2023

NATIONAL HEALTH INSURANCE &
LONG-TERM CARE INSURANCE SYSTEM
IN REPUBLIC OF KOREA

h·well
NHIS National Health Insurance Service

2023 NATIONAL HEALTH INSURANCE & LONG-TERM CARE INSURANCE SYSTEM IN REPUBLIC OF KOREA

h·well
NHIS National Health Insurance Service

www.nhis.or.kr

2023
NATIONAL HEALTH INSURANCE & LONG-TERM CARE INSURANCE SYSTEM IN REPUBLIC OF KOREA

h·well
NHIS National Health Insurance Service

2023
NATIONAL HEALTH INSURANCE & LONG-TERM CARE INSURANCE SYSTEM IN REPUBLIC OF KOREA

h·well NHIS National Health Insurance Service

CONTENTS

Preface 3

I SOCIAL SECURITY IN KOREA

1. General Status (Sociodemographic Characteristics) 8
2. Social Security System 9

II NATIONAL HEALTH INSURANCE SERVICE

1. Overview 12
2. History 14
3. Characteristics of National Health Insurance 17
4. Operational Structure 19
5. Funding 21

III NATIONAL HEALTH INSURANCE

1. Eligibility and Collection System 26
2. Management of Benefits 36
3. Health Management 53
4. Information Management 59

IV LONG-TERM CARE INSURANCE FOR THE ELDERLY

1. Overview 66
2. History of LTC Insurance for the Elderly 69
3. Eligibility System 70
4. Benefit System 72
5. Financial Resources 81

V TASK OF NHIS

1. Mission and Vision 88
2. Achievements 89
3. Future Direction 91
4. NHIS International Cooperation Activities 93
5. NUGA, Capacity Building Program on Social Health Insurance 95
6. "Financial Risk Management System Support" as International Development Cooperation Project 96
7. NHIS Help Center for Foreigners 97

List of Tables

<Table 3-1> Contribution Rates and Unit Prices Per Contribution Point 29
<Table 3-2> NHI Contribution Rates 30
<Table 3-3> Payment Methods and Service Scope 41
<Table 3-4> Benefit Types 42
<Table 3-5> Co-Payment Rates 48
<Table 3-6> Co-Payment Ceiling by Income Level 48
<Table 3-7> Payment for Catastrophic Medical Expenses by Disease and Income Level 49
<Table 3-8> Special Estimate Cases (as of January 1, 2022) 50
<Table 3-9> Types of Health Checkup 55
<Table 3-10> Types of Health Checkups and Checkup Items 56
<Table 3-11> Health Checkup Services for Cancer 57
<Table 4-1> Scope of LTC Insurance Application 71
<Table 4-2> Number of Approved Persons by LTC Level 71
<Table 4-3> Number of Elderlies and Persons Approved for LTC Insurance 71
<Table 4-4> Eligibility Scores and Functions by LTC Level 73
<Table 4-5> Monthly Home-Living Benefit Limit by Benefit Level 78
<Table 4-6> Care Visit Expenses by Visiting Hours 78
<Table 4-7> Visiting Ambulatory Bathing Service Expenses 78
<Table 4-8> Nursing Visit Expenses 78
<Table 4-9> Day and Night Care Expenses 79
<Table 4-10> Short-Term Protection Expenses 79
<Table 4-11> Special Cash Benefits 80
<Table 4-12> Institutional Benefit Expenses 80
<Table 4-13> LTC Insurance Contributions Imposed 82
<Table 4-14> LTC Benefit Expenses 82

List of Figures

[Figure 2-1] History of NHI 15
[Figure 2-2] Merger of NHIS 17
[Figure 2-3] NHI Management and Operation System 20
[Figure 2-4] Health insurance financial composition and expenditure structure based on the settlement of accounts in 2021 22
[Figure 3-1] System to Impose Insurance Contributions of the Self-Employed (as of Sep. 2022) 32
[Figure 3-2] Integrated Collection of Four Social Insurance Contributions 34
[Figure 3-3] Operation of Nursing Care Integrated Service Program 51
[Figure 3-4] Health Promotion through Health Checkups 58
[Figure 3-5] Types of Big Data 62
[Figure 4-1] Increase in Dementia Population 67
[Figure 4-2] LTC Insurance Management and Operational Structure 68
[Figure 4-3] LTC Approval Process 72
[Figure 4-4] Types of Home-Living Benefits 73
[Figure 4-5] Benefit Expense Review Process 83
[Figure 4-6] Workflow of Re-Review and Adjustment Request 83

I

SOCIAL SECURITY IN KOREA

1. General Status (Sociodemographic Characteristics)
2. Social Security System

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	• 51,460,000 (as of 2022, Ministry of the Interior and Safety, population statistics based on resident registration)
Area	• 100,412km2 (108th in the world)
Climate	• Continental
Language	• Korea
Ethnicity	• Korean
Religion	• Buddhism, Christianity, Catholicism, etc.
Currency	• KRW 1,339.8 = USD 1 (as of Nov 2022)
Government	• Presidential

Korea's population in 2022 stands at around 51,460,000. The country's population is rapidly aging, driven by the declining birth rate and rising life expectancy. Koreans aged 15 to 64 take up 70.6% of the total population, and the percentage of people under 15 is 11.5%. The percentage of elderly Koreans (aged 65 or older) rose from 17.0% in 2021 to 17.9% in 2022.

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.

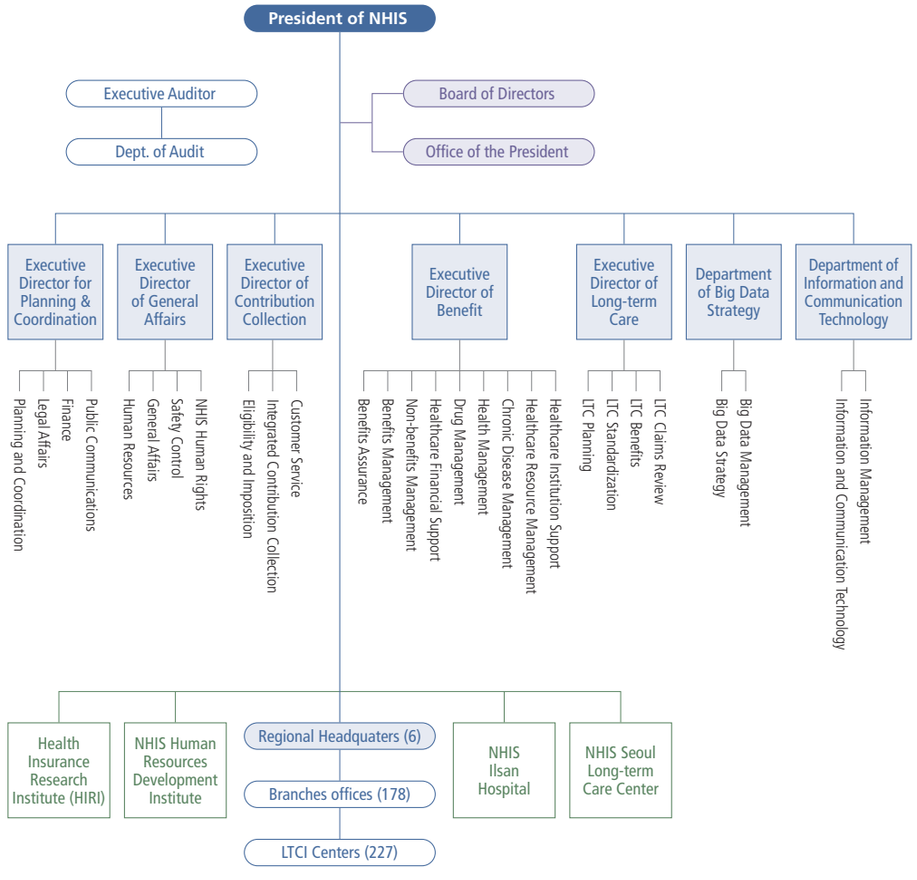
1.1 Organization

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 14,873 workers; 10,829 of them work in the NHI area, and 4,044 work in the LTC area (as of the end of October 2022; Ilsan Hospital and NHIS-Seoul Long-Term Care Center excluded).

