

2024

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

NATIONAL HEALTH INSURANCE SERVICE



2024
**National Health Insurance &
Long-Term Care Insurance System**
Republic of Korea

NATIONAL
HEALTH
INSURANCE
SERVICE



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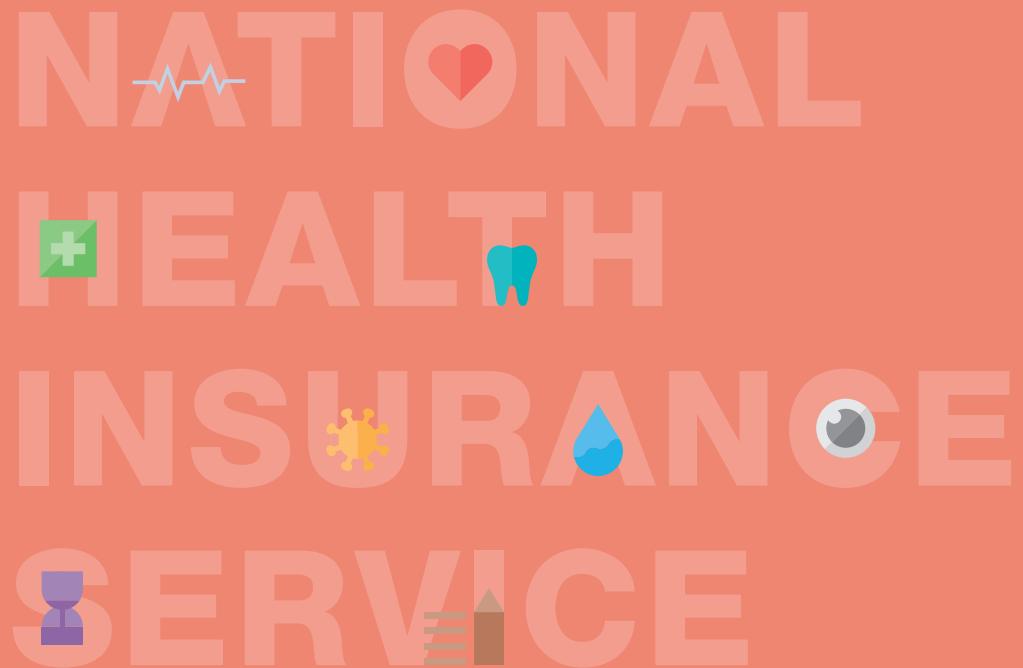
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I

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 | • 51,558,000 (as of 2023) |
| Area | • 100,412km ² (108th in the world) |
| Climate | • Continental |
| Language | • Korean |
| Ethnicity | • Korean |
| Religion | • Buddhism, Christianity, Catholicism, etc. |
| Currency | • KRW 1,319.00 = USD 1 (as of June 2023) |
| Government | • Presidential |



As of June 30, 2023, Korea's population stands at around 51,558,000. The country's population is rapidly aging, driven by the declining birth rate and rising life expectancy. Koreans aged 15 to 64 take up 70.5% of the total population, and the percentage of people under 15 is 11.0%. The percentage of elderly Koreans (aged 65 or older) rose from 17.9% in 2022 to 18.4% in 2023.

These demographic structural changes toward a super-aged society negatively affect the country's economic development and impose a significant burden on its health insurance system as aging and a low birth rate lead to workforce shortage which ultimately hinder economic growth and increase the welfare budget including healthcare.

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 healthcare and welfare costs.

The population aging also puts a strain on the country's healthcare 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 schemes, medical 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 Medical 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, healthcare, 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.

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II

NATIONAL HEALTH INSURANCE SERVICE

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

Korea has a universal healthcare 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 healthcare 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 protect 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 LTC centers are organized on the municipal (Si/Gu, also called basic local government) level to enhance accessibility.

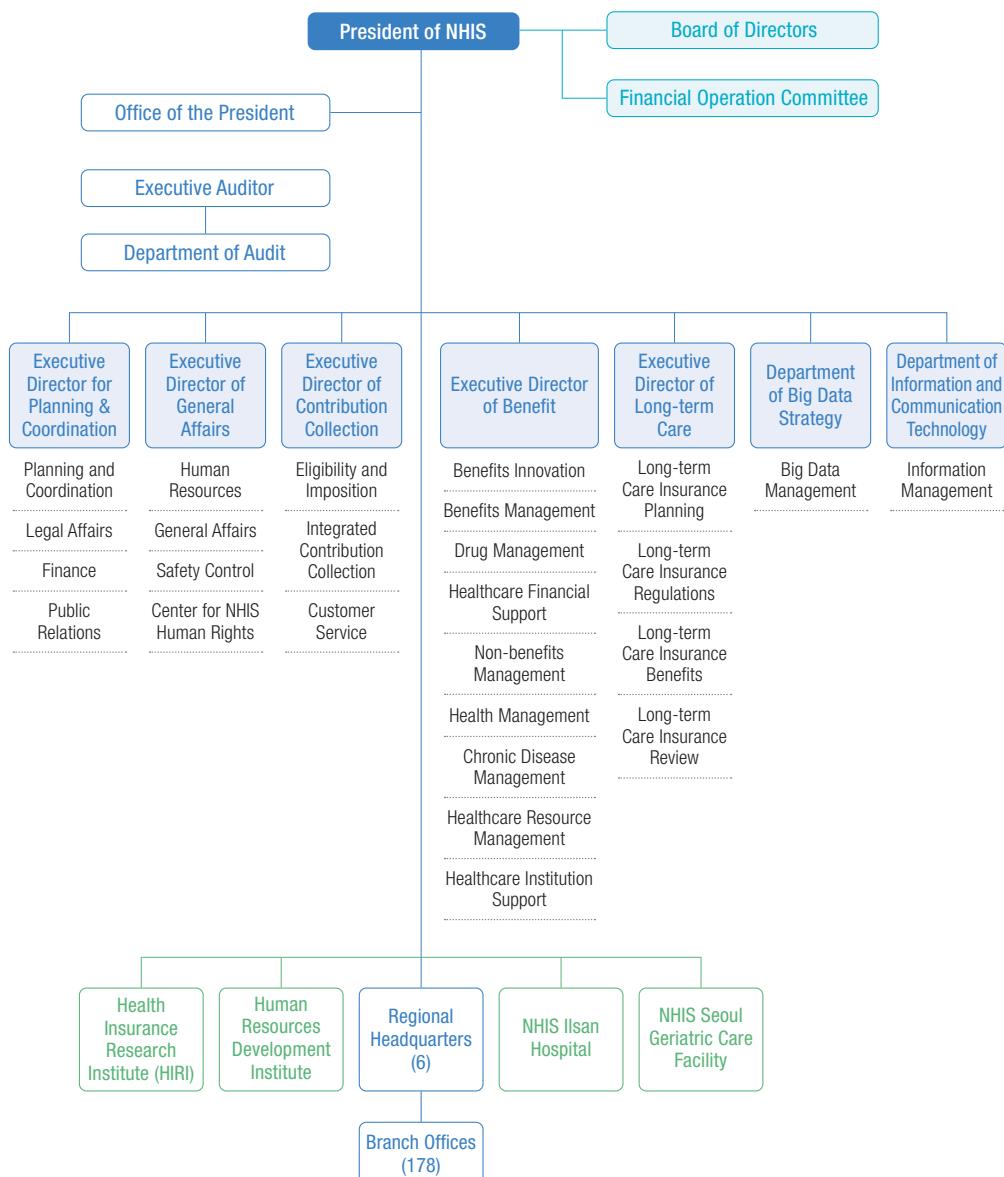
The NHIS employs 14,583 workers; 10,607 of them work in the NHI area, and 3,976 work in the LTC area (as of the end of July 2023; Ilsan Hospital and Seoul Geriatric Care Facility excluded).

1.2 Departments and Roles

The NHIS consists of the headquarters of 24 departments and one center, the Health Insurance Policy Research Institute, the Human Resource Development Institute, six regional HQs, 178 branches, 54 local offices, and 227 LTC centers. The NHIS also directly owns and operates two medical institutions: the NHIS-Illsan Hospital and the NHIS-Seoul Geriatric Facility.

NHIS Organizational Chart

(As of Jan. 1, 2023)



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 1977; 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, and, ultimately, employees and sole proprietors.

2.1 Birth of National Health Insurance and Voluntary Cooperatives

The first medical insurance association was formed in 1955 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 Social Affairs (current Ministry of Health and Welfare) also launched research projects on NHI schemes which resulted in the first enactment of the Medical Insurance Act in 1963.

2.2 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 Ministry of Health and Welfare (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.

2.3 Achieving Universal Health Coverage (1989)

With the launch of the mandatory Health Insurance for Employees (HIE) in 1977, the scope of the Community-Based Health Insurance (CBHI) expanded to all rural areas in 1988 and all urban areas in July 1989 after the CBHI pilot project in 1981. In only 12 years after the launch of the mandatory HIE, Korea accomplished universal health coverage which

marks an unprecedented and significant milestone. This achievement in just 12 years is attributable to the following reasons.

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 healthcare 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.

