Draft

LAW OF MONGOLIA

29 January 2014 Ulaanbaatar

Health Insurance Law
(Revised version)

CHAPTER ONE
General provision

Article 1. Purpose of the Law

1.1 The purpose of this Law is to define the principles and scope of compulsory health insurance, to regulate relations between the health insurance organization, health care providers, the State and individual citizens with regard to every Mongolian citizen paying the contribution in accordance with the Law, pooling, allocation and expenditure of the fund so as to protect insured persons from possible health associated financial risks.

Article 2. Health Insurance Legislation

2.1 The health insurance legislation shall consist of the Constitution, the Health Act, the Medicine and Pharmaceuticals Law, the Insurance Law, the Social Insurance Law, the Social Welfare Law, the State Inspection Law, the State Audit Law, the Budget Law, the Human Development Fund Law, this Law and other legislative acts issued in conformity therewith.

Article 3. Terms of the Law

3.1 The terms used in the present law shall be interpreted as follows:

3.1.1. The term “health insurance” means collecting health insurance contributions from the state, citizens and legal entities in accordance with the Law, pooling the health insurance fund and purchasing of health services;

3.1.2 The term ”insured person” means a citizen who pays health insurance contributions in advance regularly and who has the right to be protected from possible health associated financial risks;

3.1.3.The term ”Health Insurance Organization” means the legal entity that is responsible for the revenue generation of the health insurance fund and purchasing of health services on behalf of an insured person;

3.1.4.The term “health care provider” means a health care facility or a pharmacy contracted by the health insurance organization;

3.1.5. The term “health insurance contribution” means the prepayment for health insurance made by citizens, the State or legal entities on behalf of a citizen to the health insurance fund in accordance with the rate and amounts specified this Law;

3.1.6. The term “health insurance fund” means monetary resources consisting of contributions paid by the state, citizens, legal entities and other sources so as to share the possible financial risks of insured persons caused by illness;

3.1.7.The term ”Health insurance benefit package” means comprehensive health care services essential for insured persons including diagnostics, early detection, treatment, rehabilitative, nursing and palliative services and discounted drugs;

3.1.8.The term ”Health insurance contract” means the contract established between the health insurance organization and a health care provider;

3.1.9 The term ”payment method” means the way health insurance fund pays for the health services of providers;

3.1.10. The term ”electronic card” means a card containing information of health insurance contribution paid and health services received by the insured person issued by the health insurance organization to the insured person;

3.1.11.The term ”supplementary voluntary insurance” means non-governmental health insurance a citizen voluntarily enters into in order to get health services which are not included the Health Insurance benefit package specified in the Article 9 of this Law;

Article 4. Types of Health Insurance

4.1. Health insurance shall have two types: compulsory health insurance and supplementary voluntary health insurance.

4.2. Citizens of Mongolia shall be covered by compulsory health insurance in order to be protected from possible health associated financial risks.

4.3. Foreigners and stateless persons specified in Clause 4.2 of Social insurance law shall be covered by compulsory health insurance unless Mongolian international agreements stipulate otherwise.

4.4.Foreigners and stateless persons other than those specified in Clause 4.3 of this law can be covered by compulsory health insurance if they so choose.

4.5. The Health insurance organization shall carry out compulsory health insurance functions.

4.6. Citizens can be covered by supplementary voluntary health insurance to get health services that are not included in the benefit package under the compulsory health insurance specified in the Article 9 of this Law.

4.7. A licensed nongovernmental organization shall carry out the functions of supplementary voluntary health insurance.

4.8. Relations pertaining to supplementary voluntary health insurance shall be regulated by this Law and the Insurance Law.

Article 5. Principles of Compulsory Health Insurance

5.1. Compulsory health insurance (hereinafter referred as “health insurance”) shall be based on the principle of solidarity whereby financial risks of insured persons are shared irrespective of their contribution amount.

5.2. Health care services specified in the Article 9 of this Law shall meet health needs and requirements of insured, be based on evidence, of good quality, safe, equitable and accessible.

5.3. Facilities specified in the Clause 3.1.4 of this Law, operating on the territory of Mongolia, shall provide health services specified in the Article 9 of this Law.

