CHINA'S DRAFT MEDICAL INSURANCE LAW AND HEALTH INSURANCE REFORM

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China's draft Medical Insurance Law, released for public consultation in mid-2025, represents the most significant institutional reform of its health insurance system in over a decade. Four years in the making, the law seeks to lock in near-universal coverage while tackling the system's core weaknesses: fragmented pooling, uneven benefits, weak cost control and mounting fiscal pressures. It establishes social health insurance as a legal entitlement, promotes provincial-level pooling, strengthens fund governance and supervision, and explicitly extends coverage to migrant and informal workers, a critical gap in China's social protection architecture. At the same time, the law reflects hard trade-offs. Out-of-pocket costs remain high, catastrophic protection is under-specified and local governments, already under fiscal strain, retain substantial discretion over implementation. The law is therefore less a final solution than a framework: its real test will be whether China can translate legal uniformity into effective, portable and financially sustainable protection for households in an ageing, slower-growing economy.

(Click on the link to read the above in Chinese, French and Spanish)

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***Chinese*:**
中国医疗保险法草案与健康保险改革

中国于 2025 年年中公布征求公众意见的《医疗保险法（草案）》，这是十余年来其医疗保障体系最重大的制度性改革。该法律历时四年酝酿制定，旨在巩固近乎全民覆盖，同时解决体系的核心弱点：统筹分割、待遇不均、费用控制乏力以及不断加剧的财政压力。草案将社会医疗保险确立为法定权利，推进省级统筹，强化基金治理与监管，并明确将覆盖范围扩展至流动人口和非正规就业者，弥补了中国社会保障架构中的关键缺口。与此同时，法律也体现了艰难的权衡：个人自付费用仍然较高，灾难性医疗保障规定不够明确，而财政已承压的地方政府在具体执行中仍保留相当大的自主裁量权。因此，该法律更像是一个框架而非最终方案；真正的考验在于，中国能否在人口老龄化、经济增速放缓的环境下，将法律层面的统一转化为对家庭而言有效、可携带且财政可持续的保障。

***French*:**
LE PROJET DE LOI CHINOIS SUR L'ASSURANCE MALADIE ET LA REFORME DE L'ASSURANCE MALADIE

Le projet de loi chinois sur l'assurance maladie, publié pour consultation publique à la mi-2025, constitue la réforme institutionnelle la plus importante de son système d'assurance maladie depuis plus d'une décennie. Fruit de quatre années d'élaboration, le texte vise à consolider une couverture quasi universelle tout en s'attaquant aux faiblesses structurelles du système : mutualisation fragmentée, niveaux de prestations inégaux, contrôle des coûts insuffisant et pressions budgétaires croissantes. Il érige le régime social d'assurance maladie en droit légal, promeut la mutualisation au niveau provincial, renforce la gouvernance et la supervision des fonds, et étend explicitement la couverture aux travailleurs migrants et informels, comblant ainsi une lacune majeure dans l'architecture chinoise de la protection sociale. Parallèlement, la loi entérine des arbitrages difficiles. Les dépenses directes à la charge des patients demeurent élevées, la protection contre les risques majeurs est insuffisamment précisée, et les gouvernements locaux, déjà sous contrainte budgétaire, conservent une large marge de manœuvre dans la mise en œuvre. La loi constitue donc moins une solution définitive qu'un cadre : sa véritable épreuve sera de savoir si la Chine parvient à transformer l'uniformité juridique en une protection effective, transférable et financièrement durable pour les ménages dans une économie qui vieillit et dont la croissance ralentit.

***Spanish*:**

PROYECTO DE LEY DE SEGURO MÉDICO DE CHINA Y REFORMA DEL SEGURO DE SALUD

El Proyecto de Ley de Seguro Médico de China, publicado para consulta pública a mediados de 2025, representa la reforma institucional más significativa de su sistema de seguro de salud en más de una década. Elaborado durante cuatro años, el proyecto busca consolidar una cobertura casi universal mientras aborda las debilidades centrales del sistema: agrupación fragmentada, prestaciones desiguales, débil control de costos y crecientes presiones fiscales. Establece el seguro social de salud como un derecho legal, promueve la agrupación a nivel provincial, fortalece la gobernanza y la supervisión de los fondos, y extiende explícitamente la cobertura a los trabajadores migrantes y del sector informal, una brecha crítica en la arquitectura de protección social de China. Al mismo tiempo, la ley refleja difíciles compromisos: los gastos de bolsillo siguen siendo elevados, la protección frente a gastos catastróficos está insuficientemente especificada y los gobiernos locales, ya bajo tensión fiscal, conservan una discrecionalidad considerable en la implementación. Por tanto, la ley es más un marco que una solución definitiva: su verdadera prueba será si China puede traducir la uniformidad jurídica en una protección efectiva, portable y fiscalmente sostenible para los hogares en una economía que envejece y de crecimiento más lento.

