2022

National Health Insurance &
Long-Term Care Insurance System
in Republic of Korea

h·well NHIS National Health Insurance Service

2022 National Health Insurance & Long-Term Care Insurance System in Republic of Korea

National Health Insurance Service

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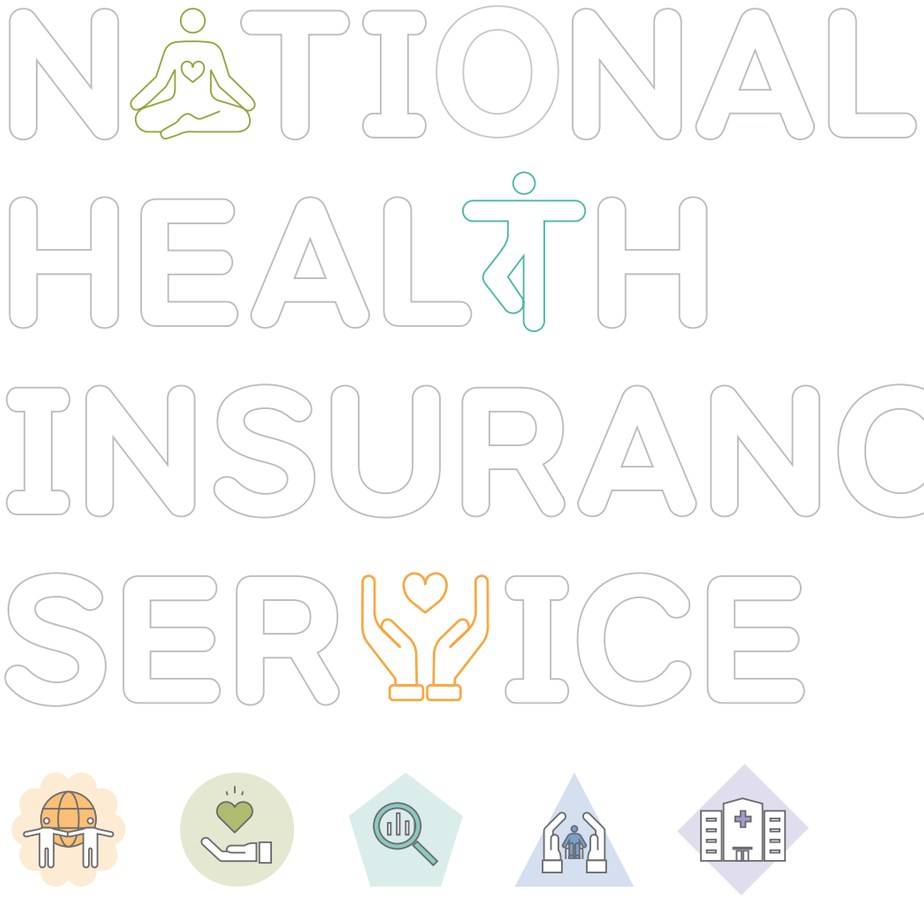

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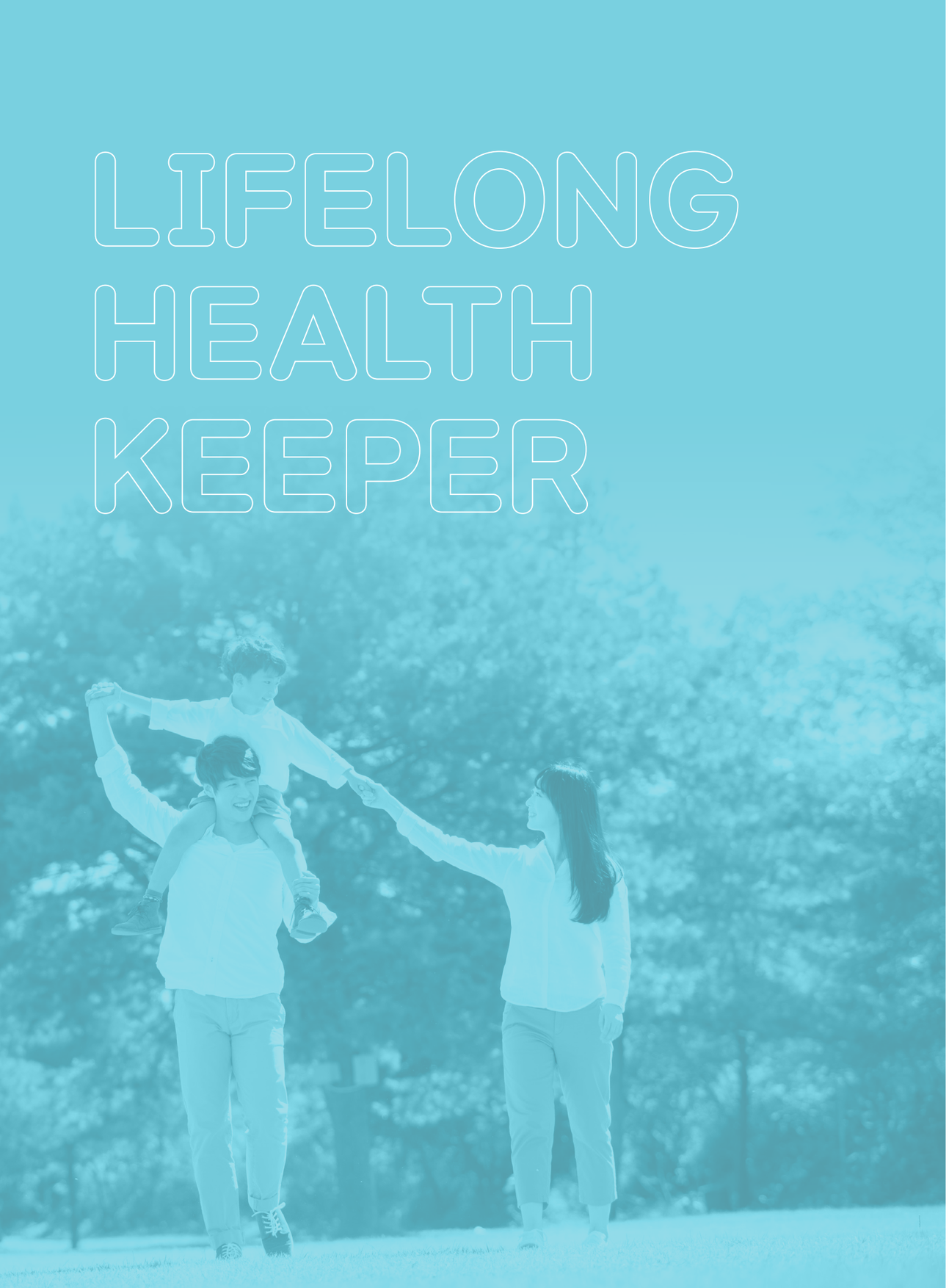


PREFACE

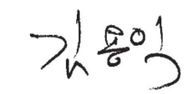
As the National Health Insurance Service (NHIS) celebrates its 44th anniversary and Long-term Care Insurance (LTCI) celebrates its 13th anniversary this year, both are establishing its positions that will be responsible of the essential social safety net for Korean citizens' health and comfortable golden years.

The NHIS achieved the world's fastest establishment of universal health coverage within 12 years since its operation in 1977. Moreover, it integrated the country's health insurance—which was once classified into employment, regional, and national insurance—into one unified system, greatly enhancing wage fairness.

In addition, we are faithfully executing our roles both as the management and operation institute of the NHIS and LTCI, as well as the 'social insurance information system.' We are also doing our best to improve Korea's healthcare and enhance social security.

In light of the recent COVID-19 pandemic, Korea's health insurance system is attracting attention globally. Therefore, we are publishing a booklet that contains an overview of the health insurance system and long-term care insurance system. More importantly, we are publishing a Chinese booklet this year in addition to the English one for the very first time, enhancing the accessibility for foreigners residing in Korea as well as Chinese-speakers worldwide.

I hope that Korea's health insurance and long-term care insurance systems will contribute to all of humanity's health insurance. I also sincerely wish that this booklet provides appropriate and credible information regarding Korea's health insurance, and becomes a tool that allows others to further understand Korea's insurance system.



Yong-Ik Kim MD, PhD
National Health Insurance Service President

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I

SOCIAL SECURITY IN KOREA

I | SOCIAL SECURITY IN KOREA

1 General Status (Sociodemographic Characteristics)

The Republic of Korea (Korea) is located in East Asia, on the southern part of the Korean Peninsula. Korea boasts stellar economic achievements, which have been accompanied by rapid changes in the demographic structure.

Category	Description
Name	• Republic of Korea
Capital	• Seoul
Population	• 51,662,000 (as of 2021, Ministry of the Interior and Safety, population statistics based on resident registration)
Area	• 100,412 ㎢ (108th in the world)
Climate	• Continental
Language	• Korea
Ethnicity	• Korean
Religion	• Buddhism, Christianity, Catholicism, etc.
Currency	• KRW 1,184.3 = USD 1 (as of Nov 2021)
Government	• Presidential

Korea's population in 2021 stands at around 51,662,000. The country's population is rapidly aging, driven by the declining birth rate and rising life expectancy. Koreans aged 15 to 64 take up 71.1% of the total population, and the percentage of people under 15 is 11.9%. The percentage of elderly Koreans (aged 65 or older) rose from 7.22% in 2000 to 17.0% in 2021.

These demographic structure changes negatively affect the country's economy and impose a significant burden on its health insurance system by reducing its workforce and increasing health-care and welfare budget.

The population aging also puts a strain on the country's health-care system by increasing the demand for medical services and facilities, raising the percentage of dementia and other diseases associated with old age, and putting more burden on families. To address this issue, the Korean government launched the Long-Term Care (LTC) Insurance for the Elderly in 2008, to provide care services for age-related diseases.

2 Social Security System

According to Article 34 (2) of the Constitution of the Republic of Korea, the "State shall have the duty to endeavor to promote social security and welfare." To fulfill the said duty, the Korean government protects its people from various risks and improves their quality of life by operating multiple social security systems such as social insurance public aid and social welfare services.

2.1 Five Social Insurance Schemes

Korea's social insurance system consists of five social insurance schemes: National Health Insurance (NHI), National Pension, Employment Insurance, Industrial Accident Compensation Insurance, and LTC Insurance for the Elderly.

2.2 Public Aid

The central and local governments provide support to Koreans in vulnerable states so that they can lead self-sufficient lives. In addition, these governments use their budget to provide people outside the NHI coverage with various medical services.

2.3 Social Welfare Services

The central and local governments offer a wide range of services aimed at helping people live with dignity. The services span across various areas, including welfare, health care, education, employment, housing, culture, and environment. The services include counseling, rehabilitation, care, information, access to facilities, competency building, and social engagement. They are designed to improve the quality of life for all citizens.

II

NATIONAL HEALTH INSURANCE SERVICE

1. Overview
2. History
3. Characteristics of National Health Insurance
4. Operational Structure
5. Funding

II | NATIONAL HEALTH INSURANCE SERVICE

Korea has a universal health-care system, in which the National Health Insurance Service (NHIS) provides insurance to almost the entire population.
The NHIS's business structure is simple and highly integrated. The NHIS Headquarters, located in Wonju, manages 6 regional headquarters in major cities and 178 branches across the country. Private health-care institutions provide various medical services, and the NHIS determines their prices by negotiating with multiple provider organizations. The NHI is funded mostly with contributions paid by corporate employers, insured employees, and sole proprietors. Certain low-income groups are covered by the medical aid system, instead of the NHI.

1 Overview

The NHI is a social security system aimed at achieving social solidarity by sharing risks and providing necessary medical services. Under the system, citizens pay contributions. The insurer, the NHIS, collects and manages the contributions to provide citizens with insurance benefits when they need them. The insurance helps citizens avoid staggering medical expenses associated with diseases and injuries. Citizens pay contributions based on their financial capabilities but enjoy equal rights to insurance benefits. In this sense, the NHI services as a public good that protects people's health.

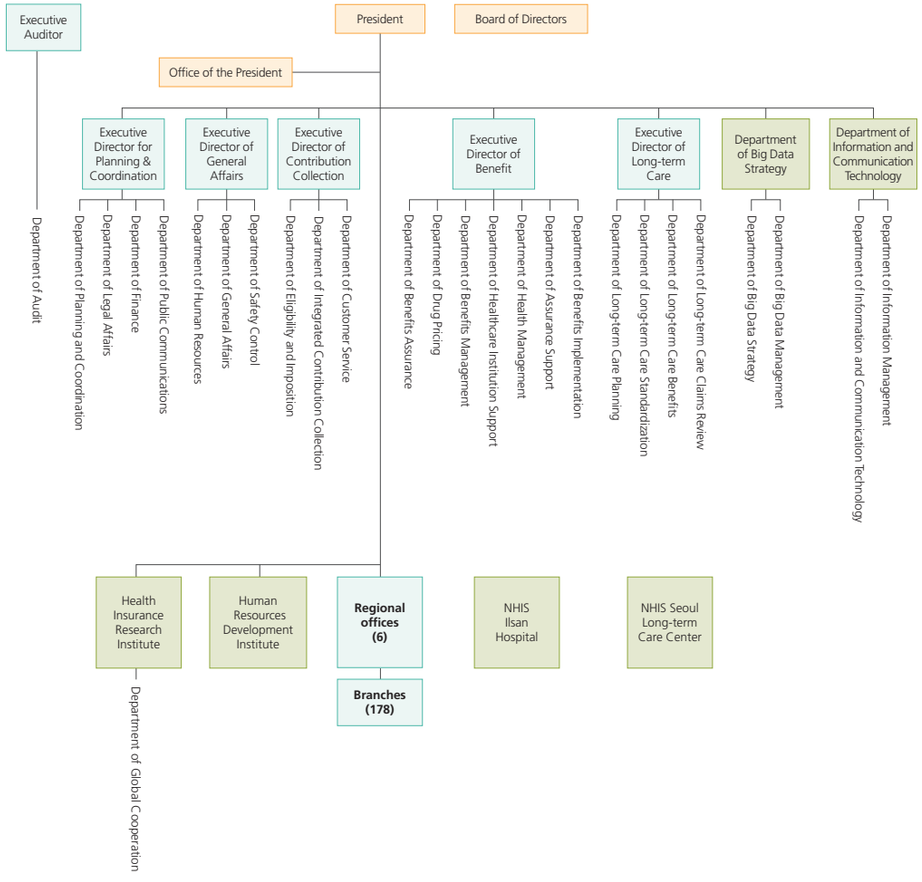
1.1 Organization

The NHIS consists of three levels: Headquarters (HQ), regional HQs, and branches. Most branches (or branch offices) and elderly LCT centers are organized on the municipal (Si/Gu, also called basic local government) level to enhance accessibility. The NHIS employs 14,755 workers; 10,749 of them work in the NHI area, and 4,006 work in the LTC area (as of the end of October 2021; Ilsan Hospital and NHIS-Seoul Long-Term Care Center excluded).

1.2 Departments and Roles

The NHIS consists of the HQ with 22 departments, the Health Insurance Policy Research Institute, the Human Resource Development Institute, 6 regional HQs, 178 branches, 54 local offices, and 227 (LTC) centers. The service also operates two medical institutions: the NHIS-Ilsan Hospital and the NHIS-Seoul Long-Term Care Center.

NHIS Organizational Chart



2 History

The history of national health insurance in Korea is divided by four turning points: the enactment of the Medical Insurance Act and the first launch of the NHI scheme in 1963; the organization of employee medical insurance associations in 1997; the achievement of national coverage in 1989; and the merger between the National Health Insurance Management Corporation and employee medical insurance associations in 2000. The insurance coverage gradually expanded from large corporations to middle-standing corporations and small and medium enterprises (SMEs), and, ultimately, employees and sole proprietors.

1) Birth of National Health Insurance and Voluntary Cooperatives

The first medical insurance association was formed in 1995 at a private hospital named Busan Labor Hospital. This medical insurance covered 38,000 people, which included workers at the hospital and their immediate families. Meanwhile, the Ministry of Health and Welfare (MOHW) launched research projects on NHI schemes, which resulted in the first enactment of the Medical Insurance Act in 1963. This act allowed business entities to establish medical insurance cooperatives at their discretion. However, most cooperatives failed to evolve into medical insurance schemes.

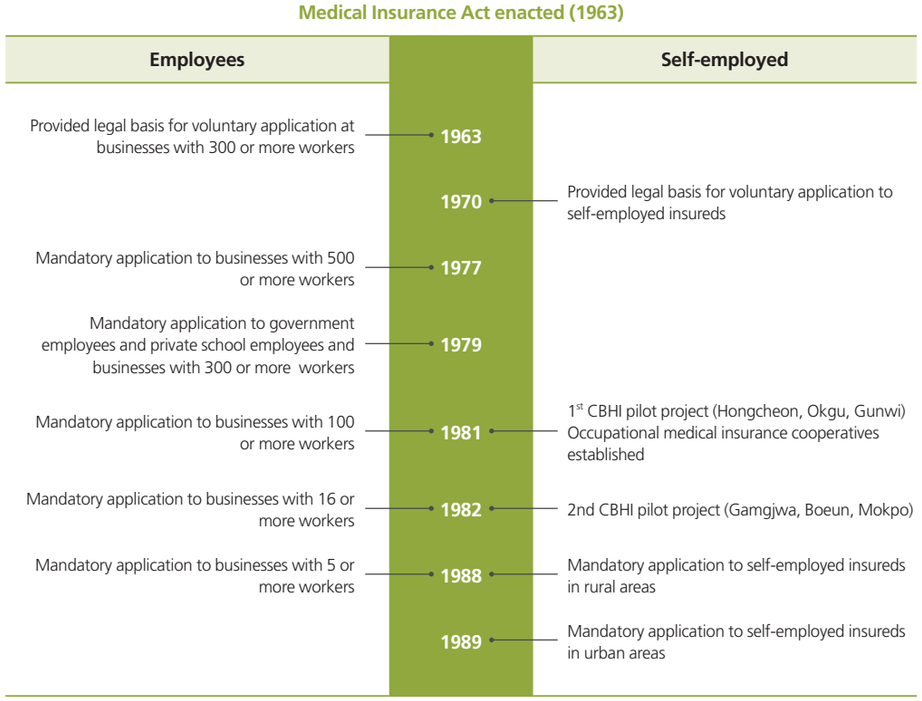
2) Mandatory Health Insurance for Employees (1977)

After the enactment of the Medical Insurance Act, Korea's medical insurance system did not see much improvement for the next 13 years. However, in 1977, the government decided to launch a mandatory medical insurance scheme. The government's success in launching a mandatory scheme can be attributed to three factors.

