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.

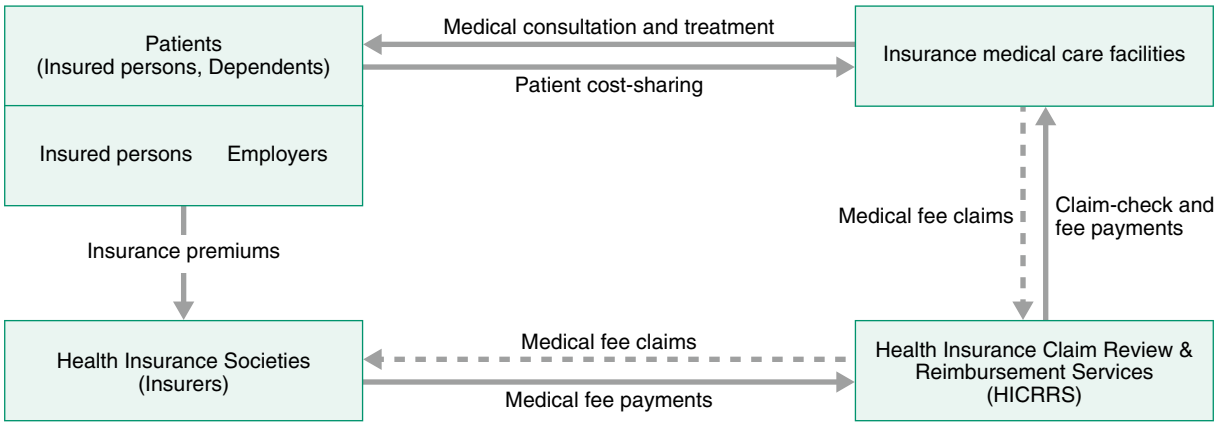
[3] Benefits

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.

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日本の健康保険と健康保険組合

Ⅰ. 健康保険

日本ではすべての国民が公的医療保険制度に加入している(国民皆保険)。公的医療保険は主に被用者を対象とする被用者保険と、農林漁業従事者、自営業者、退職者等を対象とする地域保険(国民健康保険)の 2 つに大別され、被用者保険はさらに、対象者の違いによって、健康保険、船員保険、各種共済組合に分かれている。なお、75 歳(寝たきり等の場合は 65 歳)になると、それまで加入していた医療保険を脱退し、高齢者を対象とした独立した医療制度(後期高齢者医療制度)に加入する。

健康保険は、被保険者の業務外に発生した疾病および負傷、出産、死亡と被扶養者の疾病、負傷、出産、死亡について、現物および現金の給付を行っている。健康保険の適用は事業所単位で行われる。法人事業所および一定の業種であって常時 5 人以上の従業員を雇用する事業所は強制適用され、適用事業所に常時雇用される被用者は強制的に健康保険の被保険者となる。

健康保険は、健康保険組合(組合管掌健康保険)と全国健康保険協会(全国健康保険協会管掌健康保険)によって運営されている。健康保険組合は、1 事業所の事業主が単独で設立する単一組合と、同種の事業を行う 2 以上の事業所の事業主が共同して設立する総合組合がある。健康保険組合が組織されていない比較的小規模な事業所については、全国健康保険協会(以下、協会けんぽ)が健康保険事業を執り行う。

[1]適用対象者

1. 被保険者

(1)強制被保険者

健康保険法の適用事業所で使用される労働者。

(2)任意継続被保険者

被保険者が退職等によって被保険者の資格を喪失した場合、喪失前に継続して 2 か月以上被保険者であった者は、申請により原則として 2 年間は被保険者資格を継続できる。

2. 被扶養者

日本国内に住所を有し、

(1)被保険者の直系尊属、配偶者(届出をしていないが事実上婚姻関係と同様の事情のある者を含む)、子、孫、および兄弟姉妹で、主として被保険者によって生計を維持している者

(2)被保険者の 3 親等内の親族で、被保険者と同一世帯に属し、主として被保険者によって生計を維持している者

(3)被保険者の配偶者であって、届出をしていないが事実上婚姻関係にある者の親および子で、被保険者と同一の世帯に属し、主として被保険者によって生計を維持している者

(4)被保険者の配偶者であって、届出をしていないが事実上婚姻関係にある者の親および子で、その配偶者が死亡した後も被保険者と同一の世帯に属し、主として被保険者によって生計を維持している者

