Based on the law no. 78 and 83 point 1 of the Constitution, by the proposal of Council of Ministers,

THE ASSEMBLY
OF THE REPUBLIC OF ALBANIA
DECIDED:

CHAPTER I
GENERAL DISPOSITIONS

Article 1
Scope of law

The scope of this law is the establishment and implementation of the compulsory health care insurance scheme in the Republic of Albania.

Article 2
Object of law

This law sets out the legal status, structure, functions and activity of the Compulsory Health Care Insurance Fund (hereinafter referred as Fund), which manages the financing of health care services in the compulsory health care insurance scheme.
Article 3
Definitions

Terms contained in this law has the following meaning:

1. "Fund" is the Compulsory Healthcare Insurance Fund in the Republic of Albania, established in compliance with this law.

2. "Economically active people" means all the employed, self-employed, employers and people with regular incomes from personal and real estates or other similar sources.

3. "Economically non-active people" means all the individuals, whose contribution’s payment is financed from the state’s budget or other sources, as defined by law.

4. "Employed people" means all the individuals that are employed by an employer.

5. "Employer" means all the individuals, either natural or legal, who hire other people and pay them a reward for the performed job, according to the job legislation.

6. "Self-employed" implies all the individuals who work for themselves, as handicraftsmen, small businessmen, consultants, sole owners of a business, farmers and other crafts similar to them, according to the job legislation.

7. "Contributors" implies all natural and legal persons, just like employers, employees, self-employed and the state, who are obliged to pay contributions to the Compulsory Healthcare Insurance Fund in compliance with this law.

8. "Beneficiaries" implies the individual, who is entitled to use health care services according to the compulsory health care insurance scheme or benefit reimbursement of health services costs, according to a compulsory health insurance contract.
9. "Direct payments" implies payments made from beneficiaries of the compulsory health care insurance for health services packages, regardless of the payment of contributions of the compulsory health care insurance scheme.

10. "Exclusion from benefits" implies health services, drugs, and medical equipment, which are not financed by compulsory health care insurance, but are paid totally by the patient.

11. "Price" is the monetary payment for the provision of health care services.

12. "The benefit package from the compulsory health care insurance", implies the standard of health services benefits, which includes the primary health care and hospital care services, reimbursed drugs and drugs for hospital usage as well as medical facilities.

13. "Unpaid family worker" implies a family member who works and cohabits with a self-employed and does not have any other occupation.

CHAPTER II

COMPULSORY HEALTH CARE INSURANCE

Article 4

Compulsory health care insurance

1. Compulsory health insurance is based on the contributions of employees, employers, state and other sources for other people, as provided for in this law, based on the principle of solidarity.

2. Compulsory health care insurance scheme intends to cover the population with health care services, financed by the public and private sector, according to this law.
Article 5
Insured persons

1. The compulsory health insurance and the relevant payment of contribution are obligatory for all the economically active people, with permanent residence in Albania, as:

   a) Employed;
   b) self-employed;
   c) unpaid family workers;
   ç) other economically active people.

2. The compulsory health insurance covers, also, the following categories of economically non-active people, whose contribution’s payment is financed by the State Budget or other sources as provided for in the law:

   a) people benefitting from Social Insurance Institute;
   b) people benefitting economic assistance or disability payments, in accordance with the relevant legislation;
   c) people who are registered as unemployed-jobseekers at the National Employment Service;
   d) foreign asylum seekers in the Republic of Albania;
   d) children under the age of 18 years old;
   f) pupils and students under 25 years old unless they have incomes from business activities;
   e) categories of persons defined by special laws.

3. Persons who are not included in point 1 and 2 of this Article are entitled to voluntarily join the compulsory scheme. Voluntarily insured persons have the same rights and obligations as persons subject to compulsory insurance, if they meet the requirement of a 6-month waiting period from the date of registration and payment of contribution up to the date when their right to benefit has risen.
4. After the compulsory, or voluntary insurance’s period has expired, persons not included in the categories for whom the state contributes, must register in the Fund for voluntary insurance within three months. For delayed registrations, the waiting period will be one year from the date of registration and payment of annual contribution.