2.4 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 2-1 History of NHI

| | | |
|-------------|----------------|---|
| 1963 | Dec. 6 | Enacted the Medical Insurance Act |
| 1977 | Jul. 1 | Provided the first medical insurance targeting workplace with 500 or more employees (established 486 associations) |
| 1979 | Jan. 1 | Provided medical insurance targeting government employees and private school employees |
| 1981 | Jan. 1 | Provided medical insurance targeting workplace with 100 or more employees |
| 1988 | Jan. 1 | Began to cover person who is self-employed in rural area |
| 1988 | Jul. 1 | Expanded the application of medical insurance to workplace with 5 or more employees |
| 1989 | Jul. 1 | Began to cover person who is self-employed in urban area → Accomplished the medical security for whole population |
| 1997 | Dec. 31 | Enacted the National Health Insurance Act |
| 1998 | Oct. 1 | Integrated the self-employed insurance (227 associations) and medical insurance targeting government employees and private school employees → Launched National Health Insurance Corporation |
| 1999 | Feb. 8 | Enacted the National Health Insurance Act (Act No. 5854) |
| 2000 | Jul. 1 | Integrated National Health Insurance Corporation and employee insurance association (139 associations) → Launched National Health Insurance Service |
| 2001 | Jul. 1 | Incorporated the employee insured of workplace with 5 or less employees |
| 2002 | Jan. 19 | Enacted the Special Act for the Financial Stability of National Health Insurance |
| 2003 | Jul. 1 | Integrated the separated financial accounting system between the Employee Insurance and the Self-Employed Insurance program |
| 2005 | Jul. 1 | Implemented pilot project for the long-term care insurance |
| 2007 | Apr. 27 | Enacted the Long-Term Care Insurance Act (Act No. 8403) |
| 2008 | Jul. 1 | Implemented the long-term care insurance |
| 2010 | Jan. 27 | Promulgated the amendment of act of integrated social insurance contribution collection |
| 2011 | Jan. 1 | Integrated social insurance contribution collection (NHI, National Pension, Employment Insurance, and Industrial Accident Compensation Insurance) |
| 2017 | Aug. 9 | Announced policies to strengthen National Health Insurance coverage |
| 2018 | Jul. 1 | Reorganized the phase 1 health insurance imposition system |
| 2022 | Sep. 1 | Reorganized the phase 2 health insurance imposition system |

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 mandatory subscription, only people with higher risks of contracting diseases would subscribe to national health 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 national 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 with national health insurance 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

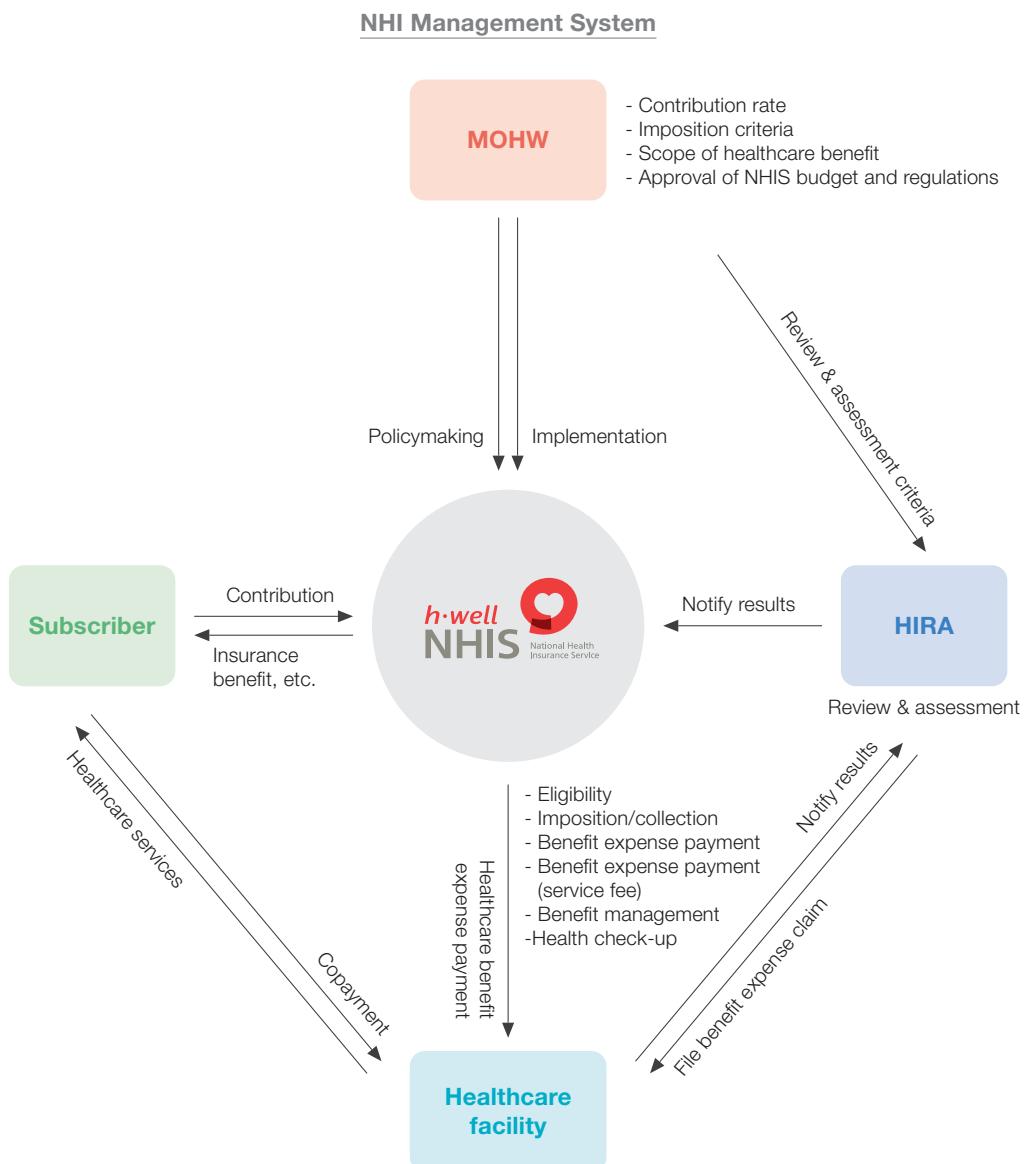
Founded in 2000 under the National Health Insurance Act, the NHIS plays an important role as the single insurer in Korea. The NHIS is responsible for providing medical benefits through medical service providers and reimbursing for these services. The NHIS is organized on three levels: HQ, regional HQs, 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 associations of medical institutions. Based on evidential data and materials, final agreements with each association are reached through a highly complex and interest-conflicting process.

Figure 2-2 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 healthcare benefit expense claims filed by healthcare facilities (medical

institutions and pharmacies, etc.) and notifies the NHIS of the review results. Medical services are provided by healthcare facilities, of which private sector entities operate 94.1%. In addition, medical service provider associations, pharmaceutical associations, labor unions, and non-government organizations (NGOs) play key roles in NHI policy decisions.

Figure 2-2 Framework of NHI Management and Operation



Source: MOHW website, 2017

4.1 Ministry of Health and Welfare (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 healthcare benefits; approving budgets and regulations of the NHIS; assessing new healthcare technologies; deciding on the benefit criteria (methods, procedures, scopes, and upper limits), upper limits of medical materials, and relative value of benefits.

4.2 National Health Insurance Service (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).

4.3 Health Insurance Review and Assessment (HIRA)

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

4.4 Medical Service Providers

Healthcare 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 healthcare services in their respective areas. Healthcare facilities designated under the National Health Insurance Act are subject to the NHI and may not refuse to provide subscribers with healthcare benefits without a justifiable reason.

5 Funding

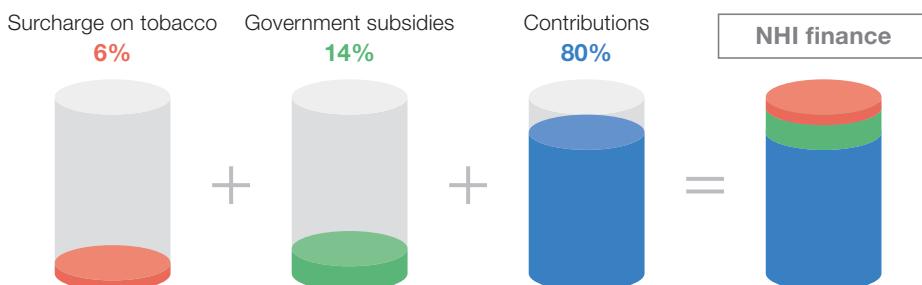
5.1 Financial Sources

The NHI scheme's financial sources consist of contributions, government subsidies, and other revenues. Contributions are collected from subscribers subject to payment obligations to finance the NHI scheme. 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 insured make up the majority of financial resources (80%) and the remainder is covered by government subsidies, such as taxes and surcharges on tobacco.

Figure 2-3 National Health insurance financial composition

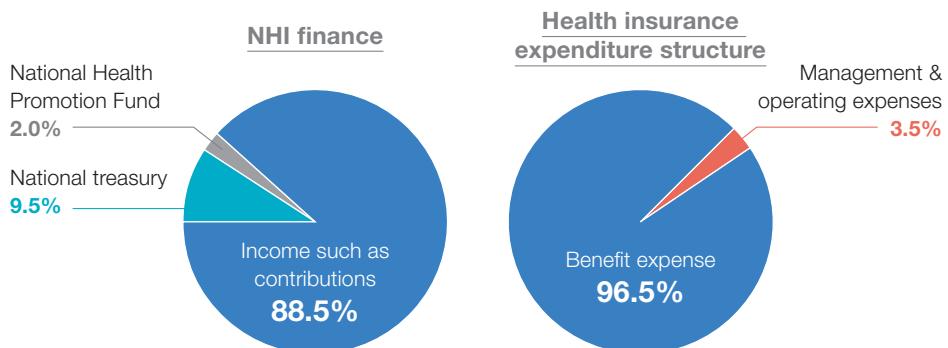


Source: NHIS, 2022

In 2022, 88.5% of the NHI budget was funded with contributions and other revenues, 9.5% was subsidized by the national treasury, and 2.0% by the National Health Promotion Fund.

96.5% of the expenditures were used for insurance benefit payments for subscribers including dependents, and management and operating expenses took up 3.5%. As seen from the figures, most of the health insurance finances are used for insurance benefit payments.

Figure 2-4 NHI financial composition and expenditure structure



Source: NHIS, 2022

5.2 History of NHI Funding

1) Government Subsidies

The HIE, introduced in 1977, had legal provisions for government subsidies since the enactment of the “Medical Insurance Act” in 1963. However, the HIE could operate stably as the employers covered 50% of the contributions of their employees, eliminating the need for 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 mergers of multiple medical cooperatives in 1998 and 2000 resulted in the birth of the NHIS as the single insurer. In addition, the separation between pharmaceutical prescription and dispensing in 2000 resulted in a serious financial deficit.