5.4. Citizens, the State and legal entities shall be responsible for paying health insurance contributions in accordance with rationale and regulations specified in this Law and other relevant legislations.

CHAPTER TWO
INSURED PERSONS, THEIR RIGHTS AND RESPONSIBILITIES

Article 6. Population Groups to be Covered by Health Insurance

6.1.Citizens of Mongolia shall be divided into the following categories in regard to their prepayments:

6.1.1.Employees specified in the Clause 4.2 of Social Insurance Law;
6.1.2. Self-employed person;
6.1.3. Herders;
6.1.4. Foreigners and stateless persons specified in Clause 4.4 of this Law;
6.1.5.Children under 18 years of age;
6.1.6.Persons who have no monetary income except pensions;
6.1.7. Citizen-family member who essentially needs social welfare;

6.1.8. Mother /father/ taking care of a child up to the age of 2 /up to the age of 3 in the case of twins/;
6.1.9. Students of universities, colleges and vocational training centers;
6.1.10. Soldiers conscripted in military service;
6.1.11. Prisoners;
6.1.12. Other citizens not specified in Clauses 6.1.1-6.1.11.

Article 7. Rights and Responsibilities of Insured

7.1. An insured person has the right to

7.1.1. Access good quality, safe and equitable health care services;
7.1.2. Receive payment from the health insurance fund at the rate set by this Law for health care services specified in the Article 9 of this law;
7.1.3. Choose a health care facility of any type of ownership contracted by health insurance organization and receive health care services;
7.1.4. Receive information on health insurance from the health insurance organization, health care providers and other organizations involved in health insurance;
7.1.5. Obtain a receipt for health care services paid out of pocket from the health care facility;
7.1.6. Make a complaint and get a settlement in regard to health insurance issues to the authorized legal entities, namely National Health Insurance Council (hereinafter referred to as “National Council”), health insurance organization and state specialized inspection body;
7.1.7. Monitor quality of care, expenditures and discounts of payments;
7.1.8. In the event that an insured person’s health service expenditure specified in Clauses 6.1.1-6.1.4, 6.1.9 and 6.1.12 of this Law exceeds annual cap on individual’s expenditures, the excess cost can be covered by another household member’s funding once a year at their consent;
7.1.9.Monitor electronically contributions paid and health care services received;
7.1.10. Receive a refund of excess health insurance contributions paid or transfer this amount to the next contribution payment;
7.1.11. Other rights specified in legislations.

7.2. An insured person is responsible for

7.2.1. Timely payment of health insurance contributions specified in this Law;
7.2.2. Accurate reporting of salary and income to account health insurance contributions;
7.2.3.Complying with lawful requirements made by the health insurance organization and inspectors;
7.2.4. Other responsibilities specified in legislations.

CHAPTER THREE
HEALTH INSURANCE CONTRIBUTION AND BENEFIT PACKAGE

Article 8. Contribution Rate and Payment Procedures

8.1.The Government shall set the contribution rates (hereinafter referred to as "contributions") of citizens specified in Clause 6.1 of this Law based on the proposal of the National Council as follows:

8.1.1. The contribution rate of insured specified in Clause 6.1.1 of this Law shall be set annually at the amount equal to at least 4% of wages or similar income;

8.1.2. The contribution rates of insured specified in Clause 6.1.5 and 6.1.9 shall be set annually at the amount equal to at least 1% of minimum monthly wages;

8.1.3.The rate of the contributions of insured other than those specified in Clauses 6.1.1, 6.1.5 and 6.1.9 of this law shall be set annually at the amount equal to at least 2% of minimum wages.