First, the MOHW steadfastly pursued the mandatory insurance policy, and utilized its experience in managing voluntary cooperatives. Second, based on the experience with the voluntary insurance scheme, the MOHW was able to decide on contribution imposition, service fees, drug prices, and other elements of the scheme in a systemic and detailed manner. Third, unlike other countries, businesses actively advocated for adopting the scheme. Fourth and last, the MOHW dispatched pretrained personnel to establish cooperatives.

[Figure 2-1] History of NHI

History of National Health Insurance



National Medical Insurance achieved (1989)	
1998	Medical Insurance Act enacted (merged Government Employee and Private School Employee Medical Insurance Management Corporation and regional medical insurance cooperatives)
1999	National Health Insurance Act enacted; merged National Medical Insurance Management Corporation and employee medical insurance associations
2000	National Health Insurance Act enforced (July 1, 2000)
2008	Long-Term Care Insurance Act enforced (July 1, 2008)
2011	Integrated social insurance contribution collection (NHI, National Pension, Employment Insurance, Industrial Accident Compensation Insurance)

Medical Insurance Act :
separate accounting and operation → National Health Insurance Act (enacted on February 8, 1999) : managed by a single insurer

Source: NHIS website, 2017

3) National Coverage (1989)

The scope of the Community-Based Health Insurance (CBHI) expanded to all rural areas in 1998, and all urban areas in July 1989. Korea accomplished national coverage in only 12 years after the launch of the mandatory Health Insurance for Employees (HIE) in 1977.

The achievement was made possible by several factors. First, the government was adamant about ensuring medical security in Korea, and pursued the "low-burden/low-benefit" policy. Given Korea's economic standing at the time, a nationwide health insurance scheme seemed somewhat far-fetched. The government achieved the improbable by lowering the level of insurance contributions, which increased the acceptability of the new scheme among the public, even though it led to complaints about excessively high out-of-pocket payments (co-payments) from medical service users.

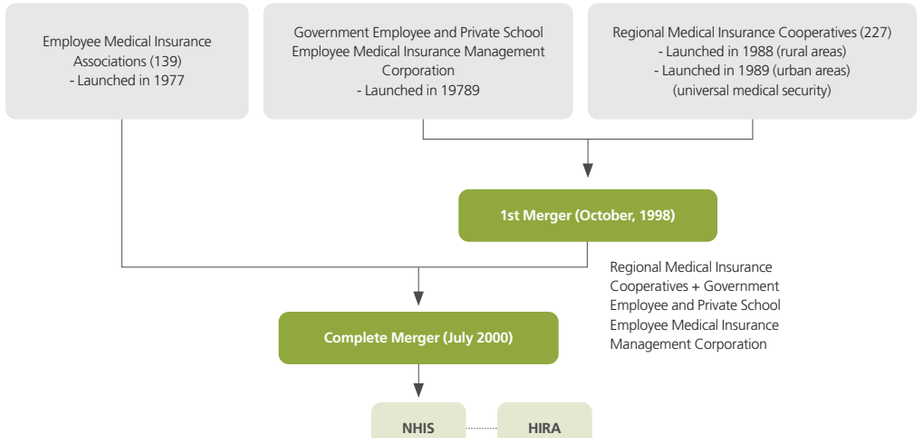
Second, the government made it a legal obligation to subscribe to the health insurance. Save for fierce opposition from some citizens, most Koreans and health-care institutions sided with the government.

Third, the government gradually but rapidly expanded the scope of the coverage. In a short period, the government significantly expanded the insurance coverage by developing the HIE, launching pilot CBHI projects, and increasing the scope of eligibility. These approaches proved to be highly effective. Fourth, the resident registration number (ID) system facilitated the management of the insured. The use of resident registration numbers and health insurance card numbers allowed the government to identify and manage subscribers with ease. Fifth and last, the Korean government established both rural and urban cooperatives across the country in a short time with minimum confusion and errors because experienced members of existing cooperatives were dispatched to new associations to ensure continuity.

4) Insurer Merger (Merger of Insurance Providers)

In October 1988, CBHI cooperatives and the medical insurance management corporations for government employees and private school employees were merged into the National Medical Insurance Management Corporation. With the National Health Insurance Act's implementation, the new Health Insurance Review and Assessment Service (HIRA) took over the medical expense review and assessment functions from the Medical Insurance Association. In addition, the National Medical Insurance Management Corporation and HIE cooperatives were merged into the National Health Insurance Service (NHIS), which became Korea's only health insurance provider. The merger improved the Korean health insurance system in many ways, including improved management and operation efficiency, narrowed gap among insurance cooperatives, equitable imposition of contributions, and income redistribution among income groups.

[Figure 2-2] Merger of NHIS



3 Characteristics of National Health Insurance

3.1 Key Features

1) Mandatory Subscription

Under the National Health Insurance Act, all Koreans satisfying the specified statutory requirements are enrolled in the NHI. Without compulsory enrollment, only people with higher risks of contracting diseases would enroll in the national insurance, which makes it impossible to fulfill one of the NHI's main goals, that is, pooling medical expense risks among citizens. Noncompulsory enrollment would result in an adverse selection where only people with poor health subscribe to the health insurance, which would raise the insurance premiums. Therefore, compulsory enrollment is a prerequisite for pooling risks among citizens with varying social backgrounds and conditions.

2) Imposition of Contributions Based on Ability to Pay

Private insurers impose contributions based on the insured's health, age, gender, wage, and other personal risk factors. However, as social insurance designed to address the issue of medical expenses through social solidarity, the NHI imposes insurance contributions based on the insured's ability to pay, regardless of their health or medical expenses incurred.

3) Equitable Provision of Insurance Benefits

Private insurers provide different benefits to each beneficiary based on the amount of contributions paid, contract period, or terms of the benefits. However, the NHI provides insurance benefits to all citizens regardless of the amount of contributions they pay.

4) Compulsory Payment and Collection

To ensure the scheme's viability, all NHI subscribers are required to pay contributions, and the insurer must collect the contributions.

5) Short-Term Insurance

The National Pension collects and manages contributions in the long term. On the other hand, the NHI is short-term insurance that uses the contributions collected in a given fiscal year to pay for medical services utilized by citizens in the relevant period.

3.2 Type of Medical Security System

Korea provides medical security with the NHI, which is social insurance covering all citizens and managed by a single insurer. The national health insurance approach is similar to the social insurance approach in that both approaches combine the insurance system with the principle of social solidarity. However, while the social insurance approach often involves multiple insurers (e.g., Germany), national health insurance is managed and operated by a single insurer. Countries that chose the first approach include Korea and Taiwan.

3.3 Legal Basis

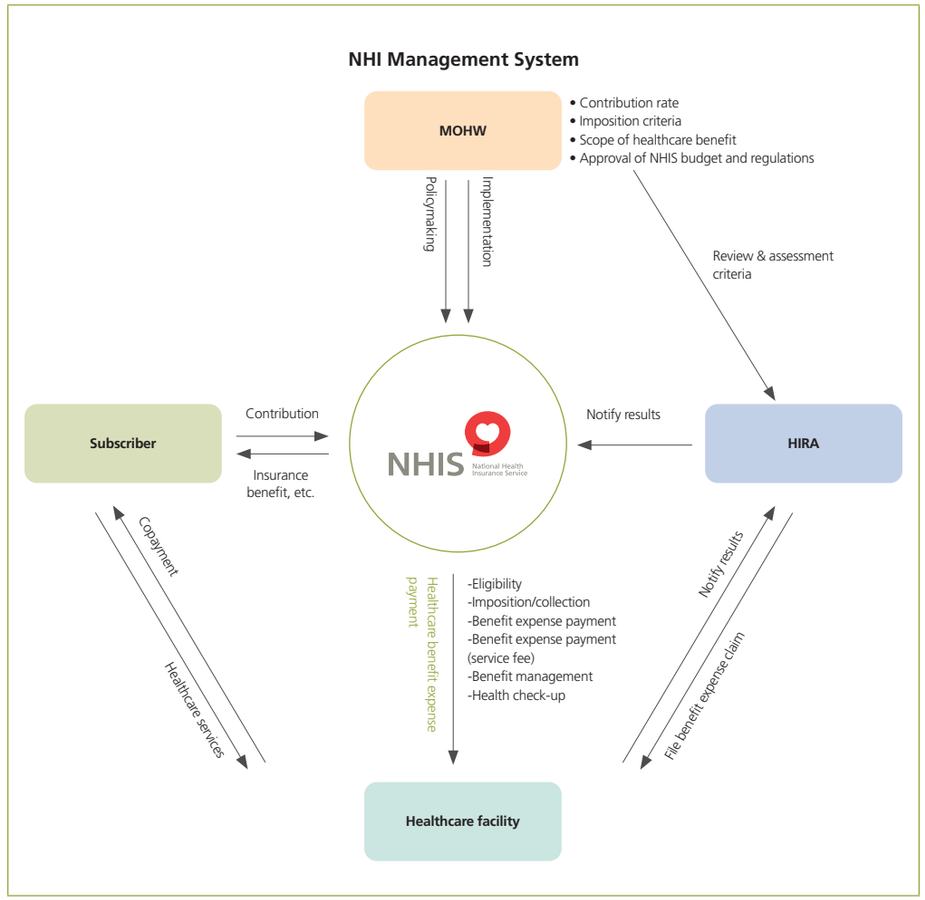
Article 34 (1) and (2) of the Constitution of the Republic of Korea provides for the people's right to live with dignity, and the State's duty to promote social welfare. Thus, the provision offers the legal backbone of the Korean social security system. According to the National Health Insurance Act (Act no. 5854, enacted on February 8, 1999), the purpose of this Act is to improve citizens' health and promote social security by providing citizens with insurance benefits for the prevention, diagnosis, and medical treatment of and rehabilitation from diseases and injury, for childbirth and death, and for health improvement.

4 Operational Structure

Founded in 1999 under the National Health Insurance Act, the NHIS serves an important role as the only health insurance provider in Korea. The NHIS is responsible for providing medical benefits through medical service providers and funding these services. The NHIS is organized on three levels: HQ, regional HQs, and branches. The 6 regional HQs manage 20 to 30 branches in their designated areas. Branches collect contributions from subscribers and provide a wide range of health information.

Each year, the NHIS negotiates the prices of medical services with medical institutions. Based on evidential data and materials, final agreements with each association are achieved through a highly complex and interest-conflicting process. Figure 2-3 represents the current NHI management and operation system. The MOHW oversees the NHI scheme, decides on related policies, and manages/supervises the scheme's overall matters. The NHIS is responsible for operating the NHI scheme. The HIRA reviews health-care benefit expense claims filed by health-care facilities (medical institutions and pharmacies, etc.) and notifies the review results to the NHIS. Medical services are provided by health-care facilities, of which private sector entities operate 94.1%. In addition, medical service provider associations, pharmaceutical associations, labor unions, and nongovernment organizations (NGOs) play key roles in NHI policy decisions.

[Figure 2-3] NHI Management and Operation System



Source: MOHW website, 2017.

1) MOHW

The MOHW decides on NHI policies and manages/supervises the overall matters of the NHI scheme. The Health Insurance Policy Deliberative Committee under the MOHW deliberates and adopts decisions on matters related to NHI policies. Its main functions include: deciding on contribution rates, the imposition criteria, and the scope of health-care benefits; approving budgets and regulations of the NHIS; assessing new health-care technologies; deciding on the benefit criteria (methods, procedures, scopes, and upper limits), upper limits of medical materials, and relative value of benefits.

2) NHIS

The NHIS is responsible for the NHI scheme's overall operation, including management of subscribers' eligibility, imposition and collection of contributions, and management of insurance benefits. It is also responsible for preventive programs for maintaining and promoting the health of subscribers and their dependents, the collection of four social insurance contributions (NHI, National Pension, Employment Insurance, and Industrial Accident Compensation Insurance), other functions delegated under the National Health Insurance Act and other statutes, and other functions related to the NHI deemed required by the MOHW Minister (Article 14, National Health Insurance Act).

3) HIRA

The HIRA reviews health-care benefit expenses and the appropriateness of health-care benefits (Article 63, National Health Insurance Act).

4) Medical Service Providers

Health-care service providers are organized into multiple associations, including: the Korean Hospital Association, Korea Medical Clinic Association, Association of Korean Medicine, Korean Pharmaceutical Association, and Korean Nurses Association. Health centers also provide health-care services in their respective areas. Health-care facilities designated under the National Health Insurance Act are subject to the NHI and may not refuse to provide subscribers with health-care benefits without a justifiable reason.

5 Funding

5.1 Financial Sources

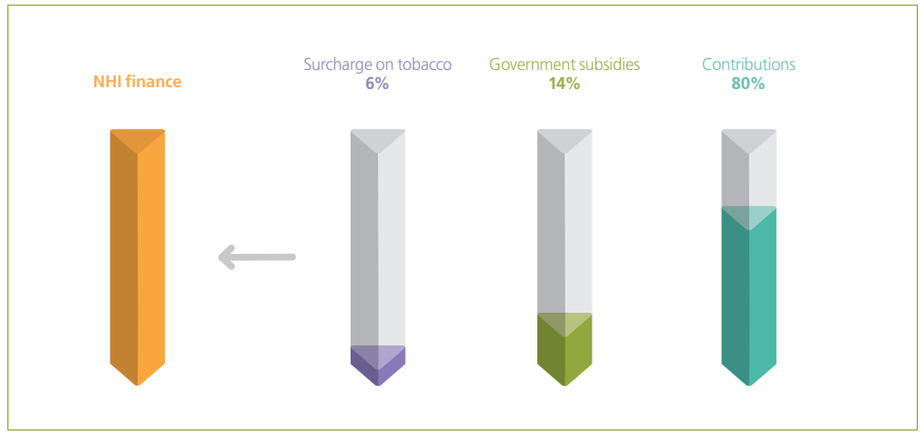
The NHI scheme's financial sources consist of contributions, government subsidies (from the national treasury and various funds), and other revenues.

Contributions are collected from subscribers subject to payment obligations to finance the NHI operation's expenses. Insured employees pay contributions determined by multiplying their monthly wage with insurance contribution rates, and self-employed

insureds pay contributions determined for each household by multiplying their contribution points with the contribution amount determined per point.

Each year, the NHIS receives subsidies from the government, corresponding to 14% of the contribution revenue expected for that year. The NHIS also receives subsidies from the National Health Promotion Fund, which corresponds to 6% of the contribution revenue expected for that year. This, however, is limited up to 65% of estimated tobacco surcharges, the source of funding.
The financial resources mostly consist of the contributions collected from the insureds. Government subsidies, such as taxes and tobacco surcharges, take up a certain percentage. The majority of the funding for health insurance go into insurance benefit payments.

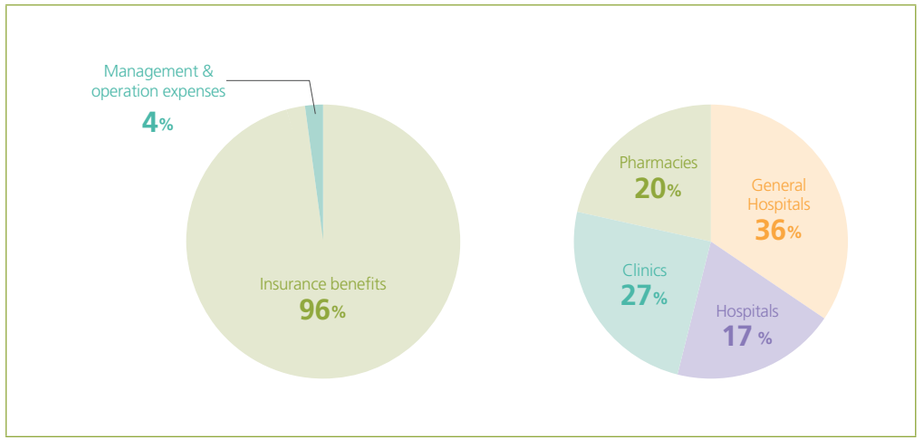
[Figure 2-4] NHI Financial Structure



Source: NHIS, 2020.

Expenditures for the NHI include insurance benefit payments, management and operation costs, and others. In 2020, 96% of the expenditures were used for the insurance benefit payments for subscribers and dependents, and management and operation payments took up 4%. By type of health-care facilities, general hospitals received 36% of the medical expense payments, hospitals 17%, clinics 27%, and pharmacies 20%.

[Figure 2-5] NHI Expenditure Structure



Source: NHIS, 2020.

5.2 History of NHI Funding

1) Government Subsidies

At the time of the HIE adoption in 1977, employers paid 50% of the contributions, with no government subsidies. However, when the CHBI was launched in 1988, the government funded around 50% of the first-year budget. The government subsidies were required because there is no “employer” for the CBHI, and many of the insureds were not financially capable.
The percentage of government subsidies declined from 54.5% in the first year to 41.1% in 1989, and 36.1% in 1990, which caused a serious financial deficit for the CBHI. The government responded by committing an additional budget. However, the percentage of government subsidies continued to decline, reaching 26% in 1999.
The decline was mainly attributable to the fact that the government subsidized 50% of the insurance benefit payments and management and operation costs estimated for each year. However, as the medical insurance system took root in Korea, the amount of insurance benefit payments greatly exceeded the estimates, which lowered the relative percentage of government subsidies and caused serious financial distress at insurance cooperatives. The government took action to increase rural areas' subsidies, which did not resolve the financial deficit suffered by insurance cooperatives.

2) Surcharge on Tobacco

The merger of insurance providers between 1998 and 2000 resulted in the birth of the NHIS as the single insurer. In addition, the separation between pharmaceutical prescription and dispensing at the time resulted in a serious financial deficit.
In response, the government enacted the Special Act on the Financial Soundness of the NHI, which provided for subsidies from the National Health Promotion Fund raised with surcharges on tobacco. The Act also fixed the percentage of government subsidies for the CBHI at 50%, consisting of 35% from the national treasury and 15% from the National Health Promotion Fund.

3) Financial Restructuring

The Special Act on the Financial Soundness of the National Health Insurance expired in 2006. Before the expiration, the government proposed a revision to the National Health Insurance Act, which required the government to provide subsidies to the NHIS corresponding to 20% of the estimated contribution revenue by December 31, 2022. Of the 20%, 14% came from the national treasury, and the other 6% came from the National Health Promotion Fund. By revising the subsidization criteria, the government emphasized the subscribers' responsibilities for insurance funding.
As a result of the revision, as of 2020, 87.7% of the NHI budget was funded with contributions and other revenues, 9.8% was subsidized from the national treasury, and 2.5% by the National Health Promotion Fund.

In a beautiful world,
a lifelong health with you!