1.2 Departments and Roles

The NHIS consists of the HQ with 24 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

Medical Insurance Act enacted (1963)

Employees		Self-employed
Provided legal basis for voluntary application at businesses with 300 or more workers	1963	
	1970	Provided legal basis for voluntary application to self-employed insureds
Mandatory application to businesses with 500 or more workers	1977	
	1979	Mandatory application to government employees and private school employees and businesses with 300 or more workers
Mandatory application to businesses with 100 or more workers	1981	1st CBHI pilot project (Hongcheon, Okgu, Gunwi) Occupational medical insurance cooperatives established
Mandatory application to businesses with 16 or more workers	1982	2nd CBHI pilot project (Gamgjwa, Boeun, Mokpo)
Mandatory application to businesses with 5 or more workers	1988	Mandatory application to self-employed insureds in rural areas
	1989	Mandatory application to self-employed insureds in urban areas

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.

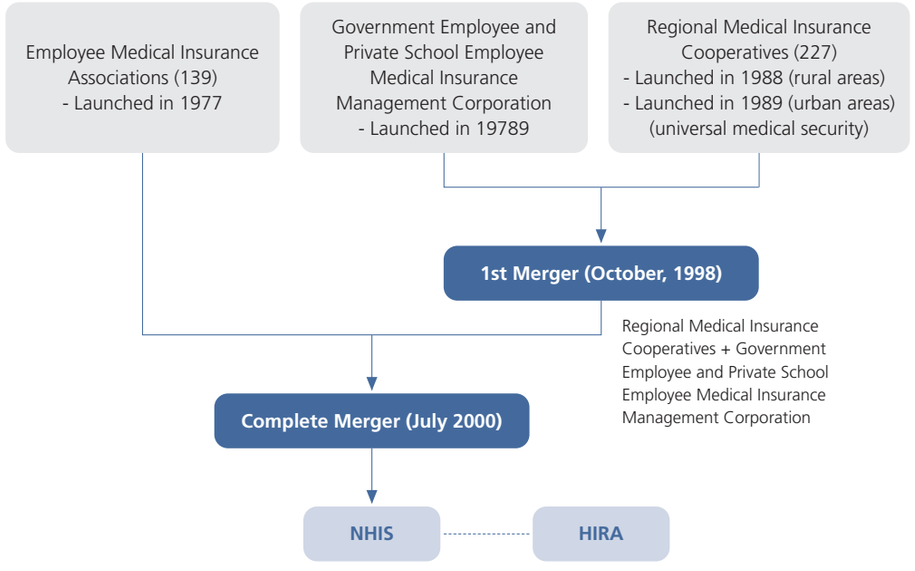
The achievement was made possible by several factors. First, the government was adamant about ensuring medical security in Korea, and pursued the "low-burden/low-benefit" policy. Given Korea's economic standing at the time, a nationwide health insurance scheme seemed somewhat far-fetched. The government 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

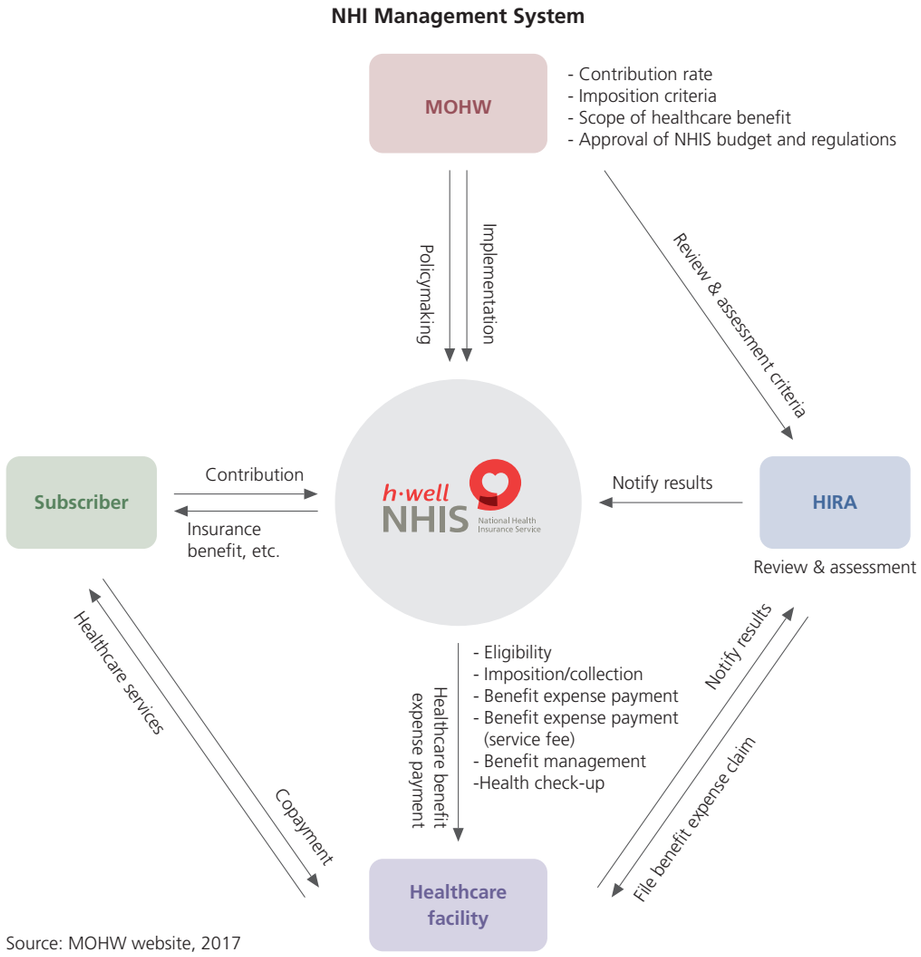
Article 34 (1) and (2) of the Constitution of the Republic of Korea provides for the people's right to live with dignity, and the State's duty to promote social welfare. Thus, the provision offers the legal backbone of the Korean social security system. According to the National Health Insurance Act (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

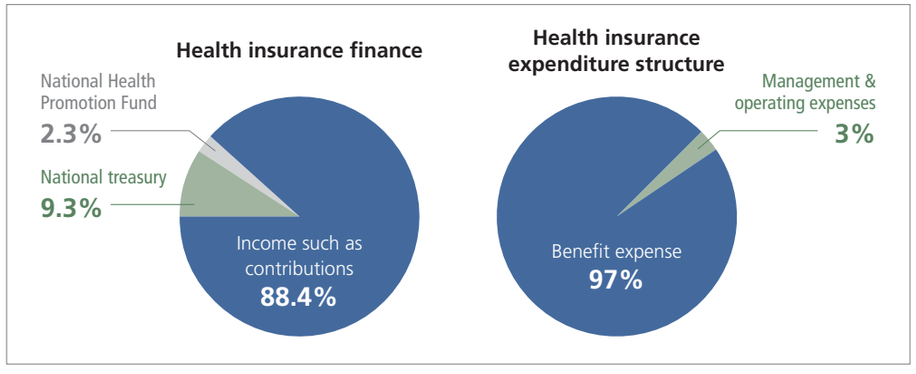
5.1 Financial Sources

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 may also receive subsidies from the National Health Promotion Fund, which corresponds to 6% of the contribution revenue expected for that year. This, however, is limited to up to 65% of the estimated surcharge on tobacco, the source of funding. Contributions collected from the insureds make up the majority of financial resources (80%). Government subsidies, such as taxes and surcharge on tobacco, take up a certain percentage.
97% of the expenditures were used for insurance benefit payments for subscribers and dependents, and management and operating expenses took up 3%. As seen from the figures, most of the health insurance finances are used for insurance benefit payments.

[Figure 2-4] Health insurance financial composition and expenditure structure based on the settlement of accounts in 2021



Source: NHIS, 2021

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.