8.2.The contributions shall be paid to the health insurance fund as follows:

8.2.1. Contribution of the persons specified in Clause 6.1.1 of this Law shall be paid equally by the employer and the employee on a monthly basis;

8.2.2. Persons specified in Clauses 6.1.2-6.1.4, 6.1.12 of this Law shall pay their contributions quarterly or annually by themselves;

8.2.3. Contributions of persons specified in Clauses 6.1.5-6.1.8 and 6.1.10 of this Law shall be paid from the government budget monthly;

8.2.4 Contributions for persons specified in Clause 6.1.9 of this Law shall be paid by the insured quarterly or annually by themselves

8.2.5. Contributions of persons specified in 6.1.11 of this Law shall be paid by the prison office monthly.

8.3. The following organizations shall be responsible for ensuring that payments of health insurance contributions are made:

8.3.1. Employers for persons specified in Clause 6.1.1 of this Law;

8.3.2. Bag or khoroo governors for persons specified in Clause 6.1.3 in accordance with a contract concluded with the insurer;

8.3.3. Educational institutes for persons specified in Clause 6.1.9;

8.3.4. Army offices for persons specified in Clause 6.1.11.

Article 9. Health Insurance Benefit Package

9.1.The following services shall form health insurance benefit package:

9.1.1. Inpatient services;

9.1.2. Outpatient examinations, follow up, diagnostics, tests and treatment;

9.1.3. Day care;

9.1.4. Palliative care for patients of cancer and other illnesses;

9.1.5. Traditional medicine, rehabilitative care and sanatorium services;

9.1.6. Some high cost health care and necessary pharmaceuticals;

9.1.7. Discounts for drugs prescribed by doctors of family, soum and bagh health centers and specialists of aimag and district outpatient services;

9.1.8. Prosthesis and orthopedic tools for rehabilitative care and artificial tubes;

9.1.9. Some rehabilitative care, home care, day care and diagnostic tests provided by family or soum or village health centers;

9.1.10. Day care for cancer chemotherapy and radiotherapy;

9.1.11. Medical treatments of illnesses of pregnant mothers before 37 weeks of gestation and after birth.

9.2. Health care providers contracted with the health insurance organization shall provide the appropriate level of health services to insured persons regardless of their administrative registration of residence.

9.3.Insured persons are entitled to discounts on generic drugs included in the list of essential drugs discounted by health insurance fund by prescriptions of family, soum and bagh doctors or specialists of outpatient services.

9.4. The insured shall be provided with prevention and early detection screening and diagnostic tests by routine schedule based on their age, gender and health risks financed by health insurance fund and regulations on prevention and early detection screening and diagnostic tests will be approved by the National Council based on the proposal of the state central administrative body in charge of health insurance and health issues.

9.5. Prevention, early detection screening and diagnostic tests and other health care services organized in the form of campaigns shall not be financed by health insurance fund.

CHAPTER FOUR
PAYMENT OF HEALTH CARE EXPENDITURES

Article 10. Establishing a Health Insurance Contract

10.1. The health insurance organization will establish a contract with health care providers qualified through the selection process in accordance with Clause 16.1.5 of this Law and shall monitor and evaluate the execution of the contract.

10.2. The contract shall specifically provide budget of expenditures for health care services specified in the Article 9 of this Law, their names, quantity, quality indicators, payment methods, payment amount and duration of the contract, rights and responsibilities of the parties and terms of contract termination.

10.3. The format of the contract will be approved by the National Council

Article 11. Payment for Health Care Service Expenditures

11.1. Health care service expenditures shall be shared by the insured and the health insurance fund.

11.2. The amount of expenditures of health care services specified in the Article 9 of this Law payable by the health insurance fund and the insured, payment methods and procedures shall be determined by the National Council based on recommendations of health insurance organization and state central administrative body in charge of social insurance, finance, budget and health issues.

11.3. The cost of health care services provided to the insured shall be paid based on performance according to the monthly budget schedule and the health insurance organization can make an advance payment to a contracted health care provider according to the terms of the contract specified in the Article 10.

11.4. An increase in the health insurance fund expenditures for health care services shall not serve as a ground to decrease the amount of state budget.

Article 12. Reimbursement of Health Care Expenditures

12.1. The following persons shall reimburse for expenditures mentioned below:

12.1.1. The relevant law enforcement agency shall be responsible to make sure that the person guilty of the crime or violation reimburses to the health insurance organization for health care expenditures incurred to an insured person due to crimes or violations;

12.1.2. In case it is proven that diagnostic or treatment complication occurred due to wrongdoing of the medical personnel or health care provider, the provider shall be responsible to reimburse the insured person for relevant health care services needed.