は、被扶養者として保険料の負担なく給付を受けることができる。
※「主として被保険者によって生計を維持している者」の対象者は原則、年収 130 万円未満を要件とする

[2] 財 源

主な財源は保険料であり、事務費など一部の費用に対して国庫補助が投入されている。

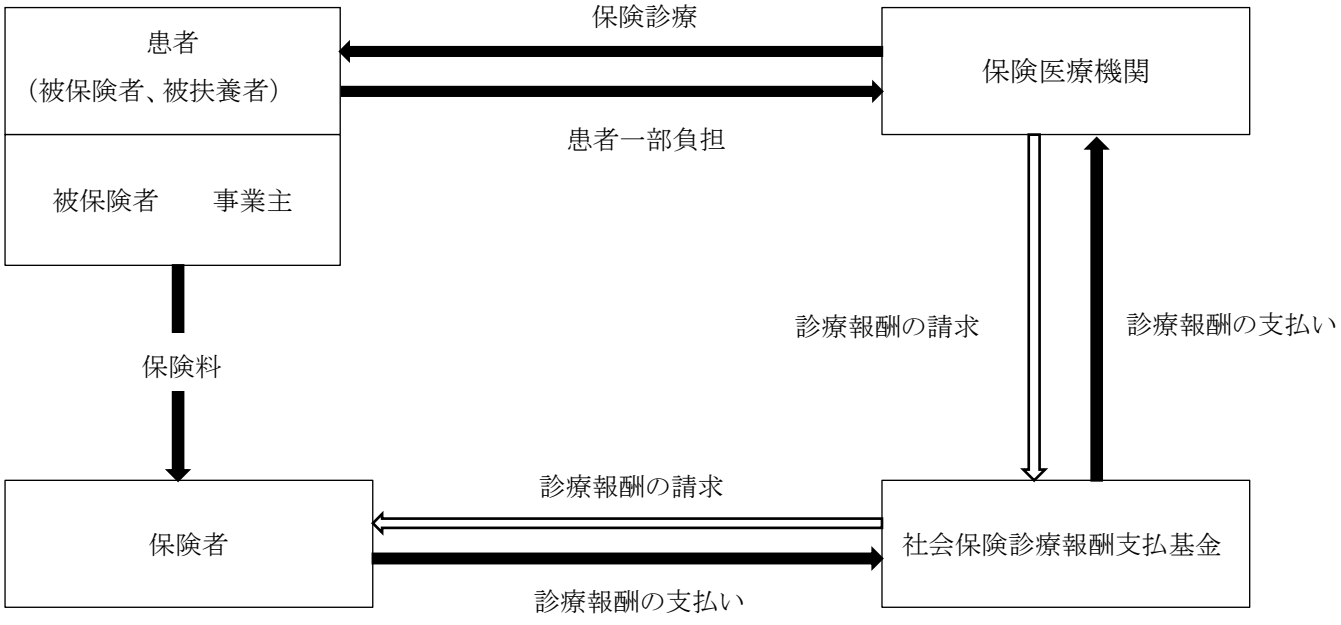
保険料は被保険者の報酬に保険料率を乗じた額である。健康保険で規定する報酬には、毎月の給与、賞与、その他の手当など、労働の対価として事業主から被保険者が受け取ったすべてのものが含まれる。保険料率は、健康保険組合、協会けんぽともに、3.0%から 13.0%の範囲内で定めることとなっている。健康保険組合の場合は組合ごとに保険料率が定められ、保険料は原則として事業主と被保険者が折半で負担するが、規約で定めれば事業主負担を多くすることができる。協会けんぽの場合は、保険料率は各都道府県の支部ごとに決定され、保険料は被保険者と事業主が折半で負担する。

[3] 給 付

健康保険では、被保険者や被扶養者が病気やけがをした場合、原則として現物給付方式により医療を受けることになっている。ただし、やむを得ない事情により現物給付が不可能なときは、まず治療に要した費用を全額自己負担し、後に一部負担金を除いた額が払い戻される。このほか、移送費、傷病手当金、埋葬料、出産育児一時金、出産手当金等は現金で給付される。健康保険組合では、これらの法定給付以外に付加給付を行うことができる。

給付率は義務教育就学前(6 歳に達する月以降の最初の 3 月 31 日まで)は 80%、義務教育就学後 70 歳未満は 70%、70 歳以上は 80%(現役並み所得者については 70%)であるが、患者が定率で負担する自己負担には一定の上限額が設けられている。