III

NATIONAL HEALTH INSURANCE

1. Eligibility and Collection System
2. Management of Benefits
3. Health Management
4. Information Management

III NATIONAL HEALTH INSURANCE

1 Eligibility and Collection System

1.1 History of Eligibility and Collection System

1) HIE (Health Insurance for Employees)

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 (Community Based Health Insurance)

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 2021, a total of 52,930,000 people enjoy health security benefits in Korea, of which the NHI covers 51,410,000 (97.1%). The other 1,520,000 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 3-1, 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 3-1> Contribution Rates and Unit Prices Per Contribution Point

(unit: %, KRW)

Category	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Insured employees (contribution rates)	5.80	5.89	5.99	6.07	6.12	6.12	6.24	6.49	6.67	6.86	6.99
Self-employed insureds (unit price per point)	170.0	172.7	175.6	178.0	179.6	179.6	183.3	189.7	195.8	201.5	205.3

In 2021, an average household paid KRW 122,201 in contributions. The average for insured employees was KRW 133,591, and KRW 97,221 for self-employed insureds. The average contribution amount per capita was KRW 65,211, KRW 67,392 for insured employees, and KRW 59,414 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 3-2 shows the contribution rates applicable to different subscribers.

<Table 3-2> 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 2022 were KRW 7,307,100 and KRW 19,500 respectively.

Insured employees earning more than KRW 20 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 was adjusted in September 2022 to cover insured employees earning more than KRW 20 million, and the calculation is as follows.

ICBMI = Amount of monthly income* × contribution rate

* Amount of monthly income = (Income other than annual remuneration – KRW 20 million) ÷ 12 × income assessment 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 September 2022, the upper monthly contribution limit is KRW 3,653,550, and the lower limit stands at KRW 19,500.*

* KRW 14,650 before the second reformation of the imposition system (as of 2022: from Aug. 2022)

Households earning less than KRW 3.36 million per year are imposed contributions based on the minimum contribution.

* The annual income of the minimum contribution households was KRW 1 million or less before the second reformation of the imposition system (Aug. 2022)

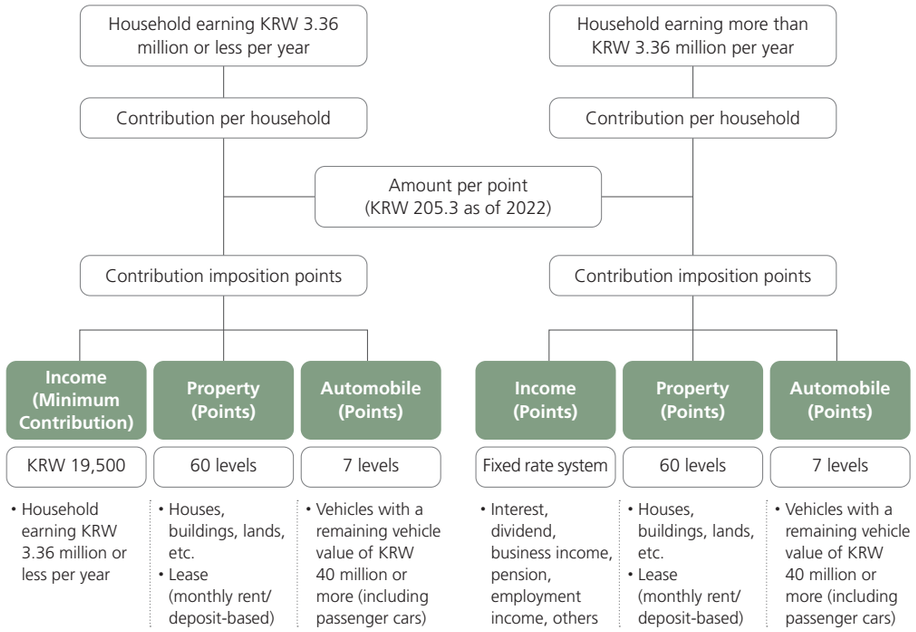
Contribution point calculation

(based on the annual income of KRW 3.36 million)

Ⓐ Household earning more than KRW 3.36 million per year: 95.334 + 2,837.3112/10,000 per KRW 10,000 of income exceeding KRW 3.36 million) + property points + vehicle points

Ⓑ Household earning KRW 3.36 million or less per year:
minimum contribution + (property points + vehicle points)

[Figure 3-1] System to Impose Insurance Contributions of the Self-Employed (as of Sep. 2022)



1.4 Mandatory Enrollment of Foreign Self-Employed Insureds and Expatriates (July 16, 2019)

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 September 2022, the NHIS will propose an amendment to the National Health Insurance Act for a uniform imposition system.

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 124,770 in 2022 (or KRW 140,070, when including the LTC contributions).

1.5 Management of Collection

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.

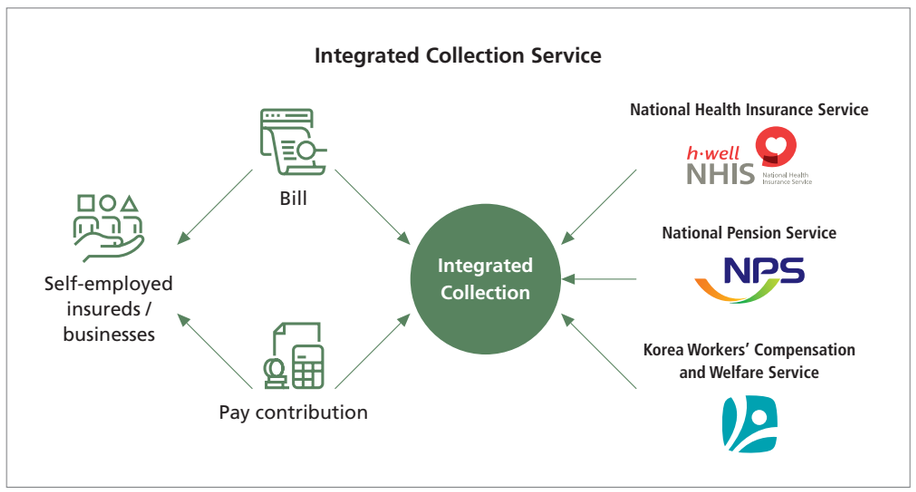
6) NHI Benefits

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

1) 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 3-2] 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.

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 8,791.

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 2022, 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 1977, 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 2020 NHI coverage rate of 65.3%, the highest since the survey was conducted. In particular, the coverage rate of general hospitals or higher showed a continuous rise, wherein tertiary hospitals reached 70% of coverage. As a result of the gradual expansion of coverage for MRI (abdomen and chest) and ultrasonography (male and female reproductive organs, head and neck), which were burdensome for patients among medical non-insured expenses required for treatment, the non-insured co-payment rate in 2020 lowered by 15.8%p, a 0.9%p decrease year over year (YoY). The implementation of the policy to lessen the burden of medical expenses for the vulnerable group saw an improvement in the coverage rates compared to the previous year: 71.2% for the elderly aged 65 or older, 62.6% for women, and 70.8% for children under 6.

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, 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 hysterectomy and salpingo-oophorectomy (excluding malignant tumor resection 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 3-3 shows the payment methods and applicable services.

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.

<Table 3-3> 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 (603 groups)			○	○			
		Outpatient							
Performance-based compensation	Adjustable	Inpatient	Acute myocardial infraction			●	●		
			Cesarean section			●	●		
			Acute phase stroke			●	●		
			Surgery preventive antibiotics		●	●	●		
			Geriatric hospitals					●	
		Outpatient	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).

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 3-4> Benefit Types

Insurance benefits	**Benefits in kind**	• Health-care benefits • Health checkups
	Benefits in cash	• Co-payment ceiling • Auxiliary device benefits for people with disabilities • 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 (e.g. minor snoring and fatigue, ennui)
- Services, medicines, and medical materials performed or used for purposes other than the improvement of essential physical functions (e.g. cosmetic surgery, freckle removal)
- Preventive services, medicines, and medical materials performed or used for purposes other than the treatment of diseases and injuries (e.g. 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.

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 2022, a total of 9,205 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 2007, 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 3-5> 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 3-6 lists the co-payment ceiling by income level.

