt the pricelists. The provincial bureau uses the fee for service and case payment methods. If the provincial bureau agreed on a case the employees have to pay 15% and retire 10% out of their pocket.

The administrative bureau introduced four different intervention levels on specific diseases:

- Under 7.200 RMB No definition
- Under 15.000 RMB Cancer, Diabetes, etc.
- Under 35.000 RMB Kidney transplant, etc.
- Unlimited which are not defined before

6% to 7% of the total budget for inpatient care of the PLSSB applies for around 2840 cases outside of the catchments area which counts for around 30 million RMB.

## **Contracting procedures with providers**

Service provider having the possibility to apply for accreditation and approval in order to deliver services for insured people of the medical insurance and therefore the hospitals have to be certificated by the medical insurance bureau. Based on the information of the hospitals the medical insurance will sign a contract. Generally speaking the provincial LSSB do not cover non-contracted hospital but emergency cases of insured population will be reimbursed. Process of the contracting system:

- The hospital has to provide the accreditation certificate of the bureau of health and apply at the provincial medical insurance policy department.
- The hospital has to fulfil the standards of the local medical insurance bureau for example providing a medical insurance department and publishing the medical insurance information within the hospital
- The administrative bureau of the local medical insurance approves the standards of the hospital.
- The medical insurance evaluates the norms and standards including the patient database if hospitals intent to prolong the contract period if there is any clause in the agreement.

## Co-payments of the MI PLSSB Hunan province

The average co-payments for inpatient services in 2008 of the insured population was 24% and the bureau intend to reduce the copayments for 2009 (sh. tables below). The ceiling line is set by 200.000 RMB. The provincial bureau decided to reduce the co-payments down to 20% which relieves the burden of the insured population in the year 2009.

Payment / Reimbursement Rate for employees and civil servants aged < or = 50  
(After policy justification)

3rd grade hospital	self-payment rate for civil servant	Pooling fund payment rate	self-payment rate for ordinary people	subsidy rate for civil servant
0-3000	4.00%	88.00%	12.00%	8.00%
3000-10000	4.00%	88.00%	12.00%	8.00%
10000-30000	3.00%	92.00%	8.00%	5.00%
30000-200000	4.00%	94.00%	6.00%	2.00%
2nd grade hospital				
0-3000	4.00%	91.00%	9.00%	5.00%
3000-10000	4.00%	91.00%	9.00%	5.00%
10000-30000	3.00%	95.00%	5.00%	2.00%
30000-200000	4.00%	94.00%	6.00%	2.00%
1st grade hospital				
0-3000	4.00%	95.00%	5.00%	1.00%
3000-10000	4.00%	95.00%	5.00%	1.00%
10000-30000	3.00%	96.00%	4.00%	1.00%
30000-200000	4.00%	94.00%	6.00%	2.00%

Payment / Reimbursement Rate for employees and civil servants from 50 year old to retirement  
(After policy justification)

3rd grade hospital	self-payment rate for civil servant	Pooling fund payment rate	self-payment rate for ordinary people	subsidy rate for civil servant
0-3000	3.00%	88.00%	12.00%	9.00%
3000-10000	3.00%	88.00%	12.00%	9.00%
10000-30000	1.00%	92.00%	8.00%	7.00%
30000-200000	2.00%	94.00%	6.00%	4.00%
				9.00%
2nd grade hospital				
0-3000	3.00%	91.00%	9.00%	6.00%

3000-10000	3.00%	91.00%	9.00%	6.00%
10000-30000	1.00%	95.00%	5.00%	4.00%
30000-200000	2.00%	94.00%	6.00%	4.00%
1st grade hospital				
0-3000	3.00%	95.00%	5.00%	2.00%
3000-10000	3.00%	95.00%	5.00%	2.00%
10000-30000	1.00%	96.00%	4.00%	3.00%
30000-200000	2.00%	94.00%	6.00%	4.00%

Payment / Reimbursement Rate for retired employees and retired civil servants  
(After policy justification)

3rd grade hospital	self-payment rate for civil servant	Pooling fund payment rate	self-payment rate for ordinary people	subsidy rate for civil servant
0-3000	1.00%	92.80%	7.20%	6.20%
3000-10000	1.00%	92.80%	7.20%	6.20%
10000-30000	1.00%	95.20%	4.80%	3.80%
30000-200000	1.00%	95.20%	4.80%	3.80%
2nd grade hospital				
0-3000	1.00%	94.60%	5.40%	4.40%
3000-10000	1.00%	94.60%	5.40%	4.40%
10000-30000	1.00%	97.00%	3.00%	2.00%
30000-200000	1.00%	95.20%	4.80%	3.80%
1st grade hospital				
0-3000	1.00%	97.00%	3.00%	2.00%
3000-10000	1.00%	97.00%	3.00%	2.00%
10000-30000	1.00%	97.60%	2.40%	1.40%
30000-200000	1.00%	95.20%	4.80%	3.80%

## Organization of the MI PLSSB

The administrative bureau is centralized in Changsha city and staffed with 40 people. The LSSB owns the office building in the governmental area of the city. The medical insurance administrative bureau is divided in six divisions:

- Medical insurance and Maternity
- Work injury insurance
- Retired higher public civil servant
- Supervision and monitoring
- Finance and auditing and control
- Coordination (collection of the premiums)

The provincial bureau and the municipal bureau use the same medical insurance department within the hospitals for example like Changsha city to administer the cases. The PLSSB is responsible for 14 municipalities and 126<sup>1</sup> county level bureaus.

## IT system of the MI LSSB

Since 2000 the provincial IT department developed and implemented an integrated hardware and network system (see Annex No. 2), they are structuring the system and the network security which based on the requirements of the different insurance schemes. All the systems are separated from each other with exception of the Medical, Maternity and Work injury Insurance. A unified system as a vertical or horizontal approach has not been realized. However, the IT department introduced common provincial software for the basic medical insurance urban residents and the work injury insurance. The basic medical insurance urban employees and retirees is different due to the initial development and implementation which means 3 software companies developed three different systems. The mainframe system is using the software ORACLE, PowerBuilder and Web logic which run on CSS/BSS model for the medical insurance. They back up the system once a week through an expert files system and daily back up every six hours. The files are stored in the same building.

Database concept:

Personal data	Surname, First name, Date of Birth, ID No., Mi No. (Provincial, municipal and county level)
Provider data	Registration No. of the hospital
Bill data	Admission, discharge, diagnosis, patient data, services, drugs, prices
ICD code	ICD 10
Individual card	Personal data
Drugs	Coding system defined by the provincial bureau
Service items	Coding system of the national list

## 3. Hunan municipal level administration of Medical insurance Changsha City

### General Figures of the MI

The medical insurance administrative LSSB was not able to provide us clear figures about

---

<sup>1</sup> The number of county level medical insurance schemes varies from 122 to 126 depends on their organizational status in Hunan province.

the coverage, the co-payments and other policies. The reason for that was that the administration just moved into the new office building and those them in a process of merging the district level MIs together with the municipal level. A couple of policies have not been decided yet. However the consultancy was dissatisfied from the low level of experience in the field of medical insurance.

By the end of 2008 the total population of Pingjiang County is 2.8 million. The Basic Medical Insurance covers 1.18 million employees and retirees. The BMI urban residents cover 780.000. The BMI is managing the around 70 to 80.000 type of flexible workers from state owned enterprises under 60/50 years old and have been injured or as well contributed for at least 10 years. This group will be subsidies by the local municipal government. The basic medical insurance is running a supplemental medical insurance to cover catastrophic diseases.

The contribution rates are fixed at 8% employer and 2% employee and the local government subsidies the budget for public civil servant by around 7%. The premium to cover catastrophic diseases is 90 RMB per person per year.

There are 170 hospitals in the municipal level and the medical insurance urban employees/retires hospitalization rate is 9.3%, these counts for 60.000 admissions and the average reimbursement rate per person is 4.581 RMB. Around 77% of the total medical expenses are reimbursed by the medical insurance and 23% are co-payments according to their regulations. The hospitalization rate 3.2% of urban residents is comparatively low which count for 4.401 admissions and an average reimbursement rate of 1.850 RMB per person per year. 47% of the total medical expenses are covered by the BMI urban resident and the co-payments 53%.

## Administration of the MI

The LSSB is rented by the local government and located in the city centre. The medical insurance administrative bureau is staffed with 72 people on permanently plus 20 contribution collections. The bureau is led by one director general and two deputy director general and is divided into ten divisions:

- Coordination and comprehensive Office
- Finance and Statistics
- Medical insurance auditing
- Medical insurance monitoring and supervision
- Medical insurance retirees (before 1949)
- Maternity
- Flexible worker
- Medical Aid
- Civil servants
- Urban residents

The IT management under the medical insurance suffers from the low financial capacity in terms of investment of the local government. Only one of 18 hospitals is connected with the

medical insurance bureau. The software is developed and implemented by a local software company which developed the hospital software as well. The database concept follows the provincial model. However, the manual workload of the medical insurance bureau is very high due to the underdeveloped IT connection between all providers and the bureau.

## 4. Hunan county level administration of Medical insurance Pingjiang and Xiangxiang County

### **Pingjiang County**

#### **General Figures of the MI**

By the end of 2008 the total population of Pingjiang County is 1.030.000 and the Basic medical insurance urban employees are implemented in 2002 and the urban residents in 2006. The Basic Medical Insurance covers 35.233 employees and retirees of which are 7.666 retirees. The employee/retiree ratio is 21.8%. The BMI urban residents cover 138.808 which are 69.4% of the total urban residents. The BMI is managing the medical expenses for 169 retirees (before 1949) and 113 servicemen (disability grade 2 and above). The basic medical insurance is running a supplemental medical insurance to cover catastrophic diseases.