5. The Administrative Council, upon the proposal of Fund’s General Director, approves the regulation on voluntary insurance, as well as the terms and wording of the voluntary health insurance contracts.

Article 6
Obligation to pay contributions

1. Employers, for themselves and their employees, self-employed and unpaid family workers are responsible for the accurate calculation and payment of contributions, under the terms stipulated in the legislation about the collection of compulsory health and social contributions.

2. Voluntary health insurance is paid from the person by his/her own and they bind a contract with the Fund concerning voluntary health insurance.

3. Contributions for persons referred to in point 2 of Article 5 of this Law are paid by the state.

4. Rules for collecting the contributions of compulsory health insurance are set out in the relevant laws and regulations.

Article 7
The basis for the calculation of the contributions

1. The basis for the calculation of the contribution is the gross wage of the insured individual.

2. The State’s contribution for the economically non active individuals is based on the consumption per capita of the health service, indexed with inflation coefficient. Consumption per capita of the health service is determined by the Fund and is approved by the Assembly together with the annual budget.

3. The basis for the calculation of self-employed contribution is the double of the minimal wage to the effect of contributions calculation. The minimal wage to the effect of self-employed contributions calculation in the city and village is defined by Council of Ministers decision.
4. For the voluntary health insurance, the basis for the calculation of contributions is the double of the minimal wage to the effect of contributions calculation.

Article 8
The contribution rate

1. The Contribution rate of the compulsory health insurance is 3.4% of the basis for the contributions calculation according to points 1, 3 and 4 of article 7 in this law.
2. Contributions for the employed are paid 50% by the employer and 50% by the employee.

Article 9
The contribution collection

1. The General Tax Directorate collects compulsory health insurance contributions from the employers, for employees and self-employed and transfers them to the Fund, in compliance with the relevant legislation in force.
2. The Social Insurance Institute collects and transfers to the Fund the compulsory health insurance contributions of the self-employed in agriculture (the farmers).
3. The Fund is responsible for the calculation and collection of the voluntary health insurance contributions.
4. The Found collects contributions from the State Budget for the economically inactive population.

Article 10
The compulsory health insurance services package

1. The compulsory insurance finances the compulsory insurance services packages that include:
   a) medical check-ups, examinations and treatment in public primary health care centers and public hospitals;
   b) medical check-ups, examinations and treatments in private primary health care and hospital providers.
   c) drugs, medical products and treatments by contracted providers of health services.
2. The compulsory insurance services packages are drafted by defining:
   a) medical check-ups, examinations and treatments in the public primary health care centers and public hospitals, which are paid by the compulsory insurance.
b) reimbursable drugs list as well as the scope of the drugs coverage. The structure of the drugs list is defined based on the list of basic drugs according to INN (active principle of drug) classification as defined by WHO and also the coverage of the cheapest alternative;

c) medical devices list as well as the scope of their coverage.

3. The inclusion of health services in the compulsory health insurance package is based on the following criteria:

- medical: the scope of the service impact on the improvement of life quality and avoidance of the further deterioration of health sector and increase of life expectancy;
- economical: the report of services cost effectiveness and availability of financial resources from the Fund;
- social: patient’s ability to pay, availability of services and number of beneficiers in relation to the population.

4. The services packages are drafted by technical committees, comprising of experts, who equally represent the division of criteria into medical, economic and social. The nominative composition of the technical committees is appointed by the Fund’s Administrative Council according to the rules set in the Fund’s Statute.

5. The Administrative Council of the Fund approves the draft packages proposed by the technical commission and thereafter delivers them to the Minister of Health, who sends them to the Council of Ministers for further procedures. The proposed package is accompanied by a financial report of the Fund’s General Director concerning the financial possible coverage from the Fund of the proposed service packages.