III

NATIONAL HEALTH INSURANCE

1. Management of Eligibility
2. Management of Benefits
3. Health Management
4. Information Management

III | NATIONAL HEALTH INSURANCE

1 Management of Eligibility

1.1 History of Eligibility and Collection System

1) HIE

At the time of adoption, employees' health insurance was applied to business establishments employing 500 or more workers. The application scope expanded to business establishments with 300 or more workers in 1979, 100 or more workers in 1981, 16 or more workers in 1984, 5 or more workers in 1987, and 5 or more workers in 1988. As of 2001, the insurance came to be applied to all business establishments, including those with less than five workers.

The HIE supports people dependent on insured employees as well, including their spouses, lineal ascendants, lineal descendants, and those who primarily rely on insured employees for livelihood. The government continued to increase the scope of dependents, which later included the lineal ascendants of spouses, the spouses of lineal descendants, and insured employees' siblings.

However, in 1988, the government reduced the dependents' scope to address financial difficulties and establish an income-based contribution imposition system in the long run.

The HIE contributions were collected by withholding the amounts from wages paid at each business establishment and transferring them to the medical insurance association for the establishment.

2) Medical Insurance for Government Employees and Teachers

The medical insurance for government employees and private school teachers covered all employees and teachers from the outset. In later years, the coverage scope gradually increased to include employees of educational foundations, temporary government employees, and part-time lecturers.

As was the HIE case, the insurance contributions for the insurance were also withheld from each institution's monthly wages and paid to the insurers: the Government Employee and Teacher Medical Insurance Management Corporation.

3) CBHI

Unlike the HIE, the CBHI covered all residents in the respective areas other than HIE subscribers. For this reason, all members of each household were designated as co-payers of insurance contributions.

In the early years, different areas were managed by different cooperatives. One could lose or gain eligibility when he/she changes the place of residence. This required each local administration to assign additional personnel to handle matters related to medical insurance eligibility.

Contribution collection was also marred with numerous difficulties. Regional medical insurance cooperatives had to spend significant time and money on billing alone. In addition, because of the low collection rate, the associations had to put more effort into sending reminders and managing delinquent payers.

4) After Merger

The merger of the health insurance providers in July 2000 abolished the concept of “jurisdiction” in the CBHI. The merger standardized eligibility management across Korea, which allowed the insurer to prevent omission and overlap of eligible persons, and track changes in subscribers’ addresses in real time.

However, because of structural differences, Korea was not able to merge the HIE with the CBHI. Managing changes in eligibility in the two areas remained a difficult challenge. In response, the government came up with the Voluntary Continuation of Subscription in July 2007, which allowed employees to maintain their HIE eligibility even after retirement. In addition, the difficulties associated with contribution collection have significantly been reduced by advancements in information technology (IT), which diversified contribution payment methods to include automatic transfer (bank accounts / credit cards), Internet banking, and virtual payment accounts.

1.2 Management of Eligibility

In this report, "covered persons" mean those who are entitled to claiming NHI benefits. Korea has a universal health insurance system. The NHI applies to all Korean nationals and expatriates whom the government is required to protect under the Constitution. In addition, foreign nationals staying in Korea can enroll in the NHI and receive benefits as long as they meet the specified requirements. Low-income earners and other vulnerable groups unable to pay insurance contributions are granted the same protection level under the Medical Service Act.

1) Covered Persons

Persons eligible for the NHI consist of two groups: insured employees and self-employed insureds. The former group consists of employees at business establishments, employers, government employees, teachers, and their dependents. The latter group consists of all persons other than Dependents are those without wages or income who rely on insured employees to maintain their livelihood. The NHI does not apply to medical aid beneficiaries, and meritorious persons who opted out of the NHI.

2) Loss and Acquisition of Eligibility

The time of acquisition and loss of NHI eligibility varies depending on the type of eligibility. Insured employees become eligible on the day when their employment at a business establishment covered by the NHI begins. They lose their eligibility on the date following the end of employment. When an insured employee loses his/her insured employee eligibility, he/she automatically becomes a self-employed insured.
Eligibility is managed with NHI card numbers and resident registration numbers.
As of the end of 2020, a total of 52,870,000 people enjoy health security benefits in Korea, of which the NHI covers 51,340,000 (97.1%). The other 1,530,000 are medical aid beneficiaries.

1.3 Contribution Imposition

The majority of the funding for the NHI comes from contributions paid by subscribers. Contributions are calculated differently between insured employees and self-employed insureds. The self-employed insureds consist of all persons other than insured employees and their dependents. Therefore, it is difficult to identify the income earned by this group's diverse members, including sole proprietors and retirees with no income.

Each group is separately charged with monthly contributions. As shown in Table 2-1, insured employees pay contributions based on contribution rates, and self-employed insureds pay contributions based on unit prices per contribution point. The contribution rates and the unit prices are determined by the National Health Insurance Policy Deliberative Committee.

<Table 2-1> Contribution Rates and Unit Prices Per Point

(unit: %, KRW)

Category	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Insured employee (contribution rates)	5.33	5.64	5.80	5.89	5.99	6.07	6.12	6.12	6.24	6.49	6.67	6.86
Self-employed insureds (unit price per point)	156.2	165.4	170.0	172.7	175.6	178.0	179.6	179.6	183.3	189.7	195.8	201.5

In 2020, an average household paid KRW 114,069 in contributions. The average for insured employees was KRW 124,629, and KRW 90,864 for self-employed insureds. The average contribution amount per capita was KRW 59,218, KRW 61,109 for insured employees, and KRW 54,165 for self-employed insureds. Insured employees paid 85.6% of the total contributions imposed, and self-employed insureds paid the other 14.4%.

1) Insured Employees

For insured employees, contributions are calculated by multiplying their monthly wages with the applicable insurance contribution rates. The calculated amounts are paid evenly by the employers and the subscribers. Employers withhold the part of contributions to be paid by workers from their wages, and transfer the amounts along with the parts to be paid by the employers.

Amount of insurance premium based on monthly remuneration = monthly wages × contribution rates

Table 2-2 shows the contribution rates applicable to different subscribers.

<Table 2-2> NHI Contribution Rates

(unit: %)

Category	Total	Subscribers	Employers	Government
Workers	100	50	50	-
Government employees	100	50	-	50
Private school teachers	100	50	30	20
Military personnel	100	50	-	50

Until June 2018, the government applied upper/lower limits to monthly wages of insured employees; the former was KRW 78,100,000, and the latter was KRW 280,000. However, the government reformed the imposition system and replaced the monthly wage limits with monthly contribution limits. The upper/lower monthly contribution limits in 2021 were KRW 7,047,900 and KRW 19,140, respectively.

Insured employees earning more than KRW 34 million in non-wage income are charged with additional Insurance Contributions Based on Monthly Income (ICBMI). Non-wage income considered for the ICBMI consists of interests, dividends, business income, pension, etc. Employment income is not included, as it is included in the monthly wages of insured employees.

The ICBMI was adopted in September 2012 to improve equity in contribution payments. The income threshold for the ICBMI was KRW 72 million per year until June 2018, before being lowered to KRW 34 million in July 2018. The ICBMI is calculated as follows.

ICBMI = (yearly non-wage income – KRW 34 million) / 12 × contribution rate

2) Self-Employed Insureds

Contributions imposed on self-employed insureds are calculated by multiplying contribution points by unit price per point. Contributions for self-employed insureds are computed for each household, considering the household members' combined income, property, and vehicle values.

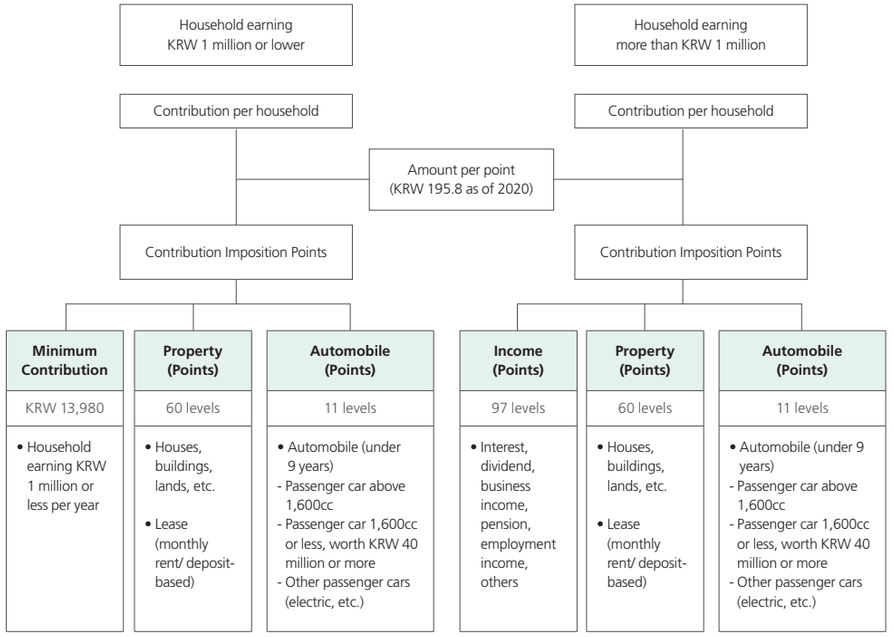
In the past, upper and lower limits applied to the imposition points. The upper limit was 12,680 points, and the lower limit was 20 points. However, in June 2018, the government replaced point limits with monthly contribution limits. As of 2020, the upper monthly contribution limit is KRW 3,523,950, and the lower limit stands at KRW 14,380.

Households earning less than KRW 1 million per year are imposed contributions based on the minimum contribution.

<Contribution point calculation>

A) Household earning more than KRW 1 million per year: income points + property points + vehicle points
B) Household earning KRW 1 million or less per year: minimum contribution + (property points + vehicle points)

[Figure 2-6] System to Impose Insurance Contributions of the Self-Employed



The NHIS has been working toward a uniform imposition system based on income. The first phase of the project was completed in July 2018. In the second phase scheduled for July 2022, the NHIS will propose an amendment to the National Health Insurance Act for a uniform imposition system.

3) Foreign Self-Employed Insureds (Expatriates)

1.4 Mandatory Enrollment of Foreigners and Expatriates (July 16, 2019)

1) Background

In the past, foreigners and expatriates could choose whether to enroll in the NHI as needed. This voluntary enrollment system resulted in medical services not being provided in certain areas, and some beneficiaries left Korea after staying for a short time to receive expensive medical services. These issues came to be hotly debated in media outlets and the National Assembly. In response, the government developed a comprehensive plan to address this issue, and adopted the mandatory enrollment of foreigners and expatriates in the NHI.

2) Covered Persons

Registered foreigners (including expatriates with resident registration and overseas Koreans who reported their places of residence) are enrolled in the NHI, as long as they satisfy the self-employed insured's requirements and resided in Korea for six months or longer. However, in case of receiving medical security benefits equal to the NHI under foreign statutes or contracts with overseas insurers or employers, a foreigner may opt out of the NHI enrollment.

3) Loss and Acquisition of Eligibility

Eligibility is individually managed (acquired) depending on the place of stay (residence). Contributions are also separately imposed. However, a foreigner or an expatriate who lives with his/her spouse and/or children under 19 at the same place may apply for paying contributions for the entire family by sending a document proof of their family relations or marriage status, certified by the foreign affair ministry of the person's country or apostille. An enrolled foreigner or an expatriate loses NHI eligibility when his/her visa expires or he/she leaves Korea for a month or longer.

4) Contributions

It is difficult to identify the income and property of foreigners. Therefore, in addition to identifying their income and property in the same way as for Korean subscribers, foreigners pay all subscribers' average contribution in the previous year if the amount calculated for them is below the average contribution. The average contribution is KRW 118,180 in 2020 (or KRW 131,790, when including the LTC contributions).

5) Penalty for Delinquency

Monthly contributions must be paid on the 25th day of the previous month. In the case of defaulting on payment, insurance benefits are restricted, starting on the following month's first day. If the arrears exceed the specified amount, the person may not apply for a visa extension at the Ministry of Justice.

6) NHI Benefits

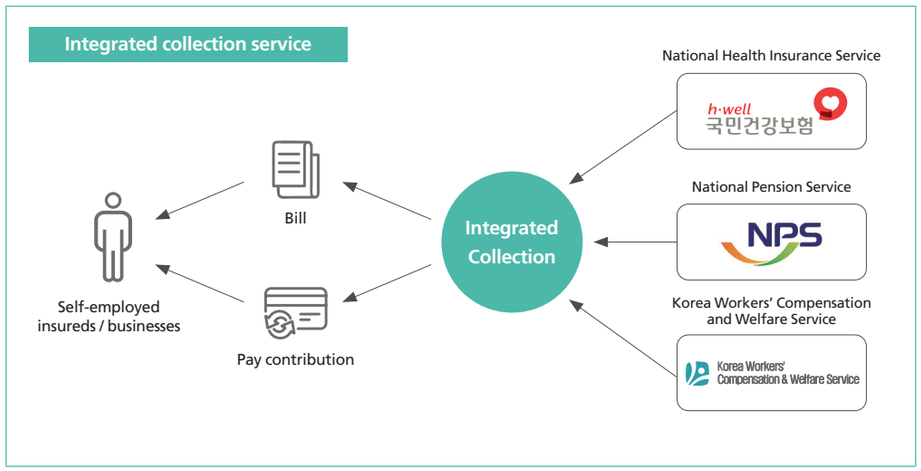
Foreigners and expatriates receive the same NHI benefits as Korean nationals, including inpatient care, outpatient care, benefits for severe diseases, and health checkups.

1.5 Management of Collection

1) Collection of Four Social Insurance Premiums

Starting in November 2011, the NHIS collects the contributions for all of the four social insurances (NHI, National Pension, Employment Insurance, and Industrial Accident Insurance), and manages insurance contribution arrearage. For all of the four social insurances, the due date is the 10th day of the month following the month on which the contributions are imposed.

[Figure 2-7] Integrated Collection of Four Social Insurance Contributions



2) Management of Collection

Management of contribution collection consists of three areas: billing management, reception management, and delinquency management. The first area, billing, consists of determining amounts to be collected and notifying contribution payers with the types, amounts, due dates, and contribution payment places. Household heads and members bear contributions imposed on self-employed insures. Employees and employers pay contributions imposed on insured employees.

Reception of contributions includes collecting the notified contributions through financial institutions and other channels, and transferring the amounts to the NHIS and the other organizations (pension, employment, and industrial accident). The NHIS has been diversifying payment options for customers. Currently, options include credit card (debit card) payment at NHIS branches, and payment through standard optical character recognition (OCR) or automatic transfer outsourced to financial companies.

For arrears not collected even after a reminder and call for collection procedures, the NHIS may proceed with compulsory payment after obtaining approval of default disposition, including seizure, repossession, and liquidation of delinquent payers' properties. The default management process contributes to achieving equity among contribution payers and stabilizing social insurance finances. Table 2-3 shows contribution collection rates over the last decade.

2 Management of Benefits

The NHIS manages various services for diseases, injuries, and childbirths of subscribers and their dependents.

2.1 Health-Care Delivery System

The term "health-care delivery system" means a system for ensuring that patients receive medical services at the appropriate time and place. Korea's delivery system consists of four levels of service provision (clinic-hospital-general hospital-tertiary hospital) and two levels of service use (clinic, hospital, and general hospital; tertiary hospital). Eligible persons can access medical services without restriction. However, the use of medical services at tertiary hospitals requires requests from other medical institutions. Without such requests, the patient should fully pay for health-care benefit expenses.

2.2 History of Insurance Benefit System

1) Expansion of Insurance Benefits

The scope of health-care benefits gradually expanded throughout the history of medical insurance in Korea. Insurance for Korean medicine and pharmacies was introduced in 1987 and 1989, respectively. Bone marrow transplant for children under four was included in 1992, followed by laparoscopic surgery, cataract surgery, and intraocular lens implants in 1993, and computed tomographic (CT) scan in 1996. In 2000, checkups, preventive services, and rehabilitation were added as health-care benefits in 2000.

At the time of launching the first public medical insurance in 1997, the number of health-care benefits stood at a mere 763. However, owing to the coverage expansion policy implemented in earnest in 2004, the number of health-care benefits increased to 9,219.

Health checkup benefits expanded to include preventive and early-diagnosis services for hepatitis, adult diseases, and cancers. After the merger in July 2000, the government shifted the focus of the relevant policies from medical security to health security. In line with the shift, Korea expanded its health checkup programs, including cancer screening programs for local household heads aged 40 or older, launched in 2000, and the Life Transition Point Health Checkup and Infant and Child Health Checkup programs in 2007. The Life Transition Point Health Checkup was discontinued in 2018. As of 2020, there are

four major health checkup programs: General Health Screening, Screening for Cancer, Infant and Child Health Checkups, and Health Checkups for Out-of-School Youth.
In addition, health-care benefits for auxiliary devices for people with disabilities were included in 1997 to lower the group's financial burden, and benefits for pregnancy and childbirth services were introduced in 2008. Thus, insurance benefits have been expanded in keeping with changes in the health-care environment.

2) Expansion of Insurance Benefit Periods

At the time of the first public medical insurance launch in 2007, insurance benefits for the same injury or disease were provided for up to 180 days. In 1988, the government allowed patients to receive benefits for more than 180 days as long as the expenses do not exceed the specified limit. The expense limit was abolished in July 2000, offering all Koreans opportunities to receive benefits without time or expense restrictions.

3) Expansion of Coverage and Scope of Benefits

After the financial stabilization of the insurance in 2004, the government moved to expand the NHI coverage with a view to building a health-care safety net for all citizens. The government began to develop five-year plans for coverage expansion and took various actions to expand coverage. The government lowered the co-payment rate from 30%–50% to 20%, and applied an upper limit to co-payments in 2004. The government also reduced the co-payment rate for four major severe diseases (cancer, heart diseases, cerebrovascular diseases, and rare and incurable diseases) to 5%, and expanded the scope of benefits to include new medical technologies and medical materials, which had been fully paid for by patients. In addition, comprehensive nursing services were introduced to lower the financial burden incurred by patient caretaking.
However, despite these efforts, the NHI coverage rate remained at around 60% for the last decade, with many services still not covered by the NHI. Koreans' financial burden remained significantly higher than that of developed countries.
To address this issue, in August 2017, the government announced the "NHI Insurance Coverage Expansion Plan." The plan was designed to cover previously non-benefit items, lower the costs of services with high OPP rates, and subsidize medical expenses exceeding a specified annual household income level through the subsidy program for catastrophic medical expenses.
After the plan's announcement, major optional medical treatment expenses were removed; the NHI came to apply to two/three-patient hospital rooms at hospitals, general hospitals, and tertiary hospitals; and the NHI coverage expanded to magnetic resonance imaging (MRI) and ultrasonography useful for diagnosis. As a result, patients' medical expenses decreased to between a third and a fourth of the previous level. In addition, the government set the upper limit for annual medical expenses paid by low-income groups at 10% of their annual income, and expanded the size and eligibility criteria of subsidies for catastrophic medical expenses.
These efforts resulted in the 2019 NHI coverage rate of 64.2%, which was the highest since 2010. In 2019, the NHI coverage was expanded to include essential medical services for severe diseases, which raised the coverage rate for general hospitals and large hospitals, which mainly treat severe diseases, by 1.0%p year over year (YoY) to 68.1%. In addition, the lowering of medical expenses for the elderly, children, and other vulnerable groups improved the coverage rates for children under 6 and the elderly aged 65 or older to 69.4% and 70.7%, respectively.