In response, the government enacted the Special Act on the Financial Soundness of the NHI in 2002, 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 40% from the national treasury and 10% from the National Health Promotion Fund. Subsequently, amendments were made for the percentage of government subsidies to be 35% and the National Health Promotion Fund to be 15% starting in 2005, due to the continued increase in the burden of the national treasury.

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. Changing the government support regulated at 50% of funding for the insurance of the self-employed to the system linked to the overall health insurance premium was also intended to emphasize the mutual aid among the insured on the insurance finance.

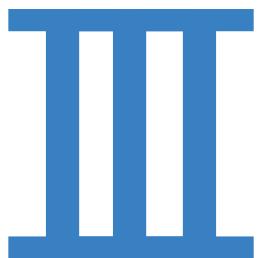
However, even when adding the provision for government support to the National Health Insurance Act, government support was stipulated to be provided temporarily for five years until December 31, 2011, along with the Special Act for the Financial Stability of National Health Insurance. This support period was extended four times and is currently stipulated to provide support until December 31, 2027, which led to ongoing social discussions regarding the abolition of the sunset law and the securement of stable funding.

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National Health Insurance &
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Republic of Korea

NATIONAL HEALTH INSURANCE SERVICE





NATIONAL HEALTH INSURANCE

- 1** Eligibility and Collection System
- 2** Management of Benefits
- 3** Health Management
- 4** Information Management
- 5** Big Data Management



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 copayers 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 achieved universal health coverage and 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 Care Assistant Act.

1) Eligibility

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 who are not acknowledged as insured employees or their dependents. 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 2022, 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 the insurance contribution rate, and self-employed insureds pay contributions based on the amount per contribution point. The contribution rate for insured employees and the amount per contribution point for self-employed insureds for imposing contributions are deliberated and decided by the Health Insurance Policy Deliberative Committee.

In 2022, an average household paid KRW 129,832 in contributions. The average for insured employees was KRW 145,553, and KRW 95,221 for self-employed insureds. The average contribution amount per capita was KRW 71,387, KRW 75,952 for insured employees, and KRW 59,377 for self-employed insureds. Insured employees paid 86.9%

(KRW 66.6845 trillion) and self-employed insureds paid 13.1% (KRW 10.202 trillion) of the total contributions imposed.

Table 3-1 Contribution Rates and Unit Prices Per Contribution Point

(unit: %, KRW)

| Category | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Insured employees (contribution rates) | 5.99 | 6.07 | 6.12 | 6.12 | 6.24 | 6.49 | 6.67 | 6.86 | 6.99 | 7.09 |
| Self-employed insureds (amount per point) | 175.6 | 178.0 | 179.6 | 179.6 | 183.3 | 189.7 | 195.8 | 201.5 | 205.3 | 208.4 |

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.

$$\text{Amount of insurance premium based on monthly remuneration} \\ = \text{monthly wages} \times \text{contribution rates}$$

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 2023 were KRW 7,822,560 and KRW 19,780 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.

$$\text{ICBMI} = \text{Amount of monthly income}^* \times \text{contribution rate}$$

* Amount of monthly income = $(\text{Income other than annual remuneration} - \text{KRW 20 million}) \div 12 \times \text{income assessment rate}$

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. In 2023, the upper monthly contribution limit was KRW 3,911,280, and the lower limit stood at KRW 19,780.

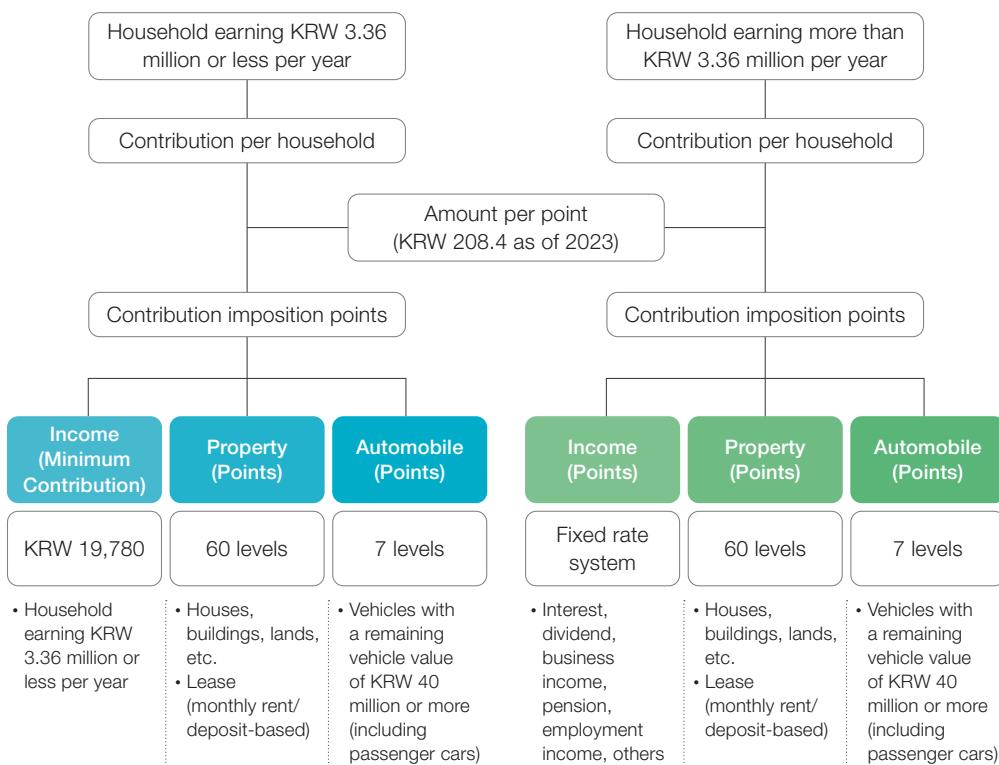
Households earning less than KRW 3.36 million per year are imposed contributions based on the minimum contribution.

* 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)

- A** Household earning more than KRW 3.36 million per year: $95.25911708 + 2,835.0928/10,000 \text{ per KRW 10,000 of income exceeding KRW 3.36 million} + \text{property points} + \text{vehicle points}$
- B** 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 Jan. 2023)**



The NHIS has been working toward a uniform imposition system solely based on income. The first phase of the project was completed in July 2018, and the second phase of the project was completed in September 2022.

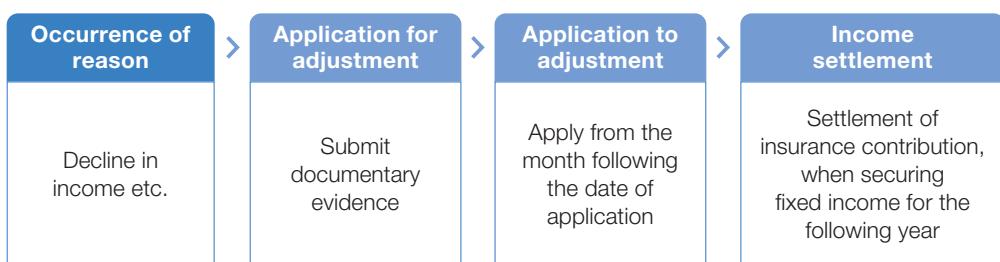
Income Settlement System

As contributions are imposed based on the previous year's income data from the National Tax Service in October, there is a significant time gap between the insureds' income and the imposition of contribution. The NHIS is operating a contribution adjustment system to reflect the actual payment ability of the insureds at the time of imposition. However, there is an increase in abuse such as maintaining the status of dependent or avoiding contributions by abusing the fact the NHIS is unable to accurately assess the current income despite having other incomes, thereby leading to a threat to health insurance finance. The legal basis for the "Income Settlement System" which is currently in effect, was prepared after discussions with various social service-related organizations during the revision of phase two of the imposition

system project in September 2022 for the fair imposition of contributions among insureds and to enhance the sustainability of health insurance.

The broad framework of the Income Settlement System involves strengthening the adjustment standard and implementing post-settlement. If the insured requested for the adjustment of contributions for business income and employment income, the difference is settled in November of the following year and is either imposed or refunded, similar to the year-end settlement for insured employees.

Figure 3-2 Workflow of Income Settlement System



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

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.

Covered Persons

Registered foreigners (including expatriates with resident registration and overseas Koreans who reported their place of residence) enrolled in the NHI include foreigners and overseas Korean nationals who have entered the country on the date of entry or resided in Korea for more than six months depending on their status of residence to be self-employed insured. 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.

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.

Contributions

It is difficult to identify the income and property of foreigners. Therefore, instead of 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 127,510 in 2023 (or KRW 143,840, when including the LTC contributions).

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.

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.

1.4 Management of Collection

1) Collection of Four Social Insurance Premiums

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

Figure 3-3 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 of the types, amounts, due dates, and contribution payment places. Household heads and members bear contributions imposed on self-employed insurees. 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 Integrated Collection Service social insurance finances.

2 Management of Benefits

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

2.1 Healthcare Delivery System

The term “healthcare 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 a referral from other medical institutions. Without such referral, the patient must fully pay for healthcare benefit expenses.

2.2 History of Insurance Benefit System

1) Expansion of Insurance Benefits

The scope of healthcare 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 healthcare benefits in 2000.

At the time of launching the first public medical insurance in 1977, the number of healthcare benefits stood at a mere 763. However, owing to the coverage expansion policy implemented in earnest in 2004, the number of healthcare benefits increased to 9,181 as of October 2022.

Now, the focus of the benefits shifted 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, healthcare 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 healthcare 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 healthcare 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 65.3% of NHI cost coverage rate in 2021, decreased by 0.8%p compared to the previous year. However, the cost coverage rate for healthcare services provided by general hospitals and higher continued to increase; the cost coverage rate for services by tertiary general hospitals reached 70.8%. The cost coverage rate for severe and high-cost diseases steeply increased and that of four major severe diseases reached 84%. Additionally, the rate for the elderly aged 65 or older was 70.3% and for children under 5 was 71.0% due to the lessening of the burden of healthcare expenses on vulnerable groups.

