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THE SOCIAL HEALTH INSURANCE REGULATIONS

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Kenya

Social Health Insurance Act

The Social Health Insurance Regulations

Legislation as at 28 February 2025

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SOCIAL HEALTH INSURANCE ACT

THE SOCIAL HEALTH INSURANCE REGULATIONS

LEGAL NOTICE 49 OF 2024

Commenced on 8 March 2024

[Amended by Social Health Insurance (Amendment) Regulations, 2024 (Legal Notice 147 of 2024) on 20 September 2024]
[Amended by The Social Health Insurance (Amendment) Regulations, 2025 (Legal Notice 55 of 2025) on 28 February 2025]

Part I – PRELIMINARY

1. Citation

These Regulations may be cited as the Social Health Insurance Regulations.

2. Interpretation

In these Regulations, unless the context otherwise requires—

"Act" means the Social Health Insurance Act (Cap. 255);

"ambulance" means an appropriately equipped and authorized vehicle either used on land, water or on air, that is designed or adapted to treat or convey a patient in an emergency care situation, marked in such a way as to indicate the category of medical care and transportation of the said vehicle and staffed with licensed ambulance service personnel;

"applicant" means a person who has made a request for registration by the Authority under the Act and these Regulations;

"Authority" means the Social Health Authority established by section 4 of the Act;

"base premium" means regular payments made to the Authority, in exchange for coverage, to cover the cost of healthcare coverage to enable contributors access various healthcare services and benefits in accordance with the Act and these Regulations;

"beneficiary" means a person who—

(a) is a contributor;

(b) has not attained the age of twenty-one years, has no income of his own and is living with the contributor;

(c) has not attained the age of twenty-five years, is undergoing a full-time course of education at a university, college, school or other educational establishment or serving under articles or an indenture with a view to qualifying in a trade or profession and is not in receipt of any income other than a scholarship, bursary or other similar grant or award;

(d) is a person with disability and is wholly dependent on and living with the contributor; or

(e) is a spouse of the contributor;

"biometric" means a physical or biological attribute including a fingerprint, hand geometry, earlobe geometry, retina or iris pattern, toe impression, voice wave or blood typing in a digital form or such other biological attributes that identifies an individual;

"biometric data" includes fingerprint, hand geometry, earlobe geometry, retina or iris patterns, toe impression, voice waves, blood typing, photograph or such other biological attributes of an individual obtained by way of biometrics;

"Board" means the Board of the Authority established under section 7 of the Act;

"Cabinet Secretary" means the Cabinet Secretary responsible for matters relating to health;

"child" means an individual who has not attained the age of eighteen years;

"chronic illness" means a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both;

"claim settling agent" means a person who engages in the business of settling or negotiating insurance claims under policies issued by insurers whether in Kenya or outside Kenya;

"contracting" means the entering into a formal agreement with an empanelled health care provider or healthcare facility for purposes of provision of services;

"contributor" means a person liable to contribute to the Social Health Insurance Fund as provided under section 27 of the Act;

"critical illness" means a serious and potentially life-threatening condition that demands urgent medical intervention and can have a substantial impact on a person's health, well-being and quality of life;

"emergency services" includes services that provide urgent prehospital care of critically ill or injured patients prior to transportation to definitive care;

"emergency treatment" means the necessary immediate healthcare that must be administered to prevent death or worsening of a medical situation;

"empanelment" means enrolment of a health care provider into the list of health care service facilities approved by the Board;

"guardian" has the meaning assigned to it under the Children Act (Cap. 141);

"health facility" means the whole or part of a public or private institution, building or place, whether for profit or not, that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health service;

"healthcare provider" means a person who provides healthcare services and includes a healthcare professional;

"healthcare services" means the prevention, promotion, management or alleviation of disease, illness, injury, and other physical and mental impairments in individuals, delivered by healthcare professionals through the healthcare system's routine health services, or its emergency health services;

"health technology assessment" means a multi-disciplinary process that uses explicit methods to determine the value of a health technology at different points in its life cycle to inform decision making in order to promote equitable, efficient and high quality systems;

"household" means a social unit comprising of an eligible contributor, whether contributing by self or paid for, and their beneficiaries, or who share the same social-economic needs associated with consumption and production;

"hub" means a primary health care referral facility which should be a level four facility;

"identification document" includes—

(a) a Social Health Authority number;

(b) a minor Social Health Authority number;

(c) an identity card;

(d) a student identity card;

(e) a passport;

(f) in the case of a child, a birth certificate or a birth notification;

(g) a prison admission number;

(h) an identification number issued to a person held in remand or police custody;

(i) the admission number of the children's remand home, rehabilitation institution or borstal institution;

(j) an asylum-seeker pass;

(k) a movement pass;

(l) a letter of recognition;

(m) a refugee identification card; or

(n) a conventional travel document;

"identity card" means the identity card issued under section 9 of the Registration of Persons Act (Cap. 107);

"intervention" includes health services, medicines, vaccines or devices that have the potential to improve the health of individuals and populations;

"level 4 primary health care referral facility" means a health facility designated as a hub pursuant to the Primary Health Care Act (Cap. 241A);

"loco parentis" means a person who is responsible for a child in place of a parent and performs functions or responsibilities of a parent;

"means testing" means a method that uses the means testing instrument to determine whether an individual or a household has the ability to pay for their social health insurance premium;

"medical insurance provider" means an intermediary, other than a broker, concerned with the placing of medical insurance business with an insurer for, or in expectation of, payment by way of a commission, fee or other remuneration;

"pre-authorization" means the restriction placed on a specified healthcare service under the benefits package offered by the Authority which obligates the healthcare provider or health facility to seek permission from the Authority before providing the specified healthcare service for purposes of determining whether a beneficiary's cover caters for the costs of the healthcare service sought;

"pre-hospital care" includes emergency medical care provided to patients in settings other than a health facility;

"primary health care" means essential health care based on practical, scientifically sound and socially acceptable methods and technology that is made universally accessible to Individuals and families in the community at levels 1, 2 and 3 of health services, to meet their health needs at every stage of the life cycle, with their full participation and at an affordable cost to the community and the county;

"Primary Health Care Network" means an administrative health region comprising of a hub and spokes established to deliver access to primary health care services for patients, as well as to coordinate with other hospitals in order to improve the overall operational efficiency of the network;

"referral" means the process by which a given health facility transfers a client service, specimen and client parameters to another facility to assume responsibility for consultation, review or further management;

"registration" means the process of collecting specified data from an individual for the purpose of access to the services under the Act and these Regulations;

"registration point" includes—

(a) any of the branches of the Authority;

(b) Huduma Centres; and

(c) such other place or form as may be designated by the Authority;

"repealed Act" means the National Health Insurance Fund Act (Cap. 255);

"resident" means a citizen of Kenya or a non-citizen who has been granted lawful residence in Kenya; and

"Social Health Insurance Fund" means the Fund established under section 25 of the Act;

“specialized healthcare services” means the provision of targeted and advanced healthcare services by a healthcare provider with specialized training and expertise in a particular area of medicine in relation to specific medical services, procedures, conditions, diseases or specialized needs using advanced equipment, technology or treatment modalities;

"Tribunal" means the Dispute Resolution Tribunal established under section 44 of the Act.

[L.N. 147 of 2024, r. 2, L.N. 55 of 2025, r. 2.]

3. Object of the Regulations

The object of these Regulations is to give effect to the provisions of the Act by—

(a) facilitating the enforcement of mandatory registration of every person resident in Kenya pursuant to section 26(1) of the Act; and

(b) facilitating access to the highest attainable standard of health care.

4. Application of the Regulations

These Regulations shall apply in respect to—

(a) implementation of the Primary Healthcare Fund;

(b) implementation of the Social Health Insurance Fund;

(c) implementation of the Emergency, Chronic and Critical Illness Fund;

(d) empanelment and contracting of healthcare providers and health facilities;

(e) benefits accruing to contributors and their beneficiaries;

(f) determination of the tariffs applicable;

(g) procedures for settlement of claims; and

(h) processes and services under the Act.

Part II – IMPLEMENTATION OF THE PRIMARY HEALTHCARE FUND

5. Purpose of the Primary Healthcare Fund

The Primary Healthcare Fund shall be used to—

(a) purchase primary healthcare services from primary healthcare facilities or a level 4 primary health care referral facility designated by the Authority for purposes of access to services under the Primary Healthcare Fund;

(b) pay health facilities for the provision of quality primary healthcare services based on the tariffs prescribed pursuant to section 32(2) of the Act; and

(c) establish a pool for receipt and payment of funds for primary healthcare in the country.