The contribution rates are fixed at 7% employer and 2% employee. The BMI receives for the Retirees (before 1949) and Servicemen (disability grade 2 and above) 5.000 RMB paid by companies or organizations per year per person for their retirees. The local government subsidizes the budget for those two groups of the medical insurance and the yearly expenditure, around 2.2 million RMB, covers all medical expenses. The premium to cover catastrophic diseases is 80 RMB per person per year. Medical insurance urban residents premium is 30 RMB for population below 18 years, between the age 18 to 60 100 RMB and above 60 the premium is 60 RMB.

The basic medical insurance urban employees/retirees generated 23 million RMB as revenues and 15.3 million RMB as expenditure by the end of 2008. The medical insurance fund is running an accumulated surplus of 18.2 million RMB. Revenues of the individual account are 9.9 million RMB and expenditure 7.6 million RMB. The surplus is 7.7 million RMB. The revenue of this scheme is 3 million RMB and expenditure 3.7 million although the fund is running still a surplus of 3.2 million RMB. The medical insurance urban residents collected 15.98 million revenues, paid 8.22 million for provider expenditure and generated an accumulated surplus of 9.79 million RMB.

There are 18 hospitals in the county and the medical insurance urban employees/retires hospitalization rate is 9.3%, these counts for 3.331 admissions and the average reimbursement rate per person is 4.581 RMB. Around 77% of the total medical expenses are reimbursed by the medical insurance and 23% are co-payments according to their regulations. The hospitalization rate 3.2% of urban residents is comparatively low which count for 4.401 admissions and an average reimbursement rate of 1.850 RMB per person per year. 47% of the total medical expenses are covered by the BMI urban resident and the co-payments 53%.

## Hunan Pingjiang County Basic Medical Insurance for Urban Employees

### Copayment / Reimbursement Rate

Groups	Copayment For Inpatient Medical Costs				
	self-financed Section		Pooling Fund		Catastrophic Disease Fund
	Hospital Grades	Amount(¥)	> Deducible Line	> ¥10,000	> ¥24,00
			to ¥ 10,000	to ¥24,000	to ¥200,000 (Ceiling line)
	Deducible Line	Reimbursed by Pooling Fund	Reimbursed by Pooling Fund	Reimbursed Rate	
In-service Employees	1st	550	85%	94%	94%
	2nd	600	85%	94%	
	3rd	750	85%	94%	
Retired Employees	1st	550	90%	96%	94%
	2nd	600	90%	96%	
	3rd	750	90%	96%	

NT: 1) The deductible line for second hospital admission is ¥200.

## Hunan Pingjiang County Basic Medical Insurance for Urban Residents

### Copayment / Reimbursement Rate

Groups	Copayment For Inpatient Medical Costs		
	self-financed Section		
	Hospital Grades	Amount(¥)	> Deducible Line
			to ¥ 60,000 (ceiling line)
		Reimbursed by Pooling Fund	
Urban Residents	Community	100	65%
	1st	200	60%
	2nd	400	60%
	3rd	800	55%

NT: 1) The deductible line for second hospital admission is ¥100.

2) The deductible line for paediatric department in Pingjiang County People's Hospital and MCH hospital is ¥200.

3) Ceiling line is ¥ 60,000

### Administration of the MI

The LSSB is in the ownership of the local government and located in the city centre but the administration will be relocated to the newly established governmental area of the city. The medical insurance administrative bureau is staffed with 14 people on permanently plus 4 on temporary basis. The bureau is led by one director general and two deputy director general and is divided into six divisions:

- General Office 2
- Contribution and premiums collection office 3
- Auditing and Monitoring office 3
- Accounting and Finance office 3
- Urban Residents office 2
- Health care service monitoring and controlling office 2

The IT management under the medical insurance suffers from the low financial capacity in terms of investment of the local government. Only one of 18 hospitals is connected with the medical insurance bureau. The software is developed and implemented by a local software company which developed the hospital software as well. The database concept follows the

provincial model. However, the manual workload of the medical insurance bureau is very high due to the underdeveloped IT connection between all providers and the bureau.

## Xiangxiang County

### General Figures of the MI

By the end of 2008 the total population of Xiangxiang County is around 1.000.000 (126.000 urban area) and the Basic medical insurance urban employees are implemented in 2002 and the urban residents in 2008. The Basic Medical Insurance covers 42.582 employees and retirees of which are 14.668 retirees. The employee/retiree ratio is 34.4%. The BMI urban residents cover 63.000 which are 50% of the total urban residents. The BMI is managing the medical expenses for 182 retirees (before 1949) and 141 servicemen (disability grade 2 and above). The basic medical insurance is running a supplemental medical insurance to cover catastrophic diseases.

The contribution rates are fixed at 6% employer and 2% employee plus 4% for pensioners paid by the companies. The BMI receives for the Retirees (before 1949) and Servicemen (disability grade 2 and above) full subsidies paid out of the governmental the budget for those two groups. The premium to cover catastrophic diseases is 80 RMB per person per year.

### Hunan Xiangxiang County Basic Medical Insurance for Urban Residents

#### Premiums

The insured groups		Standard of Pooling (¥)		Government Subsidy (¥)		Individual Contribution(¥)	
		2008	2009	2008	2009	2008	2009
	Year						
Ordinary group of urban residents	age <18 Children & students	70	100	40	80	30	20
	age >18-60 Unemployed Residents	240	240	60	90	180	150
	age >60 The elderly group	240	240	140	160	100	160

<b>*Special group of urban residents</b>	<b>age &lt;18 Children &amp; students</b>	70	100	50	90	20	90
	<b>age &gt;18</b>	240	240	180	180	60	180

\*Special group of urban residents refer to Dibao, Wubao and 1-2 grade disabled groups.

The basic medical insurance urban employees/retirees generated 95.2 million RMB as revenues and 15.3 million RMB as expenditure by the end of 2008. The medical insurance fund is running an accumulated surplus of 18.2 million RMB. Revenues of the individual account are 9.9 million RMB and expenditure 7.6 million RMB. The surplus is 7.7 million RMB. The revenue of the catastrophic diseases scheme is 3 million RMB and expenditure 3.7 million although the fund is running still a surplus of 3.2 million RMB. The medical insurance urban residents collected 6.25 million revenues, paid 1.85 million for provider expenditure and generated an accumulated surplus of 4.4 million RMB.

There are 23 hospitals, 29 pharmacies, 4 health care centres and 3 community health centre in the county and the medical insurance urban employees/retires hospitalization rate is 14%, these counts for 5.742 admissions and the average reimbursement rate per person is 5.843 RMB. Around 62% of the total medical expenses are reimbursed by the medical insurance and 38% are co-payments according to their regulations. The hospitalization rate 4% of urban residents is comparatively low which count for 914 admissions and an average reimbursement rate of 1.403 RMB per person per year. 47% of the total medical expenses are covered by the BMI urban resident and the co-payments 53%.

## Hunan Xiangxiang County Basic Medical Insurance for Urban Residents

### Copayment / Reimbursement Rate

Designated providers	Unemployed Urban Residents age > 18				Children & Students Age < 18			
	Deductible line for First Hospital Admission (¥)		Reimbursement Rate for inpatient cost above deductible line (%)		Deductible line for First Hospital Admission (¥)		Reimbursement Rate for inpatient cost above deductible line (%)	
	Year	2008	2009	2008	2009	2008	2009	2008
Community Health Service Centre	100	100	70%	75%	100	100	70%	75%
1st Grade Hospitals	300	200	65%	70%	300	200	65%	70%
2nd Grade Hospitals	500	400	50%	55%	500	400	50%	55%
3rd Grade Hospitals	800	700	40%	45%	800	700	40%	45%
Ceiling line (including outpatient services for catastrophic disease)	30,000	30,000	/	/	70,000	70,000	/	/

## Administration of the MI

The LSSB is in the ownership of the local government and located in the city centre but the administration will be relocated to the newly established governmental area of the city. The medical insurance administrative bureau is staffed with 23 people on permanent plus 4 on temporary basis. The bureau is led by one director general and two deputy director general and is divided into six divisions:

- General Office 2
- Contribution and premiums collection office 5
- Auditing and Monitoring office 6
- Accounting and Finance office 3
- Urban Residents office 4

The IT management under the medical insurance is connected to all hospitals and to Xiangtan municipal LSSB due to the raising of the pooling levels. The software is developed and implemented by a local software company. The database concept follows the provincial model and the IT investments have been made by the municipal bureau.

## 5. Analysis of the Hunan provincial Bureau to improve medical insurance administration for cross catchment area health service<sup>2</sup>

With the increase of freely migration, the demand for healthcare to hospitals outside of catchment areas is growing. Since medical insurance system adopts the local management approach, cross catchment areas medical insurance administration system and mechanisms have not yet been established whilst contradictions exist, which are the root causes making cross catchment health service management much more difficult. To solve these problems needs to build regional collaboration and supervision mechanism step by step. The first step is to implement the delegated monitoring and supervision for cross catchment area healthcare cases within the province. The second step is to achieve

---

<sup>2</sup> Ding Chunting

Director General Hunan Insurance Administration Bureau for Medical, Work Injury and Maternity

medical insurance account settlement through online connected network cross the whole province. The third step is to achieve nationwide collaboration and online pay settlement across different provinces.

### **Cross-catchment healthcare and medical insurance mechanisms, Regional Collaboration, Delegated monitoring and supervision**

As a result of economic and social development, rapid population movement and disequilibrium allocation of medical resources, the cases of medically insured people accessing healthcare outside of cross catchment areas have been steadily rising. Under the current situation that medical insurance is not portable, this add new challenge and requirement to medical insurance administration authorities for managing cross catchment medical services. How to achieve effective management and quality health services for the insured outside of catchment areas has become a most important task for medical insurance administration authorities.