Article 13. Duties and Rights of Health Care Providers

13.1. Health care providers shall exercise the following rights and duties:

13.1.1. To get payment from the health insurance fund for health care services provided to insured persons as stipulated in the Article 9 of this law;

13.1.2. To contract with the health insurance organization and ensure the implementation of the contract;

13.1.3. To provide quality, equitable and timely health care services to the insured and provide insured with relevant information;

13.1.4. To register and store the names, types, form, quantity, cost and other relevant information about health care services provided to the insured and submit this information to the health insurance organization;

13.1.5. To pay compensation for the damage caused to an insured person due to an error made by the health care provider employee according to relevant legisation;

13.1.6. To submit in a timely manner to the health insurance organization accurate expenditure reports payable by the health insurance fund and other relevant documents of insured persons;

13.1.7. To submit proposals on operations of the health insurance organization and seek resolution thereof through their representation in the National Council;

13.1.8. To reimburse insured persons using reference market prices in case the insured paid for medicines, injections or materials listed in the medical record of inpatient care;

13.1.9. To deduct the cost of services provided to an insured person payable by the health insurance fund out of the total service payment to be paid by the insured;

13.1.10. In case a violation of the law on health insurance occurs, to comply with lawful directions to remove violations given by respective authority or official;

13.1.11. To prohibit administering unnecessary hospitalization and other health care, reference services and drugs and injections to insured persons;

13.1.12. Other duties and rights stipulated in the law.

CHAPTER FIVE
HEALTH INSURANCE SYSTEM

Article 14. National Health Insurance Council

14.1. The health insurance system shall consist of National Health Insurance Council (hereafter the “National Council”), the central state administrative body in charge of social insurance, health insurance organization, aimag and district health insurance divisions and soum health insurance inspectors respectively.

14.2. The governing body for health insurance shall be the National Council.

14.3. The National council shall have the composition listed below and shall report annually to the Parliament:

14.3.1. One representative from each of the central state administrative bodies in charge of finance, budget, social insurance and health;

14.3.2. Three representatives of organizations protecting rights and lawful interests of majority of insured persons;

14.3.3. Three representatives of organizations protecting rights and lawful interests of majority of employers.

14.4. The appointment and removal of the head and members of the National Council shall be made by the Parliament based on proposals of the parties of the National Council for a term of 5 years. The members and head can be reappointed once.

14.5. Statutes of the National Council shall be approved by the relevant Standing Committee of the Parliament;

14.6. The National Council shall have a secretariat and the relevant Standing Committee of the Parliament shall approve the staffing and guidelines for its operation;

14.7. The members of the National Council shall receive additional salary quarterly depending on their participation and performance. The maximum additional salary amount shall be set by the relevant Standing committee of Parliament based on the recommendation of the central state administrative body in charge of social insurance.

14.8.The National Council shall exercise the following rights:

14.8.1. To approve the structure and statutes of the health insurance organization;

14.8.2. To approve regulations on the estimation of the amount, expenditures of the health insurance risk reserve fund and depositing them in the bank based on the proposals of the central state administrative bodies in charge of finance, budget, social insurance and health and the Central Bank respectively;

14.8.3 To approve regulations on expending or depositing in the bank the health insurance fund surplus and regulations and money to be spent on procuring government bonds and Central Bank securities based on proposals of the central state administrative bodies in charge of finance, budget, social insurance and health and the Central Bank;

14.8.4. To discuss and resolve proposals of relevant organizations on improving the legislation on hewalth insurance, health insurance system and its operations, to develop a proposal and seek its resolution by relevant authority;

14.8.5. To establish permanent or temporary working groups to work on issues related to health insurance, including professional societies and associations, experts, insured and stakeholders, to review their work results;

14.8.6. To issue regulations, resolutions and recommendations on health insurance related issues within its authority;

14.8.7. Other rights specified in legislation.

14.9. The National Council has the following duties:

14.9.1. To develop the draft operational cost budget, budget projections and fiscal framework statement of the health insurance fund and the health insurance organization based on actuarial estimations and to approve the detailed schedule of the approved budget and monitor its implementation;