2.3 Medical Expense Payment System

2.3.1 History of Payment Compensation

In Korea, the health insurance system's payment compensation began with the fee-for-service (FFS) system. At the time of the medical insurance launch, the service fees formed at around 75% of the going rates (rates determined freely by medical institutions; institutions apply similar fees to similar practices). However, the decisions did not fully reflect the health-care service providers' position, which gave rise to repeated demand for a service fee increase from the health-care sector.
In 2001, on top of the FFS system, the government introduced the relative value point system to achieve balance among services. The system multiplies relative value points with conversion indexes. The points are determined by comparing the value of medical services in terms of workload, expenses, and resource requirements.
However, the FFS system was criticized for causing overdoctoring and difficulties in expenditure management. To address this issue, the government adopted the diagnosis-related group (DRG) system. Under the DRG system, medical expenses are paid for individual diseases rather than for specific services. After the pilot phase from 1997 to 2001, the government expanded the application scope from hospitals and clinics in 2002 to clinics, hospitals, general hospitals, as well as tertiary hospitals in 2013.

The Korean government plans to expand the DRG system even further. At the same time, the government is carrying out a pilot project for a new DRG model combining the FFS system and the DRG system. As for geriatric hospitals and psychiatric hospitals, inpatient services are paid for with per diems.

1) FFS (Fee-for-Service)

Under the FFS system, service fees are calculated by multiplying the relative value points assigned to a given service with the unit price per point. However, a different system applies to medicinal and medical materials.

2) DRG (Diagnosis-Related Group)

Under the DRG system, medical expenses for inpatient care are fixed for the designated DRGs. Benefits are provided based on the disease for which a patient is hospitalized, regardless of the types and quantity of medical services provided during the hospitalization. There are seven DRGs: cataract treatment, tonsil and adenoid removal, anal surgery, hernia surgery, appendectomy, Cesarean section, and uterus surgery.

3) Performance-Based Payment Compensation

Performance-based payment compensation is an incentive provided based on the NHI health-care quality assessment. The amount is determined based on the quality and price of each assessed service. A pilot program was implemented between July 2007 and 2010 regarding acute myocardial infractions and Cesarean sections. The program was launched in earnest in 2011, and the applicable services have been expanded to include acute phase stroke, surgery preventive antibiotics, hypertension, diabetes, and medicines. Table 2-4 shows the payment methods and applicable services.

<Table 2-3> Payment Methods and Service Scope

Payment method		Service scope		Health-care facility scope					
				Clinic	Hospital	General Hospital	Tertiary General	Geriatric Hospital	Pharmacy
FFS		Inpatient		●	●	●	●		●
		Outpatient		●	●	●	●	●	●
DRG payment method	DRG	Inpatient (7 groups)		●	●	●	●		
		Outpatient							
	Per diem	Inpatient						●	
		Outpatient							
FFS + DRG	New DRG (pilot program)	Inpatient (550 groups)			○	○			
		Outpatient							
Performance-based compensation	Adjustable	In patient	Acute myocardial infraction			●	●		
			Cesarean section			●	●		
			Acute phase stroke			●	●		
			Surgery preventive antibiotics		●	●	●		
			Geriatric hospitals					●	
		Out patient	Hypertension (incentive only)	●					
			Diabetes (incentive only)	●					
			Pharmaceutical benefit assessment	●					

Source: Health and Welfare Issues and Policy Tasks (Korea Institute for Health And Social Affairs, 2014).

4) New DRG (New Diagnosis-Related Group)

The new DRG system combines the DRG and the FFS. Medical expenses are calculated for the seven DRGs as well as four major severe diseases (cancer, heart diseases, cerebrovascular diseases, and rare and incurable diseases). Basic services are covered under the DRG system, and doctors' expensive services and procedures are covered under the FFS system.

2.4 Types of Benefits

The NHI provides benefits in kind or cash for the prevention, diagnosis, and medical treatment of and rehabilitation from diseases and injury, for childbirth and death, and for health improvement. Benefits in kind are provided save for a number of exceptions for which cash benefits are provided. The NHI scheme has a negative list benefit system, and the MOHW determines non-benefit items. The table below lists the detailed items.

<Table 2-4> Benefit Types

Insurance benefits	Benefits in kind	· Health-care benefits · Health checkups
	Benefits in cash	· Co-payment ceiling · Auxiliary device expenses · Pregnancy and childbirth expenses

1) Benefits in Kind

Benefits in kind consist of health-care benefits and health checkups. Health-care benefits mean medical services received for diagnoses, tests, provisions of medicines and medical materials, procedures and surgeries, prevention and rehabilitation, hospitalization, nursing, and transportation for diseases and injuries suffered by subscribers and their dependents.

Medical services related to diseases that do not interfere with the patient's daily life or work may be excluded from the covered health-care benefits. These services are specified as non-benefit items in the relevant statutes. Health checkups are provided for the early detection of diseases. Eligible persons receive health checkup sheets and notifications from the NHIS, which also pays for the expenses incurred.

< Non-Benefit Items >

- Services, medicines, and medical materials that do not interfere with the work or daily life of the patient (minor snoring and fatigue)
- Services, medicines, and medical materials performed or used for purposes other than the improvement of essential physical functions (cosmetic surgery, freckle removal)
- Preventive services, medicines, and medical materials performed or used for purposes other than the treatment of diseases and injuries (deodorization, orthodontics)

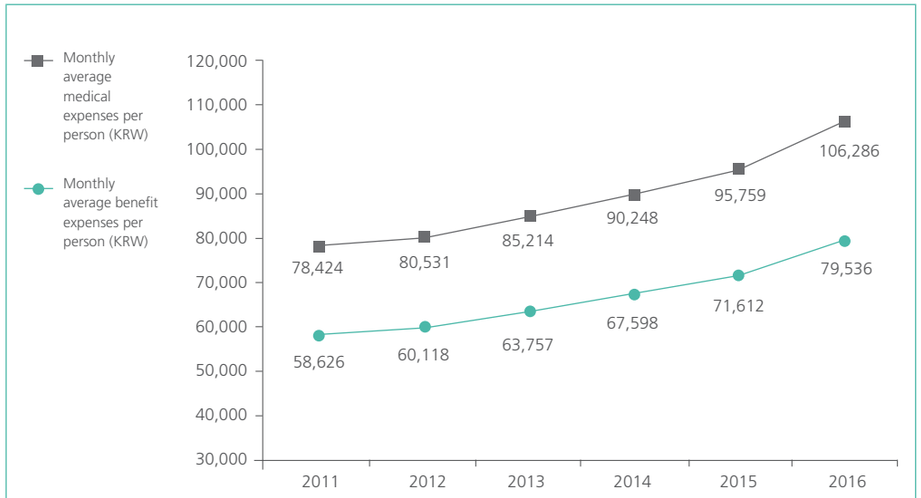
2) Benefits in Cash

Subscribers and dependents sometimes have no other option but to use medical institutions that are not covered by the NHI. In such cases, the NHI provides cash benefits corresponding to health-care facilities. Such cases include receiving health-care services for diseases, injuries, or childbirth, or giving birth to a child at a place other than health-care facilities.

A person with disability registered under the Act on Welfare of Persons with Disabilities can receive a part of the expenses spent purchasing auxiliary equipment as insurance benefit payment. A total of 90% of the purchasing price is granted for auxiliary devices under the threshold price; 90% of the base amount is provided for auxiliary devices exceeding the threshold. The monthly average medical expense per capita is on the rise. In 2020, it increased by 11.0% YoY to KRW 106,286.

[Figure 2-8] Monthly Average of Medical Expenses and Benefit Expenses by Year

(unit: KRW)



2.5 Management of Benefits

2.5.1 Registration of Benefits

A. Medical Practices

1) Definition

Medical practice or service means the diagnoses, tests, procedures, surgeries, and other actions performed on patients at health-care facilities.
Various medical services required by patients are registered and managed under the NHI scheme as health-care benefit items. To expand the scope of health-care benefits to the possible extent, the NHI maintains a negative list of benefit items. That is, the NHI covers medical services not announced as non-benefit items.

2) Registration of Medical Services as Health-Care Benefits

A new medical service should go through an assessment before it can be registered as a health-care benefit. In cases where a health-care facility or a pharmaceutical organization requests the HIRA to assess a new medical service for its eligibility as a health-care benefit item, the Healthcare Review and Assessment Committee conducts the assessment.
The Healthcare Review and Assessment Committee calculates the cost of the newly registered service (relative value points). The committee may also change non-benefit items into benefit items, or adjust existing cost calculations (relative value points).
As of February 2021, a total of 8,993 items are listed as health-care benefits.

3) New Health Technology Assessment

As a national system for verifying the safety and effectiveness of new health technologies tasked with protecting people's health and promoting the advancement of new technologies, the NHI operates the New Health Technology Assessment (NHTA) program. The National Evidence-Based Collaborating Agency carries out assessments.

B. Medical Materials

1) Definition

A medical material is a consumable material approved or reported under the relevant laws that is used for the treatment of patients covered by the NHI. Medical materials include: artificial joints, stents, and other consumable medical devices; dressing, gauze, and other sanitary aid; human tissues including bones and ligaments; and other products.
The NHI scheme maintains a list of registered medical materials and their prices. Medical materials not announced as non-profit items are deemed as health-care benefit items. As of October 2021, a total of 33,078 items are registered as medical materials.

2) Registration of Medical Materials

The registration process for medical materials begins when a health-care facility, a pharmaceutical organization, or a manufacturer or importer requests a decision on the eligibility of an item approved by, or reported to, the Ministry of Food and Drug Safety (MFDS).
The target material is assessed for safety and effectiveness, replaceability, cost and efficacy, economic feasibility, and coverage eligibility.
Based on the National Health Insurance Policy Deliberative Committee's deliberation and review, the MOHW Minister announces whether the item is a covered or a non-covered item, within 100 days from the date of the request.

C. Medicines

1) Coverage of Medicines

Under the NHI scheme, to ensure subscribers' access to pharmaceutical products and improve the quality of prescriptions, the registration and removal of pharmaceutical products as insurance benefits are strictly managed. As of October 1, 2021, a total of 25,716 items are registered as health-care benefits.
Korea also operates the Medicine Benefit Quality Assessment program, which compares and analyzes prescriptions of medicines highly affecting public health, such as antibiotics and injected medicines, and corrects the use of unnecessary or inappropriate medicines, thereby promoting the appropriate use of pharmaceutical products.

2) Registration of Medicines as Health-Care Benefits

As of January 2007, the NHI registers and manages medicines under the Positive List System. Under the Positive List System, pharmaceutical products with outstanding clinical and economic values are selected and registered.
In cases where a pharmaceutical company applies for benefit registration, the Drug Benefit Coverage Assessment Committee within the HIRA assesses the medicine for

benefit criteria, necessity, clinical use, costs, and efficacy, to determine whether the product is eligible for coverage. If deemed eligible, the NHSI and the manufacturer negotiate the price ceiling for the medicine, which is finally registered after a review by the National Health Insurance Policy Deliberative Committee.
The Drug Benefit Coverage Assessment Committee calculates price ceilings of generic medicines in accordance with its own criteria, which are listed upon consultation on relevant matters (i.e., supply and quality obligations) between the NHIS and the pharmaceutical company.

3) Rapid Registration of New Medicines

To help students access newly developed drugs in time, the NHIS has a process in place for faster registration where benefit and price decision criteria are more flexible.

4) Risk Sharing Agreements

Risk-Sharing Agreements (RSAs) allow the NHIS (insurer) and pharmaceutical companies to share risks regarding pharmaceutical products' effectiveness or their financial impact. The system was adopted in 2014 to improve access to expensive cancer drugs and treatment for rare and incurable diseases.
There are four types of risk sharing: conditional continuation of treatment; refund; total amount limit; mixed refund; and limit of use per patient. Other types of risk sharing can be applied based on the Drug Benefit Coverage Assessment Committee's assessment.

2.5.2 History of Health-Care Benefit Registration and Management

1) Medical Practices

When the first public medical insurance was adopted, the government only announced health-care benefit items covered by the insurance. However, the definitions and benefit payment procedures for newly developed technologies were not clearly specified, resulting in a non-coverage of the new medical services.
To address this issue, in July 2000, the government began to announce the Benefit List consisting of health-care benefit and non-benefit items, and provided that medical services not announced as non-benefit items are health-care benefit items (Negative List System).
In the following years, with the increase of undetermined medical services, the HIRA set up the Expert Committee on Medical Practices, which was reorganized into the Healthcare Review and Assessment Committee in 2002. In 2007, as a national system for verifying the safety and effectiveness of new health technologies tasked with protecting people's health and promoting the advancement of new technologies, the NHIS adopted the New Health Technology Assessment (NHTA) program.

2) Medicines

The coverage of medicines began with the adoption of the first public medical insurance in 1977. Since then, the number of pharmaceutical products covered by the insurance increased from 2,961 to more than 20,000.
The products' costs were determined by adding margins to factory prices to control the prices of pharmaceutical products. The reimbursement of purchasing price began in 1999, and the pharmaceutical expenditure reduction grant program was launched in September 2014.
In 2001, to control the use of pharmaceutical products at an appropriate level, the government adopted the pharmaceutical benefit quality assessment program. The program analyzes the prescriptions of medicines with a significant impact on public health and provides feedback to medical institutions to encourage them to reduce unnecessary or inappropriate medication use.
In addition, in 2006, the government abolished the negative list system for pharmaceutical products, and replaced it with the positive list system. The new system selects and registers pharmaceutical products with outstanding clinical and economic values.

3) Medical Materials

At the time of adopting the public medical insurance scheme, medical materials were deemed incidental to medical services. Therefore, medical material expenses were included in medical service fees, and no separate compensation was provided. However, purchasing price compensation was provided for 23 medical materials, including films and contrast media used for x-ray tests.
In 1984, the government introduced a negotiated price system providing coverage for materials approved by the MOHW Minister. In 1988, the single price limit system was adopted, under which compensations for certain items were provided based on actual purchasing prices within the upper limit. The two systems were abolished in 2000 and replaced by the reimbursement of transaction prices within the upper limit.

2.5.3 Management of Benefits

Accidents caused by willful acts or gross negligence are not eligible for insurance coverage. In addition, in cases where the NHIS finds out that a subscriber or a dependent received benefits by fraud or other illegitimate means, the NHIS shall collect the amount paid for by the service.
The NHIS also encourages subscribers to use medical services with moderation and takes various actions to improve access to medical services.

1) Co-Payments

When using a health-care facility, a subscriber or a dependent must pay a part of the expenses out of his/her own pocket. The requirement is aimed at preventing the uncontrolled use of medical services, and the concentration of patients at higher-level health-care facilities. Co-payments vary depending on the type of facility, and whether the patient received inpatient or outpatient care. Co-payments play a vital role in the efficient distribution and use of medical resources.

<Table 2-5> Co-Payment Rates

Category	Institution	Disease	Co-payment rate
Inpatient	-	General	20%
	-	Rare diseases	10%
	-	Severe diseases	5%
Outpatient	Tertiary hospital		60%
	General hospital		50%
	Hospital		40%
	Clinic		30%
	Pharmacy		30%

2) Co-Payment Ceiling System

Under the Co-Payment Ceiling System, the NHIS lowers the financial burden on households from high medical expenses by paying the part of the co-payments paid by a subscriber (and dependents) in a year (between January 1 to December 31) that exceeds the co-payment ceiling. The excess is paid for in two ways: pre-payment benefits and post-payment refunds. Table 2-6 lists the co-payment ceiling by income level.

<Table 2-6> Co-Payment Ceiling by Income Level

(unit: KRW 10,000)

Year	Hospital length of hospitalization	Annual average of NHI contribution bracket (from low to high income)						
		1st bracket	2 to 3rd brackets	4 to 5th brackets	6 to 7th brackets	8th bracket	9th bracket	19th bracket
2017		122	153	205	256	308	411	514
2018	120 days or less	80	100	150	260	313	418	523
	More than 120 days	124	155	208				
2019	120 days or less	81	101	152	280	350	430	580
	More than 120 days	125	157	211				
2020	120 days or less	81	101	152	281	351	431	582
	More than 120 days	125	157	211				
2020	120 days or less	81	101	152	282	352	433	584
	More than 120 days	125	157	212				

Note: Co-payments include all hospitalization fees, outpatient care fees, and medicine prices paid by the patient.

3) Subsidies for Catastrophic Medical Expenditure

This program grants subsidies to pay for excessively high medical expenses. It is designed to prevent cases where a household cannot access medical services based on financial reasons.

<Table 2-7> Payment for Catastrophic Medical Expenses by Disease and Income Level

As of September 30, 2021 (unit: no. of subsidies, KRW million, %)

Category		Total	
		Subsidies	Amount
Total		**11,712 (100.0)**	**29,569 (100.0)**
By disease	4 major severe diseases	4,749 (40.6)	17,160 (58.0)
	Severe burn injury	52.0 (0.4)	255 (0.9)
	Other diseases	6,911 (59.0)	12,154 (41.1)
By income level	Welfare beneficiaries, near-poverty groups	4,663 (39.8)	6,996 (23.7)
	Below 50% of median income	2,416 (20.7)	5,340 (18.0)
	50%–85% of median income	2,872 (24.5)	8,410 (28.4)
	85%–100% of median income	846 (7.2)	3,042 (10.3)
	100%–200% of median income	915 (7.8)	5,781 (19.6)

4) Special Estimate Cases

The special estimate case system lowers co-payment rates for severe diseases (cancer, cardiovascular/cerebrovascular diseases, severe burn injury, severe trauma, etc.), rare and incurable diseases, tuberculosis, and latent tuberculosis infection. The typical co-payment rate is 20% for inpatient care, and 30% to 60% for outpatient care. However, when registered as a special estimate case, 0% to 10% co-payment applies to both inpatient and outpatient care (note, that cardiovascular/cerebrovascular diseases and severe trauma are applicable for in-patient care.) Table 2-8 shows the specific list of the eligible diseases.

