



Spitzenverband



Our plan for reforms

Annual Report 2021



Imprint

Published by:
National Association of Statutory Health Insurance Funds
Körperschaft des öffentlichen Rechts
Reinhardtstraße 28, D-110117 Berlin

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The National Association of Statutory Health Insurance Funds (GKV-Spitzenverband) is the central association of the health insurance funds at federal level in accordance with section 217a of Book V of the German Social Code (SGB V). It also acts as the national association of long-term care insurance funds in accordance with section 53 of Book XI of the German Social Code (SGB XI). The National Association of Statutory Health Insurance Funds is a public-law corporation with self-government. In accordance with section 217b subsection (1) of Book V of the Social Code, an Administrative Council is to be formed as a self-government body which is elected by the Members' Assembly. With this Annual Report, the Administrative Council of the National Association of Statutory Health Insurance Funds is complying with its mandate in accordance with the Statutes to submit to the members, through its Chairperson and in agreement with the alternating Chairperson, an Annual Report regarding the activities of the Association (section 31 subsection (1) No. 9 of the Statutes). The Report covers the business year 2021.

Editorial deadline: 7 April 2022
Editors: René Kircher, Florian Lanz, Elke Niederhausen,
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Coordination: René Kircher
Design: BBGK Berliner Botschaft, Gesellschaft für Kommunikation mbH
Printed by: Senser Druck GmbH
Photo credits on page 127
Translated by: Neil Mussett

Order number 2022-004

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Foreword by the Chairmen of the Administrative Council

Dear Readers,

Statutory health insurance and social long-term care insurance have focused all their efforts since the outbreak of the coronavirus pandemic more than two years ago on ensuring that their 73 million insured persons continue to receive the best possible care. Based on its existing competences, self-government has reacted to the changed framework conditions and requirements. Appropriate, flexible special arrangements have been found for the various care sectors.

The subsidiarity-orientated healthcare system has proven successful as a stabilising factor for society as a whole, even in times of crisis. The pandemic thus underlines both the efficiency of statutory health insurance and social long-term care insurance, and the importance attaching to social and joint self-government. This notwithstanding, there is a need to reinforce the rights accruing to self-government. More extensive reforms are also called for in the medium term in order to enable healthcare and long-term care to face up to any future crises.

Furthermore, this legislative period poses additional major challenges that have been put on the back burner in recent times due to the pandemic. These include the need to modernise care structures, improve the quality of care, relieve the burden on individuals in need of long-term care and nursing care staff, and ensure that healthcare and long-term care are financed in a sustainable manner. These tasks must be tackled as a matter of urgency, given the increasingly pressing need to take action, resulting not only from the pandemic, but also from the expensive reforms that were undertaken in the previous legislative period.

The new Coalition Agreement contains a great deal of approaches which are both appropriate and ground-breaking, and which will improve the framework conditions for patients, individuals in need of long-term care, and their relatives. It will be of great importance to ensure a stable financial situation in the long term. A central concern of the National Association of Statutory Health Insurance Funds in this regard is to ensure in particular that no benefits are cut and that no further burdens can be created in terms of contributions.

In the immediate run-up to the 2021 Bundestag elections, the Administrative Council of the National Association of Statutory Health Insurance Funds adopted a comprehensive position paper on all areas of care that are covered by statutory health insurance and social long-term care insurance. On this basis, self-government will continue in its commitment to contribute to the political debate on healthcare and long-term care by putting forward concrete proposals and solutions for affordable high-quality care.

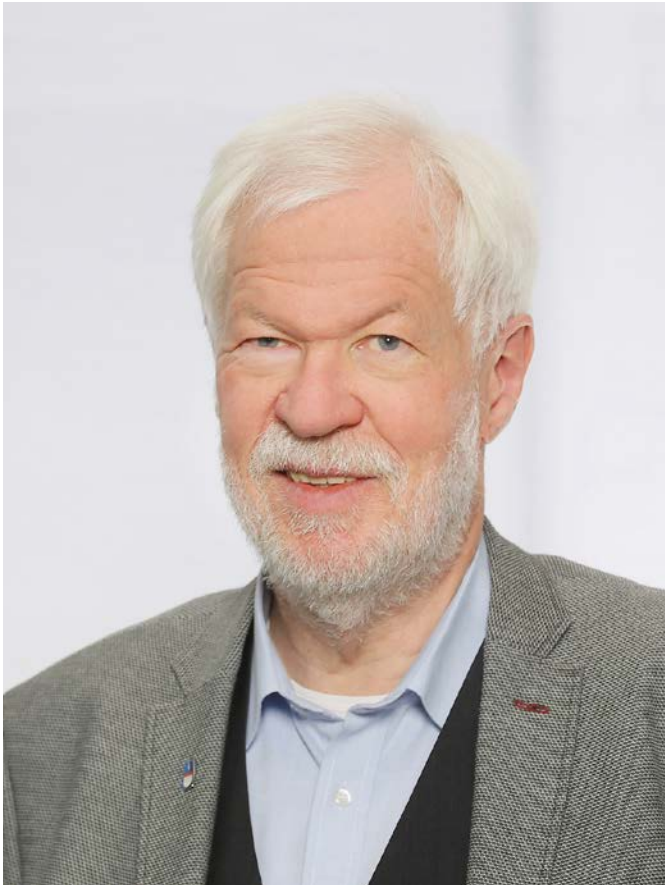
Yours faithfully,



Dr. Volker Hansen



Uwe Klemens



Foreword by the Board



Dear Readers,

2021 has been a turbulent year from a healthcare and long-term care policy point of view, and one that was greatly influenced by the coronavirus pandemic. The effect of the pandemic was that stabilising the care structures remained the top priority for policy-makers, for the National Association of Statutory Health Insurance Funds, and for its member funds. The way forward was furthermore paved by the Bundestag elections, and the formation of a Government, which culminated in the formation of the first-ever "traffic light" coalition at national level, made up of the SPD, the Alliance 90/The Greens and the FDP, with the term "traffic light" standing for the parties' colours.

Quite apart from acute pandemic management, the new Government faces challenging tasks in healthcare and long-term care policy. It is encouraging to see that important reform topics such as shaping healthcare and long-term care structures, and their financing, are specified in the Coalition Agreement. The commitment to digitalisation in the healthcare system and in long-

term care is also fitting. The health insurance funds have constructively accompanied this development in recent years, and have helped to lend it shape in the best interest of patients and insured persons.

Policy-makers are called on to create a reliable financial framework for statutory health insurance, in other words for 90 percent of the population. The pandemic has clearly left its mark here, albeit the National Association of Statutory Health Insurance Funds has had repeated successes when it came to advocating for the costs of the pandemic to be appropriately financed via taxation. The path back to sound finances must focus on the revenue and expenditure sides in equal measure. True, the Coalition Agreement already provides for steps in the right direction to be taken on the revenue side, but considerable uncertainties persist when it comes to expenditure, given that virtually no concrete measures have been specified, and in the light of several projects which are set to exert additional upwards pressure on expenditure.

A powerful signal for stable finances is also needed in social long-term care insurance. It was only possible to make up for the financial shortfall in 2021 by tapping into the reserves, so that these are now exhausted. This creates an urgent need to take action in 2022. A sustainable financing basis for long-term care insurance is needed in the medium term which does not place the burden of additional costs solely on contributors and individuals in need of long-term care. Federal funding for non-insured services, and the relief measures which are planned, are the first steps in the right direction, and these must be followed by others.

The long-overdue hospital reform will entail performing a Herculean task in this legislative period. The focus on hospitals necessitated by the pandemic must not lead to the structures that are in need of reform becoming consolidated even further. Reorganisation needs to seek to ensure that a balance is struck between needs-based primary care, on the one hand, and specialisation and concentration of specific high-quality services, on the other.

These and other trend-setting modernisation measures must now be initiated quickly in order to enable our healthcare and long-term care system to be shaped and reformed in a sustainable manner. The Administrative Council of the National Association of Statutory Health Insurance Funds has described the necessary basis for the further development of affordable, high-quality healthcare and long-term care in the positions that it has taken up for this legislative period. We will use these positions to make a constructive contribution to the political debate on the need for reform and to implementation in legislation.

We wish you a stimulating read of our Annual Report 2021.

Yours faithfully,



Dr. Doris Pfeiffer
Chairwoman of the Board



Gernot Kiefer
Deputy Chairman of the Board



Stefanie Stoff-Ahnis
Member of the Board



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Modern care structures and stable finances – on the agenda for the “traffic light” coalition

Massive challenges are on the horizon for the health-care system in the wake of the coronavirus pandemic, which will hopefully soon come to an end. The fundamental structural principles underpinning statutory health insurance and social long-term care insurance are an indispensable prerequisite for the health insurance and long-term care funds having been and still being able to cope with challenges in crisis situations, including in the short term.

Stabilising the finances of statutory health insurance in a sustainable manner

The pandemic has however left its mark. It exposed pre-existing failings, and made them much worse in some cases. There is a pressing need in particular for networked, digitally-accelerated care structures, as well as for hospitals to be funded in a manner that is orientated towards quality and needs. Above all, however, ideas and courage are needed in order to

find solutions for financing statutory health insurance that are sustainable in the long term. This is essentially about maintaining solidarity- and contribution-based funding, and once again freeing statutory health insurance from economic cycles and short-sighted tax bailout plans. That

said, it should be clear to the “traffic light” coalition government that statutory health insurance finances cannot be brought under control on the revenue side alone, but must be accompanied at the same time by improvements in efficiency and structural reforms on the expenditure side. There is a need to put an end to the expansive expenditure policy of recent years, whilst avoiding making cuts in the services provided to insured persons.

Whilst it can be assumed that contributions will remain stable in 2022, the situation looks to be quite different from 2023 onwards. The course must be set now in legislative terms if stability is to be preserved beyond 2022. The Coalition Agreement mentions important levers for this on the revenue side, these being first and foremost the plans to increase contributions for recipients of unemployment benefit II. The Federation

needs to ensure adequate funding of roughly 10 billion Euro in this process, thus putting an end to the transfer of the labour market risk from the State to the health insurance funds.

The Federation and the *Länder* need to shoulder responsibility for funding

The National Association of Statutory Health Insurance Funds would have liked to see the Coalition Agreement saying more and being more unequivocal concerning how to appropriately share responsibility for tasks and for funding among contributors and taxpayers.

“Deficit financing” has been the order of the day for a number of years, with an increasing tendency towards an inadequate level of investment in hospitals on the part of the *Länder* being compensated for by the health insurance funds via remuneration of diagnosis-related groups. The measures contained in the Coalition Agreement will lead to further cost increases on the expenditure side, and these are currently not offset by any counter-financing. It can already be stated that the measures on the revenue side will not be sufficient to compensate for the discontinuation of the supplementary federal subsidy from after 2022, amounting to 14 billion Euro, and the complete assumption, on a flat-rate basis, of medical treatment costs by the health insurance funds, amounting to up to 3 billion Euro, which was brought into being in order to ease the financial burdens placed on social long-term care insurance.

Reforming the market for medicinal products

The reform of the market for medicinal products which is described in the Coalition Agreement is a positive aspect which provides for the refund amounts to have retroactive effect from the seventh month onwards for new patented medicinal products, as well as for the price moratorium to be extended beyond 2022. At the same time, it is regrettable that the reduction of the VAT rate for medicinal products which had been discussed has not been anchored in the Coalition Agreement. This would have provided a major easing effect of up to 6 billion Euro, thus placing vital medicines on an equal footing with basic foodstuffs in terms

It is essentially a matter of maintaining solidarity- and contribution-based funding, and freeing statutory health insurance from economic cycles and short-sighted tax bailout plans.

of taxation. Applying the reduced tax rate to medicinal products is also in conformity with European law.

Cross-sector care

The Coalition Agreement contains good strategies for improving healthcare and long-term care processes, including enhancement of out-patient treatment in the in-patient sector and the promotion of digitalisation in the healthcare system. The planned reform of emergency care, which is to be provided in integrated emergency centres in close cooperation between Associations of Statutory Health Insurance Physicians and hospitals, is also necessary.

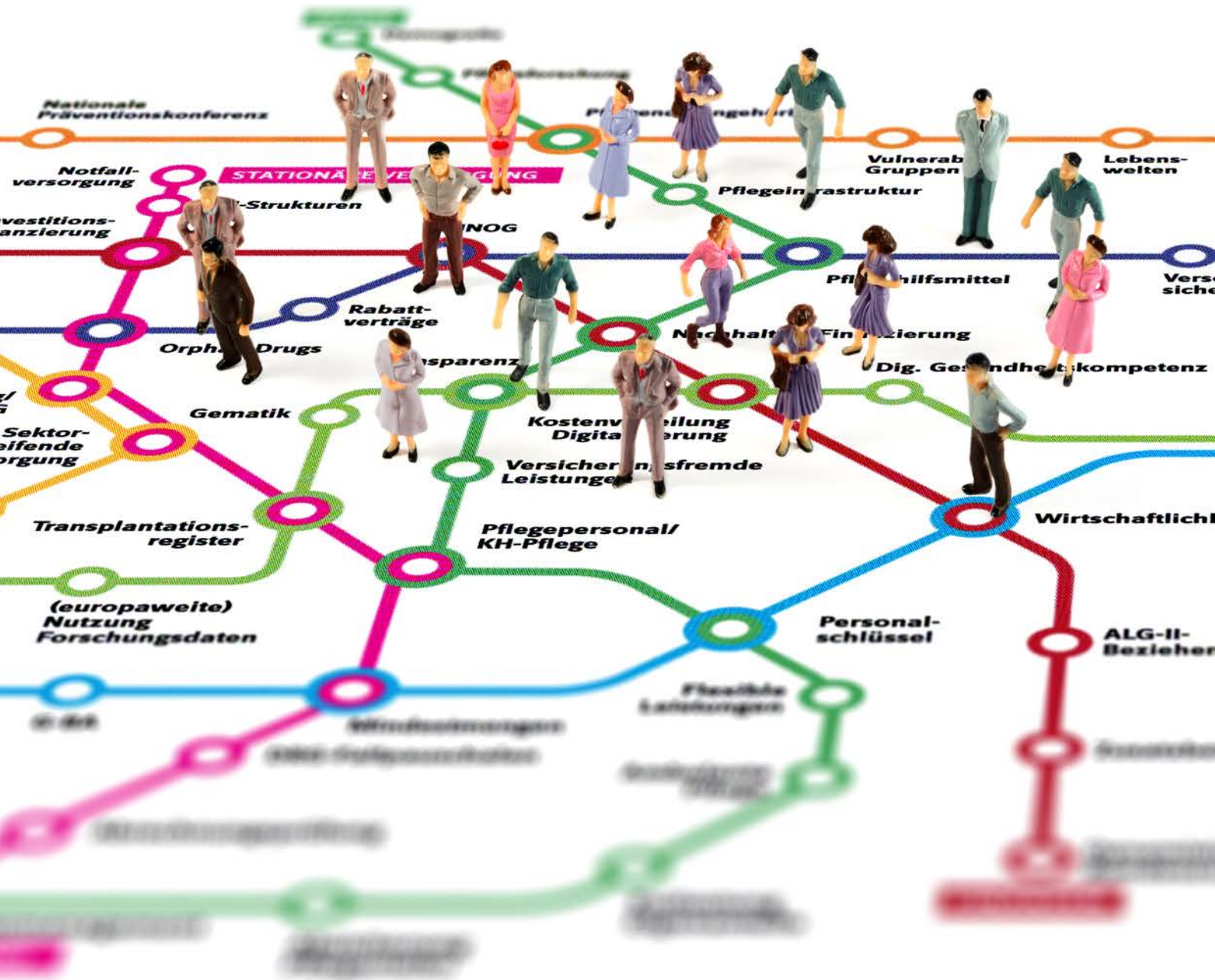
Evolving hospital financing

The National Association of Statutory Health Insurance Funds would have liked to see more unambiguous statements on hospital reform, albeit it is recognisable that efforts are being made to reduce the backlog of reforms. Diagnosis-related group remuneration is not fundamentally called into question, but it is sensibly supplemented by a reserve component. It has however been omitted to align it towards quality-orientated remuneration. What is more, a government commission is to submit proposals for evolving hospital financing. It is to be hoped that this will not lead to overly protracted consultations.

Strengthening long-term care insurance

Non-insured services in social long-term care insurance, such as pension contributions for relatives providing care, and additional costs caused by the pandemic, are to be financed from tax revenues, as had been demanded by the National Association of Statutory Health Insurance Funds. It is also positive that the co-payments on the part of individuals in need of long-term care are to be reduced by separating out the apportionment of training costs. The plans to make benefits more flexible and dynamic, as well as a number of measures aimed at easing the burden on relatives, are important and appropriate. Whilst social long-term care insurance was just about in the black in 2021, it will close this year with a deficit of about 3.4 billion Euro if no further action is taken. The "traffic light" coalition needs to act, and therefore already announced in the Coalition Agreement that there would be an increase in contributions.

Whilst social long-term care insurance was just about in the black in 2021, it will close this year with a deficit of about 3.4 billion Euro if no further action is taken.



Report from the Administrative Council

The deliberations of the Administrative Council and its specialist committees continued to be dominated by the struggle against the coronavirus pandemic in the year under report 2021. Self-government once again proved its capacity to act by introducing measures to ensure that care continues to be provided in times of crisis. Self-government will remain an indispensable player in the healthcare system in the future. Its central role was underlined not least by the Federal Social Court in a landmark judgment that was handed down in May 2021, finding that the task of self-government in statutory health insurance is to represent contributors' interests. The Court declared that payments imposed by the legislature from the health insurance funds on the Federal Centre for Health Education (BZgA) were unconstitutional. After many years, this brought to a successful conclusion the court action that the Administrative Council of the National Association of Statutory Health Insurance Funds had filed in 2016 against the measure that had been stipulated by the Federal Ministry of Health, acting as a supervisory authority. The legislature is furthermore called on to place self-government on a sound footing, and to reverse the massive curtailment of its rights that has taken place in the past.

Consequences from the judgment of the Federal Social Court

The deliberations of the bodies in the second half of 2021 centred on the judgment of the Federal Social Court, and on the consequences to be drawn from it. The Administrative Council and the specialist committees concerned emphasised in their deliberations that strengthening the commitment across different types of insurance fund in setting-related health promotion and disease prevention within the framework of the Statutory Health Insurance Alliance for Health should be further pursued as a goal, but in self-directed structures, without the involvement of the Federal Centre for Health Education. Principles regarding how the National Association of Statutory Health Insurance Funds was to handle the still valid legal norm were decided on and successfully implemented, thus forming a basis for an amendment agreement with the Federal Centre for Health Education.

Positions of the National Association of Statutory Health Insurance Funds for the 20th legislative period

Despite successful management by the self-governed healthcare system, COVID infections clearly revealed the shortcomings inherent in the healthcare system. The experiences from the pandemic should be incorporated into the considerations for reforming statutory health insurance and social long-term care insurance in order to be able to meet the challenges of the future more effectively. In its position paper for the new legislative period, the Administrative Council clearly addressed its proposals to policy-makers, spelling out specific action that needs to be taken in all care sectors. A further demand is to stabilise the financing of statutory health insurance in the long term, and to clearly assign financial responsibility for pandemic-related and non-insured tasks. There is a need for long-term care insurance to provide solid protection against the risk of long-term care in the long run. Concrete options for solutions were also developed for this. The demand to strengthen self-government was moreover clearly formulated. Prior to the consultations on the position paper, the Administrative Council adopted positions on the reforms required in individual care sectors, at the recommendation of its specialist committees. The contents of the positions were incorporated into the position paper for the 20th legislative period. The key demands made in the position paper, which was addressed to policy-makers in the run-up to the Bundestag elections, have influenced the agreements on healthcare and long-term care in the Coalition Agreement.

Position paper on the digitalisation of healthcare and long-term care

The Administrative Council made it clear with its position paper on the digitalisation of healthcare and long-term care from the spring of 2021 that the digitalisation of the healthcare system offers major opportunities on the one hand, but that there is considerable room for optimisation with regard to the steps that the legislature has initiated so far, on the other. The position paper identifies in detail the failings and

The legislature is called on to place self-government on a sound footing, and to reverse the massive curtailment of its rights that has taken place in the past.

the need for improvement with regard to the systemic prerequisites, in access to digital healthcare, and in the concrete practical applications, and calls for specific amendments to be made to the law. The current financing of digitalisation, which is largely provided by statutory health insurance contributors, is viewed critically. The Administrative Council calls for a fair

The Administrative Council is calling for a fair distribution of the burden between all stakeholders who benefit from digitalisation.

distribution in this regard of the burden between all stakeholders who benefit from digitalisation. There is also criticism of the way in which digital health applications are introduced. The lack

of a medical benefit assessment, and the fact of prices being set by manufacturers in the first year, question both the added value for insured persons, and the economic efficiency of digital health applications. Last but not least, the position paper criticises the fact that decision-making powers are increasingly being transferred to governmental institutions in this field too, and that the capacity of self-government to act is being weakened.

Position paper on patented medicinal products

The fast pace of price developments in new patented medicinal products in particular, which account for almost half of the expenditure of statutory health insurance on medicinal products, has prompted the Administrative Council to take up a fundamental position in this area of care. In view of the accelerated approval

procedures conducted by the European Medicines Agency (EMA), the efficacy and safety of an increasing number of medicinal products for patients has not yet been sufficiently proven when they are introduced. The Administrative Council criticises this development in its position paper entitled "Promoting genuine innovations in medicinal products and strengthening care", and describes the verification measures that need to be taken in order to ensure that patients in Germany receive affordable high-quality care. The position paper focuses on evolving the tried-and-tested procedure under the Act on the Reform of the Market for Medicinal Products, modifying the EMA's fast-track approval procedure in favour of more mature approval data, and sound pricing for medicinal product innovations.

A change at the helm of the Administrative Council

His name is synonymous with continuity: Dr. Volker Hansen (AOK) retired from the Administrative Council of the National Association of Statutory Health Insurance Funds at the end of 2021, after serving for almost 15 years as a member and alternating Chairman.

Dr. Hansen, who graduated in economics, had held the post of Chairman as the employer representative since May 2007, alternating annually with the representative of the insured persons, first with Willi Budde (company health insurance fund), and from 2010 onwards with Christian Zahn (substitute fund). He most recently headed the Administrative Council for more than five years together with Uwe Klemens (substitute fund).

Chairman right from the start

Volker Hansen was already one of the defining figures within the National Association of Statutory Health Insurance Funds during its founding phase. He was a member of the founding advisory board in the spring of 2007, in which the then national associations of the health insurance funds set the course for the establishment of the new Association as the joint legal representation of all health insurance and long-term care funds at national level within only three months. When Dr. Doris Pfeiffer assumed her role as the first member of the Board on 1 July 2007, the National Association of Statutory Health Insurance Funds had been founded, the statutory mandate had been complied with, and a new chapter in the history of statutory health insurance had begun. In the period that followed, Dr. Volker Hansen played a major role in ensuring that the National Association of Statutory Health Insurance Funds quickly established itself as a committed stakeholder in the healthcare system, and consolidated its position as one of the prime players in healthcare provision at national level.

“Speaking with one voice for statutory health insurance” – this aspiration was Dr. Volker Hansen’s motto for his mandate and responsibility as a prominent representative of social self-government, and was a motto that he repeated on many occasions. Soon after the establishment of the Administrative Council, his commitment became an essential contribution to the establishment of trust-based, transparent cooperation, across the types of fund, between the groups in the

Council, as well as between the voluntary and full-time agents. Even after one-and-a-half decades, this cooperation has endured, and provides a strong, reliable foundation for the National Association of Statutory Health Insurance Funds to act as a constructive, critical companion in health policy and to defend the interests of insured persons and of contributors to statutory health insurance.

In view of the wide-ranging tasks undertaken by the National Association of Statutory Health Insurance Funds, Dr. Volker Hansen’s term of office was characterised throughout by multi-faceted issues relating to the shaping of the highly complex system of healthcare provision in Germany. One of the core concerns of self-government from the very beginning was also to manage the responsible provision of resources for the Association, in view of its constantly growing tasks. The coronavirus pandemic, with its numerous impacts and demands, has largely defined the agenda in the last two years.

A vigorous proponent of self-government

The long-standing head of the Social Security Department at the Confederation of German Employers’ Associations (BDA) combined his voluntary work with a high degree of professionalism, composure and aplomb. Together with his co-chairmen from the insured persons side, most recently Uwe Klemens, and all the members of the Administrative Council, Volker Hansen vigorously opposed repeated efforts on the part of policy-makers to massively curb the rights of self-government. He regarded and continues to regard social self-government, with as little state intervention as possible, and autonomous, as a social partnership to be lived out in joint responsibility for solidarity and competition in the healthcare system.

Many goals and milestones had been achieved, said Dr. Volker Hansen as he looked back after the last Administrative Council meeting that he chaired in December 2021. An impressive example was the new Government’s Coalition Agreement, reflecting many positions and demands of the National Association of Statutory Health Insurance Funds in the healthcare and

“Speaking with one voice for statutory health insurance” was Dr. Volker Hansen’s motto for his mandate.

long-term care policy section. An outstanding success was the judgment of the Federal Social Court on the financing of the Federal Centre for Health Education, which enhanced the autonomy of self-government in a trend-setting way. However, it was also part of the overall picture that statutory health insurance and social self-government had suffered some radical cuts – especially in the last few years. Dr. Volker Hansen emphasised that his office had nevertheless given him great pleasure without exception; it had

The judgment of the Federal Social Court on the financing of the Federal Centre for Health Education enhanced the autonomy of self-government in a trend-setting way.

enabled him to take part in many enriching encounters, conversations and discussions. He considered that cooperation between volunteers and full-time staff as a

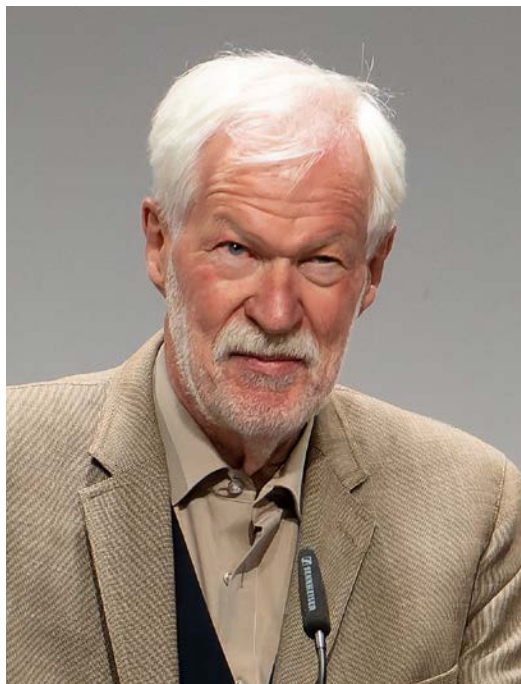
well-functioning symbiosis had been an indispensable foundation. The focus had been placed on exchange across all levels, and on the joint struggle to strike out on the right path for statutory health insurance and social long-term care insurance.

He is now looking forward to relaxation and more opportunities to pursue his personal interests without tightly-scheduled meetings and demanding agendas.

For the future of statutory health insurance, he would like to see a political course being set based on sustainability and a sense of proportion. After the cuts of the past, he hopes that social self-government will be able to expand its rights of co-determination and organisation, which as an expression of living democracy adequately takes into account its importance for the German healthcare system.

Successor Dr. Susanne Wagenmann

The Administrative Council elected Dr. Susanne Wagenmann, who graduated in economics, to succeed Dr. Volker Hansen on 23 March 2022. Dr. Wagenmann is the employer representative on the Administrative Council of AOK Nordost. She has headed the Social Security Department at the Confederation of German Employers' Associations since November 2020.



Report from the Steering and Coordination Committee

A new body was created by law at the National Association of Statutory Health Insurance Funds in 2020 in the shape of the Steering and Coordination Committee. It is made up of full-time board members of the health insurance funds who represent their respective type of health insurance fund. The new body ensures that information flows continuously between the National Association of Statutory Health Insurance Funds and the member funds, and it also liaises in organisational terms between operational business – at the level of the member funds and their associations – and the implementation of statutory tasks, under the umbrella of the National Association of Statutory Health Insurance Funds.

A rapid response to the course of the pandemic

As the first wave of the coronavirus pandemic hit, important healthcare and long-term care policies had to be developed and coordinated within the statutory health insurance system at short notice during the Committee's establishment phase in 2020. With the pandemic continuing to develop dynamically in 2021, the National Association of Statutory Health Insurance Funds was also able to make the necessary arrangements, whilst constantly consulting with the Committee. As a rule, the Committee is involved in the run-up to the Board meetings on matters relating to care. The decisions to be taken are discussed and prepared by the specialist level of the National Association of Statutory Health Insurance Funds, with the involvement of the member funds and their associations.