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 healthcare service providers' position, which gave rise to repeated demand for a service fee increase from the healthcare 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 payment method 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: phacoemulsification, tonsillectomy and adenoidectomy, anal surgery, inguinal and femoral hernia surgery, appendectomy, cesarean delivery, and uterine and adnexal surgery (excluding malignant tumor resection surgery).

3) Performance-Based Payment Compensation

Performance-based payment compensation is an incentive provided based on the NHI healthcare 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 infarctions 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 | Healthcare 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 infarction | | | ● | ● | |
| | | | 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 | <ul style="list-style-type: none">• Healthcare benefits• Health checkups |
| | Benefits in cash | <ul style="list-style-type: none">• Co-payment ceiling• Auxiliary device benefits for people with disabilities• Pregnancy and childbirth expenses |

1) Benefits in Kind

Benefits in kind consist of healthcare benefits and health checkups. Healthcare 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 healthcare 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 healthcare facilities. Such cases include receiving healthcare services for diseases, injuries, or childbirth, or giving birth to a child at a place other than healthcare 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.

An amount equivalent to 90% of the lowest amount among the threshold price, specified amount, and actual purchasing price is granted.

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 healthcare facilities.

Various medical services required by patients are registered and managed under the NHI scheme as healthcare benefit items. To expand the scope of healthcare 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 Healthcare Benefits

A new medical service should go through an assessment before it can be registered as a healthcare benefit. In cases where a healthcare facility or a pharmaceutical organization requests the HIRA to assess a new medical service for its eligibility as a healthcare 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 October 2022, a total of 9,181 items are listed as healthcare 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 healthcare benefit items. As of October 2022, a total of 35,351 items are registered as materials for medical treatment.

2) Registration of Medical Materials

The registration process for medical materials begins when a healthcare 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 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, removal, and modification of insurance benefits for pharmaceutical products used in the disease tests and treatment of patients are strictly managed. As of June 30, 2023, a total of 23,471 pharmaceutical products are registered as covered items.

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 Healthcare Benefits

As of January 2007, the NHIS 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 NHIS 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 RSAs: total expenditure limited, refund, utilization cap per patient, and performance-based refund. Other types of RSAs can be applied based on the Pharmaceutical Benefits Advisory Committee's assessment.

2.5.2. History of Healthcare Benefit Registration and Management

A. Medical Practices

When the first public medical insurance was adopted, the government only announced healthcare 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 healthcare benefit and non-benefit items, and provided that medical services not announced as non-benefit items are healthcare 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.

B. 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.

C. 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.

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 healthcare 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 healthcare 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 | | | | | |
| 2023 | 120 days or less | 87 | 108 | 162 | 303 | 414 | 497 | 780 | |
| | More than 120 days | 134 | 168 | 227 | 375 | 538 | 646 | 1,014 | |

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 June 30, 2023)

(unit: no. of subsidies, KRW million, %)

| Category | | Total | |
|-----------------|---|-------------------|-------------------|
| | | Subsidies | Amount |
| Total | | 13,680 (100.0) | 40,768 (100.0) |
| By disease | Severe diseases | 5,168 | 19,984 |
| | | (37.8) | (49.0) |
| | Other diseases | 8,512 | 20,784 |
| | | (62.2) | (51.0) |
| By income level | Welfare beneficiaries, near-poverty groups | 6,685 | 15,635 |
| | | (48.9) | (38.4) |
| | Below 50% of median income | 2,413 | 6,892 |
| | | (17.6) | (16.9) |
| | 50%–85% of median income | 2,893 | 9,289 |
| | | (21.1) | (22.8) |
| | 85%–100% of median income | 987 | 3,880 |
| | | (7.2) | (9.5) |
| | 100%–200% of median income | 702 | 5,073 |
| | | (5.1) | (12.4) |

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

| | 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 (Re-registration allowed once) | 5% |
| | Severe trauma | January 2016 | Up to 30 days | 5% |
| | Severe dementia | October 2017 | 5 years (re-registration allowed, 60 days per year in case of V810) | 10% |
| | Latent tuberculosis infection | July 2021 | 1 year (can be extended for 6 months, once) | 0% |

Note: Healthcare facilities apply reduced rates for Cerebrovascular 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)

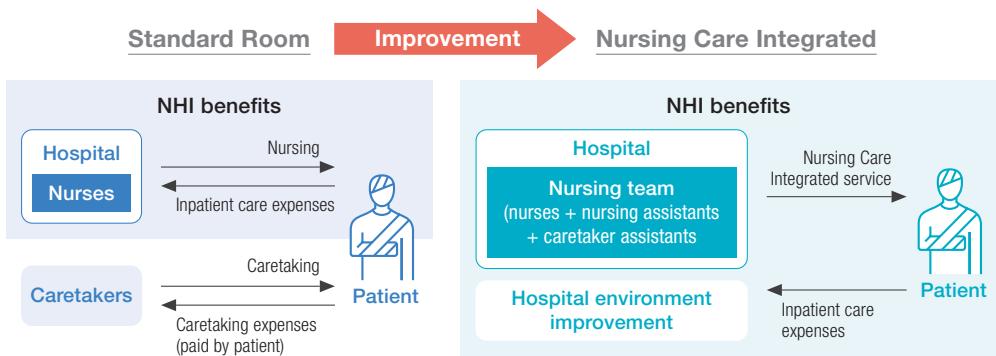
5) Selective Benefits

Selective benefits are preliminary healthcare 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, nursing assistants and nursing support staff).

Figure 3-4 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 includes: ① identifying and collecting medical expense payments provided due to unjust or mistaken claims by healthcare 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 thirdpartyactions; 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 healthcare 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, healthcare 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: healthcare facilities (files healthcare benefit claims) → the HIRA (review and assessment) → the NHIS (pre-inspection and provision) → healthcare facilities.

2) Medical Expense Review

After providing medical services to a patient, a healthcare 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 healthcare 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 healthcare facility and the NHIS, which pays the determined amount to the facility.

3) Healthcare Quality Assessment

The healthcare quality assessment determines whether medical services provided by healthcare 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 healthcare facilities. The results are also disclosed on the HIRA website.

3 Health Management

3.1 Overview

In response to the paradigm shift in healthcare 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

Health 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 healthcare 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 Examinations.

In April 2008, the Framework Act on Health Examinations 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 followup 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 Health 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 certain cancer screenings, are fully paid for by the NHIS.

1) General Health Checkup

General Health Checkups are conducted once every two years for early diagnosis of potential diseases and the provision of healthcare benefits for the diseases. They are provided to insured employees, self-employed insured householders, and self-insured family members or 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 3-9 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) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 nonoffice workers) | 2 years (1 year for colorectal cancer, 6 months for liver cancer) | 14 days to 71 months (8 checkups) -14 to 35 days 4-6 months 9-12 months 18-24 months 30-36 months 42-48 months 54-60 months 66-71 months | 3 years |

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, eGFR), urine test, and dental examination | | |
| Gender/ age-specific items (11) | Dyslipidemia | Total cholesterol HDL cholesterol Triglycerides LDL cholesterol | Men aged 24 or older women aged 40 or older (every 4 years) Men (Aged 24, 28, 32··) Women (Aged 40, 44, 48··) |
| | Hepatitis B test | | Aged 40 Excluding immune persons/ carriers |
| | Bone density test | | Women aged 54, 66 |
| | Cognitive impairment testing | | 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 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.

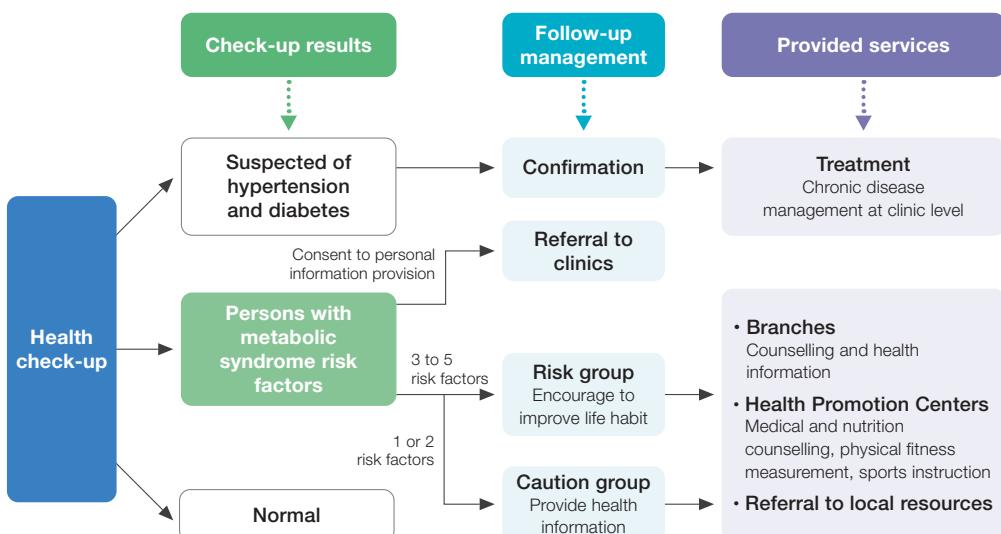
4) Health Checkups for Teens outside of Schools

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 3-5 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 g/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 Health

Checkup System; the Benefit Management System; the Integrated Collection Information System for Four Social Insurances; 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. Currently, a database is being built with national data on family relationships, addresses, income, and property tax data with 55 institutions, including government institutions, and 1,654 types of information which will be utilized to charge appropriate contributions. Health information services are provided in real-time anywhere in the country via the NHIS website and mobile app. The past method of filing claims for health checkups via diskettes changed to online which streamlined the claim processing. The website managed by the NHIS provides convenient and expedited NHIS reimbursement services for health checkup costs and LTC benefits. The NHIS is also continuing to expand the use of AI for data analysis, knowledge sharing, and provision of management information for scientific operations based on data.

4.2 History

1) Information Management in Early Years

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

2) Next-Generation Information System

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

By establishing the LTC Fair Detection System (FDS) in 2016, the usage of information analysis systems is gradually expanding such as using it for the management of fair claims through claim trend analysis of LTC facilities.