CHINA'S DRAFT MEDICAL INSURANCE LAW AND HEALTH INSURANCE REFORM

QIAN Jiwei*

A National Legal Framework for Social Health Insurance

1. In the last week of June 2025, a draft of the medical insurance law (*Yiliao Baozhangfa*) was tabled for a first reading at the 16th session of the Standing Committee of the 14th National People's Congress, marking a significant milestone in strengthening China's universal basic health insurance system.[1] The full draft was posted online from end-June to end-July for public consultation. It will undergo further deliberation and revision before final enactment.

2. The legislative process has taken over four years, following an initial draft released in June 2021 for public comment. Since then, the draft has undergone numerous revisions, incorporating feedback from diverse stakeholders. Its submission reflects growing policy momentum to consolidate and modernise China's health insurance system through a clearer, more robust legal framework.

3. A social health insurance law is important to health reform, translating universal coverage objectives into legally defined rights, obligations and institutional arrangements. Beyond organising financing and service delivery, it anchors core principles of universality, solidarity, financial risk protection and equitable access, while providing mechanisms for accountability and enforcement.

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[1] https://www.chinadaily.com.cn/a/202506/25/WS685b4d39a310a04af22c84d1.html. The draft of law can be found in https://www.nhsa.gov.cn/art/2025/6/27/art_113_17027.html, all accessed 17 October 2025.

4. This role is often illustrated by mature statutory frameworks such as Germany's Social Code Book V[2] and Japan's National Health Insurance Acts,[3] which translate universal health coverage objectives into legally defined entitlements, obligations and accountability mechanisms.

5. In this sense, the enactment of a medical insurance law is more than a technical reform of health insurance; it is a foundational step in institutionalising the right to health within a broader social protection framework.

6. The timing of China's draft Medical Insurance Law is critical. With over 15% of the population aged 65 and above in 2024 and acute local fiscal strain,[4] the draft is pivotal to three urgent policy goals: reducing catastrophic household health expenditures, ensuring long-term fund sustainability and strengthening social welfare protections. This comprehensive legal framework, anchored in the principles of universal coverage, fairness, security and sustainability (Article 3), sets forth an ambitious vision to unify and modernise China's fragmented health insurance system.

The Development of Social Health Insurance in China

7. Social health insurance mitigates household financial risk from ill health and is widely adopted across income levels as a core financing instrument.[5]

8. In China, prior to 1978, health care was largely provided through state-owned hospitals and large state-owned enterprises. Urban workers, their dependents and retirees received heavily subsidised medical care either through their work units or direct state financing. Government employees and their families were covered under

[2] See https://www.gesetze-im-internet.de/englisch_sgb_5/englisch_sgb_5.html, accessed 27 December 2025.

[3] https://www.japaneselawtranslation.go.jp/en/laws/view/2453, accessed 17 December 2025.

[4] For recent implications of local fiscal conditions, please see Oi, J C, Luo, J M and Xu, Y (2025). A Perfect Storm: Fiscal Discipline, COVID, and Local Government Debt in China. *The China Journal*, *93*(1), 76-111.

[5] For example, Banerjee, A, Hanna, R, Olken, B A and Lisker, D S (2024). Social protection in the developing world. *Journal of Economic Literature*, *62*(4), 1349-1421 and Finkelstein, A, Mahoney, N and Notowidigdo, M J (2018). What does (formal) health insurance do, and for whom? *Annual Review of Economics*, *10*(1), 261-286.

the Government Insurance Scheme. Rural residents obtained basic primary and hospital care through Cooperative Medical Schemes (CMS) with minimal out-of-pocket spending, financed by communes, government subsidies and CMS reimbursements.[6]

9. Since the 1990s, China has introduced social health insurance programmes to provide a social safety net for the urban poor, laid-off SOE workers and other vulnerable groups. The major social insurance scheme, the Basic Health Insurance Scheme for urban formal sector employees, was launched in the mid-1990s and expanded rapidly in the early 2000s. Funded through payroll deductions (6% employer, 2% employee), the scheme covers current and retired employees.

10. To cover rural populations, the New Cooperative Medical Scheme (NCMS) was introduced in 2002. In 2007, a separate health insurance programme was established for urban residents not covered by employment-based schemes, including retirees, students, the self-employed and informal sector workers. These efforts culminated in the integration of the NCMS and the basic resident health insurance scheme in 2017.[7] To encourage enrolment and enhance benefits under the NCMS, the central and local governments provide subsidies while setting minimum individual contribution levels and subsidy amounts.

11. The expansion of social health insurance in China has been substantial (Figure 1). Basic health insurance comprises two pillars: employment-based and residence-based schemes. Enrolment in residence-based health insurance increased from 769 million in 2007 to 947 million in 2024, while enrolment in employment-based health insurance rose from 180 million in 2007 to 379 million in 2024. By end-2022, approximately 95% of China's 1.4 billion population was enrolled in one of the two major social health insurance programmes.[8]

