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| **GOVERNMENT**<br>**-------** | **SOCIALIST REPUBLIC OF VIETNAM**<br>**Independence - Freedom - Happiness**<br>**----------** |
| No. 146/2018/ND-CP | *Hanoi, October 17, 2018* |

# DECREE

ELABORATING AND PROVIDING GUIDANCE ON MEASURES TO IMPLEMENT CERTAIN ARTICLES OF LAW ON HEALTH INSURANCE

*Pursuant to the Law on Government Organization dated June 19, 2015;*

*Pursuant to the Law on Health Insurance dated November 14, 2008 of which certain Articles were amended and supplemented by the Law on Health Insurance dated June 13, 2014;*

*Upon the request of the Minister of Health;*

*The Government hereby issues the Decree that elaborates and provides guidance on measures to implement certain Articles of the Law on Health Insurance.*

## Chapter I

## PERSONS ELIGIBLE TO PARTICIPATE IN HEALTH INSURANCE

### Article 1. Group of health insurance policyholders whose contributions are paid by both employees and employers

1. Employees working under indefinite-term employment contracts or fixed-term employment contracts, each of which has the term of at least 3 months; managers of enterprises, non-state public service providers, managers or administrators of cooperatives who are entitled to wages or salaries; public officials, servants and employees.

2. Lay public officers at communes, wards and townlets in accordance with laws.

### Article 2. Group of health insurance policyholders whose contributions are paid by social insurance agencies

1. Persons eligible to be entitled to retirement pensions and incapacity benefits

2. Persons currently entitled to monthly social insurance benefits in connection with occupational accidents or diseases; rubber plantation workers currently entitled to monthly benefits in accordance with the Government's regulations.

3. Employees on sick leaves in connection with diseases defined in the List of diseases of which long-term treatments are required, issued by the Ministry of Health.

4. Public officers of communes, wards or townlets who leave work and are currently entitled to monthly social insurance benefits.

5. Employees on parental leaves who are entitled to childbirth and adoption benefits.

6. Persons currently entitled to unemployment benefits.

**Article 3. Group of health insurance policyholders whose contributions are paid by the state budget**

1. Public officers of communes, wards or townlets who leave work and are currently entitled to monthly social insurance benefits financed by the state budget.

2. Persons already terminating entitlement to incapacity benefits who are currently entitled to monthly benefits financed by the state budget.

3. Persons rendering meritorious revolutionary services under the provisions of the Ordinance on preference treatment for persons rendering meritorious revolutionary services.

4. War veterans, including:

a) Veterans who participated in resistance wars from April 30, 1975 backwards according to the provisions of clauses 1, 2, 3 and 4, Article 2 of the Government's Decree No. 150/2006/ND-CP dated December 12, 2006, detailing and guiding the implementation of a number of articles of the Ordinance on Veterans (hereinafter referred to as Decree No. 150/2006/ND-CP), which was amended and supplemented in clause 1, Article 1 of the Government’s Decree No. 157/2016/ND-CP dated November 24, 2016, amending and supplementing the Government's Decree No. 150/2006/ND-CP dated December 12, 2006, detailing and guiding the implementation of certain Articles of the Ordinance on Veterans (hereinafter referred to as Decree No. 157/2016/ND-CP).

b) Veterans who participated in resistance wars after April 30, 1975 according to the provisions of clause 5, Article 2 of the Government's Decree No. 150/2006/ND-CP dated December 12, 2006, detailing and guiding the implementation of a number of articles of the Ordinance on Veterans and clause 1, Article 1 of the Government’s Decree No. 157/2016/ND-CP dated November 24, 2016, amending and supplementing the Government's Decree No. 150/2006/ND-CP, including:

- Servicemen and national defense workers already entitled to benefits under the Prime Minister's Decision No. 62/2011/QD-TTg of November 9, 2011 on compensation regimes and policies for persons participating in national protection wars, sent on international missions in Cambodia, and giving friendship supports to Laos after April 30, 1975, who have already retired, been demobilized or resigned (hereafter referred to as Decision No. 62/2011/QD-TTg);

- Officers, professional servicemen, non-commissioned officers, soldiers and national defense workers directly participating in the national defense war, dispatched on international missions in Cambodia and giving friendship supports to Laos after April 30, 1975, who are now, depending on their respective specialty, working at agencies, organizations and enterprises (not entitled to benefits under the Decision No. 62/2011 / QD-TTg);

- Officers and professional servicemen already fulfilled their active military service obligations in the period of building and defending the Fatherland, who have been demobilized, retired or transferred to agencies, organizations and enterprises;

- Militia and self-defense force members engaged in combats or directly rendering combat services after April 30, 1975, who have been entitled to benefits under the Decision No. 62/2011/QD-TTg.

5. Persons engaged in the resistance war and protecting the Fatherland, including:

a) Persons fighting the war against the US for protection of the Motherland who have been granted benefits under one of the following documents:

- Prime Minister’s Decision No. 290/2005/QD-TTg dated November 1, 2005 on compensation regimes and policies for certain persons directly fighting the anti-US resistance war who have yet to be awarded compensation treatment from the Communist Party and Government of Vietnam;

- Prime Minister’s Decision No. 188/2007/QD-TTg dated December 6, 2007 on amendments to Prime Minister’s Decision No. 290/2005/QD-TTg dated November 1, 2005 on compensation regimes and policies for certain persons directly fighting the anti-US resistance war who have yet to be awarded compensation treatment from the Communist Party and Government of Vietnam;

- Prime Minister’s Decision No. 142/2008/QD-TTg dated October 27, 2008 on implementation of compensation regimes for servicemen involved in the anti-US resistance war for national salvation who have had less than 20 years working in the army and are now demobilized and discharged from the military to return to localities;

b) Persons who have already been entitled to benefits under the Decision No. 62/2011/QD-TTg but are not veterans as stipulated in clause 4 of this Article;

c) Officers and soldiers of the People's Police participating in the anti-US resistance war for national salvation who have less than 20 years working in the People's Police, who have resigned or returned from the People's Police to their localities and have been entitled to benefits under the Prime Minister's Decision No. 53/2010/QD-TTg dated August 20, 2010 on compensation regimes for officers and soldiers of the People's Police participating in the anti-US resistance war for national salvation who have less than 20 years working in the People's Police, and currently resign and return to their localities;

d) Young volunteers who have been provided with benefits according to the Prime Minister's Decision No. 170/2008/QD-TTg dated December 18, 2008 on health insurance, funeral and

burial benefits for young volunteers involved in the resistance war against France, the Decision No. 40/2011/QD-TTg dated July 27, 2011 regulating compensation regimes for young volunteers who have completed their duties in the resistance war and the Government's Decree No. 112/2017/ND-CP dated October 6, 2017 providing for compensation regimes and policies applicable to young volunteers in the military base in the South who were involved in the resistance war during the 1965 – 1975 period;

dd) Frontline non-combat soldiers participating in the resistance war against France, against the US or the Fatherland protection war and sent on international missions who have been entitled to benefits under the Prime Minister's Decision No. 49/2015/QD-TTg dated October 14, 2015 on a number of compensation regimes and policies for frontline non-combat soldiers involved in the resistance war against France, against the United States, the war for protection of the Fatherland, or sent on international missions.

6. Incumbent National Assembly deputies and incumbent members of all-level People's Councils.

7. Children under 6 years of age.

8. Persons eligible to be entitled to monthly social protection benefits under laws on the elderly, the disabled and subject of social protection programs.

9. Members of poor households; ethnic minority people living in areas with difficult socio-economic conditions; people living in areas with extremely difficult socio-economic conditions; persons living in island communes or districts and some other subjects, specifically including:

a) Members of poor family households defined according to the classification criteria regarding incomes, members of multi-dimensional poor households that have a shortage of health insurance as stipulated in the Prime Minister's Decision No. 59/2015/QD-TTg dated November 19, 2015 promulgating the multi-dimensional poverty approach for the period of 2016-2020 and other decisions of competent authorities to amend, supplement or replace the poverty line applied over periods of time;

b) Ethnics living in areas with difficult socio-economic conditions under the regulations adopted by the Government and the Prime Minister;

c) Inhabitants living in areas with extremely difficult socio-economic conditions under the regulations adopted by the Government and the Prime Minister;

d) Residents living in island communes or districts in accordance with regulations of the Government and the Prime Minister.

10. Persons who are awarded the title of People's artisans or outstanding artisans living in families earning the monthly income per capita lower than the base pay regulated by the Government.

11. Relatives of persons rendering meritorious revolutionary services who are natural parents, spouses or children of revolutionary martyrs; persons providing accommodations for martyrs.

12. Relatives of persons rendering meritorious revolutionary services, except those defined in clause 11 of this Article, including:

a) Natural parents, spouses, children aged from over 6 years to under 18 years, or 18 years or older if they are still going to school or are suffering serious disabilities or extremely serious disabilities, of the followings: Revolutionaries carrying out activities before January 1, 1945; revolutionaries carrying out activities from January 1, 1945 to the August Uprising in 1945; heroes of the People's Armed Forces and heroes of labor in the resistance war stage; wounded soldiers and sick soldiers suffering a reduction by 61% and more of their labor capacity; partisans infected with toxic chemicals whose labor capacity is reduced by at least 61%.

b) Natural children aged 6 years or older of partisans exposed to toxic chemicals causing deformities and disabilities due to consequences thereof, unable to be self-reliant in performing everyday life activities or suffering from reductions in capabilities for self-reliance in everyday life activities, who are entitled to monthly benefits.

13. Relatives of officers, professional servicemen, non-commissioned officers and military soldiers in active service, administrative officers, non-commissioned officers and technical or engineering officers, non-commissioned officers in the people's public security forces, trainees of the people's police, non-commissioned officers and cryptographic officers who are paid salaries as servicemen, cryptographic trainees entitled to the same compensation regimes and policies as trainees of military and police education institutions, including:

a) Natural parents; natural parents-in-law; legal caregivers of selves and spouses;

b) Spouses;

c) Natural children or legally adopted children aged from 6 years to under 18 years; natural children and legally adopted children aged 18 years or older if they are still taking formal education.