Digital care services in the interest of insured persons

In addition to the pandemic, the further development of healthcare and long-term care was a central topic on the Steering and Coordination Committee in 2021. In particular, this involved an intensive discussion of digitalisation and the role played in this regard by the health insurance funds. Numerous implementation-related tasks result from the legislation of the 19th legislative period relating to digitalisation which fall within the area of responsibility of the health insurance funds, such as the electronic certificate of incapacity for work and the electronic patient record. The Committee agreed on how to proceed in this regard. The common

goal is to exploit the potential for digitalisation in care as quickly as possible in the interest of the 73 million persons with statutory insurance.

Due to the familiarity that the health insurance funds have with their insured persons, they should also be responsible for communication with them. The Steering and Coordination Committee rejects the extension of gematik's tasks beyond its core technical competence as the telematics infrastructure evolves.

The common goal is to exploit the potential for digitalisation in care as quickly as possible in the interest of the 73 million persons with statutory insurance.

Setting a new course together

The connection to the member funds via the Steering and Coordination Committee will also be vital to the National Association of Statutory Health Insurance Funds in view of the strategic course of action that needs to be steered, and the challenges to be anticipated in the new legislative period with regard to healthcare and long-term care policy, in order to agree on viable solutions for improvements in care, and to address policy-makers together.

The Steering and Coordination Committee as part of the structure of the National Association of Statutory Health Insurance Funds

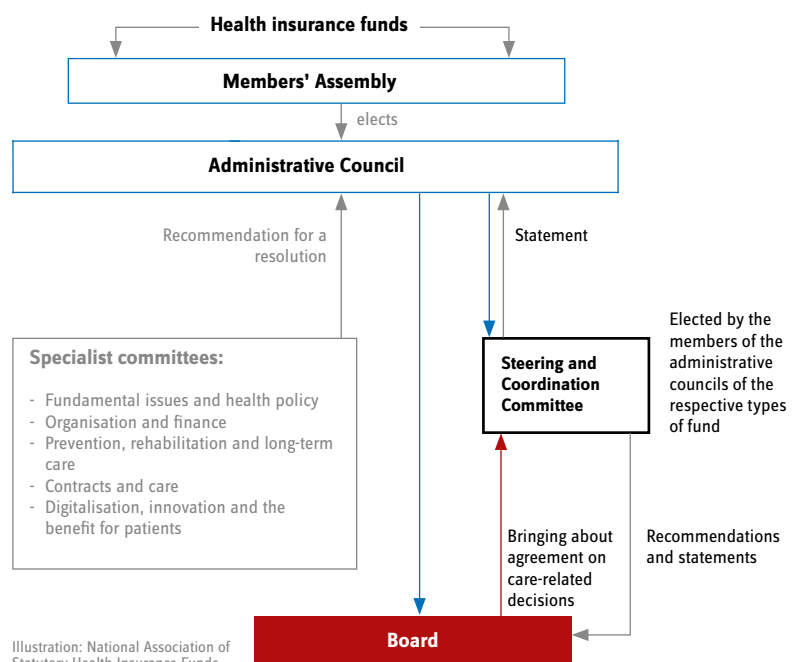


Illustration: National Association of Statutory Health Insurance Funds

Positions of the National Association of Statutory Health Insurance Funds for the 20th legislative period

The Administrative Council of the National Association of Statutory Health Insurance Funds adopted a position paper in June 2021 for the 20th legislative period 2021-2025. Aiming to ensure and further develop affordable high-quality healthcare and long-term care, it contains proposals and solutions for the broad spectrum of the areas of care of statutory health insurance and social long-term care insurance.

Learning the lessons of the coronavirus pandemic

The coronavirus pandemic has resulted in central requirements for action. It has been impressively demonstrated since the beginning of the pandemic that patients and individuals in need of long-term care, and their relatives, can continue to rely on needs-based care, even in times of crisis. The self-governing health-

There is an urgent need to tackle structural changes in order to eliminate the under-provision, over-provision or mis-provision of patient care.

care system has proven to be a stability factor for society as a whole during the crisis. The experiences with the coronavirus pandemic must be evaluated in the new legis-

lative period, and lessons learned for the future. At the same time, the need for action that existed even before the pandemic began has become more than clear.

Tackling structural problems

The position paper identifies essential places where further legislative action needs to be taken that exist independently of the pandemic. There is an urgent need to implement structural changes in order to eliminate the fundamental problems related to the under-provision, over-provision or mis-provision of patient care. In particular, in-patient and out-patient care must be evolved in order to enable greater specialisation, cooperation and target group orientation. Staged, networked treatment structures must be strengthened as part of population structure-orientated planning of care structures. In addition, greater priority must be allotted to the quality of healthcare with regard to planning and remuneration.

Making financing stable and sustainable

In view of the changes in the financial situation of statutory health insurance, which are due not least to the pandemic, there is an urgent need for sustainable, task-orientated financing. Financing by contributions must be maintained as a central structural element in the future as well. There is therefore a need to take action above all with the aim in mind of making the federal contribution for non-insured services more dynamic, and setting an appropriate contribution level for unemployment benefit II recipients who are subject to compulsory insurance. Efficiency increases on the expenditure side are also needed in order to stabilise finances.

Ensuring good long-term care

Major challenges in social long-term care insurance continue into the new legislative period. It is indispensable to have sound, solidarity-based financing to cover the risk of need for long-term care in the long run. In addition, the *Länder* and the municipalities must meet their financial obligations to safeguard the long-term care infrastructure. The offers made in support of and to relieve the burden on relatives providing care, and individuals in need of long-term care, must be made more flexible in order to better adapt them to individual needs. It is more urgent than ever to ensure that long-term care services have an adequate number of qualified staff.

Strengthening self-government

There is a need to make social and joint self-government strong again as the backbone of our healthcare system. Contrary to the current trend towards state intervention, subsidiarity must once again be the guiding principle for all areas of the healthcare system. The rights of the administrative boards of the health insurance funds must be restored and expanded. A better legal framework is needed in order to promote voluntary commitment.

Achieving improvements for insured persons

All in all, statutory health insurance and social long-term care insurance will have to implement major reforms in the years to come. It is encouraging to note that the Coalition Agreement reached by the SPD, Alliance 90/The Greens and the FDP identifies important topics, and takes up key concerns of the National Association of Statutory Health Insurance Funds. The National Association of Statutory Health Insurance Funds will contribute towards the political debate on the basis of the position paper, and will advocate for improvements for patients as well as for individuals in need of long-term care and their relatives.

It is indispensable to have sound financing in the long run in order to cover the risk of need for long-term care.



Studien
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COVID-19: Die Pandemie

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Anfragen

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Statt



Financial assistance for medical and dental practices

The financial assistance measures that had been adopted on a time-limited basis for 2020 were continued in a modified form from 1 January 2021 onwards in order to ensure that care could be sustainably provided by contract doctors during the coronavirus pandemic. The measures aim to compensate contract doctors' practices for the revenue losses caused by the pandemic.

Compensation payments for contract doctors' practices

The Act on the Continuation of the Arrangements Concerning the Epidemic Situation of National Significance (*Gesetz zur Fortgeltung der epidemischen Lage von nationaler Tragweite*) of March 2021 created a fundamental, open-ended arrangement to grant compensation payments to contract doctors' practices from the Associations of Statutory Health Insurance Physicians. The regulation that has been in force since March 2020 was extended from January 2021 to cover services related to morbidity-related total remuneration, and also to cover services that are reimbursed outside of morbidity-related total remuneration. The regulation obliges the Associations of Statutory Health Insurance Physicians to consult with the *Länder* associations of the health insurance funds and the substitute funds on the appropriate action to be taken in the distribution scale in order to ensure the continuation of contract doctors' activities by healthcare providers in spite of decreasing case numbers. The health insurance funds will thus not incur any additional costs as of 2021 for the reimbursement of revenue lost due to a pandemic, as these reimbursements are to be paid from the morbidity-related total remuneration as a matter of principle, which in turn is to be paid by the health insurance funds to the respective Association of Statutory Health Insurance Physicians with exempting effect. In addition, it is planned for reserves of the Associations of Statutory Health Insurance Physicians that have been formed and not yet liquidated to also be taken into account within the framework of the distribution of fees.

Protective equipment for contract dentists

The National Association of Statutory Health Insurance Funds reached a time-limited agreement with the National Association of Statutory Health Insurance Dentists in March 2020 to equip specialist practices with centrally-procured protective equipment in connection with COVID-19. The agreement was extended several times, and expired on 31 March 2021.

Compensation for special expenditure in dental practices

The National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Funds reached an agreement in the spring of 2021 as part of the Federal Skeleton Agreement for Dentists in order to account for the increased expenditure incurred in dental practices as a result of the pandemic. The agreement provides for a uniform federal lump-sum payment to be made for special expenditure. This includes expenditure incurred as part of patient treatment and with regard to material costs, e.g. for purchasing additional medical masks, disposable gloves or hand sanitiser. The maximum financial volume of this arrangement was set at 275 million Euro. Arrangements for the deduction procedure were laid down in the agreement in order to rule out double financing by the health insurance funds. Where health insurance funds have already compensated for special expenditure in the second quarter via the respective remuneration agreement or via other agreements, it was possible to deduct these items from the amount payable.

The health insurance funds will not incur any additional costs as of 2021 for the reimbursement of revenue lost in contract doctors' practices due to a pandemic.

Ensuring hospital care

The hospitals in particular were the focus of action on the part of policy-makers at the beginning of the coronavirus pandemic. The measures described below were taken in order to avert the threat of hospital capacities being overloaded, especially with regard to intensive care, and considerable financial resources were made available for this purpose.

Bed availability lump sums and care surcharges

All hospitals were requested to reserve capacities for COVID-19 patients during the first wave of the pandemic in the spring of 2020. The hospitals received compensation from federal funds in the shape of a mechanism known as "bed availability lump sums". When the second wave began, this financing arrangement was designed in a more targeted way from

November 2020 onwards: Uniform federal criteria were defined according to which the *Länder* designate hospitals to reserve intensive care treatment capacities. In return, these hospitals receive compensation payments from federal funds for the revenue that they lose as a result. These criteria were continuously adjusted as the pandemic progressed. The amount of the

tiered bed availability lump sums remained unchanged for somatic hospitals (360–760 Euro per reserved bed per day); psychiatric and psychosomatic facilities were not entitled to bed availability lump sums.

Only those hospitals were initially eligible that had agreed to the comprehensive or extended emergency care tiers, or had the necessary structures. It was also possible to designate basic emergency care hospitals on a subordinate basis. The legal ordinances of December 2020 and January 2021 gradually expanded the number of eligible hospitals, for instance to include specialist providers which had particular expertise in treating lung and heart diseases. The basis for this is an overview of hospital locations which is compiled by the Institute for the Hospital Remuneration System in accordance with uniform criteria that have been established nationally.

In addition to these technical requirements, threshold values were defined (COVID-19 cases per 100,000 inhabitants, unoccupied intensive care capacities in the regions), and were adjusted several times. The regulations were modified and extended a total of five times by ordinances issued by the Federal Ministry of Health. When it came to implementation, the German Hospital Federation and the National Association of Statutory Health Insurance Funds each laid down the details in compensation payment agreements. The arrangement on bed availability lump sums expired in June 2021, after having been extended one last time. The Act to Enhance Vaccination Prevention against COVID-19 and Amending other Provisions in Connection with the COVID-19 Pandemic (*Gesetz zur Stärkung der Impfprävention gegen COVID-19 und zur Änderung weiterer Vorschriften im Zusammenhang mit der COVID-19-Pandemie*) of 10 December 2021 reactivated the arrangement for the period from 15 November 2021 to 31 December 2021 in view of the renewed dynamic development of the coronavirus pandemic. The Federal Ministry of Health extended the period of validity at the end of 2021, until 19 March 2022, by means of a legal ordinance. The number of eligible hospitals was continuously increased by repeatedly expanding the criteria used to determine them and lowering the threshold values. The approximately 430 hospitals providing extended or comprehensive emergency care have thus increased to more than 1,000. The Federal Office for Social Security paid out a total of approximately 16.8 billion Euro in bed availability lump sums from federal funds in several waves between March 2020 and mid-February 2022.

The Act Amending the Infection Protection Act and Other Acts on the Occasion of the Rescission of the Determination of the Epidemic Situation of National Significance (*Gesetz zur Änderung des Infektionsschutzgesetzes und weiterer Gesetze anlässlich der Aufhebung der Feststellung der epidemischen Lage von nationaler Tragweite*) of 22 November 2021 included an additional provision for the financial support of hospitals in the pandemic. Unlike the bed availability lump sums, which were based on the number of empty beds, those hospitals that treat patients with a COVID-19 infection will now receive a care surcharge. The surcharge is fi-

The Federal Office for Social Security paid out a total of approximately 16.8 billion Euro in bed availability lump sums from federal funds in several waves between March 2020 and mid-February 2022.

nanced from federal funds, and is payable for patients who were admitted between 1 November 2021 and 19 March 2022.

Depending on the hospital, the care surcharges are up to 9,500 Euro per case and, unlike the bed availability lump sums paid as part of the compensation for COVID-related losses, only 50 % are to be offset by the hospitals. 683.5 million Euro had already been paid out to hospitals by the end of 2021 (as of mid-February 2022).

Compensation for COVID-related losses in 2021, including advance payments

The Hospital Future Act (*Krankenhauszukunftsgesetz – KHZG*) introduced compensation for COVID-related losses on a hospital-specific basis which is intended to protect hospitals against a decline in revenue caused by the pandemic in 2020. In order to calculate this amount, the hospital-specific revenue for 2020 is compared with the revenue for 2019 on a full-year basis. The bed availability lump sums paid in 2020 also had to be taken into account when determining the revenue for 2020. The contracting parties at federal level reached an implementation agreement on this matter in mid-December 2020.

The Ordinance on the Regulation of Further Measures for the Economic Security of Hospitals (*Verordnung zur Regelung weiterer Maßnahmen zur wirtschaftlichen*

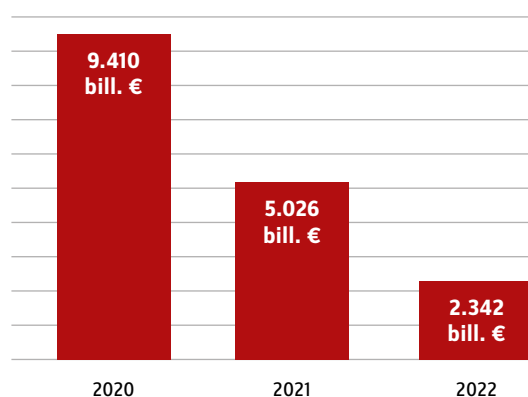
Sicherung der Krankenhäuser) of April 2021 provides for a similar compensation mechanism for 2021. The central provisions correspond to those contained in the implementation agreement of December 2020. For example, the amount of the compensation rate for the decline in revenue that had been suffered, and the offsetting rate for bed availability lump sums, are each set at 85 % in the Ordinance. Only 50 % of the care surcharges introduced at the end of 2021 are to be offset.

The Ordinance also allows those hospitals that do not receive bed availability lump sums to claim advance payments to compensate for COVID-related losses in 2021 in order to ensure that they remain solvent. This applies in particular to psychiatric and psychosomatic hospitals. The advance payments made will be credited in full as part of the compensation mechanism. The COVID-19 advance payment agreement was concluded at federal level for this purpose.

Hospitals were entitled to a surcharge for the period from October 2020 to December 2021 in order to finance additional costs not financed elsewhere that were incurred due to the pandemic.

The contracting parties at federal level concluded an agreement to regulate compensation for COVID-related losses in 2021 in good time at the end of July 2021. This agreement forms the basis for negotiations on compensation for COVID-related losses on the ground, which can be held at the request of a hospital operator, inde-

Disbursement of bed availability lump sums by the Federal Office for Social Security



Source: BAS, Version: 15 February 2022
Illustration: National Association of Statutory Health Insurance Funds

pendently of the budget negotiations. Further revenue compensation for 2021 is ruled out.

The second Ordinance Amending the Ordinance on the Regulation of Further Measures for the Economic Security of Hospitals (*Verordnung zur Änderung der Verordnung zur Regelung weiterer Maßnahmen zur wirtschaftlichen Sicherung der Krankenhäuser*) of 30 December 2021 also resolved on compensation for COVID-related losses for 2022, on the basis of revenues achieved in 2019.

Surcharge for COVID-related additional costs

Hospitals were entitled to a surcharge for the period from October 2020 to December 2021 in order to finance additional costs not financed elsewhere that were incurred due to the pandemic in connection with the fully or partially in-patient treatment of patients. The German Hospital Federation and the National Association of Statutory Health Insurance Funds initially agreed on provisional surcharges in order to secure the funding. The amount of the surcharge per case has been reduced over time from 50 Euro in the 4th quarter of 2020 to 40 Euro in the 1st half of 2021, and again to 20 Euro in the 2nd half of 2021. A surcharge of twice the amount was provided for patients infected

with the coronavirus. The hospitals or health insurance funds can retroactively request an ex-post adjustment in individual cases in 2022 if the amounts paid have led to a significant overpayment or shortfall in terms of the additional costs caused by the pandemic. In accordance with

the mandate contained in the Hospital Future Act, the contracting parties at federal level have defined the detailed specifications for the cost types and the requirements for proof.

A "COVID bonus" for workers in hospitals

The legislature decided on "COVID bonuses" in order to acknowledge the particular challenges and burdens faced by nursing care staff in hospitals during the coronavirus pandemic. 100 million Euro were paid out in November 2020 for the bonus that had been decided on in 2020 (in accordance with section 26a of the Hos-

pital Financing Act [*Krankenhausfinanzierungsgesetz*]) to 433 hospitals which suffered burdens. This was disbursed from the liquidity reserve of the Health Fund, and paid on a pro rata basis by private health insurance. The hospital operator decided on the selection of the recipients, and on the individual amount of the bonus, in consultation with the employee representatives. In 2021, the hospitals were required to prove that the funds were used for the intended purpose. The Act provides that hospitals must repay the funds if they have not been used for the intended purpose, or if hospitals have not provided the appropriate evidence. The National Association of Statutory Health Insurance Funds forwarded the funds from the liquidity reserve to the hospitals.

Following on from the 2020 arrangement, the Federation provided an extended special payment for hospital nursing care staff amounting to 450 million Euro in 2021. The National Association of Statutory Health Insurance Funds effected the transfer of funds to 983 hospitals based on a defined distribution mechanism in mid-April 2021. Similarly to the first bonus arrangement, the hospital operator decided on the selection of the recipients, and on the individual amount of the bonus, in consultation with the employee representatives, and was to effect the disbursement to the bonus recipients by the end of June 2021. The evidentiary procedure for appropriate use of the funds ends in March 2022. The funds must be repaid to the National Association of Statutory Health Insurance Funds if they have not been used for the intended purpose, or if the appropriate evidence has not been provided.

Promotion of intensive care beds and intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine (DIVI)

The COVID-19 Hospital Relief Act (*COVID-19-Krankenhausentlastungsgesetz*) provides for a new arrangement in which hospitals receive a lump-sum bonus of 50,000 Euro from the liquidity reserve of the Health Fund for intensive care beds that had been upgraded by September 2020, or for new ones created by that date. The *Land* authority responsible for hospital planning approved the procurement. Approximate-

Following on from the 2020 arrangement, the Federation provided an extended special payment for hospital nursing care staff amounting to 450 million Euro in 2021.

ly 686 million Euro were transferred to hospitals. In arithmetical terms, this corresponds to roughly 13,700 new or upgraded intensive care beds. In addition, the DIVI Intensive Care Register Ordinance (*DIVI IntensivRegister-Verordnung*) has made sure that all hospitals report to the register those intensive care bed capacities on a daily basis for which sufficient staff are actually kept available. The rapid establishment of the intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicines provided transparency for the first time with regard to intensive care treatment capacities in Germany. The register has been enhanced over time, and now also shows an emergency reserve capacity of intensive care beds, as well as differentiating between treatment capacities according to the type of treatment place. This kind of real-time monitoring should be extended to include all beds in hospital care.

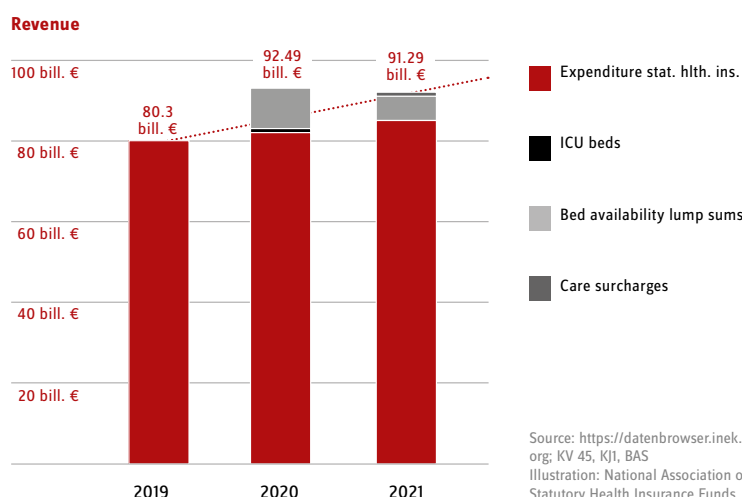
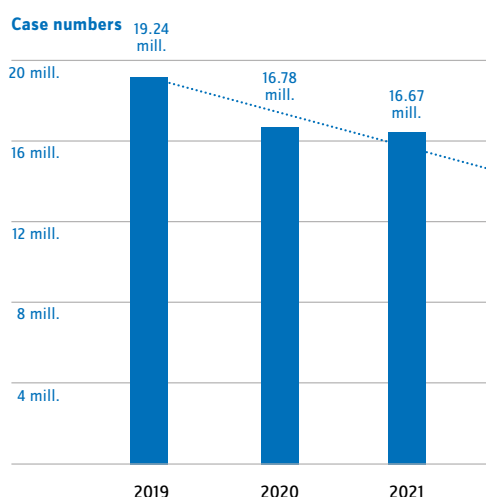
Greater transparency needed regarding the promotion of intensive care beds

The first systematic monitoring of hospital capacities ever carried out highlighted a number of existing problems that urgently need to be remedied. The Federal Statistical Office shows that there were 26,319 intensive care beds in 2019. Taking a look at the serviceable beds and the emergency bed reserve in the intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine

reveals an unexplained divergence nationwide. It is also unclear how many of the beds which were already available have been upgraded to intensive care beds. The Federal Court of Audit also criticised in its report of June 2021 that it was not possible to pinpoint where the promoted beds were located. The Act does not currently provide for proof to be furnished to statutory health insurance, which has to pay the costs, regarding how funds are used. The National Association of Statutory Health Insurance Funds is therefore calling for greater transparency regarding the appropriate use of funds and the location of the promoted intensive care beds.

The National Association of Statutory Health Insurance Funds is calling for greater transparency regarding the appropriate use of funds and the location of the promoted intensive care beds.

Case numbers and revenue



Source: <https://datenbrowser.inek.org/>; KV 45, KfJ, BAS
Illustration: National Association of Statutory Health Insurance Funds

Safeguarding vaccinations and testing

The National Association of Statutory Health Insurance Funds repeatedly demanded that the price be kept proportional to other medical services in order to ensure that the services were provided economically.

Vaccinations are a crucial tool when it comes to containing the spread of COVID, and in order to reduce the risk of severe symptoms. A mechanism was established to continuously evaluate the Coronavirus Vaccination Ordinance (*Coronavirus-Impfverordnung*), taking into account infectiological findings, the current recommendations of the Standing Vaccination Committee, and the vaccine supply situation. This led to adjustments being carried out over 2021, among other things with regard to vaccine-specific recommendations or the groups of people to be vaccinated. In addition, regular amendments were made to the Coronavirus Testing Ordinance (*Coronavirus-Testverordnung*) in view of the dynamic development of infections. The expenditure resulting from these Ordinances is reimbursed by the Federation.

Vaccinations provided by contract doctors

Contract doctors were included in the vaccination campaign from April 2021 onwards in order to ensure comprehensive vaccination coverage. In addition to billing, documentation and reporting vaccination data, the Ordinance also regulated the reimbursement of the vaccination fee by the Federation, and the amount to be paid for a variety of services:

- 28 Euro per vaccination, or 36 Euro per vaccination on Saturdays, Sundays and public holidays, as well as on 24 and 31 December
- 10 Euro per vaccination consultation without vaccination
- 35 Euro per home visit
- 6 Euro per vaccination certificate or 2 Euro in case of preparation via information technology
- 2 Euro per update of the vaccination certificate

The National Association of Statutory Health Insurance Funds repeatedly demanded that the price be kept proportional to other medical services in order to ensure that the services were provided economically. Given that other vaccinations are remunerated at 8 Euro, as agreed on a regional basis with the Associations of Statutory Health Insurance Physicians, a remuneration of up to 10 Euro per COVID vaccination would be appropriate, including participation in vaccination surveillance.

Public testing

Testing remained crucial, especially against the background of dynamic developments in case numbers over the course of the year. A comprehensive entitlement to rapid antigen testing, known as public testing, was therefore introduced. It was possible to offer vaccinations to all members of the public in the course of 2021, so that the offer of public testing was limited to selected groups of people for the period from October 2021 to November 2021. The restriction on public testing was however lifted from mid-November 2021 onwards in view of the renewed dynamic development in the number of infections.

COVID testing as part of medical treatment

COVID testing as part of medical treatment is invoiced according to the Standard Schedule of Fees. The gold standard remains the PCR test, the cost of which was reduced in the Standard Schedule from its previous price of 39.40 Euro to 35 Euro as of 1 July 2021. Remuneration for antigen laboratory testing remained unchanged at 10.80 Euro.

COVID testing as part of hospital treatment

The legislature mandated the National Association of Statutory Health Insurance Funds and the German Hospital Federation via the Second Civil Protection Act (*Zweites Bevölkerungsschutzgesetz*) to agree on a supplementary fee for coronavirus testing in hospital treatment settings. This is intended to cover the costs incurred by hospitals for testing patients who are admitted for fully or partly in-patient treatment. The amount of the supplementary fee for PCR testing was set by the Federal Arbitration Office in June 2020, and it was adjusted in line with the respective situation on the market as the pandemic progressed.

It has been possible to bill for the antigen test for direct pathogen detection via a supplementary fee since October 2020. The prices of antigen tests have also fallen significantly in the course of the pandemic, and this development was reflected by amending the agreement as of 1 August 2021. The previously undifferentiated supplementary fee for antigen testing was split into a supplementary fee for antigen testing by means of laboratory diagnostics (19.00 Euro), and PoC antigen testing (11.50 Euro). It is explicitly stated that antigen self-tests intended exclusively for self-testing may not be billed for. The number of tests increased further in the course of the third and fourth waves, and remained at this high level. More than 85 % of patients who are admitted for treatment are tested for COVID on a national average.

The number of tests increased further in the course of the third and fourth waves, and remained at this high level.

Protective shield arrangements for long-term care

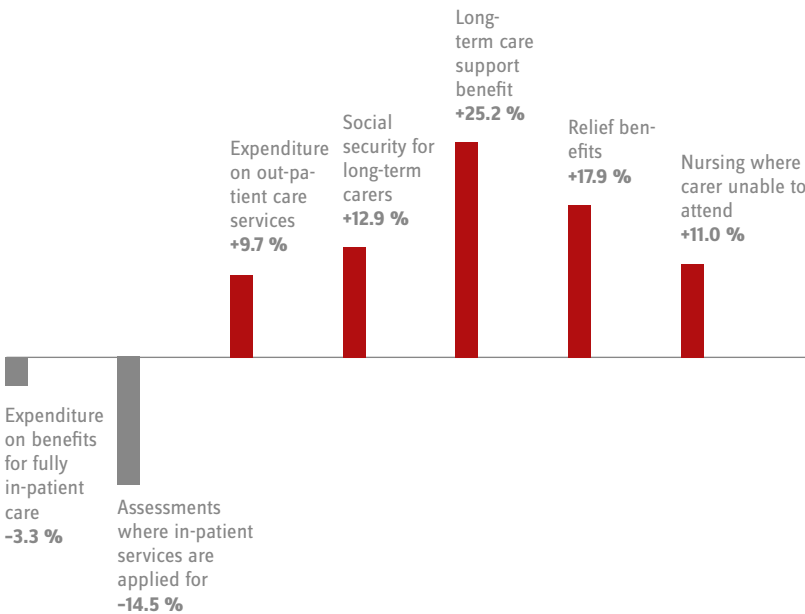
The National Association of Statutory Health Insurance Funds has been active since the beginning of the coronavirus pandemic in securing in-patient and out-patient long-term care through a protective shield arrangement.