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 consists of an internal portal system and web portal system, designed to handle tasks such as approval management and assistance for long-term care service of LTC recipients, claims of LTC facilities to recipients, and review and payment of benefit expenses for the material of claims. After the implementation of the system in March 2016, the information system was upgraded to enhance the work efficiency of internal users within the NHIS, enhance the level of information services to recipients and LTC facilities, and incorporate additional and revised matters.

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.

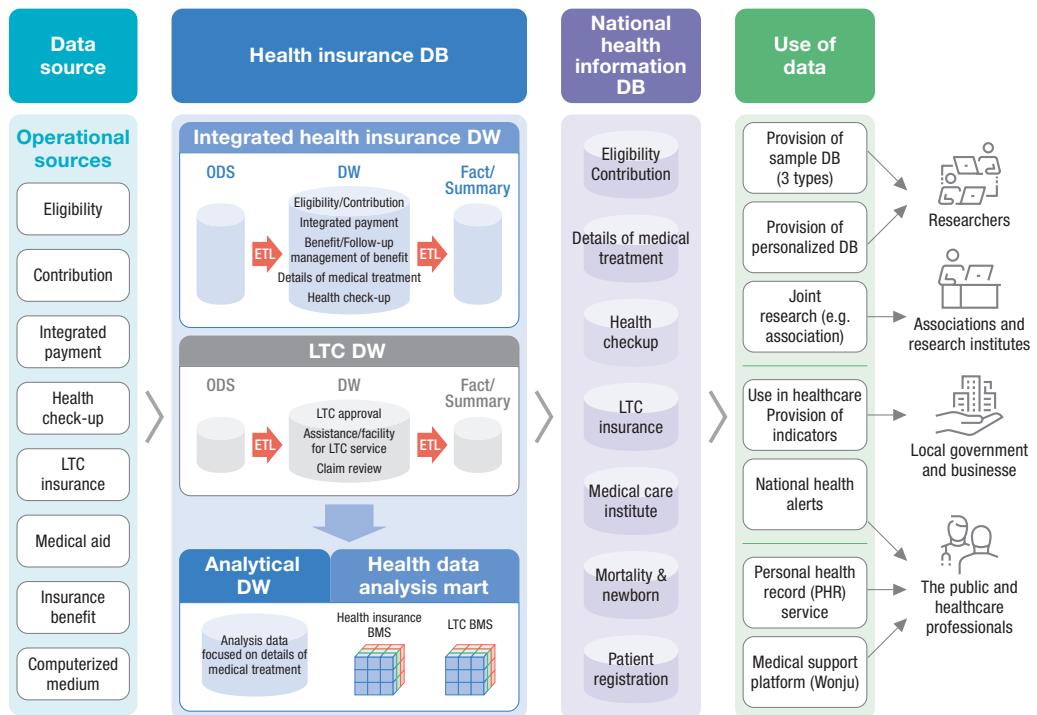
The system, which began its full operation on January 3, 2011, after six months of testing, effectively integrates contribution notification, reception, and delinquency management for all of the four insurances. As a result, duplicate work and management inefficiencies between various social insurance programs were addressed. The collection of contributions was upgraded to be more efficient and convenient by providing a one-stop national service at the NHIS for collecting contributions.

5 Big Data Management

5.1 Overview

National Health insurance big data comprises of more than 20 years of nationwide medical and examination data and more than 20 years of socioeconomic information. It is a valuable and rare dataset in the world that has been accumulated over a long period of time. The NHIS integrates extensive data scattered across various operational systems to utilize in various research support, personalized health services, and support for establishing health and medical policies. With the amendment of three Acts related data, there is a growing demand for open big data on health insurance for scientific research in healthcare and industries.

Figure 3-6 Overview of National Health Insurance DB



5.2 Changes Over Time

1) Structural Changes in the Big Data Project

The establishment of the “Health Insurance Big Data Operations Center” in 2013 was the first big data organization within the NHIS. The Department of Big Data Management was founded in 2014 to systematically manage big data including data openness, provision, integration, and management. The NHIS was designated as the “Korean Health Index Data Center” in 2015, thereby contributing to enhancing national interest in health promotion and industrial revitalization using big data.

As the importance of big data within the NHIS increased with the designation as a specialized institution for data integration in health and medical fields for the first time in October 2020, it reorganized into the “Department of Big Data Strategy” with about double the number of employees in January 2021. As of July 2023, the department oversees the health insurance big data and is organized into two divisions — Big Data Strategy and Big Data Management — with 118 employees.

2) Expansion of Big Data Infrastructure and System Implementation

The NHIS began to build a national health information database in 2012 and designed the health insurance big data platform utilizing big data and ICT. The NHIS developed and launched relevant systems in 2016 such as a self-health management system, a remote research support system free of temporal and spatial limitations, and an open system for the regional healthcare utilization index. Since 2016, the NHIS has continued to build health insurance big data platforms and advancement projects.

Infrastructures are being expanded by establishing 13 analysis centers (275 seats and 845 virtual rooms as of July 2023) with the opening of the Health Insurance Research Collaboration Center in 2019 to respond to the rapidly growing demands for open health insurance big data. Furthermore, the NHIS established the information system for specialized institutions for data integration in 2021 as it was designated for the first time as a specialized institution for data integration in the health and medical fields in 2020.

5.3 Use of Big Data

1) Support in Generating Evidence through Policies and Academic Research Support

The NHIS is rebuilding the “National Health Insurance DB” by classifying by tables after pseudonymizing to utilize national health information scattered across work systems. “Personalized DB” was established according to the research topic and the standardized sample cohort DB (three types*) based on the National Health Information DB. Data are provided more than 1,000 times each year for various policymaking and health and medical research both in Korea and overseas. It is also provided for the development of health management apps/websites and medical devices in the private industries including healthcare platform companies and clinical study organizations. As a specialized institution for data integration in health and medical fields and the secretariat for the government-led joint response council, the NHIS standardized the criteria for data provision, provided external consultations, and led the utilization of integrated data** by achieving the highest number of data exports among the specialized institutions for data integration (12 cases, as of July 2023).

* Sample cohort DB (1 million persons), health checkup cohort DB (515,000 persons), and the elderly cohort DB (510,000 persons)

** Awarded the Grand Prize for Best Utilization (Minister of Health and Welfare Award) in Sept. 2022 in the 2nd Contest for Exemplary Case Study/Idea in the Utilization of Pseudonymous Information

2) Contribution to Building a Social Safety Net by Supporting Policy Making and Social Issue Solutions

The NHIS developed the health priority inquiry tool for confirmed patients of COVID-19 in the early stages of the COVID-19 outbreak by linking the NHIS data with the Korea Disease Control and Prevention Agency to support the disease control and prevention system such as assisting in prompt patient classification and bed allocations at clinical sites to deal with a spike in demand for hospital beds. Through in-depth big data analysis, the NHIS is generating and supporting grounds required by each stage of scientific and disease control/prevention policies including implementation of COVID-19 treatment, management of infection side effects, vaccination, and post-vaccination side effects. Furthermore, the NHIS is also contributing to establishing a social safety network by establishing and evaluating key national policies such as compensation for damages related to humidifier disinfectants, the development of medical indicators for occupational diseases, the development of socioeconomic indicators, and the evaluation of the efficacy of rotavirus and influenza vaccinations.

3) Improvement of Health Insurance Scheme Using Big Data

Support in big data analysis is provided for data-based decision-making process in various fields, including health insurance, long-term care, and health checkup promotion projects, to efficiently operate and improve the health insurance scheme. Analysis related to health behavior is supported, such as chronic disease control and healthy life practice support fund, for efficient practice of health management projects by the NHIS.

Monitoring analysis is supported including performance assessment of pilot projects such as nursing care integrated service and sickness allowance pilot project, and financial forecast to support the decision-making in health insurance policies. “Data-Based Decision-Making System” is being established with the analysis using big data for scientific decision-making and stable project execution in all sectors of the NHIS’s work.

4) Provision of National Health Services

Health insurance big data is built to predict diseases in the future, provide health management information, and generate risk factors for metabolic syndrome and health promotion information based on anonymous and identifiable information.

Using this big data, the NHIS provides personalized health information services based

on personal health records, detailed medical indexes by region, age, and gender, and national health alerts by integrating weather and civil social media information. Recently, the pilot operation of the medical support platform has been underway since September 2022. The platform allows healthcare professionals to access and utilize patients' past medical and surgical records, prescription history, health checkup results, and lifestyle habits without needing patients who have consented to the service to submit their medical records to the hospital. The pilot operation is being carried out in 66 LTC facilities located in 13 cities and local areas in Gangwon province and about 4,000 residents in Gangwon province are participating as of July 2023.

5) Enhancement of Public Convenience

Since 2013, the NHIS has provided vision and hearing information required for driver's license aptitude tests from its national health checkup data to allow issuance of a driver's license without needing a physical examination. This is a case of a significant reduction in time and administrative cost, as well as about KRW 4,000 per physical examination which has been awarded the Prime Minister Award at the Government 3.0 Exemplary Case Study Competition. In addition, 18 types of confirmation and certificates are available as MyData that are frequently required by citizens, including the certificate of national health insurance. Currently, citizens and 131 institutions are downloading and using more than 200 million data.