6. Access to primary health care services

(1) Every person resident in Kenya shall access primary health care services in accordance with Section 4 of the Primary Health Care Act (Cap. 241A).

(2) A person shall register as a member of the Social Health Insurance Fund for purposes of subregulation (1).

(3) Where a person using the social health insurance cover is referred for further review, treatment and management from a primary health facility to a level 4, 5 or 6 health facility, that person shall comply with the provisions of section 27(1) and (2) of the Act.

7. Services offered under the Primary Healthcare Fund

(1) A person registered as a member of the Social Health Insurance Fund shall access facility-based primary health care services as provided for in the Primary Health Care Act (Cap. 241A) purchased under the Primary Healthcare Fund.

(2) Facility-based primary health care services shall be accessed through a level 2 or level 3 health facility or a level 4 primary health care referral facility empanelled and contracted by the Authority:

Provided that the level 4 primary health care referral facility shall be designated by the Authority for purposes of access to facility-based primary health care services purchased under the Primary Healthcare Fund.

(3) The Authority shall, using monies from the Primary Healthcare Fund, purchase from a health facility the primary healthcare services specified in the benefits package set out in the Second Schedule to these Regulations.

(4) A heath facility shall provide the primary healthcare services contracted under subregulation (3) in accordance with the tariffs prescribed pursuant to section 32(2) of the Act.

8. Payments out of the Primary Healthcare Fund

(1) For purposes of expenditure out of the Primary Healthcare Fund as provided under section 22 of the Act, a health facility shall lodge a claim with the Claims Management Office for the payment of any facility-based primary health care service.

(2) The Authority shall pay the claims lodged based on the tariffs prescribed pursuant to section 32(2) of the Act.

(3) A claim lodged under this regulation shall be processed in the manner set out in Part VIII of these Regulations.

9. Financing

The Authority shall mobilize resources for the Primary Healthcare Fund for the purchase of primary healthcare services from primary health facilities for purposes of section 21(b) and (d) of the Act.

Part III – IMPLEMENTATION OF THE SOCIAL HEALTH INSURANCE FUND

10. Purpose of the Social Health Insurance Fund

The Social Health Insurance Fund established under section 25 of the Act shall be used to—

(a) establish a pool of all contributions made under the Act;

(b) purchase healthcare services from empanelled and contracted healthcare providers and health facilities on referral from primary health facilities;

(c) pay for the provision of quality healthcare services to beneficiaries under the Act offered by empanelled and contracted—

(i) healthcare providers; and

(ii) level 4, 5 and 6 health facilities;

(d) receive funds appropriated by the National Assembly as contributions for indigents, vulnerable persons and persons under lawful custody; and

(e) receive gifts, grants, innovative financing mechanisms or donations made into the Social Health Insurance Fund.

11. Initial registration

(1) Upon the coming into force of these Regulations, every person resident in Kenya shall apply to the Authority for registration as a member of the Social Health Insurance Fund pursuant to section 26(1) of the Act with effect from the 1st July, 2024.

(2) Payment of contributions and access to healthcare services under the Act and these Regulations shall commence on the 1st October, 2024.

(3) The data of the National Health Insurance Fund under the repealed Act shall be retained until all claims have been settled.

(4) The application under subregulation (1) shall be made in Form 1 set out in the First Schedule to these Regulations and shall be accompanied by—

(a) a copy of the identity card of the applicant; or

(b) in the case of a person without an identity card, any other identification document as provided in regulation 2.

(5) The Authority shall ensure that the Centralized Digital Platform, established under regulation 64, provides for the taking of real-time photographs of an applicant when processing an application made under subregulation (1).

(6) Despite the provisions of subregulation (4), an application by a child with no form of identification shall be accompanied by documentation provided by the state department responsible for social protection for purposes of registration of the child.

(7) The Authority shall, upon examining the application and the information provided in the application, register the applicant as a member of the Social Health Insurance Fund and shall assign to each beneficiary a Social Health Authority number.

(8) The Authority shall, upon successful registration, notify the applicant of the registration within fourteen days from the date of the registration.

(9) A beneficiary shall provide his or her biometric data at a designated registration point.

(10) The Authority shall make special arrangements including availing mobile registration services, for the registration of persons with disability, older persons, persons under lawful custody, the marginalized communities and persons incapacitated by illness.

(11) The Authority shall comply with the provisions of the Data Protection Act (Cap. 411C) and the Digital Health Act (Cap. 241B) in the processing of personal data.

[L.N. 147 of 2024, r. 3, L.N. 55 of 2025, r. 3.]

12. Registration of beneficiaries

(1) A contributor may declare beneficiaries in the application Form 1 set out in the First Schedule to these Regulations, at the time of registration to enable the beneficiaries to access the benefits under his or her cover.

(2) A contributor seeking to include a beneficiary in his or her application shall provide particulars including—

(a) the full name of the beneficiary;

(b) the date of birth of the beneficiary;

(c) the place of birth of the beneficiary;

(d) the sex of the beneficiary;

(e) a passport photograph of the beneficiary;

(f) the nationality of the beneficiary, where necessary;

(g) the contact information of the beneficiary;

(h) the relationship with the beneficiary; and

(i) disability of the beneficiary, if any.

(3) A contributor shall provide the following documents of identification of a beneficiary—

(a) in the case of a spouse of the contributor, a copy of the identity document of the spouse and a copy of the document of proof of marriage;

(b) in the case of a child of the contributor, a copy of the birth certificate of the child or a copy of a birth notification where the child is below the age of six months;

(c) in the case of an adopted child of a contributor, a copy of the adoption order;

(d) in the case of a child for whom the contributor stands in *loco parentis*, a will, deed, court order or any other document recognized under the Children Act (Cap. 141);

(e) in the case of a person with disability and who is wholly dependent on a contributor, a copy of the identification document and a certificate of registration from the National Council for Persons with Disabilities;

(f) in the case of a non-Kenyan resident, a work permit or an alien identification card;

(g) in the case of a person in lawful custody, the prison admission number, the remand identification number or a copy of the identification document;

(h) in the case of a child in conflict with the law, the admission number of the children's remand home, rehabilitation institution or borstal institution or a copy of the birth certificate; or

(i) in the case of a refugee—

(i) an asylum-seekers pass;

(ii) a movement pass;

(iii) a letter of recognition;

(iv) a refugee identification card; or

(v) a conventional travel document.

(4) A contributor with more than one spouse shall pay a premium as determined by the means testing instrument and the spouse shall be eligible to access benefits fourteen days from the date of declaration under subregulation (1) and payment of the premium.

[L.N. 147 of 2024, r. 4., L.N. 55 of 2025, r. 4.]

13. Members of the National Health Insurance Fund

(1) All members of the National Health Insurance Fund under the repealed National Health Insurance Fund Act shall be transitioned to the Social Health Insurance Fund upon verification of their data by the Authority using the existing relevant government databases.

(2) Any monies paid in advance for contributions by a member of the National Health Insurance Fund under the repealed Act shall be transferred to the Authority.

[L.N. 147 of 2024, r. 5, L.N. 55 of 2025, r. 5.]

14. Amendment of beneficiaries

(1) A contributor may amend the declaration of beneficiaries under his or her cover by submitting to the Authority a duly filled Form 1 set out in the First Schedule to these Regulations.

(2) A contributor who requests for an amendment of declaration of beneficiaries shall provide —

(a) in the case of a new spouse, a copy of the identification document of the spouse, a copy of the document of proof of marriage and a court order for removal of the previously listed spouse, where applicable;

(b) in the case of a child, a copy of the birth certificate or a copy of birth notification document of the child;

(c) in the case of an adopted child for whom the contributor stands in *loco parentis*, a will, a deed, a court order or any other document recognized under the Children Act (Cap. 141);

(d) in the case of divorce, a copy of a decree absolute of divorce;

(e) in the case of death, a copy of a death certificate or a decree declaring the presumption of the death of the beneficiary;

(f) in the case of an annulment of a marriage, a decree of annulment; or

(g) in the case of a divorce or an annulment in another country, a decree absolute of divorce or annulment obtained in another country and recognized in Kenya under the Marriage Act (Cap. 150).

(3) A beneficiary shall—

(a) in the case of a spouse, access the benefits under the cover of the contributor within a period of fourteen days from the date of the amendment if the contributor complies with section 27(1) and (2) of the Act and these Regulations;

(b) in the case of a child, access the benefits under the cover of the contributor from the date of the amendment if the contributions of the contributor comply with section 27(1) and (2) of the Act and these Regulations; or

(c) cease to access the benefits under the cover of the contributor within a period of fourteen days from the date of amendment in the case of divorce, annulment of a marriage or until the expiry of the cover whichever is later.