The legislature already took a large number of measures in the spring of 2020 aiming to stabilise the provision of long-term care during the coronavirus pandemic, on the one hand, and to provide financial security for healthcare providers on the other. The measures were linked to the determination of an epidemic situation of national significance by the Bundestag. They were initially time limited until September 2020, and have since been extended several times, most recently until 30 June 2022, by the Third Ordinance to Extend Measures to Maintain Care during the Pandemic caused by the SARS-CoV-2 Coronavirus (*Dritte Verordnung zur Verlängerung von Maßnahmen zur Aufrechterhaltung der pflegerischen Maßnahmen während der durch das Coronavirus SARS-CoV-2 verursachten Pandemie*).

The following measures continued to apply in 2021:

- making the requirements for the provision of services and the take-up of services in the domestic sector more flexible
- increasing the number of days off for relatives providing care in case of absence from work at short notice to organise or ensure long-term care from 10 to 20 working days
- increasing the amount paid for long-term care medical aids from 40 to 60 Euro
- pandemic-related additional expenditure, as well as revenue shortfalls of long-term care facilities, compensated for by social long-term care insurance (e.g. higher personnel and material expenses, income shortfalls due to non-utilisation of services, costs for extraordinary antigen tests)

Impact of the coronavirus epidemic on take-up of long-term care services for 2021



The take-up of services shifted more to the homes of individuals in need of long-term care when the coronavirus epidemic struck

The National Association of Statutory Health Insurance Funds has been active since the beginning of the coronavirus pandemic in securing in-patient and out-patient long-term care through a protective shield arrangement. The measures that have been implemented to provide short-term support for individuals in need of long-term care and their relatives were understandable and necessary, even if this is associated with a not inconsiderable burden for the administration of the health insurance and long-term care funds in order to comply with these measures. From the perspective of the National Association of Statutory Health Insurance Funds, the objective must be for all parties involved – the individuals in need of long-term care, those providing long-term care, and the long-term care funds – to return to normal conditions in a responsible manner, once it is established that the pandemic has subsided, regular testing is available, and the third course of vaccinations has been carried out.

Safety precautions for assessments to determine the need of long-term care

It has been possible since mid-March 2020 for assessments to determine the need for long-term care to be carried out in the insured person's own home, even without examining the insured person, if this was absolutely necessary in order to prevent the risk of those involved becoming infected with COVID. The corresponding legal regulation was most recently

extended until 30 June 2022 by means of the Third Ordinance to Extend Measures to Maintain Care during the Pandemic caused by the SARS-CoV-2 Coronavirus. The standards for the assessment of the need for long-term care during the coronavirus pandemic that were developed by the Medical Service of the National Association of Statutory Health Insurance Funds (MDS), in consultation with the National Association of Statutory Health Insurance Funds, also remained in force until that date.

These standards were designed to regulate the protection and hygiene requirements under which an assessment was to be carried out without examining the insured person in his or her own home, or in which cases the personal assessment was to be dispensed with altogether. It was possible to carry out the long-term care assessment in the latter cases on the basis of the available documents, and as a structured telephone interview. The standards were adapted to the developments in the coronavirus pandemic on an ongoing basis.

Quality audits in long-term care facilities under pandemic conditions

The quality audits in long-term care facilities were temporarily suspended from March to the end of September 2020 because of the coronavirus pandemic, especially in order to protect people in need of long-term care from becoming infected. In view of rising infection rates, the Federal Ministry of Health has agreed with the proposal of the National Association of Statutory Health Insurance Funds and of the Medical Service to extend the suspension of the standard quality audit until March 2021.

In accordance with the Act on the Continuation of the Epidemiological Situation (*EpiLage-Fortgeltungsgesetz*), which came into force at the end of March 2021, a standard quality audit was to be carried out in all approved long-term care facilities in the period from October 2020 to December 2021 if the situation on the ground permitted this in view of the coronavirus pandemic. The quality audits were carried out in compliance with special hygiene requirements.

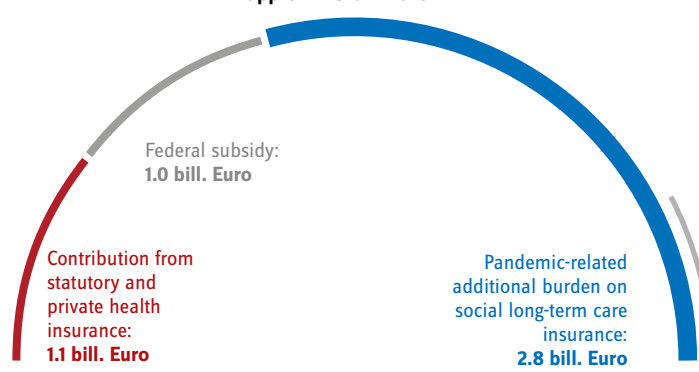
The National Association of Statutory Health Insurance Funds agreed in April 2021 with the Medical Service and the Auditing Service of the Association of Private Health Insurance, as well as in consultation with the Federal Ministry of Health, and on the basis of the Act on the Continuation of the Epidemiological Situation, on details in regulations relating to the possibility to carry out quality audits during the coronavirus pandemic.

The regulations were updated in October 2021 due to adjustments that had been made in the meantime to the Infection Protection Act, and to the progress that had been made in vaccinating the population against COVID.

A standard quality audit was to be carried out in all approved long-term care facilities in the period from October 2020 to December 2021 if the situation on the ground permitted this in view of the coronavirus pandemic.

Long-term care protective shield: Funding the anti-COVID measures in long-term care

Refund amounts claimed by the approved long-term care facilities in 2021 and offers of support in everyday life recognised under *Land* law: **approx. 4.9 bill. Euro**



For comparison: pandemic-related additional burden on social long-term care insurance in 2020: **0.8 bill. Euro**

Financial compensation for care and rehabilitation facilities

The compensation claims of in-patient care and rehabilitation facilities for revenue shortfalls due to pandemic-related under-occupancy, which were already regulated by law with the COVID-19 Hospital Relief Act in March 2020, were extended until June 2021 via ordinances enacted by the Federal Ministry of Health. This permitted compensation payments for revenue shortfalls amounting to 60 % and 50 % of the average remuneration in in-patient care and rehabilitation facilities to be made from the liquidity reserve of the Health Fund via the Federal Office for Social Security. Approximately 250 million Euro were raised through this rescue scheme for the compensation period from November 2020 to June 2021. The care and rehabilitation facilities received financial support totalling more than 560 million Euro from the contributions made by persons who had statutory health insurance (as of December 2021) - including the compensation payments made in the previous year up to September 2020. Health insurance funds were designated in 13 of the Federal *Länder* to implement the procedure. The procedure was carried out by *Länder* authorities in the other *Länder*. The basic parameters were agreed between the National Association of Statutory Health Insurance Funds and the associations of healthcare providers in what was referred to as the Compensation Payment Agreement on Care and Rehabilitation.

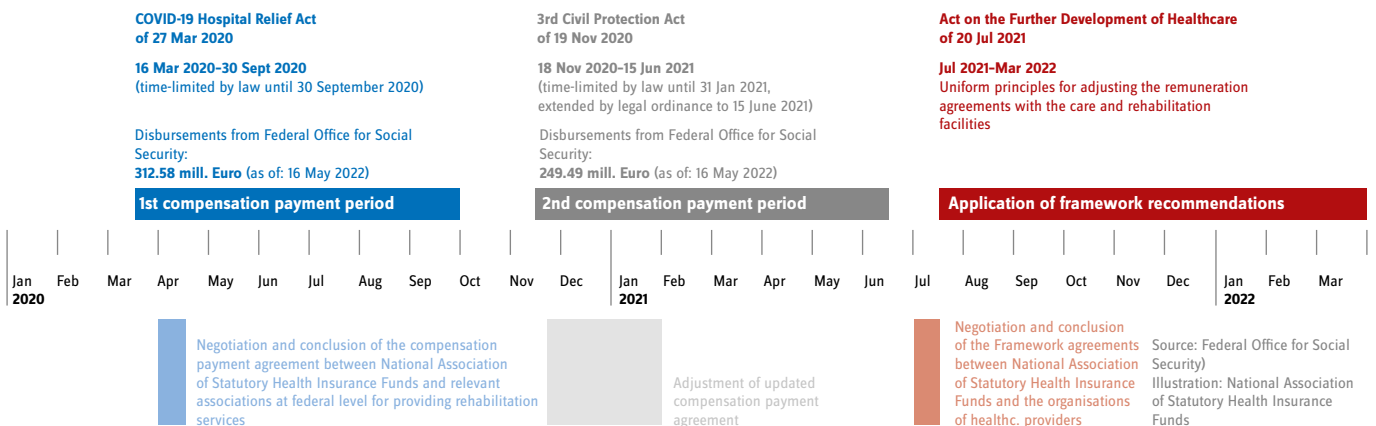
The care and rehabilitation facilities received additional financial support totalling more than 560 million Euro from September 2020 to December 2021 from the contributions made by persons who had statutory health insurance.

Health insurance funds were designated in 13 of the Federal *Länder* to implement the procedure. The procedure was carried out by *Länder* authorities in the other *Länder*. The basic parameters were agreed between the National Association of Statutory Health Insurance Funds and the associations of healthcare providers in what was referred to as the Compensation Payment Agreement on Care and Rehabilitation.

Adjusting the remuneration agreements

Coinciding with this statutory rescue scheme, the Healthcare and Long-term Care Improvement Act (*Gesundheitsversorgungs- und Pflegeverbesserungsgesetz*) of December 2020, and a corresponding ordinance of the Federal Ministry of Health, required the health insurance funds to react to the special situation caused by the coronavirus pandemic by adjusting the remuneration agreements that had previously been reached with the care and rehabilitation facilities for the period from October 2020 to December 2021. This was done in order to ensure the performance of the facilities with cost-effective operation. The National Association of Statutory Health Insurance Funds was tasked in this context by the Act on the Further Development of Healthcare (*Gesetz zur Weiterentwicklung der Gesundheitsversorgung*) of July 2021 to agree with the healthcare providers' organisations on uniform principles for adjusting the remuneration agreements. The framework recommendations on care and rehabilitation for special COVID regulations came into force on time in July 2021. They define the conditions for the payment of surcharges for pandemic-related additional expenditure and under-occupancy. The application of the existing regulation was extended until March 2022 by means of a statutory ordinance.

Compensation payments for care and rehabilitation facilities in accordance with section 111d of Book V of the Social Code



The contribution made by statutory health insurance towards relieving the burden on the economy during the pandemic

The coronavirus pandemic also posed a serious challenge to the economy in 2020 and 2021. Production downturns and temporary closures of shops, service-providers and catering establishments were cushioned by assistance that was forthcoming from the Federal Government for the economic sectors affected, and a wide-ranging package of measures to help offset the economic ramifications. From the beginning, the National Association of Statutory Health Insurance Funds emphasised the necessity of accommodating those enterprises that found themselves in serious liquidity problems despite the aid provided by the Federation, by means of appropriate measures, which were also to be enacted by the social security system.

Deferral of social security contributions

The focus was placed on deferring total social insurance contributions, and contributions payable by members themselves. The contributions were therefore deferred in the period from March 2020 to September 2021 by way of a simplified procedure. This particularly included waiving the otherwise customary security deposits, as well as late payment surcharges and reminder fees. A key factor here was low-threshold access to the deferral procedure. Enforcement measures were largely suspended. Generous use was made of the possibilities opened up, particularly in view of

the fact that, in the early stages, the state support payments could only be initiated with a time delay, and that they were not received by the affected companies for several weeks in some cases.

The measures were regularly reassessed in close consultation with the Federal Government, and with the employers, and were updated on a monthly basis. Employer contributions amounting to well over 800 million Euro were deferred in 2021 alone. Despite the considerable volume, there were no lasting financial effects for statutory health insurance or for social insurance as a whole, since it was possible to temporarily compensate for these payment defaults from the reserves. The payment conduct of the employers and the members concerned was generally in line with the agreed deferral procedure.

Employer contributions amounting to well over 800 million Euro were deferred in 2021 alone.



Correction of contract doctors' remuneration

In order to reduce waiting times for doctors' appointments, contract doctors' services have been subsidised since September 2019 for new patients, when services are provided in open consultations, and for appointment scheduling. The legislature stipulated in the Appointment Service and Care Act (*Terminservice- und Versorgungsgesetz* - TSVG) that these services will be remunerated by the health insurance funds in addition to the morbidity-related total remuneration, i.e. on an extrabudgetary basis. In order to ensure that services are not financed twice, the morbidity-related total remuneration was corrected to account for the subsidised services accounted for in the first twelve months. For the two largest constellations of new patients and open consultations, however, the volume of services was 2.488 billion Euro from September 2019 to August 2020, which is significantly less than would have been possible if the funding had been implemented in full (estimated at 4.1 billion Euro). In addition to the general decline in take-up due to the coronavirus pandemic, this was primarily due to deliberate under-categorisation in order to avoid the correction. The legislature has reacted to this, stipulating a correction procedure for the morbidity-related total remuneration adjustment as of July 2021 with the Veterinary Medicinal Products Act (*Tierarzneimittelgesetz* - TAMG), and introducing a categorisation obligation.

A new correction procedure

An adjustment of 2.235 billion Euro was carried out in the original adjustment period for the two constellations of new patients and open consultations. The difference as against the volume of services billed on an extrabudgetary basis, namely of 2.488 billion Euro, is due to the financial support for these services that policy-makers wished to see provided. The correction procedure, on the other hand, concerns the gap between the volume of services running to 2.488 billion Euro, on which the adjustment was based, and the volume of services expected to be accrued in the future, which is estimated at 4.1 billion Euro. The evaluation committee is to decide on correction amounts for the period from July 2021 to December 2022 for the districts of the respective Association of Statutory Health Insurance Physicians where the adjustment has so far been incomplete. The share of morbidity-related

total remuneration services billed for new patients in 2018 will therefore be stipulated as a reference for the correction period. The largest share of all billed morbidity-related total remuneration services that was reached in the first year in an Association of Statutory Health Insurance Physicians district will be specified as the reference for the correction period for open consultations.

The exact form to be taken by this correction procedure was decided by the evaluation committee in January 2022, after consultations had been carried out between the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds. It includes detailed specifications on the following aspects:

- the data to be taken as a basis
- the delimitation of the service volumes
- how new surgeries are dealt with in mathematical terms
- how the quotas for morbidity-related total remuneration benefits are calculated
- offsetting of any double correction
- accurate application of the corrections in accounting

According to this procedure, with the aid of preliminary calculations, the Associations of Statutory Health Insurance Physicians first use the reference values determined by the evaluation committee to make sure that the adjustment corrections for the correction period take financial effect in good time for the accounting in the sixth month after the end of the quarter. The evaluation committee also decides on the final correction amounts specific to the Associations of Statutory Health Insurance Physicians on a quarterly basis, this requiring any deviations to be corrected in each case in billing in the following quarter. The amount of the corrected adjustment is expected to total approximately 1.5 billion Euro.

There is no evidence at present to suggest that the objective stipulated in the law, namely to reduce waiting times for medical appointments, has been successfully achieved.

Extrabudgetary remuneration incentives are not the right way to achieve improvements in benefits for persons with statutory insurance.

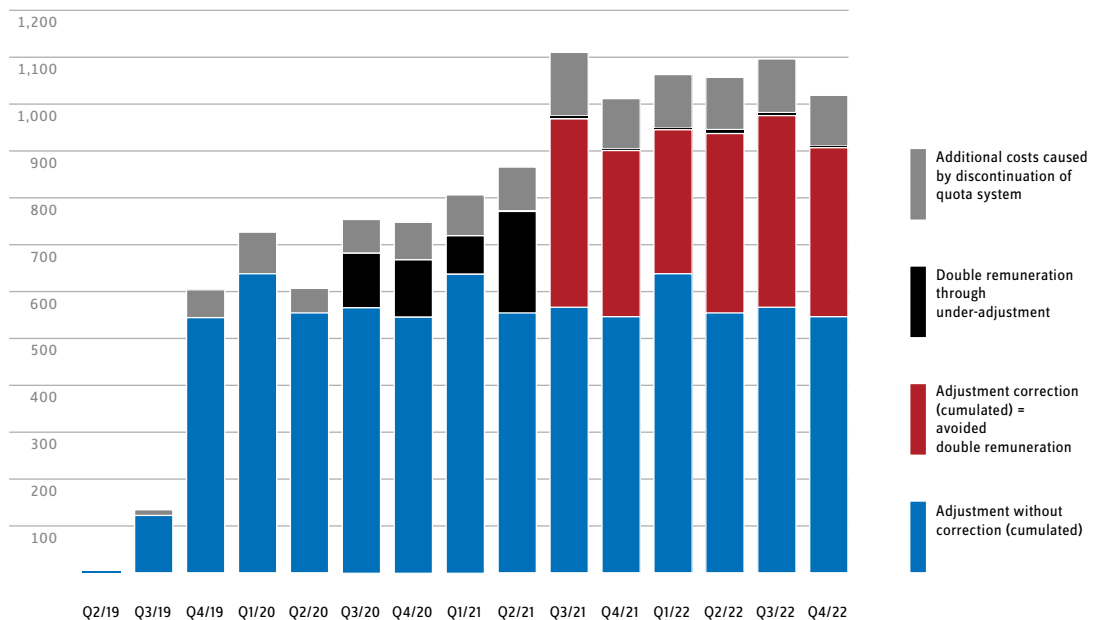
Strengthening morbidity-related total remuneration as standard funding

There is no evidence at present to suggest that the objective of the Appointment Service and Care Act, namely to reduce waiting times for medical appointments, has been successfully achieved. It is at least possible to limit the additional costs for statutory health insurance to the amount of 0.5 billion Euro, as intended by policy-makers. This can also prevent the risk of contract doctors' fees diverging between the different regions. The health insurance funds nevertheless had to make a considerable overpayment of approx. 540 million Euro in the period from September 2020 onwards, until the correction took effect on 1 July 2021, in addition to the sought-after promotion of the affected services. This overpayment would have been quite a bit higher without the general decline in the take-up of services caused by the coronavirus pandemic. That having been said, the termination of the correction period as per the same quarter of the next year, after the end of the epidemic situation of national significance, could become a problem if the

pandemic-related reduction in the take-up of out-patient services continues, and the absolute correction amounts turn out to be too low as a result.

The National Association of Statutory Health Insurance Funds considers extrabudgetary remuneration incentives not to be the right way to achieve improvements in benefits for persons with statutory insurance. Problems against this background include an increasing transfer of the remuneration volume to extrabudgetary total remuneration (currently already approx. 40 % of all services). The National Association of Statutory Health Insurance Funds therefore advocates strengthening the morbidity-related total remuneration as the standard funding for contract doctors' services, and favours targeted, care-improving promotion of selected individual services via extrabudgetary remuneration surcharges. This increases planning security and transparency for both the funds and doctors, and is less susceptible to adjustment and double remuneration effects, as well as to fluctuating take-up behaviour in special situations such as a pandemic.

Financial impact of the Appointment Service and Care Act in mill. Euro (from Q3/2021 estimate)



Source and illustration: National Association of Statutory Health Insurance Funds

Negotiation on doctors' remuneration for 2022

The Extended Evaluation Committee decided in September 2021, against the votes of the funds, to adjust the price for medical services (orientation value) for 2022. No consensual agreement had previously been reached with the National Association of Statutory Health Insurance Physicians in the negotiations that were carried out on the Evaluation Committee. The Extended Evaluation Committee was therefore convened as an arbitrator to determine the orientation value.

Contrasting positions on cost developments in surgeries

The National Association of Statutory Health Insurance Physicians had initially called for a 5.262 % increase in the orientation value, justifying this with the above-average cost developments in contract doctors' practices. The National Association of Statutory Health Insurance Physicians considered particularly the development of personnel costs, as well as the consideration of additional costs incurred, to have been critical here. According to the National Association of Statutory Health Insurance Physicians, these additional expenses resulted from what they saw as more stringent data protection requirements, and the introduction of the electronic certificate of incapacity for work, as well as the electronic prescription.

By contrast, the National Association of Statutory Health Insurance Funds demanded that the orientation value for 2022 be maintained at the level of 2021. It argued in justification, firstly, that the costs in the surgeries had declined slightly in the underlying assessment period 2019 to 2020 and, secondly, that remuneration for contract doctors' services had increased by more than 5 %. The lower costs in the surgeries in the comparison year can be attributed amongst other things to the fact that fewer contract doctor services were provided as a result of the coronavirus pandemic, that personnel costs had been reduced in some cases due to short-time work, and that the VAT rate had been temporarily lowered. The substantial increases in remuneration are a consequence of the Appointment Service and Care Act, the continued dynamic development of psychotherapeutic treatment, and the increased laboratory costs as a result of nationwide COVID testing. For these reasons, and against the background of the tight financial situation faced by the health insurance funds, the National Association of Statutory Health Insurance Funds saw no scope for an increase in the orientation value.

The costs in the surgeries declined slightly in the assessment period 2019 to 2020, whilst remuneration for contract doctors' services increased by more than 5 %.

Contract doctors' remuneration 2022

Orientation value increased by 1.275 % in 2022 (price component):	approx. 0.5 bill. Euro
Morbidity-related total remuneration adjusted in 2022 due to changes in morbidity (volume component)	approx. 0.06 bill. Euro
Volume development of extrabudgetary benefits (EGV) in 2022 (presumption: 3 %)	approx. 0.06 bill. Euro
Total increase in 2022	approx. 1.2 bill. Euro

Source and illustration:
National Association
of Statutory Health
Insurance Funds

Registered doctors will thus receive an additional roughly 1.2 billion Euro in total in 2022.

Price component increased by 1.275 %

Given that the contracting parties were unable to agree on an adjustment in the orientation value for 2022 in the first rounds of negotiations as a result of the different starting positions, the Extended Evaluation Committee determined an increase in the orientation value of 1.275 % for 2022 with the votes of the National Association of Statutory Health Insurance Physicians, and against the votes of the funds. This corresponds to an increase in remuneration of approx. 500 million Euro.

Recommendations on the rate of change in the morbidity structure (volume component)

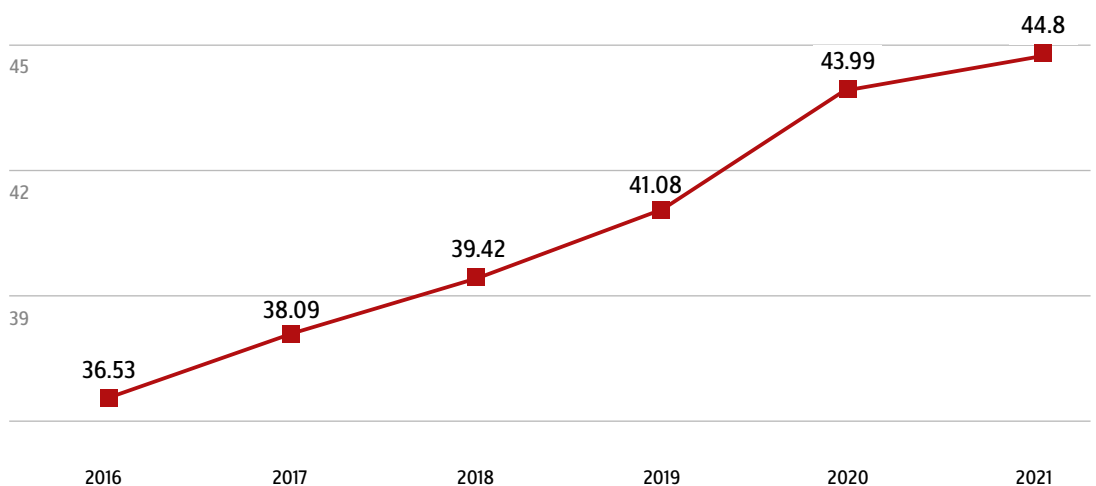
The evaluation committee also decided on the rates of change of the morbidity structure, which take into account the burden of disease suffered by persons with statutory health insurance, as a recommendation for 2022. It is expected that the nationwide treatment requirement would increase by an average of 0.24 % (approx. 60 million Euro) in 2022 if the diagnosis-related and demographic rates of change were weighted in equal halves.

Fee increases of at least 1 billion Euro in 2022

The income of doctors working as contract doctors will increase noticeably due to the resolutions that have been adopted. In addition to the increases in remuneration resulting from the adjustment of the orientation value (price component) and the morbidity structure (volume component), the number of services promoted outside of the budget, such as preventive check-ups and newly-introduced services, will also rise. It can be assumed that this development will furthermore continue next year at a rate of around 3 %, and that this will cause fees to increase by a further 600 million Euro in 2022. Registered doctors will thus receive an additional 1.2 billion Euro in total in 2022. This corresponds to a 2.5 % increase in comparison to 2021.

This increase in expenditure does not yet take into account any additional fee increases that might be agreed at *Land* level between the partners to the overall contract, expenditure due to future statutory regulations, and the expenditure to be expected due to increasing numbers of insured persons.

Expenditure on medical treatment in billion Euro



The amounts paid for early detection, vaccinations, previously other aids, and dialysis material costs, were not taken into account. Source: Official statistics KJ 1, KV 45; Illustration: National Association of Statutory Health Insurance Funds

New periodontitis treatment services

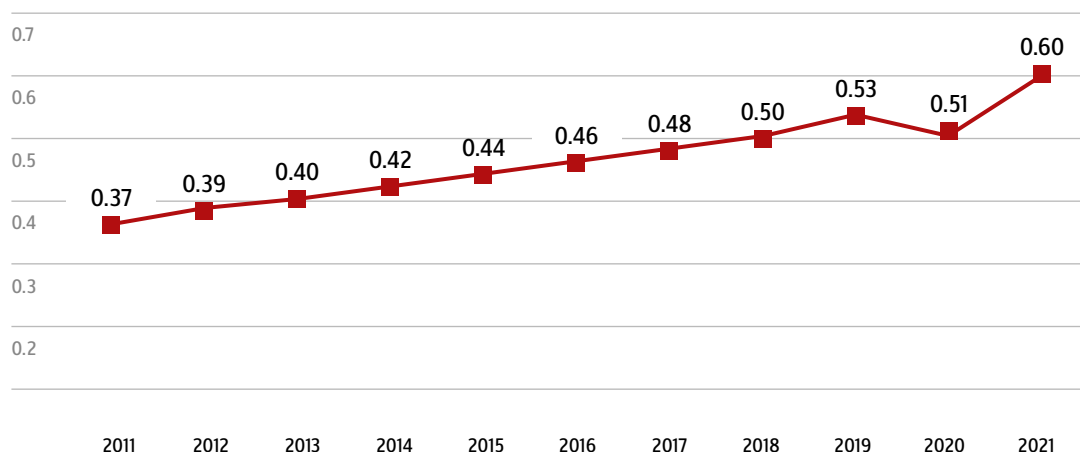
New arrangements for periodontitis treatment for persons with statutory health insurance came into force as per July 2021. The new regulations are centred on the first version of the Federal Joint Committee's Guideline for the Systematic Treatment of Periodontitis and other Periodontal Diseases (PAR Guideline). The PAR Guideline is based on a new classification of periodontal diseases (classification of periodontal and peri-implant diseases). It thus implements the current state of medical knowledge. This entails changes in the range of services provided, and in the procedure for periodontitis treatment.

Based on the guideline, the evaluation committee has defined services for periodontitis treatment as part of the dental services contained in the list of dental services (BEMA). With regard to diagnostics, the severity (staging) and progression (grading) of the periodontitis must be recorded in future. The core service of any periodontitis therapy is anti-infective therapy (AIT), which entails cleaning the inflammatory periodontal pockets. Depending on the depth of the pockets, it

may be possible to perform surgical therapy on some teeth in addition to AIT. The periodontal findings are evaluated three to six months after the end of AIT or of surgical therapy in future in order to decide on the extent of supportive periodontitis therapy (UPT) needed. The inclusion of supportive periodontitis therapy in the BEMA is one of the most important innovations in periodontitis therapy. UPT aims to stabilise the outcome of periodontitis therapy in the long term. Insured persons will be entitled to UPT as standard for a period of two years after receiving periodontitis therapy. This can be carried out between one and three times per year depending on the progress of the disease. This therapy includes an examination of the periodontal condition, oral hygiene checks and oral hygiene instruction, tooth cleaning, and treatment of periodontal pockets that are still inflamed. UPT measures may be extended; this may not go beyond six months as a rule. An extension requires prior approval by the health insurance fund.

