Health Insurance and Health Insurance Societies in Japan

CONTENTS

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NATIONAL FEDERATION OF HEALTH INSURANCE SOCIETIES

I. Health Insurance

In Japan, all citizens are enrolled in the public medical care insurance system (universal coverage). Japan's public medical care insurance is broadly divided into two entities: employees' insurance directed in the main at employees, and community-based insurance (National Health Insurance) directed at those engaged in agriculture, forestry and fisheries, the self-employed, retires and others. Employees' insurance is further divided, in accordance with those covered, into Health Insurance, Seamen's Insurance and various mutual aid associations. Also, at the age of 75 (65 in the case of the bedridden, etc.), all citizens withdraw from their previous medical insurance and join an independent medical system for the elderly (Medical Care System for the Advanced Elderly).

Health Insurance provides insured persons with medical care and cash benefits for nonoccupational sickness and injury, childbirth, and death, and dependents of the insured person for sickness, injury, childbirth and death. Applications for Health Insurance are conducted on a workplace-establishment basis. Incorporated workplaces and workplaces that employ five or more employees at all times in certain industries are applied to Health Insurance mandatorily. Employees who are always employed at the applied workplaces become compulsorily insured persons under Health Insurance.

Health Insurance is operated by Health Insurance Societies (Society-managed Health Insurance) and by the Japan Health Insurance Association (Association-managed Health Insurance). There are two types of Health Insurance Societies: a Single Health Insurance Society established at a single workplace, and a General Health Insurance Society jointly established by two or more employers engaged in the same type of industry. For relatively small establishments where no Health Insurance Society is organized, the Japan Health Insurance Association will carry out health insurance operations.

[1] Application

1. Insured Persons

(1) Compulsorily Insured Persons

Workers employed by the applied workplaces under the Health Insurance Act.

(2) Voluntarily and Continuously Insured Persons

Persons who, having forfeited their eligibility for coverage due to retirement or for other reasons, have been insured continuously for at least two months prior to the forfeiture, can in principle upon application retain their eligibility as insured persons for two more years.

2. Dependents

Those who have an address in Japan,

(1) Lineal ascendants, spouse (including when not registered but the situation is the same as if

actually married), children, grandchildren, and brothers and sisters of the insured person, whose livelihoods are mainly supported by him/her.

(2) Relatives up to the third degree of the insured person, who belong to the same household as the insured person, and whose livelihoods are mainly supported by him/her.

(3) The parents and children of a person acting as the spouse actually in a marital relationship with the insured person although not registered as such, who belong to the same household as the insured person, and whose livelihoods are mainly supported by him/her.

(4) The parents and children of a person acting as the spouse actually in a marital relationship with the insured person although not registered as such, who belong to the same household as the insured person even after the acting spouse dies, and whose livelihoods are mainly supported by him/her.

can receive benefits as dependents without paying insurance premiums.

* In principle, persons eligible for "whose livelihoods are mainly supported by him/her" are required to have an annual income of less than 1.3 million yen.

[2] Financial Resources

The main financial resources are insurance premiums, and state subsidies are provided for some expenses such as administrative expenses.

The insurance premiums are calculated by multiplying the insured person's remuneration by the premium rate. Remuneration as stipulated for health insurance includes monthly salary, bonuses, allowances and all other forms of compensation for work received by the insured person from the employer. The insurance premium rate is set within a range from 3.0% to 13.0% for both the Health Insurance Society and the Japan Health Insurance Association. In the case of the Health Insurance Society, the insurance premium rate is set by each Society. While, in principle, the employer and the insured person share the burden equally, if stipulated in the Society rules, the employers' share may be larger. In the case of the Japan Health Insurance Association, the insurance premium rate is decided by each prefectural branch, and the insurance premium is borne equally by the insured person and the employer.

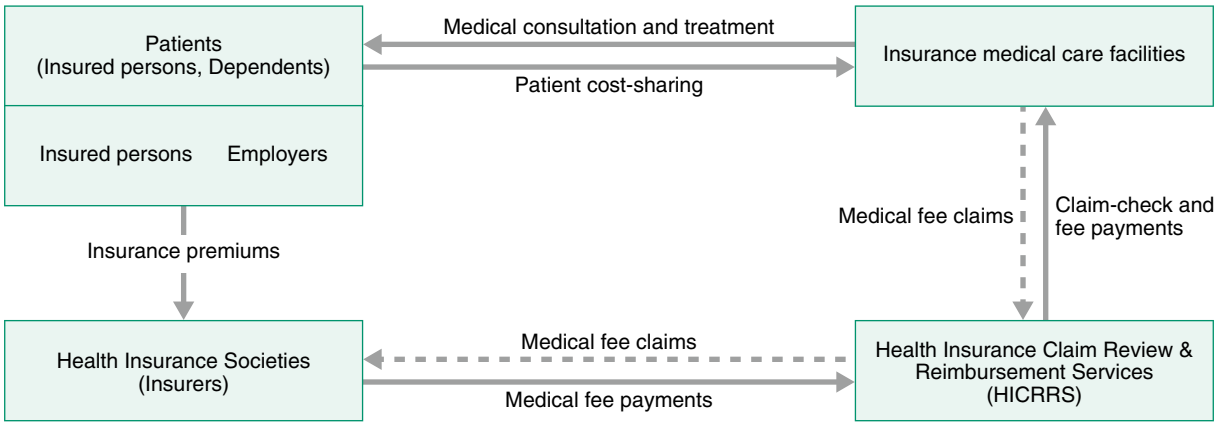
[3] Benefits

As far as health insurance is concerned, when insured persons or dependents are sick or injured, in principle they receive medical care in the form of benefits-in-kind. However, if for some unavoidable reason it is not possible to receive benefits-in-kind, they first pay the full amount required for the treatment out of their own pocket and then have this payment minus patient cost-sharing reimbursed. In addition to this, transportation expenses, injury and sickness allowance, funeral expenses, the childbirth and childcare lump-sum grant, childbirth allowance and the like are

provided for as cash benefits. Health Insurance Societies can also provide additional benefits on top of these statutory benefits.

