National Health Insurance Program

In Korea 2001

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National Health Insurance Corporation
The Republic of Korea
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I. History of Korea Health Insurance

With the successful achievement of three consecutive 5-Year Economic Development Plans between 1962 and 1977, the Republic of Korea could not only emerge from absolute poverty but also became one of the most economically successful countries among developing countries. The economic success had been accompanied by improvements in social welfare. In the 4th 5-Year Economic Development Plan began in 1977, the Korean government finally could have a real capacity to consider the health insurance issue seriously. The purpose of the consideration was to relieve the excessive burden of household medical care expenses and to promote the health status of Korean people.

Therefore, the Korean government amended entirely the Health Insurance Act in December 1976. The new health insurance system was offered on a compulsory basis. In July 1977, based on the new Health Insurance Act, all companies with more than 500 employees were required to provide health insurance. During the next several years, the compulsory coverage requirement was gradually expanded to include companies with more than 300 employees, 16 employees, and finally all companies with at least 5 employees in 1988. It was believed that big companies were more capable of absorbing the increased costs of health insurance coverage than small companies. In 1979, insurance program covered government and private school employee. In addition, a pilot insurance program, beginning in 1981 was carried out as a preparatory step to expand the health insurance to the self-employed in rural and urban areas. Based on the result of the pilot study, self-employed individuals in rural and urban areas were covered by the insurance program in 1988 and in 1989 respectively. It took 12 years to accomplish universal health insurance coverage for all of its citizens after the Republic of Korea initiated a health insurance program in 1977.

In 1997, with the enactment and promulgation of the National Health Insurance Act (NHIA), the integration of the 227
self-employed health insurance societies and the government/private school employee’s health insurance Corporation resulted in the foundation of National Health Insurance Corporation. Also, the National Health Insurance Act, which aims to adopt all health insurance societies (139 employee health insurance societies) to the National Health Insurance Corporation, was passed by the Korean parliament.

On July 1, 2000, finally the integration of health insurance management system, including all insured person, no matter if he/she is employee or self-employed, was accomplished. The integration would become the cornerstone of the health insurance development in the new millenium era. In addition, this integration of management system will contribute to increase the social solidarity and social partnership among social classes with the adoption of new contribution levy system: flat rate contribution for all employees and the single contribution levy formula for the self-employed.

Also, Health Insurance Review Agency (HIRA) was established on July 1, 2000, succeeding to the medical fees reviewing part of National Federation of Medical Insurance (NFMI) that dissolved, on June 30, 2000, by the integration of national health insurance management system. The HIRA was established to combine medical fee review and health care evaluation into an independent single agency separated from insurers, providers and other interested parties. The HIRA is responsible for reviewing medical fees, evaluating health care performance and economy of health care service provided to health insurance beneficiaries. The HIRA served as a fair and objective organization to review and assure the appropriate health care in the partnership with the NHIC throughout the country.
II. Population Coverage

A. The insured

National Health Insurance Program as an employee insured or Self-employed insured covers all Korean people who are residing in the territory of the Republic of Korea. Though single insurer administers present health insurance system of republic of Korea; National Health Insurance Corporation, it has two categories of the insured: the employees insured and the self-employed insured.

The employee covered by the health insurance program is ordinary employees and the government & private school employees. It covers all workers at industrial establishments and their dependents except for the workers: fishery, agriculture, forestry, Construction and Domestic workers at the industrial establishments with less than five employees and their dependents determined by the presidential decree with the consideration of the features of the establishment, the type of employment and the kind of business, at the industrial establishment with five or less employees. Only daily wage earners with less than one month of continuous employment are excluded from the category of the employee insured. Government employees, including military personnel, and private school employees, and their family members, are covered by national health insurance as an employee insured or their dependent. The foreigners who work at the industrial establishment mentioned above or employed as a civil servant or the teaching staffs of public school or National universities can be covered as an employee insured by the national health insurance program by his or her application.