Vulnerable insured persons are to receive easier access to periodontitis treatment.

Expenditure on periodontal care in billion Euro



Source: Official statistics KJ 1, KV 45

Illustration: National Association of Statutory Health Insurance Funds

Insured persons are entitled to periodontal screening enabling the detection of early forms of periodontal disease.

A low-threshold offer for vulnerable groups

The Federal Joint Committee has furthermore determined in the Treatment Guideline that services for the treatment of periodontitis are available to particularly vulnerable groups on a modified needs-based scale. This is to enable these insured persons to receive easier access to this treatment. The particularly vulnerable groups include:

- individuals who have been assigned to a long-term care level or who receive integration assistance benefits, and who have no or only limited ability to maintain oral hygiene
- individuals who require treatment under general anaesthesia
- individuals who are unable to cooperate or can only cooperate to a limited extent

The modified services are provided for these groups in lieu of systematic treatment of periodontitis and other periodontal diseases in accordance with the PAR Guideline. The following services are included:

- recording the medical history
- the findings and diagnosis as the basis for therapy
- anti-infective, and where appropriate surgical therapy
- UPT, including tooth cleaning and treatment of inflamed periodontal pockets once per calendar half-year, for a period of two years

In order to enable low-threshold treatment of periodontitis outside of systematic treatment for this group of insured persons, it is not subject to any application or approval procedure. The services must however be reported to the health insurance fund.

Detecting diseases earlier

Insured persons have been entitled to have the Periodontal Screening Index (PSI) assessed for some time. The PSI provides an orientation overview of the possible occurrence and severity of periodontal disease, as well as of any treatment that may be needed. The PSI can be used to detect early forms of periodontal disease. The PSI assessment is carried out prior to treating periodontitis and other periodontal diseases. What is new is that, in future, insured persons will be informed in writing of the result of the screening and of any treatment that might be needed by means of a form, and will be advised of any improvements that they may need to make in oral hygiene at the same time. The aim is to make information and decision-making on the part of insured persons more mandatory. It is assumed that the additional expenditure for statutory health insurance resulting from these new measures will be in the mid to high three-digit million range per year.

Providing better care for seriously mentally ill people

The legislature mandated the Federal Joint Committee via the Psychotherapists Training Reform Act (*Psychotherapeutenausbildungsreformgesetz*) to introduce new care elements particularly targeting seriously mentally ill patients with complex treatment needs. The Federal Joint Committee subsequently adopted a guideline in September 2021 which contains arrangements for improving care for this group of patients.

Patients with serious mental illnesses often experience major restrictions in their everyday lives. These restrictions also reduce the ability of those affected to find necessary, suitable treatment options and to make proper use of them. This can lead to the disease becoming chronic, thus causing further restrictions in

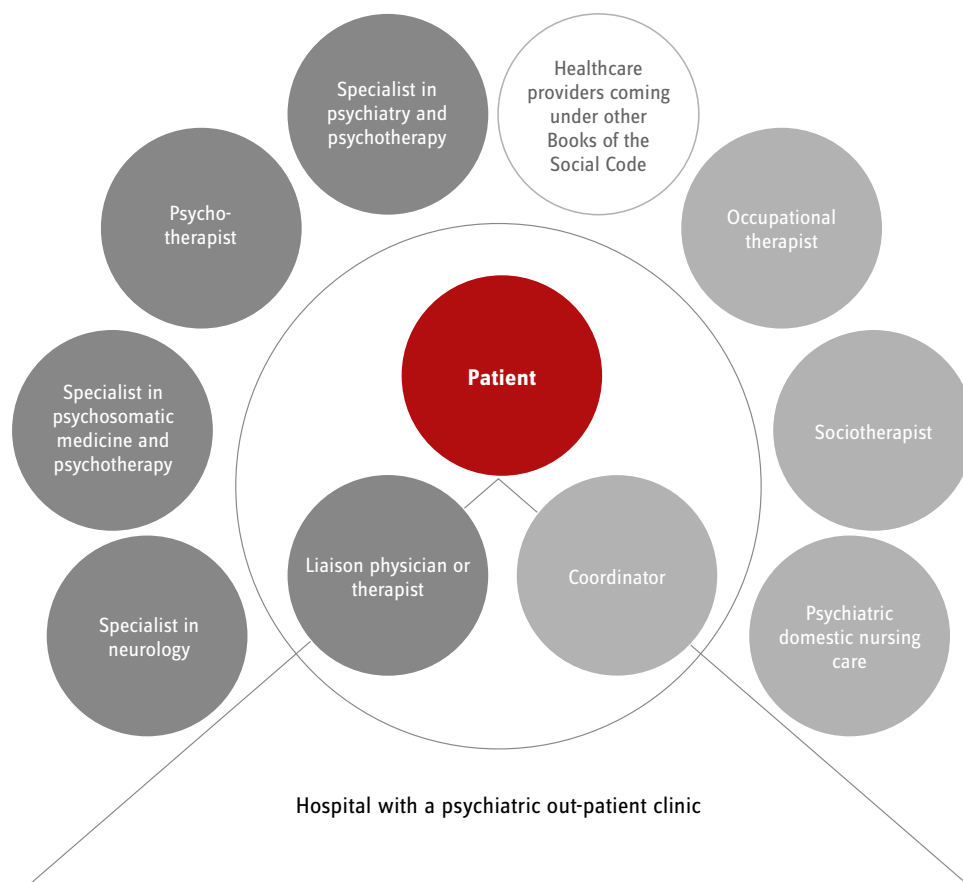
psychosocial abilities. Arrangements have been made that focus on the special, complex treatment needs in order to interrupt this negative dynamic and to counteract the under-provision and mis-provision of care to this group of individuals. Both the current psychological symptoms and somatic comorbidities, as well as the limited psychosocial functional level, are taken into account.

Arrangements have been made that focus on special, complex treatment needs in order to counteract the under-provision and mis-provision of care.

Professional coordination of complex treatment

The central element of this complex care is to provide patients with systematic, continuous support via a coordinator in a cooperation network made up of

Care network for seriously mentally ill adults with complex medical and therapeutic treatment needs in accordance with the Guideline on Interdisciplinary, Coordinated, Structured Care, especially for Seriously Mentally Ill Insured Persons with Complex Psychiatric or Psychotherapeutic Treatment Needs (KSVPsych-RL).



medical and non-medical healthcare providers. Two organisational models may be made use of to carry out the coordination function:

1. The coordinator is employed by the doctor or psychotherapist who draws up, reviews and where appropriate adjusts the overall treatment plan.
2. A coordinator works in psychiatric out-patient clinics (PIA), and doctors or psychotherapists working in the clinic draw up the overall treatment plan.

The coordinator's tasks are, firstly, to establish a network with other healthcare providers, and secondly to maintain contact with the patient. The coordinator ensures that the overall treatment plan is adhered to, makes appointments with healthcare providers where necessary, visits the patient at home if necessary in order to understand their living circumstances, and has contact with the patient once a week by telephone or in person.

Better cooperation between physicians and non-physicians

A cooperation network is created consisting of at least four specialists in psychiatry and psychotherapy, psychosomatic medicine and psychotherapy, neuro-psychiatry or neurology and psychiatry, and four psychotherapists, so that the coordinator can perform these tasks. In addition, cooperation is planned to take place with at least one non-medical healthcare provider in sociotherapy, occupational therapy or psychiatric domestic nursing care (pHKP), and with a hospital which has a psychiatric department.

The differential diagnostic evaluation is carried out by a specialist physician; as a rule, this specialist becomes the liaison physician if patients have somatic main diagnoses or relevant somatic comorbidities that determine the direction of the treatment, or if their psychopharmacological treatments require doses to be regularly adjusted, or if frequent changes are needed in the therapy regimen. Specialist physicians and psychotherapists can otherwise equally assume the role of a liaison physician or a liaison psychotherapist.

The statutory mandate also exclusively addresses the healthcare providers of Book V of the Social Code (SGB V) for reasons related to the legal system. The guideline however takes up the connection between healthcare services and other types of service (e.g. integration and participation) via a recommendation.

Specialist physicians and psychotherapists assume the role of a liaison physician or a liaison psychotherapist.



No double financing of hospital services

The three central components of the diagnosis-related group system for billing hospital services are the fee lists, the billing regulations, and the coding guidelines. Agreements were reached in 2021 on the billing regulations and the coding guidelines. The contracting parties at federal level were however unable to reach an agreement on the fee lists.

The conflict-laden discussion with the German Hospital Federation (DKG) centred on the "standardisation" of the 2022 aG-DRG system ('a' being the abbreviation of the German word "*ausgliedert*" = removed). The crux of the matter was another significant increase in long-term care personnel costs, which in turn raises

Costs in the long-term care sector increased by more than 10 % for the second year in a row, due only partly to an actual increase in staff.

questions. Costs in the long-term care sector increased by more than 10 % for the second year in a row. This corresponds to additional expenditure of about 1.8 billion Euro per year. This is only partly due to an actual increase in staff and to wage increases. Current cost data in fact prove that there were strategic reclassifications in hospital accounting. Hospital operators sometimes reclassify staff who are actually employed in the functional service to the nursing-care service in order to generate additional revenue.

The National Association of Statutory Health Insurance Funds sees a need for correction

The National Association of Statutory Health Insurance Funds considers that the additional expenditure of 1.8 billion Euro needs to be curtailed by roughly 700 million Euro. This amount needs to be accounted for in the aG-DRG system in 2022 in order to rule out double financing. In addition, with a view to the standardisation carried out in 2020, there is a further need for a correction in the amount of 200 million Euro. This additional expenditure should be subsequently separated out for 2020 (retroactively base-corrected for 2021), since it has not yet been possible to trace corresponding cost shifts as part of standardising the aG-DRG system in 2021.

The German Hospital Federation, on the other hand, did not consider any need to exist to make a correction for 2022. Instead, it would like to include extraneous individual aspects such as volume risks and potential increases in material costs in the debate. The National Association of Statutory Health Insurance Funds believes that the German Hospital Federation's proposal to combine a variety of issues would constitute a break with the consensus that has existed for many years on the set of rules for the diagnosis-related groups calculation of the Institute for the Hospital Remuneration System.

An intervention by the Ministry of Health

It was announced at the beginning of October 2021 that the negotiations had failed. As a result, the Federal Ministry of Health established the list of fees for hospitals applying the diagnosis-related groups for 2022 within the framework of substituted performance. The Ministry handing down the ordinance comes to the conclusion in this performance that there is a need for standardisation due to the double financing problem described above, and that the valuation ratios must be reduced by 175 million Euro as a result. The National Association of Statutory Health Insurance Funds is of the opinion that the substituted performance does not therefore achieve the goal of preventing double financing altogether.

Better working conditions in hospital care

The development of nursing staff positions in hospitals is being funded by statutory health insurance via two support programmes: the nursing care jobs promotion programme and the programme to promote measures to reconcile long-term care, family and work. The National Association of Statutory Health Insurance Funds is legally mandated to report on implementation to the Federal Ministry of Health at the middle of each year.

Additional nursing staff

The National Association of Statutory Health Insurance Funds submitted the fifth report on the take-up of the nursing staff positions funding programme in the funding years 2016 to 2019 to the Federal Ministry of Health at the end of August 2021. This report shows that statutory health insurance has so far provided around 1.1 billion Euro to create nursing staff positions in hospitals. Approximately 890 hospitals benefited from the funding in 2019 alone, and reached an agreement with the statutory health insurance funds on additional funding amounting to roughly 683 million Euro.

The creation of approximately 10,100 nursing care posts was agreed for all four funding years. It will only be possible to determine the extent to which additional nursing care posts have actually been created as a result of the agreements with a time lag via the audit certificates of the annual audits. At least 3,300 full-time positions have been demonstrably occupied with specialist staff so far. Further audit certificates, especially for 2019, are still pending. All nursing staff costs incurred in the hospitals have been refinanced by statutory health insurance via the nursing care budget since 2020 in accordance with the new legal provision for removing the nursing care budget from the system of diagnosis-related groups. An additional scheme to fund nursing staff positions has been dispensable since then.

Reconciling care, family and work

Hospitals can receive an additional amount of up to 0.1 % (2019) or 0.12 % (since 2020) of their budget for additional measures in the period from 2019 to 2024 in order to establish measures to better reconcile long-term care, family and work. The overarching goal of the programme is to recruit more qualified nursing care staff and midwives by offering attractive working conditions.

According to the second report of the National Association of Statutory Health Insurance Funds, approximately 10.0 million Euro were made available by the health insurance funds for 2019. 237 hospitals claimed the funds in order to implement corresponding measures. This accounted for 19 % of the eligible hospitals with a budget agreement.

A large proportion of the budget statements for the funding year 2020 have not yet been finalised, which means that 41 hospitals are so far proven to have claimed 1.6 million Euro. Measures were agreed in both years in childcare and long-term care of relatives, introducing flexible working hours models, optimising operational processes, and bringing in additional in-company benefits such as bonuses and measures to promote re-entry after a career break. Measures for direct support in childcare, or in care of relatives in need of long-term care, were taken in more than half of all participating hospitals.

At least 3,300 full-time positions have been demonstrably occupied with specialist staff so far.

Lower limits for nursing staff and nursing staff assessment in hospitals

The National Association of Statutory Health Insurance Funds advocated for the introduction of lower limits for nursing staff in all other in-patient hospital areas.

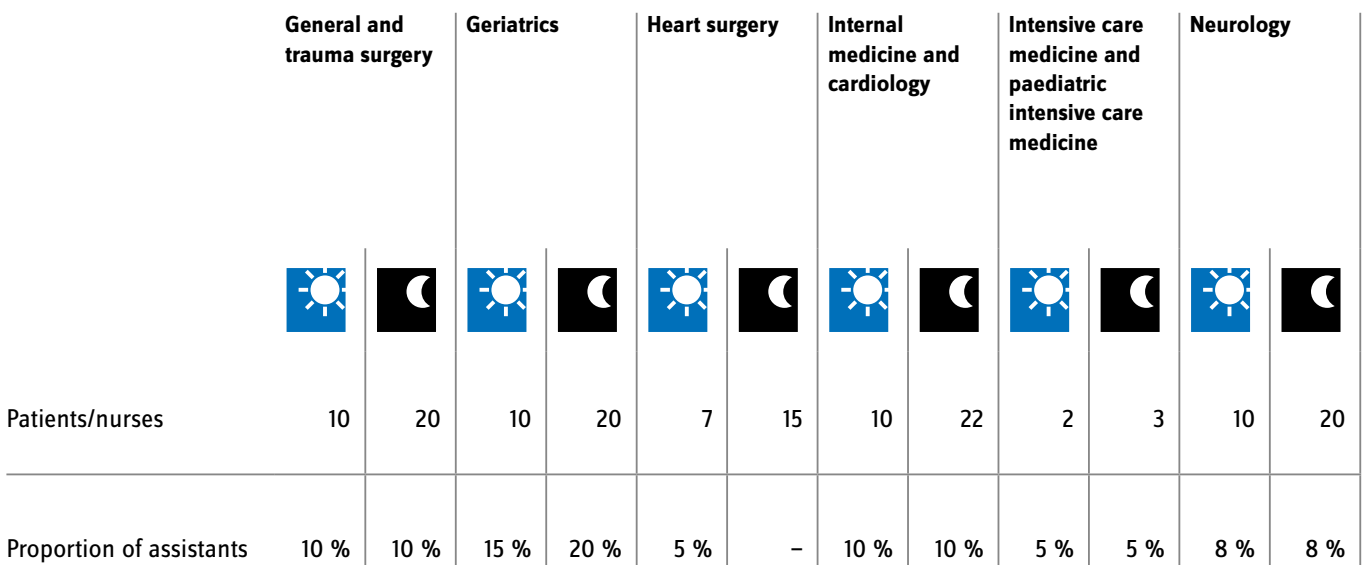
Lower limits for nursing staff in care-sensitive areas have been mandatory for hospitals since January 2019. The instrument entitled "lower limits for nursing staff" provides for a specific number of nursing care staff per sector who care for a given number of patients. If fewer nursing staff are deployed on a monthly average than is provided for, the hospital must accept reductions in remuneration or reduce the number of patients in future. After the provisions contained in the Ordinance on Lower Limits for Nursing Staff (*Pflegepersonaluntergrenzen-Verordnung - PpUGV*) were temporarily suspended by the Federal Government in 2020 due to the pandemic, the lower

limits have been mandatory again since 1 February 2021 in all previously regulated care-sensitive hospital areas.

Further development of lower limits for nursing staff for 2022

According to the legislative project, the German Hospital Federation and the National Association of Statutory Health Insurance Funds were to agree in 2021 on how existing lower limits for nursing staff are to be further developed, and in which hospital areas new lower limits for nursing staff are to be introduced. As in previous years, however, no agreement was reached. The Federal Ministry of Health therefore set new lower

Lower limits for nursing staff in accordance with the Ordinance on Lower Limits for Nursing Staff (as of: December 2021)















Source and illustration: National Association of Statutory Health Insurance Funds

limits for nursing staff for the areas orthopaedics as well as gynaecology and obstetrics, and also broke down the area of paediatrics into general paediatrics, special paediatrics and neonatal paediatrics. The National Association of Statutory Health Insurance Funds advocated for the introduction of lower limits for nursing staff in all other in-patient hospital areas.

Developing a nursing staff assessment tool

The German Hospital Federation and the National Association of Statutory Health Insurance Funds are also to commission independent research institutions or experts to develop and test a procedure for the uniform assessment of nursing personnel requirements

in hospitals in direct patient care on in-patient wards by 2024. The National Association of Statutory Health Insurance Funds intends to launch a Europe-wide call for tenders for this development and testing contract in 2022, and will agree with the negotiating partners at federal level on the contents of this service. The approach pursued by the National Association of Statutory Health Insurance Funds includes an automated nursing staff assessment based on standardised digital documentation of long-term care assessment and long-term care services.

Neurological early rehabilitation		Neurological stroke unit		General paediatrics		Special paediatrics		Neonatal paediatrics		Gynaecology and obstetrics	
											
5	12	3	5	6	10	6	14	3.5	5	8	18
10 %	10 %	-	-	5 %	5 %	5 %	5 %	5 %	5 %	5 %	-



PFLEGE

Demografie

Pflegeforschung

Pflegende Angehörige

**Vulnera
Gruppe**

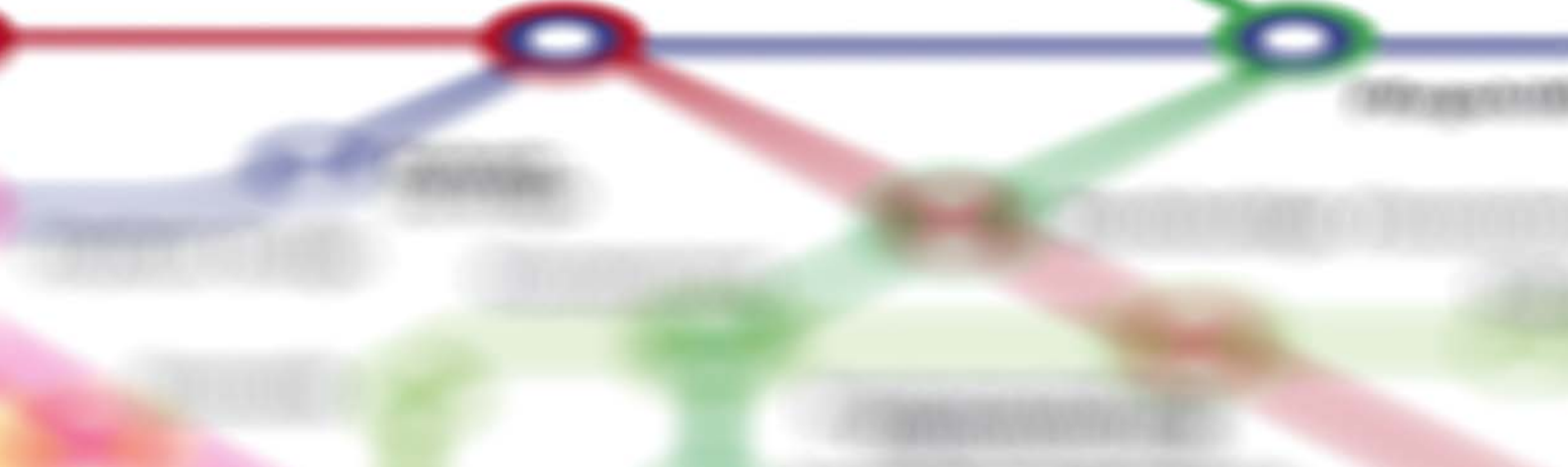
STATIONÄRE VERSORGUNG

Pflegeinfrastruktur

KH-Strukturen

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Reforms in long-term care

The legislature passed a long-term care policy reform, namely the Act on the Further Development of Healthcare, shortly before the end of the legislative period, and this will have a financial impact on nursing care staff, individuals in need of long-term care, and contributors.

New accreditation requirements for long-term care facilities

Out-patient and in-patient long-term care facilities are obliged to pay their employees in long-term care and advice at least at the level of a collective agreement or of a church labour law regulation as of 1 September 2022. Compliance with this requirement is a new prerequisite for long-term care facilities to be accredited to provide long-term care by the *Land* associations of the long-term care funds and the social assistance funding institution. Existing care contracts must be adapted accordingly.

The legislature has further provided that, with regard to the refinancing of higher staffing costs, the long-term care funds and the social assistance funding institution may not reject a remuneration as uneconomical, provided that the remuneration does not exceed the level customary in the region by more than 10 %. The respective remuneration level customary in the region is to be determined by the *Land* associations of the long-term care funds. They are to base this on relevant information from collective agreements and church labour law regulations, which in turn are to be submitted by long-term care facilities in the respective region that are bound by collective agreements.

The National Association of Statutory Health Insurance Funds was required to issue detailed guidelines by September 2021 on how to implement the new accreditation requirements and how to determine the remuneration level customary in the region. The two guidelines were adopted on time, and came into force on 27 January 2022, after being approved by the Federal Ministry of Health, in consultation with the Federal Ministry of Labour and Social Affairs.

The National Association of Statutory Health Insurance Funds supports the aim being pursued with the new regulations to promote decent pay, and thus improved working conditions, for employees in long-term care. The Association however also pointed out in the legislative process that the intended new provisions for increased adherence to collective agreements in long-term care are neither coherent nor free of inconsistencies. The Association is critical in particular of the legally-determined implementation of minimum and maximum remuneration: The long-term care funds are now assigned the task of, firstly, verifying that long-term care facilities pay their employees a specific minimum remuneration in order to be able to be accredited to provide long-term care. Secondly, they must ensure when concluding remuneration agreements that the remuneration of long-term care facilities that are not bound by collective agreements does not exceed the remuneration level customary in the region, which in turn is to be determined by the funds. The National Association of Statutory Health Insurance Funds will continue to draw the attention of the Federal Ministry of Health to difficulties encountered in implementation, and to the need for legislative improvements, in the course of implementation.

Contribution by social long-term care insurance to co-payments in fully in-patient long-term care

Individuals in need of long-term care in long-term care levels 2 to 5 who are cared for on a fully in-patient basis will receive a supplementary benefit from social long-term care insurance from January 2022 onwards. The amount of the supplementary benefit depends on the duration of the fully in-patient care, and varies between 5 % and 70 % of the respective co-payment that is payable for long-term care. The long-term care facility providing care to the individual in need of care is to charge the benefit amount as well as the supplementary benefit to the long-term care fund, and the remaining co-payment to the individual in need of long-term care.

Out-patient and in-patient long-term care facilities must pay their employees in long-term care and advice at least at the level of a collective agreement as of 1 September 2022.

The contribution surcharge for childless persons can only partially cover the increase in expenditure of social long-term care insurance.

The National Association of Statutory Health Insurance Funds welcomes the financial relief for people in need of long-term care in fully in-patient facilities associated with this new arrangement. The co-payments of individuals in need of long-term care in fully in-patient long-term care increased by an average of more than 50 % in total between 2017 and 2020 (from roughly 550 Euro per month as of 1 January 2017 to approximately 830 Euro as of 1 January 2021). The National Association of Statutory Health Insurance Funds has fleshed out the implementation of the new arrangement for long-term care funds.

Increasing the contribution rate for childless persons

The legislature raised the contribution surcharge for childless contributors by 0.1 to 0.35 contribution rate points as of 1 January 2022 in order to finance the reforms. The National Association of Statutory Health Insurance Funds however believes that this will only partially cover the increase in expenditure. Sustainable financing of social long-term care insurance is still urgently needed. Further measures such as federal subsidies are also necessary in order to make long-term care insurance sustainable.

Financial relief for individuals in need of long-term care in fully in-patient facilities from 1 January 2022 onwards in accordance with the Act on the Further Development of Healthcare

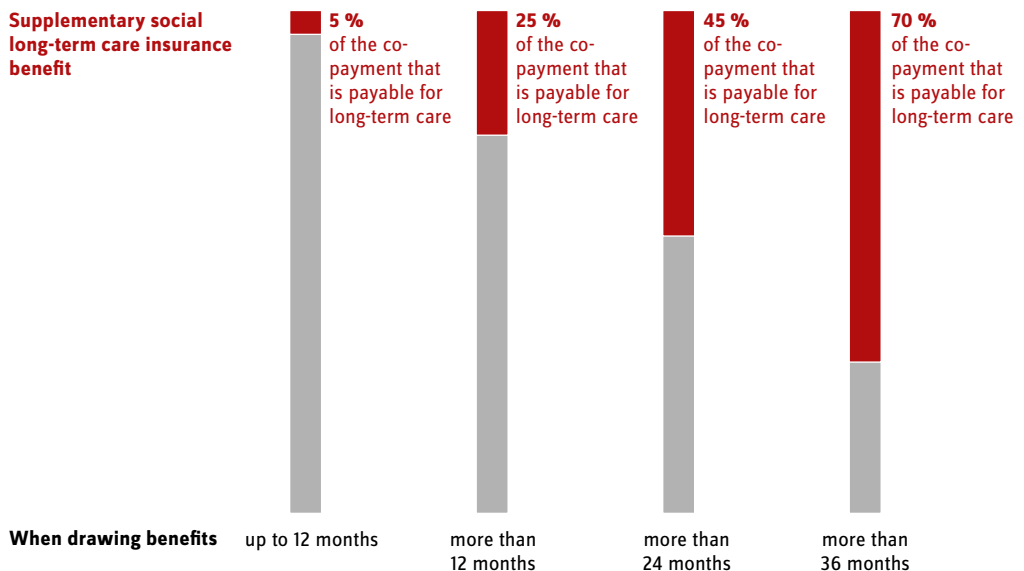


Illustration: National Association of Statutory Health Insurance Funds

A new personnel allocation instrument

The University of Bremen presented a draft for a new personnel allocation procedure for in-patient long-term care, "Algorithm 1.0", under the leadership of Prof. Heinz Rothgang in 2020. Algorithm 1.0 was developed against the background of the definition of need for long-term care and the new understanding of long-term care derived from that definition. It makes it possible to calculate the demand for long-term care specialists and long-term care assistants for fully in-patient long-term care facilities, depending on the respective resident structure. According to the results acquired by the University of Bremen, there is also a demand for more long-term care specialists, but above all for more long-term care assistants. The University of Bremen recommends that additional organisational and personnel development measures be provided in order to deploy staff in a qualification-orientated, efficient manner.

The National Association of Statutory Health Insurance Funds welcomes the uniform allocation of nursing staff throughout the country. Introducing a new personnel allocation system must help improve working conditions, at the same time as leading to better care in the long-term care homes.

Gradual introduction

Building on the scientific groundwork, the legislature has provided for several steps for implementing a personnel allocation throughout the country in order to improve staffing in in-patient long-term care facilities.

The Healthcare and Long-term Care Improvement Act has initially entitled fully-residential long-term care facilities since January 2021 to receive financing for additional nursing care assistant posts according to specific legally-defined staffing ratios. Financing is provided via supplementary remuneration to be paid by the respective long-term care fund of the person in need of long-term care, or to be reimbursed by the private insurance company. Policy-makers aim to create up to 20,000 additional assistant posts via this assistant posts programme. The National Association of Statutory Health Insurance Funds has laid down the details of a procedure for agreeing on the supplementary remuneration.