6. The compulsory health insurance services package presented by the Minister of Health and accompanied by a financial report from the Fund’s General Director is approved upon the Council of Ministers decision.

Article 11
Direct payments

1. The insured persons participate in the payment of a part of the health service cost they are provided. The rate, services and ways of direct payments are defined by the Council of Ministers in any case.
2. The Council of Ministers, based on the social policies of the government, may exclude from the direct payment specific categories of individuals, based on their capability to pay. In these cases, the Council of Ministers allocates extra funds (subsidies) in order to finance the cost of direct payments to the health service providers.

**Article 12**

**Health services which are not covered by the compulsory health insurance**

1. The compulsory health insurance Fund does not finance health care services to the uninsured people, with the exception of medical emergency cases and prevention periodical check-ups package of the population in compliance with specifications in the Council of Ministers decision.

2. The compulsory health insurance Fund does not finance health care services which are not part of the service packages as defined by this law.

**CHAPTER III**

**FUND MANAGEMENT AND THE FUNCTIONS OF GOVERNING BODIES**

**Article 13**

**The Compulsory Health Care Insurance Fund**

1. The Compulsory Health Care Insurance Fund is the only public, legal and autonomous person that provides and manages the compulsory health care insurance in the Republic of Albania.

2. The Compulsory Health Care Insurance Fund manages the scheme of the compulsory health care insurance, in compliance with the national policies of health care as defined by the Ministry of Health.

3. The Fund Budget is approved as an integral part of the annual State Budget.
Article 14

The Fund Statute

1. The Fund is organized and operates on the basis of the Fund’s Statute which is approved by the Administrative Council.

2. The Fund’s Statute defines the following among others:
   a) The Fund’s overall organizational structure, functions and relevant responsibilities;
   b) The procedures for the procedural rules approval and amendments on the activity of the Administrative Council, General Directorate and local offices;
   c) Relations between the Administrative Council, General Director and local offices;
   ç) Procedures for drafting, changing and implementing the administrative regulations, regulations on organization and staff and economic, auditing and accounting regulations as well as other procedures and regulations necessary for the Fund’s activity;
   d) The rewarding rate for members’ participation in the Administrative Council;
   dh) Inter-institutional relations with domestic and foreign institutions;
   g) Legal and professional criteria for the election of the General Director.

Article 15

Governing Bodies

1. The Fund is governed by:
   a. The Administrative Council
   b. The General Director
Article 16

Administrative Council

1. The Administrative Council is the highest decision making body of the Fund and it comprises of 7 members as follows:
   a. The Minister of Health or his/her representative;
   b. The Minister of Finance or his/her representative;
   c. The Minister of Social Welfare and Youth or his/her representative;
   ç. The Fund’s General Director, or his/her representative;
   d. The Director of the Social Insurance Institute or his/her representative;
   dh. One representative from the employees union;
   e. One representative from the health professionals organization.

2. The Administrative Council Members term of service is 4 years with the right for reelection, or as long as the member is representative of the relevant body.

3. The Council of Ministers defines the medical professionals union or organization, which is going to nominate its representative in the Administrative Council.

Article 17

Administrative Council Governance

1. The Administrative Council elects its chairman from among the representatives of the Council of Ministers through a secret ballot.

2. The Administrative Council elects its vice/chairman from among representatives of non-governmental contributors.

3. The Administrative Council is headed by the Chairman, or vice/chairman in case of his/her absence.
Article 18

Meetings and decisions of the Administrative Council

1. The routine meetings of the Administrative Council are convened by the General Director, not less than once in every two months.

2. The agenda is proposed by the General Director and is approved by the Administrative Council.

3. The chairman convenes the Administrative Council in extraordinary meetings upon the request of at least 3 members of the Administrative Council or of the General Director.