医療保険の仕組み



Ⅱ． 健康保険組合

[1] 組織構成とその機能

健康保険組合は、組合管掌による健康保険の保険者である。健康保険法上は、事業主が単独で、または 2 つ以上が共同して、厚生労働大臣に申請し、その許可を得ると設立できることになっている。単独の事業所で設立する場合（単一健康保険組合）は 700 人以上、また同種の事業を行う 2 つ以上の事業主が共同して設立する場合（総合健康保険組合）は 3,000 人以上の被用者を有していることが認可に必要である。なお、一定地域に集まっている複数の異業種の事業主も共同で健康保険組合を設立することができる。

健康保険組合には様々な長所がある。第1に、組合員が直接経営に参加することによって、自主的かつ民主的に運営されており、これは組合管掌健康保険の最も大きな特質となっている。このような自主的な運営組織を持っているため、経営の責任が明らかにされやすく、十分な経営努力を行うことができる。第 2 に、効率的かつ効果的な運営が可能であることから、事業主の協力が得られやすい。第 3 に、常に被保険者の日常生活の実態を把握し、実情に即した事業を行い、被保険者にキメ細かなサービスを提供できる。

すべての健康保険組合は、民主的に運営するため、以下のような組織を構成している。

1. 議決機関（組合会）

組合会は、健康保険組合における最高の議決機関である。健康保険組合の構成員は事業主と被保険者であるので、組合員の意志が民主的に反映されるように、組合会は双方の代表者で構成されている。経営者側は事業主から指名された「選定議員」で構成され、被保険者側は選挙によって選ばれた「互選議員」で構成されている。双方の利益が公平に代表されるように、選定議員と互選議員は、それぞれ同数ずつ選ばれる。双方の意見は組合会で表明され、健康保険組合の運営に反映される。

組合会は、規約の変更、収入支出予算および事業計画、収入支出決算および事業計画、規約および規程で定める事項、その他重要な事項ーを、議決すべき重要項目としている。

2. 執行機関（理事会）

理事会は、議員によって互選された理事で構成されている。組合会によって民主的に定められた健康保険組合の運営方針に従い、実際の運営および決定を執行する機関として、組合運営の重要な機能を果たしている。

[2] 事業活動

健康保険組合は被保険者の適用（資格管理）、保険料の設定・徴収、保険給付、審査・支払などの基本的業務のほか、下記の事業も行っている。

1. 医療費の適正化

医療機関から提出される診療報酬明細書（レセプト）は、社会保険診療報酬支払基金で審査されるが、計算の誤りや不適切な診療内容が見過ごされる場合もある。このため、健康保険組合はレ

セプトの再点検を行い、誤りや不適切な診療については、基金に対して調整や再審査をするよう申し出ている。また、医療費に対する患者の認識を高めると同時に、医療費の不正請求を防止するため、医療費の額を患者に知らせている。

2. 保健事業

健康保険組合の特色のひとつは、事業主と協働して、母体企業の実態に即した保健事業を実施できることである。例えば健康保険組合ではメタボリックシンドロームに着目した特定健診・特定保健指導や、電子データを活用し加入者（従業員・家族）の特性に応じたより効果的、効率的な保健事業を目指すデータヘルス計画を実施している。また、近年は健康保険組合と事業主が協働し、明確な役割分担と良好な職場環境のもと、加入者の健康づくりを効果的・効率的に実行するコラボヘルスが盛んに取り組まれている。従業員の労働環境や健康への配慮は、企業を評価する指標としても重視されており、健康保険組合と事業主によるコラボヘルスは企業のイメージアップ、生産性向上にも資する活動となっている。

3. 一部負担還元金と付加給付

健康保険組合は、規約で定めることにより、被保険者が医療を受けたり入院したりしたときに支払う 30%（または 20%）の患者自己負担の一部を被保険者に償還し、その負担を軽減することを目的とする一部負担還元金制度を実施することができる。また、財政的な余裕がある場合、法定給付に加えて付加給付を行っており、これは健康保険組合の重要な特徴となっている。ただし、付加給付は法定給付の際の被保険者の自己負担等を軽減するものであり、特別な病室や法定給付で認められていない医療を給付するものではない。付加給付の内容は、それぞれの組合運営の特性や財政状況の違いによって異なっている。