15. Registration of a child

(1) A parent or guardian of a child born after the commencement of these Regulations shall, within fourteen days of the birth of a child, apply to the Authority for the registration of the child when notifying the birth of the child to the registrar of the registration area in which the birth occurs.

(2) The application under subregulation (1) shall be accompanied by a birth notification document.

(3) An applicant seeking the registration of a child whose birth occurred outside Kenya shall provide a notification of birth or a birth certificate issued by the appropriate authority from the country in which the birth occurred.

(4) The Authority, shall upon receipt and examination of the application, register the child into the Social Health Insurance Fund and assign the child a minor Social Health Authority number.

(5) The Authority shall update the information of the child captured at birth on a continuous basis.

(6) A parent or guardian of a child shall, within thirty days of change in circumstances or on becoming aware of an error, notify the Authority of such change or error in the information in relation to the child.

(7) Upon the child attaining the age of seven years, a parent or a guardian shall present the child at a designated registration point for the purposes of obtaining the child's biometric data in accordance with the provisions of the Data Protection Act (Cap. 411C).

(8) Every parent or guardian and the Cabinet Secretary responsible for matters relating to social protection in the case of vulnerable children shall, pursuant to section 16(6) and 31(2)(a)(v) of the Children Act (Cap. 141), ensure that every child has a social health insurance cover for purposes of receiving healthcare services under the Act and these Regulations.

(9) Within ninety days upon attaining the age of eighteen years, an individual shall make an application using Form 1 set out in the First Schedule to these Regulations for updating of their registration details as a contributor and as a household separate from the parent or guardian's household:

Provided that a person who has attained the age of eighteen years and who has not attained the age of—

(a) twenty-one years, has no income of their own and is living with the contributor; or

(b) twenty five years, is undergoing a full-time course of education at a university, college, school or other educational establishment or serving under articles or an indenture with a view to qualifying in a trade or profession and is not in receipt of any income other than a scholarship, bursary or other similar grant or award shall continue to access healthcare services as a beneficiary under the cover of the contributor.

(10) On receipt of the application made under subregulation (9), the Authority shall verify and update the individual's registration details and issue a new Social Health Authority number to the applicant within thirty days of the application.

(11) The Authority shall, upon the lapse of the period under subregulation (9), suspend the minor Social Health Authority number for members who were previously children but have attained the age of majority and have not updated their registration details.

[L.N. 147 of 2024, r. 6, L.N. 55 of 2025, r. 6.]

16. Death of a beneficiary

(1) The Authority shall deregister a person as a beneficiary upon the death of the person.

(2) Where a death occurs, the Principal Registrar of Births and Deaths appointed under section 3 of the Births and Deaths Registration Act (Cap. 149) shall notify the Authority of the death of the beneficiary and shall submit a copy of the certificate of death of the beneficiary to the Authority.

(3) Despite the provisions of subregulation (2), a household shall notify the Authority of the death of any beneficiary and shall submit a copy of the certificate of death of the beneficiary to the Authority.

(4) The Authority shall, upon receipt of notification of the death of the beneficiary, retire the Social Health Authority number of the deceased beneficiary.

(5) Where a deregistered person was making contributions on behalf of the household, the other beneficiaries shall continue to access benefits until the end of the period for which the contributions have been paid.

17. Household with income from salaried employment

(1) A household whose income is derived from salaried employment shall pay a monthly statutory deduction contribution to the Social Health Insurance Fund at a rate of 2.75% of the gross salary or wage of the household by the ninth day of each month.

(2) The amount payable every month under subregulation (1) shall not, in any case, be less than Kenya shillings three hundred per month.

(3) The Cabinet Secretary responsible for matters relating to the National Treasury shall deduct and remit the contributions of employees in the public service in the National Government and in a public office in the National government to the Authority on behalf of National Government by the ninth day of each month.

(4) The County Executive Committee member responsible for matters relating to the County Treasury shall deduct and remit the contributions of employees in the county public service to the Authority on behalf of county public offices by the ninth day of each month.

18. Household whose income is not derived from salaried employment

(1) A household whose income is not derived from salaried employment shall pay an annual contribution to the Social Health Insurance Fund at a rate of 2.75% of the household income as determined by the means testing instrument in the manner prescribed under regulation 21.

(2) The amount payable every month under subregulation (1) shall not, in any case, be less than Kenya shillings three hundred per month.

(3) The amount payable under subregulation (1) shall be paid fourteen days before the lapse of the annual contribution of the beneficiary.

(4) The Authority, in collaboration with the Cabinet Secretary responsible for matters relating to cooperatives and micro, small and medium enterprises development and other financing institutions, shall provide premium financing to non-salaried persons to enable them pay their annual contributions within the intervals under which their income becomes available.

(5) Money paid on behalf of a contributor through premium financing shall be remitted directly to the Authority.

(6) The Authority shall inform its members on the available premium financing products.

19. Household in need of financial assistance

(1) The Authority shall use the means testing instrument in the manner provided in regulation 21 to identify the indigent households that require financial assistance and for whom the National Government or the County Government is liable to pay contributions pursuant to section 27(2)(c) of the Act.

(2) The Cabinet Secretary responsible for matters relating to social protection shall be liable as a contributor under subregulation (1) in the case of the national government.

(3) The County Executive Committee member responsible for matters relating to social protection shall be liable as a contributor under subregulation (1) in the case of the county government.

(4) The amount payable every month for households under subregulation (1) shall be the base premium calculated using statistical data and actuarial models and guided by the benefits packages set out in the Second, Third and Fourth Schedules to these Regulations and shall be payable on an annual basis.

(5) The Cabinet Secretary responsible for matters relating to the National Treasury shall deduct and remit the contribution to the Authority on behalf of the Cabinet Secretary responsible for matters relating to social protection for the national government within nine days from the date when the annual contribution of the beneficiaries is due.

(6) The County Executive Committee member responsible for matters relating to the County Treasury shall deduct and remit the contribution to the Authority on behalf of the county government within nine days from the date when the annual contribution of the beneficiaries is due.

20. Contributions for persons under lawful custody

(1) The Cabinet Secretary responsible for matters relating to correctional services shall be liable as a contributor for persons in lawful custody including children in conflict with the law and persons under police custody pursuant to section 27(2)(d) of the Act.

(2) The amount payable every month for persons under lawful custody under subregulation (1) shall be the base premium calculated using statistical data and actuarial models and guided by the benefits packages set out in the Second, Third and Fourth Schedules to these Regulations and shall be payable on an annual basis.

(3) The Cabinet Secretary responsible for matters relating to the National Treasury shall deduct and remit the contribution to the Authority on behalf of Cabinet Secretary responsible for matters relating to correctional services within nine days from the date when the annual contribution of the beneficiaries is due.

21. Means testing

(1) The Authority shall collect data from households for the purposes of conducting means testing.

(2) In collecting data pursuant to subregulation (1), the Authority shall use the means testing instrument developed by the Cabinet Secretary in collaboration with the Cabinet Secretary responsible for matters relating to social protection.

(3) The data collected from households shall be based on various socio-economic aspects including—

(a) housing characteristics;

(b) access to basic services; and

(c) household composition and characteristics.

(4) The data collected shall be used to determine and estimate the household income for the purposes of the payment of the premiums set out in regulations 18 and 19.

(5) The Authority shall from time to time conduct means testing reviews on households whose income is not derived from salaried employment and on households in need of financial assistance pursuant to section 27 (2)(b) and (c).

(6) The Authority shall conduct means testing using the formula set out in the Fifth Schedule to these Regulations.

22. Obligations of an employer

(1) An employer shall deduct the contribution of a salaried contributor and submit the contribution to the Authority on behalf of the employee at the rate provided in regulation 17 by the ninth day of each month.

(2) An employer shall inform the Authority of any changes in the employment status of its employees.

(3) Where an employer terminates the employment of a salaried contributor, the employer shall notify the Authority within thirty days of the termination and remit the final contribution of the employee.

(4) The obligations of an employer in relation to a salaried contributor whose services have been terminated shall cease immediately the Authority receives the notification under subregulation (3).

(5) For purposes of this Regulation, an employer shall register with the Authority using Form 5 set out in the First Schedule to these Regulations.

(6) The application for registration under subregulation (5) shall be accompanied by documents including—

(a) a copy of the certificate of registration or incorporation from the relevant authorized body; and

(b) a copy of the PIN Certificate of the employer issued by the Kenya Revenue Authority.

23. Payment of penalty

The Authority shall notify a contributor of any penalty imposed under the Act in relation to the payment of contributions and the manner of remitting such penalty to the Authority.