The National Association of Statutory Health Insurance Funds is making a major contribution towards gradually implementing a new personnel allocation procedure, amongst other things with a pilot programme.

No. of nursing care assistants funded
(as of: 31 December 2021)

Nursing care assistant posts approved	3,724*
of which	
No. of posts for individuals who have completed their training (section 85 subsection (9) No. 1a of Book XI of the Social Code)	2,812
No. of posts for individuals who have started in-service training (section 85 subsection (9) No. 1b of Book XI of the Social Code)	228
No. of posts for individuals who start in-service training within two years of funding via supplementary remuneration (section 85 subsection (9) No. 1c of Book XI of the Social Code)	644

* Number higher than the total of the following lines as no breakdown by qualification for individual facilities is available.

Source: PV 45;
Illustration: National Association of Statutory Health Insurance Funds

The next step consisted of the legislature setting nationally-uniform staffing ratios for long-term care specialists and long-term care assistants for the different long-term care levels from July 2023 onwards by bringing the Act on the Further Development of Health-care into force. These are based on Algorithm 1.0, and correspond to approximately 40 % of the additional staffing requirements calculated there.

A personnel allocation pilot programme

The National Association of Statutory Health Insurance Funds, in consultation with the Federal Ministry of Health and the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, is conducting a pilot programme for the scientifically-supported introduction of the new personnel allocation procedure. The results are to be used amongst other things

to evolve the statutory staffing ratios.

A concept for distributing tasks in a qualification-orientated manner in fully in-patient long-term care will be developed from 2022 onwards as part of the pilot programme. The concept will be backed up by measures for organisational and personnel development, as well as for digitalisation and technology.

The implementation of the concept is to be tested and scientifically evaluated. In addition, an implementation strategy will be developed for the subsequent nation-

wide dissemination and implementation of the tested concept in all fully in-patient facilities.

The long-term care facilities participating in the pilot programme receive staffing for testing the concept based on Algorithm 1.0. The additional staff requirements of the participating facilities will be financed from funds of the pilot programme for the duration of the project.

There will be ongoing evaluation of the concept testing. The evaluation looks at the quality of care and at staff satisfaction, among other things. In addition, insights will be gained on how to make efficiency improvements in staff deployment. The personnel allocation instrument is to be adapted on the basis of the evaluation results, and a refined Algorithm 2.0 will be recommended.

The National Association of Statutory Health Insurance Funds expects the pilot programme to provide insights into the increase in staffing that is actually required. In addition, the nationwide introduction of tried-and-tested organisational and personnel development measures, or digitalisation measures, for effective, efficient, qualification-orientated personnel deployment, is being prepared.

A concept for distributing tasks in a qualification-orientated manner in fully in-patient long-term care will be developed and trialled from 2022 onwards as part of the pilot programme.

Transferring medical tasks to long-term care specialists

Meeting the need for skilled workers is a central challenge in long-term care. The necessity of promoting the long-term care profession in order to counteract the risk of staff shortages has become clear once again, not least during the pandemic. Alongside issues related to financing, the National Association of Statutory Health Insurance Funds considers transferring medical tasks to long-term care professionals to be of central political importance.

Preparing nationwide pilot projects

The Act on the Further Development of Healthcare imposes an obligation on the health insurance funds to carry out pilot projects on transferring medical tasks in each Federal *Land* across different types of insurance fund. The pilot projects are to start on 1 January 2023 at the latest, and are limited to a maximum of four years. The National Association of Statutory Health Insurance Physicians, the National Association of Statutory Health Insurance Funds, and the umbrella organisations at federal level that are responsible for

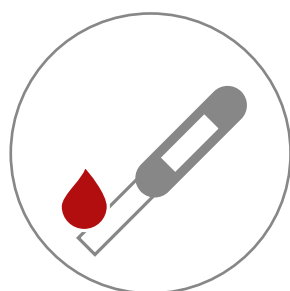
representing the interests of long-term care services, must conclude a framework agreement by 31 March 2022 which is to contain the following:

- a list of medical tasks that can be performed autonomously by nursing care staff with the appropriate additional qualifications
- agreements on the balanced consideration of all care sectors when implementing pilot projects
- uniform requirements for billing and on measures to ensure economic efficiency
- frameworks for interprofessional cooperation

This statutory provision is a result of the strategy process of the concerted action on long-term care. The provision aims to pilot test the performance of tasks previously assumed by physicians by long-term care professionals who perform healthcare tasks autonomously and on their own responsibility.

The necessity of promoting the long-term care profession has become clear once again, not least during the pandemic.

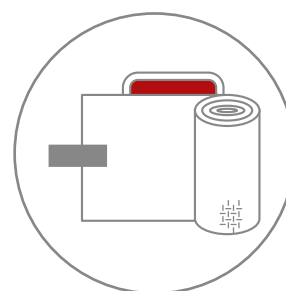
Fields of activity in healthcare with the possibility of transfer to long-term care specialists



Diabetes mellitus



Dementia



Chronic wounds

Research on further developments in long-term care insurance

The Research Unit on Long-Term Care Insurance supervises the various pilot programmes for the further development of long-term care insurance, and thus helps create a scientifically-sound knowledge base for policy decisions in long-term care. One of the most important topics in the year under report was once more digitalisation in long-term care.

Digitally connecting long-term care facilities

The legislature mandated the National Association of Statutory Health Insurance Funds with the Digital Care Act (*Digitale-Versorgung-Gesetz*) and the Patient Data

Protection Act (*Patientendaten-Schutz-Gesetz*) to set up a pilot programme for scientifically-supported testing of the integration of long-term care facilities into the Telematics Infrastructure (TI). The digital, cross-sector exchange of information is being tried out in both out-patient and in-patient care of individuals in need of long-term care in the period from 2020 to 2024. 88 out-patient and in-patient long-term care facilities

have been taking part in the pilot programme since 2021. The focus in these facilities is initially placed on installing and implementing the technical infrastructure, and on testing the applications that are currently available for long-term care and will be available in the future. The first step will be to implement the Communication in Medicine application. Other applications

such as emergency data management, the electronic medication plan, and electronic medical records, will be added successively at a later date.

In addition to this, the pilot programme provides new digital applications in selected projects to be tested from 2022 onwards that are not yet components within the TI, but which hold innovation potential for the long-term care sector. The concepts for instance aim to connect existing sector-specific software (e.g. long-term care documentation) to the TI by developing open interfaces. This could enable parts of the communication between different healthcare providers to be standardised and carried out digitally via the TI in order to make the cross-sector exchange of information more secure, as well as to accelerate and improve it. Other concepts aim to develop standards for a structured exchange of information between the healthcare providers involved on the basis of specific practical cases in long-term care (e.g. transfer of a person in need of long-term care to or from hospital).

The entire pilot programme is to be evaluated scientifically. The key criteria for success are:

- improving cross-sector care
- benefitting people in need of long-term care and the long-term care facilities
- economic efficiency

The digital, cross-sector exchange of information is being tried out in both out-patient and in-patient care of individuals in need of long-term care from 2020 to 2024.

Individualised music for people with dementia

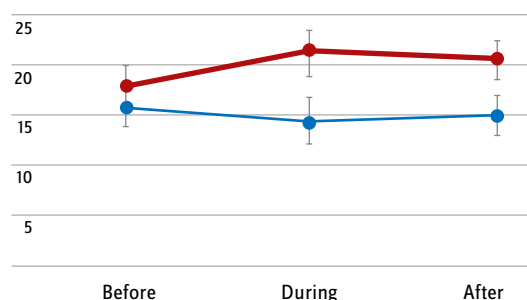
Dementia is one of the greatest challenges for ageing societies, as no successful drug therapy for dementia has yet emerged. Non-drug interventions are therefore gaining in importance where they can help stabilise the status of those with the disease over a prolonged period of time, delay the decline in cognitive functions, and enhance individuals' quality of life. The promoted pilot project entitled "Individualised music for people with dementia", conducted at the University of Jena, presents the first randomised controlled study on individualised music interventions in institutional long-term care in Germany. The study was implemented in five in-patient long-term care facilities (in Weimar, Erfurt and Jena). More than 100 residents were given a music programme over a period of 18 weeks that corresponded to their individual preferences and was associated with positive experiences and emotions.

Among other things, the results show a reduction in restlessness, greater social participation, and a variety of positive reactions to the music intervention. Offering people the opportunity to listen to their own favourite music on a regular basis thus shows itself to be an effective way of caring for dementia patients. The project will be expanded to include care at home in a further stage from 2021 onwards. An app is being developed as part of the project so that as many people in need of long-term care as possible can benefit from this new intervention in the future.

Observing behaviour during the intervention "Individualised music for people with dementia"

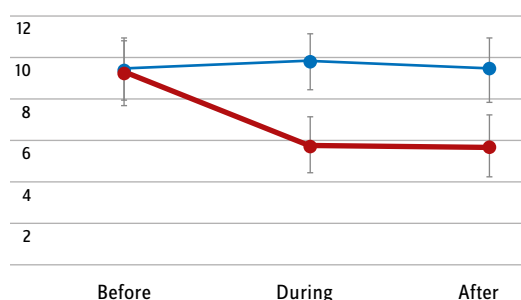
Pleasure

Frequency as a percentage (better: ▲)



Tension

Frequency as a percentage (better: ▼)



● Intervention group (IG) ● Control group (CG)

IG: n = 58; CG: n = 56

Source: Friedrich Schiller University Jena; Illustration: National Association of Statutory Health Insurance Funds

Challenges for social long-term care insurance

Assuming that pandemic-related additional expenditure is incurred up to the end of June 2022, there will be a financing shortfall of 3.6 billion Euro in 2022.

The pandemic and its ramifications once again presented social long-term care insurance with enormous financial challenges in 2021. Due to the reimbursement of extraordinary expenditure and revenue shortfalls at approved long-term care facilities, and services providing support in everyday life recognised under *Land* law, as well as expenditure on COVID testing, the pandemic-related additional expenditure of social long-term care insurance amounts to 4.9 billion Euro. A federal subsidy of 1 billion Euro was paid to social long-term care insurance in October 2021 in order to prevent a shortfall in terms of the long-term care funds' statutory operating resources and reserve targets. Contributions from private long-term care insurance and statutory health insurance in the pandemic-related additional expenditure of approximately 1.1 billion Euro meant that the pandemic-related net burden on social long-term care insurance was approximately 2.8 billion Euro in 2021. Social long-term care insurance met its statutory funding target as per the end of 2021, so that the long-term care funds were solvent in 2021.

The outlook for 2022

The National Association of Statutory Health Insurance Funds considers that the long-term care reforms contained in the Act on the Further Development of Healthcare, which will take financial effect as per January 2022, will lead to additional expenditure of 3.6 billion Euro. This is counted against additional revenues of 1.4 billion Euro. 1 billion Euro of this is accounted for by the annual federal subsidy from 2022, and approx. 0.4 billion Euro by the increase in the contribution supplement for childless persons from 0.25 to 0.35 contribution rate points. This means that

the financial impact of the Act for 2022 was estimated at around -2.2 billion Euro. Assuming that pandemic-related additional expenditure is incurred up to the end of June 2022, the National Association of Statutory Health Insurance Funds estimates that there will be a financing shortfall of 3.6 billion Euro in 2022. In order not to fall short of the statutory resource target of social long-term care insurance in 2022, an additional federal subsidy of 3.6 billion Euro would be required, independently of the Federation's lump sum contribution towards the expenditure of social long-term care insurance amounting to 1 billion Euro per year. The general contribution rate would otherwise have to be raised from its current level of 3.05 % to 3.40 % as early as mid-2022. This could be averted by the Federation taking over the non-insured, pandemic-related additional expenditure for 2020-2022. If the Federation were to additionally undertake to permanently pay the social insurance contributions for relatives providing care, as provided for in the Coalition Agreement, no further federal subsidy or increase in the contribution rate would be necessary until the end of 2024.

Challenges

Placing the financing of long-term care insurance on a balanced, sustainable footing thus remains one of the most pressing challenges of the new legislative period. The National Association of Statutory Health Insurance Funds advocates for an adequate federal subsidy that covers non-insured services, on the one hand, and provides tangible relief for individuals in need of long-term care, on the other. In addition, the *Länder* and municipalities must meet their financial obligations in order to secure the long-term care infrastructure.

Revenue & expenditure of social long-term care insurance 2021

Year	Revenue	Expenditure	Result
2020	50,616,110,779	49,077,357,862	1,538,752,917
2021	52,503,215,470	53,850,223,733	-1,347,008,263

Source: Official financial statistics (PV45); Illustration: National Association of Statutory Health Insurance Funds



Pharmazeutische

Pflegende A

INÄRIV

kturen



AMNOG

**Rabatt-
verträge**

n Drugs

Transparenz

Nationally-uniform provisions for remedies

The Appointment Service and Care Act tasked the relevant remedy suppliers' associations and the National Association of Statutory Health Insurance Funds with carrying out negotiations on nationally-uniform contracts and on prices for remedies from January 2021 onwards. This meant that the agreements that had previously been made at *Land* or fund level had to be negotiated at national level for the first time.

This commission was preceded by a series of remuneration adjustments resulting from amendments to the law that were carried out in the last two legislative periods. The main provisions included introducing nationwide prices in July 2019, decoupling remedy prices from the basic rate of pay, and increasing prices due to the lower price limits for remedies. Remedy suppliers' incomes rose by 43 % between 2015 and 2019 because of these statutory provisions, after healthcare providers had previously demanded increases of more than 80 % in some cases.

Remedy suppliers' incomes rose by 43 % between 2015 and 2019 because of new statutory provisions.

Physiotherapy

The contract for the largest remedies area, namely physiotherapy, was established by the Arbitration Office with effect from the beginning of August 2021. The previous prices were increased by 14.09 %. As the final arbitration decision was not made until after the statutory period of three months had expired, payment amounts had to be provided to compensate for the shortfalls in remunerations. As a result, the prices were temporarily increased by 26.67 % in the period from August to November 2021. Both the professional associations and the National Association of Statutory Health Insurance Funds appealed against the Arbitration Office's ruling, but this had no suspensive effect. The contract therefore came into force as per August 2021, and the remuneration agreement runs until July 2022, as part of the contract.

Occupational therapy

The contract in occupational therapy was established by the Arbitration Office on 15 December 2021 with effect as per 1 January 2022. The previous prices were increased by 5.85 %. As the final arbitration decision was not made until after the statutory period of three months had expired, shortfalls in remunerations had to be compensated for. The prices have been temporarily increased by 11.7 % from January to September 2022. The professional associations appealed against the Arbitration Office's ruling.

Voice, speech, language and swallowing therapy

It was possible to reach a consensus between the National Association of Statutory Health Insurance Funds and three out of four relevant professional associations on the contract for voice, speech, language and swallowing therapy before the statutory deadline expired. Since however one professional association had appealed to the Arbitration Office, it was not possible for the Office to put the contract into effect until March 2021. The contract contains a multi-tiered remuneration agreement:

- as per 1 January 2021 +7.0 %
- as per 1 January 2022 +3.5 %
- as per 1 January 2023 +3.5 %
- as per 1 October 2023 +3.5 %

The agreement can be terminated for the first time as per 30 June 2024.

Podiatry

It was also possible to reach a consensus on the contract before the statutory deadline expired in the remedy area Podiatry, so that it came into force as per January 2021. The contract also contains a multi-tiered remuneration agreement which can be terminated for the first time as per 30 June 2023.

Dietary therapy

The contract for dietary therapy was finally established by a decision of the Arbitration Office on 15 October 2021. The prices which it stipulated were increased by 23.3 % compared to the previous price level. They apply retroactively to prescriptions from 27 April 2021 onwards. The remuneration agreement can be terminated for the first time as per 30 April 2023.

Contracts with extended supply responsibility in accordance with section 125a of Book V of the Social Code (SGB V)

The Appointment Service and Care Act furthermore tasked the relevant professional associations and the National Association of Statutory Health Insurance Funds with concluding contracts regarding the supply of medical aids with extended supply responsibility. This is a form of care in which the remedy suppliers themselves can determine the selection and duration of the therapy, as well as the frequency of the treatment units, for remedy therapy on the basis of a diagnosis and indication made by a contract doctor or dentist. The contracts were originally to be concluded by March 2021. The Act on the Further Development of Healthcare however postponed the statutory deadline for their conclusion to 30 September 2021.

Negotiations on the contracts with extended supply responsibility were also initiated in the physiotherapy remedies sector, after the conclusion of the arbitration proceedings. The contracting parties have agreed that they will continue beyond the statutory deadline for

conclusion, probably until March 2022. It was not possible to conduct negotiations on the healthcare provider-determined course of treatment in occupational therapy in the year under report 2021 due to the arbitration decision on the contract in accordance with section 125 subsection (1) of Book V of the Social Code, which was not made until December 2021. The contracting parties have agreed to start negotiations on healthcare provider-determined care levels in the area of voice, speech, language and swallowing therapy during 2022. A contract was concluded agreeing to postpone the negotiations in podiatry to the end of May 2022, and this was the case in dietary therapy until the end of 2024.

Arrangement on remedies that can be provided by telemedicine

The Act on Digital Modernisation of (Long-term) Care (*Gesetz zur digitalen Modernisierung von Versorgung und Pflege*) created a legal entitlement for insured persons to remedies that can be provided via telemedicine. The contracting partners have to agree on the details and technical requirements for remedies that can be provided via telemedicine. The Federal Joint Committee defined general requirements in the remedies guidelines in October 2021, and these were used as a basis for the contractual regulations. Videotherapy is possible on a time-limited basis due to COVID-related exemptions, until such time as corresponding contractual agreements come into force.

The Act on Digital Modernisation of (Long-term) Care created a legal entitlement for insured persons to remedies that can be provided via telemedicine.

Taking stock of the Act on the Reform of the Market for Medicinal Products in 2021

The Federal Joint Committee carried out 769 sets of proceedings for the early benefit evaluation - with 2,493 sets of advisory proceedings - of medicinal products from the new and existing markets between January 2011 and December 2021. 97 orphan drug evaluations were carried out by the Federal Joint Committee during the same period, albeit orphan drugs are always considered by law to have an additional benefit. 30 out of 88 applications for exemption from the Federal Joint Committee's benefit evaluation ended with the medicinal product being exempted from the procedure under the Act on the Reform of the Market for Medicinal Products.

Pharmaceutical companies do not have to submit any evidence of an additional benefit of orphan drugs in such cases below a turnover threshold of 50 million Euro.

Refund amounts existed for a total of 290 active ingredients at the end of 2021. 264 of these were concluded through agreement being reached between the contracting parties; 26 sets of proceedings were concluded with a ruling handed down by the Arbitration Office. 60 sets of refund amount negotiations, and six sets of arbitration proceedings, were pending in December 2021. 31 sets of pending refund amount negotiations constitute new negotiations on an active ingredient, which had been

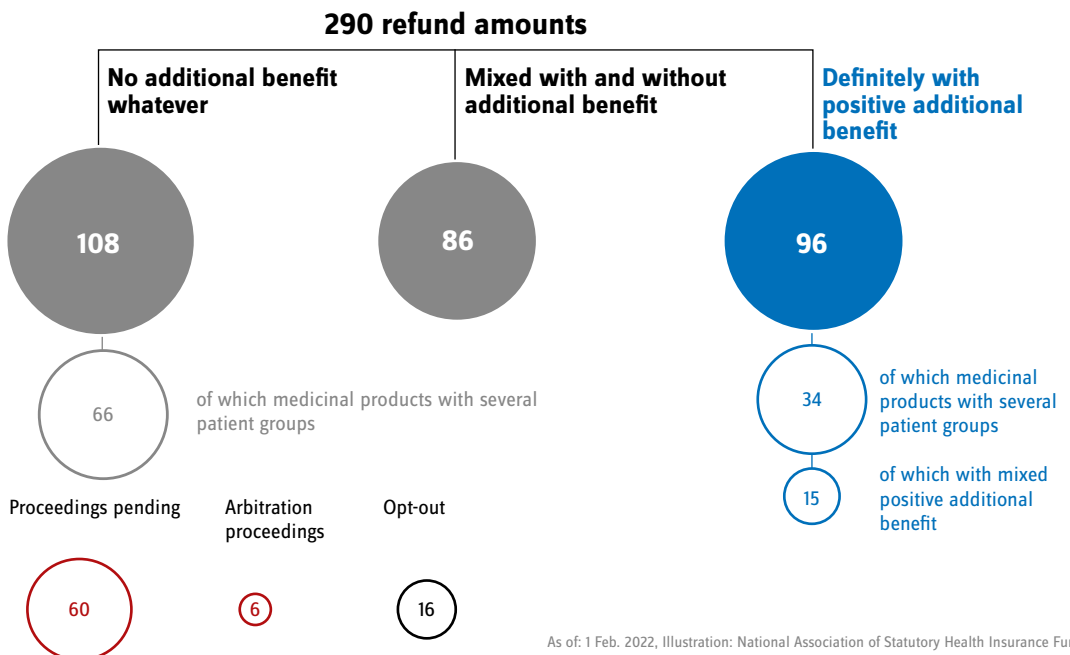
necessitated by new resolutions of the Federal Joint Committee in conjunction with new areas of application, expiry of a deadline, or the termination of existing refund amount agreements.

Six active ingredients have so far been directly attributed to existing fixed-amount groups without a previous benefit assessment procedure. Six fixed amounts for active ingredients that were previously regulated by a refund amount have now become effective in the period from September 2017 to December 2021.

Data collections for orphan drugs to accompany their application

The legislature assumes an additional benefit to exist as long as the sales of a medicinal product with orphan drug status from the approval procedure are below 50 million Euro within twelve months. The pharmaceutical companies do not have to submit any evidence of an additional benefit in such cases. It is only when the turnover limit is exceeded that a standard, complete benefit assessment takes place with all the obligations of proof for the pharmaceutical companies.

Taking stock of the Act on the Reform of the Market for Medicinal Products



As of: 1 Feb. 2022, Illustration: National Association of Statutory Health Insurance Funds

17 active ingredients were already subject to a full benefit assessment after exceeding the sales threshold of 50 million Euro: Thirteen of these subsequently underwent a renegotiation of the refund amount; four were in ongoing negotiations on the refund amount at the end of 2021. One further active ingredient was in the process of being assessed for its benefit by the Federal Joint Committee.

The Federal Joint Committee has been able to mandatorily link the application of individual orphan drugs to a data collection from care practice since a legal amendment that was made in 2019, in order to fill existing gaps in the evidence with authoritative care data. The Federal Joint Committee imposed an obligation on a pharmaceutical company for the first time in February 2021 to create the foundation for a renewed benefit assessment by means of a data collection to accompany the application of medicinal products, and an evaluation. A register study is to be carried out for Zolgensma®, a gene therapy for treating spinal muscular atrophy in children which can be used to assess the therapeutic status in comparison to alternative treatments. For this purpose, all doctors who would like to use Zolgensma® are obliged to take part in the data collection.

Developments in turnover of products under the Act on the Reform of the Market for Medicinal Products in the in-patient sector in 2020

Data in accordance with section 21 of the Hospital Remuneration Act (*Krankenhausentgeltgesetz*) for 2020 have

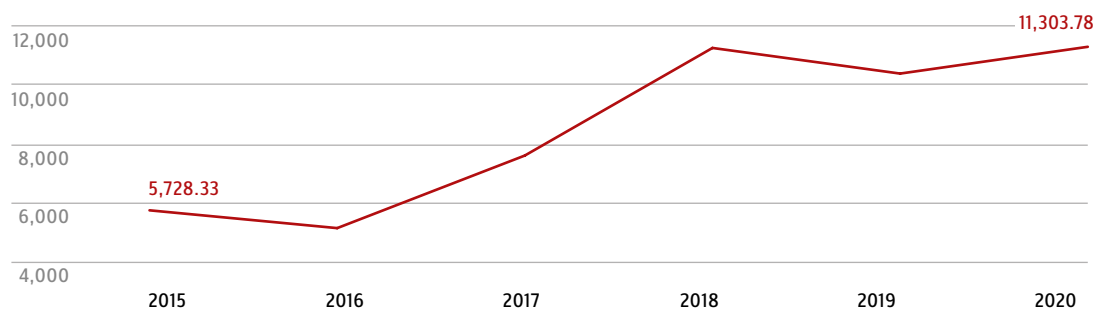
been available since the third quarter of 2021. These data permit an analysis to be made of the fees billed by the hospitals to the health insurance funds within a calendar year for new and particularly expensive medicinal products that are not covered by a diagnosis-related group case flat-rate.

The updated data show that the health insurance funds spent a good 40 % more on medicinal products under the Act on the Reform of the Market for Medicinal Products in 2020 (934 million Euro) than they did one year previously. The corresponding increase in the out-patient sector was only 23 %, which again highlights the increasing importance attaching to the in-patient sector in the high-priced market for patented medicinal products.

Increasing importance attaches to the in-patient sector in the high-priced market for patented medicinal products.

Developments in the (average) fee amount per billed case for medicinal products under the Act on the Reform of the Market for Medicinal Products are also striking. This value rose from a good 5,700 Euro in 2015 to more than 11,300 Euro in 2020. The development of the most expensive fees billed separately for medicinal products coming under the Act over time is even more concerning. Whilst this value was still at 42,500 Euro in 2015 (for using the active substance Defibrotid), health insurance funds already had to pay 2.25 million Euro for Zolgensma® in 2020.

Cost developments of medicinal products under the Act on the Reform of the Market for Medicinal Products (per billed case in the in-patient sector in Euro)



Source and illustration: National Association of Statutory Health Insurance Funds

Capping medicinal product prices after patent protection

The legislature closed a loophole in the price control of new medicinal products with the Act for Fair Competition in Statutory Health Insurance (*Gesetz für einen fairen Kassenwettbewerb in der gesetzlichen Krankenversicherung*), and the Act on the Further Development of Healthcare. In terms of time, this loophole existed between the expiry of data exclusivity and patent protection, and the possibility to set a fixed amount. It was made clear that, after data exclusivity and patent

The refund amount for the medicinal products that are already known, and all successor products, will continue to apply as the maximum price after data exclusivity and patent protection have expired.

protection had expired, and the end of market exclusivity that this entailed, the refund amount for the medicinal products that are already known, and all successor products, will continue to apply as the maximum price. The pharmaceutical companies are free to set their sales prices below this maximum price.

their economic interests are mandated to regulate the details for determining the maximum permissible sales price (maximum price) in a framework agreement. If no agreement is reached, the impartial members of the Arbitration Office are to establish the framework agreement in consultation with the associations. A statutory deadline of January 2022 is provided for amending the agreement.

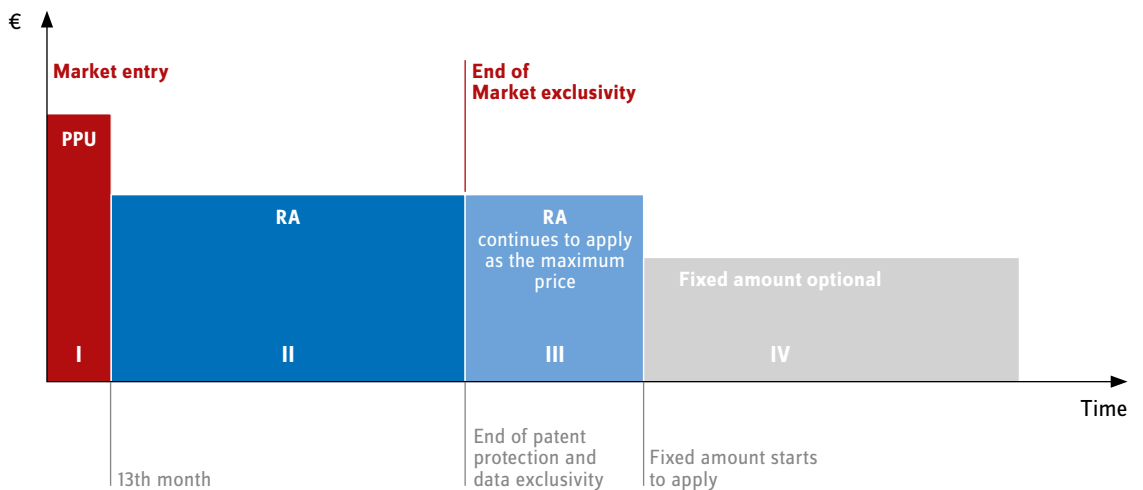
The maximum prices must be predictable for all market participants

It is the task of the associations to include appropriate requirements in the framework agreement that enable all market participants to determine the permissible maximum prices for a new launch. This includes a description of the possible price structure models (e.g. linear, flat), and the calculation steps for the pharmaceutical company, as well as the modalities of the statutory obligation to publish the price structure model that is incumbent on the National Association of Statutory Health Insurance Funds.