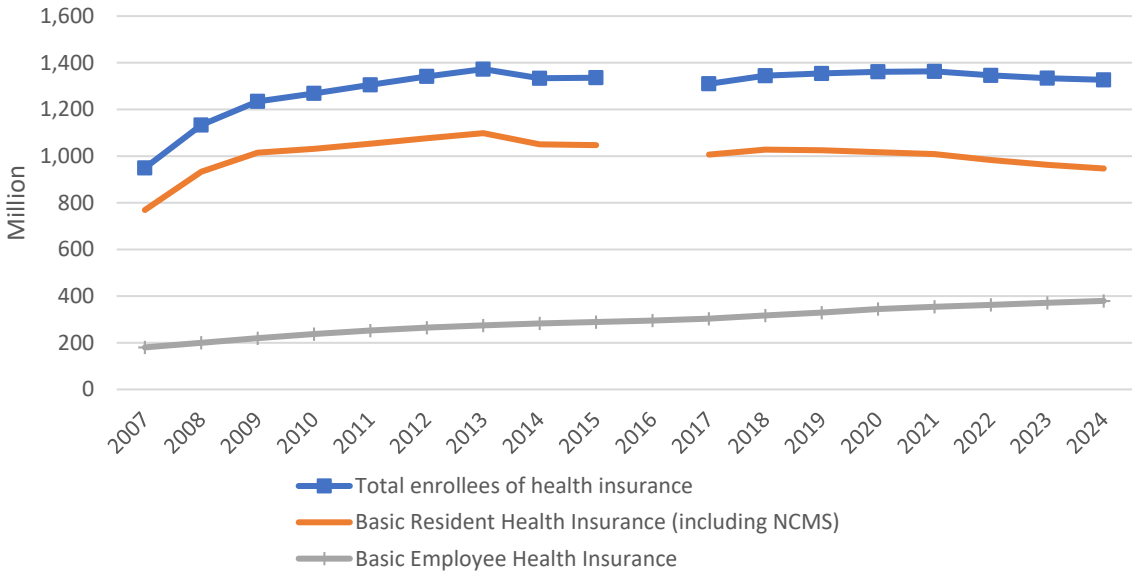
[6] See some detailed discussion on this point in Qian, J (2026). Reforming China's Social Welfare System: Addressing Disparities and Embracing Change, in *The Sage Handbook of the Chinese Economy,* edited by Ronald Schramm. SAGE Publications.

[7] Qian, J (2021). *The political economy of making and implementing social policy in China*. Singapore: Palgrave Macmillan.

[8] https://www.gov.cn/lianbo/bumen/202307/content_6891062.htm, accessed 17 October 2025.

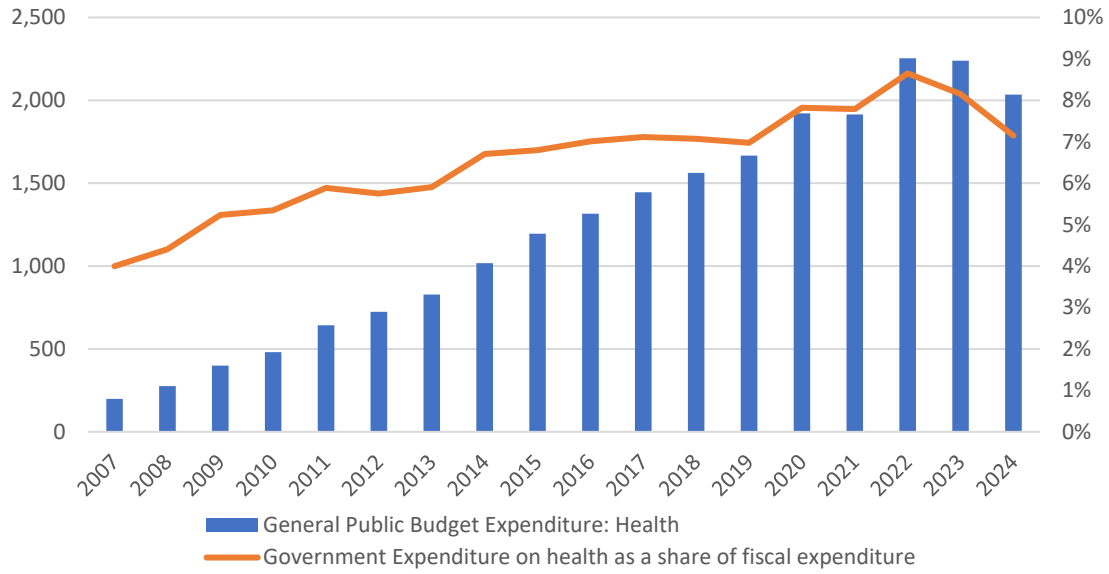
12. In parallel with expanding coverage, public financing has grown to improve benefit levels. Government health expenditure as a share of total public spending rose steadily from the 2000s through 2022, increasing from around 4% in 2007 to over 8.6% in 2022 (Figure 2).

FIGURE 1 NUMBER OF ENROLLES IN SOCIAL HEALTH INSURANCE PLANS IN CHINA (MILLION), 2007–2024



Source: CEIC.