<Table 2-8> Special Estimate Cases

As of January 1, 2020

Category	Eligible disease							
	Cancer	Heart diseases	Cerebrovascular diseases	Rare and incurable diseases	Severe burn injury	Severe trauma	Tuberculosis	Severe dementia
Adoption date	September 2005	September 2005	September 2005	July 2009	July 2010	January 2016	July 2016	October 2017
Registration period	5 years (re-registration allowed)	Up to 30 days (60 days for CHDs and heart transplant)	Up to 30 days	5 years (re-registration allowed)	1 year (extendable by 6 months)	Up to 30 days	Treatment period	5 years (60 days per year for V810)
Co-paymentrate	5%	5%	5%	10%	5%	5%	0%	10%

Note: Health-care facilities apply reduced rates for vascular disease, heart disease, and severe trauma patients without separate registration. CHD: X heart disease.

* Excludes non-benefits, selective benefits (preliminary benefits), full co-payment, meal expenses, and hospitalization in rooms for 2 to 3

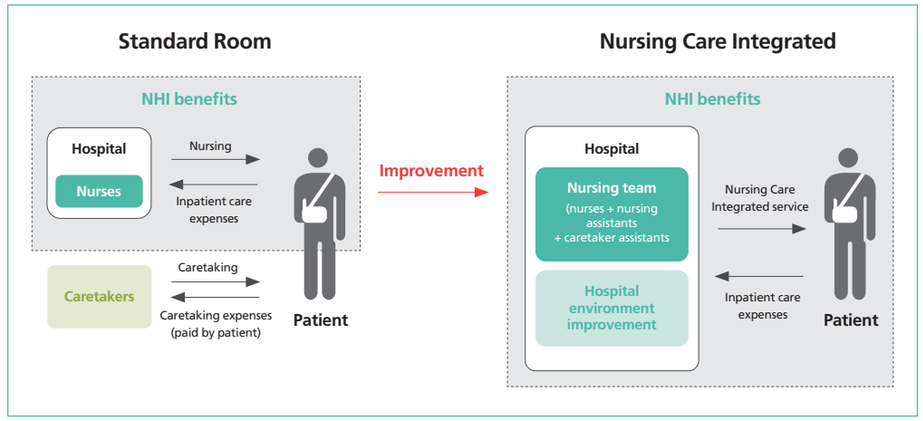
5) Selective Benefits

Selective benefits are preliminary health-care benefits prescribed and announced by the MOHW Minister in cases where the benefits are deemed to offer potential benefits for recovery despite their low economic feasibility (cost-effectiveness) or effectiveness requiring additional evidence for verification.

6) Nursing Care Integrated Service

The nursing care integrated service is an inpatient service program where patient caretaking services are provided by nurses, nursing assistants, and other caretakers, instead of the patient's guardians or caretakers personally hired by the patient.

[Figure 2-9] Nursing Care Integrated Service Program



2.5.4 Follow-Up Management

(1) Definition

Through the follow-up management of insurance benefits, the NHIS verifies whether the benefits previously claimed and provided to a beneficiary were claimed and provided in accordance with the relevant laws.

(2) History of Follow-Up Management

Follow-up management of benefits include: ① identifying and collecting medical expense payments provided based on illegally established health-care facilities or fraudulent or erroneous claims; ② restricting insurance payments and collecting insurance payments on account of third-party actions; ③ collecting insurance benefits paid to non-eligible persons and other unlawful profits; and ④ filing objections against the HIRA's medical expense review results.

The NHIS took numerous actions to prevent the illegal establishment of health-care facilities or fraudulent or erroneous claims. Primary examples include the medical examination guidance (previously called "medical examination history notification") adopted in 1979 and the Benefits Management System (BMS) launched in 2010. The BMS uses statistical techniques, such as data-mining the corporation's big data, including medical expenses and eligibility status, to predict and detect health-care facilities suspected of fraudulent claims, unlawful grant, and illegal establishment.

2.5.5 Review and Provision of Benefits

1) History of Review and Provision System

At the time of the initial implementation, health-care facilities filed medical expense claims to insurers, that is, the employee medical insurance associations and the Government Employee and Private School Employee Medical Insurance Management Corporation. The insurers reviewed the claims and paid for the claimed expenses. In 1979, the review and provision of benefits were delegated to the National Medical Insurance Association. In 1988, the medical expense review for government employee and school employee medical insurances started to be conducted by insurer organizations.

After the medical insurance associations' merger into the NHIS in 2000, the medical expense review function was undertaken by the HIRA, and the benefit provision function was assigned to the NHIS. As a result, the benefit provision process under the NHI came to have the structure that we see today: health-care facilities (files health-care benefit claims) → the HIRA (review and assessment) → the NHIS (pre-inspection and provision) → health-care facilities.

2) Medical Expense Review

After providing medical services to a patient, a health-care facility files a benefit claim with the HIRA, which reviews whether the claim satisfies the specified criteria. The review system deters unnecessary medical services, prevents fraudulent claims, and hinders excessive and inappropriate use of medical resources.

Upon receiving a medical expense claim from a health-care facility, the HIRA reviews the claim in two stages: electronic checkup (stage 1) and electronic review powered by an artificial intelligence program (stage 2). The HIRA conducts a specialized review for claims requiring expert medical opinions or confirmation by reviewers (stage 3).

The HIRA notifies the review results to the health-care facility and the NHIS, which pays the determined amount to the facility.

3) Health-Care Quality Assessment

The health-care quality assessment determines whether medical services provided by health-care facilities (diagnosis, administration of medicines, tests, etc.) are appropriate in pharmaceutical and cost-effective terms. The quality assessment forms the foundation

for assessing medical services' quality and achieving more advanced medical services.
The assessment results, including the assessment ratings, are reviewed by the Central Assessment Committee and notified to health-care facilities. The results are also disclosed on the HIRA website.

3 Health Management

3.1 Overview

In response to the paradigm shift in health care from treatment to prevention and promotion, the NHIS provides health checkups, follow-up management, and other services to ensure reasonable use of medical services and prevent various diseases and complications.

3.2 History of Health Management

1) Launch of Health Checkup Program

Heath checkup services under the NHI scheme began with the health checkups provided to government employees and private school employees under the Government Employee and School Employee Medical Insurance. In 1986, several employee medical insurance associations launched hepatitis prevention programs for their members. These programs grew into health checkup programs that spread across the country.

2) Enactment of the National Health Promotion Act

The enactment of the National Health Promotion Act in 1995 opened the door for more systemic and broader health management programs. Regional cooperatives began checkup programs for adult diseases, and employee medical insurance associations launched checkup programs for gastric cancer, colon and rectal cancer, breast cancer, and lung cancer.
At the same time, Korea saw the rapid growth of various health promotion programs. The Health Promotion Fund was established for national health promotion programs, including health management programs for smokers, and programs aimed at increasing facilities and equipment for public health care and health promotion.

3) Paradigm Shift: From Treatment to Prevention

The merger of the NHI in July 2000 was accompanied by a paradigm shift in national health insurance from treatment to prevention. The government continued to expand the list of covered cancers and services, and engaged in various follow-up management programs for the health management of chronic patients.
To enhance the public's ability to fight diseases, the NHIS launched Health IN, a portal site for health information. The NHIS also brought health promotion programs closer to people's living, such as obesity management programs, a sports program for all citizens, and "Healthy 100-Year-Old Exercise Classes." In 2007, the NHIS improved the effectiveness of its preventive activities by launching the Life Transition Point Health Checkup program and health checkup programs for young children in 2007.

4) Health Promotion Programs after Enactment of the Framework Act on Health Checkups.

In April 2008, the Framework Act on Health Checkups was enacted. The Act provided for citizens' rights and obligations to health checkups. Under the Act, the government established 5-Year Master Plans for National Health Checkups to ensure health checkups' effectiveness and provide appropriate follow-up management activities.
Under the Act, follow-up management programs for chronic diseases were merged in 2010 for integrative management. Since 2021, the government has pursued various policies across all stages of health management under the Third Master Plan for National Heath Checkups, from early detection of diseases to improvement of health behaviors.

3.3 Health Management Programs

(1) Health Checkups

Health checkups under the NHI scheme include General Health Screening, Screening for Cancer, Infant and Child Health Checkups, and Health Checkups for Teens outside of Schools. The expenses for the checkups, excluding cancer screenings, are fully paid for by the NHIS.

<Table 2-9> Types of Health Checkup

Category	General Health Screening	Screening for Cancer	Infant and Child Health Checkups	Health Checkups for Teens outside of Schools
Target diseases	Cardio and cerebrovascular diseases (hypertension, diabetes, etc.)	Gastric cancer, colorectal cancer, breast cancer, cervical cancer, and lung cancer	Growth and development disorders, hearing and visual impairments, etc.	Hypertension, diabetes, infectious diseases, etc.
Eligible persons	Subscribers aged 20 or older (no age restriction for insured employees and household heads)	• Gastric cancer, breast cancer (40 or older) • Colorectal cancer (50 or older) • Cervical cancer (women, 20 or older) • Lung cancer (54–74, high-risk group) • Liver cancer (40 or older, high-risk group)	Infants and children under 6	Teens outside of school aged 9–18
Checkup items	Common items (blood test, urine test, chest radiography) and age-specific items	• Gastric cancer: EGD or UGI • Colorectal cancer: FOBT (if positive, colonoscopy or double-contrast barium enema (DCBE) • Liver cancer: Liver ultrasonography, maternal serum alpha-fetoprotein screening • Breast cancer: breast imaging • Cervical cancer: Pap Smear test • Lung cancer: Low-dose chest CT and follow-up counseling	Body measurement, diagnosis, developmental assessment and counseling, and health education	Urine test, blood test, imaging test, dental examination, infectious disease test (HIV antibody, serologic syphilis test, sexually transmitted diseases)
Checkup cycle	2 years (1 year for non-office workers)	2 years (1 year for colorectal cancer, 6 months for liver cancer)	14 days to 71 months (8 checkups) - 14 days, and 4, 9, 18, 30, 42, 54, and 66-months	3 years

1) General Health Checkup

General Health Checkups are conducted once every two years for early diagnosis of potential diseases and the provision of health-care benefits for the diseases. They are provided to insured employees, self-employed insureds aged 20 or older, and dependents aged 20 or older. Persons suspected of hypertension or diabetes are referred to hospitals or clinics for confirmation. Checkup items are as follows.

<Table 2-10> Types of Health Checkups and Checkup Items

Category	Checkup items and eligibility			
Common items (18)	Diagnosis and counseling, body measurement (weight and height, waist, and obesity), visual and hearing checkups, blood pressure measurement, chest imaging, blood test (hemoglobin, fasting glucose, AST, ALT, y-GTP, serum creatinine, e-GFR), urine test, and dental examination			
Gender/age-specific items (11)	Dyslipidemia	Total cholesterol	Men aged 24 or older, women aged 24 or older, (every 4 years)	Men (aged 24, 28, 32…) Women (aged 40, 44, 48…)
		HDL cholesterol		
		Triglycerides		
		LDL cholesterol		
	Hepatitis B test		Aged 40	Excluding immune persons/carriers
	Bone density test		Women aged 54, 66	
	Cognitive impairment		Aged 66 or older (every 2 years)	Aged 66, 68, 70…
	Mental health examination (depression)		Aged 20, 30, 40, 50, 60, 70	Once in each decade starting from the ages indicated
	Life habit assessment		Aged 40, 50, 60, 70	
	Bodily function test for the elderly		Aged 66, 70, 80	
	Dental plaque test		Aged 40	Dental examination items

2) Screening for Cancer

Screenings for gastric cancer, breast cancer, cervical cancer, and lung cancer are conducted every two years, and screenings for colorectal cancer and liver cancer are conducted every year and twice per year. The examinees pay for 10% of the cancer screening expenses, and the NHIS fully pays for screenings for colorectal cancer and cervical cancer. The central and local governments pay the co-payments to be paid by persons eligible for national cancer screening programs (10%), and fully pay cancer screening expenses for persons eligible for medical aid.

<Table 2-11> Health Checkup Services for Cancer

Category	Checkup age	Checkup cycle
Gastric cancer	Aged 40 or older	2 years
Liver cancer	High-risk group, aged 40 or older	6 months
Colorectal cancer	Aged 50 or older	1 year
Breast cancer	Women aged 40 or older	2 years
Cervical cancer	Women aged 20 or older	2 years
Lung cancer	High-risk group, aged 54-74	2 years

3) Infant and Child Health Checkups

Infant and child health checkups consist of growth/development tracking, examination, and dental examination. The test periods are based on the growth cycle of infant and child, which are 14 days, 4 months, 9 months, 18 months, 30 months, 42 months, 54 months, 66 months after birth. The NHIS conducts health checkups for young children and adults, and schools and local governments provide health checkups for juveniles.

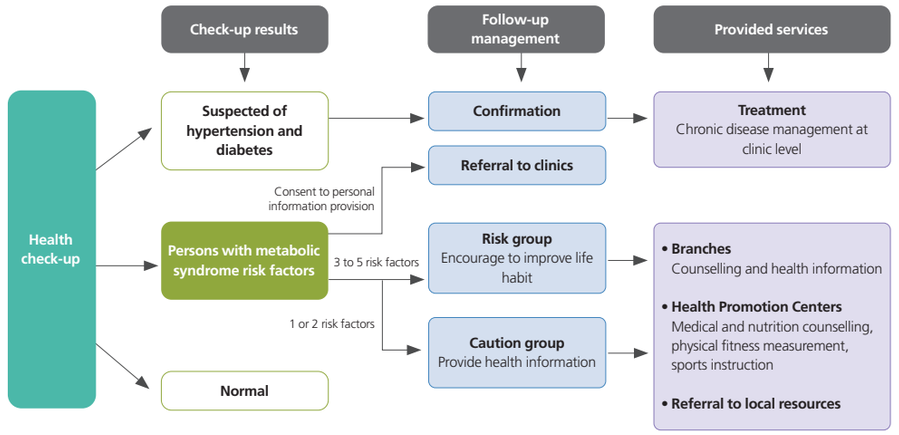
4) Health Checkups for Teens outside of Schools

The health checkup program for teens outside of schools was delegated to the NHIS by the Ministry of Gender Equality and Family. The program targets adolescents aged between 9 and 18 (international age) who do not attend schools. The services consist of a basic examination (including dental examination), optional examinations, and confirmation tests. Expenses are fully paid by the government.

(2) Health Promotion

An increase in life expectancy and the elderly population came with changes in the pathological map of the society, especially with regard to chronic diseases such as hypertension and diabetes. In addition, people's demand for health promotion has increased along with the improvements in the quality of living. In keeping with these trends, the NHIS carries out various health promotion programs, including health education, support for sports for all, health checkups and follow-up management, and health management for chronic patients.

[Figure 2-10] Health Promotion through Health Checkups



1) Follow-Up Management

The NHIS provides follow-up management for people found to have risk factors for metabolic syndrome in health checkups. Metabolic syndrome means a pre-disease state in which a person is diagnosed with a combination of more than two of the five risk factors. A person with metabolic syndrome is at a higher risk of suffering from myocardial infarction, stroke, and other serious complications, as well as cardiovascular diseases.
Persons with three or more risk factors are classified as the risk group, and persons with one or two risk factors are classified as the caution group if they want follow-up management. The NHIS provides the two groups with telephone counseling and visitations, as well as information on how to deal with metabolic syndrome. The NHIS also prevents the syndrome from turning into actual diseases by helping people with the syndrome improve their life habits and manage their physical conditions.

<Risk Factors of Metabolic Syndrome>

- Abdominal obesity: Abdominal circumference 90 cm or larger (men) or 85 cm or larger (women), or BMI 25 or higher
- High blood pressure: Systolic pressure 130 mmHg or higher, or diastolic pressure 875 mmHg or higher
- High blood glucose: Fasting blood glucose 100 mg/dL or higher
- Hypertriglyceridemia: Neutral fat 150 mg/dL or higher
- Low HDL cholesterol: HDL cholesterol below 40 gm/dL (men) or 50 mg/dL (women)

4 Information Management

The NHIS manages its information using advanced systems powered by information and communication technologies (ICT), and uses big data to develop bespoke health information services.

4.1 Information Management System

Throughout its history, the NHIS has built a number of well-organized and specialized information systems: the National Health Insurance Information System; the Medical Aid Eligibility Management System; the Joint Disaster Restoration Center; the Integrated Collection Information System for Four Social Insurances; the Health Checkup System; the Benefit Management System; and the Long-Term Care Information System. These systems allowed the NHIS to maximize its operational efficiency, and promote public health while providing easier access to its services.

The NHIS completed the transition to a centralized and advanced information system and streamlined/automated data processing on insurance contributions imposed on self-employed insureds. The advancements improved customer experience with the integrated health checkup database, and streamlined claim processing by allowing customers to file claims via the Internet rather than diskettes.

4.2 History

1) Information Management in Early Years

In the early years of the public medical insurance system, each cooperative managed its own information, using its own information management system. The National Medical Insurance Management Corporation led the first IT system integration, and the second integration came with the foundation of the NHIS as a result of the merger in July 2000. The second integration resulted in the NHI Information System, which has played a central role in the NHI operation.

2) Next-Generation Information System

In 2006, the NHIS built the Next-Generation Information System powered by rapidly advancing information technologies. The NHIS also built a state-of-the-art data mining system to improve operational efficiency and the quality of its public services. These efforts led to the launch of the NHI Benefit Management System (NHI-BMS) for the management of fraudulent claims in 2010. The system utilizes data mining technologies on an unprecedented level.

3) LTC Information System

With the adoption of the LTC Insurance for the Elderly on July 1, 2008, the NHIS developed the LTC Information System. The system is linked with the NHI Information System for efficient management of LTC beneficiaries and contribution imposition. In addition, the service opened an Internet portal system for information sharing and coordination among LTC institutions and the NHIS's information systems

4) Integrated Collection Information System

The NHIS is responsible for collecting the contributions for the four major social insurances. In June 2010, the NHIS launched the Integrated Collection Information System for the Four Major Social Insurances after a year of development.

The system, which began its full operation on January 3, 2011, after six months of testing, effectively integrates contribution notification, reception, and delinquency management for all of the four insurances. The system enabled the NHIS to collect contributions in a smoother and more efficient way.

5) Big Data and Development of ICT Information System

In 2012, the NHIS built the National Health Information Database offering access to the NHI (big) data of all citizens. The development of the database was followed by an ICT-powered NHI big data platform in 2014. In 2016 and 2017, the NHIS developed and launched a self-health management system, a remote research support system, and a system for regional health-care information.