4. The quorum for the ordinary meetings is by 2/3 of the Council members. Decisions are approved by a majority of the present members. Abstention is not permitted during the voting process.

5. In extraordinary cases, according to the internal regulation of the Council, the chairman may convene the Council and the meetings may be held with a quorum of 5 members. In these cases, the decision is made unanimously by all the members present in the meeting.

6. The chairman reports to the Administrative Council and presents for approval at the first row meeting all the decisions made in extraordinary meetings.

Article 19

The General Director

1. The General Director is appointed by the Administrative Council from not less than three candidatures presented by the members of this Council in line with the criteria and regulations defined in the Fund’s statute.

2. The General Director is appointed by the Administrative Council through a secret ballot procedure, by 2/3 of the votes of all its members.

3. The General Director stays in office for 5 years period.

5. The General Director’s salary is determined by the Council of Ministers decision.

6. The General Director reports to the Administrative Council.

7. The Administrative Council decides on the General Director dismissal, in the following cases:
a) if sentenced by final decision for committing a criminal action;

b) if he/she violates the Statute’s provisions, the Administrative Council decisions and the legislation in force.

**Article 20**

**Duties of the Administrative Council**

1. The Administrative Council carries out the following duties:

a) elects, appoints and dismisses the Director General for reasons provided for in this law;

b) appoints the members of the technical committee, under section 10 of this Law, to draft the health services package and the list of reimbursable drugs;

c) approves the service packages financed by compulsory health insurance scheme, designed by the technical committee, which are sent to the Ministry of Health which delivers them to the Council of Ministers for further procedures;

ç) approves the statute and economic, financial, procedural, audit and control regulations as well as other internal regulations, which it deems necessary during the Fund’s performance in appliance to this Law;

d) approves the criteria for binding contracts as well as for contracts made with providers of public and private health services;

dh) approves the annual report, the financial report and the annual balance sheet submitted by the Director General;

e) approves the Fund's annual draft budget and the projections for the next three years;

ë) approves the employees payroll system of the Fund;

f) approves the opening or closure and the distribution of Fund’s local offices;

g) determines the total number of Fund’s employees;

gj) recommends amendments to the compulsory health care insurance legislation and proposes them to the Minister of Health;

h) decides on other issues provided for in the law.
Article 21
Duties of the General Director

1. The General Director carries out the following duties:

a) proposes to the Administrative Council the approval of the statute, the economic, financial, auditing and controlling regulations, the annual report and the annual draft budget;

b) heads the Fund’s performance, in compliance to the statute and regulations approved by the Administrative Council;

c) proposes to the Administrative Council the total number of the employees, approves the internal structure and job description of the General Directorate and local offices as well as regulations on the Fund’s overall organization and operation;

ç) appoints and dismisses the staff and submits proposals to the Administrative Council regarding staff salaries;

d) submits to the Administrative Council all the policies for the development of health insurance scheme;

dh) represents the Fund in legal relations with third parties, in relations with media and communication with the insured individuals and health service providers;

e) executes the Administrative Council’s decisions and reports to the Council on his/her performance;

ë) delegates competences to the Fund local offices;

f) executes other tasks as assigned by the Administrative Council.

2. The General Director may seek advice from external specialists on issues requiring specific knowledge.

Article 22
Reporting

1. The General Director develops the annual report regarding finance, management, contracting, health services packages and population coverage by the compulsory health insurance, which it presents to the Administrative Council.
2. The Administrative Council prepares an annual report for the Minister of Health.

3. The General Director responds to specific requests for providing information to the Ministry of Finance about that part of the budget financed by the State Budget.