<Table 3-6> 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	10th 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				
2021	120 days or less	81	101	152	282	352	433	584
	More than 120 days	125	157	212				
2022	120 days or less	83	103	155	289	360	443	598
	More than 120 days	128	160	217				

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 3-7> Payment for Catastrophic Medical Expenses by Disease and Income Level

As of October 31, 2022 (unit: no. of subsidies, KRW million, %)

Category		Total	
		Subsidies	Amount
Total		15,884 (100.0)	48,773 (100.0)
By disease	Severe diseases	6,132 (38.6)	26,369 (54.1)
	Other diseases	9,752 (61.4)	22,405 (45.9)
By income level	Welfare beneficiaries, near-poverty groups	8,010 (50.4)	18,144 (37.2)
	Below 50% of median income	2,811 (17.7)	8,206 (16.8)
	50%–85% of median income	3,073 (19.3)	10,919 (22.4)
	85%–100% of median income	916 (5.8)	3,946 (8.1)
	100%–200% of median income	1,074 (6.8)	7,559 (15.5)

4) Special Estimate Cases

The special estimate case system is a policy to support the public by alleviating the burden of medical expenses of severely ill patients and strengthening essential medical coverage. The co-payment rate for outpatients and inpatients (including home nursing care) is 5% for severe diseases such as cancer and 10% for rare and incurable diseases. The co-payment system does not apply to tuberculosis and latent tuberculosis infection. As for the scope of support, the special estimate case system is valid for the treatment of diseases subject to special cases and complications that have a clear causal relationship therewith. Table 3-8 shows the specific list of the eligible diseases.

<Table 3-8> Special Estimate Cases (as of January 1, 2022)

Category		Adoption date	Registration period	Co-payment rate*
Eligible diseases	Cancer	September 2005	5 years (re-registration allowed)	5%
	Cerebrovascular diseases	September 2005	Up to 30 days	5%
	Heart diseases	September 2005	Up to 30 days (60 days for CHDs and heart transplant)	5%
	Rare and incurable diseases	July 2009	5 years (re-registration allowed)	10%
	Tuberculosis	July 2009	Treatment period	0%
	Severe burn injury	July 2010	1 year (can be extended for 6 months)	5%
	Severe trauma	January 2016	Up to 30 days	5%
	Severe dementia	October 2017	5 years (60 days per year in case of V810)	10%
	Latent tuberculosis infection	July 2021	1 year (can be extended for 6 months)	0%

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

* Applicable only to items that cover part of the healthcare benefit expense (excluding fully burdened medical expenses, non-covered, selective, and preliminary benefits, meal expenses, and hospitalization in rooms for 2 to 3)

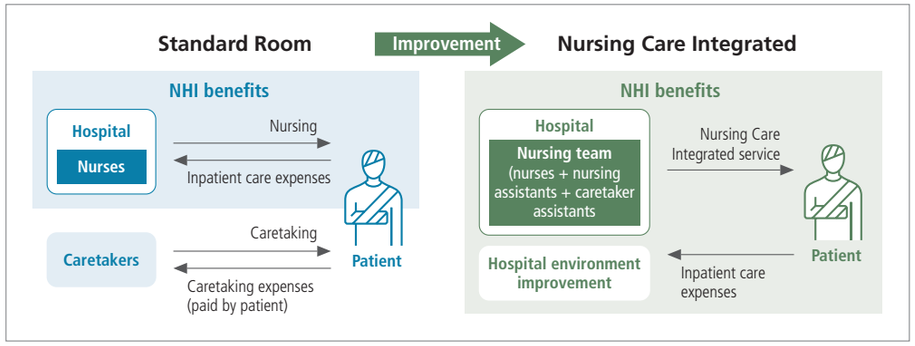
5) Selective Benefits

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 a program that increases the number of nursing staff and improves the hospital room environment so that the guardians or caregivers do not need to stay by the patient's side. Inpatient caretaking services are directly provided by the nursing staff (nurses and nursing assistants) and nursing support staff.

[Figure 3-3] Operation of 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 due to unjust or mistaken claims by health-care facilities; ② identifying and collecting medical expense payments provided by institutions suspected of illegal opening (illegally operated hospitals and pharmacies by non-registered pharmacists); ③ restricting insurance payments and collecting insurance payments on account of third-party actions; ④ collecting insurance benefits paid to non-eligible persons and other unlawful profits; and ⑤ filing objections against the HIRA's medical expense review results.
The NHIS took numerous actions to prevent 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 and illegal receipt of health benefits from patients.
In addition, the NHIS began investigating illegally operated hospitals in 2014 and expanded the investigation to cover pharmacies operated by non-registered pharmacists in 2017. To date, the NHIS ensures management in all directions, including preventive measures, administrative investigations, and follow-up management.

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 Program

3.3.1. 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 3-9> 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 3-10> 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, γ-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 40 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 3-11> 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.

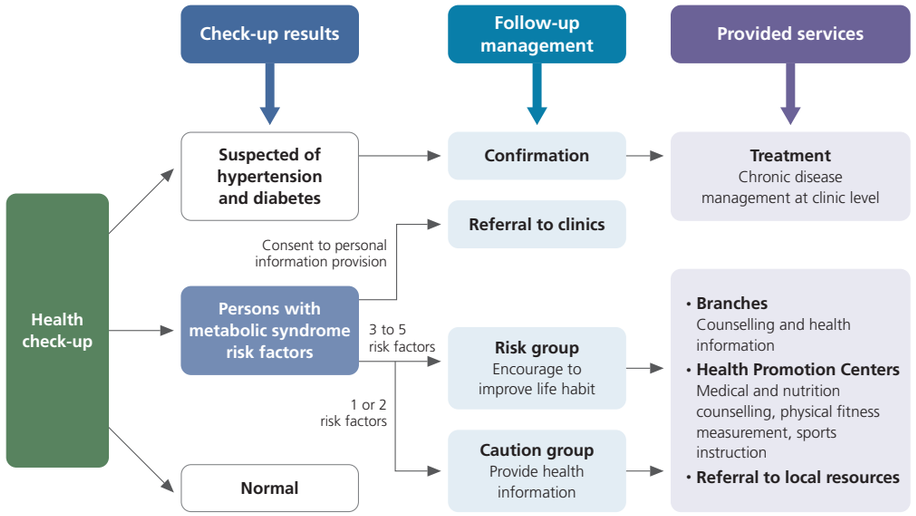
4) Health Checkups for Teens outside of Schools

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.

3.3.2. 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 3-4] 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 sends customized information (via electronic documents and mail) using big data to the two groups, and provides them with information on how to deal with metabolic syndrome through telephone counseling and visitations. 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>

① Abdominal obesity: Abdominal circumference 90 cm or larger (men) or 85 cm or larger (women), or BMI 25 or higher

② High blood pressure: Systolic pressure 130 mmHg or higher, or diastolic pressure 875 mmHg or higher

③ High blood glucose: Fasting blood glucose 100 mg/dL or higher

④ Hypertriglyceridemia: Neutral fat 150 mg/dL or higher

⑤ 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

4.2. History

experience with the integrated health checkup database, and streamlined claim processing by allowing customers to file claims via the Internet rather than diskettes.

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 Information and Communication Technology (ICT) 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 (individual), a remote research support system free of temporal and spatial limitations (research), and a system for regional health-care information (regional). In addition, the NHIS has emerged as a leader in health insurance big data management by opening a health information research cooperation center in 2019 and designating institutions specializing in combining health and medical fields in 2020.
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.

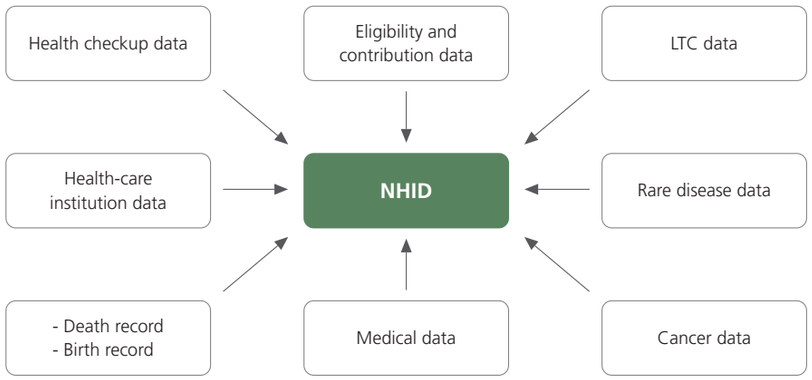
1) Relevant Areas

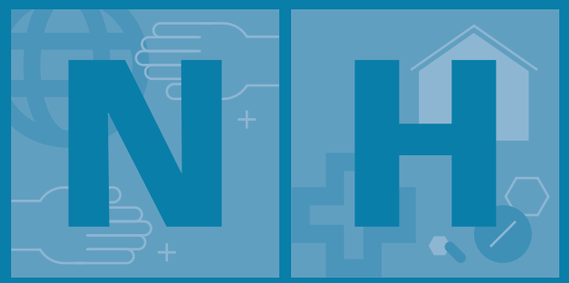
The big data stored in the database are organized in a way that enables the NHIS to predict disease risks, provide health management information, predict risk factors for metabolic syndrome, and produce information on health promotion. The NHIS uses the data to provide the public with bespoke health information services based on personal health record (PHR); detailed medical indexes tailored to different regions, age, and gender; and national health alert services using weather data and social media.