The rise of demand for healthcare outside of catchment area is an inevitable phenomenon with economic and social development

Cross catchment area health service refers to medically insured residents accessing to healthcare organizations and pharmacies in areas outside of catchment other than their registration or participation place. It is a type of medical seeking behaviour crossing catchment areas whereas the so-called outside catchment area is as opposed to participation place of the insured, in which they become registered in medical insurance. With China's economic and social development and transition, cross regional employment and migrant population are ever increasing. Under such major background, the number of medically insured people living, working and seeking health services outside of catchment areas is growing. In Hunan province, for example, the insured population outside of catchment areas for living or working purposes has currently reached more than 180,000 people, accounted for about 3% of total insured residents whereas above 60% of these people are retirees. In addition, average about 20,000 hospital visits every year are happened outside of catchment areas, accounted for 5% of the total number of hospital visits by the insured. According to people's living state, local residents for cross catchment healthcare can be divided into the following types:

- Type 1 Inhabitation group: It refers to the insured retirees who have resettled back their hometown or with their children or relatives seek healthcare in resettled location outside of catchment area after registration on their resettlement at original insured place.
- Type 2 Referral group: It refers to the insured patients who are firstly diagnosed by hospitals in catchment area but needed for referral to hospitals outside of catchment areas due to limited medical technology and equipment. After registration of cross catchment area medical treatment at original insured place, these patients are treated at referral hospitals outside of catchment areas.

- Type 3 Working Group: It refers to the insured employees who are sent by their companies working outside of catchment areas for a long term and seek healthcare in their work-based area. After registration of cross catchment area medical treatment at original insured place, these employees can access to healthcare providers in their work-based outside of catchment area.
- Type 4 Temporarily travelling group: They refer to the insured people who may seek emergency, outpatient or inpatient service outside of catchment area due to illness when they are temporarily out on business trips, for study, tour or visiting relatives.

Table 1 Distribution of Hunan provincial level resettlement and working group in 2007 (according to in or out of Hunan Province)

types	Retired		Employed		Total
	Number of People	%	Number of People	%	
In Hunan Province	1,700	38.20%	2,751	73.67%	4,451
Outside Hunan Province	2,785	61.80%	1,721	26.33%	4,506
Total	4,840	100.00%	2,317	100.00%	8,957

Table 1 shows that about each half of total retirees for resettlement group at provincial level are within Hunan and outside of Hunan, of which 4,451 people in the province, accounted for 49.69%, 4,506 people outside the province, accounted for 50.31 percent. Moreover, the employees accessing healthcare outside of catchment area are mainly distributed within the province, accounted for 73.67% of total number in working group whilst retirees are largely distributed outside of Hunan accounted for 61.8% of total number of retirees in resettlement group.

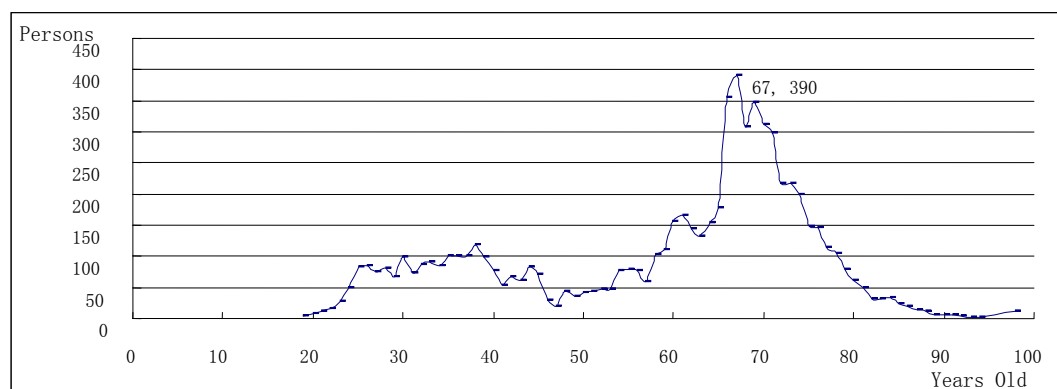
Table 2 Distribution of Hunan provincial level resettlement and working group in 2007 (according to different provinces base)

Serial Nr.	Province	Persons	%
1	Hunan	4,451	49.69%
2	Guizhou	1,200	13.40%
3	Guangdong	816	9.11%
4	Hubei	682	7.61%
5	Sichuan	536	5.98%
6	Beijing	496	5.54%
7	Shanghai	348	3.89%
Total		8,529	95.22%

As presented in Table 2, most retirees and employees who need for healthcare outside of Hunan province are respectively in the Guizhou Province (13.40%), Guangdong Province

(9.11%) and Hubei Province (7.61%).

Figure 1 Age distribution of Hunan provincial level resettlement and working group



Above figure illustrates that the average age of resettlement and working group for healthcare outside of catchment area is 58.8 years old. There are 4,473 retirees and employees aged above 60 years old and based outside catchment areas, which is accounted for 62.5% of total number of people in these groups whilst the number of people aged 67 is 390, which has the maximum size.

Table 3 Distribution of hospital admissions by provincial insured people outside of catchment areas in the years of 2003 - 2007

Year	People insured but not resettled outside of catchment areas		People insured and resettled outside of catchment area		Total
	Number of hospital admissions	%	Number of hospital admissions	%	
2003	1,543	74.65%	524	25.35%	2,067
2004	1,496	70.43%	628	29.57%	2,124
2005	796	53.67%	687	46.33%	1,483
2006	732	50.24%	725	49.76%	1,457
2007	1,021	54.42%	855	45.58%	1,876
Total	5,588	62.04%	3,419	37.96%	9,007

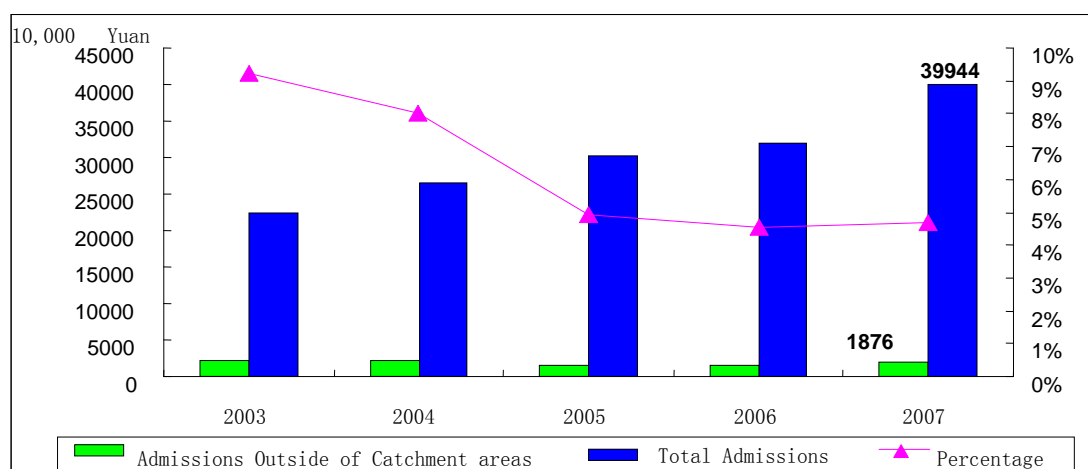
Table 3 shows that the number of hospital admissions outside of catchment areas by the provincial insured is 9,007 during 2003-2007, which involves groups for resettlement, emergency services and referrals. Whilst total 5,588 admissions between 2003 to 2007 belongs to non resettlement group, accounted for 62.04%, there are present 3,419 falling into resettlement group, accounted for 37.96% which is lower than the figure of non resettlement group. This was mainly due to the fact that some insured people for resettlement group were withdrawn in 2007. As it is presented in the table, the proportion of admissions for resettled group and non resettlement group were 45.58% (855 admissions) and 54.42% (1021 admissions) respectively.

Table 4 Distribution of hospital admissions by provincial insured people outside of catchment areas between 2003-2007

Year	Retired		Employed		Total
	Number of hospital admissions	%	Number of hospital admissions	%	
2003	1,478	71.50%	589	28.50%	2,067
2004	1,430	67.33%	694	32.67%	2,124
2005	1,110	74.85%	373	25.15%	1,483
2006	1,168	80.16%	289	19.84%	1,457
2007	1,409	75.11%	467	24.89%	1,876
Total	6,595	73.22%	2,412	26.78%	9,007

As shown on table 4, hospital admission rate in 2007 of the people insured and resettled outside of catchment area is 11.95%, which is slightly lower than the rate of hospital admissions in catchment area. Ex-patient staff retiree's account for about 3 / 4 admissions outside of catchment areas were retirees, numbered 6,595 and accounted for 73.22% of total number of admissions during 2003-2007, no significant statistic variance among different years.

Figure 2 Variance Trend of Hospital Admission outside of catchment areas of the provincial insured



Above graphic demonstrates that hospital admissions ratio outside of catchment areas in total admissions declined from 9.32% in 2003 to 4.70% in 2007 whereas the rates during 2005-2007 were remained about 5%.