In addition, using the NHIS HQ's relocation to Wonju, Gangwon-do, the NHIS built a new ICT center complete with data center infrastructure and a state-of-the-art network environment, and moved its information systems to the Wonju Data Center within the new HQ building. The stabilization of the system was completed in March 2016, ensuring that the center and its advanced information systems can fulfill their role as the vanguard of NHI informatization.

4.3 Use of Big Data

The NHIS manages the NHI Information Database, which stores massive data on eligibility, contributions, medical records, prescription, health checkups, health-care facilities, and LTC of all Koreans. The NHIS uses the database to develop bespoke health services, support research projects and policymaking, and share information with external institutions.

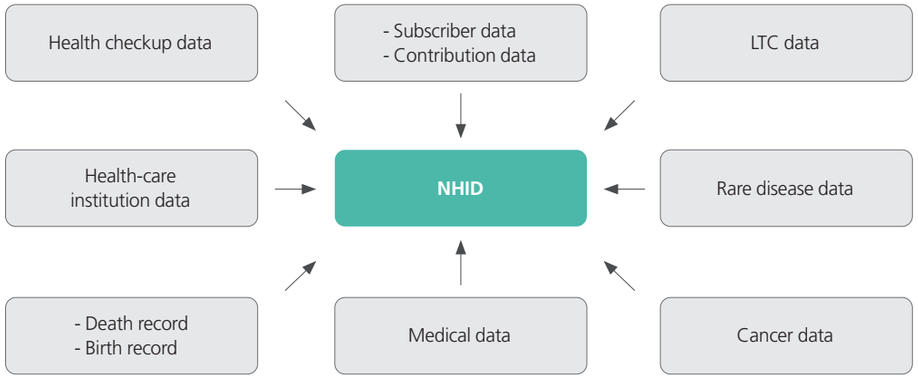
1) Relevant Areas

The big data stored in the database are organized in a way that enables the NHIS to predict disease risks, provide health management information, and produce information on metabolic syndrome risk factors and health promotion. The NHIS uses the data to provide the public with a wide selection of services, including: personalized medicine administration management programs; bespoke health information services based on personal health record (PHR); health and disease indexes tailored to different regions or business establishments; and national health alert services.

2) Other Areas

The NHI big data are also used outside the NHIS for various purposes, including sample cohort development, driver's license physical examinations, and litigations against tobacco companies, to name a few.

[Figure 2-11] Types of Big Data



In a beautiful world,
a lifelong health with you!

Ⅳ

LONG-TERM CARE INSURANCE FOR THE ELDERLY

Ⅳ LONG-TERM CARE INSURANCE FOR THE ELDERLY

The Long-Term Care (LTC) Insurance for the Elderly is a social insurance scheme that provides long-term care benefits to elderly citizens experiencing difficulties with daily routines for six months or longer on account of old age or age-related diseases.

1 Overview

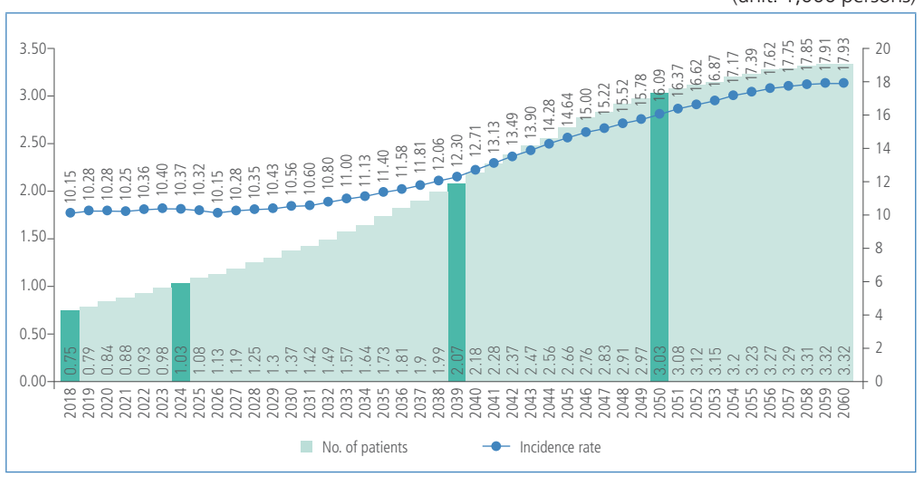
1.1 Background

Driven by increased life expectancy and a sharp decline in birth rate, population aging has emerged as a serious issue in Korea. The issue led to the awareness that supporting the elderly is the responsibility of the state and the society as a whole, rather than individual households. In line with these newfound welfare needs, the government launched the LTC Insurance for the Elderly in July 2008.

The significance of the insurance is expected to grow, driven by the rapid increase of dementia patients, as shown in Figure 3-1.

[Figure 3-1] Increase in Dementia Population

(unit: 1,000 persons)



Source: 1) 2016 Nationwide Survey on the Dementia Epidemiology of Korea (MOHW, National Institute of Dementia)
2) Population Projections (Statistics Korea, 2019)
Source: 2019 Korea Dementia Report (MOHW and National Institute of Dementia), p. 34.

1.2 Features

The NHI covers services provided by hospitals, clinics, and pharmacies, including diagnosis, inpatient and outpatient care, and rehabilitation. On the other hand, the LTC Insurance covers services provided by nursing facilities and LTC institutions to provide assistance with physical activities and household chores for patients experiencing difficulties with daily tasks on account of aging or age-related diseases such as dementia and stroke.

In the recent social changes such as population aging and the increase of nuclear families, the LTC Insurance shifts the responsibility for the elderly from individual households to the social plane. The insurance lowered the burden on households, and contributed to the government's job creation efforts.

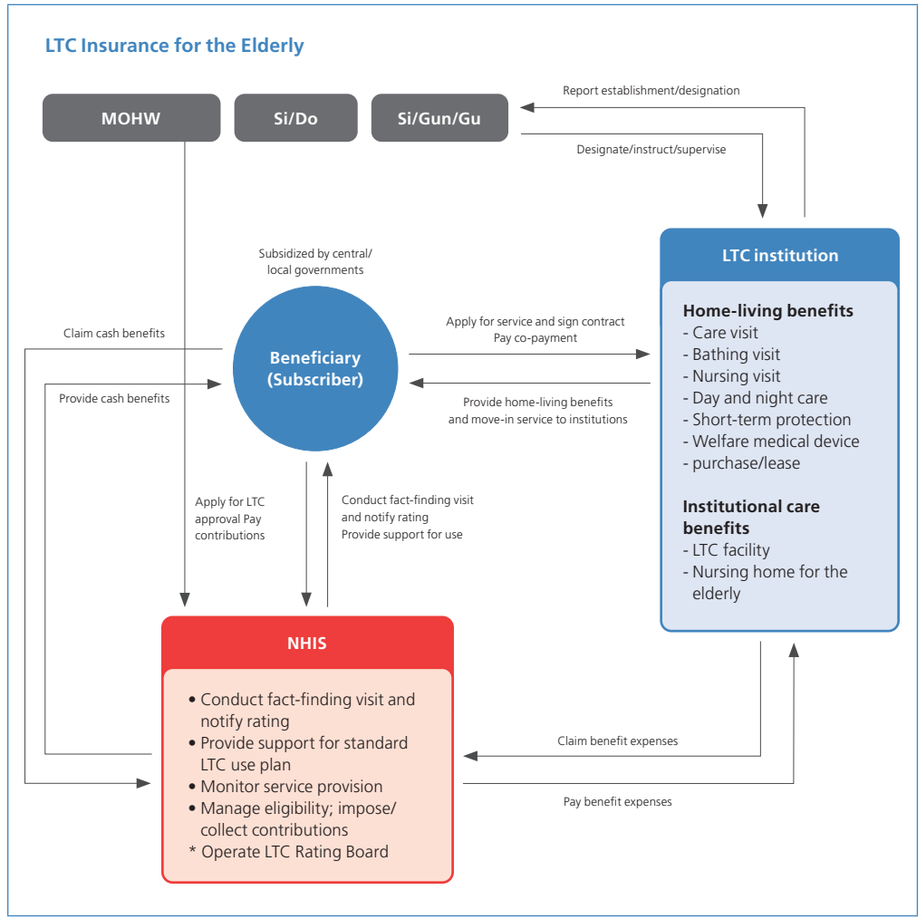
1.3 Legal Basis

The Long-Term Care Insurance Act was enacted on April 27, 2007. The Act contains provisions on LTC benefits for the elderly experiencing difficulties with daily activities on account of old age or age-related diseases. The Act stipulates LTC insurance benefits for physical or domestic activities.

1.4 Operational Structure

The LTC Insurance is managed and operated by the NHIS under the supervision of the MOHW Minister. A person who intends to operate a long-term care institution should obtain a designation from a Special Self-Governing City Mayor, a Special Self-Governing Province Governor, or the head of a Si/Gun/Gu who has jurisdiction over the location of the institution.

[Figure 3-2] LTC Insurance Management and Operational Structure



2 History of LTC Insurance for the Elderly

1) Adoption of LTC Insurance for the Elderly

Faced with a rapid increase in the elderly population, the Korean government began preparation for the LTC Insurance for the Elderly in 1999. After years of the design process, the government launched a three-year pilot project in July 2005. The pilot project was designed to verify the scheme's feasibility in terms of LTC Level rating tools, LTC benefit expenses, service provision, and systems. In addition, the Long-Term Care Insurance Act was enacted and promulgated in April 2007. A total of 225 LCT Insurance Centers were established in May 2008, and the programs began in earnest on July 1 across Korea.

2) Development of LTC Insurance for the Elderly

The LTC Insurance for the Elderly was positively received by Koreans. The number of applications far exceeded the initial expectation, and 214,000 applicants were approved as beneficiaries. In 2009, 287,000 applicants received approval for LTC benefits.

The number of live-in LTC institutions increased 3.4 times between 2008 and 2020, reaching a total of 5,762 institutions. Home-living service institutions also increased 2.9 times from 2008, to 19,621 institutions. A total of 1,786,000 care workers were trained (4.5 elderly persons per care worker), which provided a stable foothold for service provision.

However, the infrastructure's rapid construction gave rise to some undesirable behaviors among LTC facilities, such as poor safety management and service provision, and excessive competitive behaviors as some facilities tried to attract or broker beneficiaries.

The government established the Primary Master Plan for LTC Benefits (2013–2017) for the smooth provision of long-term benefits. Subsequently, the Secondary Master Plan for LTC Benefits (2018–2022) was set up based on social-economic changes, such as baby boomers' entry into the aged population and the preliminary master plan results.

The NHIS established operation regulations and participated in the LTC Development Planning Team to raise the quality of services. Moreover, we launched our "LTC Development Action Team" for short- to mid-term strategies and institutional development.

As of 2020, the LTC recipients were expanded to 858,000 elderlies, as well as a 3.4-time

jump to 5,762 LTC institutes (from 2008), a 2.9-time jump to 19,621 home care facilities (from 2008), and training 1.93 million care workers (each in charge of 4.4 elderlies) to strengthen service delivery systems.

3) LTC Institutions Operated by NHI

The NHIS opened its first directly-run "NHIS Seoul Long-Term Care Center" in November 2014 in Gangnam-gu, Seoul to accommodate 150 elderlies and 44 weekday guardians. Furthermore, the NHIS, as a public institution, developed the long-term benefit standard through combined facility and home care services and presented a standard model for appropriate benefit reviews to improve services quality.

4) Long-Term Care Institute Dedicated to Dementia

In July 2016, the government introduced the Long-term Care Institute Dedicated to Dementia system to provide bespoke services to dementia patients. The new system aimed to address one of the issues with the LTC Institution scheme, where dementia patients receive the same services from the same facilities as other beneficiaries. The new institutions provide patients with dementia with an environment where they can feel comfortable, along with trained professionals assigned to each patient for optimized bespoke care services.

5) Cognitive Assistance Level

Under the "national responsibility system for dementia," the government newly introduced a new LTC level called the Cognitive Assistance Level, so that beneficiaries with minor cases of dementia may receive LTC benefits regardless of their physical functions. This opened doors for patients with mild dementia who had been experiencing difficulties with accessing the LTC Insurance scheme.

3 Eligibility System

3.1 Eligibility

LTC benefits are not available for all NHI subscribers. Beneficiaries are required to obtain LTC approval in accordance with the specified rating procedures. Application for LTC approval may be filed by elderly persons aged 65 or older, or persons under 65 with age-related diseases such as dementia, Parkinson's Disease, and cerebrovascular diseases. Targets also include LTC insurance subscribers, dependents, and medical benefit recipients. Given the physical and mental states of beneficiaries, applications may be filed by beneficiaries' family members, relatives, and other related persons via visit, mail, fax, or the Internet. However, foreign workers who opted out of the LTC Insurance and/or the NHI may not apply for LTC approval. Table 3-1 shows the scope of LTC Insurance.

<Table 3-1> Scope of LTC Insurance Application

Category	Eligible persons
Persons eligible for LTC Insurance	All Korean nationals (LTC insurance subscribers and dependents + medical aid beneficiaries) ※ Excludes: Foreign workers who opted out of the LTC Insurance and/or the NHI
Contribution payer	Insured employees and self-employed insureds for the LTC Insurance
LTC approval application	Elderlies aged 65 or older or persons under below 65 who are LTC insurance subscribers, dependents, or medical aid beneficiaries
LTC beneficiaries	LTC approval applicants deemed incapable of carrying out daily activities alone for six months or longer by the Long-Term Care Rating Board.

3.2 Beneficiaries

The Long-Term Care Rating Board selects beneficiaries among elderlies aged 65 or older and persons under 65 with age-related diseases who are deemed incapable of carrying out daily activities alone for six months or longer. As of 2020, the number of persons enjoying medical security aged 65 or older was 8.48 million, and the number of persons approved for the LTC Insurance is 860,000 (approval ratio: 10.1%). Tables 3-2 and 3-3 show the number of persons approved for the LTC Insurance by level and year.

<Table 3-2> Number of Eligible Persons by LTC Level

(unit: no. of persons)

	Total	Level 1	Level 2	Level 3	Level 4	Level 5	Cognitive Assistance Level
2020	857,984	43,040	86,998	238,697	378,126	91,960	19,163

<Table 3-3> Number of Persons Approved for LTC Insurance

(unit: no. of persons)

Category	2015	2016	2017	2018	2019
Elderlies (65 or older)	6,940,396	7,310,835	7,611,770	8,003,418	8,480,208
Persons deemed eligible (approved + nonrated)	681,006	749,809	831,512	929,003	1,007,423

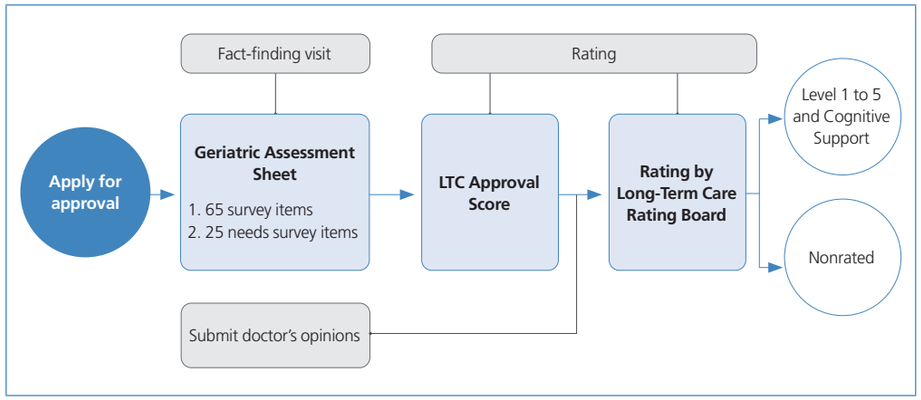
4 Benefit System

4.1 Approval Application

LTC approval is granted through a number of stages: approval application, geriatric assessment, submission of doctor's opinions, LTC level rating, approval result notification (issuance of Certificate of Long-Term Care Insurance and Standard Long-Term Care Utilization Plan), selection of LTC institute, and execution of health-care benefit contract.

① An applicant sends an application form to the Long-Term Care Insurance Operation Center (an NHIS branch in the area). ② Qualified NHIS personnel visit the applicant to verify his/her state using the Geriatric Assessment Sheet (90 items). ③ The Long-Term Care Rating Board determines the LTC Level based on the assessment results and doctor's opinions (Levels 1 to 5 + Cognitive Assistance Level). ④ The approved beneficiary is issued with the Certificate of Long-Term Care Insurance, the Standard Long-Term Care Utilization Plan, and the Confirmation of Welfare Medical Device Benefit. ⑤ Depending on the level determined by the Long-Term Care Rating Board, the beneficiary can receive benefits at home or an LTC facility. In the case of a non-rated applicant, the applicant is referred to the comprehensive elderly care service program provided by the local government. Figure 3-3 shows the LTC approval process.

[Figure 3-3] LTC Approval Process



As a result of the rating process shown in Figure 3-3, an applicant is assigned an LTC approval score depending on his/her physical and mental functions. The applicant's LTC level is determined based on the score. Level 1 and 2 beneficiaries can access home-living benefits or institutional care benefits. Level 3, 4, and 5 beneficiaries and Cognitive Assistance Level beneficiaries can receive only home-living benefits (only day and night care available for beneficiaries at the Cognitive Assistance Level). If approved by the Rating Committee, Level 3, 4 and 5 beneficiaries can access institutional care benefits. LTC levels are valid for between two and four years, depending on the state of the beneficiary. A beneficiary may apply for an extension of the valid period.

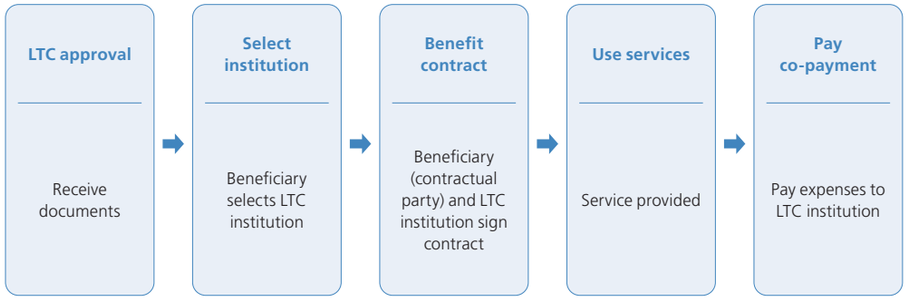
<Table 3-4> Eligibility Scores and Functions by LTC Level

Level 5	Physical and mental functions	LTC approval score
Level 1	Needs help from others for all daily activities	95 or higher
Level 2	Needs help from others for a large part of daily activities	75–94
Level 3	Needs help from others for a part of daily activities	60–74
Level 4	Needs help from others for certain daily activities	51–59
Level 5	Dementia (confined to age-related diseases under Article 2 of the Enforcement Decree of the Long-Term Care Insurance Act) patient	45–50
Cognitive Assistance Level	Dementia (confined to age-related diseases under Article 2 of the Enforcement Decree of the Long-Term Care Insurance Act) patient	Below 45

Source: Article 7, Enforcement Decree of the Long-Term Care Insurance Act (Standards for Assessment).