14. Persons already donating human body organs under laws on organ donation and transplantation.

15. Foreigners studying in Vietnam who receive scholarships financed by the state budget of Vietnam.

16. Home attendants of persons rendering meritorious revolutionary services, including:

a) Attendants of Vietnamese heroic mothers;

b) Attendants of wounded soldiers, sick soldiers who suffer from a reduction by at least 81% of labor capacity;

c) Attendants of partisans suffering diseases due to exposure to toxic chemicals whose labor capacity is reduced by at least 81%.

17. Persons aged 80 years or older who are entitled to monthly benefits for elderly people under laws on social insurance.

**Article 4. Group of health insurance policyholders whose contributions are supported by the state budget**

1. Members of near-poor family households defined according to the near-poor criteria under regulations of the Government and the Prime Minister.

2. Members of multidimensional-poverty family households falling into the cases specified in point a, clause 9, Article 3 hereof.

3. Pupils and students.

4. Members of family households doing business in the agriculture, forestry, aquaculture and salt industry who earn an average income in accordance with regulations of the Government and the Prime Minister.

**Article 5. Group of family-based health insurance policyholders**

1. Persons whose names are inscribed in family household records, except those subjects specified in Article 1, 2, 3, 4 and 6 hereof.

2. Persons whose names are inscribed in temporary residence records, except those specified in Article 1, 2, 3, 4 and 6 hereof and those already participating in health insurance as prescribed in clause 1 of this Article.

3. The following persons eligible for family-based participation in health insurance:

a) Dignitaries, sub-dignitaries and clergy;

b) Persons residing in social relief establishments, except for those defined in Articles 1, 2, 3, 4 and 6 hereof without health insurance contributions supported by the state budget.

**Article 6. Group of health insurance policyholders whose contributions are paid by employees**

1. Relatives of public national defense workers and employees on active service in the military, including those defined in point a, b and c, clause 13, Article 3 hereof.

2. Relatives of public security workers on active service in the People’s Police, including those defined in point a, b and c, clause 13, Article 3 hereof.

3. Relatives of those performing other tasks in cryptographic organizations, including those defined in point a, b and c, clause 13, Article 3 hereof.

## Chapter II

## CONTRIBUTION RATES, STATE BUDGET SUPPORT RATES AND CONRIBUTION METHODS APPLIED TO CERTAIN POLICYHOLDERS

### Article 7. Health insurance contribution rates and health insurance contribution responsibilities

1. Monthly health insurance contribution rates shall be subject to the following regulations:

a) The contribution rate shall be equal to 4.5% of the employee's monthly pay with respect to those policyholders specified in clause 1, Article 1 of this Decree.

- Employees on sick leaves from at least 14 days per a month in accordance with laws on social insurance shall not be required to pay health insurance contributions and shall be entitled to health insurance benefits;

- With respect to employees that are detained, held in custody or suspended from work for investigations, consideration of judgement whether they have committed violations against laws, the monthly contribution rate shall be defined as 4.5% of 50% of each employee's monthly pay. In case where a competent authority makes its judgement that none of violations has been committed, the employee shall be required to pay health insurance contributions in proportion to the accrued pay amount that he/she has received;

b) The contribution rate shall be equal to 4.5% of the retirement pension and incapacity benefit with respect to those policyholders specified in clause 1, Article 2 of this Decree;

c) The contribution rate shall be equal to 4.5% of the monthly pay that an employee receives before his/her pregnancy and parental leave with respect to those policyholders specified in clause 5, Article 2 of this Decree;

d) The contribution rate shall be equal to 4.5% of the unemployment benefit with respect to those policyholders specified in clause 6, Article 2 of this Decree;

dd) The contribution rate shall be equal to 4.5% of the base pay rate with respect to those policyholders other than the abovementioned;

e) The health insurance contribution rate of those policyholders defined in Article 5 hereof shall be determined as follows: The first policyholder shall be required to pay 4.5% of the base pay rate; the second, third and fourth policyholder shall be required to pay 70%, 60% and 50%, respectively, of the contribution rate of the first policyholder; the fifth and subsequent policyholder shall be required to pay 40% of the contribution rate of the first policyholder.

Any relief or deduction in the health insurance contribution rate as specified in this point shall be granted only if family members participate in the family-based health insurance within the same financial year.

2. With respect to those policyholders whose contribution rates are supported by the state budget, the relief or deduction in the contribution rate shall not be applied in accordance with point e, clause 1 of this Article.

3. In case where a policyholder referred to in clause 1, Article 1 hereof enters into one more or multiple indefinite-term employment contracts or fixed-term employment contracts, each of which has the term of at least three months, he/she shall be bound to pay the health insurance contribution rate determined on the basis of the employment contract under which the highest pay is agreed upon in comparison with other employment contracts.

4. In case where health insurance policyholders specified in Article 6 hereof and those specified in Article 1, 2, 3 and 4 hereof overlap, health insurance contributions shall be paid in the following order: Health insurance contributions are paid by both employees and employers; by social insurance agencies; by the state budget; by employers.

5. The Ministry of Health shall preside over and cooperate with the Ministry of Finance in appealing to the Government for approval of adjustments to the health insurance contribution rates in order to ensure the balance of the health insurance package, comparability with state budget capabilities and contributions of those responsible for paying health insurance contributions in accordance with the Law on Health Insurance.

**Article 8. State budget's support rate**

1. From the entry into force of this Decree, the state budget's support rates shall be applied to the following policyholders:

a) The state budget's support shall be paid for 100% of the health insurance contribution rate with respect to members of near-poor families residing in poor districts referred to in the Government's Resolution No. 30a/2008/NQ-CP dated December 27, 2008 regarding quick and sustainable poverty reduction support programs, and districts where regimes and policies defined in the Resolution No. 30a/2008/NQ-CP are applied;

b) The state budget's support shall be paid for at least 70% of the health insurance contribution rate with respect to those policyholders referred to in clause 1 and 2 Article 4 hereof;

c) The state budget's support shall be paid for at least 30% of the health insurance contribution rate with respect to those policyholders referred to in clause 3 and 4, Article 4 hereof.

2. In case where a policyholder falls into multiple beneficiaries of the state budget's health insurance contribution support as prescribed in clause 1 of this Article, the state budget's support for the policyholder entitled to the highest support rate shall be applied.

3. People's Committees of provinces and centrally-affiliated cities shall, based on the local government budget's capabilities and other legal funding sources, and after taking into account 20% of the funding defined in point a, clause 3, Article 35 of the Law on Health Insurance (if any), formulate and appeal to the provincial-level People's Councils for their decision on the rate of support for health insurance contributions which is higher than the minimum support rate specified in clause 1 of this Article.

**Article 9. Method for paying health insurance contributions by certain policyholders**

1. With respect to persons entitled to monthly retirement pensions, incapacity benefits and social insurance benefits covered by the state budget as prescribed in Article 2 and clause 2 of Article 3 hereof: On a monthly basis, social insurance agencies shall pay health insurance contributions for these policyholders by using funds for retirement pensions and social insurance benefits covered by the state budget.

2. With respect to policyholders prescribed in clause 3, 8, 11, 12 and 16 of Article 3 hereof: On a quarterly basis, agencies of labor, war invalids and social affairs shall remit funds derived from state budget spending on implementation of compensation policies for persons rendering meritorious revolutionary services, or funds derived from state budget spending on implementation of social protection policies, into the health insurance package. Not later than December 15 of each year, agencies of labor, war invalids and social affairs must complete payments and fund transfers to the health insurance package during that year.

3. With respect to policyholders referred to in clause 1, 4, 6, 7, 10, 13, 14 and 17 of Article 3, and those specified in clause 1 and 2 of Article 4 hereof of whom 100% of the health insurance contribution has been covered by the state budget's support: On a quarterly basis, social insurance agencies shall prepare a consolidated report on the number of health insurance cards which have already been issued and the contribution and contribution support amounts according to the Form No. 1 of the Appendix to this Decree, send it to the financial institution to transfer the funds to the health insurance package as stipulated in clause 9 of this Article. The time of calculation of the health insurance contribution payable: Policyholders shall be listed annually and their health insurance contributions shall be calculated as from January 1; with respect to policyholders added to the list, their contributions shall be calculated from the date specified in the Decision on approval of the abovementioned list issued by the competent authority.

4. As for policyholders specified in clause 6 of Article 3 hereof (except policyholders other than those mentioned above, policyholders entitled to retirement pensions, social insurance benefits and benefits for persons rendering meritorious revolutionary services): On a periodic basis, every 3 months, 6 months or 12 months, agencies in charge of management of policyholders shall pay health insurance contributions for these policyholders.

5. With regard to pupils and students specified in clause 3 of Article 4 hereof:

a) On a periodic basis, every 3 months, 6 months or 12 months, pupils and students, or parents or guardians thereof, shall be responsible for paying health insurance contributions on their part as prescribed in clause 2 of Article 10 hereof to social insurance agencies;

b) The state budget shall give support as follows:

- Health insurance contributions of pupils and students studying at educational institutions or vocational training establishments affiliated to ministries and central bodies shall be supported by the central budget. On a periodic basis, every 3 months, 6 months or 12 months, provincial-level Social Insurance agencies shall make general reports on the number of health insurance cards which have already been issued, contribution amounts collected from pupils and students and contribution amounts supported by the state budget by using the Form No. 1 of the Appendix to this Decree and send them to the Vietnam Social Security so that the Vietnam Social Security prepares a consolidated report for submission to the Ministry of Finance in order to transfer the state budget's support amounts to the health insurance package in accordance with clause 9 of this Article.

- Health insurance contributions of pupils and students studying at educational institutions or other vocational training establishments shall be supported by the budget of the local jurisdictions where these educational entities are located, irrespective of registered permanent residences of pupils and students, including the central budget allocations (if any). On a periodic basis, every 3 months, 6 months or 12 months, social insurance agencies shall make general reports on the number of health insurance cards which have already been issued, contribution amounts collected from pupils and students and contribution amounts supported by the state budget by using the Form No. 1 of the Appendix to this Decree and send them to the financial authority in order to transfer state budget expenditures used for supporting health insurance contributions to the health insurance package in accordance with clause 9 of this Article.