2) Other Areas

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

[Figure 3-5] Types of Big Data





M

LONG-TERM CARE INSURANCE FOR THE ELDERLY

1. Overview
2. History of LTC Insurance for the Elderly
3. Eligibility System
4. Benefit System
5. Financial Resources

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

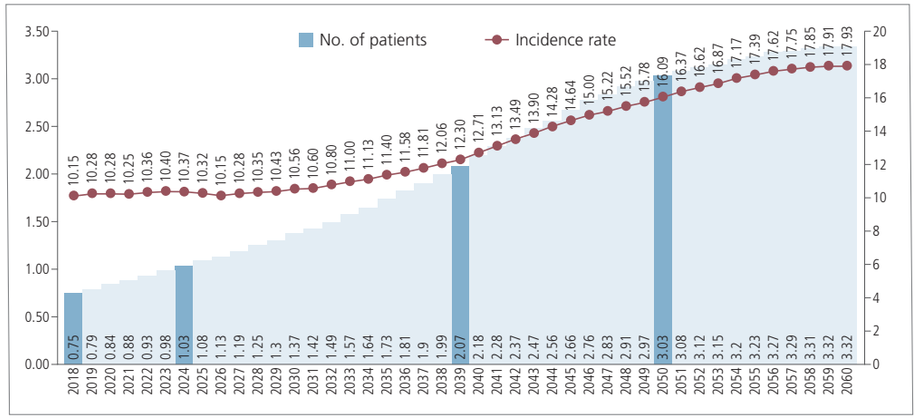
1.1. Background

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 4-1] 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 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.

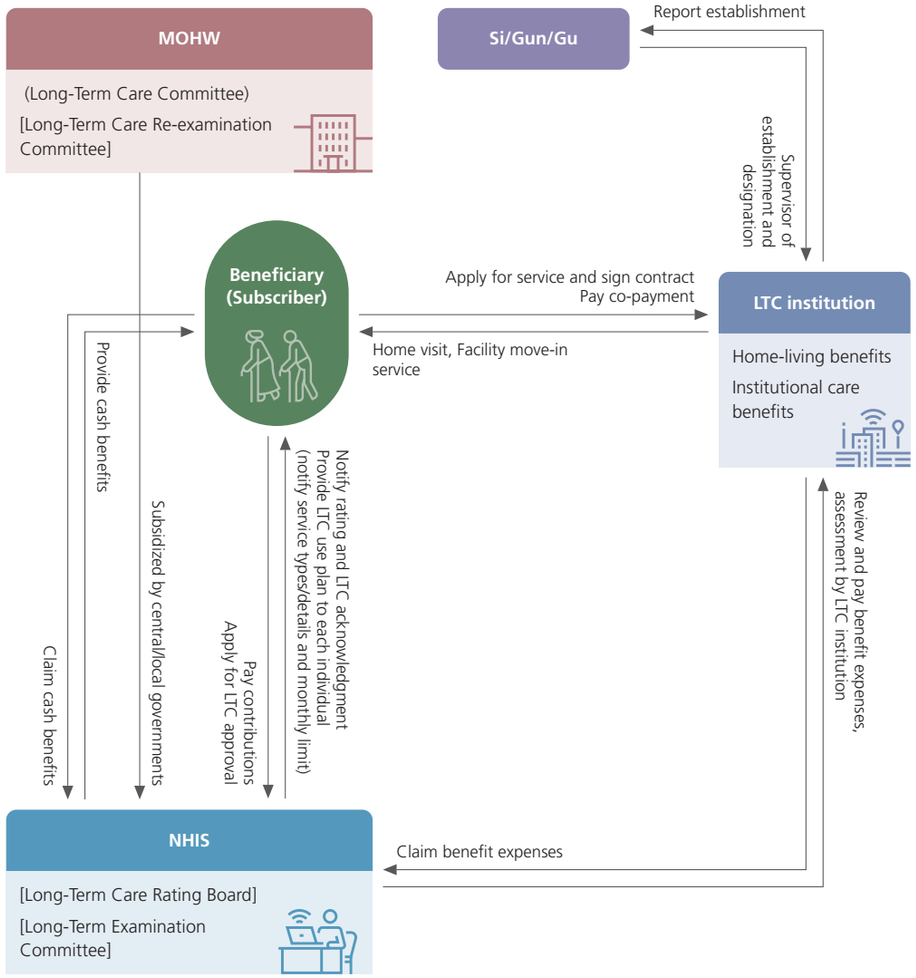
1.3. Legal Basis

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 4-2] LTC Insurance Management and Operational Structure



2 History of LTC Insurance for the Elderly

2.1. 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.

2.2. 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.

As of 2021, the LTC recipients were expanded to 954,000 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.

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.

2.3. LTC Institutions Operated by NHI

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.

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.

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 4-1 shows the scope of LTC Insurance.

<Table 4-1> 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 2021, the number of persons enjoying medical security aged 65 or older was 8.91 million, and the number of persons approved for the LTC Insurance was 950,000 (approval ratio: 10.7%). Tables 3-2 and 3-3 show the number of persons approved for the LTC Insurance by level and year.

<Table 4-2> Number of Approved Persons by LTC Level

(unit: no. of persons)

Year	Total	Level 1	Level 2	Level 3	Level 4	Level 5	Cognitive Assistance Level
2021	953,511	47,800	92,461	261,047	423,595	106,107	22,501

<Table 4-3> Number of Elderlies and Persons Approved for LTC Insurance

(unit: no. of persons)

Category	2017	2018	2019	2020	2021
Elderlies (65 or older)	7,310,835	7,611,770	8,003,418	8,480,208	8,912,785
Approved persons	585,287	670,810	772,206	857,984	953,511

Note: Elderlies refer to those aged 65 or older among the population eligible for medical security

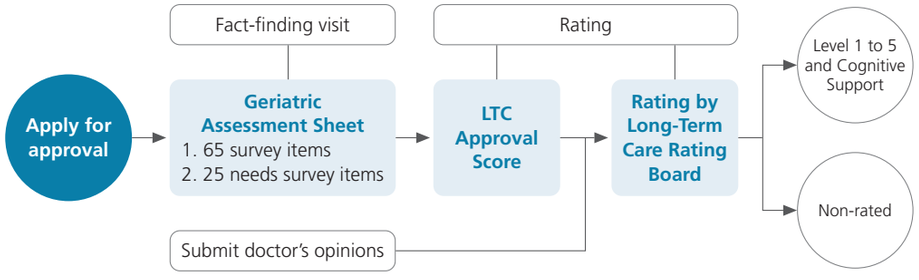
4 Benefit System

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 4-3] 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 4-4> Eligibility Scores and Functions by LTC Level

Level	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.

LTC approval	Select institution	Benefit contract	Use services	Pay co-payment
Receive documents	Beneficiary selects LTC institution	Beneficiary (contractual party) and LTC institution sign contract	Service provided	Pay expenses to LTC institution

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: Care worker (LTC personnel) visits a beneficiary's home to provide assistance with physical activities and household activities.
  - Care visits for cognitive activities: Care worker trained for dementia care 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, nursing assistant, dental hygienist, 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 and cognitive 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 (other home care benefits): 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 4-4] Types of Home-Living Benefits

Care visits
LTC personnel visits a beneficiary's home to provide assistance with physical activities (bathing, defecation, hair washing, changing clothes, etc.) and household activities (cooking, purchasing essential supplies, cleaning, tidying up, etc.).

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 (including day and night care for dimentia patients)
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
This LTC benefit provides or rents welfare medical devices required by beneficiaries to support their daily and physical activities and maintain/improve their cognitive functions, as specified and announced by the MOHW Minister (manual wheelchair, electronic/manual reclining bed, etc.).