FIGURE 2 GOVERNMENT BUDGETARY EXPENDITURE ON HEALTH IN CHINA AND ITS SHARE IN TOTAL FISCAL EXPENDITURE (%, RMB BILLION), 2007–2024

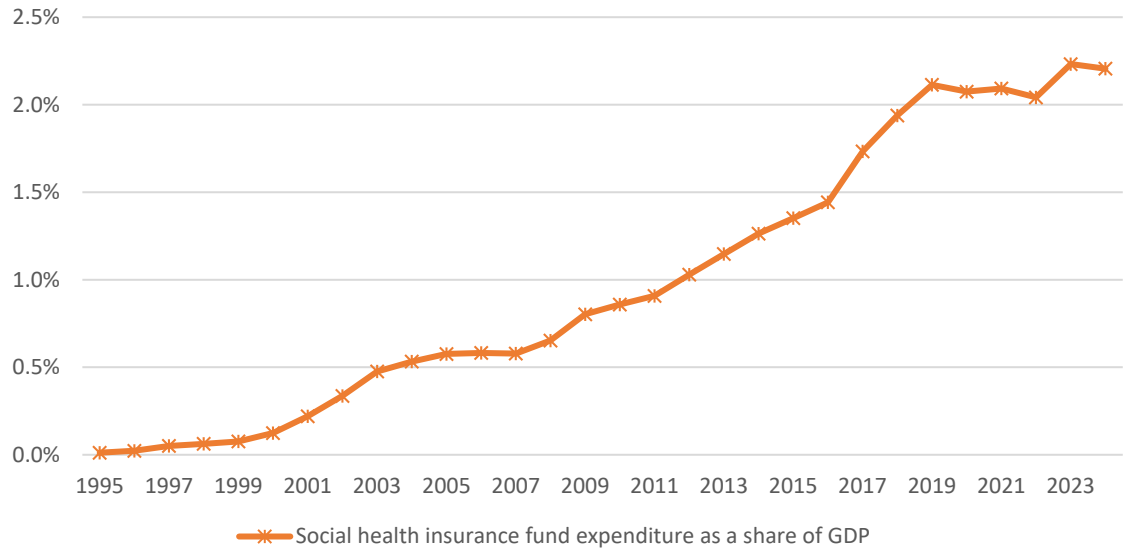


Source: CEIC.

13. Social health insurance fund expenditure has experienced dramatic growth, rising from a mere 0.2% of gross domestic product (GDP) in 2001 to 2.2% of GDP in 2024 (Figure 3),[9] reflecting expanded access to healthcare services and stronger financial protection.

14. At the central level, health insurance policy was previously jointly overseen by the Ministry of Human Resources and Social Security and the National Health Commission. Since 2018, the National Healthcare Security Administration has become the primary central government agency responsible for social health insurance.

FIGURE 3 EXPENDITURE OF SOCIAL HEALTH INSURANCE FUNDS AS A SHARE OF GDP IN CHINA (%), 1995–2024



Source: CEIC.

Benefits, Contribution and Payment Method

15. China's social health insurance system is governed differently across employment types and organised as a tiered structure linked to employment status. Urban formal workers, and informal sector workers (i.e. those without formal labour contracts) are enrolled in distinct insurance schemes, each with different contribution rules and benefit entitlements.

[9] CEIC and Statistical Communiqué of Health Insurance, National Healthcare Security Administration, various years.

16. Enrolment in employment-based social insurance requires mandatory employer and employee contributions, calculated as a proportion of wages. Contribution rates are highly complex, varying across provinces and cities, and remain comparatively high for the self-employed and business owners.[10] Within this framework, urban employee health insurance comprises two core components: a social pooling fund (primarily reimbursing inpatient expenses) and an individual account (accessible only to insured individuals for outpatient services and drug purchases at recognised retail pharmacies).[11]

17. Benefit design varies substantially across schemes. In 2024, substantial disparities in benefit generosity persisted between employment-based and resident schemes. For inpatient services within insurance's list of covered services and drugs, the reimbursement ratio reached 84.8% under employee health insurance versus 68.6% under resident insurance, with gaps evident across all tiers of medical institutions. Differences were particularly pronounced at tertiary hospitals, 83.8% (employee) versus 64.1% (resident), underscoring persistent inequities in financial protection by insurance status.[12]

18. Payment methods in insurer-hospital contracts include capitation, pay-for-performance, global budgets and diagnosis-related groups (DRGs). Insurers may negotiate caps on total reimbursements through innovative contracting, or rely on lower reimbursement rates.

19. To control the rapid increase in health expenditure, social health insurance schemes have implemented price controls and favoured domestic firms in national drug procurement through collective negotiation.[13]

[10] Qian, J (2021). *The political economy of making and implementing social policy in China*. Singapore: Palgrave Macmillan.

[11] He, A J, Zhu, L and Qian, J (2025). Policy design and policy feedback in welfare retrenchment: A survey experiment in China. *Policy Studies Journal*, 53, 2: 307-327.

[12] https://www.nhsa.gov.cn/art/2025/7/14/art_7_17248.html, accessed 24 December 2025.

[13] https://www.nhsa.gov.cn/col/col148/index.html, accessed 22 January 2026.

20. For patients, reimbursement is determined by designated lists of covered services and drugs.[14] In practice, variation in application and reimbursement across schemes produces divergent spending outcomes indicating scope for efficiency gains if best practices were more widely adopted.