Adaptation of the framework agreement

The National Association of Statutory Health Insurance Funds and the relevant central organisations of the pharmaceutical companies formed to represent

The price phases of a new medicinal product



Key: PPU = price freely chosen by the pharmaceutical company; RA = refund amount in accordance with section 130b of Book V of the Social Code

Source and illustration: National Association of Statutory Health Insurance Funds

Price regulations for pharmacies

Uniform dispensing prices applied in Germany to finished medicinal products available on prescription in accordance with the Medicinal Products Act (*Arzneimittelgesetz*), from which pharmacies were not allowed to deviate by granting bonuses. Mail-order pharmacies operating abroad offered just such bonuses to insured persons for redeeming prescriptions. This business model was the subject-matter of proceedings before the Court of Justice of the European Union (CJEU), which declared it to be lawful. Accordingly, the provision contained in the Medicinal Products Act which rules out granting bonuses is not compatible with European law.

Local Pharmacies Promotion Act

The main purpose of the Local Pharmacies Promotion Act (*Vor-Ort-Apotheken-Stärkungsgesetz*) was to introduce price regulations via a provision of social law which are also binding on foreign mail-order pharmacies. Pharmacies are therefore obliged to comply with the stipulations of the Medicinal Products Price Ordinance (*Arzneimittelpreisverordnung*) when dispensing prescribed medicinal products to insured persons as benefits in kind, and not to grant any bonuses to insured persons. Foreign mail-order pharmacies already stated during the legislative process that legal clarification would be needed.

The new statutory provisions serve to transfer the review of compliance with these price regulations to the contracting partners of the framework agreement for which the law provides, namely the German Pharmacists' Association (DAV) and the National Association

of Statutory Health Insurance Funds. The latter have reached a consensus to introduce a body with equal representation into the framework agreement for the imposition of contractual penalties which is staffed with representatives of the Pharmacists' Association and of the National Association of Statutory Health Insurance Funds. In order to minimise the liability risk, an arrangement was agreed according to which only the DAV or the National Association of Statutory Health Insurance Funds bears the internal liability risk if the decision is made exclusively on the basis of the vote of one partner.

Pharmaceutical services

The Act also includes provisions on new types of pharmaceutical services that are to be provided by pharmacies for insured persons. Both the type of service and its implementation are also to be negotiated by the contracting parties to the framework agreement. A surcharge of 20 Cent plus VAT is levied on each finished packet of medicinal products in order to finance these new services.

The contracting parties have agreed that the general contractual provisions for all pharmaceutical services to be agreed on, as well as the billing practices, will be set out in an annex to the framework agreement. It was not possible to reach a consensus with regard to the concrete formulation of the individual pharmaceutical services. The DAV has referred this matter to the Arbitration Office.

Pharmacies are obliged to comply with the stipulations of the Medicinal Products Price Ordinance when dispensing prescribed medicinal products, and not to grant any bonuses to insured persons.

Future-proof supply of medicinal products

There is hardly any other area in the healthcare system that is as dynamic as the development of new medicinal products. The data quality that is desirable in the interest of patient safety is increasingly falling by the wayside in this process. More and more medicinal products are being approved with the aid of expedited procedures – at a time in their development when it has often not yet been proven whether they actually constitute a benefit to patients. The National Association of Statutory Health Insurance Funds has outlined necessary measures in a position paper to make the assessment and pricing of new medicinal products in Germany future-proof, and thus to continue to ensure solidarity-based, high-quality, innovative care for patients.

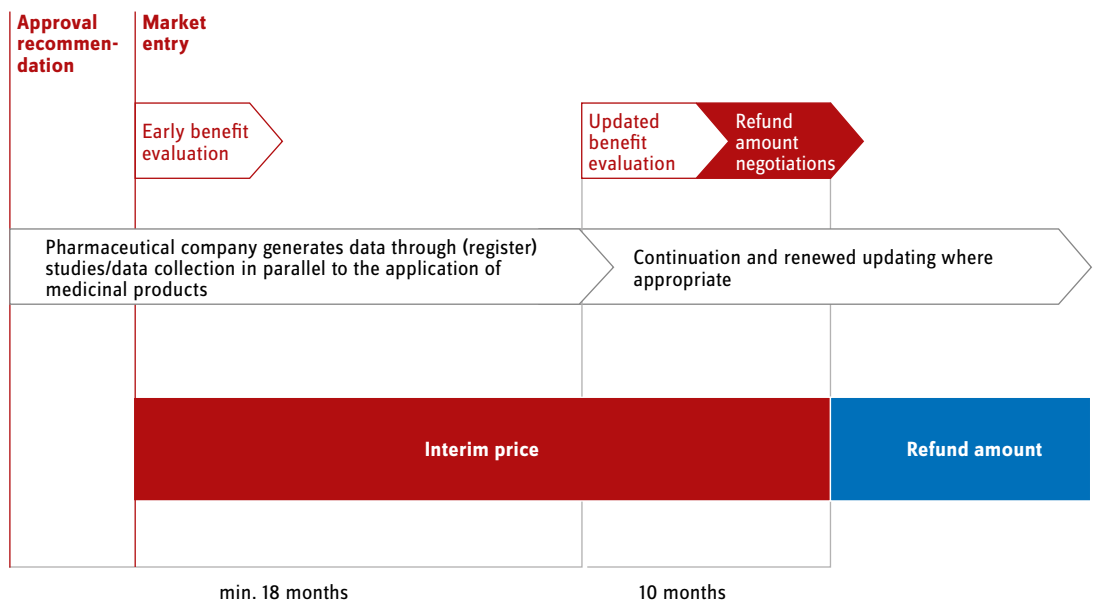
The evaluation by the Federal Joint Committee should be systematically updated for all medicinal products.

Positions of the National Association of Statutory Health Insurance Funds

If medicinal products are approved despite a lack of study data, it is necessary to collect missing data without delay. Data collections to accompany the application on the basis of independent, disease-specific registers are suitable for this purpose. The respective pharmaceutical companies have to pay the costs incurred in this regard.

There are extreme data shortcomings in some cases for individual sub-areas of application of a new medicinal product. The Federal Joint Committee is to be able to specify in such cases in a focus list the legitimate prescription of a medicinal product for a specific sub-area of application until such time as meaningful data are available on the others.

Interim price model of the National Association of Statutory Health Insurance Funds for medicinal products with accelerated approval



Source and illustration: National Association of Statutory Health Insurance Funds

Several new medicinal products that are medically comparable are approved for many diseases. Incentives for price competition are however lacking. It is therefore proposed that the Federal Joint Committee should define a list of medically- and therapeutically-comparable medicinal products. The health insurance funds would then have the option to select individual products from among these for the preferred care of their insured persons, and to negotiate price reductions.

The evaluation by the Federal Joint Committee should be systematically updated for all medicinal products. This is because it also serves as an independent source of information for individual evidence-based therapy decisions taken by doctors and patients.

An interim price should apply in future from the time of market entry onwards to medicinal products where there is no sufficient evidence. As a rule, this is set on the basis of the costs of the expedient comparison therapy, and can only be replaced by a refund amount on the basis of an updated benefit assessment. This enhances incentives to improve the evidence, and protects the community of insured persons from fictitious prices.

The negotiated refund amount is to apply retroactively to the first day on which it was placed on the market to a new medicinal product with standard approval. The period for negotiating the refund amount should be limited to four months in the interest of all parties involved.

The actual research and development costs should replace the "costs of comparable medicinal products" in future as the price criterion for medicinal products with an additional benefit. If there are indications that rebates in other European countries were not reported by the company, only the lowest European price including the advance payment should be taken into account.

Should the financial situation of statutory health insurance deteriorate further, the price controls on patented medicinal products should be supplemented by impos-

ing a limit on expenditure on medicinal products. This limitation can be implemented at the level of individual medicinal products or of a group of medicinal products, or for the total expenditure volume.

Conclusion: Combining innovation and quality

Advances in medicine offer major opportunities for patients and for our society as a whole.

At the same time, it is essential to ensure that new therapies also prove that they are truly innovative. The community of solidarity must not be burdened by expenditure that does not provide any actual (additional) benefit for patients.

An interim price should apply in future from the time of market entry onwards to medicinal products where there is no sufficient evidence.



GKV
Spitzenverband

**Echte Arzneimittelinnovationen fördern
und die Versorgung stärken**

Positionspapier des GKV-Spitzenverbandes zu
patentgeschützten Arzneimitteln



**Versorgung
sicherheit**

ig
Dig. Gesundheitskompetenz

**ung
ung
fremde**



Wissenschaft

Wissenschaft

Wissenschaft

The expansion and the future of the telematics infrastructure

The Digital Care and Long-Term Care Modernisation Act (*Digitale-Versorgung-und-Pflege-Modernisierungs-Gesetz - DVPMG*), which came into force in mid-2021, was already the third Digitalisation Act in the past legislative period. It builds on the Patient Data Protection Act (*Patientendatenschutzgesetz*) and the Digital Care Act, and sets the stage for comprehensively digitalising healthcare. The goal is to connect more healthcare providers, and to implement more and more applications.

The expansion of TI as a basis

As a starting point, the players in the healthcare system are networked with one another through a joint communication platform known as the telematics infrastructure (TI). The connection of the various players, as well as the development and integration of online applications, have been progressing gradually since 2017. After first of all contract doctors', contract dentists' and psychotherapists' practices were connected to the TI, pharmacies and hospitals will gradually follow. In addition, it is expected that the first facilities and healthcare providers in other sectors, such as long-term care facilities, midwives and facilities run by midwives, as well as physiotherapy practices, will be connected to the TI in the second half of 2022.

In order to use the TI, the facility, and where appropriate the healthcare providers themselves, must be able to identify themselves electronically. This is carried out with cards such as the electronic health professional card for healthcare providers, and the security module card for facilities. A separate electronic register of health professions has been set up for professional groups that are not organised in professional chambers, such as nursing carers, midwives and physiotherapists, in order to issue these cards. This started up in mid-2021.

The facilities also need technical components in order to be able to connect to the TI. This primarily includes the connector, which must be further developed, tested and launched nationwide in order to enable other online applications to be used. After only the insured persons' master data management was available in the first stage of expansion, the first medical applications such as emergency data management and the elec-

tronic medication plan, as well as the secure Communication in Medicine online application (KIM), were rolled out in the next stage. The National Association of Statutory Health Insurance Funds concludes funding agreements with all sectors for the applications that are prescribed by law.

A separate electronic register of health professions has been set up for professional groups that are not organised in professional chambers.

Evolution towards TI 2.0

The TI must be technically evolved in order to continue to satisfy the requirements for a networked healthcare system. For example, in the light of the new legal provisions contained in the Digital Care and Long-Term Care Modernisation Act, the TI must be able to provide electronic identities, operate a messenger service for insured persons to communicate with healthcare providers, promote interoperability, and involve other groups of healthcare providers.

For these reasons, gematik has started to think about a TI 2.0, and has fleshed it out in a feasibility study as well as in an implementation concept. In contrast to TI 1.0, TI 2.0 will no longer use its own network that is physically separate from the Internet. Instead, the specialised applications of TI 2.0 will be made available directly via the Internet. The connector, which currently still functions as a hardware component providing an essential access element for healthcare providers, is to be eliminated as far as possible. At the same time, access will be made possible via healthcare providers' mobile devices. Insured persons should see as few changes as possible in this regard, and will continue to access the TI via their own devices. In addition to the existing smart cards (eGK, HBA, SMC-B), healthcare providers and insured persons will use digital identities in order to register for services using their mobile devices.

gematik's shareholders' meeting decided on the principles to be applied when modernising the TI in August 2021. The concepts presented leave a number of questions unanswered at present. The shareholders' meeting therefore commissioned gematik to set up a working and coordination structure, and to particularly focus the specialist work on care processes, including

taking vulnerable groups into consideration, as well as the benefit for patients, and economic efficiency.

Provisions of the Digital Care and Long-Term Care Modernisation Act on gematik

The Digital Care and Long-Term Care Modernisation Act also included a variety of new provisions on gematik in Book V of the Social Code. These include the authority of the Federal Ministry of Health to enact statutory instruments, in accordance with which extensive organisational arrangements can be made in gematik without the consent of the Bundesrat, such as:

- promoting open standards and interfaces
- establishing and organising a coordinating office for interoperability in the healthcare system, operated at gematik
- a panel of experts set up by the coordinating office, and its necessary work structures

TI 2.0 is no longer to use its own network that is physically separate from the Internet, but the specialised applications are to be made available directly via the Internet.

gematik's statutory tasks and mandates have also been expanded. This concerns for example the operation of components and services belonging to the central infrastructure that are essential in order to ensure the security or maintain the functionality of the TI, but also measures that are necessary in order to establish an instant messaging service as a secure transmission procedure, or to make digital identities available to insured persons and healthcare providers. In addition, gematik must furthermore implement the measures needed to enable the electronic medication plan to be used in a stand-alone application within the TI, and to enable contract doctors or psychotherapists to transmit their prescriptions for digital health applications electronically.

Progress in digitalising care

The expansion of digital care services is also progressing with backing from legislation. The Digital Care and Long-Term Care Modernisation Act, for example, recently defined the framework conditions for expanding video consultations and telemedicine services. In addition, the foundations were laid for using video-based procedures as part of long-term care advice and for other digital applications.

Video consultations

The National Association of Statutory Health Insurance Funds, together with the National Association of Statutory Health Insurance Physicians (KBV), created the conditions in 2021 for psychotherapeutic services to also be provided in video consultations. Both the psychotherapy agreement and the Standard Schedule of Fees (*Einheitlicher Bewertungsmaßstab - EBM*) were adapted for this purpose. The technical requirements were defined, as were the content-related and structural specifications for video consultations. It was also determined how existing services contained in the Standard Schedule of Fees can also be charged when they are provided via a video format.

Digital services in long-term care advice

In accordance with the Digital Care and Long-Term Care Modernisation Act, the National Association of Statutory Health Insurance Funds revised the long-term care advice guidelines by the end of 2021. They now contain important provisions on the use of digital applications. At the request of the eligible person, long-term care advice can also be provided as a digital service forming part of video long-term care advice. In addition, applications from the long-term care funds can be used that are largely based on digital technologies and are intended to support the long-term care advice process (e.g. digital information services). It is important that the entitlement to advice in the home environment or in the facility in which the person lives remains unaffected if the long-term care advice is provided by video, or is supported by digital applications. In the interest of digitalisation, the National Association of Statutory Health Insurance Funds welcomes the addition of digital advice services and the opportunities that they create for using long-term care advice more flexibly. Especially in the face of a pandemic situation,

this can safeguard the entitlement to long-term care advice. The entitlement to personal, face-to-face advice remains in place.

Electronic medical records

The electronic medical record (ePA) version 1.0 has also been in operation since the beginning of 2021 in the next expansion stage of the telematics infrastructure. The health insurance funds developed both records systems and ePA apps, and made them available in good time at the beginning of 2021. The connectors developed for this purpose were successfully tested and approved in the first half of 2021. In addition to these, the respective practice management system or hospital information system must be adapted in order for healthcare providers to use the ePA. The adaptation process was sluggish to start with, but a high level of coverage can now be assumed to have been achieved.

The stage has been set for comprehensively digitalising healthcare and long-term care.

The ePA is being refined in a parallel process. The health insurance funds have been offering their insured persons the second stage of the ePA (ePA 2.0), which contains important innovations such as a fine-tuned authorisation system, and an extended substitution arrangement, since 1 January 2022. No connectors are however yet currently available for the productive use of ePA 2.0 in the field.

Electronic certificate of incapacity for work

The transmission of certificates of incapacity for work from healthcare providers to the health insurance funds was also digitalised in 2021. The National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds have agreed to use the online Communication in Medicine application as a transmission channel. This also requires electronic identification. The health insurance funds have commissioned the National Association of Statutory Health Insurance Funds with issuing the necessary keys and certificates. The Association had to launch a Europe-wide call for tenders for this purpose. Both the call for tenders and the subsequent implementation were successfully completed despite a tight schedule. The National Association of Statutory

All the health insurance funds were ready to start receiving the electronic certificates of incapacity for work (eAU) on 1 October 2021.

Health Insurance Funds, as the card issuer, provided all the health insurance funds with the necessary certificates in good time, thus ensuring that all the health insurance funds were ready to start receiving the electronic certificates of incapacity for work (eAU) on 1 October 2021.

The eAU field test started in August 2021, but with only a very small number of participants at the beginning. This was due to the fact that, initially, not only a small number of health insurance funds, but also only a few doctors' practices had the necessary equipment. When it became predictable that all the health insurance funds would be able to receive the eAU by 1 October 2021, but that not all doctors working in the out-patient sector are able to transmit them, the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds agreed on a transitional period ending on 1 January 2022. Doctors' practices that were not yet fully equipped would be allowed to issue the traditional certificates of incapacity for work until that time. The test operation made it possible for a number of errors to be identified and subsequently corrected with a view to regular operation.

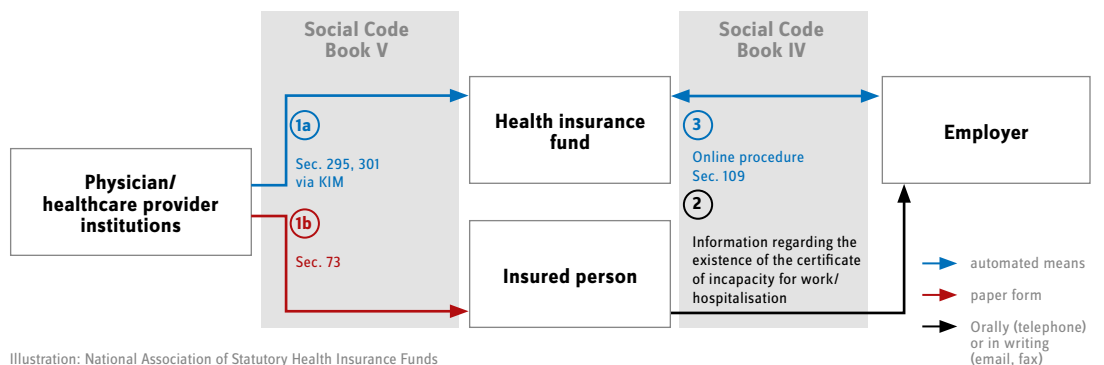
When it became clear that still not all practices would be able to transmit eAUs at the beginning of 2022, the National Association of Statutory Health Insurance Physicians unilaterally established transitional arrange-

ments in a guideline which it adopted. Negotiations which had been held in the meantime between the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds remained unsuccessful, as it was not possible to reach a consensus, particularly on the question of the period of validity and the associated content.

Electronic prescriptions

Electronic prescriptions (e-prescriptions) are to become mandatory as of 1 January 2022 for all persons with statutory insurance for medicinal products requiring a prescription or to be dispensed by a pharmacy. In accordance with its legal mandate, gematik GmbH provided all necessary services and components by June 2021. The test phase then began in the pilot region Berlin-Brandenburg for an initial period of three months. Here too, the problem was initially that only a few adapted practice systems were available. Initially extended by two months, the test phase was tied to quality criteria in January 2022. The nationwide roll-out can only be decided on when these have been satisfied. This is conditional on 30,000 e-prescriptions being billed successfully. Serious errors must have been eliminated. According to gematik, just under 1,000 e-prescriptions had been filled by the beginning of February 2022.

Electronic certificate of incapacity for work (eAU)



Digital health applications as a new benefit under statutory health insurance

The Digital Care Act (*Digitale-Versorgung-Gesetz - DVG*) created the new area of care of "digital health applications" in statutory health insurance. The introduction of digital health applications in standard care provided by statutory health insurance is conditional on the application being approved by the Federal Institute for Drugs and Medical Devices (BfArM) in accordance with the "fast-track assessment procedure", and being included in the register of digital health applications.

Approval and prescription

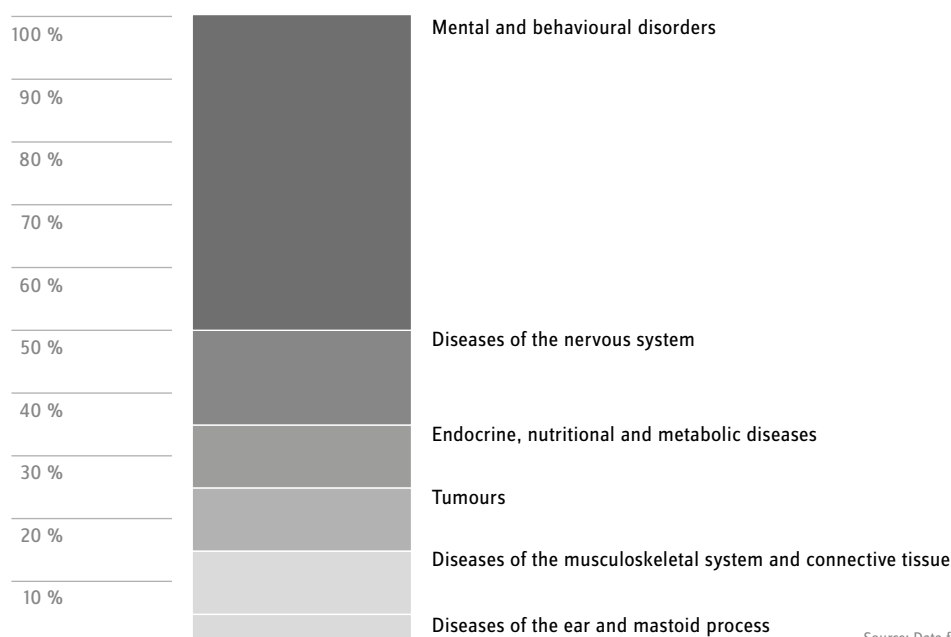
A digital health application is approved as care provided by statutory health insurance either on a permanent basis, on condition that the application can already be demonstrated as having a benefit for care (positive care effect), or on a provisional basis (for testing) if no such evidence has yet been furnished when the application is submitted to the Federal Institute for Drugs and Medical Devices. The first digital health applications have been available nationwide as a benefit provided by statutory health insurance since the autumn of 2020. Insured persons can receive a digital

health application either by having it prescribed to them by a physician or psychotherapist, or by having it approved by their health insurance fund. In order to support a uniform interpretation of the law, the National Association of Statutory Health Insurance Funds has coordinated and communicated the implementation issues relating to the law on benefits arising in this context in a circular letter.

24 digital health applications had become a benefit available under statutory health insurance in the autumn of 2021, one year after the fast-track procedure was launched, albeit only six applications had already been permanently included in the Federal Institute's list of digital health applications. 75 % of digital health applications were initially included for testing. It has yet to be proven whether they have a positive care effect.

Insured persons can receive a digital health application either by having it prescribed to them by a physician or psychotherapist, or by having it approved by their health insurance fund.

Digital health applications grouped according to addressed indicators (up to September 2021)



Source: Data from the National Association of Statutory Health Insurance Funds in accordance with section 33a subsection (6) of Book V of the Social Code; Illustration: National Association of Statutory Health Insurance Funds

The first digital health applications that were included in standard care refer to diseases with very high prevalence rates, and therefore promise high user numbers. One focus is on mental illnesses.

Framework agreement and price negotiations

Manufacturers are free as a matter of principle to set their own prices in the first year after inclusion in the list of digital health applications. It is only as per the second year that the remuneration amounts need to be negotiated with the National Association of Statutory Health Insurance Funds. The prices freely set by the manufacturers currently range from 119 Euro to 743.75 Euro per quarter. The prices average around 400 Euro per quarter, and

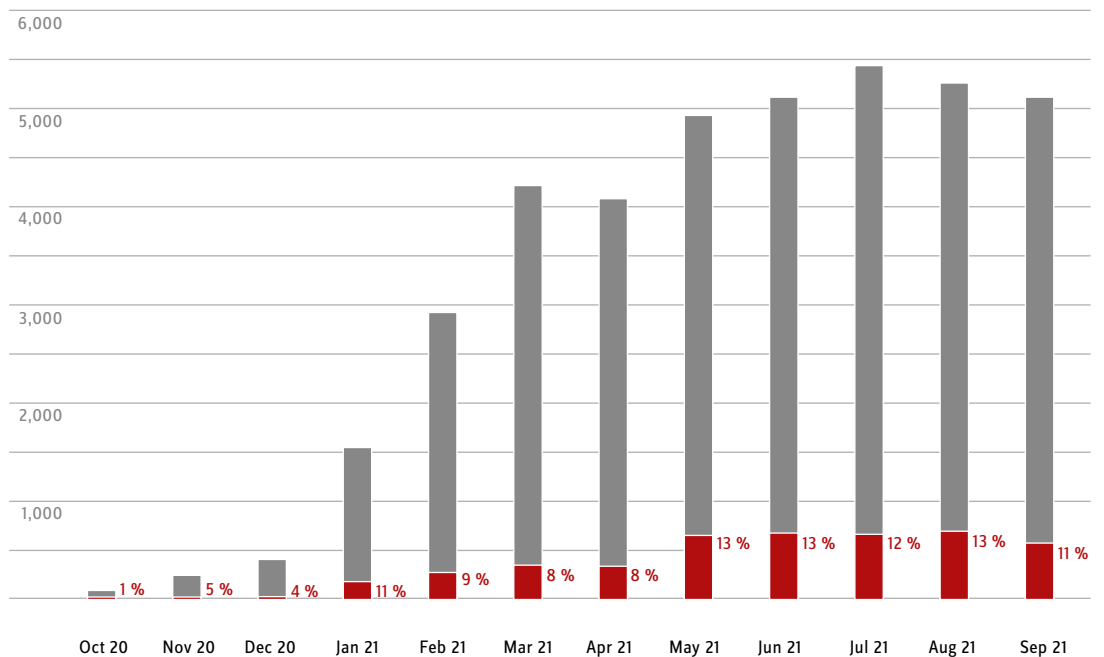
The prices freely set by the manufacturers currently range from 119 Euro to 743.75 Euro per quarter.

are thus significantly higher in some cases than those charged for digital applications which are not on the list of digital health applications.

The structure and procedure of the negotiations for agreeing on the refund amounts for digital health applications, as well as the remunerations to be taken into account in this regard for setting prices, were laid down in a collective framework agreement that was reached between the National Association of Statutory Health Insurance Funds and the relevant associations of digital health application manufacturers at national level.

The framework agreement provides, firstly, for regulations for "maximum amounts". As a corrective to

Distribution of prescriptions over the year under report by month
No. of prescriptions redeemed: 39,318



Type of prescription

- Prescriptions
- Approval (share)

Source: Data from the National Association of Statutory Health Insurance Funds in accordance with section 33a subsection (6) of Book V of the Social Code; Illustration: National Association of Statutory Health Insurance Funds

the manufacturers' very extensive right to set prices, the legislature has additionally provided that uniform maximum amounts for temporary reimbursement can be set in the first year for groups of comparable digital health applications. In addition, the framework agreement also contains a provision on "threshold values", below which no price negotiations with the National Association of Statutory Health Insurance Funds need to be carried out, so that the manufacturer's price is reimbursed on a permanent basis.

Linking with other services provided by statutory health insurance

Only one year after the Digital Care Act came into force, the first legislative steps were taken to refine and adjust the area of care constituted by digital health applications. The legislature for instance initiated measures in the shape of the Digital Care and Long-Term Care Modernisation Act in particular to further integrate digital health applications into care, for instance in connection with inputting data from digital health applications into electronic medical records.

The Digital Care and Long-Term Care Modernisation Act also enshrined in law an entitlement on the part of insured persons in need of long-term care to receive care via digital long-term care applications and complementary support services. Inclusion in a separate list at the Federal Institute for Drugs and Medical Devices means that digital long-term care applications become a benefit provided by social long-term care insurance that can be applied for. Unlike digital health applications, however, prices for digital long-term care applications cannot be set freely for a period of one year. Instead, the compensation amounts negotiated between the National Association of Statutory Health Insurance Funds, in consultation with the Federal Association of Regional Social Assistance Agencies and Integration Assistance, and the manufacturers of digital long-term care applications, apply retroactively from the first day that a digital long-term care application is included in the corresponding list of the Federal Institute for Drugs and Medical Devices. The Act also sets a reimbursement ceiling of 50 Euro per month for digital long-term care applications and necessary supplementary support services.

Positions on organisation in the future

The National Association of Statutory Health Insurance Funds considers the introduction and use of digital health applications to have the potential to improve medical care and to make services more networked.