24. Statement of account

(1) The Authority shall provide a statement of account to a contributor upon request within seven days from the date of the request.

(2) The statement of account shall contain information on the contribution by a contributor including —

(a) the list of beneficiaries under the cover of the contributor;

(b) the benefits paid out and balance of benefits;

(c) the status of contributions; and

(d) penalties imposed, if any.

(3) The Authority shall ensure that the statement of account is updated on a regular basis.

25. Payments out of the Social Health Insurance Fund

(1) For purposes of expenditure out of the Social Health Insurance Fund, a healthcare provider or health facility shall lodge a claim with the Claims Management Office for the payment of healthcare services provided to the beneficiaries of the Social Health Insurance Fund.

(2) The Authority shall pay the claims lodged based on the tariffs prescribed pursuant to section 32 (2) of the Act.

(3) The claim lodged under this regulation shall be processed in the manner set out in Part VIII of these Regulations.

Part IV – IMPLEMENTATION OF THE EMERGENCY, CHRONIC AND CRITICAL ILLNESS FUND

26. Purpose of the Emergency, Chronic and Critical Illness Fund

The Emergency, Chronic and Critical Illness Fund shall be used to—

(a) ensure access to quality emergency services and critical care;

(b) ensure access to quality treatment of chronic and critical illnesses;

(c) finance the provision of emergency, chronic and critical medical care; and

(d) pay healthcare providers and health facilities for the provision of emergency services based on the tariffs prescribed pursuant to section 32 (2) of the Act.

27. Transition to the Emergency, Chronic and Critical Illness Fund

(1) A beneficiary under the Social Health Insurance Fund shall be entitled to the benefits under the Emergency, Chronic and Critical Illness Fund.

(2) For purposes of benefitting under the Emergency, Chronic and Critical Illness Fund, the beneficiary referred to under subregulation (1), shall transition from the Social Health Insurance Fund to the Emergency, Chronic and Critical Illness Fund after depletion of his or her benefits in the benefits package under the Social Health Insurance Fund.

(3) A beneficiary suffering from a chronic illness shall, upon exhaustion of his or her benefits under the Social Health Insurance Fund, access treatment for the chronic illness from an empanelled and contracted healthcare provider or health facility in accordance with the benefits package set out in the Fourth Schedule to these Regulations, to be paid for under the Emergency, Chronic and Critical Illness Fund.

(4) Despite the provisions of subregulation (2), every person shall be entitled to access emergency treatment in accordance with the benefits package set out in the Fourth Schedule to these Regulations.

(5) For the purposes of this regulation, emergency medical treatment shall include—

(a) pre-hospital care;

(b) stabilization of the health status of the individual; or

(c) arranging for referral in cases where the healthcare provider or health facility of first call does not have facilities or capability to stabilize the health status of the victim.

28. Benefits under the Emergency, Chronic and Critical Illness Fund

(1) A beneficiary shall be entitled to the benefits under the benefits package of emergency services set out in the Fourth Schedule to these Regulations.

(2) Despite the provisions of subregulation (1), emergency services shall include the management of—

(a) cardiac or pulmonary arrest;

(b) major trauma including burns and any serious injuries that are life-changing and could result in death or serious disability including head injuries, severe wounds and multiple fractures;

(c) shock states including trauma, haemorrhagic, septic shock, dehydration, hypotension and significant tachycardia or bradycardia;

(d) unconscious or altered level of consciousness or confusion;

(e) severe respiratory distress;

(f) seizures or status epilepticus;

(g) acute coronary syndrome or chest pain;

(h) acute cardiovascular accidents or stroke;

(i) pregnancy related complications; and

(j) ambulance and evacuation services.

29. Payments out of the Emergency, Chronic and Critical Illness Fund

(1) For purposes of expenditure out of the Emergency, Chronic and Critical Illness Fund, a healthcare provider or health facility shall lodge a claim with the Claims Management Office for the payment —

(a) of healthcare services provided in the treatment and management of chronic and critical illnesses provided to the beneficiaries of the Social Health Insurance Fund; or

(b) for the provision of emergency services in accordance with the benefits package.

(2) The Authority shall pay the claims lodged based on the tariffs prescribed pursuant to section 32(2) of the Act:

Provided that the payments by the Authority for the provision of emergency services shall be made to a licensed and certified healthcare provider or health facility in accordance with the benefits package.

(3) The claim lodged under this regulation shall be processed in the manner set out in Part VIII of these Regulations.

30. Emergency medical care code

The Authority shall inform the beneficiaries of the Social Health Insurance Fund of the national single short toll-free emergency medical care code developed by the Cabinet Secretary for purposes of handling medical emergencies.

Part V – EMPANELMENT AND CONTRACTING

31. Empanelment

(1) The Authority shall pay claims to empanelled and contracted healthcare providers or health facilities.

(2) Despite the provisions of subregulation (1), the Authority may pay claims to a healthcare provider or health facility that provides emergency treatment in accordance with the benefits package:

Provided that the healthcare provider or health facility has been licensed and certified.

(3) The Authority shall empanel all licensed and certified healthcare providers and health facilities in the list submitted to the Authority from time to time by the relevant body responsible for accreditation for quality of care.

(4) The Authority shall continuously empanel healthcare providers and health facilities.

32. Contracting healthcare providers and health facilities

(1) The Authority shall contract healthcare providers and health facilities under the Act in accordance with the provisions of the Public Procurement and Assets Disposal Act (Cap. 412C).

(2) An empaneled and contracted healthcare provider or health facility shall provide the healthcare services set out in the Second, Third or Fourth Schedules to these Regulations, as applicable, within or outside Kenya.

(3) In providing the healthcare services referred to under subregulation (2), the healthcare provider or health facility shall—

(a) provide healthcare services to beneficiaries in accordance with—

(i) the Act;

(ii) these Regulations;

(iii) the terms of the contract with the Authority; and

(iv) the quality standards set by the Ministry of health;

(b) use and verify the data provided by the Authority in relation to beneficiaries in the provision of the healthcare services;

(c) provide healthcare services to a beneficiary based on the benefits package applicable to the beneficiary;

(d) administer healthcare services within the limits provided in the benefits package as may be applicable to a beneficiary;

(e) maintain and improve the standards of healthcare services that it provides at all times;

(f) provide healthcare services that are medically necessary and of therapeutic value to a beneficiary;

(g) not encourage or influence a beneficiary to obtain a healthcare service that is not medically necessary in the circumstances of the beneficiary;

(h) provide healthcare services in a timely manner, as appropriate in the circumstances;

(i) inform the beneficiary and the Authority where the financial limit set by the Authority is close to being exceeded in any particular case provided that the healthcare provider or health facility shall not withhold the treatment of a beneficiary for financial reasons in case of accident and emergency services;

(j) ensure that the persons employed by the healthcare provider or health facility comply with the Act, these Regulations and the laws and policies issued by the relevant regulatory authorities in relation to healthcare services;

(k) ensure its employees or agents shall not, in the performance of the obligations of the healthcare provider or health facility under the contract with the Authority, engage in any corrupt practice or fraudulent practice;

(l) ensure the availability of the relevant healthcare professionals and administrative officers with the relevant skills to appropriately provide quality healthcare services to beneficiaries;

(m) where the healthcare provider or health facility does not have capacity to treat any beneficiary, refer the beneficiary to a contracted healthcare provider or health facility;

(n) ensure that it has adequate equipment including computers and mobile phones with working internet connection at all times for purposes of verifying the details of beneficiaries and their respective account status on the Centralized Digital Platform;

(o) maintain an adequate system for the collection, processing, maintenance, storage, retrieval and distribution of beneficiaries' records;

(p) retain the records of beneficiaries in a readily accessible format;

(q) provide healthcare services to all beneficiaries with the same degree of care and skill without discriminating against any beneficiary on any grounds provided under Article 27(4) of the Constitution; and

(r) obtain and maintain an adequate insurance cover during the contractual period with the Authority in respect of public liability, professional liability and insurance for the healthcare provider or health facility, its ambulances and all other equipment of the health facility or healthcare provider.

33. Onboarding healthcare providers and health facilities

Where a healthcare provider or health facility is contracted in accordance with the Act and these Regulations, the healthcare provider or health facility shall be onboarded into the Centralized Digital Platform maintained by the Authority.

34. Termination of contract

(1) The Authority shall terminate the contract of a healthcare provider or health facility where the healthcare provider or health facility has failed to adhere to the criteria and standards under regulation 32(3) or has breached the terms of its contract with the Authority.