Social Health Challenges in China

21. Despite notable reform gains, implementation still faces major challenges: limited financial protection, regional disparities, fiscal sustainability risks and inequitable access. Decentralised management has resulted in significant variation in coverage and benefits across regions, as schemes are managed and financed locally (county, prefecture and provincial levels) rather than centrally, unlike in many countries. In 2020, there were 578 employment-based and 561 residence-based pooling units nationwide, indicating funds are largely pooled at the city level rather than provincial level; China has 31 provinces and more than 690 cities.[15]

22. Local authorities accounted for 75% of total government health expenditure in 2022.[16] Variations in fiscal and administrative capacity have led to inconsistent scope and quality of health coverage across provinces.[17] Relatedly, programme solvency is a growing concern, particularly for fiscally constrained local governments.[18]

[14] For example, see an explanation for Beijing's health insurance reimbursement https://www.beijing.gov.cn/fuwu/bmfw/sy/jrts/tzxx/202402/t20240229_3573022.html, accessed 22 January 2026.

[15] National Audit Office 2020. See https://www.audit.gov.cn/n5/n26/c145346/part/75586.pdf. For the number of cities, there were about 691 cities in China by the end of 2021, including 297 prefecture-level (and above) cities and 394 county-level cities. See https://www.stats.gov.cn/xxgk/jd/sjjd2020/202209/t20220929_1888803.html, accessed 21 January 2026.

[16] Excluding central-local fiscal transfers. Calculated based on CEIC.

[17] Qian, J (2026). Reforming China's Social Welfare System: Addressing Disparities and Embracing Change, in *The Sage Handbook of the Chinese Economy,* edited by Ronald Schramm. SAGE Publications.

[18] See a discussion on a pilot reform addressing this issue in He, A J, Zhu, L and Qian, J (2025). Policy design and policy feedback in welfare retrenchment: A survey experiment in China. *Policy Studies Journal*, 53, 2: 307-327.

23. Broader coverage has not eliminated high out-of-pocket burdens. A 2024 report indicates that inpatient care under resident insurance still requires enrollees to cover approximately 30% of costs out of pocket on average.[19]

24. As purchasers, insurance agencies have not been very effective in restraining expenditure growth, reflecting a fragmented, highly decentralised structure.[20] Negotiated payment arrangements require stronger local capacity, including contract design, bargaining and systematic evaluation of policy outcomes, underpinned by robust data and analytics to assess provider behaviour and cost-containment effects.

25. Payment reform has yielded limited cost-containment effects. By 2023, 190 cities had implemented DRG-based payments,[21] yet public hospital spending has continued to rise, as fee-for-service payments incentivise volume and profit-seeking behaviour and have not been fully eliminated.[22]

26. Limited portability of benefits and decentralised implementation often exclude migrant workers and informal sector workers. The decentralised social safety net and *hukou* restrictions leave many migrants without effective access to core protections when working outside their home regions.

27. Annual surveys by China's National Bureau of Statistics show consistently lower coverage among migrants than urban residents. For 2013, migrant enrolment in pensions, health insurance and unemployment insurance was a respective 62%, 52.3% and 42%.[23] By 2017, only 22% of migrants were enrolled in pension schemes and

[19] https://www.gov.cn/lianbo/bumen/202403/content_6941259.htm, accessed 17 October 2025. See also an earlier discussion in Qian, J (2022). Health reform in China: developments and future prospects. *Health Care Science*, *1*(3), 166-172.

[20] Qian, J (2022). Health reform in China: developments and future prospects, 166-172.

[21] https://www.nhsa.gov.cn/art/2024/7/25/art_7_13340.html, accessed 21 January 2026.

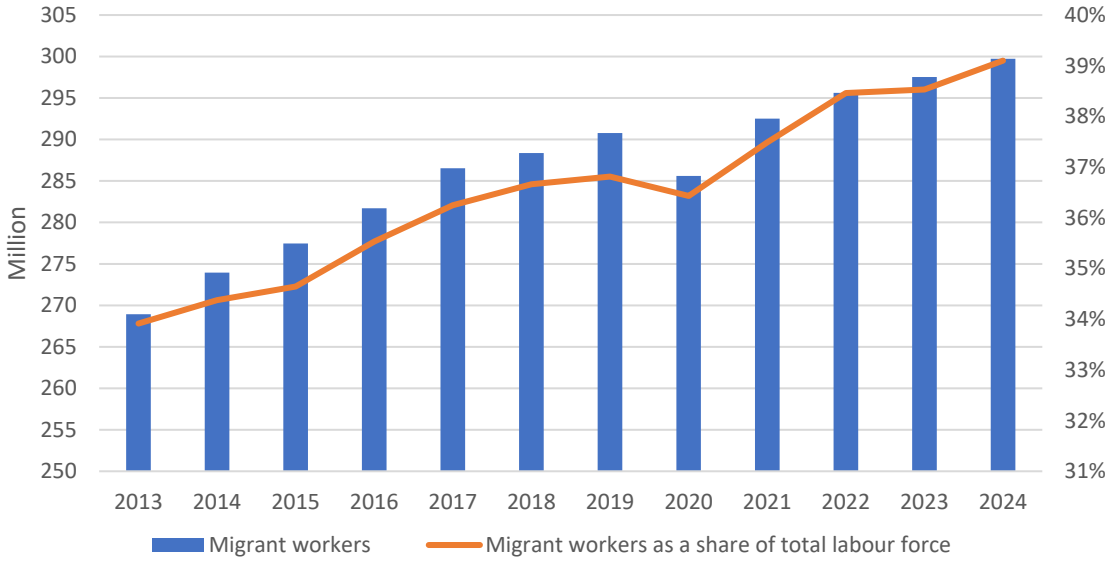
[22] Yip, W, et al. (2019). 10 years of health-care reform in China: progress and gaps in Universal Health Coverage. *The Lancet*, *394*(10204), 1192-1204.