Digital health applications can empower insured persons to actively shape their own care and make their own contribution to successful treatment. At the same time, there is considerable, fundamental criticism from a statutory health insurance perspective of the legal requirements for the approval of digital health applications as a benefit provided by statutory health insurance, and of the evaluation and approval procedure used by the Federal Institute for Drugs and Medical Devices.

There is for instance a discrepancy between the comparatively modest access requirements for digital health applications in relation to other areas of standard care in statutory health insurance, relating to the proof of a benefit, on the one hand, and economic efficiency on the other. This becomes particularly evident in the above-average prices that manufacturers set when they are initially able to set their own prices.

Overall, there is a need for further legal reworking when it comes to the design of the fast-track procedure, as well as for the framework conditions for digital health applications to be aligned with other areas of services in statutory health insurance.

There is a discrepancy between the comparatively modest access requirements for digital health applications relating to the proof of a benefit, on the one hand, and economic efficiency on the other.

Digital long-term care applications as a service offered

The Digital Care and Long-Term Care Modernisation Act created an entitlement for individuals in need of long-term care to be provided with digital long-term care applications and complementary support services from out-patient long-term care facilities. If the long-term care fund approves care with a digital long-term care application, the person in need of long-term care is entitled to reimbursement of expenses for digital long-term care applications, as well as to benefits for the use of complementary support services of out-patient long-term care facilities up to a total of 50 Euro per month.

Everyday long-term care

Digital long-term care applications are primarily software- or web-based care services that guide individuals in need of long-term care in specific care-related situations. They are designed to help individuals in need of long-term care to reduce impairments in terms of their independence or in specific abilities, or to help ensure that their need for long-term care does not become worse. The new entitlement is also intended to cover applications that support relatives providing care or other voluntary long-term carers in housekeeping and in home care situations.

Inclusion and remuneration

Only those digital long-term care applications and ancillary support services which the Federal Institute for Drugs and Medical Devices has included in the register of digital long-term care applications are covered by the claim. The Federal Institute decides on the inclusion of a digital long-term care application, and of any ancillary support service that might be required, in the list of digital long-term care applications within

three months of receiving the application documents from the manufacturer. The National Association of Statutory Health Insurance Funds consults with the Federal Association of Regional Social Assistance Agencies and Integration Assistance, and agrees on the amount of remuneration with the manufacturer of a digital long-term care application, within three months of its inclusion in the list of digital long-term care applications. This amount applies retroactively from the date of inclusion in the list of digital long-term care applications.

Further legal framework conditions

The National Association of Statutory Health Insurance Funds consults with the Federal Association of Regional Social Assistance Agencies and Integration Assistance, and reaches a framework agreement with the relevant central organisations of the manufacturers that have been established to represent the economic interests on the standards for agreeing on the remuneration amounts, as well as on the principles of the technical and contractual framework conditions for making the digital long-term care applications available. The Federal Ministry of Health is still to regulate in a statutory ordinance on the details, including on the content of the register, on details of the application procedure, on the technical and data protection requirements for digital long-term care applications, as well as on the benefit to care.

The National Association of Statutory Health Insurance Funds welcomes the statutory entitlement of persons in need of long-term care to software- and web-based out-patient care services. The decisive prerequisite for a digital long-term care application is a proven benefit to care for the person in need of long-term care.

Digital long-term care applications are designed to help reduce impairments in terms of independence, or to help ensure that the need for long-term care does not become worse.

Reorganising data transparency

Using data for care research can make a major contribution to the planning and management of healthcare and long-term care. Data transparency aims to make the billing data of health insurance funds accessible to researchers and other eligible institutions for defined purposes, such as improving the quality of care or the management of the healthcare system.

The Research Data Centre, which will be set up at the Federal Institute for Drugs and Medical Devices, will begin operation in the late summer of 2022 according to the current planning. The evaluation options for users will however initially be limited to the data of the morbidity-orientated risk structure equalisation until the extended framework data are available in 2023.

The National Association of Statutory Health Insurance Funds, as the data collection point, is tasked in the new procedure with receiving the billing data from the health insurance funds, checking them for completeness, plausibility and consistency, and forwarding them to the Research Data Centre. The protection of insured persons' data takes the highest priority in this context. A two-stage pseudonymisation of the insured persons' data is planned, in which the Robert Koch Institute (RKI) is involved as a trust centre in coordination with the Federal Office for Information Security and the Federal Commissioner for Data Protection and Freedom of Information.

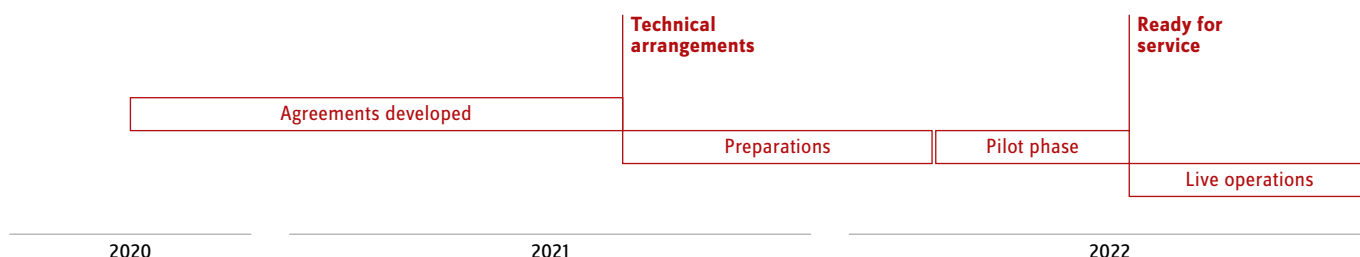
The data collection point is being established on schedule

Important milestones were reached in the establishment of the data collection point at the National Association of Statutory Health Insurance Funds. The predominantly technical details of the procedure were already agreed in the autumn of 2021, together with the health insurance funds and their associations, and thus ahead of the deadline set by law. Agreements with the RKI as the trust centre, and with the Federal Institute for Drugs and Medical Devices as the Research Data Centre on financing and technical design, were also concluded earlier than required by law.

According to the stipulations made by the legislature, the first data are to be forwarded from the health insurance funds via the data collection point to the Research Data Centre and the trust centre in the autumn of 2022. The necessary preparations for data acceptance, verification and forwarding are currently being made on the basis of the technical arrangements that have been made. The medium-term goal is to carry out pilot phases with a large number of participating institutions.

Using data for care research can make a major contribution to the planning and management of healthcare and long-term care.

Milestones of the data collection point



Positions on refining a digital healthcare system

Key applications such as the electronic medical record must be further developed to form the nucleus of a new digital ecosystem.

The digitalisation of the healthcare system and long-term care holds considerable potential for high-quality, economical healthcare services. The interests and the well-being of the insured persons, that is the patients, must always be central to the processes of change. It is in their interest that structures must be changed, processes improved and innovations implemented. In its position paper, the Administrative Council of the National Association of Statutory Health Insurance Funds describes the central need for further development in light of the necessary systematic prerequisites, the structure of access to digital care, and practical applications.

Action was taken in many areas in the previous legislative period with regard to digitalisation through various legislative initiatives, and by the Digital Care Act, the Patient Data Protection Act, and the Digital Care and Long-Term Care Modernisation Act in particular. But this can only be the beginning. There is still a considerable need for expansion and optimisation.

The benefit for insured persons as a yardstick

Central aspects such as the forward-looking expansion of the telematics infrastructure (TI), facilitating interoperability in the healthcare system, as well as harmonising data protection, must be orientated in terms of their implementation, and with the decisive participation of statutory health insurance, to the benefit of the 73 million persons with statutory insurance. At the same time, key applications such as the electronic medical record must be further developed to form the nucleus of a new digital ecosystem that provides insured persons with central, secure, rapid access to all data and information on their health in a manner that is free of media discontinuities.

Enabling informed decisions

It is indispensable in this context to protect the dignity, autonomy and empowerment of insured persons when introducing and using new technologies and procedures. One factor that is directly relevant to this is enhancing digital literacy. This however applies not only to insured persons, but also to healthcare providers, authorities and healthcare facilities. In order to achieve this, professionally-defined levels of digital maturity must be established and reached by the healthcare providers, in terms of both knowledge of digital treatment methods, and with a view to establishing digital processes in the routines of doctors' surgeries and hospitals, developing the requisite hardware and software infrastructure, as well as connecting to the TI and using its applications.

The range of care available must furthermore be presented to insured persons in a more transparent and low-threshold manner as digitalisation advances in order to optimise patient pathways in healthcare and to enable informed decisions to be taken when choosing services and healthcare providers.

Also ensuring evidence in the course of digitalisation

New technologies, methods and active ingredients must meet the same high standards of evidence-based medicine as their traditional counterparts. Instead of foregoing corresponding tests and evaluations, established procedures should be further developed. This applies to the traditional areas of care in general, as well as to the new ones in particular, such as digital healthcare and long-term care applications.

Spreading costs and responsibilities fairly

What applies with regard to a proven benefit must naturally also apply when it comes to economic efficiency. Not only is there a continuous increase in costs in the context of digitalisation, but it is also almost exclusively on the shoulders of the contributors of the health insurance funds at present. At the same time, more and more decision-making powers are being transferred to state facilities and, in parallel, the capacity to act of social self-government is being weakened. This imbalance must be redressed, both by spreading the costs among all players within the healthcare system fairly, and – as part of digitalisation – through relevant transfers of competences to statutory health insurance and to the social self-government system underpinning it.

No other player in the healthcare system can better protect and represent the interests of insured persons and contributors – both in the process of digitalisation, and beyond.

Digitalisation needs to involve a relevant transfer of competences to statutory health insurance and to the social self-government system underpinning it.



Digital health literacy

With the support of experts, the National Association of Statutory Health Insurance Funds has developed specifications in accordance with section 20k of Book V of the Social Code which provide the health insurance funds with a framework in which contributions towards enhancing digital health literacy can be anchored in the statutes.

The following key objectives are to be achieved for insured persons:

1. Insured persons are to be informed and empowered when it comes to accessing and making use of digital health services for themselves.
2. They are to be enabled to make self-determined decisions regarding the use of digital services within healthcare.
3. Digital health services are to take user-specific aspects into account, and should encompass issues related to data security and data protection.
4. Enhancing digital health literacy aims to increase equal opportunities for the public by enabling them to enhance their health-related self-efficacy by making appropriate use of digital health applications.



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Innovation in the supply of medical aids

The list of medical aids, and the list of long-term care medical aids, are continuously being updated by means of application procedures and revisions in order to ensure that innovative products as well as new care forms, manufacturing techniques and materials are quickly introduced into care, and that insured persons benefit quickly from technical progress as a whole. Major steps in this direction were taken in 2021, and innovations were introduced in both areas.

A new web portal of the list of medical aids and of the list of long-term care medical aids

The list of medical aids and the list of long-term care medical aids currently contain a total of around 36,200 products – from digital hearing aids to walkers and exoskeletons. The National Association of Statutory Health Insurance Funds has set up a new web portal for the two lists which offers an improved service and replaces the old online version.

Since June 2021, manufacturers of medical aids have been able to submit online applications for inclusion as well as applications for amendments to their existing listed products. Furthermore, after registering, applicants can enter the necessary data, upload documents, and view the processing status of their application, at any time. More than 280 manufacturers are already using the web portal to submit paperless applications. This means that the portal helps make the application process more dynamic and cut red tape.

The web portal additionally contains detailed information on the listed products, as well as on the requirements applicable to the products and to service provision. Healthcare providers, health insurance funds and insured persons can use the new web-based application to call up, sort and filter this extensive information.

Revising and modernising the product groups

According to the legal requirements, product groups which are on the list of medical aids must be reviewed every five years at the latest, and product groups on the list of long-term care medical aids must be reviewed every three years at the latest, and updated as far as necessary. A total of nine product groups were

updated in 2021. The further development of the two lists was dominated by digitalisation for some product groups.

With regard to long-term care medical aids intended to facilitate long-term care and to make for a more independent way of life as well as greater mobility, and the long-term care medical aids intended for consumption, three of the four product groups on the list of long-term care medical aids for improving long-term care were substantially updated.

Greater autonomy through digital long-term care medical aids

Special attention was paid to digital long-term care medical aids which are to quickly find their way into care. In order to encourage applications for such innovative products, the National Association of Statutory Health Insurance Funds has created two new sub-groups in product group 52 "Long-term care medical aids for more independent living/mobility". Products that serve to improve cognitive and communication skills can be included in the first sub-group. Examples here are memory aids, GPS trackers to determine location, or cooker monitoring systems. The second sub-group includes medical aids that help insured persons cope with the demands and stresses of illness or therapy, such as digital medication dispensers.

The restructuring of the product group met with a positive response all-round, and sparked a lively interest on the part of manufacturers of digital long-term care medical aids. The National Association of Statutory Health Insurance Funds provides a corresponding advisory service in order to make applications easier for them.

Better care for people who are blind

Numerous new arrangements were also made as part of the update of product group 07 "Medical aids for the blind", so that persons with statutory health insurance are able to have access to digital medical aids of high product quality. Digital medical aids for the blind, such as orientation devices that can be worn on the body and spectacle-shaped devices that serve to convert

Since June 2021, manufacturers of medical aids have been able to submit applications for inclusion as well as applications for amendments to their existing listed products.

writing and help to recognise objects, make everyday life easier for those concerned, and can thus help them lead a self-determined life. The quality requirements for these types of product were defined in order to guarantee the quality of care, and the descriptions and indications were formulated.

Orientation devices that can be worn on the body belong to the group of electronic medical aids for orientation and mobility, and beneficiaries are taught to use them properly in special training courses.

Special attention was paid to digital long-term care medical aids which are to quickly find their way into care.

An additional ten hours of instruction are now planned in order to learn how to best use these digital medical aids and to prevent the misprovision of care. Intensive courses can be taken for these additional training courses, as they can also for the basic training courses in orientation and mobility.

The most important new feature in the update of the product group however related to the general indication for medical aids for the blind, which was reformulated. Blindness can have many causes. Psychological stress or cerebral disorders can for example also lead to blindness. The indication was therefore expanded so that insured persons whose visual impairment is functionally equivalent to blindness can now also be entitled to receive care with medical aids for the blind.

The screenshot shows the 'Hilfsmittelverzeichnis' website. The main content area displays the 'Produktgruppe: 07 - Blindenhilfsmittel' with an update date of 12.10.2021. Below this, there are sections for 'Definition', 'Indikation', and 'Querverweise'. A table lists products with columns for 'Pos.-Nr.', 'Produktbezeichnung', 'Artikelnummern', 'Hersteller', 'Aufnahmedatum', and 'Änderungsdatum'.

Pos.-Nr.	Produktbezeichnung	Artikelnummern	Hersteller	Aufnahmedatum	Änderungsdatum
07.50.01.0003	Kinderlangstock einteilig		Comde-Derenda CmbH	26.04.2017	
07.50.01.1014	Dürener Blindenstock	FS-I-0, FS-I-32, FS-...	Rurtalwerkstätten Lebenshilfe Düren gemeinnützige GmbH	15.01.2008	23.02.2021
07.50.01.1016	Kinderlangstock zweiteilig, Griffstü...		Comde-Derenda CmbH	26.04.2017	
07.50.01.1021	MCCane Fallstock CT85 bis CT165	87050-87066	CareTec International GmbH	23.02.2021	23.09.2021
07.50.01.2002	MCCane Teleskopstöcke CT73-126...	87020-87022	CareTec International GmbH	07.12.2018	

Greater transparency on additional costs for medical aids

The amount of additional costs in the medical aids sector, and the frequency of care cases associated with additional costs, have repeatedly been the focus of public debate for many years. According to the principle of benefits in kind that applies to statutory health insurance, persons with statutory insurance should receive sufficient, needs-based care without having to pay any additional costs. At the same time, they have the possibility, granted by law, to also choose equipment or services that go beyond what is medically necessary. They do however have to meet the corresponding additional costs themselves in these cases.

Stronger rights to information and advice

In order to ensure that additional costs are only based on an informed, considered decision taken by the insured person, the Remedies and Medical Aids Supply Act (*Heil- und Hilfsmittelversorgungsgesetz - HHVG*) of 2017 improved the information and advice provided to insured persons regarding their eligibility for benefits and care options. At the same time, healthcare providers were obliged to disclose the amount of additional costs billed to insured persons. This information forms the basis for the annual report published by the National Association of Statutory Health Insurance Funds on developments in additional cost agreements for the supply of medical aids. The report, which is differentiated according to product groups, serves to create the necessary transparency concerning the extent and the amount of the additional costs.

Data evaluation published for the third time

The report on additional costs for 2021 provides a comprehensive data evaluation concerning the additional costs that were paid in 2020. More than 95 % of the billing data were analysed across different types of insurance fund in a format not associated with specific healthcare providers. As a result, the available report shows that, at around 80 %, the lion's share of care is carried out at no additional cost, and that the proportion of care where additional costs were paid has hardly changed in comparison to the previous two years. That having been said, the average additional costs per insured person have increased slightly. The National Association of Statutory Health Insurance Funds will carefully monitor whether this trend continues in the years to come.

Healthcare providers were obliged to disclose the amount of additional costs billed to insured persons.

It remains a challenge to assess the extent of the additional costs in order to determine whether they are paid for care that is medically necessary, and which should be financed on a solidarity basis, or for optional services that go beyond this. It is not possible to obtain reliable findings on this question on the basis of the current legal provisions, as the reasons for additional cost agreements do not have to be stated and documented. It is therefore only possible to make qualitative statements on the reasons for additional cost agreements, or separate studies, on the basis of improved legal foundations. The National Association of Statutory Health Insurance Funds has already called for these in legislative procedures.



Enhancing psychosocial health

Disease prevention courses offer insured persons competent support for an everyday lifestyle that is beneficial to their health. The disease prevention guidelines of the National Association of Statutory Health Insurance Funds, in cooperation with the associations of the health insurance funds at federal level, have provided the content and quality framework for this for more than 20 years. It has been continuously developed during this time. The importance attaching to enhancing psychosocial health resources and promoting exercise in everyday life has become especially clear since the beginning of the coronavirus pandemic, and particularly during the contact restrictions. Statutory health insurance made it possible to hold classic disease prevention courses via a livestream as an immediate measure right after the start of the pandemic.

Further developments in stress and resource management

Stress and resource management has been fundamentally revised in the latest edition of the disease prevention guidelines. The content now includes support for coping with acute stressful situations, e.g. through better self-management and time management, as well as support for the long-term development of psychosocial health resources on an equal footing. The courses can focus on acute stress management, or on long-term resource building, depending on the target group. Courses on stress and resource management target "insured persons undergoing stress who want to learn how to deal with it in a safer and more health-conscious way". A new focus is also placed on insured persons who are not currently undergoing stress, or who are experiencing other psychosocial burdens such as loneliness, reorientation after retirement, or chronic illness.

Healthy sleep plays a key role among health resources as the most important factor for physical recovery. The health insurance funds will be able to offer courses to their insured persons to promote healthy sleep from April 2022 onwards. Sleep-promoting behaviours are to be practised here in particular, e.g. physical and

mental relaxation, rituals for falling asleep, and structuring the sleep-waking rhythm, but also how to deal with coffee and alcohol, as well as with time spent lying awake.

Digitally-supported health promotion and disease prevention in settings and workplaces

The new version of the disease prevention guidelines adopted by the Administrative Council of the National Association of Statutory Health

Insurance Funds in September 2021 defines for the first time quality criteria for using digitally-supported health promotion and disease prevention in settings and workplaces. Corresponding criteria for digital applications in disease prevention for individuals had already been published last year.

Support for the long-term development of psychosocial health resources is now on an equal footing with support for coping with acute stressful situations.



More cooperation across society in disease prevention

In order to clearly emphasise the cross-society approach in disease prevention once again, the National Prevention Conference (NPC) launched pilot testing of cross-societal cooperation in 2021 on the topics of "Mental health in the family context", and "Health promotion and disease prevention in long-term care". Up to and including 2026, it is to be tested and evaluated how society-wide cooperation can succeed within

Support options are to be identified and interlinked with one another, and a cross-player as well as cross-policy-area approach is to be promoted.




the framework of the national disease prevention strategy, and which goals can be achieved. Support options are to be identified with the involvement of all relevant players and interlinked with one another, and a cross-player as well as cross-policy-area approach is to be promoted. The focus in the area of mental health is on children from families with addiction and mental problems. The focus with regard to long-term care is placed on professional long-term carers, relatives providing care, and people in need of long-term care.

Finding a consensus on joint goals

Time-limited goals were agreed on in workshops in April 2021 with the overall aim of promoting the health, safety and participation of these target groups. Exemplary measures were agreed on that can improve the framework conditions and strengthen the health resources of the target groups. Based on this, support contributions from the partners involved were collected for cooperation within society as a whole. There is to be a regular exchange in future on the focus topics with all those who have been involved so far, as well as with other relevant players.

Interim results in the second disease prevention report 2023

The NPC will already report on progress in its own respective areas of responsibility, as well as on interim results of pilot testing of collaboration across society as a whole, in its second disease prevention report 2023 spanning funding institutions. The report will be submitted to the Federal Ministry of Health in July 2023. The conception and preparation of the report will be supported in an advisory capacity by a scientific advisory board.

The National Prevention Conference

Detailed information on the NPC, and an overview of the support services provided by the NPC's funding institution, both for hospitals and long-term care facilities and for relatives providing care and voluntary long-term carers, can be found at:

www.npk-info.de/umsetzung/gesund-in-der-pflege

Backing for self-government from the Federal Social Court

The National Association of Statutory Health Insurance Funds has been obliged since 2016 to commission the Federal Centre for Health Education to support the health insurance funds in health promotion and disease prevention in settings, and to pay it an annual lump sum of approx. 35 million Euro from contributions, irrespective of the actual specific commissions and the work performed. This is regulated in section 20a subsections (3) and (4) of the Disease Prevention Act (*Präventionsgesetz*). The Administrative Council of the National Association of Statutory Health Insurance Funds was of the opinion from the beginning that this statutory provision was not compatible with either constitutional law or with the law relating to self-government. It therefore blocked the budgetary funds allocated for commissioning the Federal Centre for Health Education for 2016. The Federal Ministry of Health lifted the budget freeze by way of substituted performance. The National Association of Statutory Health Insurance Funds brought a court action against this measure under the law on supervision.

The Federal Social Court finds mandatory commissioning of the Federal Centre for Health Education to be unconstitutional

After Berlin-Brandenburg Regional Social Court had dismissed the action in early 2020, the National Association of Statutory Health Insurance Funds filed an appeal on points of law with the Federal Social Court. This was granted in full in May 2021. The Federal Social Court ruled that the Federal Ministry of Health's actions were formally unlawful. In addition, it found that the provisions on commissioning the Federal Centre for Health Education, as a federal agency, were unconstitutional in its view. Social security funds may not be misappropriated for tasks pertaining to society as a whole. Furthermore, according to the Constitution, social insurance tasks should be performed by independent public corporations. Transferring them to a direct federal authority such as the Federal Centre for Health Education was said to be in violation of the Constitution.

Social security funds may not be misappropriated for tasks pertaining to society as a whole.



Statutory Health Insurance Alliance for Health



GKV-Bündnis für
GESUNDHEIT

- The Statutory Health Insurance Alliance for Health is a joint initiative of the health insurance funds for health promotion and disease prevention in settings.
- Its activities are particularly aimed at target groups with social and health-related disadvantages, e.g. unemployed people, children and juveniles from families affected by addiction and mental stress, as well as older people.

Focal points:

- Health promotion in municipalities: More than 60 municipalities supported by the Alliance are working to establish municipal structures for health promotion and disease prevention, or to further develop them as needed.
- Reducing gender-related inequalities in health opportunities: Four promoted projects explore gender-specific characteristics in health promotion and disease prevention in settings.

Further information at: www.gkv-buendnis.de

It should furthermore be emphasised that the Federal Social Court has explicitly found that the National Association of Statutory Health Insurance Funds is the guardian of the interests of the members of the statutory health insurance funds. The Court held that, in this context for example, a constitutional review-and-reject competence was to be granted to the Association in supervisory proceedings.

Financing exclusively social security tasks

The judgment considerably strengthens the right of self-government in social insurance. The legislature will have to verify even more carefully in future whether a task that is financed with funds obtained from social insurance can actually be attributed to social insurance law. The National Association of Statutory Health Insurance Funds will continue to demand such verification.

Continuation of the Statutory Health Insurance Alliance for Health

Since ultimately only the Federal Constitutional Court can decide on the unconstitutionality of a provision, the legal norm remains in force for the time being despite the unambiguous assessment of the Federal Social Court. The latter Court did not consider that there was any possibility to refer the matter to the Federal Constitutional Court in Karlsruhe for an appropriate ruling, as the case had already been settled in favour of the National Association of Statutory Health Insurance Funds by granting the appeal on points of law concerning the supervisory order of the Federal Ministry of Health. The National Association of Statutory Health

Insurance Funds nevertheless discontinued payments to the Federal Centre for Health Education as a result of the Federal Social Court's ruling, and reached an agreement with the Centre, with the close involvement of the Federal Ministry of Health. The health insurance funds and the National Association of Statutory Health Insurance Funds consider

the arrangement for supporting setting-related health promotion and disease prevention which is entrenched in section 20a subsections (1) and (2) of Book V of the Social Code to constitute an important task of

statutory health insurance which must be implemented in statutory health insurance's own structures. They are committed to ensuring that the good initiatives of the Statutory Health Insurance Alliance for Health, which were developed as part of the commission to the Federal Centre for Health Education, in particular to improve the health opportunities of vulnerable groups, are continued and enhanced without the Federal Centre for Health Education. The legal basis for continuation as a joint task to be performed by statutory health insurance, without the Federal Centre for Health Education, needs to be redefined.

The good initiatives of the Statutory Health Insurance Alliance for Health are to be continued and enhanced, in particular to improve the health opportunities of vulnerable groups.



QUALITÄTSSICHERUNG

Evidenz

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Quality assurance in medical care

Important clarifications and changes for the further development of existing quality standards were made with the Act on the Further Development of Healthcare (*Gesundheitsversorgungsweiterentwicklungsgesetz – GVWG*) towards the end of the last legislative period. These concern minimum quantities, quality contracts, and transparency of quality.

Minimum quantities

Minimum quantities are a central instrument in in-patient care when it comes to ensuring a high quality of care and patient protection. The new provisions

contained in the Act on the Further Development of Healthcare on the Federal Joint Committee's minimum quantities arrangements aim to further enhance the implementation of the minimum quantities regulation. Important adjustments have thus been made in order to be able to enforce compliance with the minimum

quantities in a legally-certain manner. In addition, the planning authorities will no longer be able to grant exemptions on their own authority if targets have not been met. These are only possible for a limited period of time, and always also require the approval of the health insurance funds. Furthermore, the possibilities for the Federal Joint Committee to set new minimum quantities are being expanded: Individual minimum quantities can be combined with one another, and also supplemented by structural requirements. The enforceability of the Federal Joint Committee's mini-

mum quantities arrangement is improved by a clear legal safeguard in Book V of the Social Code: In the event of doubts regarding the correctness of a forecast submitted by the hospital for achieving the minimum quantities, the health insurance funds are now obliged to explain their doubts to the hospital in a decision (administrative act). It is furthermore clarified that court actions filed against this do not have any suspensive effect.

Quality contracts

The mandate to test quality contracts as an instrument of quality assurance was already established by the Hospital Structure Act (*Krankenhausstrukturgesetz*). It has been possible since 2018 to test quality contracts in four service areas defined by the Federal Joint Committee:

- endoprosthetic joint replacement
- prevention of postoperative delirium in the care of elderly patients
- cessation of respirator treatment for patients with prolonged ventilation treatment
- care of people with mental disabilities or severe multiple disabilities in hospital

Given that so far only a small number of contracts have been concluded (39, as of 14 December 2021), the implementation of the previously voluntary trial is to be regulated more stringently in order to establish the necessary data basis for a meaningful evaluation.

The enforceability of the Federal Joint Committee's minimum quantities arrangement is improved by a clear legal safeguard in Book V of the Social Code.

The new provision in the Act on the Further Development of Healthcare places the health insurance funds under an obligation to conclude quality contracts with hospitals and to spend a defined amount of Euros per insured person on this. The National Association of Statutory Health Insurance Funds will verify on an annual basis from 2022 to 2028 whether the health insurance funds reach the legally-stipulated spending volume of 0.30 Euro per insured person. If health insurance funds fall short of the stipulated amount, they must transfer the shortfall to the liquidity reserve of the Health Fund. The National Association of Statutory Health Insurance Funds has developed the necessary verification procedure together with the health insurance funds, and submitted it to the Federal Ministry of Health for approval in good time in October 2021. The procedure determines the lump sums to be taken into account in the expenditure volume of a health insurance fund for contract preparation.