<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

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), beneficiaries belonging to the second-lowest income bracket and subject to partial reimbursement (pursuant to Article 15 of the Enforcement Rule of the National Health Insurance Act), and beneficiaries experiencing difficulties in their livelihood due to acceptable reasons such as natural disasters 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 4-5 shows the monthly limit of home-living benefits by LTC Level. Any amount exceeding the limit must be paid by the beneficiary.

<Table 4-5> Monthly Home-Living Benefit Limit by Benefit Level

As of January 1, 2023 (unit: KRW/month)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5	Cognitive Assistance Level
Monthly limit	1,885,000	1,690,000	1,417,200	1,306,200	1,121,100	624,600

<Table 4-6> Care Visit Expenses by Visiting Hours

January 1, 2023 (unit: KRW/visit)

Service time	Amount (KRW)	Service time	Amount (KRW)
30 minutes or longer	16,190	150 minutes or longer	46,970
60 minutes or longer	23,480	180 minutes or longer	52,880
90 minutes or longer	31,650	210 minutes or longer	58,930
120 minutes or longer	40,280	240 minutes or longer	65,000

<Table 4-7> Visiting Ambulatory Bathing Service Expenses

As of January 1, 2023 (unit: KRW/visit)

Classification		Amount (KRW)
Visiting ambulatory bathing service	Bathing in vehicle	82,160
	Bathing at home	74,070
No visiting ambulatory bathing service		46,250

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 4-8> Nursing Visit Expenses

As of January 1, 2023 (unit: KRW/visit)

Service time	Amount (KRW)
15–30 minutes	39,440
30–60 minutes	49,460
60 minutes or longer	59,500

<Table 4-9> Day and Night Care Expenses

As of January 1, 2023 (unit: KRW/day)

Service time	Level	General	Dementia Unit	Service time	Level	General	Dementia Unit
3 hours or longer Less than 6 hours	1	38,630	-	10 hours or longer 13 hours or less	1	70,950	-
	2	35,760	44,980		2	65,720	82,690
	3	33,010	41,520		3	60,720	76,380
	4	31,510	39,620		4	59,190	74,440
	5	30,000	37,730		5	57,690	72,550
	Cognitive	30,000	37,730		Cognitive	52,050	65,470
6 hours or longer Less than 8 hours	1	51,780	-	Longer than 13 hours	1	76,080	-
	2	47,960	60,330		2	70,480	88,640
	3	44,270	55,680		3	65,110	81,920
	4	42,770	53,800		4	63,600	80,000
	5	41,240	51,880		5	62,100	78,100
	Cognitive	41,240	51,880		Cognitive	52,050	65,470
8 hours or longer Less than 10 hours	1	64,400	-				
	2	59,660	75,060				
	3	55,080	69,280				
	4	53,580	67,400				
	5	52,050	65,470				
	Cognitive	52,050	65,470				

<Table 4-10> Short-Term Protection Expenses

As of January 1, 2023 (unit: KRW/day)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5
Short-term protection	63,250	58,570	54,110	52,680	51,240

<Table 4-11> Special Cash Benefits

As of January 1, 2023 (unit: KRW/month)

Classification	Level 1	Level 2	Level 3	Level 4	Level 5
Dependent support expense	223,000				
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 4-12 by the number of days in a month.

<Table 4-12> Institutional Benefit Expenses

As of January 1, 2023 (unit: KRW/day)

Classification	Level	General	Dementia Unit Type A	Dementia Unit Type B
LTC facilities (2.5 persons / 1 caregiver)	Level 1	78,250	-	-
	Level 2	72,600	89,540	80,590
	Levels 3–5	66,950	82,570	74,300
LTC facilities (2.3 persons / 1 caregiver)	Level 1	81,750	-	-
	Level 2	75,840	89,540	80,590
	Levels 3–5	71,620	82,570	74,300
Nursing home for the elderly	Level 1	68,780	-	
	Level 2	63,820	79,110	
	Levels 3–5	58,830	72,940	

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 (12.27% of health insurance contributions as of 2022) 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 (12.27%) (to be calculated by multiplying the NHI contribution by the ratio of the LTC Insurance contribution rate to the NHI contribution from 2023). 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 4-13, a total of KRW 7,888.6 billion was imposed as LTC Insurance contributions in 2021. As of 2021, the monthly average of benefit expenses (KRW) for a single LTC benefit beneficiary stands at KRW 1,322,679 as shown in Table 4-14.

<Table 4-13> LTC Insurance Contributions Imposed

Category		2016	2017	2018	2019	2020	2021
Contributions imposed (KRW 100 million)		30,916	32,772	39,245	49,526	63,568	78,886
Per household (KRW)	Self-employed	5,497	5,710	6,300	7,309	9,278	11,150
	Employee	6,788	6,979	8,186	10,044	12,526	15,142
Per person (KRW)	Self-employed	2,957	3,124	3,536	4,244	5,531	6,814
	Employee	2,979	3,135	3,786	4,809	6,142	7,639

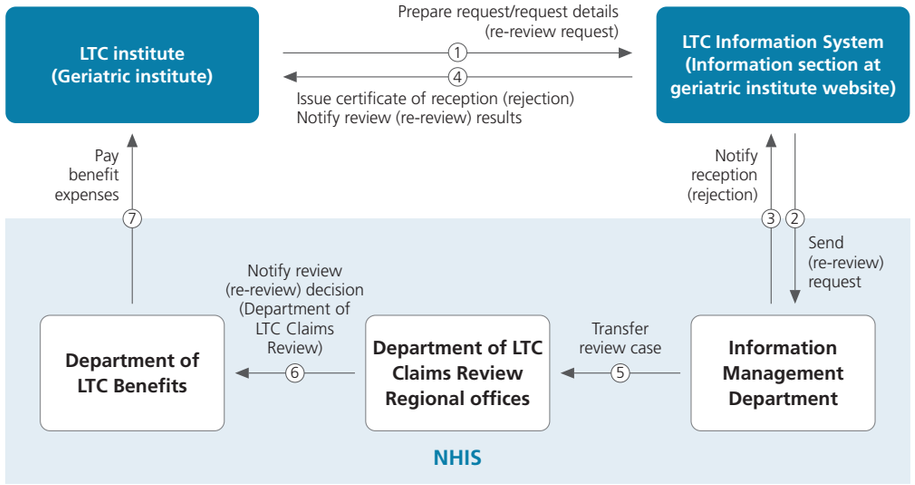
<Table 4-14> LTC Benefit Expenses

Category	2016	2017	2018	2019	2020	2021
Benefit expenses (KRW million)	50,052	57,600	70,670	85,653	98,248	111,146
NHIS contributions (KRW million)	44,177	50,937	62,992	77,363	88,827	100,957
Beneficiary (no. of persons)	520,043	578,867	648,792	732,181	807,067	899,113
Monthly average benefit expenses per person	1,067,761	1,103,129	1,208,942	1,284,256	1,315,195	1,322,679

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.

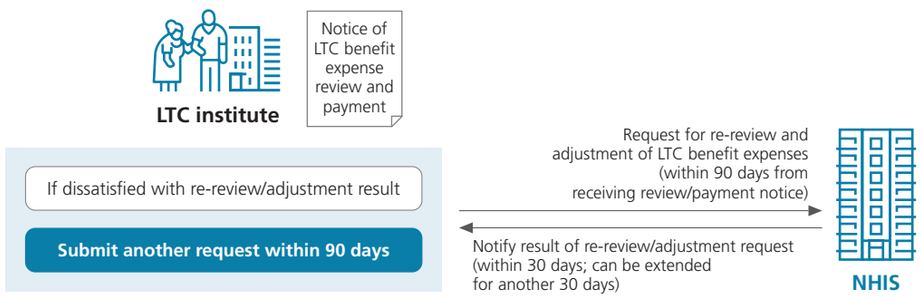
[Figure 4-5] Benefit Expense Review Process



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 4-6] Workflow of Re-Review and Adjustment Request



5.3. Follow-Up Management of Benefits

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.