(2) The Authority may, at any time, terminate the contract with a healthcare provider or health facility where the Authority establishes that the healthcare provider or health facility—

(a) is unable to provide the contracted service;

(b) billed for a service that is not required by a beneficiary;

(c) billed for a service that is not covered within the level of care of the healthcare provider or health facility;

(d) billed for a service that is not within the scope of professional practice of the healthcare provider;

(e) billed a patient for services or medicine not provided to the patient;

(f) falsified or altered any information with intent to defraud the Authority; or

(g) submitted separate claims to the Authority for the same service.

(3) Where the Authority has resolved to terminate a contract under these Regulations, the Authority shall within seven days of making that decision—

(a) issue a notice of termination of contract to the healthcare provider or health facility before termination of the contract; and

(b) provide a reasonable transition period to ensure continued service delivery to beneficiaries.

(4) Upon termination of the contract, the Authority shall publish on its website and in the *Gazette* the healthcare providers or health facilities whose contracts have been terminated.

(5) The Authority shall not purchase healthcare services from any healthcare provider or health facility whose contract has been terminated.

(6) A healthcare provider or health facility aggrieved by the Authority's decision to terminate its contract may lodge an appeal with the Dispute Resolution Tribunal.

35. Quality assurance

The Authority shall from time to time conduct quality assurance surveillance in claims management to ensure compliance with the provisions of the Act and these Regulations.

36. Healthcare provider or health facility outside Kenya

(1) A healthcare provider or health facility outside Kenya shall be contracted by the Authority where the healthcare provider or health facility is—

(a) accredited by the relevant authority in its country of origin and recognized by the relevant authority in Kenya;

(b) linked to an empaneled and contracted health facility in Kenya that will follow up on the treatment and management of a beneficiary upon his or her return to Kenya; and

(c) providing a healthcare service that is not available in Kenya.

(2) The Benefits Package and Tariffs Advisory Panel shall, at the beginning of each financial year, generate a list of healthcare services to be accessed outside Kenya by the beneficiaries of the Social Health Insurance Fund.

(3) The Authority shall, guided by the list in subregulation (2), identify and contract a panel of healthcare providers and health facilities to offer the specified healthcare services outside Kenya based on the tariffs prescribed pursuant to section 32(2) of the Act.

(4) The Authority shall maintain the necessary records on services provided by healthcare providers and health facilities outside Kenya in accordance with the Digital Health Act (Cap. 241B) and the Data Protection Act (Cap. 411C).

(5) The Authority shall, based on the records in subregulation (4), advise the Cabinet Secretary on matters relating to treatment outside Kenya.

37. Obligations of a healthcare provider or health facility

An empanelled and contracted healthcare provider or health facility shall—

(a) provide quality and safe healthcare services;

(b) subscribe to a quality improvement certification program;

(c) assess and review healthcare services for purposes of improving the quality and safety of the healthcare services provided;

(d) establish and maintain the necessary infrastructure for purposes of linking the administration of benefits and submission of claims to the Centralized Digital Platform of the Authority;

(e) maintain accurate and orderly medical records of the beneficiaries in respect to the services provided;

(f) prepare and avail a statement containing information in relation to claims for any healthcare services rendered; and

(g) comply with any requests made by the Authority.

Part VI – BENEFITS

38. Identification of beneficiaries at the point of access

A beneficiary seeking to access a benefit from an empanelled and contracted healthcare provider or health facility shall provide the following documents for purposes of identification—

(a) in the case of a contributor—

(i) their identification document and their biometrics; or

(ii) where the biometric identification required under (i) is not available, the contributor's identification document and the one-time password;

(b) in the case of a spouse—

(i) the identification document of the spouse, the number of the identification document of the contributor and the biometrics of the spouse; or

(ii) where the biometric identification required under subparagraph (i) is not available, the identification document for the spouse, the number of the identification document of the contributor and the one-time password;

(c) in the case of a child who is below seven years, the contributor's identification document and the one-time password or biometrics of the parent or guardian;

(d) in the case of a child who is seven years and above—

(i) the number of the contributor's identification document and the biometrics of the child; or

(ii) where the biometric identification required under subparagraph (i) is not available, the number of the contributor's identification document and the one-time password;

(e) in the case of a beneficiary who has not attained the age of twenty-five years, is undergoing a full-time course at a university, college, school or other educational institution or serving under articles of an indenture with a view to qualifying in a trade or profession and is not in receipt of any income other than a scholarship, bursary or other similar grant or award—

(i) the beneficiary's identification document and the number of the contributor's identification document and the biometrics of the beneficiary; or

(ii) where the biometric identification required under subpragraph (i) is not available, the beneficiary's identification document and the number of the contributor's identification document and the one-time password;

(f) in the case of a person with disability and is wholly dependent on and living with a contributor—

(i) the identity document of the person with disability, the number of the contributor's identification document and the biometrics of the beneficiary; or

(ii) where biometric identification required under subparagraph(i) is not available, the identity document of the person with disability, the number of the contributor's identification document and the one-time password.

39. Treatment outside Kenya

(1) A beneficiary may access treatment outside Kenya where the—

(a) contributions in favour of the beneficiary comply with section 27(1) and (2) of the Act and these Regulations;

(b) treatment sought is not available in Kenya; and

(c) treatment sought is being provided by a healthcare provider or health facility contracted by the Authority.

(2) A beneficiary who requires treatment outside Kenya shall request the Authority to authorize the treatment by providing—

(a) a referral for overseas treatment from the treating doctor or consultant submitted online in Form 2 set out in the First Schedule to these Regulations; and

(b) a duly filled referral form prescribed under the Medical Practitioners and Dentists Act (Cap. 253).

(3) The referral under subregulation (2)(a) shall contain—

(a) the name of the receiving healthcare provider or health facility;

(b) the diagnosis of the beneficiary including all results from the tests done by the treating doctor or consultant;

(c) the medical history of the beneficiary including any relevant medical conditions including allergies and recent or related diseases;

(d) clear and concise medical reasons for the referral; and

(e) the signature of the treating doctor or consultant.

(4) The Claims Management Office shall review the request and shall confirm that—

(a) the healthcare service for which the beneficiary is being referred is not available in Kenya;

(b) the referral is to a healthcare service provider or health facility that is contracted by the Authority;

(c) based on peer review undertaken by the Claims Management Office, the referral is medically necessary;

(d) the financial implication of the healthcare service sought outside Kenya is within the limits of the benefits package; and

(e) the treatment sought is not unproven, experimental or an unconventional therapy.

(5) Where the Authority approves the request, the Authority shall undertake to pay for the treatment sought at the health facility outside Kenya based on the tariffs prescribed pursuant to section 32 (2) of the Act.

40. Benefits packages under the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund

(1) A beneficiary shall be entitled to the benefits under the benefits packages under the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund set out in the Second, Third and Fourth Schedules to these Regulations.

(2) The benefits package under the Primary Healthcare Fund shall comprise of preventive, promotive, curative, rehabilitative and palliative health services provided at the level 2, 3 and 4 health facilities.

(3) The benefits package under Social Health Insurance Fund shall comprise of integrated preventive, promotive, curative, rehabilitative and palliative health services provided at the level 4, 5 and 6 health facilities under the Social Health Insurance Fund.

(4) The benefits package under the Emergency, Chronic and Critical Illness Fund shall comprise of—

(a) emergency services that shall be provided by a licensed and certified healthcare provider or health facility in accordance with the benefits package;

(b) critical care services upon depletion of the benefits in the benefits package of the Social Health Insurance Fund; and

(c) treatment and management of chronic illnesses beyond the benefits in the benefits package of the Social Health Insurance Fund.

41. The Benefits Package and Tariffs Advisory Panel

(1) In furtherance of section 31(1) of the Act, the benefits packages referred to under regulation 40(1) shall be reviewed every two years.

(2) To facilitate the review under subregulation (1), the Cabinet Secretary shall establish a Benefits Package and Tariffs Advisory Panel to advice the Cabinet Secretary and the Authority on the benefits packages under regulation 40(1).

(3) The Benefits Package and Tariffs Advisory Panel shall be based at a local public university appointed by the Cabinet Secretary.

(4) The Benefits Package and Tariffs Advisory Panel shall consist of—

(a) a person nominated by the local public university who shall be the chairperson of the Panel;

(b) the Director-General for Health;

(c) a person from the National Treasury nominated by the Principal Secretary in the Ministry responsible for matters relating to finance;

(d) one person, who is an actuary, nominated by the Authority;

(e) two persons nominated by the Council of Governors, one of whom shall be a clinician;

(f) one person nominated by the Health Non-Governmental Organizations' Network (HENNET) to represent civil society organizations;

(g) one person nominated by the development partners involved in health matters;

(h) one person nominated by the consortium of healthcare providers; and

(i) two persons, a health economist and an epidemiologist, nominated by the Cabinet Secretary.