Table 5 Categories of the insured seeking healthcare outside of catchment

Types	Characteristics	Medical Cost	Current administration
Working	Majority in-service staff; comparatively concentrated; having	low morbidity rate; moderate costs	Settlement via computerized network; local management

	large group		
Referral	Both in-service staff and retirees; comparatively dispersed; small group	Catastrophic diseases; high costs; normally in large cities	Reimbursed at original insured place according to referral letter and relevant required files
Inhabitation	Majority retirees, comparatively dispersed; large group	High morbidity rate; high costs	Reimbursed at original insured place according to relevant required files
Temporarily Travelling	Both in-service staff and retirees; comparatively dispersed; small group	Emergency services; moderate costs	Reimbursed at original insured place according to relevant required files

The absent of relevant policies in medical insurance system is the root cause making cross catchment areas healthcare services management much more difficult

One of the fundamental principles of current medical insurance policy is local management principle. As stipulated in the policy of No. 44 of the State Council, the basic medical insurance (BMI) system adopted municipal or county level pooling whilst the local governments make their corresponding service administration policies according to the principal of 'spend-and-tax' and 'the balance of revenue and expenditures'. As a result, various corresponding policies have been made according to their local economy level, which means great variation in different local policies, different copayment rate, benefit package and different three lists on service, drug and medical facilities. Such medical insurance relations can not be transferred since it was built on the basis of local policies, measures and management model, which means contradictions exist among different regions in implementing cross catchment areas health insurance administrations. Cross regional mechanisms on service management ought to be established to solve or eliminate such contradictions. Due to the absent of relevant policies in medical insurance system, cross catchment area healthcare and health insurance administrations become much more difficult.

Without relevant mechanisms, cross catchment area healthcare and administrative services have been a weak link in developing harmonious medical insurance system. Several major issues have been resulted from such weak link. The first major issue includes difficult access to healthcare, expensive medical treatment, and a lot of complains from the insured. Since Medical expenses outside of catchment areas can not be paid direct from medical institutions and medical insurance administration authorities, the insured have to make advanced full payments for treatment received out of their own pockets, which will be reimbursed by local medical insurance administration authorities via individuals or their employers. Problems emerged, such as huge advanced payments, long period for reimbursement, complicated procedures, etc. At the same time, certain insured groups of people, for example the elderly with chronic diseases, may be

reimbursed for certain medications within catchment area but may lose such insurance benefits outside of catchment area due to different policies and prices implemented among different areas. Such expenses adds burden to the insured and leads high proportion of individual co-payment to patients who use cross catchment areas medical services. As a result, huge concerns have been raised and frequent complaints have been sent to higher authorities by the service users. The second major issue is the excessively rising medical costs leading to higher medical expenses outside of catchment areas than the local medical expenses. This is mainly because effective monitoring and supervision has been limited to hospital practices by medical insurance administration authorities whilst healthcare providers lack awareness and responsibility in controlling medical costs as all costs have been paid in full and in advance by the insured patients. The third major issue is the fraud of medical insurance fund occurred from time to time. Administration authorities have often detected and exposed some defrauders who provided forged medical documentation, false medical cases, fake invoices and committed malicious crimes of medical insurance fraud. The fourth major issue is great difficulties in monitoring and high administrative cost have to be faced by those managerial authorities. Therefore, the development of a harmonious medical insurance system ought to place emphasis on identifying problems existing in cross catchment area health services and developing management mechanisms for the services.

Table 6 Inpatient medical expenses outside of catchment areas by the provincial insured between 2003-2007

Year	Retired			Employed			Total		
	Number of admission	Average cost per admission ( Yuan/per admission)	Subtotal ( 10,000Yuan )	Number of Admission	Average cost per admission (Yuan/per mission)	Subtotal ( 10,000Yuan )	Number of Admissions	Average cost per admission (Yuan/per admission)	Total (10,000Yuan)
2003	1,478	5,532.62	817.72	589	6,008.54	353.90	2,067	5,668.24	1,171.62
2004	1,430	7,210.33	1,031.08	694	5,051.03	350.54	2,124	6,504.8	1,381.62
2005	1,110	9,857.98	1,094.24	373	13,490.12	503.18	1,483	10,771.53	1,597.42
2006	1,168	10,859.70	1,268.41	289	10,488.99	303.13	1,457	10,786.17	1,571.54
2007	1,409	10,688.17	1,505.96	467	13,786.69	643.84	1,876	11,459.5	2,149.80
Total	6,595	8,669.31	5,717.41	2,412	8,932.82	2,154.60	9,007	8,739.88	7,872.01

It is apparent from table 6 that the medical expenses of the provincial insured for inpatient services outside of catchment areas was continuously increased year after year from about 11.72 million Yuan in 2003 to 21.498 million in 2007 with an average annual growth rate of 20.87%. In addition, average cost of one admission for cross catchment area healthcare rose from 5,668 Yuan in 2003 to 11,459 Yuan in 2007 with an annual growth rate of 25.54%, representing a 20% higher cost growth rate than the local figure.

Figure 3 Hospital admissions and medical expenses outside of catchment areas by Hunan provincial insured people during 2003-2007

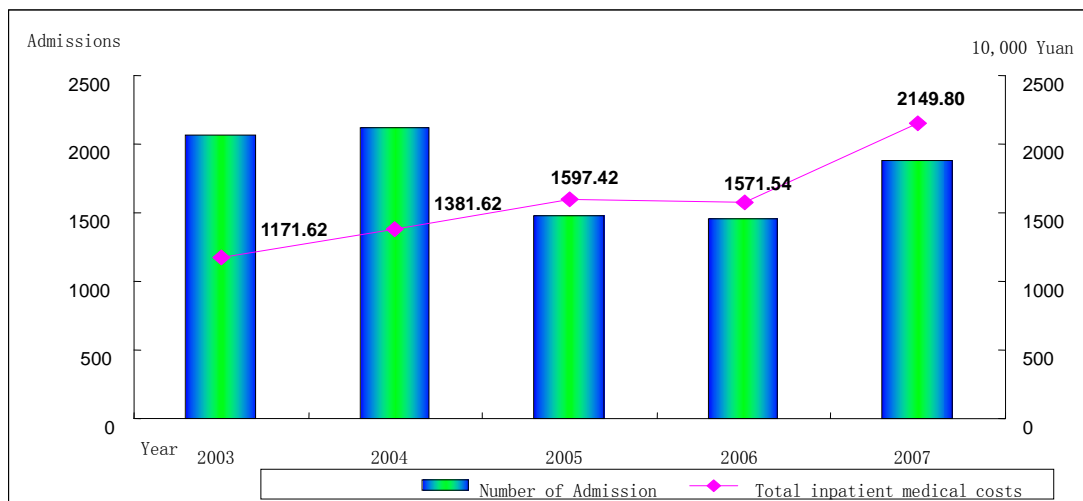


Table 7 Comparing average inpatient medical costs per admission between outside and in catchment areas of the provincial insured during 2003-2007

Year	Average cost at hospitals outside of catchment areas (Yuan)	Average cost At appointed local hospitals (Yuan)
2003	5,668.24	8,542.38
2004	6,504.80	8,167.21
2005	10,771.53	8,131.67
2006	10,786.17	8,257.72
2007	11,459.50	8,026.99

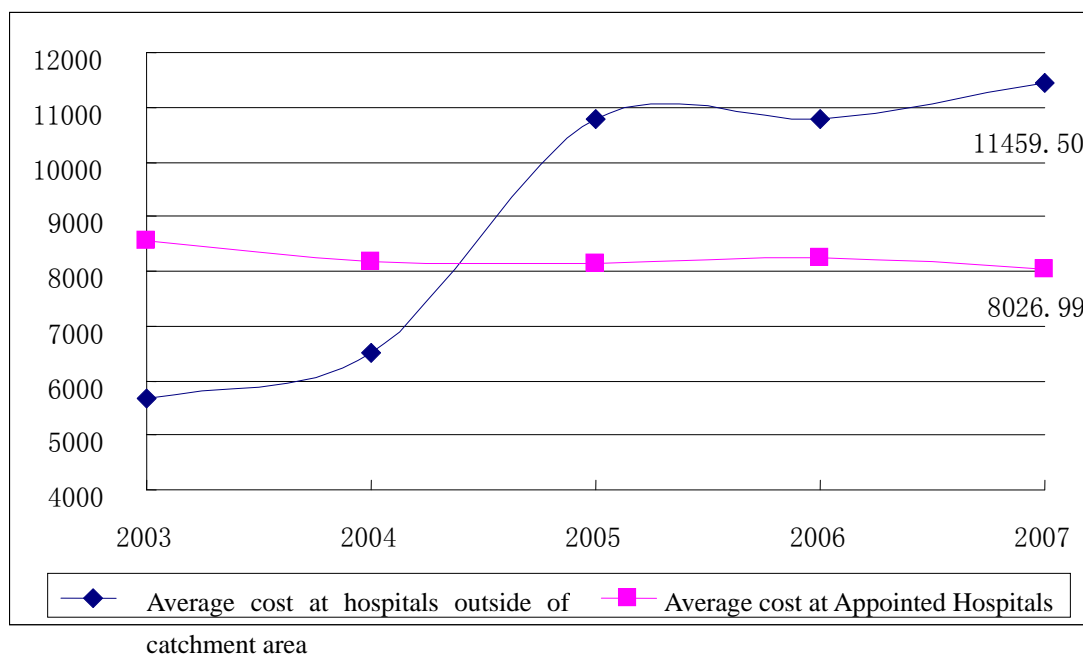


Figure 4 Comparing total inpatient medical costs between outside and in catchment areas of the provincial insured during 2003-2007