14.9.2. To review the operational reports of the health insurance fund and the health insurance organization, to monitor, estimate and make conclusions on operational and administrative expenditures;

14.9.3. To approve the list of health care services to be included into the benefit package of the health insurance fund stipulated in the Article 9.1 of this Law based on proposals of the central state administrative bodies in charge of health and social insurance;

14.9.4. To set cap on the reimbursement to be paid by the health insurance fund for the healthcare expenditures of the insured person and the amount of payment to be borne by the insured stipulated in the Article 11.2 of this Law based on proposals of the central state administrative bodies in charge of social insurance and health;

14.9.5. To define the names and types of essential drugs to be discounted by the health insurance fund, to set maximum prices and discount amounts based on proposals of central state administrative bodies in charge of social insurance and health;

14.9.6. To approve regulations on selection of health care providers based on proposals of central state administrative bodies in charge of social insurance and health;

14.9.7. To review and resolve petitions and complaints submitted in regard to health insurance issues;

14.9.8. Other duties duties stipulated in legislation.

14.10. The National council shall conduct at least two meetings quarterly. If necessary, ad hoc meetings can be held based on the decision of the council chair or majority of members. The quorum of a council meeting requires two-thirds of council members with voting rights representing all stakeholders to be in attendance;

14.11. The chairperson, deputy chairperson and members of the National Council shall be dismissed on the following grounds:

14.11.1. Repeatedly showing poor performance or no more able to execute council member roles;

14.11.2. Absence from 3 consecutive council meetings without justification;

14.11.3. Voluntary resignation from council membership before the expiration of the term;

14.11.4. Confirmed by court of conviction in crime;

14.11.5. Withdrawal of the member by the representative organisation;

14.11.6. In case of a death of the member or other grounds legislated to dismiss the member.

14.12. Parliament can dismiss the chairperson, deputy chairperson and member based on the specific written request made by at least two-thirds of council members.

14.13. The council chairperson and members shall submit their request for voluntary termination before their membership term expiry to the relevant Standing committee of the Parliament.

Article 15. Health Insurance Organization and Its Management

15.1. The health insurance organization shall be a government implementing agency and shall have local health insurance units which will operate under the authority of the health insurance organization;

15.2. The head of the health insurance organization shall be appointed and dismissed by Cabinet member in charge for social insurance based on the proposal of the National Council.

15.3. The head of health insurance organization shall meet requirements specified in the Article 16 of the Law on Civil Service.

15.4. The head of a local health insurance unit shall be appointed and dismissed by the director of the health insurance organization from staff with experience of at least 3 years of work in social and health insurance sectors;

15.5. A soum health insurance officer shall be appointed and dismissed by the head of the local health insurance unit;

Article 16. Health Insurance Organization Functions

16.1. The health insurance organization shall perform the following functions:

16.1.1. To manage implementation of the laws and regulations on health insurance;

16.1.2. To pool health insurance fund, to ensure the balance of the fund revenue and expenditure and to report on its activities;

16.1.3. To conclude contracts with health care providers on behalf of the insured to reimburse the cost of healthcare services and monitor and evaluate the implementation of contracts;

16.1.4. To organize the selection of health care providers in consideration of the health care quality, safety and accessibility among licensed and accredited health care providers of any ownership type operating on the territory of Mongolia according to regulations stipulated in the Article 14.9.6.

16.1.5. To monitor the health expenditures provided to the insured persons and issue recommendations and instructions to health care providers on improving the quality of care;

16.1.6. To develop proposals on issues reflected in Articles 14.9.1, 14.9.3-14.9.6 of this law and seek their resolution by the National Council in consultation with the relevant state central administrative body;

16.1.7. To conduct financial monitoring on revenue and expenditure performance of the health insurance fund;

16.1.8. To create an integrated information system on health insurance and introduce advanced information technology;

16.1.9. To provide information, estimations and surveys to the National Council and other authorized bodies needed for completion of their duties and to support their activities;

16.1.10. To conduct necessary estimations, research and develop proposals on the development of health insurance and improvement of insurance functions, on results of health care, cost and contribution rate, to submit them to relevant authority and to seek their resolution;