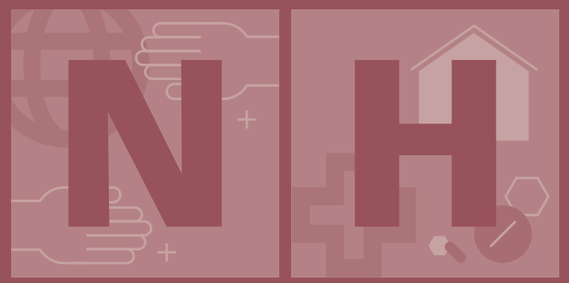
Follow-up management of benefit means a series of actions taken by the NHIS under Article 48 (2) of the Long-Term Care Insurance Act (the Act), including the redemption of amounts paid for illegal and fraudulent claims.

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

TASK OF NHIS

1. Mission and Vision
2. Achievements
3. Future Direction
4. NHIS International Cooperation Activities
5. NUGA, Capacity Building Program on Social Health Insurance
6. “Financial Risk Management System Support” as International Development Cooperation Project
7. NHIS Help Center for Foreigners

V TASK 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.

The NHIS vision is ensuring the happiness of the people, the health of the nation, and reliable national health insurance. Our goal aims at becoming a trustworthy national health insurance provider and a partner to guarantee happier lives for each individual and, going further, healthier lives for the people through a lifelong health management system.

Mission	Improving the quality of life of the people by promoting public health and social security				
Vision	Ensuring the happiness of the people, the health of the nation, and reliable national health insurance				
Core value	Health and happiness	Equity and trust	Innovation and expertise	Integrity and ethics	Communication and harmony
Management policy	**People** Securing reliability in public health anytime, anywhere	**System** A sustainable system based on equity and common sense	**Partner** A partner that communicates for cooperation	**Organization** A future-oriented organization that pursues to innovate together	
5 Strategic goals	Health coverage system responsible for the lifelong health of the people	Customized health management to increase life expectancy	Long-term care insurance that guarantees reliability in safety	Enhanced financial stability of health insurance	Trustworthy management based on innovation and responsibility

2 Achievements

1) Globally Recognized Korean Health Insurance

① The health insurance system of South Korea has achieved universal healthcare in terms of the covered population since the application of medical insurance to all citizens in 1989. The expansion of health insurance coverage served as a steppingstone to improving the access to medical care for the people. Nationwide medical insurance was achieved by implementing medical insurance for urban areas in 1989, a year after the community-based health insurance for rural areas was adopted. 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, in terms of healthcare indicators that represent major institutional achievements, South Korea's life expectancy is 83.5 years, longer than the OECD average of 80.5 years, and the infant mortality rate is 2.5, lower than the OECD average of 4.1 (as of 2020).

② The NHIS promotes health insurance establishment and development cooperation projects in developing countries to spread the excellence of South Korea's health insurance to the world and share experiences in achieving universal health care (UHC). The NHIS carries out health insurance cooperation projects with Indonesia, Kazakhstan, Georgia, and Moldova, along with Costa Rica's long-term care project, Guatemala's health insurance improvement project, and capacity-building training related to COVID-19 quarantine by inviting healthcare officials in Asia. As part of the corporation's efforts to vitalize international development cooperation projects, the NHIS held an international seminar attended by five countries, including Indonesia and Moldova, and an international development cooperation workshop attended by nine countries, including Cambodia and Mexico. Additionally, we are positioning ourselves as a global health security leader by conducting a wide range of projects like the "Consulting program to support the establishment of adaptive financial risk management system for ASEAN"carried out by the international cooperation planning group for promoting Korean health insurance system.

③ Even in the global pandemic situation, the NHIS eased the burden on the public through support for COVID-19 medical expenses, vaccination expenses, and four major social insurance premiums, and contributed to the return to normal lives by encouraging COVID-19 vaccination and providing national subsidies. In addition, the NHIS provided rigorous assistance in quarantine by employing a network of 178

nationwide branches, entrusted the full-time operation of 17 quarantine facilities (the largest number among public institutions), and provided treatment and quarantine facilities. The NHIS quickly expanded insufficient medical facilities and equipment so that medical institutions could focus on treating severely ill patients. It also provided financial support through early payment of benefit expense, post-settlement after payment in advance, and payment guarantee to maintain the medical system and provide essential services for responding to infectious diseases.

2) Strengthening the Social Safety Net by Alleviating the Public's Burden of Medical Expenses and Expanding the Provision of Customized Health Care Services to the Public by Utilizing Big Data

① As a result of mitigating the burden of national medical expense through the gradual expansion of benefit coverage for medically necessary treatment and the expansion of participating institutions in the nursing care integrated service, the health insurance coverage rate reached a record high of 65.3% as of 2020 (announced at the end of Dec. 2021). In addition, the NHIS strengthened the social safety net for the socially underprivileged, such as the vulnerable, by improving the medical expense system with supplementary nature, such as disastrous (catastrophic) medical expenditure and co-payment ceiling system, and by expanding the special estimate cases and benefit for assistive devices for the disabled.

② The NHIS strives to improve the national health level by strengthening the screening system for each life cycle through the introduction of newborn examination services and efforts to improve the rate of cancer screening and by stepping up the customized health service provision system through the vitalization of chronic disease management in primary care and induction of correct use of medical service. In particular, the NHIS is expanding the base of the customized health service provision area by conducting a pilot project in 2021 to provide subsidies for practicing healthy life to citizens, who manage their own health, for the first time since the government's health promotion policy was implemented.

③ As an institution that holds and manages health and medical data for all citizens, the NHIS made efforts to shorten the time required to provide data and expand infrastructure, and thereby, the number of research data openings reached 1,166 cases in 2021 alone, a significant increase from that of the previous year (871 cases) and is operating analysis centers with 160 seats in 10 regions with excellent public accessibility (as of the end of Dec. 2021). In addition, in response to the increasing demand for digitally mediated services due to the spread of new infectious diseases and the acceleration of Industry 4.0, the NHIS expands the provision of personal health record (PHR) app services and is making great efforts to strengthen the people's data sovereignty by promoting the establishment of a community-based platform for sharing health information among patients, doctors, pharmacists, and NHIS.

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. To this end, the NHIS continues to promote new development and expansion of long-term care services such as integrated home care service through the implementation of Korean long-term care future development projects, mobility support service, support for counseling services, and expansion of benefits for welfare equipment to alleviate the burden of caring for family caregivers.

② In an awareness survey conducted with the general public, when asked about their intention to use LTC insurance services, 93.2% of respondents as of 2021 answered that they would use it. And in a satisfaction survey conducted with LTC service users (guardians of benefit recipients), satisfaction with the overall LTC insurance system rose from 89.1% in 2014 to 91.6% in 2021.

3 Future Direction

The NHIS has developed a system essential to people's lives through several changes and reforms despite difficult circumstances. However, in order to maintain the sustainability of the system in the face of rapid environmental change, greater change and innovation are required.

As of 2020, the total fertility rate is 0.84, which is half of the OECD average (1.59), and the "productive population" is significantly declining due to rapid population aging. This means a decrease in the population paying insurance premiums, and if the trend of income decline in consideration of the domestic economic downturn due to overlapping external risk factors is followed, it is expected to have a direct impact on the reduction in "insurance premium income."

Moreover, the rate of increase in social insurance costs is the highest among OECD countries due to rapid population aging, and in the aftermath of rapid population aging and COVID-19, last year, medical insurance and medical expenses, including health insurance and medical benefits, exceeded KRW100 trillion for the first time ever. The proportion of health care costs to GDP was 8.4%, according to the 2020 data. This is less than the OECD average of 9.7%, but the average annual growth rate over the past decade is considerably higher (6.9%) compared to the OECD average (3.3%). Trends such as "revenue decline" and "rising expenditures"—long regarded as future risks—are becoming a reality.

In addition, while the average coverage rate of OECD countries is 80%, that of the National Health Insurance is 65.3%, which results in a relatively high burden in medical expenditure for Korean citizens. As for health insurance, each Korean government has promoted policies with its own goals to strengthen coverage and alleviate the burden of medical expenses on the vulnerable class, but the coverage rate remains low at around 60%. One of the reasons is that the insurance contribution rate of Korea is relatively low compared to that of OECD countries, so there is a limit to raising the necessary financial resources to expand insurance benefits, and another one is that non-covered medical expenditures are also rapidly increasing in line with the expansion of insurance benefits.