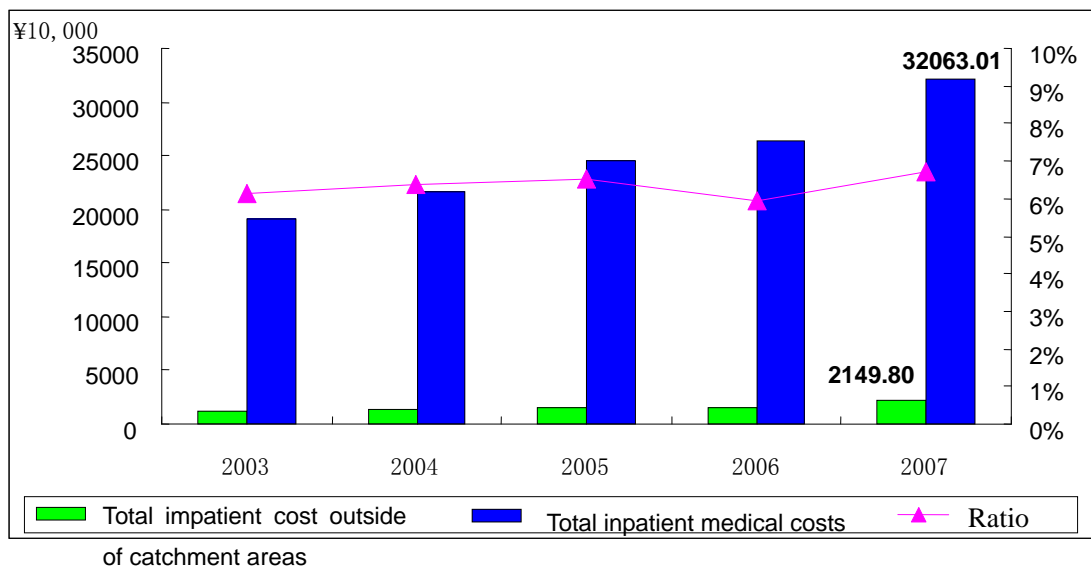
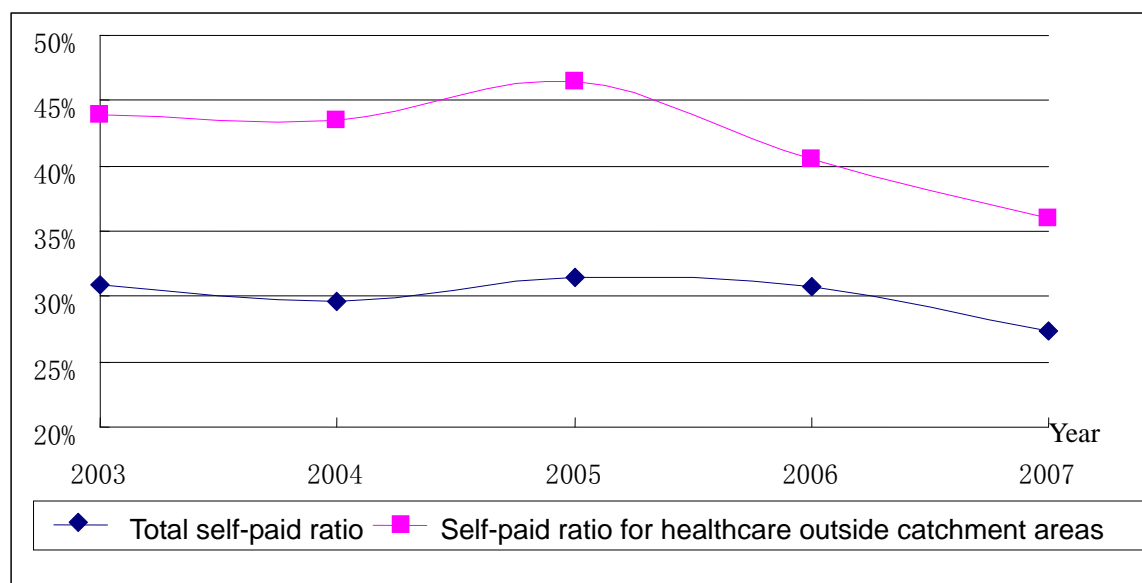


Table 8 Co-payment rate for inpatient medical cost outside of catchment areas by the provincial insured patients during 2003-2007

Year	Number of Admissions	Total cost	Reimbursed	Self-paid	Reimbursement rate	Self-payment rate
		¥10,000	¥10,000	¥10,000	%	%
2003	2,067	1,171.62	656.86	514.77	56.06%	43.94%
2004	2,124	1,381.62	780.54	601.08	56.49%	43.51%
2005	1,483	1,597.42	854.40	743.02	53.49%	46.51%
2006	1,457	1,571.54	935.67	635.88	59.54%	40.46%
2007	1,876	2,149.80	1,374.94	774.86	63.96%	36.04%
合计	9,007	7,872.01	4,602.40	3,269.60	58.47%	41.53%

Figure 5 Comparing co-payment rate for inpatient cost between outside and in catchment areas during 2003-2007



As it can be seen from figure 5 and table 8, the self-paid proportion presented a decreasing trend among 2003-2007 for treatments outside of catchment areas by Hunan provincial insured people. However, such self-paid proportions for healthcare outside of catchment area are still 10%-15% higher than local figures.

Innovative mechanisms and management system is the essential solution for strengthening cross catchment areas healthcare and medical insurance management

Three thoughts for cross-catchment areas healthcare and insurance management  
Raising pooling level to municipal or provincial level, reducing the total number of catchment areas so as to decrease the total number of cross catchment areas health services users.

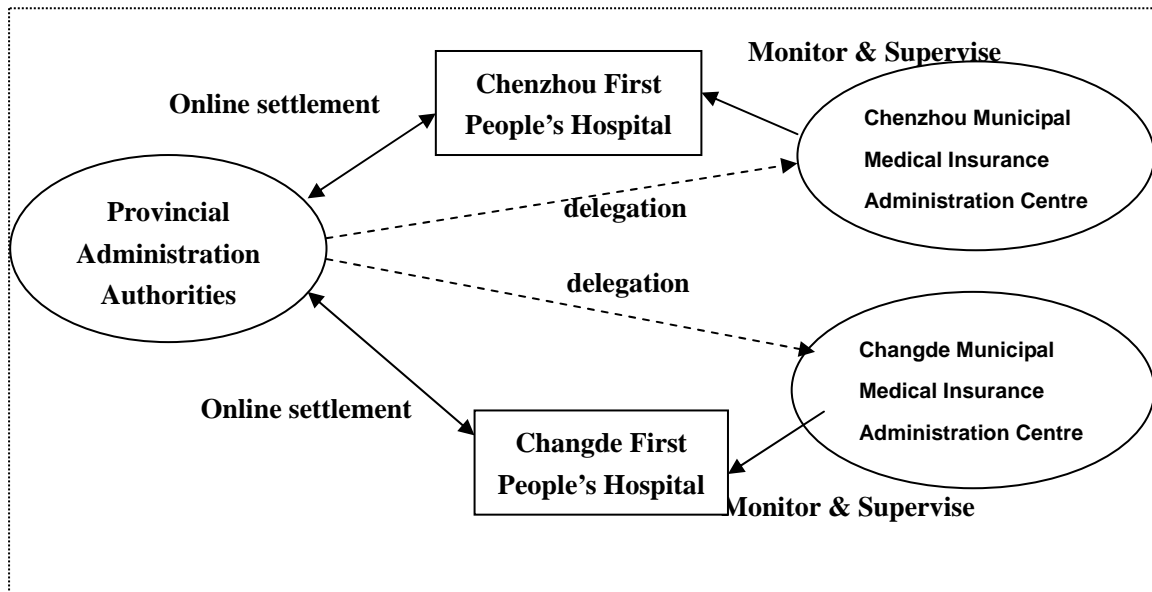
Releasing national medical insurance policy on insurance portability issues and eventually eliminating the cases of cross catchment area healthcare. Establishing cross catchment areas health service management mechanisms to achieve long-distance administrative goals.

Exploratory trial on cross catchment areas health insurance administration in Hunan

To explore cross catchment areas health insurance management in Hunan, emphasis has been placed on the establishment of cross catchment areas administrative mechanisms and long-distance management implementation.

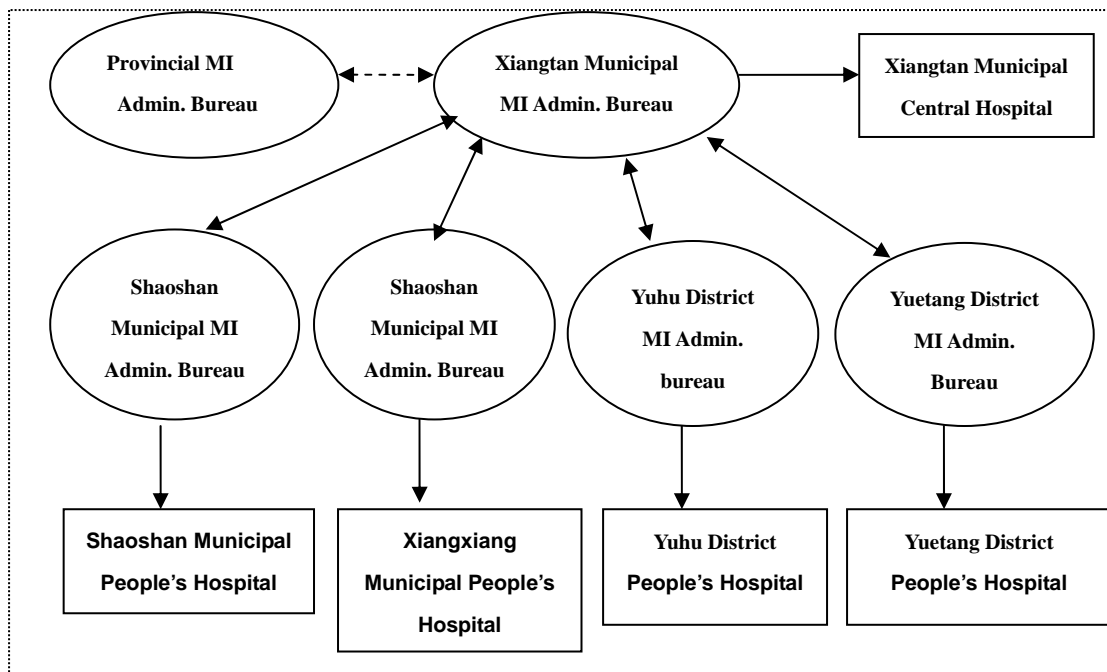
Online settlement & delegated monitoring and supervision