The benefit ratio varies with age. For the child prior to commencing compulsory education, up to the first March 31st after the month of attaining six years of age, it is 80%. From then until the age of seventy it is 70%, and after reaching seventy years old it is 80% (70% if still working with an income the same level as active workers), with a given maximum established for cost-sharing at a fixed rate borne by the patient.

Mechanism of Health Insurance System



II. Health Insurance Societies

[1] Organization and Functions

A Health Insurance Society is a self-managed insurance carrier. By Health Insurance Act, a Society can be established by an employer acting independently or by two or more employers acting jointly, applying to and obtaining approval from the Minister for Health, Labour and Welfare. For approval it is necessary to have at least 700 employees when a Society is established at a single workplace (Single Health Insurance Society), and at least 3,000 employees when a Society is established by two or more employers (General Health Insurance Society). In addition, the Society can also be established by a number of employers in different industries centered on a given area.

A Health Insurance Society has a number of advantages. In the first place, because Health Insurance Society members participate directly in the management, the Society is run autonomously and democratically. This is the most distinctive feature of Society-managed Health Insurance. Because they possess this independently run organization, it is easy to clearly assign responsibility,

and they can work hard at the job of administering. Secondly, in that the Society is run efficiently and effectively, the employer's cooperation is easily obtainable. Thirdly, the Society always has a firm grasp of how insured persons lead their everyday lives, takes actions pertaining to the circumstances, and is capable of providing detailed services to its members.

So that they can be run democratically, all of Health Insurance Societies are organized as follows.

1. Deliberative Organ (Society Committee)

The Society committee is the supreme deliberative organ of the Health Insurance Society. In that the Society is made up of employers and insured persons, the committee comprises representatives from both sides so that it can democratically reflect the intentions of the members. The management side is made up of "appointed members" nominated by the employer, while the insured members' side comprises "elected members" chosen by them. For both sides' interests to be impartially represented, equal numbers of committee members are appointed and elected. The opinions of both sides are expressed in the committee and reflected in the running of the Health Insurance Society.

The most important matters to be decided by the Society Committee are follows: altering the rules, budgeting for income and expenditure and operations plan, settlement of accounts and operation reports, matters stipulated in rules and regulations and other important matters.

2. Executive Organ (Board of Directors)

The board of directors is made up of individuals co-opted by the Society committee members. As the organ which actually executes the operation and makes the decisions pursuant to policy of the Health Insurance Society democratically determined by the committee, the board has an important part to play in the running of the Society.

[2] Undertakings

Health Insurance Societies are engaged in the following operations in addition to basic services such as the application of insured persons (eligibility management), setting/levying of insurance premiums, providing insurance benefits, examination/payment of medical fees, etc.

1. Rationalization of Medical Care Costs

The claim statements submitted by the medical care facilities are examined by the Health Insurance Claims Review & Reimbursement Services (HICRRS). However, there are times when calculation errors and inappropriate content are overlooked. Therefore, Health Insurance Societies recheck the statements, and in cases where errors and inappropriate medical treatment are detected, they ask the HICRRS to reexamine the details and put things right. Furthermore, they inform the patient as to

how much the treatment costs for the purpose of heightening the individual's awareness regarding the expense, while at the same time preventing unjust claims.

2. Health Activities

One of the special features of the Health Insurance Society is that it can, in collaboration with the employer, implement health activities consonant with the conditions prevailing in the company. For example, the Society is implementing a data health plans that aims to implement more effective and efficient health services according to the characteristics of subscribers (employees and families) by utilizing the specific health checkups and the specific health guidance which are focusing on metabolic syndrome, and electronic data. Furthermore, in recent years, Health Insurance Societies and employers have collaborated to actively engage in “Collabo Health (health collaboration)” which effectively and efficiently promotes the health of subscribers under a clear division of roles and a good working environment. Consideration of the working environment and the health of employees is also emphasized as an index for evaluating companies, and “Collabo Health (health collaboration)” by Health Insurance Societies and employers contributes to improving the image and productivity of companies.

3. Patient Cost-Sharing Reimbursements and Additional Benefits

The Health Insurance Society can implement a system in effect to reimburse the insured person of part of the 30% (or 20%) patient cost-sharing incurred when receiving medical care or when hospitalized for the purpose of mitigating the insured person’s liabilities by stipulating in the rules. Furthermore, an important distinguishing feature of the Society is that, if the Society has a financial surplus, it provides additional benefits on top of statutory benefits. However, additional benefits are for lightening the burden of patient cost-sharing upon receipt of statutory benefits; they are not benefits to cover special ward charges or medical care not sanctioned under statutory benefits. The contents differ depending on the particular way the Society is run and its financial circumstances.