[23] National Bureau of Statistics Monitoring Report on Migrant Workers, various years.

17% in urban-employee unemployment insurance, versus national averages of 69% and 44%,[24] underscoring persistent gaps.

28. In 2024, migrant workers constituted over 20% of the population and approximately 39% of the country's labour force. Despite their significant contribution (Figure 4), migrant workers often cannot access equivalent benefits to urban *hukou* holders in the same city due to programme decentralisation and *hukou*-based restrictions.

FIGURE 4 NUMBER OF MIGRANT WORKERS AND ITS SHARE IN THE TOTAL LABOUR FORCE IN CHINA, 2013–2024



Source: National Bureau of Statistics.

29. These exclusionary dynamics extend beyond migrant status to informal sector workers. Informal workers, now a substantial and growing share of the urban labour market, face significant enrolment and access barriers because eligibility remains tied to formal employment relationships and labour contract.[25]

30. Many informal workers are migrants, further compounding their exclusion. Recent policy has promoted flexible employment such as part-time work, task-based jobs and self-employment, and many platform-engaged delivery drivers fall into these

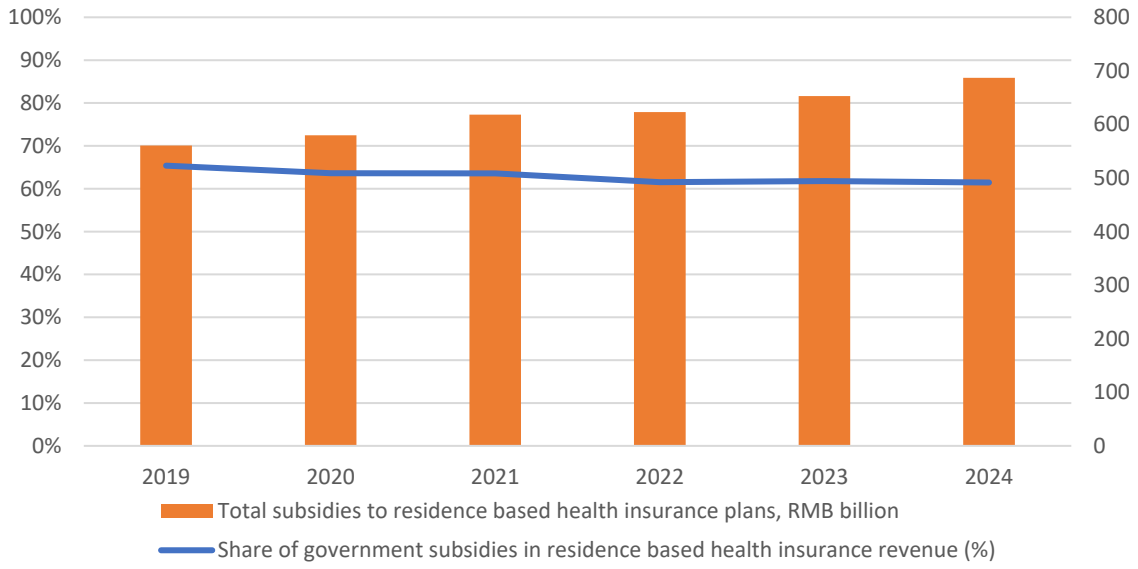
[24] Qian, J and Wen, Z (2021). Extension of social insurance coverage to informal economy workers in China: An administrative and institutional perspective. *International Social Security Review*, *74*(1), 79-102.

[25] Jiang, J, Qian, J and Wen, Z (2018). Social protection for the informal sector in urban China: institutional constraints and self-selection behaviour. *Journal of Social Policy*, *47*(2), 335-357. See also Qian, J, Wen, Z and Jiang, J (2024). Firm compliance, state enforcement and social insurance coverage in China. *Journal of Current Chinese Affairs*, *53*(3), 477-506.

categories. However, the under-coverage of platform-based workers has emerged as a serious concern. Without a formal employment relationship, platforms often avoid contributing social insurance premiums, despite requirements under labour and social insurance regulations.