One or two appointed hospitals are determined in cities outside of catchment areas, in which have relative large number of provincial insured people for long-term living. These appointed hospital is regarded the same as other in-area designated hospitals providing both outpatient and inpatient services, implementing connected networking system for pay settlement and no advanced payment by the insured users. However, administration and monitoring have been delegated to ex-area medical insurance administrative authorities on information authenticity such as hospital admissions of insured patients, necessary treatments and health services standards of appointed hospitals. This is due to difficulties in monitoring and high cost in management for provincial bureau as these ex-areas generally are far away from Changsha- the provincial medical insurance administrative bureau base. So far, implementation pilots for cross catchment areas healthcare has reached Zhuzhou, Chenzhou, Changde in Hunan province, Wuhan in Hubei province and etc, which have solved healthcare issues of thousands of provincial insured people outside of catchment area whilst reduced their financial burden.



**In-areas online account settlement at municipal level**

Xiangtan municipal in Hunan province has achieved 'four unification' at municipal, district and county levels in basic medical insurance, that is, unified information system, unified database, a unified operating software, and unified platform for online account settlement. All insured people in Xiangtan municipal has been freely referred to appointed hospitals cross different catchment areas in Xiangtan municipal for inpatient services whilst payments have been able to be settled via connected network and in real-time. Provincial medical insurance administration bureau is currently working with Xiangtan municipal administration bureau for achieving online settlement on medical expenses cross two different cities between Changsha and Xiangtan, which could be the first example in China achieving online account settlement at provincial level.



The establishment of joint audit and investigation mechanisms in Hunan province for ex-areas referral cases

All medical insurance authorities conduct spot-check on a regular basis on medical records of referral cases and medical insurance reimbursement on their expenses according to the regulations. The results of spot-checking are presented as evidence in assessing annual work performance and credit rank of medical institutions whilst they are announced in order to effectively control and guide the insured patients for medical treatment. Moreover, local express ways and inter-area mechanisms are established between different medical insurance administration authorities for monitoring and auditing delegation. For Any violation or breach of contract on fees proved after investigation, designated healthcare organizations will be punished by local medical insurance administration authorities according to relevant regulations whilst related medical insurance authorities will be informed in time. The Implementation and establishment on ex-area referral system whilst local management approaches and joint audit and investigation at provincial level is beneficiary to unify different fee settlement standards gradually, to strengthen the supervision on designated medical institutions and to prevent the loss of funds.

Ex-areas designated hospitals contract management:

Some medical insurance administration authorities in different cities or areas have signed service agreements with some designated acute hospitals in Changsha whilst particular personnel is appointed for monitoring the implementation of the medical services agreement. However, insured patients still have to make advance payment in full for medical expenses in these appointed acute hospitals in Changsha but costs can be reimbursed at their insurance participation place.

Ex-area collaboration approach

For any doubts on any fees and invoices in the process of reimbursement, local administration authorities are delegated via telephone, fax or official letter for joint investigation. Fraud can be detected to some certain extent by this approach.

Future expectation on cross catchment area health insurance management in Hunan province

Through exploratory implementation so far, we reckon that innovative and collaborative management mechanisms cross catchment areas ought to be established under the current medical insurance administrative system in order to strengthen ex-area medical insurance management. Hunan therefore plans for next stage to set up cross catchment areas medical insurance administrative service system for developing ex-areas health services step-by-step.

Short-term targets – municipal (or regional) freely referral system in catchment areas

Xiangtan model will be copied to other regions in the province wide. In addition, ‘four unification’ at municipal, district and county levels on basic medical insurance system need to be achieved in future one to two years, that is, unified information system, unified database, a unified operating software, and unified platform for online account settlement. Information can then be shared whilst all insured patients from different catchment areas can be freely referred at municipal level and payment for inpatient service at ex-area appointed hospitals can be settled via online network and in real time.

Middle term targets – to achieve province-wide online account settlement

The model of basic medical insurance for urban dwellers adopted in Hunan is united development, municipal level implementation and connected network via whole province, which has laid a solid foundation for province wide online account settlement on medical insurance system. Through urban dwellers system network, provincial basic medical insurance system can be linked with all other municipal or regional system for information flow so as to achieve province wide online account settlement for cross catchment areas healthcare cases. This connected system will be the foundation to achieve provincial level pooling in the future.

Long-term goal - to achieve in-province wide roaming, cross provincial medical insurance online network settlement

Under the leadership of MOHRSS, the status quo of region or area based segmentation in medical insurance system will be defragmented whilst regional coordination will be strengthened so as to achieve province wide and eventually nationwide network for online medical insurance account settlement.

## **6. Recommendation**

ITAT has visited Hunan Medical Insurance Management Bureau, Provincial Information Centre, Changsha Municipal Medical Insurance Centre, and its information centre in this week from 1st December to 5th December. PLSSB and LSSB is on the right track in developing IT and coding system, such as unifying information system, information flow and database, which is very helpful for implementing cross catchment medical insurance scheme in near future. As for the administration of medical insurance, however, ITAT pointed out many places need to improved or be further developed. For example, services for reimbursing cross-catchment medical cases can be increased from current 1day/per week to all working days during the week. In addition, the control system for payment needs to be more efficient and secure, such as lessen seven signatures approval procedure (like using no more than 4 signature for example in the Germany system),

reducing unnecessary work load by implementing better control through IT system for checking or using co-check or co-sign system. Three lists in general is clearly organized but the coding system for drug list has not been set up from the central level, which may create extra work for local authorities.

Mr. Stueker indicates that municipal level medical insurance is defragment in system since traditionally the system is divided as BMI for urban employees, urban residents, flexible workers, medical aid and employees in difficult SOEs. Although the structure shows systematical way but it should be managed in an easy way. For instance, employees in difficult SOEs have no income so that unable to pay premium. On the one hand, local government has provided subsidy for covering this group of people in a good way onto MI scheme. On the other hand, the way in managing this group's medical insurance is separated from the main streaming, which is not the right way and is different from EU experiences. EU experience shows that any groups of people receiving insurance subsidy from the government are handled in the same way as others because they are belong together and could be managed as the main streaming line in the system. If employees in difficult SOEs are administered in separate ways, problems will emerge affecting both the insured in SOEs and administration bureau, such as lower benefits on the insured side in SOEs whilst increased administration cost on administration bureau side. One suggested solution is to integrate them into medical insurance stream line.

Mr. Shi has introduced that Changsha, Changde and Xiangtan are currently pilot municipals in Hunan implementing golden insurance project. All pilots are able to do registration work for the insured but the settlement has not been processed which is still under the construction in Changsha. Mr. Shi has indicated that one reason could be that PLSSB and Changsha LSSB used the same platform, IT system and company before but Changsha LSSB has changed the system newly developed by another company whilst PLSSB has maintained the old system with upgrade. The new system in Changsha LSSB has many problems right now and PLSSB plans to hold a meeting with them on this issue. Since Changsha Municipal Social Security Bureau has just moved to this new working place and not really been settled yet, Mr. Stueker is aware of this and noticed that some process were even not connected due to this reason, such as pay settlement to providers. Mr. Stueker has concluded that the visit this time is the right start and another 2 field visits are necessary in January. One is fund management field visit for two days at both provincial and municipal level in Hunan together with fund management ITAT. Another is county level medical insurance field visit in Hunan for 5 working days at two counties as agreed with Hunan Medical Insurance Administration Bureau.

If Hunan is confirmed as project pilot province by the ministry and SIAC and according to project revised plan, Mr. Stueker plans to recruit one international short-term expert and one Local Senior Sort-term expert. All appointed experts will work closely and coordinately in conducting further research, delivering planned seminars, workshop and study tour. Details needs to be further discussed and confirmed.

One of major key stone is IT system, including coding system. For future project cooperation work, it is significant to meet and work closely with IT departments who manage the implementation of golden insurance project. This is the milestone towards cross-catchment medical insurance management, rising pooling level and fraud control and prevention.

Hunan Medical Insurance Bureau requests to involve Hunan as project pilot city in CI medical insurance scheme. In addition, they would like to know more about how to manage service providers better, especially the contract management, cost control mechanisms, co-payment reduction methods, how to improve the supervision and monitor towards the insured, and how to manage cross catchment medical insurance, to supervise and to settle the payment. Moreover, they would like to know and to learn more about EU experiences in solving these issues.

Regarding contract management, Mr. Stueker compared the contracting mechanism in China in general and EU experiences. The service agreement for providers (Annex 1) needs to be more concrete, more specified on what MI bureau want from hospitals (e.g. Service type, good quality), clear definitions and better regulations. Mr. Liu requests to have an EU example on service agreement for hospitals and price list example of medical materials.

Mr. Stueker agreed to discuss with MOHRSS and SIAC on involving Hunan as a project pilot province in cross catchment medical insurance Management scheme as Hunan PLSSB requested.

Mr. Stueker agreed that county level field visits in Hunan will be conducted either one week before or one week after the spring festival. Two specific counties and time line needs to be confirmed by the ITAT.

An example of EU service agreement will be delivered by Mr. Stueker as Hunan Medical Insurance Management Bureau requested.