CHAPTER IV
FINANCING FUND

Article 23
Sources of financing

The financing sources of the Fund are as follows:

a) compulsory health insurance contributions, according to point 1 of Article 5 of this Law;

b) compulsory health insurance contribution from the State Budget for the economically non-active people, according to point 2 of Article 5 of this Law;

c) voluntary health insurance contributions, according to point 3 of Article 5 of this Law;

d) transfers from the Ministry of Health to subsidize a portion of direct payments, as according to point 2 of Article 11 of this Law;

e) transfers from the Ministry of Health for the services it has required, excluding those budgeted or contracted by the Fund;

dh) transfers approved by the State Budget in order to balance the Fund’s budget or compensate for the non-materialization of contributions during the process of the budget implementation.

e) other sources, donations, and grants from national and international sources.

Article 24
Financial Structure of the Fund

1. The financial structure of the Fund is as follows:

a) the compulsory health insurance includes all incomes from contributions and other sources, according to Article 23 of this Law, incomes from contingency fund as well as the expenditures to pay health care services packages under the compulsory health insurance scheme;
b) The contingency fund of compulsory insurance comprises of accumulation surpluses of incomes toward expenditures. The contingency fund is an emergency fund aiming to cover temporary transfers and operational deficits concerning compulsory health insurance, in accordance with the rules established for that purpose by the Council of Ministers Decisions. Contingency fund shall not exceed a rate of 10 percent of annual expenses of the Fund;

c) administration includes current and capital expenditures for the management of the Fund;

ç) voluntary health insurance, which consists of incomes and expenditures under health insurance contracts.

2. The Fund’s cash in hand are deposited in licensed and registered banks in the Republic of Albania.

**Article 25**

**Fund’s solvency**

1. The Fund manages its activity through valid financial resources and it doesn’t go into debts.

2. The Fund does not cover health care services that aren’t included in the compulsory insurance package and relevant contracts.

**Article 26**

**Accounting and Auditing**

The accounting and auditing procedures are carried out in line with enforced Albanian legislation.

**CHAPTER V**

**PROCEDURES**

**Article 27**

**Registration and identification of the insured people**

1. All the individuals mentioned in article 5 of this Law are obliged to be registered at the Fund.
2. The employers are responsible for the registration of their employees at the Fund as well as to inform the Fund on the following:

a) the number of the insured persons,
b) the names of the insured persons and insurance number,
c) the insured persons salaries
c) insured persons contribution rate,
d) employment period.

3. All the registered individuals have a Compulsory Health Insurance Number as well as a document that proves their registration at the Fund and identifies the insured individual.

4. The individuals, subject to the compulsory health insurance, are registered at the Fund within a period of 30 days starting from the date they become subject to obligations to pay contributions. The changes to the status of the insured individuals are registered and identified by the Fund.

5. The Council of Ministers defines responsible public institutions and the period in which they are forced to inform the Fund on the number and identity of the individuals, according to the categories mentioned in Article 5 of this Law.

6. The Council of Ministers decides on the rules for the registration and identification of the insured individuals and ways of submitting a feedback.

**Article 28**

**Identification of insured**

Insured persons are identified via health insurance identification document issued by the Fund.

**Article 29**

**Contracts**

1. The Fund pays the health service providers only for the service they provide to the insured individuals and according to the terms and conditions defined in the respective contracts.

2. The Administrative Council approves the procedures and criteria for binding contracts and making payments with the intention to stimulate access to services, cost’s efficiency and
increase the services quality provided by the private and public service providers to the community.

3. The Fund makes contracts with public health service providers, licensed by the competent authority and covers all the services provided by the providers, which are included in the services package, according to Article 10 of this Law.

4. The Fund can bind contracts with private providers of health services, licensed by the competent authority. The contract defines the health services that will be covered by the Fund. Contracts are bound for a set duration and can be renewed.

5. The Fund terminates the contract with a service provider in cases when the performance analysis shows that this provider does not meet the criteria, according point 2 of this article. The Fund must inform the Ministry of Health prior to the contract’s termination and must assign a deadline for the service providers within which they have to meet all the criteria.

6. The Fund creates the Selected Health Care Providers Register, where the public and private service providers that meet the criteria mentioned in point 3 of this article are recorded.