6. With respect to those policyholders whose health insurance contributions are partially supported by the state budget in accordance with clause 4 of Article 4 hereof:

a) On a periodic basis, every 3 months, 6 months or 12 months, representatives of family households shall directly pay health insurance contributions on their part as prescribed in clause 2 of Article 10 hereof to social insurance agencies;

b) On a periodic basis, every 3 months, 6 months or 12 months, social insurance agencies shall make general reports on the number of health insurance cards which have already been issued, contribution amounts collected from policyholders and contribution amounts supported by the state budget by using the Form No. 1 of the Appendix to this Decree and send them to the financial authority in order to transfer state budget expenditures used for supporting health insurance contributions to the health insurance package in accordance with clause 9 of this Article.

7. With respect to family-based policyholders as defined in Article 5 hereof: On a periodic basis, every 3 months, 6 months or 12 months, representatives or members of families participating in the health insurance shall pay health insurance contributions as prescribed in clause 3 of Article 10 hereof to social insurance agencies.

8. With respect to health insurance policyholders referred to in Article 6 hereof, on a monthly basis, employers shall make health insurance contribution payments for them and pay health

insurance contributions for their employees in accordance with regulations in force by using the following funding sources:

a) If these employees work for state budget-financed units, state budget allocations shall support health insurance contributions of these policyholders;

b) If these employees work for public service units, their health insurance contributions shall be paid by each unit's budget in accordance with laws on autonomy mechanisms of public service units;

c) If these employees work for enterprises, their health insurance contributions shall be paid by each enterprise's budget.

9. Based on regulations on delegation of authority by competent authorities and the general report on policyholders, state budget expenditures on health insurance contributions and health insurance contribution support, sent by social insurance agencies, the financial authority shall be responsible for transferring these expenditures to the health insurance package once every quarter of a financial year. Not later than December 15 of each year, transfer of state budget expenditures to the health insurance package in that year must be completed.

10. With respect to policyholders specified in clause 15 of Article 3 hereof, on a quarterly basis, scholarship-granting entities or organizations shall pay health insurance contributions in accordance with regulations in force into the health insurance package.

**Article 10. Determination of contribution and support amounts applied to certain policyholders in case of the State's adjustments to health insurance contribution rates and base pay rates**

1. With respect to policyholders referred to in Article 4 hereof whose health insurance contributions are wholly supported by the state budget:

a) The amount of the state budget's monthly payment of or support for health insurance contributions shall be defined as the health insurance contribution rate multiplied by (x) the base pay rate. If the state adjusts the health insurance contribution rate and the base pay rate, the amount of health insurance contribution paid or supported by the state budget shall be adjusted from the date of application of the new health insurance contribution rate and the new base pay rate;

b) The amount of health insurance contribution for children under 6 years of age shall be calculated from the date of birth to the date on which children reach 72 months of age. If a Vietnamese child is born abroad, the amount of health insurance contribution shall be calculated from the date on which that child returns and resides in Vietnam in accordance with laws.

2. With respect to those policyholders whose health insurance contributions are partially supported by the state budget in accordance with clause 3 and 4 of Article 4 hereof:

a) The monthly amount of health insurance contribution paid by the policyholder and the state budget's monthly support for health insurance contributions shall be defined as the health insurance contribution rate multiplied by (x) the base pay rate determined on the date of the policyholder's payment of health insurance contribution;

b) If the State adjusts the health insurance contribution rate or the base pay rate, the policyholder and the state budget shall not be required to make additional payments or shall not be entitled to reimbursement of the difference arising owing to any adjustment to the health insurance contribution rate or the base pay rate for the rest of time during which the policyholder has already paid his/her health insurance contributions.

3. With respect to family-based policyholders as defined in Article 5 hereof:

a) The monthly amount of health insurance contribution shall be defined as the health insurance contribution rate multiplied by (x) the base pay rate determined on the date of payment of health insurance contribution;

b) In case where the State adjusts the health insurance contribution rate or the base pay rate, the policyholder shall not be required to pay additional health insurance contributions or shall not be entitled to reimbursement of the difference arising owing to any adjustment to the health insurance contribution rate or the base pay rate for the remaining time during which the policyholder has already paid health insurance contributions.

4. If the policyholder participates in the health insurance amidst days of a month, the health insurance contribution amount shall be determined in a unit month from the date of payment of health insurance contribution.

## Chapter III

## HEALTH INSURANCE CARDS

### Article 11. Preparation of list of policyholders awarded health insurance cards

1. Employers shall prepare the list of policyholders belonging in the group of policyholders prescribed in Article 1 hereof.

2. Educational institutions and vocational education establishments shall be responsible for preparing the list of policyholders in the group under their jurisdiction as provided in clause 15 of Article 3 and clause 3 of Article 4 hereof.

3. Affiliates of the Ministry of National Defence or the Ministry of Public Security shall be responsible for compiling the list of policyholders belonging in the group under their management as provided in clause 1 of Article 1 and clause 13 of Article 3 and Article 6 hereof and under the instructions of the Ministry of National Defence or the Ministry of Public Security.

4. As regards any policyholder who donates his/her organs under laws, social insurance agencies shall consult his/her hospital discharge form, issued by the healthcare establishment where he/she donates his/her organs, in order to issue the health insurance card.

5. Commune-level People's Committees shall be responsible for compiling the list of policyholders referred to in Article 2; clause 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 16 and 17 of Article 3; clause 1, 2 and 4 of Article 4 and Article 5 hereof.

6. The list of health insurance policyholders shall be prepared by using the Form No. 2 and No.3 of the Appendices to this Decree.

**Article 12. Health insurance cards**

Health insurance cards shall be issued by competent social insurance agencies and contain the following information:

1. Personal information of a policyholder, including full name, gender, date of birth, permanent residence or workplace address.

2. Health insurance coverage rate stipulated in Article 14 hereof.

3. Start date of a health insurance card.

4. Name of the primary healthcare establishment.

5. The consecutive 5-year or longer period of health insurance participation of policyholders making co-payment of healthcare costs. The consecutive period of health insurance participation refers to the date subsequent to the previous date of issue inscribed on a health insurance card; in case of an interval, it must be less than 03 months.

With respect to persons dispatched by competent authorities to go on an educational or business trip; spouses, natural children, or legally adopted children aged under 18 years, accompanying their parents serving terms of office at Vietnam's overseas missions, their overseas stay period shall be accepted as the period of health insurance participation.

With respect to employees working abroad, the period of their health insurance participation before their overseas work shall be assumed as the period of health insurance participation if they resume participating in the health insurance within duration of 30 days from the date of their entry.

If employees await completion of required procedures for entitlement to unemployment benefits as provided by the Law on Employment, the period of the previous health insurance participation shall be assumed as the period of health insurance participation.

With respect to policyholders, referred to in point a of clause 3 of Article 12 of the Law on Health Insurance, who retire, are demobilized, transfer to other business or resign, if they have

not yet participated in the health insurance during the period of their study or military service in the people's army, the people's public security force or a cryptographic body, that period shall be assumed as the consecutive period of health insurance participation.

6. Photo of the policyholder (not applicable to children under 6 years of age) in case where he/she does not have any photo personal identification document issued by competent bodies or authorities, or any certificate issued by commune-level police authorities or other documents endorsed by educational institutions or vocational education establishments in charge of management of pupils or students, or other legitimate personal identity documents.

**Article 13. Validity period of health insurance cards**

1. With respect to policyholders specified in clause 6 of Article 2, health insurance cards shall have validity from the first month of entitlement to unemployment benefits which is determined in the decision on entitlement to unemployment benefits, issued by a competent regulatory authority.

2. With regard to policyholders specified in clause 7 of Article 3 hereof:

a) If a child is born before September 30, his/her health insurance card shall be valid until the end of September 30 of the year in which he/she reaches 72 months of age;

b) If a child is born after September 30, his/her health insurance card shall be valid until the end of the last date of the month in which he/she reaches 72 months of age.

3. With respect to policyholders referred to in clause 8 of Article 3 hereof, their health insurance cards shall be valid from the date of social welfare entitlement determined in the decision issued by the district-level People's Committee.

4. With respect to the policyholders specified in clause 9 of Article 3, or the policyholders prescribed in clause 1 of Article 4 hereof, if their health insurance contributions are wholly supported by the state budget, their health insurance cards shall be valid from the date specified in the decision on approval of the list of policyholders, issued by a competent authority.

5. With respect to the policyholders specified in clause 10 of Article 3 hereof, their health insurance cards shall be valid from the date specified on the decision on approval of the list of policyholders, issued by a competent authority.

6. With respect to the policyholders specified in clause 14 of Article 3 hereof, their health insurance cards shall be valid immediately after the date of donation of their organs.

7. With regard to policyholders specified in clause 3 of Article 4 hereof:

a) Health insurance cards shall be annually issued to students at general education institutions, including the following cases:

- As regards 1st - grade pupils, each health insurance card shall be valid from the 1st day of October of the first year of elementary education;

- As regards12th - grade students, each health insurance card shall be valid till the end of September 30 of that school year.

b) Each health insurance card shall be annually issued to pupils and students at higher education establishments and vocational training facilities, including the following cases:

- As regards first-year students of academic programs, each health insurance card shall be valid from the first date of the academic year, except the case in which 12th - grade students hold their health insurance cards remaining valid;

- As regards last-year students of academic programs, each health insurance card shall be valid till the last date of the final month of each academic program.

8. With regard to others, each health insurance card shall be valid from the first date of payment of health insurance contribution. If the policyholders referred to in clause 4 of Article 4, Article 5 and 6 hereof participate in the health insurance for the first time or do not incessantly participate in the health insurance for at least 3 months in a financial year, each health insurance card shall have the validity period of 12 months from the date on which it is in effect as per point c of clause 3 of Article 16 in the Law on Health Insurance.

9. The validity of each health insurance card as prescribed in this Article shall be equivalent to the amount of health insurance contribution in accordance with regulations in force, except policyholders who are children under 6 years of age.