Samples of medical material price list in Germany (e.g. cardio surgery stents) will be sent by Mr. Stueker as Hunan Medical Insurance Management Bureau requested for the comparison of service list price in Hunan.

Ms Sylvia agrees to post a copy of CD on 4th high level provincial training materials to Mr. Shi PLSSB.

Hunan county level field visit - Mr. Sun, deputy director general of Hunan Medical Insurance Management Bureau, suggests experts selecting one county close to Changsha and another county far from Changsha region. Specific counties can be decided by ITAT. County level field visit needs to be clarified by the project.

Hunan as project pilot province in Cross catchment medical insurance scheme needs to be confirmed by the Chinese project Director Mr. Dai as DG Mr. Ding Chunting requested.

Annexes:

1. Service Contract

## ***SERVICE AGREEMENT FOR CHANGSHA URBAN BASIC MEDICAL INSURANCE DESIGNATED HOSPITALS***

---

**Party A: Hunan provincial administration Bureau for medical insurance, work injury and maternity insurance**

**Party B:**

To ensure the basic medical need of the insured and the legal rights of both parties, to clarify the rights and obligations of both parties and the cost settlement and to unify basic operation measures of doing basic medical insurance in Changsha urban areas in order to promote the standard management of Changsha urban medical insurance service, based on national and provincial relevant medical insurance policies and regulations and through negotiation between the two parties, the following agreement is signed.

### **Chapter 1 General Principals**

1. After the agreement is signed by the two parties, Party B shall be recognized as the designated hospital for Changsha urban basic medical insurance and for the transferred insured all over the province. Both parties shall follow all policies and regulations of medical insurance.  
Party in accordance with the provisions of access to or copying the medical records of insured workers to verify the hospital fees, verification of identity of patients, the B should be supported and provide convenience.
2. Party B shall designate an academy-level director to lead the medical insurance work and set up a special organization; at the same time, Party B should equip the organization with professional management personnel and establish proper and corresponding medical insurance management system to work with Party A's medical insurance service management work.
3. Party B shall, in accordance with medical insurance service management requirements, give convenience to the insured to facilitate medical treatment, such as the establishment of Medicare window, notice of the phone numbers, set-up of a suggestion box and the update of the policy advocacy column, etc.; and provide the insured with detailed list of medical expenses or provide information consultation. When Party A check or copy the insured's record information, check inpatient medical cost or check patients' identities, Party B should give full support and convenience.
4. Party B shall use medical insurance management software authorized by Party A and the software should meet the demand of information management of both

parties. The maintenance cost of the medical insurance management software shall be charged on Party B but Party A shall assist with the coordinating work. Party B must connect its settlement with Party A's network; otherwise, Party A has the right to end the agreement. Party B is not allowed to make any change to the software; otherwise, Party A has the right to end the agreement. The medical insurance fund loss due to Party B's bad operation shall be undertaken by Party B.

5. Party A shall be responsible to organize medical insurance management and operation training for the personnel from Party B and Party B shall cooperate with and participate to make sure all relevant people are qualified.
6. Both parties have the right to give each other reasonable advice and reveal or make a complain about any violation behaviour.

## **Chapter 2 Medical service management**

7. When there's a inpatient insured, Party B shall check his ID or IC card and the diagnosis and treatment handbook and follow relevant medical insurance regulations formed by Provincial and municipal departments. If the card does not belong to the patient, Party B shall inform Party A and not settle the bill according to medical insurance policy, besides, Party B shall detain the IC card and diagnosis and treatment handbook. After the insured stay in hospital, Party B shall manage the handbook and IC card by a central system. Party A can check the system regularly.
8. Party B is not allowed to refuse to accept the insured that is qualified to be accepted or to accept the insured that is not qualified to be accepted. For those who are ready to leave hospital because of recovery, Party B shall do the leave procedure and record all the inpatient treatment details in the handbook.
9. The inpatient treatment interval shall be over 28 days for the insured (the following is not included: emergency inpatient, normal transfer-in, tumor radiation treatment and different disease type inpatient treatment). Party shall not order the insured to pay the bill by outpatient or individual account; Party should understand the meaning of Party A's cost control policy and use it properly and shall not send out the inpatient patients before recovery or charge them in the way of individual payment. Party B is not allowed to lower the service quality because of the cost control policy; otherwise, Party B is liable to relevant consequences. If there's any complaint from the insured, Party A shall handle accordingly.
10. If there is any case needs to be transferred to hospitals of other provinces because of the limitations of medical technology or medical facility in Changsha, Party A shall authorize Xiangya Hospital, Xiangya Er Hospital and Provincial Cancer Hospital (only for malignant tumour). These hospitals shall do the transfer procedure accordingly and report for approval by Party A.
11. When Party B accept the insured who has provincial medical insurance and is transferred from other cities, Party B should check the transfer paper (emergency is not included), diagnosis and treatment handbook and the ID card and other

relevant credentials etc. and record the personal information and the medical cost information about the insured into Provincial medical insurance information system. The information shall be supervised by provincial medical insurance department. The patient shall pay all bills by himself first and Party B shall include the medical cost list and medical insurance settlement list in a paper bag and seal it. The patient shall go back to his insurance area and use the papers to reimburse accordingly. If there's any questions arise during the reimbursement, Party B is responsible to coordinate with the insurance department and provincial medical insurance department.

12. In accordance with the policy to reduce individual payment of the insured, Party B shall use insurance medicine as possible. If it is demanded by the disease situation that self-payment medicine (partially or not partially), treatment task, medical service facility need to be used, Party B shall fill in the form of "Changsha urban medical insured self-payment project agreement" and explain to the patient or his family member beforehand. The medicine shall be used after the signature (medicine used during operation could be signed afterwards). The medicine used without signature or without complete information, Party A and the insured have the right to deny the cost. If the insured wants beyond-the-standard medical service, he shall sign an agreement to ensure his self payment for the beyond-the-standard bed cost. In this case, the cost shall not be included in the medical cost control range.
13. Party B should check disease adaptation strictly about all tests and examinations and shall not list unnecessary examinations or special test (such as colour supersonic detection, CT, MRI and meal etc.) into regular examination list.
14. New medical service programs launched by Party B shall not be included in medical insurance collective fund payment range. For those special clinic program that have good treatment result and reasonable price, their cost standard and relevant data shall be report to price Bureau and health administrative department for approval. Provincial medical insurance bureau shall check the program very carefully. After the payment standard for the program is specified, Party B shall be noticed.
15. If there's medical dispute during the treatment of the insured, Party B shall inform Party A in time and Party A shall decide whether to pay according to medical accident examination conclusion. All medical accidents or medical disputes during the treatment should be reported to Party A; otherwise, Party A has the right to refuse to settle the medical cost occurred. If there's very serious consequence due to many medical disputes or accidents happened during Party B's treatment, Party A shall have the right to end the agreement unilaterally.
16. When doing examinations, using medicines, giving treatment, Party B shall be very reasonable. All test and examination, medicine usage and treatment shall be recorded in the handbook and give the result analysis. Party B should try to meet four compliance of inpatient cost: medical cost list, inpatient diagnosis, treatment record and recovery record.
17. When the insured leave the hospital, Party B is only allowed to provide oral

medication related to the disease and no examination and treatment programs. The quantity and category of the medicine shall be recorded very carefully in the recovery record book and recovery instructions. As for quantity, 7-day medicine is allowed for acute disease while 15-day for chronic disease; as for category, it shall not exceed 4 kinds.

18. Medical cost occurred during the emergency treatment which is within 72 hours before the inpatient treatment shall be included in the inpatient medical cost after being approved by the medical insurance department of Party B. The cost does not be included but is qualified for reimbursement shall be refused to pay the collective fund for the emergency cost. Emergency cost occurred for transferred patients shall be reported to Party A for reimbursement after the recovery.
19. Party B should do the management work carefully for the special disease outpatient treatment, establish original documents, keep all original credentials, make disease treatment plan, keep good treatment record and implement cost control policy strictly. If there are no complete original documents or credentials, they shall be recognized as fake cases.
20. The following accidental patients' payment can be reported to Party A for reimbursement: the elder who are not good at movements, accidental patients caused by special diseases (such as high blood pressure, hypoglycaemia, osteoporosis and cerebrovascular sequela and etc.) or of unpredictable reasons. The accidental injury range shall not include: work injury, maternity, self-duplication, suicidal, trauma by other people, crime, drunken, drug use, pet accident, traffic and medical accidents. When Party B needs to accept a patient of accidental injury, they shall examine the case very carefully according to relevant papers and include the adequate ones into medical insurance and get the documents in record for later inspections. Party A shall check the documents selectively and periodically. If Party B accept some patients that are not qualified for the medical insurance settlement, Party A shall refuse to pay three times of the medical cost occurred and give a 5 points punishment of the year-end appraisal.

## **Chapter 3 Cost settlement and information transmission**

21. The deposit Party B charges on the patient shall not exceed 30% of the predicted medical cost. When the patients leave the hospital, Party B shall charge them for the self-payment part of the medical cost, and the left part shall be paid by Party A monthly. Within 5 weekdays of each month, Party B should send Party A the following data: medical inpatient settlement bill, cost control analysis, medical cost settlement requisition form, medical cost settlement list, special incidents requisition form. Party A shall finish all the settlement before the end of that month (except for holiday postpone). Medical cost that is not reported in time shall be included in the next month's settlement. 95% of the total amount shall be paid by Party A while the other 5% shall be included in preparation fund. The return of the preparation fund depends on the year-end appraisal.