16.1.11. To publicize the legislation on health insurance and its functions and provide necessary information to the insured;

16.1.12. To receive and resolve complaints raised by insured persons on issues related to health care quality and accessibility;

16.1.13. To approve regulations on incentives for health care providers stipulated in the Article 20.1.3 of this law;

16.1.14. To approve regulations on health care expenditure claims, claim check, payments and dispute settlement;

16.1.15. To approve regulations on the provision of drug discounts reimbursed by the health insurance fund;

16.1.16. To issue methodologies, procedures and instructions on issues related to health insurance;

16.1.17. To inform in advance the insured persons scheduled timing of preventive and early detection screening, diagnostics and tests stipulated in the Article 9.4 of this Law;

16.1.18. Other duties stipulated in legislation.

16.2. The health insurance organization shall undertake phased purchasing of some health care services included into the benefit package funded by the government budget on the basis of contracts.

16.3. The Government shall approve the regulations related to implementation of the activities specified in the Article 16.2 of this Law.

Article 17.Rights, Duties and Responsibilities of the Health Insurance State Inspector

17.1. The head of the health insurance organisation shall grant, suspend and revoke the rights of a state inspect to an employee with work experience of at least 2 years in social insurance and health insurance organization, with specialization and high professional qualifications.

17.2. The head of the health insurance organisation shall approve the term of reference of the health insurance state inspector.

17.3. The state health insurance inspector shall have the following rights and duties:

17.3.1. to conduct reviews on patient medical records, hospital card, diagnostics and tests and other treatment documents related to health care provided to the insured person and seek explanations and clarifications where necessary;

17.3.2. to obtain copies of documents required for monitoring and review by the health insurance organization free of charge;

17.3.3. to monitor the quality, expenditures and results of health care, issue conclusions and recommendations;

17.3.4. to take disciplinary action specified by the law and, if necessary, to take the matter to the responsible authority when relevant standards or guidelines are violated, causing damage to the health of insured or treatment and services are provided for illegal payments;

17.3.5. any stakeholder in the health insurance relations, organization, official, citizen or insured person who violates the health insurance law or regulations shall be liable as stated in this law, and in case it occurs repeatedly, their wrongful actions shall be published in the mass media to inform general public.

17.4. A health insurance state inspector shall be subject to disciplinary, administrative, financial or criminal liabilities if they fail to fulfill their lawful functions such as covering up illegal actions related to the payment of contributions, using health insurance fund assets for personal gain, taking bribes, violating the code of ethics, disclosing confidential information and abusing one's power.

Article 18. Benefits, Grading and Grade Allowance of the State Health Insurance Inspector or Officer

18.1. In case a health insurance state inspector or officer temporary loses professional working capacity, or becomes disabled, or dies while performing official duties, an allowance shall be paid to him/her or his/her family as follows:

18.1.1. allowance for temporary loss of professional working capacity and basic salary difference of the position;

18.1.2. in the case of disability, disability pension and basic salary difference of the position;

18.1.3. in the case of death, families are given a lump-sum allowance equal to 3 year basic salary.

18.2. The allowance specified in the Article 18.1.3 shall be paid by the employer and the cost shall be compensated by the guilty person as specified in the law.

18.3. State health insurance inspectors shall have professional qualification grades. The National Council shall approve regulations to set "professional qualification grades" and increments of the grade.

18.4. Monetary incentives shall be provided to the state health insurance inspector or officer in order to retain them and resolve their social issues. The National Council shall approve regulations on monetary incentives.

CHAPTER SIX
HEALTH INSURANCE FUND

Article 19. Sources of Health Insurance Fund Revenue

19.1. The Health insurance fund revenue shall be generated from following sources:

19.1.1. health insurance contributions paid by insured;

19.1.2. health insurance contributions paid by employers;

19.1.3. health insurance contributions of government subsidized citizens paid by the state budget;

19.1.4. payments by human development fund as stated in the law;

19.1.5. state budget transfers in case the benefit package funded by the state budget is to be financed through the health insurance organization;

19.1.6. interest earned from the fund surplus;

19.1.7. interest earned from the risk reserve fund;

19.1.8. penalties imposed for late payment of health insurance contributions;

19.1.9. other sources;

19.2. The health insurance fund revenue shall be exempt from all types of taxation and payments.

19.3. The social insurance organization shall be responsible for collection of contributions and penalties specified in 19.1.1, 19.1.2 and 19.1.8 and the relevant relations shall be regulated by the Social Insurance Law.