(5) A person shall be eligible for appointment as a Chairperson of the Benefits Package and Tariffs Advisory Panel if the person—

(a) is a Kenyan citizen;

(b) holds a minimum of a Master's degree from a university recognized in Kenya;

(c) has knowledge and experience of not less than ten years in medicine, epidemiology, health economics or health financing; and

(d) meets the requirements of Chapter Six of the Constitution.

(6) A person shall be eligible for appointment as a Member of the Benefits Package and Tariffs Advisory Panel if the person—

(a) is a Kenyan citizen;

(b) holds a minimum of a Master's degree from a university recognized in Kenya;

(c) has knowledge and experience of not less than five years in medicine, epidemiology, health economics or health financing; and

(d) meets the requirements of Chapter Six of the Constitution.

(7) The members of the Benefits Package and Tariffs Advisory Panel shall hold office for a period of three years and shall be eligible for reappointment for one further term of three years.

(8) The office of the Chairperson or Member of the Benefits Package and Tariffs Advisory Panel shall become vacant if the member—

(a) dies;

(b) resigns;

(c) is unfit by reason of mental or physical infirmity to perform the duties of his office;

(d) is convicted of an offence and is sentenced to a term of imprisonment for a period of six months or more;

(e) has failed to attend at least three consecutive meetings of the Panel; or

(f) is removed from office on grounds of—

(i) gross violation of the Constitution or any other written law; or

(ii) gross misconduct or misbehaviour.

(9) The Benefits Package and Tariffs Advisory Panel shall meet at least twice every year.

(10) Unless a unanimous decision is reached, a decision on any matter before the Benefits Package and Tariffs Advisory Panel shall be by the resolution of a majority of all the members present and voting at the meeting.

(11) The quorum for the meetings of the Benefits Package and Tariffs Advisory Panel shall be five members.

(12) The Panel may co-opt any person whose knowledge and expertise may be necessary for the effective performance of the functions of the Panel.

42. Functions of the Benefits Package and Tariffs Advisory Panel

The Benefits Package and Tariffs Advisory Panel shall advise the Cabinet Secretary on the—

(a) review and updating of the existing benefits package in accordance with the applicable health technology assessment;

(b) review and updating of the existing tariffs in accordance with the applicable health technology assessment; and

(c) identification and definition of the health interventions that are not available in Kenya.

43. Secretariat of the Benefits Package and Tariffs Advisory Panel

(1) The Benefits Package and Tariffs Advisory Panel shall be supported by a joint secretariat with representation from the Ministry of health and the local public university.

(2) The secretariat shall provide technical assistance and secretarial support to the Benefits Package and Tariffs Advisory Panel.

(3) The secretariat constituted under subregulation (1) shall have knowledge and expertise in medicine, health economics and epidemiology.

44. Designing a benefits package

(1) The process of designing and reviewing a benefits package shall be—

(a) based on research;

(b) transparent;

(c) consultative; and

(d) inclusive.

(2) The process shall involve—

(a) proposal of interventions;

(b) selection of interventions;

(c) assessment of interventions;

(d) appraisal of interventions; and

(e) decision making on the intervention.

(3) The process in subregulation (2) shall be guided by considerations including—

(a) clinical effectiveness, safety and quality of the intervention;

(b) burden of disease;

(c) incidence or occurrence of diseases;

(d) the population;

(e) equity;

(f) cost-effectiveness;

(g) budgetary impact and affordability;

(h) feasibility of implementation of the intervention;

(i) catastrophic health expenditure;

(j) access to healthcare; and

(k) congruence with existing priorities, policies and guidelines in the health sector.

45. Proposal of interventions

(1) The relevant stakeholders including the Authority, policy makers, the academia, members of the public, health professional associations, civil society organizations involved in matters of health, the Kenya Medical Supplies Authority and the county governments may propose interventions for inclusion in the benefits packages under regulation 40(1).

(2) Proposals for interventions under subregulation (1) shall be made on a continuous basis to the Secretariat of the Benefits Package and Tariffs Advisory Panel using the benefit package intervention proposal Form 4 set out in the First Schedule to these Regulations.

(3) The proposals made shall be received by the secretariat of the Benefits Package and Tariffs Advisory Panel through various channels including—

(a) direct requests by the Panel to key stakeholders;

(b) scheduled stakeholder meetings or forums; or

(c) digital platforms including a web-based platform and a designated email.

46. Selection of interventions

(1) A selection working group formed by the Cabinet Secretary shall select an intervention within a period of one month.

(2) The selection working group shall using the considerations under regulation 45(3) review the interventions proposed and select the interventions that shall be subjected to assessment.

(3) The selection working group shall meet at least twice every year.

47. Assessment of interventions

(1) The selected interventions will be assessed based on the considerations under regulation 44(3).

(2) The Benefits Package and Tariffs Advisory Panel shall undertake scientific assessment of the selected interventions within a period of six months.

(3) Despite the provisions of subregulation (2), the Benefits Package and Tariffs Advisory Panel may request for an extension of the assessment period.

(4) The Benefits Package and Tariffs Advisory Panel shall assign an academic and research institution to undertake the scientific assessment of the selected interventions using a standard methodology developed by the Cabinet Secretary and adopted by the Benefits Package and Tariffs Advisory Panel.

48. Appraisal of interventions

(1) The Benefits Package and Tariffs Advisory Panel shall, guided by the considerations in regulation 44(3), appraise the findings of the interventions assessed under regulation 47 within a period of two months.

(2) On conclusion of the appraisal, the Benefits Package and Tariffs Advisory Panel shall make a recommendation on—

(a) the inclusion of the proposed intervention in the benefits package; and

(b) where it has recommended inclusion of an intervention, the manner in which the intervention may be included in the benefits package.

49. Decision making on interventions

(1) The Benefits Package and Tariffs Advisory Panel shall submit its recommendation to the Cabinet Secretary for approval.

(2) In making a decision on the inclusion of the recommended intervention in a benefits package, the Cabinet Secretary shall consult the Authority.

(3) Where an intervention is rejected by the Cabinet secretary, the intervention may be reconsidered where additional information is provided to the Benefits Package and Tariffs Advisory Panel.

Part VII – TARIFFS

50. Rates payable

All benefits payable to a healthcare provider or health facility under the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund shall be paid based on the tariffs prescribed pursuant to section 32(2) of the Act.

51. Applicable tariffs

(1) In furtherance of section 32(2) of the Act, the tariffs applicable to the benefits packages referred to under regulation 40(1) shall be determined by the Cabinet Secretary in consultation with the Board upon the advice of the Benefits Package and Tariffs Advisory Panel.

(2) The process of determining the applicable tariffs shall involve—

(a) data collection and analysis of benefits;

(b) proposal of a tariff;

(c) engagement with stakeholders on the proposed tariff;

(d) recommendation of the proposed tariff to the Cabinet Secretary; and

(e) approval and gazettement of the set tariff.

(3) The process in subregulation (2) shall be guided by considerations including—

(a) evidence on the cost of intervention;

(b) evidence on actuarial analysis; and

(c) budgetary impact and affordability of benefits.

(4) The tariff determined may be reviewed by the Benefits Package and Tariffs Advisory Panel every two years or as may be determined by the Cabinet Secretary in consultation with the Board.

(5) The review under subregulation (4) shall be informed by considerations including—

(a) advancement in technology providing more efficient health interventions;

(b) economic factors significantly causing alteration in the cost of healthcare;

(c) change in the disease burden;

(d) changing dynamics in the market and population health risk; and

(e) feedback from healthcare providers.

52. Data collection and analysis

(1) The Benefits Package and Tariffs Advisory Panel shall undertake data collection and analysis for the purposes of determining the unit cost, population need and the total cost of the interventions in the benefits package.

(2) In undertaking the data collection and analysis under subregulation (1), the Benefits Package and Tariffs Advisory Panel shall—

(a) collect data from primary data, secondary data and evidence and operational data;

(b) analyse the collected data on the costs of interventions; and

(c) conduct an actuarial analysis of the population health risks and financial implications of the interventions in the benefits package.

(3) The Benefits Package and Tariffs Advisory Panel may assign the data analysis to an academic and research institution.

53. Proposal of a tariff

(1) The Benefits Package and Tariffs Advisory Panel shall, guided by the finding of the data collection and analysis, propose a tariff.

(2) The tariff shall be a percentage adjustment, upwards or downwards, of the base cost.

(3) The adjustment in tariff shall be guided by—

(a) budget impact and affordability; and

(b) market trends.