## Chapter IV

## BENEFIT ENTITLEMENT RATES, PROCEDURES FOR INSURANCE COVERED HEALTHCARE SERVICES

### Article 14. Rates of entitlement to health insurance coverage with respect to cases prescribed in clause 1 and clause 7 of Article 22 in Law on Health Insurance

1. When receiving medical examination and treatment services in accordance with Article 26, 27 and 28 in the Law on Health Insurance; clause 4 and 5 of Article 22 in the Law on Health Insurance, health insurance policyholders shall be entitled to the health insurance fund's coverage of permissible medical costs at the following rates:

a) 100% of medical costs paid by the policyholders prescribed in clause 3, 4, 8, 9, 11 and 17 of Article 3 herein;

b) 100% of medical costs, and any restrictions on the rate of payment of medical costs such as medicines, chemicals, medical supplies and medical technology services as regulations of the Minister of Health shall not be applied to:

- Revolutionaries performing their activities before January 1, 1945;

- Revolutionaries performing their activities from January 1, 1945 to the date of the uprising event taking place in August, 1945;

- Vietnamese heroic mothers;

- War invalids, beneficiaries of the same compensation policies as war invalids, class-B war invalids and sick soldiers whose labor capacity is reduced by at least 81%;

- War invalids, beneficiaries of compensation policies as war invalids, class-B war invalids and sick soldiers whose injuries are cured or whose diseases relapse;

- Partisans suffering diseases due to exposure to toxic chemicals whose labor capacity is reduced by at least 81%;

- Children under 6 years of age.

c) 100% of healthcare service costs at the commune level;

d) 100% of medical service costs if the cost of each medical examination or treatment accounts for less than 15% of the base pay rate;

dd) 100% of medical costs if a patient participates in the health insurance for a consecutive period of at least 5 years and has made the co-payment of medical costs in a year which is greater than total base pay amount received during 6 months, except self-referrals to inappropriate-level healthcare establishments;

e) 95% of medical costs paid by the policyholders prescribed in clause 1 of Article 2, clause 12 of Article 3, and clause 1 and 2 of Article 4 herein;

g) 80% of medical costs paid by others;

h) With respect to patients who are diagnosed, given therapeutic indications and referred to commune-level healthcare establishments for their management, monitoring and dispensing of medicines by higher-level healthcare establishments under regulations of the Minister of Health, their medical costs shall be paid by the health insurance fund within their scope of insurance benefit entitlement and contribution rates as prescribed in point a, b, dd, e ad g of clause 1 of this Article.

2. If a person is classified into different groups of policyholders, he/she shall be entitled to the health insurance benefit which is offered to the policyholder entitled to the highest health insurance benefit in accordance with clause 1 of this Article.

3. In case where a health insurance card holder visits an inappropriate-level healthcare establishment at his/her discretion, and then is referred to another healthcare establishment by the

receiving healthcare establishment, he/she shall be paid the health insurance fund's coverage at the coverage rate specified in clause 3 of Article 22 in the Law on Health Insurance, except the following cases: he/she is given emergency treatment services; he/she is given inpatient treatment services while being diagnosed with any other disease of which treatment is out of professional capabilities of the referring healthcare establishment; his/her pathological conditions have changed to the extent that they are out of competencies of the referring healthcare establishment.

4. Health insurance policyholders who register their primary healthcare services at commune-level healthcare establishments in adjacent provinces shall be entitled to 100% coverage of costs of healthcare services in the list of covered healthcare services with respective coverage rates as defined in clause 1 of this Article if they are offered medical services rendered by these commune-level healthcare establishments in adjacent provinces.

5. In case of conversion of the health insurance benefit entitlement rate, the new entitlement rate shall be applied from the effective date of the new health insurance card.

**Article 15. Procedures for insurance covered healthcare services**

1. When visiting healthcare establishments for medical examination or treatment services, health insurance policyholders must present photo health insurance cards; in case of absence of the photo, they shall be required to present one of their photo identity documents issued by competent bodies or authorities, or certificates endorsed by commune-level police authorities or others endorsed by educational institutions in charge of management of pupils or students; other legitimate personal identification documents.

2. When children under 6 years of age go to healthcare establishments to receive medical examination or treatment services, only health insurance cards shall be needed. If a child is not awarded health insurance cards, a copy of the written evidence of birth or a copy of the birth certificate must be shown; in case where such child needs medical treatment after birth but he/she is not awarded the written evidence of birth, the head of the healthcare establishment, parents or guardian of that child shall be required to sign in the medical record as a basis for payment of health insurance benefits as prescribed in clause 1 of Article 27 hereof and shall bear responsibility for their endorsement.

3. When visiting healthcare establishments to receive medical examination or treatment services, a health insurance policyholder who is expecting a new health insurance card which is reissued or replaces the preexisting one must present the note of appointment for reissuance and replacement of health insurance card issued by the social insurance agency or any entity or individual authorized by the social insurance agency to receive applications for reissuance and replacement of health insurance cards by using the Form No. 4 of the Appendix to this Decree, and any document evidencing personal identity of that policyholder.

4. When a health insurance policyholder who has donated his/her organ visits healthcare establishments to receive medical examination or treatment services, he/she must present documents referred to in clause 1 or clause 3 of this Article. In case where the medical treatment

is needed immediately after the organ donation, the head of the healthcare establishment performing organ procurement and the patient or the patient's relative must bear their signature on the medical record as a basis for payment of health insurance benefits in accordance with clause 2 of Article 27 hereof, and shall be responsible for their endorsement.

5. In case of a referral to another healthcare establishment at the different level, a policyholder shall be required to present his/her referral dossier formulated by the referring healthcare establishment and the referral form by using the Form No. 6 of the Appendix to this Decree. In case where the referral form is valid until the end of December 31 while the medical treatment has not yet been completed, use of that referral form till the end of that medical treatment shall be allowed.

In case of a follow-up examination, a health insurance policyholder must show the note of follow-up appointment of the healthcare establishment which is prepared by using the Form No. 5 of the Appendix to this Decree.

6. In case the emergency treatment service is needed, a health insurance policy may choose to be hospitalized at any healthcare establishment and shall be required to present documents referred to in clause 1, clause 2 or clause 3 of this Article before discharge from that healthcare establishment. After the emergency treatment stage, if the insured patient is allowed by the healthcare establishment to implement procedures for referral to another ward or department of that healthcare establishment in order for them to receive further health monitoring and treatment, or to be referred to another healthcare establishment, these referrals shall be defined as appropriate-level referrals.

The healthcare establishment that does not enter into the health insurance-covered healthcare service contract shall be responsible for providing patients allowed for hospital discharge with valid documents and evidences relating to medical costs which they use for directly claiming payments of their health insurance benefits at social insurance agencies under the provisions of Article 28, 29 and 30 hereof.

7. If a health insurance policyholder takes up a temporary residence while going on a business trip, working on the move or taking a full-time training program, he/she shall be entitled to receive primary health care at an appropriate-level healthcare establishment or the healthcare establishment at the level equivalent to the healthcare establishment providing primary care which is inscribed on his/her health insurance card, and shall be required to present documents stipulated in clause 1, clause 2 or clause 3 of this Article and one of the following documents (either in the form of an authentic copy or a duplicate): business travel form, decision to send personnel to participate in a training course, student identity card, temporary residence evidencing document and school transfer approval form.

8. Healthcare establishments and social insurance agencies shall not be allowed to adopt supplemental procedures for health insurance-covered services in addition to those procedures stipulated in this Article. In case where healthcare establishments or social insurance agencies need copies of the health insurance card and other documents relating to medical examination

and treatment of patients to serve administrative tasks, they shall be required to make copies at their expense and shall not be allowed to request patients to make copies or pay photocopy costs.

## Chapter V

## HEALTH INSURANCE-COVERED SERVICE CONTRACTS

### Article 16. Health insurance-covered service contracts

1. In case of a first-time health insurance-covered service contract, documents shall include:

a) Request form for signing the contract, prepared by the requesting healthcare establishment;

b) Duplicate of the healthcare license, issued by a competent regulatory authority to the requesting healthcare establishment;

c) Internally stamped duplicate of the decision on ranking of hospitals made by a competent regulatory authority (if any) or the decision on medical level issued by a competent regulatory authority with respect to non-public healthcare establishments;

d) List of medical technology services, medicines, chemicals or medical supplies, approved by a competent regulatory authority (whether in the written or electronic form).

2. In case where a healthcare establishment obtains a competent regulatory authority's approval of supplementation of functions, duties, scope of professional practices and hospital ranking, that healthcare establishment shall be responsible for informing a competent social insurance agency of adding the abovementioned information to the health insurance-covered service contract. Within duration of 10 working days of receipt of the written document stating approval from the healthcare establishment, the receiving social insurance agency shall be responsible for completely signing on appendices to the contract or entering into a new contract.

### Article 17. Contractual terms and conditions, requirements for eligibility of a healthcare establishment for signing a health insurance-covered service contract with

1. Contractual terms and conditions shall be established by using the Form N0.7 of the Appendix to this Decree. Depending on conditions of a healthcare establishment, a social insurance agency and that healthcare establishment shall agree on supplements to contractual terms and conditions without committing any violation against legislative regulations on health insurance.

2. Requirements for eligibility of a healthcare establishment for signing a health insurance-covered service contract shall be comprised of the followings:

a) Fully meet requirements for conformance to medical practicing regulations in accordance with laws on healthcare services and have obtained a competent regulatory authority's medical service license;

b) Ensure provision of medicines, chemicals and medical supplies are in line with the scope of functions of that healthcare establishment.

**Article 18. Conclusion of health insurance-covered service contracts**

1. In case of entering into a health insurance-covered service contract for the first time:

a) A healthcare establishment sends 01 set of documents referred to in Article 16 hereof to a social insurance agency;

b) Within duration of 30 days of receipt of all required documents (based on the postmark date of received document), a social insurance agency must complete the processing of submitted documents and contract signing. In case of refusal to sign a health insurance-covered service contract, a written response clearly stating reasons for such refusal must be sent.

2. Validity period of a health insurance-covered service contract:

a) The validity period of a contract shall range from January 1 to end of December 31 of each year, but shall be restricted to 36 months;

b) In case of the health insurance-covered service contract signed for the first time, the validity period of this contract shall start from the signature date to end of December 31 in the year on which the contract expires, but shall not exceed 36 months;

c) In case of signing a health insurance-covered service contract on an annual basis, a healthcare establishment and a social insurance agency shall completely conclude the contract of the following year before December 31 of that year.

10 days before the contract expires, if the healthcare establishment and the social insurance agency agree on the contract extension and negotiate about the implementation of the contract based on an appendix to that contract, that appendix shall have legal value, unless otherwise agreed upon.

3. If a policyholder receives medical services prior to January 1, but is discharged from a healthcare establishment ahead of January 1, his/her medical costs shall be subject to the following regulations:

a) In case where that healthcare establishment continues to sign a health insurance-covered service contract, such medical costs shall be taken into account as the following year's medical costs;

b) In case where that healthcare establishment decides not to continue to sign a health insurance-covered service contract, such medical costs shall be taken into account as that year's medical costs.