31. A slowing economy and growing fiscal constraints heighten concerns over the financial sustainability of health insurance funds. With tax revenue falling 18.4% in 2014 to 13% of GDP in 2024[26] and local debt rising, pressures on public finance have intensified. While annual government subsidies account for less than 1% of total revenue in employment-based funds, fiscal subsidies for residence-based health insurance account for more than 60% of fund revenue (Figure 5).

FIGURE 5 SUBSIDIES TO RESIDENCE-BASED HEALTH INSURANCE PLANS AND ITS SHARE IN REVENUE: 2019–2024



Source: Ministry of Finance.

Legal Responses to Address Social Health Insurance Challenges

32. To address these issues, a unified regulatory foundation for social welfare is promising. A legal framework both consolidates central control over the bureaucracy and creates a more predictable and manageable environment for health

[26] Wong, C and Schipke, A (2025). "Beyond Land And Debt: Rebuilding The Fiscal Foundation To Revitalise Local Government Finance In China", *EAI Background Brief*, No. 1858.

insurance governance.[27] A landmark Social Insurance Law enacted in 2011 provides the foundational legal basis for participation and financing.

33. National audits soon after the law enactment revealed persistent non-compliance. A 2012 audit report documented contribution rebates to local firms in 27 cities and 70 counties, the underreporting of workers' payroll by enterprises in 1,214 counties across 274 cities in all 31 provinces and the diversion of social insurance funds to administrative costs or local budget balancing.[28]

34. These problems have continued. A National Audit Office report found that 47 local taxation bureaus failed to comply with premium-collection regulations in 2016 and more than 26,500 employers evaded contributions.[29] Enforcement and fund management thus remain subject to local discretion and bargaining between firms and bureaucrats, in a manner comparable to tax collection.

35. However, the Social Insurance Law is insufficient as a comprehensive health insurance framework; its provisions on medical insurance are largely principle-based, leaving substantial regulatory gaps in implementation and coordination.

36. The 2025 draft medical insurance law seeks to standardise and strengthen the system, aiming at more equitable access and stronger financial protection. It comprises seven chapters and 50 articles, providing a comprehensive governance framework.[30]

37. Substantively, the draft advances equitable access by defining the rights and responsibilities of key stakeholders, including the government, employers and individuals. It recognises social health insurance as a universal entitlement (Article 4), formally establishes employment-based and residence-based insurance systems

[27] See some discussions on this point in Zhang, T & Ginsburg, T (2019). China's turn toward law. *Va. J. Int'l L.*, *59*, 306 and chapter 8 of Qian, J (2025). *Governing China's Digital Transformation: Industrial Policy, Regulatory Governance, and Innovation*. Taylor & Francis.

[28] https://www.audit.gov.cn/n5/n25/c63607/content.html, accessed 27 December 2025.

[29] https://www.audit.gov.cn/n5/n25/c92641/content.html?from=groupmessage&isappinstalled=0&winzoom=1, accessed 27 December 2025.

[30] Seven chapters include General Provisions, the Medical Security System, Medical Security Funds, Medical Security Services, Supervision and Administration, Legal Liability and Supplementary Provisions.

(Articles 8–10) and encourages participation of flexible and non-standard workers in employee schemes.

38. By defining principles, coverage, funding and benefits, the draft also seeks to enhance standardisation across regions, countering excessive decentralisation. It promotes provincial-level pooling of health insurance (Article 20).

39. The draft underscores "fair and appropriate" individual contributions and benefit levels aligned with economic development (Articles 10, 12, 15). Articles 20–21 specify that benefit scope must reflect both medical necessity and fund sustainability.

40. Responding to slower growth and fiscal pressure, the draft prioritises financial sustainability. It mandates revenue-expenditure balance and long-term sustainability for the basic health insurance fund (Article 20), calls for enhanced actuarial analysis, requires local governments to establish robust risk control and long-term fund management mechanisms and authorises timely adjustments to financing and benefits in emerging deficits. It prohibits misappropriation and mandates multi-agency supervision to prevent misuse or fraud (e.g. Articles 42–44).

41. The draft strengthens the role of health insurers in improving healthcare quality, addresses the reimbursement policy of social health insurance and strengthens the enforcement of health insurance entitlements. The draft emphasises the role of insurers in managing service agreements, monitoring fund use and setting reimbursement rates (Articles 27–30).

42. In particular, the draft law assigns social health insurers a more active purchasing and governance role, for example through collective negotiation mechanisms in pharmaceuticals and healthcare services (Article 28). It requires insurers to strengthen oversight of fund use through internal control systems, provider guidance and training, and firm contractual enforcement (Article 30). Together, these provisions signal a shift towards more strategic purchasing, enhanced accountability and stronger protection of insured persons' entitlements.

43. It also establishes administrative and legal remedies for violations: rectification orders, fines, restitution and sanctions for misconduct, including delayed payments,

failure to settle reimbursable expenses, mismanagement or falsification of records, fund diversion and internal control breaches (Article 42). For fraud, abuse of authority, or serious harm, it provides for heightened penalties, professional disqualification and, where applicable, criminal liability (Article 43).