NHIS



2024

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

NATIONAL HEALTH INSURANCE SERVICE

IV

LONG-TERM CARE INSURANCE FOR THE ELDERLY

- 1** Overview
- 2** History of LTC Insurance for the Elderly
- 3** Long-Term Care Approval
- 4** Benefit System
- 5** Financial Resources

IV

LONG-TERM CARE INSURANCE FOR THE ELDERLY

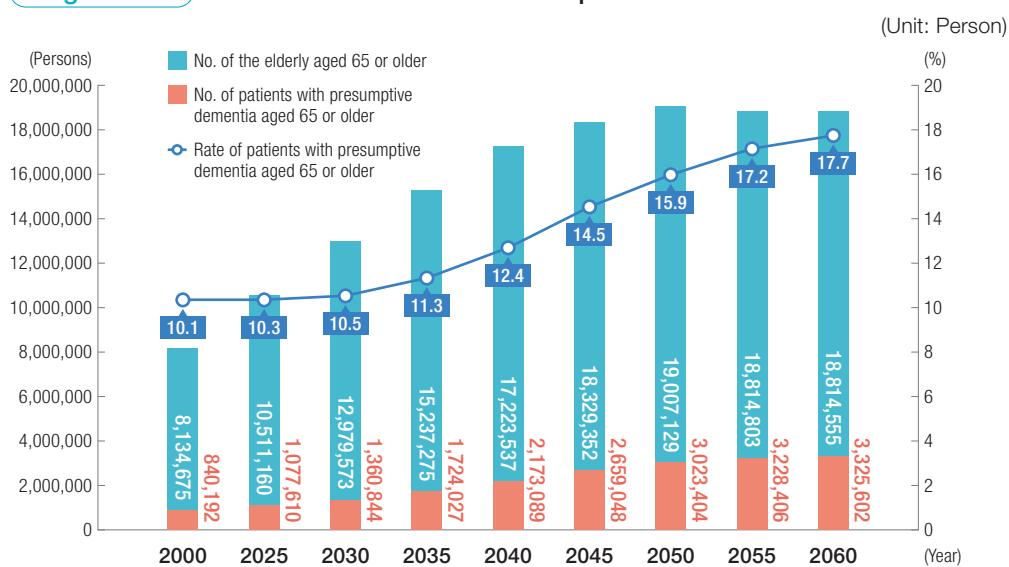
Long-Term Care (LTC) Insurance for the Elderly is a social insurance scheme that provides long-term care benefits, including support in physical activities and housework, to elderly citizens experiencing difficulties with daily routines for six months or longer on account of old age or age-related diseases. This scheme aims to promote a stable elderly life and lessen the burden on their families.

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 4-1.

Figure 4-1 Trend of Patients with Presumptive Dementia

Note: Rate of patients with presumptive dementia aged 65 or older = (No. of patients with presumptive dementia aged 65 or older/No. of the elderly aged 65 or older) × 100

Source: 1) Nationwide Survey on the Dementia Epidemiology of Korea 2016 (Ministry of Health and Welfare and National Institute of Dementia, 2017)

2) Future Population Projection (Statistics Korea, 2020)

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.

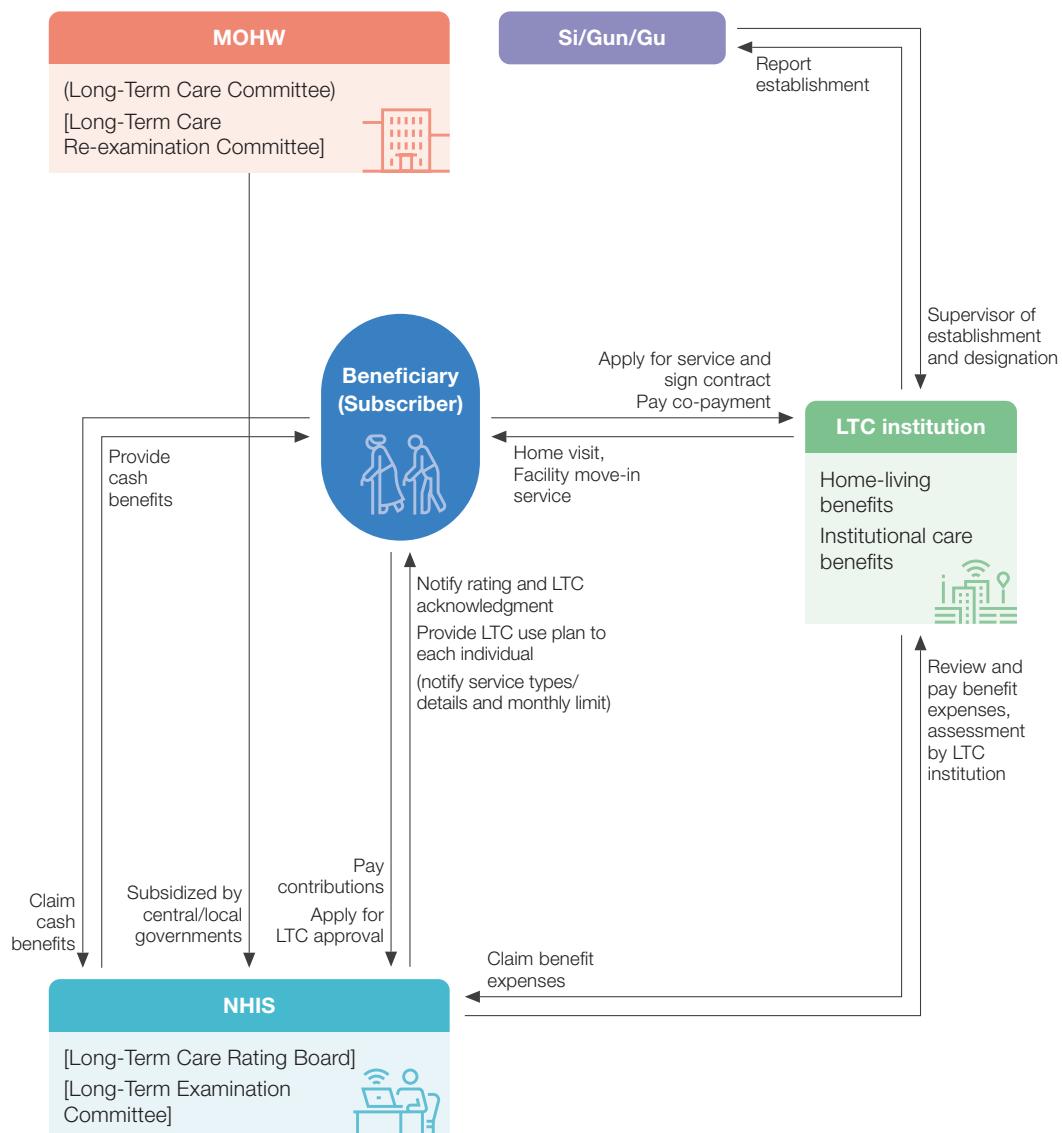
1.3 Legal Basis

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 LTC 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.

LTC facilities provided with institutional care benefits increased by 2.5 times compared to 1,700 institutes in 2008 and 4,326 institutes in 2012. Institutes provided with home care benefits also increased by 1.6 times from 6,744 institutes in 2008 and 10,730 institutes in 2012. As of 2012, 285,491 care workers were produced, providing a basis for stable services.

However, the infrastructure's rapid construction gave rise to some undesirable behaviors among LTC facilities, such as poor safety management and service provision, and excessive competitive behaviors as some facilities tried to attract or broker beneficiaries. The government established the Primary Master Plan for LTC Benefits (2013–2017) for the smooth provision of long-term benefits. Subsequently, the Secondary Master Plan for LTC Benefits (2018–2022) was set up based on social-economic changes, such as baby boomers' entry into the aged population and the preliminary master plan results. The NHIS established operation regulations and participated in the LTC Development Planning Team to raise the quality of services. Moreover, we launched our "LTC Development Action Team" for short- to mid-term strategies and institutional development.

The insurance coverage expanded with 1,019,000 being approved as LTC recipients as of 2022, and there are 6,150 LTC facilities provided with institutional care benefits (an increase of 3.6 times compared to 1,700 institutes in 2008) and 21,334 institutes provided with home care benefits (an increase of 3.2 times compared to 6,744 institutes in 2008). The service delivery system was strengthened by training about 2.52 million

care workers (3.7 elderly per care worker).

In August 2023, the government formulated and announced the Tertiary Master Plan for LTC Benefits (2023–2027). This plan outlines the vision of “LTC insurance for the elderly that thoroughly prepares for the super-aged society” and sets forth policy directions for comprehensive preparation such as improvement and development of the LTC insurance scheme overall, preparing for a super-aged society expected in 2025.

2.3 LTC Institute Operated by NHIS

The NHIS opened its first directly-run “NHIS Seoul Geriatric Care Facility” in November 2014 in Gangnam-gu, Seoul to accommodate 150 elderlyies 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 Long-Term Care Approval

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.

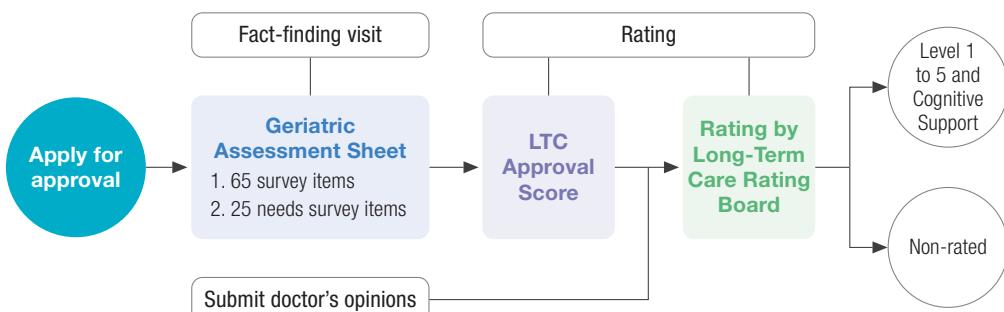
Table 4-1 Scope of LTC Insurance Application

| 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 determines 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.

The selection process includes the following: ① An applicant submits an application form for LTC approval to the Long-Term Care Insurance Operation Center (branch offices of the NHIS). ② Qualified NHIS employee visits the applicant to verify their state, using the Geriatric Assessment Sheet (90 items) and the applicant submits the doctor's opinions. ③ The Long-Term Care Rating Board determines the LTC rating based on the assessment results and doctor's opinions (Ratings 1 to 5 + Cognitive Assistant Rating). ④ The approved beneficiary is issued the Long-Term Care Approval Certificate, the Personalized Long-Term Care Utilization Plan, and the Confirmation of Welfare Medical Device Benefit. Figure 4-3 shows the LTC approval process.