The employee excluded from the category of employee insured is covered by the national health insurance as a category of a self-employed insured. Also, the Korean residing in abroad and the foreigners who are registered his residing in Korea can be covered by the national health insurance program as a self-employed insured by
his application.

The total number of insured at present is around 30.5 million; 7.4 million of the employees insured (6.0 million of ordinary employee, 1.4 million of the Government and Private School Employee Insurance), 23.1 million in Self-employed Insurance, respectively.

**B. The Dependent**

The insured that are in the category of the self-employed has no concept of a dependent. All self-employed persons and their family members are considered to be the insured. But in the category of the employee insured, only the employees, and not their family members, are considered to be the insured.

Currently, dependents in the category of the employees health insurance include the insured's spouse, direct lineal ascendants (including those of the spouse), direct lineal descendants and their spouses, and brothers or sisters of the insured. They have to can prove that they meet the qualification standards set by the Ministry of Health and Welfare. Those qualification standards are “no income and actually depend on the insured”.

At present, the total numbers of dependents are around 15.4 million; 12.0 million have the ordinary employee and 3.4 million of the government and private school employee. The average number of dependents per insured is 2.08.
III. Health Insurance Finance

The financial resources of the national health insurance system are contributions paid by the insured and their employers and government subsidies. As the system has social insurance characteristics, contributions are the major source of income of the national health insurance program. In both employees health insurance including the government and private school employees, contributions are based on the incomes of the insured; the scopes and items of income and the contribution rates are same.

As of 2001, though health insurance program was operated under the single insurer NHIC, the methods of contribution calculation are different among the two categories of the insured; the employee insured and the self-employed. Thus, the pooling of insurance finance between the finance of employees and that of self-employed is expected to begin on Jan. 2002. These step-by-step approaches, however, are somewhat inevitable measures in order to achieve successful integration, with alleviation of the opposition from opponents during the policy-making process.

A. Contribution Rate

According to the Health Insurance Act, the insurance fund operation committee establish at the National Health Insurance Corporation is allowed to set contributions rate for the employee insured under the 8% of monthly wages and salaries. The contribution rate of the employee insured is 3.4% for the ordinary employees insurance and for the government and private school employee.

The minimum standard monthly wage used as the basis of calculating insurance contributions is 280,000 won. However, there is no ceiling.
B. Share of Contribution

The contribution of the employee insured is borne by both employee and employer. For the ordinary employee, the employer pays 50% of the contribution and the employee pays the other 50%. For the government employee, the government, as their legal employer, pays 50% of the contribution, whereas the employee pays the other 50%. For the private school employee, the owner of the private school pays only 30% of the contribution and the government subsidizing 20% of the contribution, whereas the employee pays the other 50%.

For the self-employed insured, contributions are calculated by using a formula consisting of the insured person's properties, income, motor vehicles, age and gender. Contributions are calculated on the basis of income: less than or more than 5 million won per year or with no taxable document. The calculated contribution is paid by the insured and the government subsidizes about 30% of the contribution of the self-employed insured’s.

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<th>Contribution of Self-employed</th>
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<tr>
<td>Income</td>
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<tr>
<td>· Individuals with income less than</td>
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<tr>
<td>· Individuals with taxable income</td>
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<tr>
<td>30 Strata (1) 50 Strata (2)</td>
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<tr>
<td>Property</td>
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<tr>
<td>· Property Basis</td>
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<tr>
<td>· Car Basis</td>
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<tr>
<td>50 Strata (3) 7 Strata (4)</td>
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· In case of individuals with income less than or equal to 5 million
won per year or with no taxable document: ① + ③ + ④
- In case of individuals with income more than 5 million won a year: ② + ③ + ④

C. Reduction of contribution

The insured person working on an island or in remote areas and working in foreign countries but with their dependents in Korea shall be reduced 50% of their monthly contributions.