4. A health insurance-covered service contract shall clearly specify the method for payment of health insurance-covered medical costs where relevant to actual conditions of that healthcare establishment.

5. Contracting parties shall be responsible for assuring rights and interests of patients holding health insurance cards under laws on health insurance and preventing any suspension of medical services provided for patients holding health insurance cards.

**Article 19. Contracts for health insurance-covered medical services performed at commune- or ward-level health stations, public maternity homes, regional general clinics and healthcare establishments of public service entities and educational institutions**

1. With respect to commune- or ward-level health stations, public maternity homes and regional general clinics

a) A social insurance agency shall sign a contract with a district-level healthcare center or hospital or other healthcare establishment approved by the provincial-level Department of Health to provide medical services at a commune- or ward-level health stations, maternity homes and regional general clinics for health insurance policyholders;

b) The healthcare establishment signing the health insurance-covered medical service contract prescribed in point a of this clause shall be responsible for providing medicines, chemicals and medical supplies for commune- or ward-level health stations, public homes, regional general clinics and paying costs incurred from use of patient beds (if any) and medical technologies within the scope of its medical functions; concurrently, making monitoring, supervisory and consolidated reports for the purpose of making payments to social insurance agencies.

2. With respect to healthcare establishments of entities or educational institutions (except those receiving state budget allocations funding primary care services as prescribed in clause 1 of Article 34 hereof), social insurance agencies shall be authorized to sign health insurance-covered medical service contracts directly with entities and educational institutions.

**Article 20. Rights and responsibilities of social insurance agencies for implementation of health insurance-covered medical service contracts**

1. Rights of social insurance agencies:

a) Implement regulations laid down in Article 40 of the Law on Health Insurance;

b) Request healthcare establishments to carry out the transfer of electronic data for evaluation and payment of health insurance-covered medical costs under regulations promulgated by the Minister of Health.

2. Responsibilities of social insurance agencies:

a) Implement regulations laid down in Article 41 of the Law on Health Insurance;

b) Within duration of 10 first days of the first month in the validity period of a contract, provide healthcare establishments with the list of holders of health insurance cards submitting an electronic or signed and stamped written application for registration of primary care services by using the Form No. 8 of the Appendix to this Decree at the beginning of each quarter;

c) Ensure compliance with laws on medical examination and treatment, regulations on management of medical records in accordance with regulations promulgated by the Minister of Health;

d) Cooperate with healthcare establishments in receiving and checking procedures for health insurance-covered medical services; revoke and temporarily impound health insurance cards and take actions within their jurisdiction against any violation; give information technology support for evaluation of health insurance-covered medical costs and payment thereof to healthcare establishments;

dd) Protect rights and interests of health insurance policyholders; deal with claims or complaints related to health insurance benefits under their jurisdiction;

e) Establish a perfect system for evaluating and ensuring the continuous receipt of electronic data and results of evaluation of health insurance-covered medical services, and the timely response upon receipt thereof to healthcare establishments under regulations promulgated by the Minister of Health.

**Article 21. Rights and responsibilities of healthcare establishments for implementation of health insurance-covered medical service contracts**

1. Rights of healthcare establishments:

Implement regulations laid down in Article 42 of the Law on Health Insurance.

2. Responsibilities of healthcare establishments:

a) Implement regulations laid down in Article 43 of the Law on Health Insurance;

b) Ensure provision of medicines, chemicals or medical supplies and medical technology services is in line with their level of medical practices as regulated by the Minister of Health;

c) Send electronic data for the purpose of performing the task of management of health insurance-covered medical services immediately after completion of each medical examination or completion of each outpatient treatment or completion of each inpatient treatment of a patient under regulations of the Minister of Health;

d) Send electronic data on health insurance-covered medical costs to request payments made not later than 7 working days from the date of completion of medical examination and treatment of patients in accordance with the regulations of the Minister of Health.

**Article 22. Contract amendment and supplementation**

1. In the course of implementation of a health insurance-covered medical service contract, if there is any party requesting amendments or supplements to contractual terms and conditions, they must inform the other party in writing for at least 30 days in advance of which terms and conditions subject to amendment or supplementation in that contract.

2. In case where both parties agrees on which terms and conditions are amended or supplemented, amendment and supplementation shall be carried out by bearing their signatures on appendices or entering into a new contract.

3. In case where both parties fail to reach agreement on amendment or supplementation, the existing contract shall remain valid for implementation.

**Article 23. Cases of contract termination**

1. A contract shall be terminated in case the contracting healthcare establishment is subject to business closure, dissolution, bankruptcy or revocation of its license.

2. A contract shall be terminated in case both parties agree on contract termination in accordance with laws.

3. In the course of implementation of a health insurance-covered medical service contract, if a social insurance agency, entity, organization or individual discovers that any healthcare establishment commits any violation against the contract, they must inform the provincial Department of Health, the Ministry of Health or a health authority of a ministry or sectoral administration with respect to the healthcare establishment under its respective control (hereinafter referred to as regulatory authority).

Within duration of 5 working days of receipt of the notification, the regulatory authority shall be responsible for sending the defaulting healthcare establishment a written request for submission of a written explanation for matters relating to the allegation of violations.

After receipt of the written explanation from the regulatory authority, the healthcare establishment shall be responsible for sending the regulatory authority the written explanation, enclosing evidences (if any).

After receipt of the written explanation from the defaulting healthcare establishment, the regulatory authority shall be responsible for cooperating with the same-level social insurance agency in carrying out review, verification and judgement of the allegation of violations. The judgement must clearly conclude whether or not the healthcare establishment at question commits any violation and may suggest remedial actions (if any).

4. In the course of implementation of a health insurance-covered medical service contract, if an entity, organization or individual discovers that a social insurance agency commits any violation against the contract, a notification of such violation must be sent to the regulatory authority.

Within duration of 05 working days of receipt of the abovementioned notification, the regulatory authority shall be responsible for sending the social insurance agency a written explanation for matters relating to the allegation of violations.

After receipt of the written request for explanation from the regulatory authority, the social insurance agency shall be responsible for sending the regulatory authority the written explanation, enclosing evidences (if any).

After receipt of the written explanation from the social insurance agency, the regulatory agency shall be responsible for cooperating with the same-level social insurance agency (in the event that the same-level social insurance agency is the body reported for violations, the higher-level social insurance agency is invited to cooperate with the regulatory authority) in carrying out the review, verification and judgement of the allegation of violations. The judgement must clearly conclude whether or not the social insurance agency at question commits any violation and may recommend remedial actions (if any).

## Chapter VI

## ARRANGEMENT FOR PAYMENT OF MEDICAL COSTS BETWEEN SOCIAL INSURANCE AGENCIES AND HEALTHCARE ESTABLISHMENTS

### Article 24. Service price-based payment

1. Payment made based on a service price refers to the method of payment of medical costs on the basis of the price of the medical examination and treatment service which is decided by a competent regulatory authority and costs of medicines, chemicals, medical supplies, blood, blood products which have not yet been included in the service price when being used for treatment of patients at a healthcare establishment.

2. The method for making payments based on prices of medical services shall be applied to the payment of health insurance-covered medical costs, except those costs of medical services which have been settled according to another payment method.

3. Payment principles:

a) The prices of health insurance-covered medical services shall be applied uniformly to same-rank hospitals nationwide;

b) If costs of medicines, chemicals and medical supplies have not been yet included in the prices of medical services, they shall be settled at the purchase prices under legislation on bidding;

c) Costs of blood and blood products shall be settled following instructions given by the Minister of Health.

4. Total annual payment of health insurance-covered medical costs to healthcare establishments shall be calculated according to the following formula:

$T = [T_{n-1} \times k]_{\text{medicines, chemicals}} + [T_{n-1} \times k]_{\text{medical supplies}} + [T_{n-1}]_{\text{blood, blood products}} + [T_{n-1}]_{\text{medical services}} + C_n$

Where:

a) T means total payment of health insurance-covered medical costs at a healthcare establishment equal to an addition of total inpatient medical cost and total payment of outpatient medical costs;

b) $T_{n-1}$ means the health insurance-covered medical cost incurred in the preceding year at a healthcare establishment of which settlement is audited by the social insurance agency;

c) k means the indexing factor indicating any adjustment made owing to any change in the price of medicines, chemicals and medical supplies at a healthcare establishment, relevant to specific elements of medicines, chemicals and medical supplies which have not been included in service prices, exclusive of costs included in $C_n$.

d) $C_n$ means the cost increasing or decreasing within a year at a healthcare establishment for the following reasons: applying new technologies; providing an additional amount of medicines, chemicals and medical supplies; applying new prices of health insurance-covered medical services; applying new prices of blood and blood products; adjusting hospital ranks; adjusting persons eligible to be awarded health insurance cards; changing the scope of operations of the healthcare establishment under the competent authority's decisions (if any); changing illness models; changing the number of a patient's medical visits. This cost shall be integrated into the actual cost used as a basis for calculation of total payment of health insurance-covered medical costs to that healthcare establishment.

5. The health insurance fund shall pay medical costs based on the annual financial report of a healthcare establishment which have been evaluated but do not exceed total payment of health insurance-covered medical costs determined according to clause 4 of this Article.

6. On an annual basis, depending on the price indices of specific elements of medicines, chemicals and medical supplies, declared by the General Statistics Office, the Ministry of Health shall inform the k coefficient after reaching an agreement with the Ministry of Finance.

**Article 25. Capitation payment**

1. The capitation payment method shall be applied to healthcare establishments providing health insurance-covered outpatient medical services.

2. The capitation payment method shall be applied to costs in the list of health insurance-covered costs with entitlement rates with respect to health insurance card holders registering primary care services and those registering primary care services at another healthcare establishment who seek care at the healthcare establishment making capitation payments.

3. The capitation payment method shall not applied to diseases, groups of diseases, medical services or medical costs which are not in the list of those permitted for capitation payments, regulated by the Minister of Health.

4. The capitation payment fund's allocations given to healthcare establishments providing health insurance-covered medical services must be within the provincial-level or national capitation payment fund limit.