The Selected Health Care Providers Register is approved by the Administrative Council and is released in the Fund’s official page.

Article 30

Payments to the Health Care Services Providers

1. The Administrative Council defines and decides the different payment forms to the health care service providers and the health care institutions, by guaranteeing the population’s access to these services, the services’ cost efficiency and their quality increase.

2. The Fund pays the contracted service providers, for health services, drugs and medical products, included in the compulsory health insurance packages in compliance with the terms and conditions of the contracts signed with the Fund.

3. The Fund reimburses the insured individuals, who receive services from domestic health service providers that don’t have a contract with the Fund, only when the contracted health care providers are absent and after the Fund makes all the necessary verifications. The Administrative Council specifies the cases of the insured individual’s reimbursement as well as the reimbursement procedures and rules.

4. The Fund is entitled and assigned to verify every payment provided in conformity with the terms and conditions of the contracts as well as to refuse every request for payment in cases set out in Financial Regulations approved by the Administrative Council.
5. The payment to the providers of the health service providers are transferred only through bank accounts.

6. The local offices of the Fund pay regularly all the payment’s requests submitted by the contracted health care providers in accordance with the terms and conditions of the respective contracts and after appropriate verification.

7. The procedure of filing a claim for their payment and their verification are defined in the regulations drafted by the General Directorate and approved by the Administrative Council.

Article 31
Verification of payment’s requests

1. The Fund is entitled and responsible to verify the authenticity and consistency of any payment request from the health care providers, prior to the payment.

2. In cases when these payment’s requests are considered as excessive or irregular, they must be suspended until clarification or correction. Otherwise the payment must be rejected.

3. The verification and controlling procedures of payments requirements must be determined in the regulations drafted by the General Director and approved by the Administrative Council.

CHAPTER VI
THE INFORMATION SYSTEM

Article 32
Obligation of public authorities to provide information

1. The Fund receives information from the Ministry of Finance about macro-economic development indicators, data on the GDP and other financial information regarding the functioning of the Fund.

2. The Fund receives information from the Ministry of Health on the policies and strategies related to health system, on the health status data and other health information regarding the performance of the Fund.
3. The General Taxation Directorate delivers to the Fund a periodic information on the amount of health insurance contributions collected from all entities that are obliged to deposit their contributions at this Directorate, on the number of the contributors and the relevant payrolls.

4. The Council of Ministers determines the institutions or other organizations that must provide data regularly, according to the needs of the Fund.

5. The Fund reaches inter-institutional agreements to steadily exchange detailed information with private and public entities, according to the above paragraphs of this Article and elaborates the received information.

Article 33
Obligation of the contracted health care service providers to report

1. The Health Care Providers are obliged to submit to the Ministry of Health and the Fund, periodic information regarding their performance, according to their reporting obligation, as stipulated in the contracts with the Fund.

2. The Administrative Council, upon the proposal of the Director General is entitled to terminate the contract and remove the health service providers from the Register of Selected Health Services Providers for a certain period of time in case the above mentioned report is not submitted for unjustified reasons.

Article 34
Confidentiality of Information

All information on the health of an insured person, collected and transferred to the Fund, is confidential. The Fund administers the information generated by this law, in accordance with the rules defined in the legislation, especially the legislation on personal data protection.

Article 35
Public Information

1. The Fund is legally-bound to periodically inform the public, through mass media, websites, magazines and brochures, published by the Fund and other means of public communication on:
a) Decisions made pursuant to this Law;
b) Fund’s activity
c) Benefit packages
c) Direct payments and fees

2. The Fund prepares and publishes an annual report on its overall performance concerning the covered population and services as well as its finances.

**Article 36**

**Statistics**

1. The Fund compiles the necessary statistics regarding the development of the health insurance costs. Providers are obliged to deliver the necessary information to the Fund. The Fund respects the relevant legislation on data protection.