22. After the negotiation between the two parties, the cost control policy is as follows: Medicine cost shall not exceed 45% (Level A medicine cost shall not be lower than 30% of the total medicine cost); patients who stay in hospital twice or more (These refer to those who come back to hospital within 2 months after recovery from hospital) shall not exceed 20%; test for results shall not exceed 15%; self-payment proportion shall not exceed 25%, and the self-payment only shall not exceed 4%; positive rate for special test shall not be lower than 75%.

Inpatient cost per capita:

(1) 7200 yuan is the limit for ordinary disease, inpatient cost per capita for department transfer patients shall not exceed the twice of the ordinary.

(2) Special circumstances

A. Inpatient cost per capita for malignant tumour (except Argon-Helium Cryoablation、CRT conformal radiation therapy、Gamma therapy) shall not exceed 15000 Yuan. The standard for malignant tumour operation and radiation treatment is as the next policy.

B. For other special diseases: Uremic inpatient dialysis treatment, severe liver cirrhosis with ascetic fluids, pulmonary encephalopathy, Orthopaedics built-in material implantation, Chronic cardiac and pulmonary disease with 3-grade heart failure, cardiac catheterization therapeutic surgery (except coronary angiography , self-financed orthopaedics and cardiovascular built-in material) , severe intestinal obstruction, severe pancreatitis, stroke (including cerebral haemorrhage, large-area cerebral infarction-whole lobe or cross-lobe brain infarction), major operations (such as open craniotomy, cancer open chest surgery for cancers) , the per capita cost standard shall not exceed 35000 Yuan.

(3) Special cost for the above 10 diseases and other serious diseases can be reported for settlement in the current month and the settlement shall be within that month, but the number of case shall be controlled within 5‰. Patients transferred from level 2 and level 3 hospitals can be reported for payment on the basis of current-month transfer paper. After the approval of medical insurance department, this case can be exempt from the 5‰ control policy.

23. The following shall be included into year-end appraisal: cost per case, medicine cost proportion, self-payment proportion, laboratory test and examination proportion, inpatient return rate, positive case rate for special inspections. At the end of the year, appraisal shall be made according to “Changsha Urban basic medical insurance designated hospitals agreement implement examination policy” and the preparation fund shall be paid accordingly. As for the medical cost exceeding the cost control of the average cost, Party A shall pay late and settle at the end of the year. The calculating method for the cost that shall be refused to pay due to beyond the standard:

$(\text{Actual per capita cost} - \text{standard per capita cost}) \times \text{number of patients} \times \text{payment rate}$ . Medical cost within the same control standard area can offset each other. Cost left after the offsetting shall not be paid.

24. When there's new inpatient insured, Party B shall complete the input of the

insured's information and the daily medical cost should be recorded every day (except holiday postpone). Meanwhile, Party B should ensure the accuracy and completion of the recorded information (which includes diagnosis of leave, conclusion of treatment effect, especially the death information). With 3 days after the leave of the insured, Party B shall finish the leave settlement and not charge any more medical cost or change any information.

25. If Party B break any one of 4, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18 and 19, Party A shall replevy the cost after confirming the breach and give a punishment that deny 1-3 times the breach number. If there's any case that Party B dismiss the patient due to cost standard, Party A shall deduct corresponding pints according to "Appraisal instructions" and deduct payment by the fund.
26. If Party B has serious breach behaviour, Party A can end the agreement unilaterally; meanwhile, Party A shall inform labour administrative department at the same level to deal with the breach behaviour according to relevant regulations and the punishment can be the cancelling of its designated qualification. The punishment result shall be noticed all over the province through provincial medical insurance bureau. During the termination period of the agreement, Party B shall not receive patients that have medical insurance in Changsha urban area or are insured in other cities but transferred there; otherwise, relevant medical insurance department has the right to deny the settlement.

## **Chapter 4 Disputes solution process**

27. During the valid term of this agreement, both parties shall try to solve disputes through negotiation; for those cannot be solved, both parties can appeal to the local people's court.

## **Chapter 5 Others**

28. The agreement will be valid from April 1, 2008 to March 31, 2009.
29. During the valid term, if there's any change of national law or regulations, both parties shall negotiate to make possible changes of the agreement and if no new agreement can be reached, both parties shall be allowed to end the agreement. During the valid term, if there's any change of registration capital, service terms, service contents or corporate representative with Party B, Party B shall inform Party A in time.
30. During the valid term of this agreement, if Party A or Party B wants to end the agreement, no matter what reasons are, the one shall notify the other 3 months earlier; 30 days before the ending of this agreement, Party A shall evaluate Party B's implement situation of this agreement and make a decision to renew the agreement or not and inform Party B.
31. For matters not covered by the agreement but concerned by both parties, both parties shall negotiate and make additional clauses in the form of exchange of letters or amendments to the agreement. The additional clauses shall have the same validity.

32. The agreement shall have two copies and each party has one. Both copies have the same validity.

## **Chapter 6 Supplementary Terms**

33. Inpatient cost per capita of public servants of department-director level and above shall not exceed 15400 Yuan; medical cost per capita of tumour patients shall not exceed 21000 Yuan. The medical cost of public servants of non-department-director level sent to cadre wards shall be handled according to 22, and there's no additional charge.

34. The management of single disease complete-task management designated institutions and standard shall be executed according to relevant papers of medical insurance institutions.

Party A:

Corporate Representative:

YY/MM/DD

Party B:

Corporate Representative:

YY/MM/DD

## 2. Golden Insurance Project (GIP) - Hunan province report

### **Changsha Preceding Report On the Implementation of Golden Insurance Project (GIP)**

Under the leadership of local bureau leading party members' group and the strong support from all departments, the GIP implementation has made significant progress. Since October 2006, core application system has been running on line. In last year November, MOLSS granted Changsha as 'National GIP Implementation Model City', which became the only authorised city in Hunan province. The following presented is the preceding report on the implementation of GIP in Changsha.

#### **1 Stabilised GIP core application system**

GIP core application system has been operated on the line since October 2007. Before implementing the GIP core system, the Information Centre had been doing data backup and seal up for previous old system whilst database servers and application servers have been carefully planned, designed and the platform has been built to ensure the stability of the system on line. After implementing GIP system, we do weekly secure data backup, monthly data storage in another remote place, 24 hours operation monitoring for application servers and database servers. Meanwhile, for the smooth progress on the operation of this new the Information Centre has setup service windows for data calculation and verification on the ground floor of the Government Affair Hall and has organised professional technicians to help operational departments solve a variety of issues in the operation of IT equipment, data processing and business area. So far, we have solved over 8,000 business related problems requested by all divisions, have dealt over 120,000 data related questions, over 3,000 system related issues through analysis, and have managed over 1,200 requested changes, which have ensured stable running of two major systems (i.e. social insurance core application system and the system for employment and synthetic management). Application system has presently becoming stabilised.

#### **2 Gradually emerged advantages of implementing GIP application system**

Although the newly applied system still exist some problems, the benefits brought by its implementation has been gradually emerged. Firstly, new system on line has helped us reveal all data related great and difficult hidden problems existing in social insurance system for such a long time, such as the loss of some individual accounts, historical debts by insured employers, error basic information of personal and employers, inaccurate premium base, default finance and accounting book keeping, etc. The running of new system have made us pay attention to these problems and determine to solve these difficult issues in order to ensure the safety of social insurance fund and to meet the requirement of the insured people. Secondly, the collection of five respective compulsory insurance can be unified into one collection after the implementation of new system on line, which helps extend the coverage of social insurance, increase pooling fund collection, speed up the development process for

coverage and fund collection. To the end of June, local social insurance has been added 118,815 newly insured people into the system, which has beat our 6 month social insurance coverage target whereas unemployment insurance has accomplished fund collection objective of the whole year. Thirdly, the new system on line has simplified the business process, enhanced efficiency and avoided the error of data and the loss of fund as a result of personnel change. Fourthly, the new system has further promoted the social insurance baseline reporting system and ensured the smooth baseline reporting work. So far, we have carried out annual auditing to 4,229 companies including 390,000 people. Fifthly, it benefits the development of public services more, such as unified online services and administration, 12333 consultancy hotline, and issuing and management of social security card.

### 3 Re-plan and developed service website of our municipal labour and social security

Since implementing GIP application system, all enquiry or search function in previous old system has to be completely redoing it. The Information Centre of LSSB therefore re-planned and designed our municipal LSSB service website (web address: [www.csldbz.gov.cn](http://www.csldbz.gov.cn)) in order to serve our people better and build communication channel between general public and our bureau. Under the situation of being short of hands, we have still arranged particular staff for website development and maintenance and the majority of column has been opened now on line whilst relevant information can be searched synthetically or enquired through this website. These information, for instance, include preferential certificate of laid off workers, pension individual accounts, companies' profile and contribution, name list, appointed hospitals and pharmacies, drug list and service list, etc. Since these columns opened online, more and more people visit our website and have reached over 40,000 monthly visiting volumes currently. Through this website, the social public image of our bureau has been improved whilst general public is greatly facilitated to access to relevant information.

### 4 The establishment of database centre as GIP required is taken shape

The Information centre has upgraded and reconstructed host machine and storage system in database centre. In 2006, we purchased 1 high valued HP small host machine and a set of SAN storage devices. In 2007, we purchased 5 PC servers to be used as application server. After adopting the new system, it requires higher and higher application server and database server. Therefore, we bought 7 new PC servers again and a set of internet network security equipments in the first half of this year and bought 2 small host machine and new core network equipment in August. These have ensured the improvement of data backup system and the security of internal network. Through system upgrading and reconstruction, the speed of system running has been improved whilst the efficiency of all departments has been enhanced. Furthermore, the security of social insurance data has been ensured whilst the standards and requirements for the development of unified database centre has been reached essentially.