5. Handling of the difference in the capitation payment fund's allocations given to healthcare establishments

a) In case where the capitation payment fund has the residual value (i.e. the positive difference in which the capitation payment fund's allocations are greater than medical costs), the healthcare establishment shall be required to post such residual value into its revenues and use it as a basis for determination of the next year's capitation payment fund. In case where a healthcare establishment is authorized to sign a contract for provision of primary care services, even including commune-level health stations, it shall be responsible for transferring a part of the residual value to a commune-level health station;

b) In case of the capitation payment fund's overspending within a financial year (i.e. the negative difference in which the capitation payment fund's allocations are less than medical costs), the healthcare establishment shall balance its revenue of their own accord in compliance with regulations in force.

6. In case where total cost falling within the national capitation payment fund's annual limit on allocations is greater than total allocations already given by that fund, the Vietnam Social Security shall send a general report to the Council for Management of Vietnam Social Security for its approval and preparation of another report for submission to the Ministry of Finance and the Ministry of Health. The Ministry of Health shall preside over and cooperate with the Ministry of Finance in reviewing the submitted report and preparing the consolidated report for submission to the Prime Minister to seek decisions.

7. The Minister of Health shall regulate the scope and schedule of implementation, techniques for determination of the fund and capitation payment as prescribed in this Article.

**Article 26. Payment of patient transportation costs**

1. Patient transportation costs must be paid if a health insurance policyholder defined as one of those referred to in clause 3, 4, 7, 8, 9 and 11 of Article 3 hereof seeks emergency care or wishes to refer to shift the level of medical practices from a district-level healthcare establishment to the higher-level one, including:

a) From the district level to the provincial level;

b) From the district level to the central level.

2. Rate of payment of transportation costs:

a) In case of use of the means of transport owned by a referring healthcare establishment, the health insurance fund shall pay two-way transportation costs to that healthcare establishment at the rate equal to 0.2 petrol litre/kilometer based on the actual distance between two healthcare establishments and the petrol price quoted at the time of referral. If there is more than one patient transported on the same vehicle, the rate of payment shall be the same as that for transportation of a single patient. The receiving healthcare establishment shall sign on the transport order issued by the referring healthcare establishment; in case of such referral occurring out of administrative hours, the receiving physician's signature shall be required;

b) In case of use of the means of transport which is not owned by a referring healthcare establishment, the health insurance fund shall pay one-way (departing) transportation costs to that healthcare establishment at the rate equal to 0.2 petrol litre/kilometer based on the actual distance between two healthcare establishments and the petrol price quoted at the time of referral. The referring healthcare establishment shall be responsible for paying these costs directly to a patient before his/her referral, and then making payment arrangements with a social insurance agency.

**Article 27. Payment of medical costs in certain cases**

1. With respect to payment of medical costs to children under 6 years of age, if they have not been awarded health insurance cards, the healthcare establishment shall prepare the list of under-six-years-old children and health insurance-covered medical costs belonging in the list of costs covered by health insurance benefits with respective benefit entitlement rates for submission to the social insurance agency in accordance with regulations in force.

The receiving social insurance agency shall, based on the list of children who are sent from another healthcare establishment and have been provided with medical care services, assume responsibility for checking and verifying the issuance of health insurance cards to these children; making payments for medical costs. If they have not been awarded health insurance cards yet, these cards must be issued in accordance with regulations in force.

2. With respect to payment of medical costs to a person donating his/her organs, if he/she is required to receive medical treatment after donation but he/she has not been awarded the health insurance card yet, the healthcare establishment receiving his/her organ shall be responsible for preparing the list of donators and medical costs in the list of costs covered by health insurance benefits together with respective rates of benefit entitlement after donation for submission to the health insurance agency for completion of payments in accordance with regulations in force.

The health insurance agency shall, based on the list of organ donators who have receive medical examination and treatment services after donation and costs sent by the healthcare establishment, make payments and issue health insurance cards.

3. With respect to payment of medical costs of a patient participating in the health insurance for a consecutive period of at least 5 years and has made the co-payment of medical costs in a year

which is greater than total base pay amount received during 6 months in accordance with point dd of clause 1 of Article 14 hereof:

a) If a patient makes co-payment for each visit or multiple visits for medical care at the same healthcare establishment which is greater than the base pay amount received during 6 months, that healthcare establishment shall not be allowed to collect the patient's co-payment which is greater than the base pay amount that he/she has received during 6 months. The healthcare establishment shall be responsible for providing an invoice for the co-payment amount equal to the base pay amount during 6 months so that the patient can use it as a basis for requesting the health insurance agency to give its certification of exemption from making any co-payment in that year;

b) In case where the patient's accrued amount of co-payments in a financial year at different healthcare establishments or at the same healthcare establishment is greater than 6 months' base pay amount, that patient may present evidencing documents to the social insurance agency issuing his/her health insurance card to pay the amount of co-payment greater than 6 months' total base pay amount and receive the certification of exemption from co-payment in that year;

c) In case where the patient's co-payment amount is greater than the 6 months' total base pay amount as from January 1, the health insurance fund shall cover 100% of costs incurred from healthcare services falling within the scope of a patient's interests from the anniversary date of 5 consecutive years of health insurance participation to the end of December 31 in that year.

4. With respect to a hospital referral, if medical staff is required to accompany the patient, and medicines or medical supplies used to meet medical demands during the process of patient transportation are needed, costs incurred from use of these medicines or medical supplies shall be taken into account as medical care costs of the referring healthcare establishment.

5. In case where a patient retrieves a stable health conditions after the inpatient care stage, but continues to use medicines after hospital discharge according to the healthcare establishment's medical indication, subject to regulations of the Minister of Health, the health insurance fund shall pay costs of medicines falling in the list of health insurance-covered medicines with respective coverage rates determined according to the prescribed insurance benefits. The healthcare establishment shall enter costs of medicines into costs of medical care services of a patient before hospital discharge.

6. In case where a healthcare establishment does not perform any subclinical test, imaging diagnosis, functional assessment and has to refer a patient or send a pathology specimen to another healthcare establishment providing health insurance-covered medical services or any healthcare establishment accredited by a competent authority to render these services, the health insurance fund shall pay costs incurred from performing medical services in the list of health insurance-covered medical services with respective coverage rates in accordance with regulations adopted by the healthcare establishment referring the patient and sending the pathology specimen. The healthcare establishment referring the patient and sending the pathology specimen shall be responsible for paying costs incurred by the receiving healthcare

establishment or the service provider, and then entering these costs into the patient's medical costs as a basis for making payment arrangements with the social insurance agency.

The Minister of Health shall regulate principles and the list of subclinical test, imaging diagnosis and functional assessment services allowed to be sent to a healthcare establishment or a service provider.

7. Payment of medical costs for medical technology services performed by staff members of the transferor healthcare establishment of medical technologies according to programs for giving directions to lower-level healthcare establishments and schemes for promotion of professional competencies for the transferee healthcare establishment of medical technologies or medical technology transfer contracts under regulations promulgated by the Minister of Health.

a) If a medical technology service is transferred under the approval decision of a competent authority to the healthcare establishment receiving the handover of that medical technology service, the health insurance fund shall make payments at the approved service price;

b) If a medical technology service is not approved by a competent authority for transfer to the healthcare establishment receiving the handover thereof, the transferee healthcare establishment shall be responsible for informing a social insurance agency signing the health insurance-covered medical service contract in writing of medical technology services permitted to be provided according to programs, schemes or contracts as a basis for payments, and concurrently submit the list of medical technology services to the competent authority for its approval for provision of these services upon receipt thereof;

c) As for costs incurred from use of medicines, chemicals or medical supplies, the health insurance fund shall pay them at the purchase prices determined by the healthcare establishment providing health insurance-covered medical services in accordance with existing regulations on bidding.

8. With respect to payment of medical costs, if a healthcare establishment uses a new medical technology and method approved by a competent authority and their service price has not been regulated yet, that healthcare establishment must set and apply for the competent authority's approval of prices of medical technology services as a basis for payment. In this case, the healthcare establishment must inform the social insurance agency in writing of use of a new medical technology or method.

9. If the health insurance card of a health insurance card holder who is receiving inpatient treatment services at a healthcare establishment has expired, his/her medical costs may be covered by the health insurance fund provided that medical services that he/she has received belongs in the list of health insurance-covered medical services with respective coverage rates until the date of his/her hospital discharge, and the interval between the expiration date and the date of receipt of medical services does not exceed 15 days. The healthcare establishment shall be responsible for informing the patient and the social insurance agency signing a health insurance-covered medical service contract with that healthcare establishment so that the patient continues to participate in the health insurance, and the social insurance agency issues or renews

the patient's health insurance card when he/she is receiving medical treatment services at that healthcare establishment.

10. Payment of medical costs with respect to a healthcare establishment providing health insurance-covered medical services on weekly rest days and holidays:

a) When receiving medical services at the healthcare establishment, health insurance card holders shall be entitled to the health insurance fund's coverage for medical services in the list of health insurance-covered medical services with respective coverage rates;

b) The healthcare establishment shall be responsible for satisfying personnel and professional requirements, publicly disclosing costs that are paid at the patient's expense and are not in the list of health insurance-covered medical costs with respective coverage rates, and informing the patient of this in advance; sending a written notification to the social insurance agency so that they supplement the health insurance-covered medical service contract with terms and conditions of provision of medical services on weekly rest days and holidays as a basis for later payments before the official provision of such medical services.

## Chapter VII

## DIRECT PAYMENT OF MEDICAL COSTS BETWEEN SOCIAL INSURANCE AGENCIES AND HEALTH INSURANCE POLICYHOLDERS

### Article 28. Documents required to claim direct health insurance benefit payments

1. Photocopied documents (enclosing original copies for verification purposes) shall include:

a) Health insurance card and identification card, prescribed in clause 1 Article 15 hereof.

b) Hospital discharge form, health check-up form or health check-up number of the medical examination or treatment visit for which payment is claimed.

2. Relevant invoices and evidencing documents.

### Article 29. Submission and processing of documents submitted to claim direct health insurance benefit payments

1. The patient or his/her relative or legal representative prescribed by laws shall directly submit these documents as provided in Article 28 hereof to the social insurance agency at the district where these persons reside.

2. The district-level social insurance agency shall assume the following responsibilities:

a) Receive these documents and issue the note of receipt. In case of lack of required documents, they must provide instructions for later submission of sufficient documents;

b) Within duration of 40 days of receipt of all required documents, health insurance examination and evaluation, and payment of medical costs to the patient or his/her relative or legal representative must be completed. In case of refusal to make payments, they must send a written response clearly stating reasons.