2. The Fund publishes an annual statistical report.

**CHAPTER VII**

**SANCTIONS**

**Article 37**

**Sanctions related to the contributions**

1. The following offenses, when they do not constitute a criminal offense, are administrative violations and must be penalized as follows:

a) failure to register is penalized with a fine of All 25 000 for each violation;

b) employers that delay paying of contributions are penalized by a fine of 5 percent of outstanding contributions amount. The amount cannot be less than All 10 000 in no case;

c) violations such as contributions payment evasion, filing of lower contributions and false certificate are punished with a fine equal to 100 percent of the difference between the calculated amount and the factual amount in case they don’t constitute a criminal offense;

ç) refusal to provide information, in accordance with the provisions of this law must be punished by a fine of All 10,000 to 50,000 for each violation.

3. The non-payment of contributions disenfranchises the citizens to benefit reimbursed health services from the Fund during the period of non-payment of contribution.

**Article 38**

**Sanctions for compulsory insurance scheme**

1. The Health Service Providers must be penalized for the violation of the provisions contained in this Law and the contract with the Health Insurance Fund. The penalties are defined in the specific contracts and can vary from fines imposed in All up to a percentage of the contract’s amount.

2. In case the health service providers violate seriously and recurrently the contractual obligations and refuse to be subject to audits and inspections by the Fund, the contract may be terminated and the service provider is removed from the Register of Selected Health Care Providers. In such cases, the health care service providers can reapply for inclusion in the register a year after.

3. Seeking reimbursement for services based on false claims by the insured, when not a criminal offense constitutes an administrative offense punishable by a fine of All 50 000. The decision is made by the Fund, pursuant to Law no. 10 279, dated 20.5.2010 "On Administrative Offences".

4. In case of repeated requests for services reimbursement based on false claims, the insured must be punished with suspension of the right to profit reimbursed health care services from 1 to 3 months.

**Article 39**

**Appeals against the decisions**

1. The insured individuals, the contributors and the health service providers, enjoy the right to appeal to the General Directorate or first instance Court on the verdict for fine or benefit suspension.

2. The Administrative Council, upon the proposal of the General Director, approves the rules and the procedure of the Administrative Revision Committee at the headquarters, or local offices of the Fund.
CHAPTER VIII
TRANSITIONAL PROVISIONS

Article 40
Social insurance beneficiaries

1. Up to the moment the Fund will decide about the registration, in compliance with Article 27 of this Law, all the insured individuals via the Social Insurance Institute, are automatically registered at the Compulsory Health Care Insurance Fund and they are obliged to pay the contributions for the compulsory health insurance.

2. The Social Insurance Institute shall transfer to the Fund the compulsory health insurance contributions via the General Taxation Directorate for all the persons registered at the social insurance.

Article 41

The Council of Ministers has the authority to issue bylaws pursuant to article 6, point 4, article 10, point 6, article 11, point 2, article 14, point 1, article 16, point 3, article 19 point 5, article 24 point 1 letter "b", article 27 point 5 and article 6 and 32 point 4 of this Law.

Article 42

Law No. 7870, dated 13.10.1994 "On health insurance in the Republic of Albania", as amended, is abrogated as soon as this Law is enforced.

Article 43

This law enters into force 2 (two) years after its publication at the Official Gazette.

The last sentence is abrogated.

This law is enforced 15 days after its publication at the Official Gazette.

This law is enforced instantly, is published at the Official Gazette and extends its financial effects from 1 January 2014.

As amended by laws:
Law 126/2013 dated 25.04.2013


Promulgated by decree no. 6920, dated 8.03.2011 of the President of the Republic of Albania, Bamir Topi,

Promulgated by decree no. 8150, dated 02.05.2013 of the President of the Republic of Albania, Bujar Nishani,

Promulgated by decree no. 8451, dated 30.12.2013 of the President of the Republic of Albania, Bujar Nishani