54. Engagement on proposed tariff

The Benefits Package and Tariffs Advisory Panel shall engage stakeholders including the Authority, healthcare providers, actuaries and other relevant experts on the tariff proposed in regulation 53(1).

55. Recommendation of tariff

(1) The Benefits Package and Tariffs Advisory Panel shall, taking into consideration the views of the stakeholder engagement under regulation 54, and make recommendations on the tariff.

(2) The Benefits Package and Tariffs Advisory Panel shall submit its recommendations to the Cabinet Secretary for approval.

56. Approval of the tariff

(1) On receipt of the recommendations of the Benefits Package and Tariffs Advisory Panel, the Cabinet Secretary shall either—

(a) approve the tariff; or

(b) reject the tariff with reasons.

(2) Where the recommended tariff is rejected, the Benefits Package and Tariffs Advisory Panel shall consider the reasons for rejection and subject the tariff to the process provided in regulation 51(2).

Part VIII – CLAIMS SETTLEMENT

57. Benefits payable

(1) The Authority may, in respect of a healthcare service provided under the Act, pay benefits to—

(a) an empanelled and contracted healthcare provider or health facility within or outside Kenya; and

(b) any healthcare provider or health facility that has been licensed and certified to provide emergency services in accordance with the benefits package of the Emergency, Chronic and Critical Illness Fund.

(2) All benefits under the Act and these Regulations shall be paid where valid claims in respect of a beneficiary of the Social Health Insurance Fund are lodged and approved for payment by the Authority:

Provided that a registered member of the Social Health Insurance Fund shall receive healthcare services at a primary healthcare facility paid for under the Primary Health Care Fund.

(3) Despite the provisions of subregulation (2), the benefits under the Act shall be paid to a healthcare provider or health facility that provides emergency services to any person in accordance with the benefits package of the Emergency, Chronic and Critical Illness Fund.

(4) All claims shall be lodged, reviewed, processed, validated, appraised and paid under the Act and these Regulations through the Centralized Digital Platform.

58. Lodging of claims

(1) A healthcare provider or health facility shall, within seven days from the date of discharge of the patient, lodge a claim to the Claims Management Office or a medical insurance provider and claim settling agent, where applicable, for review and processing of the claim.

(2) The medical insurance provider and claim settling agent referred to in subregulation (1) shall—

(a) be registered by the Insurance Regulatory Authority as a medical insurance provider and a claim settling agent;

(b) have a valid licence issued by the Insurance Regulatory Authority;

(c) have at least two qualified and experienced medical doctors;

(d) be registered with the Office of the Data Commissioner established under the Data Protection Act (Cap. 411C); and

(e) comply with the provisions of the Data Protection Act (Cap. 411C) and the Digital Health Act (Cap. 241B).

(3) The medical insurance provider and claim settling agent referred to in subregulation (1) shall be procured in accordance with the provisions of the Public Procurement and Assets Disposal Act (Cap. 412C).

(4) The claim under subregulation (1) shall be made in Form 3 set out in the First Schedule to these Regulations and shall contain information including—

(a) the Social Health Authority number of the patient;

(b) the hospital registration number of the patient;

(c) the name, date of birth, gender, address and contact details of the patient;

(d) the clinical details of the patient; and

(e) amount claimed.

59. Processing of claims

(1) On receipt of claims lodged, the Claims Management Office or the medical insurance provider and claim settling agent shall review the claims and where—

(a) the claim is approved, submit the claim to the Authority for payment within ninety days from the date of the approval of the claim;

(b) the claim is incomplete or contains errors, return the claim to the healthcare provider or health facility with reasons for amendment of the claim; or

(c) the claim is rejected, notify the healthcare provider or health facility of the rejection and the reasons for the rejection immediately but not later than fourteen days from the date of the rejection.

(2) The Authority may review and make an adjustment if a healthcare provider or health facility received payment from the Authority with respect to a claim and the healthcare provider or health facility subsequently requests an adjustment to be made where there is an error in respect of the amount paid.

(3) In the review and processing of claims, the Claims Management Office shall—

(a) be guided by the tariffs prescribed pursuant to section 32(2) of the Act and these Regulations; and

(b) develop formularies to be used to inform benefits packages development, mapping diagnostics, costing and tariff development.

[L.N. 147 of 2024, r. 7, L.N. 55 of 2025, r. 7.]

60. Pre-authorization

(1) A healthcare provider or health facility shall send an online pre-authorization request to the Authority for the specialized healthcare services as determined by the Authority.

(2) The request shall be accompanied by information including—

(a) the details of the beneficiary;

(b) the details of the healthcare provider or health facility; and

(c) the details of healthcare service required.

(3) The Claims Management Office shall review the request and make a decision on the request immediately but not later than seventy-two hours of receipt of the request for pre-authorization and notify the beneficiary of its decision:

Provided that pre-authorization shall not apply for emergency services.

(4) The Claims Management Office may, conduct peer review, during the consideration of the pre-authorization requests.

(5) The Authority shall review the list of specialized healthcare services from time to time.

61. Adjudication of claims and pre-authorization

(1) The Claims Management Office may, in considering pre-authorization requests and any claims that it deems inappropriate, constitute an independent panel to adjudicate such pre-authorization requests and claims and check whether they are complaint.

(2) In conducting the adjudication, the Claims Management Office shall ensure objectivity of the process by—

(a) concealing the identity of the panel members;

(b) anonymizing the identity of the patient;

(c) anonymizing the identity of the doctor; and

(d) anonymizing the identity of the healthcare facility.

(3) Where the independent panel finds that—

(a) the pre-authorization request is not compliant, the pre-authorization request shall be rejected by the Authority;

(b) before the Authority has effected any payment, the claim is not complaint, the healthcare provider or health facility shall not be paid for the claim; or

(c) after the Authority has effected a payment, the claim is not complaint, the healthcare provider or health facility shall be requested to refund the monies paid to it in respect of that claim.

(4) The healthcare provider or health facility aggrieved by the decision of the Authority in this regulation may, with new evidence, request for a review of the decision by the Authority within seven working days.

62. Zones

(1) Where the Authority has contracted a medical insurance provider and claim settling agent, the medical insurance provider and claim settling agent shall manage the claims in zones.

(2) The zones shall be clustered based on the counties specified in the First Schedule to the Constitution and the cluster shall be based on—

(a) population size;

(b) population density and demographic trends;

(c) administration costs;

(d) efficiency;

(e) caseload of claims;

(f) disease burden;

(g) geographical size of the county; and

(h) the estimated claims as informed by existing health records and data.

(3) A medical insurance provider and a claim settling agent or a consortium of the medical insurance provider and a claim settling agent may not be assigned more than three zones.

(4) The Authority may terminate the contract of a medical insurance provider and claim settling agent where—

(a) the medical insurance provider and claim settling agent becomes insolvent as defined in the Insolvency Act (Cap. 53);

(b) the registration of the medical insurance provider and claim settling agent has been cancelled;

(c) the licence of the medical insurance provider and claim settling agent has been revoked; or

(d) the medical insurance provider and claim settling agent engages in fraudulent activities.

(5) Where the Authority has terminated the contract of a medical insurance provider and claim settling agent, the medical insurance provider and claim settling agent may appeal to the Dispute Resolution Tribunal established under section 44 of the Act.

63. Limitations in the payment of claims

The Authority shall not pay out of the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund, any claims arising from—

(a) *deleted by L.N. 55 of 2025, r. 8;*

(b) any revoked or suspended healthcare provider or health facility;

(c) any unauthorised referrals;

(d) healthcare services that are not included in the benefits package;

(e) all costs by which the annual limits of a beneficiary in respect of the relevant healthcare services are exceeded, for any treatment; and

(f) all costs related to interest charged arising out of delays in reimbursement of claims.

[L.N. 147 of 2024, r. 8, L.N. 55 of 2025, r. 8.]

Part IX – GENERAL PROVISIONS

64. Centralized Digital Platform

(1) The Authority shall implement and maintain a Centralized Digital Platform, with a minimum enterprise resource planning functionality, that shall handle all the processes and services at the Authority.

(2) Any processing of data for any purpose under the Act and these Regulations shall be done through the Centralized Digital Platform.

(3) In furtherance of subregulation (2), the Platform shall perform functions including to—

(a) provide for the digital payment of contributions in a simple, accurate and verifiable manner;

(b) generate statement of accounts to be made available upon request to beneficiaries on the status of their membership, contributions, usage of their contributions and pre-authorization requests;

(c) provide for the registration of members of the Social Health Insurance Fund under the Act and these Regulations;

(d) assign Social Health Authority numbers to registered members of the Social Health Insurance Fund;

(e) identify the registered members of the Social Health Insurance Fund at the point of access of services;

(f) review and process the claims lodged under the Act and these Regulations;

(g) process pre-authorizations;

(h) provide for the follow up of claims lodged by healthcare providers and health facilities;

(i) provide for the contracting of healthcare providers and health facilities; and

(j) provide for the payment of empanelled and contracted healthcare providers and health facilities for the provision of healthcare services under the Act.