19.4. The social insurance organization shall transfer revenues collected to the health insurance fund weekly.

Article 20. Expenditures of the Health Insurance Fund

20.1. The health insurance fund shall be spent on the following expenses:

20.1.1. purchasing the health care services specified in the Article 9 of this law;

20.1.2. purchasing health care services that state is responsible for through health insurance organization;

20.1.3. costs of incentives given to health care providers contracted by the health insurance organization based on the health care quality and performance;

20.1.4. expenditures stated in the Article 9.4 of this law;

20.1.5. cost of activities implemented by the investment of the health insurance organization;

20.1.6. the health insurance organization administrative costs;

20.1.7. the operational costs of the function performed by the social insurance organization stated in the Article 19.3 of this law;

20.1.8. costs related to the information and marketing activities for the increasing the coverage;

20.1.9. additional salary of the members and administrative cost of the secretariat of the National Council.

20.2. The health insurance risk reserve fund shall be established with resources up to 10% of the health insurance fund annual revenue.

20.3. Costs specified in the Articles 20.1.6 to 20.1.9 of this law shall not exceed 5% of the health insurance fund annual revenue.

20.4. Primary accounting templates of the fund shall be approved jointly by government cabinet members responsible for finance, budget and social insurance.

20.5. The risk reserve fund of the health insurance, revenue generated by depositing it in the bank and health insurance fund surplus shall be used according to regulations specified in the Articles 14.8.2 and 14.8.3 of this Law in order to cover the losses of the health insurance fund caused by complications due to forces majeure and economic and financial difficulties and to ensure the fund sustainability.

Article 21. Approval and Financial Reporting of the Fund Revenues and Expenditures Budget

21.1.The Parliament of Mongolia shall approve annual budget of revenues and expenditures of health insurance fund.

21.2.The National Council shall submit the budget proposal of the health insurance fund within the 15th of August of each year to the state central administrative body in charge of finances and budgeting.

21.3.The state central administrative body shall present health insurance fund budget proposal to the Cabinet.

21.4.The Cabinet shall submit the budget proposal of the health insurance fund to the Parliament within the 1st of October each year.

21.5. The health insurance organization is responsible for compiling and consolidating quarterly and annual fiscal reports on the revenues and expenditures of the health insurance fund within the specified timeframe below and for submitting them to the state central administrative body in charge of social insurance and the National Council.

21.5.1.Soum and district health insurance organization shall submit revenue and expenditure reports within the 15th day of month following the end of the quarter and aimag health insurance organizations shall submit their reports within the 25th of that month to the health insurance organization respectively;

21.5.2.The health insurance organization shall submit consolidated quarterly reports within the 10th of the second month of the following quarter and annual reports within the 25th of February of the following year to the state central administrative body in charge of social insurance;

21.5.3.The state central administrative body in charge of health insurance shall ensure that the National Council reviews quarterly reports within the 10th of the last month of the following quarter and annual reports within the 1st quarter of the following year.

21.6.Health insurance fund expenditure reports shall be audited as specified in the State Auditing Law and the opinions shall be formed.

Article 22. Information Database of Health Insurance and Electronic Card of the Insured

22.1.The health insurance organization shall maintain an integrated electronic information database (hereinafter referred to as the information database) for insured persons, contribution payments and registry of payments for expenditures of healthcare services provided to insured persons.

22.2.The information database shall store information on the health insurance fund revenues, expenditures and operations and it shall create the conditions for monitoring, evaluation and projections.

22.3.The information database shall store the list of healthcare providers contracted by the health insurance organization, their locations, levels, the quantity and quality assurance data on health care services available.

22.4. The health insurance organization shall issue an electronic card to an insured person which certifies their coverage.

22.5. The electronic card specified in the Article 22.4 shall be an information tool used for receiving the health care services specified in the Article 9 of this Law and for reimbursing health care providers.