**Article 30. Rate of direct health insurance benefit payment**

1. With respect to a patient seeking medical care at a district- or equivalent-level healthcare establishment without any health insurance-covered medical service contract (except that case in which he/she needs emergency care), he/she shall be entitled to payments as follows:

a) If he/she receives outpatient care services, he/she shall be entitled to health insurance coverage which is equivalent to the actual medical costs in the list of health insurance-covered costs with respective coverage rates in accordance with regulations in force, but is not 0.15 times greater than the base pay rate determined on the date of provision of medical services;

b) If he/she receives inpatient care services, he/she shall be entitled to health insurance coverage which is equivalent to the actual medical costs in the list of health insurance-covered costs with respective coverage rates in accordance with regulations in force, but is not 0.5 times greater than the base pay rate determined on the hospital discharge date.

2. In case where a patient receives inpatient care services at a provincial- or equivalent-level healthcare establishment without holding any health insurance-covered medical service contract (except the case in which he/she needs emergency care), he/she shall be entitled to health insurance coverage which is equivalent to the actual medical costs in the list of health insurance-covered costs with respective coverage rates in accordance with regulations in force, but is not 1.0 times greater than the base pay rate determined at the hospital discharge date.

3. In case where a patient receives inpatient care services at a central- or equivalent-level healthcare establishment without holding any health insurance-covered medical service contract (except the case in which he/she needs emergency care), he/she shall be entitled to health insurance coverage which is equivalent to the actual medical costs in the list of health insurance-covered costs with respective coverage rates in accordance with regulations in force, but is not 2.5 times greater than the base pay rate determined at the hospital discharge date.

4. In case where a patient receives medical services at a primary medical care service provider in breach of regulations laid down in clause 1 of Article 28 of the Law on Health Insurance, he/she shall be entitled to the health insurance fund's coverage which is equivalent to the actual medical costs in the list of health insurance-covered costs with respective coverage rates, but is not 0.15 times greater than the base pay rate determined at the date of receipt of medical services with respect to outpatient care services, and is not 0.5 times greater than the base pay rate determined at the hospital discharge date with respect to inpatient care services.

**Chapter VIII**

**USE AND MANAGEMENT OF HEALTH INSURANCE FUND**

**Article 31. Distribution and use of the health insurance fund**

Total health insurance contribution amount prescribed in Article 7 hereof shall be distributed and utilized as follows:

1. 90% of such amount intended for medical services (hereinafter referred to as medical service fund) shall be used for the following purposes:

a) Paying costs in the list of health insurance-covered costs of a health insurance policyholder as prescribed in Article 14, 26, 27 and 30 hereof;

b) Setting aside a part of such amount given to educational institutions or vocational training establishments, entities, organizations or enterprises satisfying prescribed requirements in accordance with clause 1 of Article 34 hereof.

2. 10% of health insurance contributions shall be intended for the provisional fund and payment of costs of management of the health insurance fund and shall be subject to the following provisions:

a) The payment amount of costs of management of the health insurance fund is equal to 5% of total health insurance contribution amount. The annual payment amount of costs of management of the health insurance fund and the payment items shall be regulated by the Prime Minister;

b) The amount set aside for the provisional fund is the remaining amount resulting from the deduction from the health insurance fund for costs of management of the health insurance fund under the provisions of point a of this clause, and shall be equal to 5% of total health insurance contribution amount at minimum.

**Article 32. Costs of management of the health insurance fund**

1. Costs of management of the health insurance fund shall be comprised of the followings:

a) Payments for performing activities by the organizational machineries of all-level social insurance agencies;

b) Payments for propagating and disseminating regulatory policies and law soft; attracting and managing health insurance policyholders; organizing professional training; reforming administrative procedures; carrying out collection activities; conducting inspection and audit activities and other payments in accordance with laws on health insurance;

c) Payments for application of information technologies and capital investments.

2. Specific payment items prescribed in clause 1 of this Article shall be subject to regulations promulgated by the Prime Minister.

**Article 33. Payment amounts for primary medical care services**

1. The amounts set aside for payments to an educational institution or vocational training establishment shall include:

a) 5% of health insurance revenues in connection with total number of children under 6 years of age, pupils or students studying at that educational institution shall be calculated according to the following formula:

Amount = 5% x ($N_{\text{number of persons}}$ x $M_{\text{health insurance}}$ x $L_{\text{base}}$ x Th)

Where:

- $N_{\text{number of persons}}$: Number of children under 6 years of age, pupils or students studying at an educational institution or a vocational training establishment participating in the health insurance.

- $M_{\text{health insurance}}$: Rate of payment of health insurance contribution applied to policyholders who are children under 6 years, pupils or students prescribed in clause 1 of Article 7 hereof.

- $L_{\text{base}}$: Base pay rate determined on the date of payment of health insurance contribution.

- Th: Number of months of health insurance contribution payment.

On a periodic basis, every 03 months, 06 months or 12 months, the social insurance agency shall be responsible for transferring the amount prescribed in this point to an educational institution or vocational training establishment, and consolidating such amount into the financial report of the fund for health insurance-covered medical services.

b) With respect to 1% of the monthly health insurance contribution for an employee working at an educational institution or a vocational training establishment, the social insurance agency shall be responsible for covering this amount immediately after receipt of the health insurance contribution from the educational institution or the vocational training establishment.

2. The amount retained for an entity, organization or enterprise meeting requirements as prescribed in clause 1 of Article 34 hereof shall be equal to 1% of the monthly health insurance contribution amount that such entity, organization or enterprise pays for their employees. The social insurance agency shall be responsible for paying such cost immediately after receipt of the health insurance contribution paid by this entity, organization or enterprise.

3. The amount retained for persons aboard an offshore fishing vessel:

a) The payment amount equal to 10% of the health insurance revenue in connection with the number of persons aboard such vessel who participates in the health insurance for the purpose of buying medicine cabinets, medicines and medical supplies for medical first aid and primary care services shall be calculated according to the following formula:

Amount = 10% x ($N_{\text{number of persons}}$ x $M_{\text{health insurance}}$ x $L_{\text{base}}$ x Th)

Where:

- $N_{number\ of\ persons}$: Number of participants in the health insurance program who work aboard a fishing vessel.

- $M_{health\ insurance}$: Health insurance contribution rate applied to the first policyholder in a family household in accordance with point e of clause 1 of Article 7 hereof.

- $L_{base:}$ Base pay rate determined on the date of payment of health insurance contribution.

- Th: Number of months of health insurance contribution payment.

b) President of the provincial People's Committee shall manage purchase and donation of medicine cabinets, medicines and medical supplies for owners of offshore fishing vessels. The health insurance agency shall transfer the amount prescribed in point a of this clause to the entity or organization authorized by the President of the provincial People's Committee to purchase medicine cabinets, medicines and medical supplies; enter such amount into the financial report of the fund for health insurance-covered medical services.

4. Based on the actual demands and capability of balancing of the health insurance fund, the Minister of Health shall recommend any proper adjustment in the amount retained for payment of primary care costs to the Government for its approval.

**Article 34. Medical cost payment and accounting requirements and contents with respect to primary care services**

1. The educational institutions, vocational training establishments, entities, organizations or enterprises prescribed in point b of clause 1 of Article 31 hereof (except those that have signed health insurance-covered medical service contracts as per Article 19 hereof) shall be entitled to the health insurance fund's allocations for performing primary care services if they satisfy the following requirements:

a) Have at least a person who conforms to medical practicing requirements under laws on medical examination and treatment, and work under the single-employment or multiple-employment regime in the primary care domain;

b) Have medical care wards or private rooms for first aid or primary care activities for policyholders under the management of an educational institution or vocational education establishment, entity, organization or enterprise in case of accidents resulting in injuries, common diseases when studying or working at these educational institutions, vocational training establishments, entities, organizations or enterprises.

2. Payment items:

a) Payments for medicines, medical supplies for first aid or primary care services for children, pupils, students policyholders under the management of these entities, organizations or

enterprises in case of accident-related injuries, common diseases when studying or working at the abovementioned entities;

b) Payments for purchase and repair of common medical equipment serving the needs of primary care, filing cabinets used for archival of medical records at these entities;

c) Payments for purchase of stationery accessories used for provision of medical services in the primary care domain.

3. Cost payment and settlement:

a) Pubic educational institutions or vocational education establishments shall record medical costs arising in the primary care domain in costs intended for operation of their medical service operations and carry out the settlement thereof with higher-level supervisory units in accordance with existing regulations;

b) Non-pubic educational institutions or vocational education establishments shall record medical costs arising in the primary care domain in their operational costs and carry out the settlement thereof with higher-level supervisory units (if any);

c) Enterprises and economic organizations shall create a separate accounting book to reflect the receipt of the health insurance fund's allocations, the use of these allocations and shall not be allowed to consolidate costs incurred into the cost settlement report of each enterprise or economic organization;

d) Other entities shall record medical costs arising in the primary care domain in costs incurred by performing their healthcare activities of these entities and carry out the settlement thereof with higher-level supervisory bodies (if any) or same-level financial institutions under existing regulations.

4. Educational institutions, vocational training establishments, organizations or enterprises given allocations for medical services in the primary care domain as prescribed herein shall be responsible for using them for primary care services, shall not be allowed to use them for other purposes. The remaining amount of allocations which are given for use to the end of the year and have not been used up shall be brought forward for use in the following year and may not need to be settled with social insurance agencies.

**Article 35. Management and utilization of the provisional fund**

1. Funding sources:

a) Amounts retained annually as prescribed in point b of clause 2 of Article 31 hereof and point a of clause 3 of Article 35 in the Law on Health Insurance;

b) Amounts derived from deferrals or evasions of health insurance contribution payment;

c) Returns yielded from the health insurance fund's investments;

d) Interests accruing due to deferred payment or evasion of health insurance contributions.

2. Purposes of the provisional fund's allocations:

a) Allocations used as supplementary amounts funding medical services in cities and provinces in case of total health insurance revenue intended for medical services referred to in clause 1 of Article 31 hereof which is less than total expenditure in the year. After evaluation of the cost settlement report, the Social Security of Vietnam shall be responsible for offsetting the difference by using the provisional fund.

b) Allocations used as state budget refunds owing to recurring issuance of health insurance cards.