Figure 4-3 LTC Approval Process

As a result of the rating process shown in Figure 4-3, an applicant is assigned an LTC approval point depending on his/her physical and mental functions. LTC ratings 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 4-2 LTC approval point and functional status by LTC rating

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

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

As of 2022, the number of persons enjoying medical security aged 65 or older was 9.37 million, and the number of persons approved for the LTC benefits was 1.01 million (approval ratio: 10.9%). <Table 4-2> and <Table 4-3> show Number of Approved Persons by LTC Level and Number of Elderlies and Persons Approved for LTC Insurance.

Table 4-3 Number of Approved Persons by LTC Level

(unit: no. of persons)

| Year | Total | Rating 1 | Rating 2 | Rating 3 | Rating 4 | Rating 5 | Cognitive Assistant Rating |
|------|-----------|----------|----------|----------|----------|----------|----------------------------|
| 2022 | 1,019,130 | 49,946 | 94,233 | 278,520 | 459,316 | 113,842 | 23,273 |

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

(unit: no. of persons)

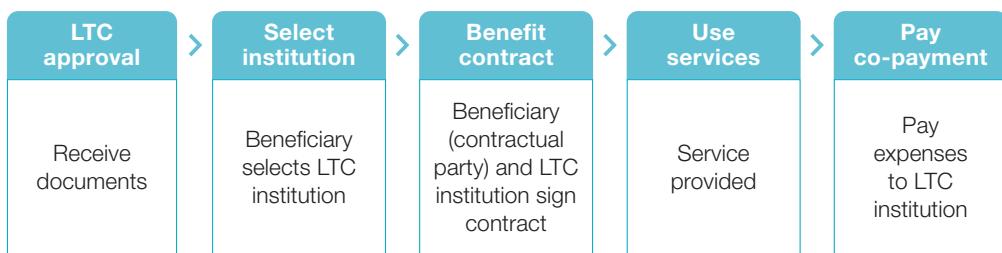
| Category | 2018 | 2019 | 2020 | 2021 | 2022 |
|-------------------------|-----------|-----------|-----------|-----------|-----------|
| Elderlies (65 or older) | 7,611,770 | 8,003,418 | 8,480,208 | 8,912,785 | 9,377,049 |
| Approved persons | 670,810 | 772,206 | 857,984 | 953,511 | 1,019,130 |

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

4 Benefit System

4.1 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 choose an LTC facility and sign the benefit contract in accordance with the Long-Term Care Approval Certificate and the Personalized Long-Term Care Utilization Plan. LTC facilities establish Benefit Provision Plans based on the Personalized Long-Term Care Utilization Plan and the needs of beneficiaries. Care providers (including care workers) provide the covered services in accordance with the plan.



4.2 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 dementia 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

4.3 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 homelivingbenefit 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.

4.4 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 4-6 through 4-10 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 | Rating 1 | Rating 2 | Rating 3 | Rating 4 | Rating 5 | Cognitive Assistant Rating |
|----------------|-----------|-----------|-----------|-----------|-----------|----------------------------|
| 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 (As of 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 |
| | Bathing at home |
| 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 Short-Term Protection Expenses (As of January 1, 2023)

(unit: KRW/month)

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

Table 4-10 Day and Night Care Expenses (As of January 1, 2023)

(unit: KRW/day)

| Service time | Rating | General | Dementia Unit | Service time | Rating | 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 | - | More 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 4-11 Special Cash Benefits (As of January 1, 2023)

(unit: KRW/month)

| Classification | Rating 1 | Rating 2 | Rating 3 | Rating 4 | Rating 5 |
|--|----------|----------|------------------------|----------|----------|
| Dependent support expense | | | | 223,000 | |
| Special case care expenses | | | | | |
| Geriatric hospital caretaking expenses | | | Currently not provided | | |

Source: Tables 4-5 to 4-11, "Public Announcement on Long-Term Care Benefit Criteria Benefit and Calculation of Benefit Expenses (MOHW Announcement No. 2022-301 (December 28, 2022))" and "Detailed Matters regarding Long-Term Care Benefit Criteria and Calculation of Benefit Expenses (Department of LTC Management No. 2022-2 (December 28, 2022))"

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 | | Benefit Expenses | | |
|--|-----------------------------------|------------------|----------|------------|
| | | Rating 1 | Rating 2 | Rating 3-5 |
| LTC facilities | 1 person or more per 2.3 people | 81,750 | 75,840 | 71,620 |
| | Less than 1 person per 2.3 people | 78,250 | 72,600 | 66,950 |
| Dementia unit in LTC facility | Type A | - | 89,540 | 82,570 |
| | Type B | - | 80,590 | 74,300 |
| Nursing home for the elderly | | 68,780 | 63,820 | 58,830 |
| Nursing home for the elderly dedicated to dementia | | - | 79,110 | 72,940 |

Source: Tables 4-5 to 4-12, "Public Announcement on Long-Term Care Benefit Criteria Benefit and Calculation of Benefit Expenses (MOHW Announcement No. 2022-301 (December 28, 2022))"

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 (0.9082% as of 2023). The LTC insurance contributions 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 calculated by multiplying the national health insurance contribution with the rate of LTC insurance contribution (0.9082%). 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 9,297.5 billion was imposed as LTC Insurance contributions in 2022. As of 2022, the monthly average of benefit expenses (KRW) for a single LTC benefit beneficiary stands at KRW 1,356,473, as shown in Table 4-14.

Table 4-13 LTC Insurance Contributions Imposed

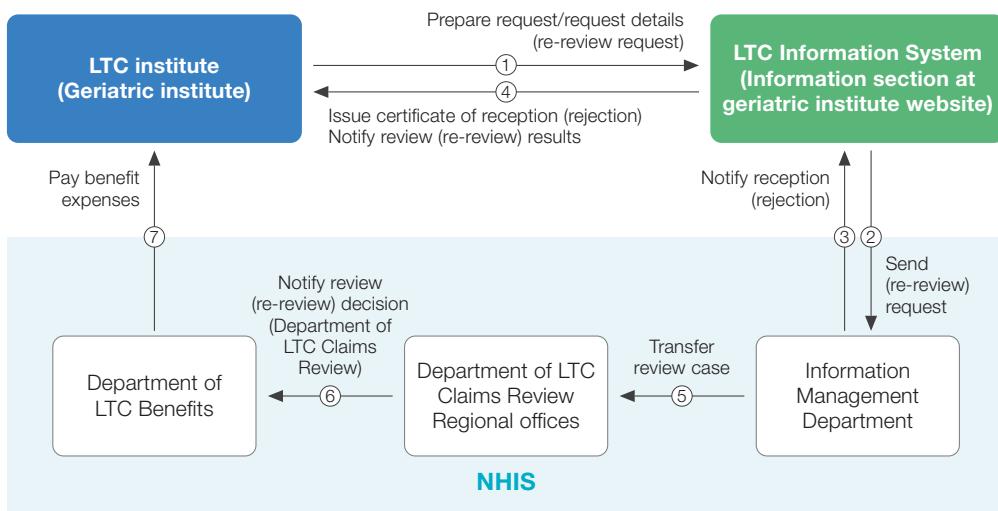
| Category | | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---------------|--------|--------|--------|--------|--------|--------|
| Contributions imposed (KRW 100 million) | | 32,772 | 39,245 | 49,526 | 63,568 | 78,886 | 92,975 |
| Per household (KRW) | Self-employed | 5,710 | 6,300 | 7,309 | 9,278 | 11,150 | 11,624 |
| | Employee | 6,979 | 8,186 | 10,044 | 12,526 | 15,142 | 17,609 |
| Per person (KRW) | Self-employed | 3,124 | 3,536 | 4,244 | 5,531 | 6,814 | 7,248 |
| | Employee | 3,135 | 3,786 | 4,809 | 6,142 | 7,639 | 9,189 |

Table 4-14 LTC Benefit Expenses

| Categor | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|-----------|-----------|-----------|-----------|-----------|-----------|
| Benefit expenses (KRW million) | 57,600 | 70,670 | 85,653 | 98,248 | 111,146 | 125,742 |
| NHIS contributions (KRW million) | 50,937 | 62,992 | 77,363 | 88,827 | 100,957 | 114,442 |
| Beneficiary (no. of persons) | 578,867 | 648,792 | 732,181 | 807,067 | 899,113 | 999,451 |
| Monthly average benefit expenses per person | 1,103,129 | 1,208,942 | 1,284,256 | 1,315,195 | 1,322,679 | 1,356,473 |

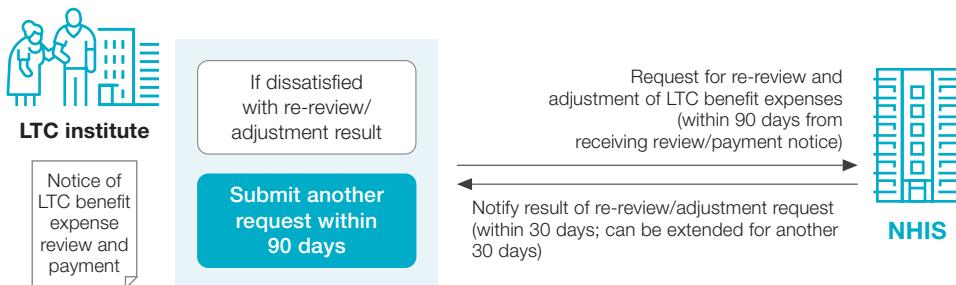
5.2 Review and Management of Benefit Expenses

Healthcare 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

2) On-Site Verification Review

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

5.3 Follow-Up Management of Benefits

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

1) Control of Limited Coverage Benefit

Unless a justifiable reason exists, the NHIS may limit the entire or part of the LTC benefits if an LTC beneficiary refuses NHIS's reinvestigation of the approval due to suspicions of receiving LTC approval through false information or fraudulent means, or deliberately caused accidents or unlawful acts in the process of being approved as LTC beneficiary, or if the beneficiary, without a justifiable reason, does not respond or refuses to respond to the NHIS's request for documents, or questioning by the Minister of Health and Welfare, Special Metropolitan City Mayor, Metropolitan City Mayor, Governor, Special Self-Governing City Mayor, Special Self-Governing Province Governor, Mayor, the head of a Gun, or the head of a Gu. Moreover, if the recipient engages in the receipt of LTC benefits by the LTC facility through fraudulent or any unlawful act, the number and period of the LTC benefit receipt may be restricted. In addition, upon receiving duplicate LTC benefits, delinquency in insurance premium, and suspension of health insurance status, the receipt of LTC benefits may be restricted or suspended.