D. Exemption the contribution

The insured person working in foreign countries with no dependents in Korea, the sergeants and privates serving in compulsory short-term military duty, military cadets and the insured person detained in a correctional institution or other facilities exempt his/her monthly contribution.

IV. Benefits Package

Health Insurance is a program for the enhancement of national health and social security. Towards these ends, benefits are payable to the insured and their dependents in cases of prevention and treatment of sickness and injury resulted from the daily life, childbirth, the health promotion, rehabilitation. Benefits are granted both in cash and in kind.

From October 1989, medication at pharmacies began to be included in Health insurance benefits. The insured shares less of the cost of medication if he has a doctor's prescription.

However, with the implementation of the new National Health Insurance Act, effective on July 1, 2000, benefits that have not been
entitled before; preventive care, rehabilitation, and health promotion, etc. are included into the benefit package of the national health insurance.

A. Benefits in Kind

Benefits in kind include Health care benefits and medical services for the childbirth, health care benefits are payable for diagnosis, pharmaceutical or medical treatment materials, surgery, other treatments, hospitalization and nursing. Medical services for the childbirth are payable when an insured woman or a dependent woman gives birth at a medical care institution. Benefits in kind include health care benefits, maternity benefits, and health examinations.

(1) Health care benefits

In the event of sickness or injury, the insured persons and their dependents are entitled to health care services from health care facilities. Health care benefits include in-patient and outpatient care, dental services, traditional oriental medicines, prescription drugs, essential preventive services, etc.

(2 Health Examinations

In other to prevent a disease by early detection, the insured and their dependents with 40 years and above are entitled to health examinations every two years or every year for the blue color workers.

B. Cash Benefits

Cash benefits are reimbursements for health care expenses, delivery expenses and paid by the insured or their dependents and some fixed amounts for funeral expenses. Cash benefits, also, include compensatory grants when the total expenses borne by the insured or
their dependents exceed 1,000,000 won for each 30-day.

Health expense and delivery expense can be offered when the insured or their dependents have, in an emergency or for other unavoidable reasons, been treated or gave childbirth in an institution not authorized by the Ministry of Health and Welfare as a medical services provider.

Benefits in cash include health care allowances, maternity allowances, funeral allowances, compensatory reimbursement, and allowance on caring aids and appliances.

C. Co-payment

(1) In-patient medical services

In order to curtail the overuse of the medical care services, and the concentration of the services in large urban hospitals, the level of co-payment for outpatient services and in-patient services was set differently across medical care institutions. When a patient is admitted to a clinic, a hospital, or a general hospital, 20% of the total medical charges have to be paid by the patient.

(2) Out-patient medical services

For outpatient services provided at a clinic, the patient must pay 3,000 Won when the total charges do not exceed 15,000 Won (at a dental clinic; 3,500 Won). However, the aged patient pays 1,500 Won. When total charges exceed 15,000 Won 30% of the total charges including the diagnosis and the patient pays consultation fee. For outpatient services provided at a hospital or a general hospital, 40% or 65%, respectively, of the total charges excluding the patient pays the diagnosis and consultation fee. When the patient visit the general hospital or the hospital for out patient services, the patient if the total cost is not exceed 15,000 Won pay 4,600 Won or 4,100 Won.
(3) Pharmacy

In case of using a pharmacy, a patient must pay 30% of the dispensing and drug cost (a patient without a prescription slip must pay 40%). When the total drug and dispensing cost is less than 10,000Won (for a patient without prescription slip, it is 4,000Won) the patient pays only 1,500Won (1,400Won for 1 day, 1,600Won for 2 days, 2,000Won for 3 days). However the aged person over 65 years old pays 1,200Won).

D. Exclusions from the benefits

The excluded items from coverage under the scheme are treatment for simple fatigue, dermatology problems (e.g. freckles, macula, acne, etc) which cause no problems in everyday life, congenial, genetic malformation or urogenic and gynecological diseases which cause no problems in everyday life or at work, vaccination, except a serum injection of tetanus (when judged as necessary), physical examination without any symptoms, treatment of addiction to narcotics, cosmetic surgery, dental prosthesis, orthodontics and scaling only for prevention of dental disease.