3. In case where the provisional fund is insufficient to provide supplementary amounts for medical services in cities and provinces under point a of clause 2 of this Article, the Vietnam Social Security shall report to the Council for Social Insurance Management and recommend measures to deal with such situation before submitting a consolidated report to the Ministry of Health and the Ministry of Finance.

The Ministry of Health shall preside over and cooperate with the Ministry of Finance in recommending measures to the Government to ensure adequacy and timely provision of funds for health insurance-covered medical services in accordance with regulations in force.

**Article 36. Financial planning and settlement**

1. On an annual basis, the Vietnam Social Security shall draw up plans for the health insurance fund's revenues and expenditures; funds for management of the health insurance fund and investments derived from temporarily idle amounts of the health insurance fund. The Ministry of Finance shall preside over and cooperate with the Ministry of Health in submitting the review and general report to the Prime Minister to receive his decision on assignment of the financial plan.

2. On an annual basis, prior to October 1, the Vietnam Social Security shall be responsible for preparing the general and cost settlement report of the health insurance fund in the previous year as prescribed in Article 32 of the Law on Health Insurance.

## Chapter IX

## APPLICATION OF INFORMATION TECHNOLOGIES IN MANAGEMENT OF HEALTH INSURANCE-COVERED MEDICAL SERVICES

**Article 37. Principles of application of information technologies in management of health insurance-covered medical services**

1. Comply with legislative regulations on application of information technologies; legislative regulations on health insurance-covered medical services; laws on protection of state and other relevant secrets; legislative regulations on electronic transactions, information storage and security.

2. Comply with technical standards and regulations, ensure compatibility, smooth connection and safety, facilitations for electronic transactions between healthcare establishments, the Ministry of Health and social insurance agencies.

3. Ensure confidentiality and privacy of medical service data and information of health insurance policyholders.

4. Ensure technical infrastructure facilities, connection lines, software and personnel meet requirements concerning management of medical services, evaluation and payment of health insurance-covered medical costs.

**Article 38. Tasks and costs of application of information technologies in management of health insurance-covered medical services**

1. Tasks to be performed in the information technology application process shall include:

a) Apply information technologies to medical service tasks within a healthcare establishment;

b) Apply information technologies to meet the health insurance fund management needs;

c) Apply information technologies to exercise the state management of health insurance affairs;

d) Apply information technologies to serve tasks of management of health insurance-covered medical service activities.

2. Costs of application of information technologies in management of health insurance-covered medical service activities shall be subject to legislative regulations on information technology application.

## Chapter X

## IMPLEMENTARY PROVISIONS

**Article 39. Transitional provisions**

1. Health insurance policyholders receiving medical services before the entry into force of this Decree and discharged from the entry into force of this Decree shall be entitled to the health insurance fund's coverage for medical costs in the list of health insurance-covered costs with respective coverage rates and provisions laid down in Article 14 hereof.

2. Health insurance-covered medical service contracts signed before the effective date of this Decree shall be continuously implemented by end of December 31, 2018.

3. Tasks of payment, management and settlement of medical costs arising in the primary care domain at educational institutions, vocational training establishments, organizations and enterprises in 2018 which have been performed shall be continued till the end of December 31, 2018.

4. The settlement of costs of the health insurance fund in 2017 and 2018 shall be subject to provisions laid down in the Government's Decree No. 105/2014/ND-CP dated November 15, 2014 elaborating and providing guidance on implementation of certain articles of the Law on Health Insurance and other directive documents.

5. If healthcare establishments have not yet implemented the regulations set forth in point c of clause 2 of Article 21 hereof, they shall be required to send all required electronic data on health insurance-covered medical service activities not later than end of December 31, 2019.

**Article 40. Reference provision**

In case where reference documents mentioned in this Decree are replaced or revised, the substitute or revised document shall prevail.

**Article 41. Entry into force**

1. This Decree shall be in effect on December 1, 2018.

2. The following documents shall be repealed from the entry into force of this Decree:

a) Government's Decree No. 105/2014/ND-CP dated November 15, 2014 elaborating and providing guidance on implementation of certain articles of the Law on Health Insurance; In particular, point b of clause 1 of Article 6 and Article 8 shall remain in effect till end of December 31, 2018;

b) Joint Circular No. 41/2014/TTLT-BYT-BTC dated November 24, 2014 of the Ministry of Health, the Ministry of Finance providing guidance on implementation of the health insurance program; In particular, provisions laid down in Article 11, clause 2 of Article 17 and Article 18 shall remain in effect till end of December 31, 2018;

c) Joint Circular No. 16/2015/TTLT-BYT-BTC dated July 2, 2015 of the Ministry of Health, the Ministry of Finance amending clause 5 of Article 13 of the Joint Circular No. 41/2014/TTLT-BYT-BTC dated November 24, 2014 providing guidance on implementation of the health insurance program;

d) Article 8 and clause 2 of Article 9 of the Decree No. 151/2016/ND-CP dated November 11, 2016 elaborating and providing guidance on implementation of certain articles on compensation

regimes and policies under the Law on Professional Servicemen, National Defence Workers and Public Employees;

dd) Clause 6 of Article 11, point c of clause 1 and clause 2 of Article 12 of the Circular No. 40/2015/TT-BYT dated November 16, 2015 of the Ministry of Health prescribing registration of health insurance-covered primary care services and referral to levels of healthcare establishments.

**Article 42. Implementation guidance responsibilities**

1. The Ministry of Health shall assume the following responsibilities:

a) Provide guidance on implementation of articles or clauses enshrined in this Decree;

b) Preside over and cooperate with relevant ministries and bodies in implementation of policies and laws on health insurance;

c) Provide guidance on evaluation of requirements for signing health insurance-covered primary care contracts with healthcare establishments providing health insurance-covered medical services;

d) Issue code sets of the commonly used Classification Schedule for nationwide use, including medical technology services, modern and traditional medical drugs, medical supplies, equipment, blood and blood products, diseases viewed in the traditional medicine, diagnosis codes in the International Classification of Diseases (ICD), codes of healthcare establishments and other code sets meeting managerial requirements;

dd) Direct healthcare establishments to enhance application of information technologies to their provision of medical services; implied factor unalike; keep a timely, accurate and sufficient update of information about health insurance-covered medical services and transfer data to the system for receipt of health insurance-covered medical services of the Ministry of Health and the system of evaluation information of the Vietnam Social Security to serve the tasks of health insurance management, evaluation and payment of health insurance-covered medical costs;

e) Adopt regulations on specific tasks of application of information technologies to the provision of medical services;

g) Regulate the schedule of connection of data on results of tests, imaging diagnoses, medical therapy information of patients holding health insurance cards;

h) Preside over and cooperate with the Ministry of Finance and Vietnam Social Security in sending a report to the Government for its representation to the National Assembly on implementation of health insurance regimes and policies, including the review report on management and use of the health insurance fund prepared on an ad-hoc, regular or annual basis.

2. The Ministry of Finance shall assume the following responsibilities:

a) Balance the central budget and provide the central budget's allocations for localities which are unable to balance its budget on their own in order to ensure availability of funds for implementation of health insurance policies under the provisions of laws on the state budget;

b) Report to the Government on the current state of management and use of the health insurance fund on an annual or unscheduled basis upon the request of the Government.

c) Prepare the review report on management and use of the health insurance fund on an annual basis and sent it to the Ministry of Health for its report synthesis as per point h of clause 1 of this Article;

3. The Ministry of National Defense and the Ministry of Public Security shall be responsible for providing guidance on implementation of the health insurance program with respect to policyholders under their management in accordance with clause 1 of Article 1, clause 13 and 15 of Article 3, clause 3 of Article 4 and Article 6 hereof.

4. The Ministry of Labor, War Invalids and Social Affairs shall assume the following responsibilities:

a) Research and establish criteria for determination of family households doing business in the agriculture, forestry, aquaculture and salt production industry which are earning average income to ensure that they are in line with socio-economic situations over periods of time, and submit them to the Prime Minister to seek his approval of promulgation thereof;

b) Provide guidance on preparing the list of policyholders referred to in clause 3, 5, point a of clause 9, 11, 12, 16 and 17 of Article 3, clause 1, 2 and 4 of Article 4 hereof.

5. The Vietnam Social Security shall assume the following responsibilities:

a) Give directions to all-level social insurance agencies for conclusion of contracts with healthcare establishments conforming to requirements prescribed herein;

b) Direct social insurance agencies in cities and provinces to preside over and cooperate with Departments of Health, Departments of Finance and healthcare establishments providing health insurance-covered medical services within localities under their jurisdiction and neighboring localities and relevant authorities in handling, within their competency, or requesting competent authorities to consider and take timely action on any difficulty that may arise;

c) Direct all-level social insurance agencies to provide forms and instructions for commune-level People's Committees used for preparing lists and managing lists of family-based health insurance policyholders;

d) Perfect information technology systems in order to meet the needs of receipt, evaluation of and timely response to healthcare establishments related to health insurance-covered medical service data; ensure accuracy, safety, confidentiality of information and protection of interests of related parties;

dd) Prepare a regular, annual or ad-hoc review report upon the request of the state regulatory authority on implementation of health insurance regimes and policies; revenues, expenditures and management and use of the health insurance fund, and send it to the Ministry of Health and the Ministry of Finance for synthesis purposes as prescribed herein;

e) Regulate authority to sign health insurance-covered medical service contracts between social insurance agencies and healthcare establishments in order to ensure relevance to functions, duties, rights and organizational structures of the Vietnam Social Security;

g) Not later than January 1, 2020, social insurance agencies must issue electronic health insurance cards to health insurance policyholders.

6. People's Committees of provinces and centrally-affiliated cities shall be responsible for submitting the budgetary plan to same-level People's Councils to ensure the adequate budget for payment of health insurance contributions for policyholders whose health insurance contributions are covered or supported by the state budget in accordance with existing regulations.

**Article 43. Implementary responsibilities**

Ministers, Heads of Ministry-level agencies, Heads of Governmental bodies, and Chairpersons of People's Committees of centrally-affiliated cities and provinces, shall be responsible for implementing this Decree./.

**PP. GOVERNMENT**
**PRIME MINISTER**

**Nguyen Xuan Phuc**

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