2) Collection of Unlawful Profits

The NHIS collects amounts equivalent to the LTC benefits or the cost of LTC benefits from those who received LTC benefits or the cost of LTC benefits if they are found to have obtained LTC approval through false information or fraudulent means, deliberately caused accidents or unlawful acts, exceeded the monthly limit, made claims through false information or other unlawful means, or unlawfully received LTC benefits or the cost of LTC benefits.

NHIS



2024

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

NATIONAL HEALTH INSURANCE SERVICE



The word "NATIONAL" features a small red heart icon where the letter "I" would be. The word "HEALTH" features a green cross icon where the letter "I" would be. The word "INSURANCE" features a yellow virus/cell icon where the letter "U" would be, a blue water droplet icon where the letter "A" would be, and a grey eye icon where the letter "C" would be. The word "SERVICE" features a purple wine glass icon where the letter "E" would be, and an orange pencil icon where the letter "I" would be.

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** NHIS Centers for Foreign Nationals

V | **TASK OF NHIS**

1 Mission and Vision

The mission of the NHIS refers to the purpose of its establishment and was established based on Article 1 of the National Health Insurance Act. The mission aims to improve the quality of life of the people by promoting public health and social security. The vision of the NHIS is to contribute to happy people, healthy Korea, and reliable NHI. The vision represents our pursuit of becoming a trustworthy insurer of national health insurance and a partner for all people to ensure their healthy and happy lives.

Mission

Improving the quality of life of the people by promoting public health and social security

Vision

Happy people, healthy Korea, and reliable NHI

Core value

Communication
and Consideration

Health
and happiness

Equity
and trust

Innovation
and expertise

Integrity
and ethics

2 Achievements

2.1 Globally Recognized 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 was 83.6 years, longer than the OECD average of 80.3 years, and the infant mortality rate was 2.4, lower than the OECD average of 4.0 (as of 2021).

- 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 healthcare (UHC). Through strengthening international networks and institutional improvements, the NHIS established the foundation for global partnerships, distributed the NHIS's exemplary case studies throughout the world, and expanded health and medical industries overseas. The NHIS promotes the excellence of K-national health insurance and LTC insurance schemes by further developing partnerships with a variety of international organizations and strengthening the status of NHIS in the global social security.
- 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.

2.2

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

- 1) The NHIS included essential medical services like ultrasound and MRI in the coverage and reduced the national healthcare costs by expanding the coverage of essential medical services with the foundation for discovering new essential insurance coverage and government policy support.

In addition, the NHIS strengthened the social safety net for the socially underprivileged

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. The NHIS is also strengthening the effort of citizens to seek healthy lives by creating an environment that facilitates healthy life, prevents diseases, and promotes health in association with related organizations.
- 3) As an institution that holds and manages health and medical data for all citizens, the NHIS made efforts to reduce the time required to provide data and expand infrastructure, as a result, the number of research data openings increased by 5.9% from the previous year in 2022, with 2,890 datasets made available. The NHIS is striving for data openness as the number of open public data also increased by 56.6%, compared to the previous year, as 117 datasets became available.

2.3 LTC Insurance Thoroughly Supporting the Super-Aged Society

- 1) We are developing LTC services as the key social safety net in the rapidly aging society. The NHIS continues to promote new development and expansion of LTC services such as integrated home care services by establishing a care system centered on recipients, mobility support service, consultation services, and expansion of welfare medical devices to alleviate the burden of caring for family caregivers.
- 2) In the national care awareness survey 2023 conducted with the public, 93.8% of respondents answered they would use the service when asked about their intention to use LTC services. In the survey on the actual conditions of LTC conducted by the Ministry of Health and Welfare in 2022, 86.2% were satisfied overall on the LTC insurance, which is an increase of 2.1%p compared to 2019.

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 2022, the total fertility rate was 0.78, which is significantly low, 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 health expenditure is the highest among OECD countries due to rapid population aging, and in the aftermath of rapid population aging and COVID-19, recently, health expenditure including health insurance and medical benefits, exceeded KRW100 trillion for the first time ever. The proportion of healthcare costs to GDP was 9.3%, according to the 2021 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, the suicide rate per 100,000 people was 24.1%, according to the 2021 data which is more than double the average of 11.0% among OECD countries. The rate of those who smoke daily aged 15 or older was 15.4%, a similar figure to the OECD average of 15.9%.

The NHIS intends to enhance our status as the single insurer by setting five strategic goals. First, we will establish a "healthcare system responsible for the lifelong health of the nation" to alleviate the financial burden of medical expenses for citizens by continuing to expand health insurance coverage that focuses on essential medical services and the public medical safety net. Second, we will prevent diseases and promote health through personalized health management to extend "healthy life expectancy" with the advancement of preventive systems by improving health behavior and strengthening health management competencies.

Third, we will provide "the LTC insurance that the public can rely on" by providing services centered around residents in local communities through the improvement of LTC facilities and care workers, and the establishment of an integrated/linked project

system to provide high-quality LTC services in preparation for an era of “100-year life expectancy”. Furthermore, we aim to strengthen the sustainability of health insurance finance through active efforts to secure stable finances, establish a leak prevention system, and enhance expenditure management. Lastly, we will endeavor to encourage an ethical organizational culture and secure the trust of the people through innovative and responsible management of NHIS personnel.

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 the single insurer by establishing well-designed mid, to long-term tasks, and do our best to achieve our vision of “Happy people, healthy Korea, and reliable NHI”

4 NHIS International Cooperation Activities

4.1 NHIS has carried out diverse international cooperation activities

First, since 2004, NHIS has organized an annual international training course on social health insurance in collaboration with WHO and MOHW, titled “NHIS UHC Global Academy (NUGA)”.

Second, NHIS has maintained close cooperation with various international organizations such as Inter-American Development Bank, ISSA, World Bank, and WHO. Especially, NHIS serves as Bureau Member and Liaison Office for East Asia of ISSA, Joint Learning Network steering committee member, and WHO collaborating center, aimed at contributing to the development of healthcare systems in developing countries.

Third, NHIS has signed a memorandum of understanding (MoU) with partner countries to form solid foundation for bilateral and/or multilateral cooperation.

1) NUGA, Capacity Building Program on Social Health Insurance

- ➡ To share the experiences in operating K-NHI and LTCI globally
- ➡ On average, 40 healthcare officials from 10 countries participate in NUGA

2) Cooperation with international organizations

- ➔ ISSA: Bureau Member (2012-present), Liaison Office for East Asia (2011-present), Technical Commission on Medical Care and Sickness Insurance (2017-present)
- ➔ JLN: Steering Committee Member (2017-present), Collaboratives on Domestic Resource Mobilization, Data Foundation, People-centered Integrated Care, Primary Healthcare Financing & Payment, Population Targeting, Systematic Prioritization/Efficiency
- ➔ World Bank: Cooperative projects for Armenia, Azerbaijan, Belarus, Colombia, Georgia, Moldova, Peru, Philippines, Ukraine
- ➔ Inter-America Development Bank: Cooperative project for Mexico

3) MoU with partner countries

- ➔ Laying the foundation for bilateral/multilateral cooperation
- ➔ Belarus, Belgium, Cambodia, Denmark, Ethiopia, Indonesia, Kazakhstan, Kenya, Mexico, Moldova, Mongolia, Pakistan, Peru, Philippines, Sudan, Thailand, Vietnam, Uzbekistan, and international organizations such as WHO/WPRO, WB

4.2 How to launch a development cooperation project with NHIS

Partner countries may be able to launch a development cooperation project with NHIS largely in three ways. First, they may directly request NHIS for a project. In this case the project shall be financed by their own budget.

Second, they may use funds from international organizations to start a project with NHIS. Using the Korea-World Bank Partnership Facility fund may be a good idea since the fund is contributed to the WB by the Korean government. Depending on availability of funds, partner countries may work with other international organizations of their choice.

Third, partner countries are encouraged to work with Korean organizations that provide official development assistance (ODA) programs. Some of the ODA organizations are Korea International Cooperation Agency (KOICA), Korean Foundation for International healthcare (KOFIH), and Export-Import Bank of Korea (Eximbank).

KOICA and KOFIH provide a grant for ODA programs whereas Eximbank offers a loan, using the Economic Development Cooperation Fund. Contacting a Korean embassy can be a good start to find out funding opportunities.

5 NUGA, Capacity Building Program on Social Health Insurance

NHIS has annually organized "NHIS UHC Global Academy (NUGA), 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.

5.1 Background

Today, the global community is showing their interest in achieving UHC more than ever before, and the support for and commitment to UHC gathers momentum accordingly. Many of developing countries have set UHC as one of their top priorities, and actively mobilize resources and pursue reforms to achieve it.

In this context, there has been a growing demand for knowledge and experience exchange for health system reforms and operations, aimed at facilitating movements towards UHC.

In an effort to contribute to the international endeavors, since 2004, NHIS has annually organized "Capacity Building Program on Social Health Insurance" in close collaboration with the MoHW and World Health Organization/Western Pacific Regional Office (WHO/WPRO).

5.2 Objectives

This program enables participants to:

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

6 NHIS Centers for Foreign Nationals

Since July 23, 2018, all health insurance matters for foreign nationals living in South Korea have been handled by “NHIS Centers for Foreign Residents”

National Health Insurance Service established such centers for foreign nationals and overseas Koreans living in South Korea.

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 matters, a foreign national/overseas Korean must go to a branch office of their jurisdiction.

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

* 1577-1000

Dial 6 for information on foreign languages

* 033-811-2000

Service in foreign languages (English, Chinese, Vietnamese and Uzbek) available

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