E. Restrictions and Suspension of Benefits

For the purpose of maintaining financial stability and appropriate standardization of benefits, current health insurance program has some limiting conditions.

(1) Restrictions of Benefits

* Excluded by Application of Health Care Standards: special or non-standard treatments not recognized by the medical professional

* Impermissible Cases: slight fatigue or ennui, health checkups, inoculation, cosmetic surgery, skin ailments not affecting daily life, special consultations, room charges beyond the allowed amount
* Other Limitations: bodily harm suffered while committing criminal acts or from intentional accidents, expenses compensated by benefits or cash grants from other sources

(2) Suspension of Benefits

While in military service, during travel abroad, or when in the care of correctional institutions.

V. Medical Care Supply

A. The Medical Care Institution

More than 90% of the medical care services in Korea are provided by the private sector. All pharmacies are owned and operated by individual pharmacists.

To provide medical care services for patients who are the insured or the dependent under the national health insurance program, every legal medical care institutions are authorized to provide the medical services for the national health insurance program.

As of present 61,465 medical care institutions are supplying medical services for the national health insurance program. They including 284 general hospitals, 678 hospitals, 20,454 clinics, 135 herb medicine hospitals, 7,301 herb medicine clinics, 63 dental hospitals, 10,626 dental clinics, 18,409 pharmacies, 99 midwifery clinics and 3,416 public health offices.

B. Medical Care Delivery System
To utilize medical resources more efficiently the government introduced medical care delivery system in 1989.

The patient can select any practitioner or any medical care institution. When a patient wishes to receive the care from a secondary hospital (General or Special hospital), the patient must present a referral slip issued by the doctor who see the patient first. There is an exception in medical care delivery system in case of a childbirth or emergency medical care, dental care services, rehabilitation services, family medicine services, and medical services for a hemophiliac in which case any medical care institution can be utilized without any limitation.

VI. Payment of Medical Fee and Drug & Medical Materials

A. Fee-schedule and the cost of drug & medical materials

The Minister of Health and Welfare announces the point of unit value of medical services based on the RBRVS (Resources-based Relative-value Scale) after get the decision of the National Insurance Deliberation and Coordination Committee, which is composed of the representatives from the insurer, the insured, the employer, medical association, and the public. However, the chairman of National Health Insurance Corporation and the chairman of the Medical Care Fee Contract Committee composed of the representative medical circles make contract on the monetary value of per unit of medical services annually. Also, the Ministry of Health and Welfare announced the upper limit of the reimbursement of drug cost and the medical treatment materials. By controlling the level of fees, the government tries to contain medical cost inflation.

B. Payment of medical care fees
The payment of health care services is a kind of merit system, which pays for the actual services rendered on the basis of an itemized cost for each medical service. The medical fees payment system is based on fee-for-service principle.

The payment of medical care claims is made the National Health Insurance Corporation. The Health Insurance Review Agency review and evaluate the claims submitted by the medical care institute and transfer the result to the National Health Insurance Corporation.

The cost of drug and medical materials are paid direct to the person or the entity supplied the drug or medical materials to the medical care institution and reported the amount of drug and medical materials, the name of the medical care institution, and etc to the National Health Insurance Corporation.

**VII. Review and Evaluation of Medical Services**

The Medical Fees Review and Evaluation Committee at HIRA (Health Insurance Review Agency) review submitted claims. The committee consists of ten full-time and 630 part-time members who are medical specialists. It is divided into a central committee and local committees. The committee reviews the appropriateness of medical care claims based on the fee schedule and announced drug prices.

The current system of the review for health care fees is an indirect system. Medical care institute that submit health claims to HIRA makes direct contact with the patients. HIRA then reviews claims according to the standard of health benefits standards and fee schedule determined by the Ministry of Health and Welfare. The Act gives HIRA the authority to review services furnished by hospitals, health care practitioners, or other providers of health care services.