To this end, we are going to promote "site-centered institutional innovation for a new leap forward in health security" by setting eight key tasks as the operational direction of the NHIS. First of all, we will realize a thicker guarantee by easing the burden of public medical expenses, and strengthen the people-centered preventive health care and health care system in preparation for the age of 100. Next, as an insurer in charge of insurance finances, we will build a system that is trusted by citizens by reforming the insurance contribution imposition system, and we will strive to improve system sustainability through tight financial management. Lastly, by strengthening ESG management, we will take the lead in creating a healthier environment and society, enhance the satisfaction of employees (internal) and customers (external) by building organizational capabilities based on expertise and creativity and by creating a healthy organizational culture based on understanding and respect.

Furthermore, as an effort to implement the national tasks related to the NHIS, such as "strengthening the essential medical base and reducing the burden of public medical expenses," we will faithfully play a pivotal role in achieving national goals as an insurer by selecting mid-to-long-term tasks to secure company-wide executive power, and do our best to achieve our vision of "Ensuring the happiness of the people, the health of the nation, and reliable national health insurance."

4 NHIS International Cooperation Activities

1) Diverse International Cooperation Activities of the NHIS

First of all, since 2004, the NHIS has organized an annual international training course on social health insurance in collaboration with the WHO and MOHW. Secondly, the NHIS has had close cooperation with international organizations such as the Inter-Americam Development Bank, the International Social Security Association (ISSA), and the World Bank. Especially, the NHIS, as an ISSA Bureau member and Joint Learning Network (JLN) steering committee member, has contributed to the development of the healthcare system in diverse ways. Thirdly, the NHIS established MOU with many partner countries to form a solid foundation for bilateral or multilateral cooperation.

① NHIS UHC Global Academy (NUGA), Capacity Building Program on Social Health Insurance

- ➡ Sharing Korea's operational experience of NHI
- ➡ Participation of 40 healthcare officials from 10 countries (average)

② Cooperation with international organizations

- ➡ ISSA: ISSA Bureau member (2012–present), ISSA Liaison Office for East Asia (2011–present), ISSA Technical Commission member (2017–present)
- ➡ JLN: JLN Steering Group member (2017–present), JLN Collaborative

* Participations

Collaborative participation: Domestic resource mobilization, Data foundation, People centered integrated care, Primary healthcare financing and payment, Population Targeting, Efficiency Collaborative

- ➡ World Bank: Cooperative projects (the Philippines, Colombia, Peru, Belarus, Armenia, Azerbaijan, Georgia, Moldova, and Ukraine)
- ➡ Inter-American Development Bank: Cooperative project (Cyber Security, Mexico)

③ MoU with partner countries

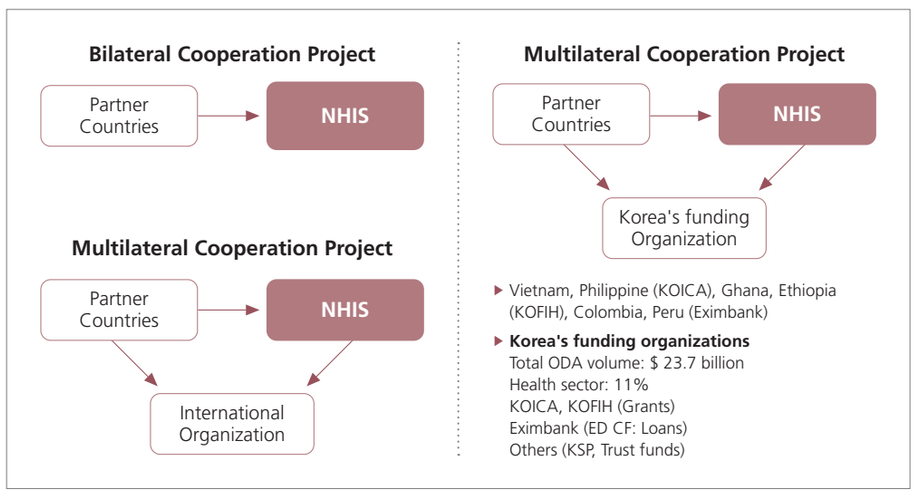
➡ Laying the foundation for bilateral/multilateral cooperation

➡ Denmark, Pakistan, Kazakhstan, Moldova, Belarus, Cambodia, Thailand, the Philippines, Vietnam, Belgium, Sudan, Mexico, Ethiopia, Kenya, Mongolia, Indonesia, Peru, Uzbekistan, Cambodia
+ international organizations (WHO/WPRO, WB)

2) Future directions

① Ways to initiate development cooperation projects with the NHIS

Partner countries can build cooperation with the NHIS in several ways. First, partner countries can ask NHIS to provide consultation for them with their budget. Second, partner countries can use funds from international organizations to start cooperative projects with the NHIS. For example, the World Bank has Korea-World Bank Partnership Facility (KWPF), the fund that Korea's government contributed to the World Bank. Third, through Korea's funds, partner countries can implement health insurance projects with the NHIS. Korea has several funding organizations. The Korea International Cooperation Agency and the Korea Foundation for International Healthcare are government organizations for grants. The Export-Import Bank of Korea is the organization for Economic Development Cooperation Fund loans. One of the ways to receive Korea's funds is to contact the Korean embassy in your country and send concept papers for cooperation to it.



5 NUGA, Capacity Building Program on Social Health Insurance

The NHIS has annually organized the "NHIS UHC Global Academy, Capacity Building Program on Social Health Insurance" since 2004 in close collaboration with the MOHW and World Health Organization/Regional Office for Western Pacific (WHO/WPRO) to contribute to the international endeavors to achieve UHC.

1) Background

Today, the global community is showing their interest in achieving UHC more than ever and the support for and commitment to UHC gathers momentum accordingly. Almost all developing countries have set UHC as the top priority, and actively mobilize resources and pursue reforms to achieve it. In this context, there has been a growing demand for global knowledge and experiences in health system reforms and operations, aimed at facilitating movements towards UHC. In an effort to contribute to international endeavors, the NHIS has annually organized the "Capacity Building Program on Social Health Insurance" in close collaboration with the MOHW and WHO/WPRO since 2004.

2) Objectives

This program enables participants to:

- Identify policy priorities at a national level designed to ensure adequate access, quality and equity in health care service delivery;
- Develop the most suitable options for population coverage, sources of financing, health benefits, payment methods, and others;
- Share other countries' experiences and promote cooperation and mutual understanding among them; and
- Establish a global network for further strengthening international cooperation

6 "Financial Risk Management System Support" as International Development Cooperation Project

1) Background

The NHIS has been able to build an integrated financial risk management system based on high-tech ICT systems and big data. With this system, the NHIS gained a reputation for stably managing the NHI finance as the single insurer of Korea. Using its integrated financial risk management system as a benchmark, the NHIS is providing an international development cooperation project, titled "Financial Risk Management System Support".

2) Project Purpose

This project is to support the establishment of a data-based financial risk management system to help partner countries overcome financial challenges associated with their healthcare systems. It aims to strengthen the stability of NHI finance, support evidence-based policy decisions, and maximize financial management efficiency. This project can be the starting point for customized health security as well as stable management of the NHI finance.

3) Stages of Project

This project is composed of three stages as follows.

- **Stage 1: Feasibility Study and Consulting**
  The validity, efficiency, and effectiveness of the project are analyzed through a feasibility study and the customer requirements are established to develop a financial risk management system based on the needs of the partner countries.
- **Stage 2: Prototype Solution Development**
  A prototype solution is developed by analyzing the key source data needed to reliably operate and manage the NHI finance and by reflecting feedback from the stakeholders.
- **Stage 3: Pilot Project**
  A pilot project is designed to establish a financial risk management system suitable for the partner countries, taking into consideration its ICT infrastructure, accumulated data, technological maturity, NHI finance status, and other relevant factors.

7 NHIS 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.

1) Target: Foreign nationals and overseas Koreans.

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.

3) Location

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

4) Consultation

* +82-1577-1000
  Dial 7 for information on foreign languages
* +82-033-811-2000
  Service in foreign languages (English, Chinese, Vietnamese and Uzbek) available

2023

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

Published on Dec. 2022
Publisher Do-tae Kang
Published by National Health Insurance Service

www.nhis.or.kr