(4) The staff of the Authority or any other person who, with the authorization of the Authority, processes information under the Centralized Digital Platform shall treat the information that comes to their knowledge as confidential.

(5) The Authority shall conduct a Data Protection Impact Assessment of the Centralized Digital Platform and document the necessary mitigation measures in accordance with the provisions of the Data Protection Act (Cap. 411C).

(6) The Centralized Digital Platform referred to under subregulation (1) shall be interoperable with the Comprehensive Integrated Health Information System established under section 15 of the Digital Health Act (Cap. 241B) and in accordance with approved standards.

65. Access to national databases

The Authority shall utilize the existing relevant government databases in the performance of its functions.

66. Duties of a person at registration

A person applying for registration under the Act and these Regulations shall—

(a) provide correct information to the Authority during registration;

(b) inform the Authority of any errors in their information;

(c) provide all particulars requested by the Authority;

(d) permit his or her fingerprints and other biometric data to be taken; and

(e) furnish the Authority with documents requested including such documentary proof of identification.

67. Duties of members of the Social Health Insurance Fund

A person registered to the Social Health Insurance Fund shall—

(a) provide correct information to the Authority;

(b) inform the Authority of any errors in their information;

(c) notify the Authority of the need to update their particulars whenever there is any change in any particulars or in their household;

(d) report any fraudulent activity that comes to his or her knowledge; and

(e) pay their contributions as required by the Act.

68. Obligations of the Authority in processing of information

(1) A person registered by the Authority has a right to—

(a) be informed of the manner in which their personal data may be utilized;

(b) access their personal data;

(c) object to the sharing of all or part of their personal data without his or her consent;

(d) correction of any false or misleading data about them without delay; and

(e) obtain a copy of the particulars of his or her personal data held by the Authority.

(2) Personal data collected pursuant to the Act and these Regulations shall not be—

(a) used for unlawful purpose; or

(b) disclosed except with the prior consent of the individual to whom such personal data relates.

(3) The Authority shall implement reasonable and appropriate security measures to ensure that personal data held by the Authority is protected against unauthorized access, use or disclosure.

69. Public engagement

The Authority shall, at least every five years, convene fora through meetings, colloquiums, webinars, workshops or such other consultative platforms for purposes of—

(a) facilitating consultations, co-ordination and collaboration in the implementation of the Act and these Regulations;

(b) making recommendations aimed at improving the furtherance of the objects of the Act and these Regulations;

(c) creating awareness on any matter under the Act and these Regulations; and

(d) promoting data and information sharing including sharing of experiences, best practice or emerging issues on matters of social health insurance.

70. Travel health insurance cover

(1) A person travelling into Kenya shall possess a travel health insurance cover pursuant to section 26(6) of the Act.

(2) The travel health insurance shall—

(a) cover the person's entire period of stay in Kenya; and

(b) provide for benefits including—

(i) personal accident that may lead to death or permanent total disability;

(ii) emergency medical expenses;

(iii) emergency medical evacuation;

(iv) repatriation of mortal remains;

(v) hospital benefits; and

(vi) prescription medicines.

(3) A person traveling into Kenya may obtain the travel health insurance cover at the point of entry in Kenya.

(4) Despite the provisions of subregulation (3), the Authority shall not provide travel health insurance covers for Kenyans or non-Kenyans.

Part X – REVOCATION

71. Revocation .

The following Regulations are hereby revoked—

(a) the National Hospital Insurance Fund (Accreditation) Regulations, L.N. 186/2003; and

(b) the National Hospital Insurance Fund (Claims and Benefits) Regulations, L.N. 188/2003.

FIRST SCHEDULE

FORM 1 [r.11(6),12(1),14(1),14(9)]

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

[L.N. 47/2024]

APPLICATION FOR REGISTRATION

III: PHOTOGRAPHS

Please attach one colored passport size photo for each of the persons named in Part I, II and III. Indicate the name of the person and contributor's I.D. Number at the back of the individual passport size photo.

IV. DECLARATION OF BENEFICIARIES (Use additional form if necessary)

Part A: Patient Particulars (To be completed by the principal member)

FORM 2 (r.39(2)(a))

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

[L.N. 47/2024]

SOCIAL HEALTH AUTHORITY

REFERRAL FOR OVERSEAS TREATMENT FORM

(Part a: Patient Participation particulars (To be completed by the principal member)

Part C: Undertaking by Principal Member

I hereby declare that the information given above is true to the best of my knowledge and belief. I fully understand the rules governing the medical benefits extended to the Members as provided by the Social Health Authority.

.

SIGNATURE OF THE PRINCIPAL MEMBER:

.....

.

Date: .....

_____

.

Part D: Undertaking by Physician In- Charge.

All the above particulars furnished are true/correct. The Member has signed the

undertaking before me.

.

Name of the Physician/Specialist .....

FORM 3 **(r.58(4))**

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

[L.N. 47/2024]

CLAIMS

FORM 4 **(r.45(2))**

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

[L.N. 47/2024]

BENEFIT PACKAGE INTERVENTION PROPOSAL

N.B The form has to be duly filled for an intervention to be considered for selection

FORM 5 **(r.22(5))**

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

[L.N. 47/2024]

To be completed in triplicate

APPLICATION FOR EMPLOYERS' REGISTRATION

EMPLOYER'S/ORGANIZED GROUP CODE

……

Tick where applicable ☐ Employer ☐ Organized groups ☐ Sponsored ☐

1. EMPLOYER'S / ORGANISED GROUP'S PARTICULARS / SPONSORED
   (a) Employer's Name / Name of Organised Group: ……
   (b) Postal Address: ……
   (c) Telephone Number /Mobile: ……
   (d) Email Address: ……
2. Headquarters' Registered Office
   (a) Business Location/……
   (b) Road/Street: ……
   (c) Building/Floor/Room ……
3. Current Number of Employees/……
4. Certificate/Registration Number (Attach copy)*: ……
5. Company PIN Number (Attach copy): ……

…… ……

Full Name of Authorized Officer

Employer's/Organized Group

....

....
Signature

Date

FOR OFFICIAL USE ONLY

1. Checked by: Code Number issued by Code Number issued by

   (a) Full Name..... (a) Full Name.....

   (b) Signature..... (b) Signature.....

   (c) Date.....

2. Approved by:

   (a) Full Name _____ (b) Signature _____ (c) Date _____

Official Stamp

NB: The following other documents are also valid

^ Copy of Kenya Gazette

^ Copy of the Act of Parliament

SECOND SCHEDULE

[r.7(3),(r.19(4),(r.20(2),(r.32(2), (r.40(1)]

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS, 2024

BENEFITS PACKAGE- PRIMARY HEALTHCARE FUND

(SERVICES RENDERED BY EMPANELLED AND CONTRACTED HEALTHCARE PROVIDERS)

THIRD SCHEDULE

[r.19(4), (r.20(2), (r.32(2), (r.40(1)]

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

(L.N. 47/2024)

BENEFITS PACKAGE- SOCIAL HEALTH INSURANCE FUND SERVICES RENDERED BY EMPANELLED AND CONTRACTED HEALTHCARE PROVIDERS)

FOURTH SCHEDULE

[(r.19(4), (r.20(2), (r.27(3), (r.28(1), (r.32(2), (r.40(1))]

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS, 2024

(L.N. 47/2024)

BENEFITS PACKAGE-EMERGENCY, CHRONIC AND CRITICAL ILLNESS FUND

(SERVICES RENDERED BY EMPANELLED HEALTHCARE PROVIDERS)

The Emergency, Chronic disease and Critical illness Fund (ECCF) aims to improve access to quality emergency services and critical care and to reduce catastrophic expenditure experienced during management of the selected conditions.

The services covered under ECCIF shall include Emergency services, Critical care services, Oncology services beyond SHIF, Drug and Substance Abuse Rehabilitative services above the SHIF limit, Assistive Devices for chronic conditions, Chronic conditions and Immunosuppressive therapy post renal transplant.

FIFTH SCHEDULE [(r. 21(6)]

REPUBLIC OF KENYA

SOCIAL HEALTH INSURANCE ACT

(Cap. 255)

SOCIAL HEALTH INSURANCE REGULATIONS

(L.N. 47/2024)

MEANS TESTING