4.2 Usage of Benefits

An LTC beneficiary rated at Levels 1, 2, 3, 4, 5, or Cognitive Assistance Level can receive benefits by signing a contract with an institutional or home-living LTC service provider. The NHIS offers objective information and counseling to help beneficiaries freely choose the LTC provider. Beneficiaries and their families select LTC institutions and sign benefit contracts in accordance with the Certificate of Long-Term Care Approval and the Standard Long-Term Care Utilization Plan. LTC institutions establish Benefit Provision Plans based on the Standard Long-Term Care Utilization Plan and the contracts. Care providers (including care workers) provide the covered services in accordance with the plan.



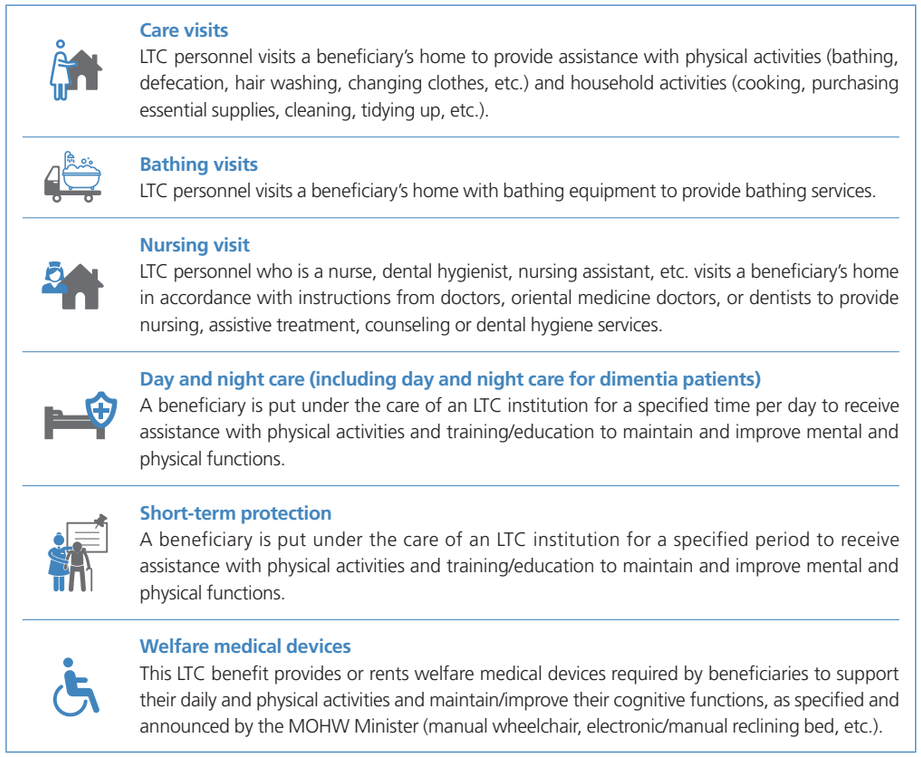
4.3 Types of Benefits

LTC benefits consist of home-living, institutional care, and special cash benefits. As for institutional care benefits, an institution with a capacity of 10 or more beneficiaries is classified as an LTC facility, and an institution with a capacity of between 5 and 9 beneficiaries is classified as a nursing home for the elderly. Special cash benefits are divided into dependent support expenses, special case care expenses, and geriatric hospital caretaking expenses. However, among the three, only the dependent support expenses are provided.

<Home-Living Benefits>

- Care visits: LTC personnel visits a beneficiary's home to provide assistance with physical activities and household activities.
  - Care visits for cognitive activities: LTC personnel visits a beneficiary with dementia for cognitive stimulation activities and training on daily tasks for maintaining and improving remaining functions.
- Bathing visits:LTC personnel visits a beneficiary's home with bathing equipment to provide bathing services.
- Nursing visit: LTC personnel who is a nurse, dental hygienist, nursing assistant, etc. visits a beneficiary's home in accordance with instructions from doctors, oriental medicine doctors, or dentists to provide nursing, assistive treatment, counseling or dental hygiene services.
- Day and night care: A beneficiary is put under the care of an LTC institution for a specified time per day to receive assistance with physical activities and training/education to maintain and improve mental and physical functions.
- Short-term protection: A beneficiary is put under the care of an LTC institution for a specified period to receive assistance with physical activities and training/education to maintain and improve mental and physical functions.
- Welfare medical devices: Long-term care benefit spent in purchasing or leasing welfare medical devices for supporting the recipient's daily and physical activities and maintaining/improving his/her cognitive functions.

[Figure 3-4] Types of Home-Living Benefits



<Institutional Care Benefits>

- LTC facilities: LTC facilities provide assistance with physical activities and training/education to maintain and improve mental and physical functions.
- Capacity: 10 or more
- Nursing homes for the elderly: Nursing homes for the elderly provide assistance with physical activities and training/education in a home-like environment to maintain and improve mental and physical functions.
- Capacity: 5 to 9

<Special Cash Benefits>

- Dependent support expenses: Cash benefit provided to a beneficiary who experienced difficulties with accessing LTC benefits because he/she lives in a remote area or was affected by a natural disaster, etc. and received care from family members, etc. corresponding to care visits
- Special case care expenses: For a beneficiary who received LTC services corresponding to home-living benefits or institutional care benefits from a non-LTC institution, a part of the LTC benefit expenses is reimbursed to the beneficiary.
- Geriatric hospital caretaking expenses: For a beneficiary admitted to a geriatric hospital, a part of the LTC expenses during the hospitalization is reimbursed to the beneficiary.

※ Special case care expenses and geriatric hospital caretaking expenses are not provided at the moment, despite the relevant provisions in the statutes.

<Non-Covered Expenses>

- Expenses for meals and ingredients, additional expenses for higher-class hospital rooms, and cosmetic/hairdressing expenses
- In case of receiving LTC benefits not specified in the Certificate of Long-Term Care Insurance, the difference between the received benefits and the specified benefits
- LTC care benefits exceeding the monthly limit

4.4 LTC Co-Payment Reduction

1) Co-Payment

Beneficiaries are required to pay co-payments, which lowers the financial burden on the LTC Insurance and prevents the excessive use of benefits by beneficiaries. A beneficiary pays 15% of home-living benefit expenses, and 20% of institutional care benefit expenses as co-payments. A Medical aid beneficiary under the National Basic Living Security Act is exempted from co-payment.

2) Co-Payment Reduction

Beneficiaries experiencing financial difficulties may have their co-payments reduced by 40% or 60%. Medical aid beneficiaries (excluding basic living support beneficiaries) and beneficiaries experiencing difficulties in their livelihood can have their co-payments reduced by 60%. Beneficiaries below the specified income and property threshold receive 40% or 60% co-payment reduction.

4.5 Expense Payment

LTC institutions receive benefit expenses based on the types and number of LTC services provided to beneficiaries, in accordance with the service fee criteria for each type of benefit. The NHIS pays for 85% of home-living benefit expenses, and 80% of institutional care benefit expenses. Expenses for meals and ingredients, cosmetic and hairdressing services, and additional expenses for higher-class hospital rooms must be paid by service users.

LTC benefit fees are calculated as follows. For care visits, bathing visits, nursing visits, day and night care, and short-term protection, two or more of these benefits may not be provided at the same time to the same beneficiary. However, care visits or bathing visits can be provided at the same time as nursing visits if required. Tables 3-6 and 3-10 list benefit expenses.

In the case of a live-in facility, a full-day rate applies if the beneficiary received services at the facility for 12 hours or longer, and 50% of the full-day rate applies if the beneficiary received services for less than 12 hours.
Table 3-5 shows the monthly limit of home-living benefits by LTC Level. Any amount exceeding the limit must be paid by the beneficiary.

<Table 3-5> Monthly Home-Living Benefit Limit by Benefit Level

As of January 1, 2021 (unit: KRW/month)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5	Cognitive Assistance Level
Monthly limit	1,520,700	1,351,700	1,295,400	1,189,800	1,021,300	573,900

<Table 3-6> Care Visit Expenses by Visiting Hours

As of January 1, 2021 (unit: KRW/visit)

Service time	Amount (KRW)	Service time	Amount (KRW)
30 minutes or longer	14,750	150 minutes or longer	43,570
60 minutes or longer	22,640	180 minutes or longer	48,170
90 minutes or longer	30,370	210 minutes or longer	52,400
120 minutes or longer	38,340	240 minutes or longer	56,320

<Table 3-7> Visiting Ambulatory Bathing Service Expenses

As of January 1, 2021 (unit: KRW/visit)

Classification		Amount (KRW)
Visiting ambulatory bathing service	Bathing in vehicle	75,450
	Bathing at home	68,030
No visiting ambulatory bathing service		42,480

Note: Bathing visit expenses are fully reimbursed when two or more care workers provided the service for 60 minutes or longer, or 80% if the service time is between 40 and 60 minutes.

<Table 3-8> Nursing Visit Expenses

As of January 1, 2021 (unit: KRW/visit)

Service time	Amount (KRW)
Below 30 minutes	36,530
30–60 minutes	45,810
60 minutes or longer	55,120

<Table 3-9> Day and Night Care Expenses

As of January 1, 2021 (unit: KRW/visit)

Service time	Level 5	General	Dementia Unit	Service time	Level 5	General	Dementia Unit
3 hours or longer Less than 6 hours	1	35,480	-	10 hours or longer Less than 12 hours	1	65,180	-
	2	32,850	41,320		2	60,380	75,960
	3	30,330	38,140		3	55,780	70,160
	4	28,940	36,400		4	54,370	68,390
	5	27,560	34,660		5	52,990	66,650
	Cognitive	27,560	34,660		Cognitive	47,820	60,150
6 hours or longer Less than 8 hours	1	47,570	-	12 hours or longer	1	69,000	-
	2	44,060	55,420		2	63,930	81,430
	3	40,670	51,150		3	59,050	75,250
	4	39,290	49,420		4	57,690	73,490
	5	37,890	47,660		5	56,310	71,750
	Cognitive	37,890	47,660		Cognitive	47,210	60,150
8 hours or longer Less than 10 hours	1	59,160	-				
	2	54,810	68,950				
	3	50,600	63,640				
	4	49,220	61,910				
	5	47,820	60,150				
	Cognitive	47,820	60,150				

<Table 3-10> Short-Term Protection Expenses

As of January 1, 2021 (unit: KRW/day)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5
Short-term protection	58,070	53,780	49,680	48,360	47,050

<Table 3-11> Special Cash Benefits

As of January 1, 2021 (unit: KRW/month)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5
Dependent support expense	150,000				
Special case care expenses	Currently not provided				
Geriatric hospital caretaking expenses					

Source: Tables 3-5 to 3-11, "Public Announcement on Long-Term Care Benefit Criteria Benefit and Calculation of Benefit Expenses (MOHW Announcement No. 2020-298 (December 21, 2020))" and "Detailed Matters regarding Long-Term Care Benefit Criteria and Calculation of Benefit Expenses (Department of LTC Management No. 2020-1 (December 22, 2020))"

LTC benefits must be provided within the monthly limits. Monthly limits are calculated based on the types of LTC levels and LTC benefits. Monthly limits for institutional services are calculated by multiplying the daily expenses in Table 3-12 by the number of days in a month.

<Table 3-12> Institutional Benefit Expenses

As of January 1, 2021 (unit: KRW/day)

Classification	Level 5	General	Dementia Unit Type A	Dementia Unit Type B
LTC facilities	Level 1 Level 2 Levels 3–5	71,900 66,710 61,520	- 82,280 75,870	- 74,050 68,270
Nursing home for the elderly	Level 1 Level 2 Levels 3–5	63,050 58,510 53,930	- 72,520 66,870	

5 Financial Resources

5.1 LTC Finance

1) Revenues

The LTC Insurance is mainly funded by subscribers' contributions, government subsidies, contributions from the central and local governments supporting medical aid beneficiaries, and co-payments. LTC contributions are one of the main sources of funding (10.25% of NHI contributions as of 2020). The LTC insurance contributions (11.52% of health insurance contributions as of 2021) are the main source of funds, and the national treasury supports 20% of its expected income. National and local government funds fully support medical benefit recipients.

2) Imposition, Collection, and Reduction

LTC Insurance contributions are imposed and notified as a part of the NHI contributions. For insured employees, the NHIS collects contributions from, and sends notifications to, each business establishment. For self-employed insureds, the NHIS collects contributions from, and sends notifications to, each household.

LTC Insurance contributions are determined by multiplying the amount of the NHI contribution with the LTC Insurance contribution rate (11.52%). Suppose a LTC insurance subscriber has not been determined as a recipient has a severe disability specified under the Act on Welfare of Persons with Disabilities or has a rare, incurable disease notified by the MOHW. In this case, 30% of the subscriber or household's premium may be reduced. As shown in Table 3-13, a total of KRW 6,356.8 billion was imposed as LTC Insurance contributions in 2020. As of 2020, the monthly average of benefit expenses (KRW) for a single LTC benefit beneficiary stands at KRW 1,315,195, as shown in Table 3-14.

<Table 3-13> LTC Insurance Contributions Imposed

Category		2015	2016	2017	2018	2019	2020
Contributions imposed (KRW 100 million)		28,833	30,916	32,772	39,245	49,526	63,568
Per household (KRW)	Self-employed	5,279	5,497	5,710	6,300	7,309	9,278
	Employee	6,533	6,788	6,979	8,186	10,044	12,526
Per person (KRW)	Self-employed	2,794	2,957	3,124	3,536	4,244	5,531
	Employee	2,800	2,979	3,135	3,786	4,809	6,142

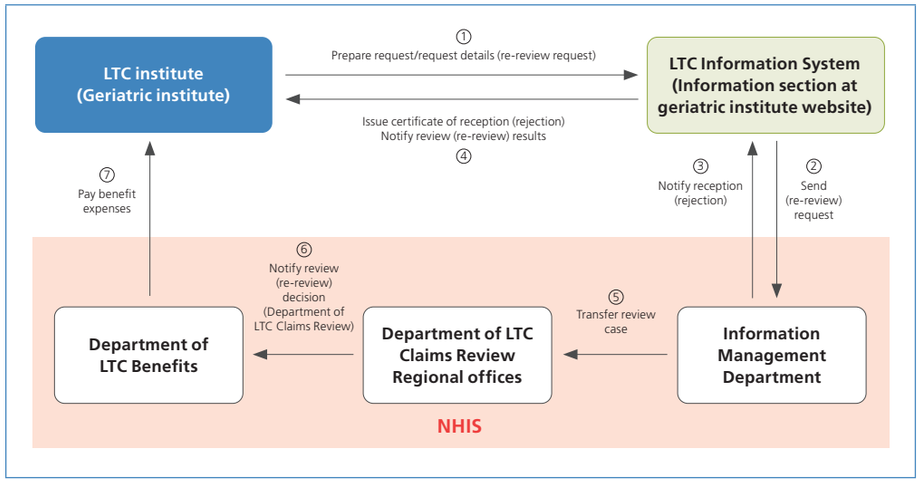
<Table 3-14> LTC Benefit Expenses

Category	2013	2014	2015	2016	2017	2018	2019	2020
Benefit expenses (KRW million)	35,234	39,849	45,226	50,052	57,600	70,670	85,653	98,248
NHIS contributions (KRW million)	30,830	34,981	39,816	44,177	50,937	62,992	77,363	88,827
Beneficiary (no. of persons)	399,591	433,779	475,382	520,043	578,867	648,792	732,181	807,067
Monthly average benefit expenses per person	996,714	1,024,520	1,057,425	1,067,761	1,103,129	1,208,942	1,284,244	1,315,195

5.2 Review and Management of Benefits

Health-care benefit expenses are reviewed by the HIRA. However, LTC benefit expenses are reviewed by the NHIS. Benefit expense review means a process by which the NHIS verifies and determines the appropriateness of LTC benefit claims filed by LTC institutions (via electronic document exchange or electronic media) in accordance with the relevant laws and standards. An expense claim from an LTC institution is reviewed and the result is notified to the institution in the form of the Reviewed Payment Notice, within 30 days from the NHIS's reception of the claim. Then, the expenses are paid to the registered account of the institution.

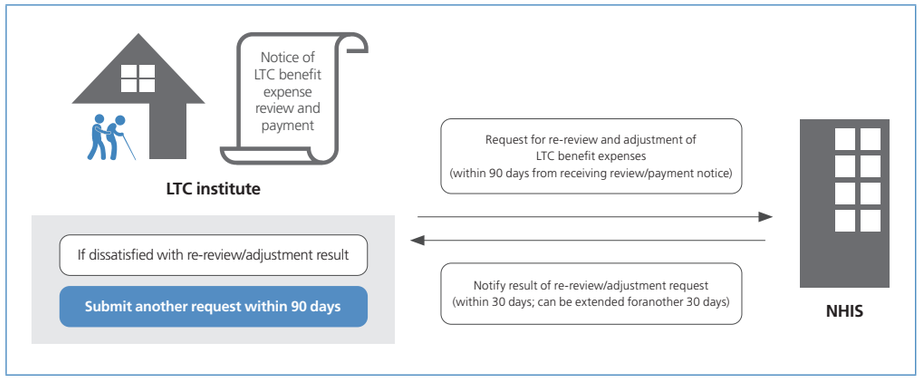
[Figure 3-5] Benefit Expense Review Process



1) Re-Review and Adjustment Request

If not satisfied by a review and payment decision of the NHIS, an LTC institution may request a re-review and adjustment of the benefit expenses before filing a request for review. If not satisfied by the result of the re-review and adjustment request, the institution can file a request for review within 90 days from the notification date.

[Figure 3-6] Workflow of Re-Review and Adjustment Request



2) On-Site Verification Review

In cases of difficulty determining the appropriateness of benefit expenses claimed by an LTC institution or need for confirmation regarding previously paid expenses, the NHIS may conduct an on-site review. Depending on the review results, the NHIS may reduce the covered amount, reject the claim, recover unjust enrichment, or request on-site investigation.

5.3 Follow-Up Management of Benefits

Follow-up management of benefit means a series of actions taken by the NHIS under Article 48 (2) of the Long-Term Care Insurance Act (the Act), including the redemption of amounts paid for illegal and fraudulent claims.

1) Control of Benefit Restriction

Unless a justifiable reason exists, a beneficiary refusing to submit requested documents, reports, inspections, or failing to answer may lose all or part of the LTC benefits. In addition, in the case of overlaps in benefits or suspension of NHI eligibility, LTC benefits may be restricted or suspended.