44. Despite the inclusion of such foundational elements supporting the goal of universal health coverage, gaps remain, particularly with catastrophic-cost protection mechanisms, addressed only briefly in Article 15. Given high out-of-pocket burdens, the law would do well to establish clear caps on co-payments for high-cost treatments, define out-of-pocket maximums for catastrophic illnesses and specify income-based protection thresholds, to enhance protection.

45. The law could further address institutional fragmentation. While provincial pooling is welcomed (Article 20), an explicit mandate for national integration of benefit standards and data systems is needed to improve portability and equity.

46. Commercial health insurance is not addressed in the current draft and remains under the jurisdiction of insurance sector regulators. In September 2025, the National Financial Regulatory Administration issued guidelines on regulating and developing high-quality commercial health insurance.[31] Yet commercial health insurance market influences reimbursement rates, service/drug coverage and benefit design, creating coordination challenges between the two regulatory frameworks.

Local Health Insurance Laws in China

47. Since 2021, several economically advanced provinces and municipalities, most notably Zhejiang (2021), Jiangsu (2023) and Shanghai (2025),[32] have led in enacting comprehensive local health insurance regulations. These local laws codify medical security governance in the absence of a national Medical Insurance Law. While differing in emphasis, they share a common objective of institutionalising

[31] https://www.gov.cn/zhengce/zhengceku/202509/content_7043072.htm accessed 17 October 2025.

[32] See https://news.sina.cn/gn/2021-04-16/detail-ikmyaawc0100370.d.html, https://m.caixin.com/m/2023-06-06/102062538.html and https://ybj.sh.gov.cn/ybdt/20250106/6c7ff5ab6eb54ff6ba83568b9aea321d.html, all accessed 22 January 2026.

reform experience and providing a stable legal basis for managing an increasingly complex system. Together, they define the scope of basic health insurance, catastrophic- illness insurance, medical assistance and supplementary arrangements, while clarifying administrative responsibilities, fund management rules and service provision mechanisms.

48. A central priority in these laws is stronger pooling and financial sustainability. Zhejiang and Jiangsu raise pooling to the prefecture level and articulate a gradual transition to provincial pooling to strengthen risk sharing, reduce inequities and improve fund efficiency. Shanghai similarly emphasises prudent fund management, budget discipline and early-warning risk mechanisms.

49. In parallel, local laws promote policy capacity by digitalisation, including real-time settlement, cross-programme integration and data sharing to improve administrative capability and service efficiency. Together, these reforms place fiscal stability and administrative coherence at the centre of local health insurance legislation.

50. These local laws also seek to standardise benefit eligibility, waiting periods, reimbursement scopes and special coverage for chronic and severe diseases. These provisions respond directly to public concerns over uneven access and policy fragmentation across regions and population groups.

Progress and Persistent Gaps

51. The draft Medical Insurance Law completed public consultation in July 2025 and is expected to undergo further rounds of revision before final enactment.[33] It provides a foundational framework for unifying China's diverse and fragmented health insurance system within a coherent legal structure. Its emphasis on universal participation, fund security and system standardisation represents a significant step towards strengthening social protection and advancing universal health coverage.

52. To fully align with core social health insurance principles, further refinement and sustained institutional reform will be required. Priorities include equitable access

[33] It was reported over 2,000 comments/opinions received from the public. See https://m.mp.oeeee.com/a/BAAFRD0000202507241105917.html, accessed 22 January 2026.

for migrant and informal workers, clearer scope and governance of the benefit package, stronger catastrophic cost protection, enhanced legal enforceability, better coordination with commercial insurance and deeper integration and portability across fragmented regional schemes.

53. Recent developments include accelerated provincial-level pooling: by 2025, 20 provinces had issued policies to advance provincial pooling of basic health insurance,[34] potentially reducing fragmentation by strengthening risk pooling and cross-jurisdiction coordination.

54. Another recent development is expanded drug reimbursement. As coverage has grown, social health insurance funds play a larger role in financing pharmaceuticals, particularly innovative drugs. A 2025 policy articulates a clear vision for including innovative medicines in the reimbursement list.[35] These developments signal deeper system integration and benefit enhancement, while raising new demands on governance capacity and fiscal coordination.

55. Ultimately, effectiveness will hinge on implementation. China's highly decentralised system gives local governments wide discretion over financing, administration and enforcement. While this allows policy flexibility, it also generates uneven implementation capacity and incentives that may dilute the uniform national standards. Without stronger central coordination, data integration and accountability, disparities in benefit levels, reimbursement practices and access to care are likely to persist even under a unified legal framework.

56. A further uncertainty is slowing growth and its impact on health insurance financing. Sluggish revenue growth, rising local government debt and mounting demographic pressures are tightening fiscal space, particularly at the subnational level where social health insurance is largely administered and funded. As constraints bite, localities may trade off cost control against benefit adequacy, limiting reimbursement, delaying expansions, or shifting costs to households through higher

[34] https://www.nhsa.gov.cn/art/2025/12/13/art_14_19020.html, accessed 22 January 2026.

[35] https://www.nhsa.gov.cn/art/2025/7/1/art_104_17058.html, accessed 24 December 2025.

co-payments, risking the erosion of the redistributive and protective functions for low-income, elderly and chronically ill populations.

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