All relevant information on medical services, manpower,
equipment, and facilities etc., which are reported by health care facilities, is stored in database system and is readily used in the process of claims review. Every effort is exerted to make the review as accurate as possible. Guidelines for claims review, review guidebook, standards for claims are published and used in the review process.

Ⅷ. Management and Operation

A. Ministry of Health and Welfare

The Ministry of Health and Welfare manages and supervises the overall matters relating to health insurance program, with the Pension and Health Insurance Bureau being the major bureau in charge. The Ministry of Health and Welfare makes policy with regard to the health insurance, enacts laws and regulations on health insurance, and approves the annual plans and budgets of the National Health Insurance Corporation and the Health Insurance Review Agency.

B. National Health Insurance Corporation (NHIC)

National Health Insurance Corporation is only one insurer administer the national health insurance program. NHIC is responsible for the management of the national health insurance with the functions: management of the qualifications of the insured and their dependents; collection of contributions; payment for the medical services rendered to the insured; and operation of other related projects.

C. Health Insurance Review Agency (HIRA)

HIRA is responsible for reviewing medical fees, evaluating health
care performance and economy of health care service provided to health insurance beneficiaries. HIRA served as a fair and objective organization to review and assure the appropriate health care in the partnership with the NHIC throughout the country.

**IX. Performance and Prospect of the National Health Insurance**

**A. Performance**

The health insurance program in Korea has contributed greatly to the promotion of people's health by reducing people's burden of medical care expenses and improving the access to medical care services. Even though the Korean health insurance program has achieved the universal coverage within twelve years, there remain areas to be improved. Along with the rapid economic development, the living standard in Korea has improved a lot, and the people have demanded the high quality of medical care services.

To achieve more efficiency in operation of nation health insurance program, to extend the benefits package to meet the demand of the insured person and to keep the equity and social solidarity among the insured person, Korean Government has enforced the new national health insurance act from July 1, 2000. And the result, the previous management systems changed into single one. The contribution levy and collect system was changed into flat rate for the all employee insured and same deadline for payment of contribution. The benefits package expanded to the medical service for the prevent of diseases and strengthened health promotion activities.

**B. Prospect of the National Health Insurance**

In the 21st century, the national health insurance of the republic of
Korea will be developed to meet the needs of the insured person and play key roles to secure the health of the Korean people.

Though we achieved the universal coverage of national health insurance, the expansion of benefits package and the integration of its management, we are on the start line of the national health insurance reform process. The goals of the health insurance programs to be achieved and the problems to solve in near future are the appropriate benefits and contribution, the financial stability, the efficiency in the management of national health insurance.

The 'low-contribution' policy and limited benefits coverage was inevitable in the last two decades to make the national health insurance took root in its early stages. These polices result in lots of complaints to the previous national health insurance polices. To meditate these complains the new national health insurance system should be developed in the basis of appropriate benefits and contribution structure by the adoption of various alternatives.

As there is a rapid increase in the aging population and many new introductions of new technology in medical fields, financial instability becomes one of the hot issues in the national health insurance program.

Actually, the financial deficit of the national health insurance program is unavoidable due to the expansion of health insurance benefits package. The annual increase rate during the last 5 years (from 1996 to 2000) is 18% whereas the increase rate of the contribution during that time has risen only 15%. In order to cope with the upcoming financial problems, the national health insurance program should develop a new medical fee payment system such as a global budget system or case payment system. Also, the increases of contribution collection rate and cost containment methods are required to achieve the financial stabilization.

One of the most important tasks is how to ensure the efficiency
in the administration of the integrated national health insurance program. Overcome of the potential bureaucratic failure of the single management system will be a critical determinant of the efficiency. The national health insurance program of republic of Korea needs an institutional mechanism to maximize the insured's satisfaction on the national health insurance program with the introduction of the competition within all organization.

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