2) Collection of Unlawful Profits

The NHIS collects amounts provided to those who obtained LTC approval granted through false or fraudulent means, or deliberately caused accidents or illegal activities.

V

TASKS OF NHIS

1. Mission and Vision
2. NHIS Endeavors and Achievements
3. Future Direction
4. NHIS International Cooperation Activities
5. NHIS UHC Global Academy on Social Health Insurance
6. National Health Insurance Service Announcement of
   the opening of the Help Center for Foreigners

V | TASKS OF NHIS

1 Mission and Vision

The NHIS's missions are as follows. The NHIS contributes to the enhancement of national health and social security. Moreover, we pursue improving the quality of life for all by operating NHI and LTC Insurance to guarantee the people's healthier and more stable lives.

Our visions are as follows. The NHIS leads lifelong health, the happiness of the people, and the health of people worldwide. We endeavor to transform the minor contribution and low benefit system into a moderate contribution and appropriate benefit system to guarantee happier lives and better lifelong health services. Our goal aims at being a global health service leader by introducing the Korean health coverage system to the global standard.

2 NHIS Endeavors and Achievements

2.1 Better Health Insurance System

1) Our system has grown into a better health insurance system that is globally recognized by ensuring medical access through the achievement of universal healthcare in the shortest period of time. It has taken 127 years for Germany to ensure universal healthcare coverage, 118 years for Belgium, and 36 years for Japan, but we have done it in a mere 12 years. Moreover, the number of outpatient visits per person is 14.9 times, which is higher than the OECD average of 6.8 times. The average hospitalization per person is 16.5 days, which is longer than the OECD average date of 7.5 days.

Even with a comparatively low insurance contribution rate of 6.67%, the health of South Koreans is above the average level of OECD member states. By way of comparison, the health insurance contribution rate is 9.48% in Japan, 15.5% in Germany, and 13.85% in France. Furthermore, life expectancy is considerably higher while infant mortality is lower than the OECD averages..

2) The NHIS has offered an international training course since 2004 which attracts visitors from Asia, Africa, the Middle East, the Americas and Oceania. The course is being leveraged as a bridge for promoting South Korea's health insurance program and fostering international cooperation. Through global cooperation on universal health coverage, the NHIS is increasing its role in driving health insurance coverage in the international community. In the 16 years since 2004, 660 people from 60 countries have participated in this course. In cooperation with international organizations such as the WHO and WB, the NHIS has been leading the development of health coverage systems in the international arena and spreading the word about the excellence of South Korea's health insurance by sharing South Korea's experience in achieving universal health care (UHC).

The NHIS has carried out health insurance development projects tailored to the needs of developing countries, as well as signing MOUs with diverse countries in Asia, Africa, and Latin America to provide insurance program consulting. NHIS has completed the development projects with Ghana and Ethiopia and provided the insurance program consultation in Columbia, Peru, and the Philippines. NHIS is currently working on the development project with Nepal, the Philippines, and Indonesia. It is also increasing its international reputation and leading the international debate on health issues by hosting international symposiums on a wide range of topics including the development of health insurance based on ICT, the dangerous effects of smoking, the need to prevent obesity, dementia care, hospice care, national health checkups, and increasing the scope of insurance coverage.

2.2 Expansion of Customized Health Care Service for Longer Healthy Life

1) It is now possible with big data. Based on the data of 3.0 trillion cases accumulated by the Korean government, the National Health Information Database for Analysis and Research Sample DB are constructed and updated every year. Through customized health checkup service, we are continuing to improve the participation rate of health checkup and consumer-oriented health checkup system. The uterine cervical cancer test is now expanded to all women aged over 20.

2) The NHIS is engaged in providing preventive health management services with the aim of increasing healthy life expectancy. For example, to promote a healthy lifestyle through non-medical approaches (better nutrition, physical exercise), the NHIS is operating twenty health promotion centers. 142 Furthermore, as part of a campaign to popularize physical exercises among people in the pre elderly stage (~64 years) and elderly persons, the NHIS is operating 4,291 Centenarian Exercise Classrooms.

It also provides health support services such as health counseling, and disease and health information sessions in its branch offices and dispatch centers (232 across the nation) in order to help patients suffering from diabetes and high blood pressure to better manage their health at home.

3) The NHIS is actively responding to public health hazards such as obesity and smoking. It formed the Obesity Management Committee, composed of specialists from academia and the medical profession, to conduct research on the current state and preventive management of obesity among the morbidly obese population, children and teenagers, and lowincome groups. In order to act decisively against the spread of obesity, the NHIS publishes an obesity index every year to inform the general public of the risks of obesity.

This index is calculated using data from the results of checkups and disease data collected by the NHIS, and is used as reference data by researchers in academia. The NHIS has also created a visual map of obesity rates by district; and, in what was a first for any public institution in Korea, it published a white paper on obesity to warn the public that obesity is a disease. In addition, the NHIS has raised public awareness of the danger of smoking through its lawsuit against tobacco companies. At the same time, it is leading an antismoking campaign by launching a project that extends insurance coverage to the costs involved in quitting smoking.

< NHIS Lawsuit against Tobacco Companies >

In April 2014, the National Health Insurance Service attracted international publicity when it filed a lawsuit against three domestic tobacco companies, including KT&G, claiming compensation for damages caused by smoking. Among patients diagnosed with one of three cancers (squamous cell carcinoma of lung cancer, squamous cell carcinoma, squamous cell carcinoma of larynx carcinoma) showing a high causality with smoking, a number of patients who had smoked one packet of cigarettes every day for at least 20 years were selected (verifiable on the basis of their medical records and insurance benefit data). The NHIS is now in the process of filing lawsuits claiming damages for the medical fee (53.7 billion won) it has had to pay.

- **Smoking cessation treatment health insurance support service:**
  We are supporting medical consultation (up to 6 times) and smoking cessation drug supplement subsidy osts (80%) and incentives for 8 ~ 12 weeks.

2.3 Strengthening the Support System for High-Quality Long-Term Care Services Centered on Consumers

1) We are developing long-term care services as the representative social safety net in the rapidly aging society. With measures such as reducing accreditation scores and establishing the 5th grade level, we have increased the number of beneficiaries: 210,000(2008) to 316,000(2010), 342,000(2012) to 519,000(2016).

2) The NHIS Seoul Geriatric Care Institute is being operated to establish a standard model for long-term care services. In addition, we are establishing a consumer-oriented system based on the research services provided between May and December 2014, which include 28 major tasks such as benefit provision requirements.

2.4 We are working to improve the health insurance imposition system and expand the health insurance coverage in order to secure the sustainability of health insurance and strengthen its coverage.

With the first revision of the health insurance contribution implemented in July 2018, the insurance contribution for people in the low-income bracket was lowered while that of people in the high-income bracket was readjusted to more appropriate levels, thereby improving the fairness ofthe health insurance plan and increasing the financial sustainability of the national health insurance service. This was a particularly significant

milestone in that it was the first step toward realizing the vision of a uniform insurance contribution levying system that was income-based - a long-cherished goal over the past eighteen years.

As a side note, in order to help increase public acceptance ofthe revised health insurance program following the implementation of the Phase 1 revision in July 2018, a health policy improvement committee composed of representatives from the related government bodies and experts was formed and tasked with evaluating the performance of its implementation through discussions with the public and then finding areas for improvement based on a study of the problems thus identified. The 2nd Phase ofthe revision will be implemented in about four years' time, i.e. July 2022.

The insurance contribution portion deriving from the income of the self-employed insured was 33% before June 2018. However, after the 1st revision of July this portion was raised to 53%; and it will be further increased to 59% with the 2nd revision scheduled for July 2022. As for the income portion ofthe total insurance contribution, it was 88% before June 2018, rose to 92% after the 1st revision of July, and is expected to increase to 95% with the 2nd revision planned for July 2022.

3 Future Direction

NHIS will stay faithful to its duties as an insurer and put all its resources into pursuing its vision of "Global leader in healthcare for your lifelong health and happiness."

Amid a difficult environment, NHIS managed to produce significant achievements, but the given situation demands greater changes and innovations. 2017 is the year when the "working age population," the most symbolic indicator of low birth rate and aging population, begins to decline. This implies declining population for collecting contributions; if this is compounded by reduced incomes caused by stagnant national economic growth, it will also directly impact contribution revenues.

Moreover, due to the rapid aging of the population, the speed at which social insurance costs are rising is the highest among the OECD countries. These costs were estimated to have surpassed the 1 trillion won mark in 2016. According to the 2015 data, the proportion of health care costs to GDP was 7.2%. This is less than the OECD average of 9.0%, but the rate of increase is at a very high level of 6.8% when compared to the OECD average of 2.0%. Trends such as "revenue decline" and "rising expenditures" - long regarded as future risks - are becoming a reality.

In 2017, the government announced plans to expand the coverage of the national health insurance in order to realize its vision of "A nation that can take care of its medical fees."

Thanks to the government's continuing efforts to expand coverage, the coverage of the 4 major conditions has improved to a level that is now considered to be equivalent to that of advanced countries (77.5% in 2013 -> 79.9% in 2015). The medical fee portion of the 3 major non-covered medical services has been significantly reduced, but the insurance coverage rate of 63.4% (2015) is still low compared to the OECD average of 80%.

The key features of the government's plan for expanding coverage include reducing non-covered items and realigning the role played by the private health insurance sector.
Through these measures, the goal is to raise the coverage rate to 70% by 2022. In order to prepare forthe environment ofthe future, the National Health Insurance Service(NHIS) announced its new vision and future strategy in 2015, wherein the main objective is the creation of "a sustainable health insurance program that takes care of all your medical fee worries."

The national agenda with regard to NHIS matches or accelerates NHIS' new vision and future strategy agenda. The national government will do its best to help NHIS achieve its agenda successfully. To prepare for these risks, NHIS has set four directions for operating the organization so that it could "produce measurable outcomes for a new vision of realizing sustainable health coverage."

First, establish an equilibrium of "appropriate burden-appropriate benefit system" by strengthening health coverage at each lifecycle that a person goes through, securing a steady source of future revenues, and reinvigorating prevention-enhancing campaigns for improving the longevity of healthy life.

Second, as the body responsible for the financing of insurance, the insurer must tighten control over expenses and define its role as insurer by realizing win-win growth with

various stakeholders. Third, in response to the rapidly changing times and environment, increase the adoption of health insurance big data and ICT-based health care services and support efforts to develop and incubate new growth businesses for the future. Fourth, build a new organizational culture of communication and harmony and manage the organization efficiently to foster an office culture of innovation and freedom. By instituting such changes, customer and employee satisfaction can be improved at the same time. NHIS will stay faithful to its duties as an insurer and put all its resources into pursuing its vision of "Global leader in healthcare for your lifelong health and happiness."

4 NHIS International Cooperation Activities

4.1 NHIS has carried out diverse international cooperation activities.

First, since 2004, NHIS has organized annual international training course on social health insurance in collaboration with WHO, UNESCAP and MOHW. Second, NHIS has had close cooperation with international organizations such as ISSA, JLN, and World bank. Especially, NHIS, as ISSA bureau member and JLN steering committee member, has contributed to the development of healthcare system in diverse ways. Third, NHIS established MOU with many partner countries to form the solid foundation for bilateral or multilateral cooperation.

1) NHIS international training course on social health insurance

- ➡ Sharing Korea's operational experience of NHI (2 weeks, annually)
- ➡ Participation of 660 healthcare officials from 60 countries

2) Cooperation with international organizations

- ➡ ISSA: ISSA Bureau member(2012-present), ISSA Liaison office for East Asia (2011-present), ISSA Technical committee member (2017-present)
- ➡ JLN : Steering committee member(2017-present), JLN collaborative
  * participation
  Collaborative participation : Domestic resource mobilization, Data foundation, People centered integrated care, Primary healthcare financing and payment
- ➡ World Bank: Cooperative project(Philippine, Colombia, Peru, Saluderecho)

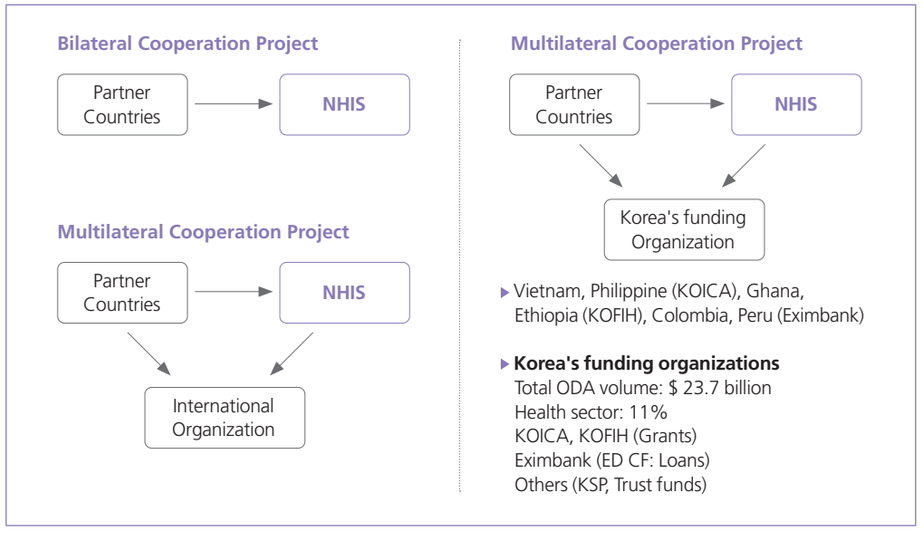
3) MoU with partner countries

- ➡ Laying the foundation for bilateral/multilateral cooperation
- ➡ Taiwan, Thailand, Philippines, Vietnam, Belgium, Sudan, Mexico, Ethiopia, Kenya, Mongolia, Indonesia, Peru, Uzbekistan, Cambodia + international organizations (WHO/WPRO, ISSA, WB)

4.2 Future directions

1) The ways to initiate development cooperation projects with NHIS

Partner countries can build cooperation with NHIS in several ways. First, partner countries can ask NHIS to provide consultation forthem with their budget. Second, partner countries can use funds from international organizations to start cooperative project with NHIS. For example, World bank has KWPF, Korea-World Bank Partnership Facility, the fund that Korea's government contributed to World Bank. Third, through Korea's funds, partner countries can implement health insurance projects with NHIS. Korea has several funding organizations. KOICA and KOFIH are government organizations for grants. Eximbank is the organization for EDCF, loans. One of the ways to receive Korea's funds is to contact Korea embassy in your country and send concept papers for cooperation to it.



5 NHIS UHC Global Academy on Social Health Insurance

In an effort to contribute to the international endeavors, since 2004 National Health Insurance Service(NHIS) of Republic of Korea has annually organized "NHIS UHC Global Academy on Social Health Insurance" in close collaboration with World Health Organization Western Pacific Regional Office(WHO/WPRO), and Korean Ministry of Health and Welfare (MOHW).

5.1 Background

Today in the global community, interest in universal health coverage(UHC) has never been greater and the support and commitment for UHC have also never had such momentum. Almost all developing countries have made universal health coverage(UHC) a top priority with actively mobilizing resources and pursuing reforms to achieve it. In this context there has been a growing demand that global knowledge and experiences on health system reforms and operations be shared proactively among countries to facilitate their movements towards UHC. In an effort to contribute to the international endeavors, since 2004 National Health Insurance Service(NHIS) of Republic of Korea has annually organized "Training Course on Social Health Insurance" in close collaboration with World Health Organization Western Pacific Regional Office(WHO/WPRO), and Korean Ministry of Health and Welfare(MOHW).

5.2 Objectives

This course enables participants to

- Identify policy priorities at a national level that will achieve UHC ensuring adequate access, quality and equity in health care services
- Develop the most suitable options for various subsystems such as population coverage, sources of financing, health benefits, payment methods, and so on
- Share other countries experiences and promote cooperation and mutual understanding among them
- Establish an global network for further strengthening international cooperation

6 National Health Insurance Service Announcement of the opening of the Help Center for Foreigners.

As of July 23, 2018, all health insurance matters for foreign nationals will be handled by the Help Center for Foreigners.

National Health Insurance Service established the Help Center for Foreigners & Overseas Koreans.

6.1 Target: Foreign nationals and overseas Koreans who are residing in the following districts*(employee insured persons are excluded).

* Yeongdeungpo-gu, Guro-gu, Geumcheon-gu, Gwanak-gu, Dongjak-gu, Yangcheon-gu, Gangseo-gu.

- Foreign nationals and overseas Koreans residing in other districts must visit the branch office associated with their address

6.2 Services: Eligibility management for the employee insured and self-employed insured, and contribution management, etc.

- For other tasks, visitors must go to the branch office associated with their address.

6.3 Location : (Near Sindorim Station) Seomallo 97, Guro-gu, Seoul, 3rd floor, Sindorim Techno Mart, Upmu-dong 3rd floor

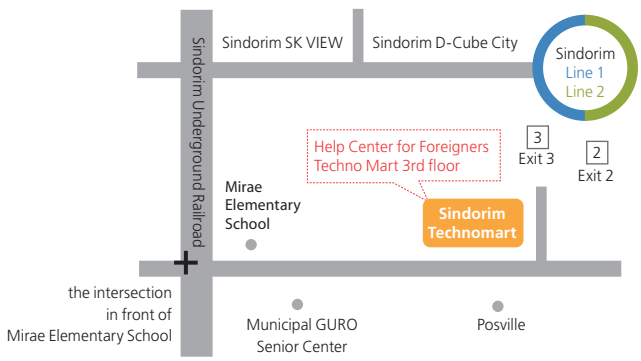
▶ **Subway**: Lines 1 and 2, Sindorim Station, Leave via Exit 2 or 3 → Connects to Bl of Techno Mart (in the direction of the West Finance Center)

▶ **Bus**: Get off at Sindorim Station

◎ Line (Green Bus): 5619, 6411, 6511, 6611

◎ Town Bus: Yeongdeungpo 01, Yeongdeungpo 08, Yeongdeungpo 09, Yeongdeungpo 12, Yeongdeungpo 13

▶ **Parking**: B3F-B6F Parking is free for 1 hour (However, Floors B3-B4 open after 10:30 AM.)



Center Name	Jurisdiction Area
Seoul Center	Seoul
Ansan Center	Ansan, Siheung, Gunpo
Suwon Center	Suwon, Yongin, Hwaseong, Osan, Seongnam
Incheon Center	Incheon, Bucheon, Gimpo, Gwangmyeong
Uijeongbu Center	Uijeongbu, Namyangju, Gapyeong, Pocheon, Dongducheon, Yeoncheon, Yangju, Guri, Goyang, Paju

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