22.6. The Government shall approve the design of the electronic card, the information to be stored on it and regulations on its use based on proposal of the National Council.

CHAPTER SEVEN
MONITORING AND ACCOUNTABILITY OF HEALTH INSURANCE FUNCTIONS

Article 23. Monitoring Health Care Quality and Payments

23.1. The health insurance organization shall have units for monitoring of health care quality and payments.

23.2. The units specified in the Article 23.1 of this Law shall carry out the following functions:

23.2.1.developing and implementing programmes, plans and recommendations on the continuous improvement of quality of care;

23.2.2. resolving petitions, complaints and comments of insured persons regarding the quality of care and payments made for health care services within the framework of related laws and legal regulations and defending rights of the insured persons;

23.2.3.other functions stipulated by the law.

23.3. The health insurance organization shall collaborate with specialized inspection body, professional societies and associations, experts, insured persons and other stakeholders in order to review and monitor health care quality and reimbursements for services provided and settle disputes.

Article 24. Monitoring on Activities of the Health Insurance Organization

24.1. The National Council shall review annually the reports on operations of the health insurance organization and quarterly financial reports of the health insurance fund and make decisions on relevant issues.

24.2. The health insurance organization shall have an internal audit unit which shall comply with the by-laws approved by the health insurance organization.

24.3. Activities of the health insurance organization shall be monitored by the state auditing authority, external auditors and specialized inspection body.

24.4.A citizen and a legal entity can monitor compliance with the health insurance law and legislations, demand correction of errors detected and take the matter to the authorized organization for resolution.

Article 25. Accountability for Violations of the Health Insurance Legislation

25.1. Compliance with the health insurance law and regulations shall be monitored by the National Council, the health insurance organization and its branches, other organisations and officials authorized by the law within their respective duties.

25.2.If any violations of health insurance law or regulations are not subject of criminal conviction, the guilty party shall be subject to the following administrative sanctions depending on the violations by the authorized official:

25.2.1.if insured specified in the Articles 6.1.2-6.1.4 and 6.1.12 of this law failed to pay health insurance contributions within the timeframe specified by the law, they shall be subjected to a fine equal to double the amount of contributions payable in that year;

25.2.2. if an organization or an official specified in clause 8.3 of this law fails to fulfill their duties, the contributions shall be recovered and the guilty legal

entity shall be imposed with a fine equal to double or triple the amount of minimum wages for one month;

25.2.3. If it is proven that a damage was caused to the health insurance fund, damages shall be recovered and an individual shall be subject to a fine of MNT30,000-50,000 and a legal entity shall be subject to a fine equal to amount of three to five times of minimum wages for one month.

25.3. If the health insurance organization delays payment for health care services specified in the Article 9 of this Law for more than 14 days, a fine equal to 0.3 per cent of the outstanding payment per day of delay shall be paid to the health care provider.

25.4. If an employer or a general manager fails to transfer health insurance contributions within the timeframe specified by this law and the Social Insurance Law, the contributions shall be recovered and a fine equal to 0.3% of the contributions due per each delayed day shall be paid. The amount of payment shall not exceed 50% of the contributions outstanding;

25.5. If a health care provider violates the Article 13.1 of this law, it shall reimburse for the damage and be imposed with a fine equal to the amount of two to five times of monthly minimum wages. If a violation is repeated within the same year, reimbursement of the expenses for health care and services for that month shall be reduced up to 10% or the contract shall be terminated.

25.6. If a guilty party avoids paying or reimbursing expenses for healthcare and services indicated in the Article 12 of this law, a complaint shall be filed in the courts for the reimbursement of the damage.

Article 26.Regulations of Other Health Insurance Relations

26.1.Any other health insurance relations not stipulated by this law shall be regulated by the Social Insurance Law and other relevant provisions of the law.

CHAPTER EIGHT
MISCELLANEOUS

Article 27. Enactment of the Law

27.1.This law shall come into effect from July 1, 2015 and Articles 8.1, 8.2.4 and 15.1 shall come into effect from January 1, 2016 respectively.

SPEAKER OF THE PARLIAMENT **Z.ENKHBOLD**