The Federal Joint Committee has to expand the scope of application of the quality contracts from four topics to eight by the end of 2023. The National Association of Statutory Health Insurance Funds, together with the health insurance funds, has developed proposals for topics, and has introduced them into the consultation process. In addition, the defined duration of the trial was extended at federal level together with the German Hospital Federation. This gives the health insurance funds the opportunity to conclude new contracts or to extend their existing ones accordingly.

Transparency of quality

The regular publication of facility-based comparisons is intended to promote quality and transparency in in-patient and out-patient care. To this end, the Federal Joint Committee will define uniform requirements in a guideline by the end of 2022. These relate in particular to the content which will enable doctors to make data-driven recommendations in future, and patients to make an informed choice. The basis is formed by data from hospitals and contract doctors, as well as from health insurance funds, which are already available from the various quality assurance procedures. In addition, specifications are to be made on the type and scope of publication of the respective evaluation results.

The regular publication of facility-based comparisons is intended to promote quality and transparency in in-patient and out-patient care.

Quality requirements for domestic nursing care services

The National Association of Statutory Health Insurance Funds and the central organisations representing the interests of nursing care services have agreed to supplement the "Federal Framework Recommendations" in domestic nursing care in 2021. The aim is to achieve a high level of nursing care nationwide for insured persons with chronic and difficult-to-heal wounds by specialised healthcare providers.

Bearing care quality in mind

Qualified wound management is crucial to enable insured persons with chronic wounds to recover quickly. The National Association of Statutory Health Insurance Funds therefore focused on improving the quality of care in the negotiations on the requirements for

the care of chronic and difficult-to-heal wounds. In principle, the revised Federal Framework Recommendations are aimed at further developing the care structures. Insured persons with chronic and difficult-to-heal wounds are to be cared for primarily by specialised healthcare providers who have appropriately qualified nursing care specialists in future.

Enabling flexibility

This specialised care structure is being developed alongside safeguarding care within the framework of the existing services. Nursing care services are given the opportunity to gradually specialise in this care sector and to successively build up the skills of their staff through appropriate transitional arrangements. The Framework Recommendations thus offer the necessary flexibility for the requisite adaptation processes.

Insured persons with chronic and difficult-to-heal wounds are to be cared for primarily by specialised healthcare providers who have appropriately qualified nursing care specialists.

A special form of care

Wound management can also be provided in specialised facilities, outside the patient's own home, in accordance with the provisions contained in the Federal Joint Committee's guideline on domestic nursing care services, if this is necessary owing to the complexity of the care for the wound or the circumstances in the patient's own home. The Federal Framework Recommendations regulate the special structural requirements that these facilities must satisfy. The Framework Recommendations, supplemented by these regulations, came into force as of 1 January 2022.



Supplementing the Federal Framework Recommendations

The following regulations are to be implemented in care contracts concluded between health insurance funds and nursing care services:

- qualification requirements for the responsible managers and nursing care specialists involved in the care process
- structural requirements
- minimum content of nursing care documentation
- cooperation with others involved in care
- special structural requirements for suitable facilities outside the person's home
- transitional arrangements for existing healthcare providers

Trialling new examination and treatment methods

The benefit of new examination and treatment methods must be reviewed by the Federal Joint Committee before they are adopted into standard care. Until now, this review has been based on existing data as a matter of principle. The legislature however enacted a fundamental restructuring process in 2019. The Committee must now generate its own data for methods where the benefit does not yet correspond to the generally recognised state-of-the-art of medical knowledge by commissioning clinical studies. The costs for this are met by statutory health insurance.

Such studies may be prompted by the following circumstances:

- If it emerges in an assessment procedure that the benefit is not yet sufficiently proven, but that the potential exists to constitute a necessary alternative treatment, the Federal Joint Committee must adopt a trial guideline. The aim is to obtain the necessary information to complete the assessment procedure.
- Manufacturers of medical devices and other companies with a commercial interest may apply directly to the Federal Joint Committee to have a new method trialled.
- If a hospital submits information to the Federal Joint Committee on the use of a high-risk medical device which it considers is not yet being adequately reimbursed, the Committee examines whether it has been sufficiently proven that the method is beneficial. If this is not the case, the Committee must initiate a trial study if it has not been proven that the method and/or the product is harmful or ineffective.

Proof of benefit before the interest in remuneration

Five trial studies are already underway, and five are currently being prepared. The Federal Joint Committee is engaged in consultations on a trial guideline for a further ten topics (as of November 2021). Implementation presents the Committee with almost insurmountable challenges. The National Association of Statutory Health Insurance Funds estimates that the primary motive of medical device manufacturers and hospitals when engaging in many study projects is to achieve (better) remuneration. The level of interest in successfully completing a clinical trial appears to differ widely. Some of these methods are also at such an early, experimental stage of development that no sufficient data basis is currently available for planning a trial study. The Federal Joint Committee is nevertheless obliged by law to carry out such studies. It is questionable whether the goal of clarifying the benefit of innovative treatment methods as quickly as possible, which is relevant for the organisation of care, can be achieved for all the questions that arise. Given this circumstance, the National Association of Statutory Health Insurance Funds is calling for a reform of the legal basis in order to advance innovation management that is orientated towards providing a benefit for patients.

The National Association of Statutory Health Insurance Funds estimates that the primary motive of medical device manufacturers and hospitals when engaging in many study projects is to achieve (better) remuneration.

Merging cancer register data

The Act on Merging Cancer Register Data - Cancer Registry Data Act (*Gesetz zur Zusammenführung von Krebsregisterdaten – Krebsregisterdatengesetz*) came into force in August 2021. The Act makes changes, some of them far-reaching, to the Federal Cancer Registry Act (*Bundeskrebsregistergesetz*), to the organised cancer screening programmes, and to the clinical cancer registries.

Comprehensive data from epidemiological cancer registries on the incidence and mortality of cancer have been available for many years. They are brought together in the Centre for Cancer Registry Data (ZfKD) at the Robert Koch Institute. In addition, 18 clinical cancer registries have been fully established since the end of 2020. They record details regarding therapy and the progression of the cancer.

Combining clinical and epidemiological cancer registry data can help improve research and cancer treatment.

The Cancer Registry Data Act stipulates that these data are to be integrated into the Centre's dataset in future. This will create substantial added value for both

the Federation's health reporting, and for research and care, by providing an expanded dataset.

Successive expansion of the data

The second stage will create the basis for further data to be used for patient- and healthcare provider-related evaluations in research and care. The Federal Joint Committee is to determine cancer-specific mortality, and to identify interval carcinomas, for quality assurance purposes by comparing cancer register data with data from organised cancer screening programmes. The Act now creates opportunities to implement this reconciliation. The specific provisions on clinical cancer registries also create the necessary conditions for merging epidemiological and clinical cancer registry data, and further developing the requirements for uniform data collection. At the same time, the health insurance funds' financing arrangements are being changed, and an evaluation arrangement for the implementation of the clinical cancer registry is to be included. The commissioning of this newly-introduced evaluation has to be carried out jointly by the National Association of Statutory Health Insurance Funds and all the highest *Land* authorities responsible for the clinical cancer registries.

Keeping benefit and practicality in mind

Combining clinical and epidemiological cancer registry data can help improve research and cancer treatment. That said, many of the provisions contained in the Cancer Registry Data Act, especially those concerning the tasks and financing of the cancer registries, however also involve higher costs for statutory health insurance. These include expanding the diagnoses and the follow-up information that need to be collected, the repeated disbursement of the cancer registry lump sum, laborious data reconciliations, and the complex framework conditions for commissioning evaluations. The National Association of Statutory Health Insurance Funds considers that adequate consideration was given to neither the cost-benefit ratio, expediency, nor timely and comprehensive feasibility.

Six years of the Innovation Fund

The Innovation Committee that is part of the Federal Joint Committee has been promoting innovative care models and application-orientated care research since 2016. 507 projects are currently receiving funding. An annual funding volume of 300 million Euro was available from 2016 to 2019, and the amount per year has been 200 million Euro since 2020.

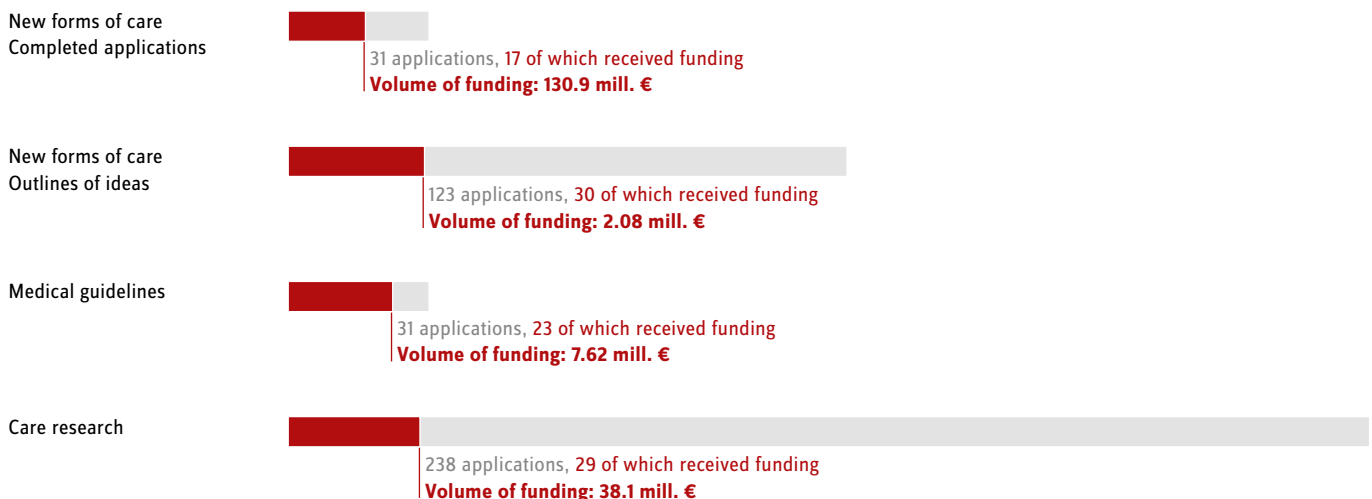
The Innovation Fund is now reaching a crucial phase in which it will become clear how many of the innovations that have been tested will actually be transferred to standard care, and which findings can be used. The Federal Ministry of Health is responsible for having the results of the Innovation Fund scientifically evaluated. A corresponding report will be presented to the German Bundestag in March 2022. The "traffic light" coalition partners however already agreed on the continuation of the Innovation Fund in the Coalition Agreement for the 20th legislative period.

Evaluation of new forms of care

The Innovation Committee published a funding announcement for the area of "New forms of care" in March 2021. 123 outlines of ideas with a requested funding amount of more than 8.71 million Euro were received in the two-stage application and funding procedure. One-third of the applications focused on the topical area of "Interdisciplinary or cross-sectoral care networks and pathways". The next step involved selecting those project ideas that were able to submit a fully-developed plan in the shape of a completed application within six months. The applicants were able to apply for up to 75,000 Euro from the Innovation Fund for the preparatory work. The Innovation Committee finally decided on the funding in the fourth quarter of 2021.

The continuation of the Innovation Fund was already agreed on in the Coalition Agreement for the 20th legislative period.

Funding decisions of the Innovation Fund in 2021



Transfer recommendations have already been published for a total of 52 completed projects.

Care research

Furthermore, the Innovation Committee published one funding announcement in June 2021 for each of the areas of "Care Research" and "Medical Guidelines". A total of 161 applications had been submitted for Care Research by the beginning of October 2021. One focus here was placed on the evaluation of digital healthcare. More than 190 million Euro were applied for. The Innovation Committee is expected to decide on funding in the second quarter of 2022.

Development and refinement of Medical Guidelines

The funding announcement for the development or refinement of selected medical guidelines provided for the following priorities:

- care for rare diseases
- care for more common diseases, treatment of risk factors for non-communicable diseases, multimorbidity and improving medicinal product therapy safety in care
- care for target groups with special needs (e.g. children, juveniles, the elderly and/or people in need of long-term care)
- operations on the skeletal/locomotor system

31 applications with a funding amount of more than 14 million Euro were submitted for this area up to the beginning of September 2021. The Innovation Committee is expected to decide on funding in the second quarter of 2022 here too.

Moreover, the Innovation Committee once more received large numbers of funding applications from health insurance funds, physicians' associations, hospitals, Universities and research institutes in 2021, and selected the most promising among them to receive funding.

Transfer recommendations

The Innovation Committee has the task of making recommendations on whether and how projects that have received funding should be transferred to standard care. Transfer recommendations have already been published for a total of 52 completed projects.

42 completed projects were evaluated in the area of "Care Research". It was recommended that the findings be put to use with regard to 19 projects, and no recommendation was made for 23 projects. A positive recommendation can include the following:

- forwarding information on the results to various stakeholders in the healthcare system
- forwarding with a request to verify whether the results can be put to use or implemented
- where appropriate, recommendation for further research to be carried out in follow-up projects

Ten projects were evaluated in the area of "New forms of care". Four of these projects received a recommendation for full or partial transfer to standard care. Three projects did not receive such a recommendation, but the project results were forwarded to various stakeholders in the healthcare system due to the positive trends that were identified.

The resolutions of the Innovation Committee, as well as the final reports from the projects, can be viewed by following this link: www.innovationsfonds.g-ba.de/beschluesse.

Making the fight against misconduct in the healthcare system more effective

“Offices responsible for combating misconduct in the healthcare system” have been set up at all health insurance and long-term care funds, at their associations, as well as at the National Association of Statutory Health Insurance Funds, in order to monitor and punish misconduct in the healthcare system. In order to promote the exchange of experience across organisations between the anti-misconduct offices, the National Association of Statutory Health Insurance Funds organised an event on the topic of “Making the fight against misconduct in the healthcare system more effective”. More than 300 participants from health insurance funds and criminal prosecution authorities accepted the invitation to attend this online event.

Prosecuting fraud and corruption in the healthcare system

In his opening speech, the Bavarian State Minister of Justice used the example of the new Central Office for Combating Fraud and Corruption in the Healthcare System (ZKG) at the chief public prosecution office in Nuremberg to explain that the special prosecutors at the Central Office will not only be supported by special investigators from the criminal police in future. Additional positions for medical billing specialists and IT forensic specialists have been created with the aim in mind of making criminal prosecution in the healthcare system more effective.




The first focus of the agenda was once more placed on the problems that arise with regard to prosecuting accounting fraud committed on a gang basis in nursing care services because this involves targetedly exploiting existing weaknesses in the control system. Regulatory shortcomings in social legislation were therefore pointed out, as seen by Augsburg criminal police station, and potential solutions were put up for discussion, e.g. the electronic recording of the start and end times of each assignment.

Accounting fraud in nursing care services involves targetedly exploiting existing weaknesses in the control system. Regulatory shortcomings in social legislation are revealed here.

The very large amounts of data that are secured during searches also pose a particular challenge. Representatives of Leipzig criminal police station and of the Fraunhofer Institute for Industrial Mathematics therefore provided information on the interim results of a third-party-funded project to make prosecution of long-term care fraud more effective. Handwritten entries in performance records, and entries in table form, as well as route plans and duty rosters, are to be digitalised using innovative procedures. The very time-consuming and labour-intensive manual inspection and evaluation of evidence is to be shifted to automated recording and evaluation in future, and will thus be considerably simplified.

Combating property crime and corruption in the healthcare system

(Specialised) public prosecution offices and specialist commissariats of the criminal police

-  Land-wide (specialised) public prosecution offices for property crime and corruption in the healthcare system
-  Land-wide investigation groups of the criminal police for property crime and corruption in the healthcare system
-  No public prosecution authorities specialised in this field

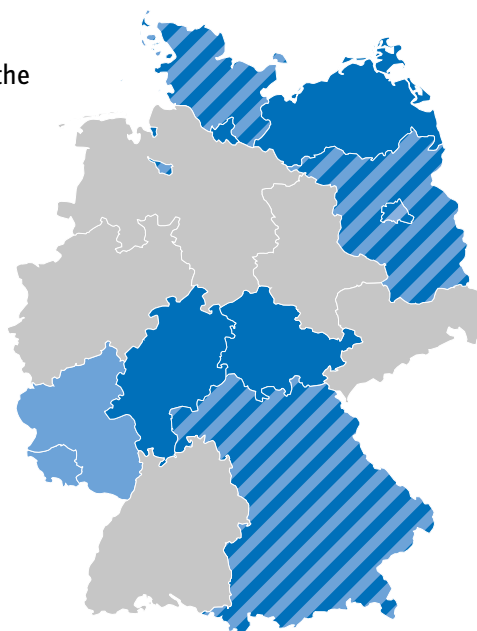


Illustration: National Association of Statutory Health Insurance Funds, Version: 1 June 2021

Effectiveness of crime prevention measures in the healthcare system

The presentation of the results of a criminological study on the effectiveness of crime prevention measures using the example of anti-misconduct offices in accordance with section 197a of Book V of the Social Code, in which large numbers of funds had participated, was eagerly awaited. The study was the first to provide empirical statistical evidence that institutionalised monitoring leads to a higher misconduct detection rate, and to a higher rate of reclaiming financial losses that have been incurred. In order to combat misconduct more effectively still, the author of the study proposes amongst other things that proactive measures on the part of the anti-misconduct offices be explicitly anchored in law.

Combating misconduct in the healthcare system using artificial intelligence

It became clear when two pilot projects were subsequently presented that misconduct could be combated more effectively by making targeted use of artificial intelligence. Billing data compiled across health insurance funds could be used to generate and analyse for instance patterns of suspicion that cannot be detected on the basis of the funds' own data. These patterns could then be applied to individual health insurance funds and lead to new cases of suspicion. This proactive approach can contribute to a new quality and quantity. The legal basis necessary for this would have to be expanded in the interest of legal certainty.

The need for action in the 20th legislative period

The participating experts agreed in the concluding panel debate that whistle-blowers must be protected from legal disadvantages in the future, not only when they report violations of EU law, but also when they provide information about misconduct in the healthcare system. With a view to the new legislative period, they advocated an evidence-based criminal policy. In exchanges with academia and practitioners, the new Federal Government should evaluate the new criminal offences of taking and giving bribes in the healthcare system that were created five years ago. Since it can be presumed that a considerable number of cases of accounting fraud and corruption in the healthcare system do not come to light, a study on unknown cases should furthermore be put out to public tender in order to investigate the extent of the problem in Germany more closely.



Städt
2010

**Beitrags-
finanzierung**

**Finanz-
autonomie**



FINANZEN



Gesamtge

Statutory health insurance financing stabilised for the time being

The financial result of the health insurance funds was negative in 2021 for the third year in a row. Following on from deficits of 1.7 billion Euro in 2019 and 2.7 billion Euro in 2020, a deficit of around 5 billion Euro is expected for the year under report. This result is solely due to the transfer of capital of the health insurance funds that was adopted by the legislature via the Healthcare and Long-term Care Improvement

89 of the 102 health insurance funds had to transfer 8 billion Euro of their fund-specific financial reserves to the Health Fund in 2021 in order to cope with the financing shortfall expected to result from the pandemic.

Act in December 2020: 89 of the 102 health insurance funds had to transfer 8 billion Euro of their fund-specific financial reserves to the Health Fund in 2021 in order to cope with the expected financing shortfall. Statutory health insurance would have achieved a positive result without this "capital levy" that was paid to the Health Fund. The Health Fund, on

the other hand, is expected to close 2021 with an income surplus of around 0.5 billion Euro. The financial result of statutory health insurance thus adds up to approximately -4.5 billion Euro.

Majority of health insurance funds keep contributions stable

By making considerable efforts for the interests of the contributors, it was possible to ensure that the health insurance funds were able to start the third year of the pandemic in 2022 with sufficient financial standing and, at the same time, with largely stable additional contribution rates. The majority of the health insurance funds financed by the Health Fund, of which there were only 96 as of the turn of the year due to mergers, were able to maintain their additional contribution rate as per the turn of the year; the weighted average additional contribution rate of all health insurance funds rose from 1.28 % (December 2021) to 1.36 % (January 2022).

As long as the Federation and the *Länder* continue to comprehensively fulfil their financial responsibility for civil protection in the pandemic, the health insurance funds will probably be able to fulfil their financing task without any relevant surges in contribution rates

One-off financial transfers 2021

	Legal basis	Payment amount in mill. Euro	Share acc. for by funding agencies
Supplementary federal subsidy to stabilise the average additional contribution rate	sec. 221a subs. (1) Book V Social Code	4,970	Federation: 37 %
Supplementary federal subsidy to compensate for the additional expenditure of the health insurance funds resulting from the additional "COVID childcare sickness benefit"	sec. 221a subs. (2) Book V Social Code	300	
Capital levy on the health insurance funds	sec. 272 Book V Social Code	8,000	Statutory health insurance: 63 %
Allocation from the liquidity reserve for partial compensation for the revenue shortfalls due to the introduction of an allowance on company pensions subject to contributions from 2020	sec. 271 subs. (4) Book V Social Code	900	
Total		14,170	

during the year. The Health Fund is however "on the edge" for 2022. If the development in the income trend does not exceed the forecast, the Fund will fall below the minimum reserve level for the following year at the end of 2022 - with far-reaching consequences for the financing of healthcare in 2023. Statutory health insurance financing from 2023 onwards is one of the most urgent tasks of the healthcare and financial policy of the "traffic light" coalition - in addition to coping with the coronavirus pandemic.

Financial development in 2021

The income of the members of statutory health insurance that is used as the basis for the assessment of contributions (basic wage and pension total) increased in the year under report by 2.9 % in comparison to the previous year, reaching 1,540.8 billion Euro. A general contribution rate of 14.6 % hence resulted in income from contributions amounting to approx. 225 billion Euro. Factoring in contributions from marginal employment (approx. 2.9 billion Euro), and with the Federa-

tion's contribution for non-insured services reduced by the share accounted for by the Agricultural Health Insurance Fund (14.4 billion Euro), the income of the Health Fund was 242.3 billion Euro. As it was foreseeable that this financial volume would not be sufficient in the second year of the pandemic to be able to maintain the average additional contribution rate at the level set by policy-makers of 1.3 %, the legislature increased the financial resources of the Health Fund by means of various financial transfers.

The largest item among these transfers is the capital levy which the law requires health insurance funds to pay: All health insurance funds that had financial reserves above 40 % of average monthly expenditure at the end of the second quarter of 2020 had to transfer 66.1 % of their surplus financial reserves in this regard to the Health Fund in the year under report. In addition to the capital of the health

All health insurance funds that had financial reserves above 40 % of average monthly expenditure by mid-2020 had to transfer 66.1 % of these reserves to the Health Fund in 2021.

One-off financial transfers 2022

	Legal basis	Payment amount in mill. Euro	Share acc. for by funding agencies
Supplementary federal subsidy to stabilise the average additional contribution rate	sec. 221a subs. (3) Book V Social Code in conj. w. Federal Subsidies Ordinance 2022	13,916	Federation: 87 %
Supplementary federal subsidy to compensate for the additional expenditure of the health insurance fund resulting from the additional "COVID childcare sickness benefit"	sec. 221a subs. (4) Book V Social Code	300	
Allocation from the liquidity reserve to safeguard funding of statutory health insurance in 2022	sec. 272a Book V Social Code	1,466	Statutory health insurance: 13 %
Allocation from the liquidity reserve for partial compensation for the revenue shortfalls due to the introduction of an allowance on company pensions subject to contributions from 2020	sec. 271 subs. (4) Book V Social Code	600	
Total		16,282	

insurance funds of 8 billion Euro that was collected by these means, the allocation for the partial compensation of the revenue shortfalls due to the introduction of an allowance on company pensions subject to contributions was also financed from statutory health insurance reserves, and thus by the contributors. The contributors' financing share of the one-off transfers totalled 63 %. Taking all financial transfers into account, the total income in 2021 amounted to approximately 256.4 billion Euro.

The health insurance funds have stable additional contribution rates on average in 2022.

Given the increased income, the Health Fund was able to finance in full the allocations of 255.0 billion Euro pledged to the health insurance funds for 2021. The

surplus funds were added to the liquidity reserve of the Health Fund. Taking into account its other statutory payment obligations, such as to the Innovation Fund and the Hospital Structural Fund, the Health Fund will close the year 2021 with a revenue increase of approximately 0.5 billion Euro. The liquidity reserve will thus amount to approximately 6.4 billion Euro as of 15 January 2022.

According to the statutory health insurance appraisers, the expenditure of the health insurance funds in 2021 amounted to approximately 272.2 billion Euro. It increased by 14.7 billion Euro, or 5.7 %, compared to the previous year. With allocations from the Health Fund to the health insurance funds amounting to around 255.0 billion Euro, the shortfall in the coverage of fund-relevant expenditure was therefore around 17.2 billion Euro. The additional contribution rates actually levied to fund this shortfall varied between 0.2 % and 2.7 %, bearing in mind the average additional contribution rate of 1.3 % set by the Federal Ministry of Health. No health insurance fund was able to forego levying an additional contribution in the year under report.

The financial forecast for 2022

At 2.4 %, the statutory health insurance appraisers unanimously still only anticipate a moderate increase in income subject to contributions, to reach 1,577.3 billion Euro for 2022. They estimate that income from contributions will be approx. 230.3 billion Euro on this basis, plus contributions from marginal employment amounting to approx. 3.0 billion Euro. The annual

Overview of anticipated revenue and expenditure in bill. Euro

	2021	2022
Anticipated revenue of the Health Fund	256.4	264.0
Allocations to the health insurance funds	255.0	263.7
Anticipated expenditure of the health insurance funds	272.2	284.2
Calculated shortfall in coverage of the health insurance funds	-17.2	-20.5
Calculated additional contribution rate requirement	1.12 %	1.30 %
Average additional contribution rate set by the Federal Ministry of Health	1.3 %	1.3 %

Source: National Association of Statutory Health Insurance Funds

contribution from the Federation for non-insurance services remains unchanged at 14.5 billion Euro. The total regular income thus amounts to around 247.7 billion Euro. In addition, there will be extraordinary income in the coming year to ensure that the average additional contribution rate does not rise above 1.3 % in the third year of the pandemic (Table 2).

The largest item in the one-off transfers to the Fund in 2022 is the supplementary federal subsidy of approx. 14 billion Euro, which is to be paid by taxpayers.¹ This measure was the prerequisite for a stable additional contribution level, as continues to be demanded by the legislature, as well as the consequence of the fact that the financial reserves of the health insurance funds have now been largely depleted. The Act on the Further Development of Healthcare of 11 July 2021 stipulates that the supplementary federal subsidy for 2022 is to be set in such a way that the average additional contribution rate can continue at 1.3 %. The Federation's financing share of the one-off transfers consequently amounts to 87 %. Taking into account all financial transfers, the income of the Health Fund will amount to approximately 264 billion Euro in 2022. The health insurance funds will receive around 263.7 billion Euro of this as guaranteed allocations, since the supplementary federal subsidy of 300 million Euro to compensate for the "COVID childcare sickness benefit" will not be paid to the fund as an increase in allocations. These funds remain in the liquidity reserve, although the health insurance funds are paying the pandemic-related additional expenditure.

The fund reserve will decrease by approximately 1.9 billion Euro to an estimated 4.5 billion Euro as per the end of 2022 due to the financing shares for the Innovation Fund and the Structural Fund that need to continue to be paid by the Health Fund in 2022, as well as to the statutory additions to the allocation volume amounting to approximately 2.1 billion Euro.

¹ The statutory health insurance appraisers still had to assume a supplementary federal subsidy of 7 billion Euro on 13 October 2021. It became clear when the German Bundestag approved the 2022 Federal Subsidy Ordinance on 18 November 2021 that the supplementary federal subsidy for 2022 would instead be 14 billion Euro. This is taken into account here in deviation from values established by the appraisers.

Based on the expenditure estimate for 2021, the statutory health insurance appraisers estimated the projected fund-relevant expenditure of the health insurance funds for 2022 to be 284.2 billion Euro. This corresponds to an increase of 12.1 billion Euro, or 4.4 %, compared to the previous year. The estimate particularly includes the anticipated financial impact of the COVID-19 legislation from 2021, as well as of the Act on the Further Development of Healthcare and of the Local Pharmacies Promotion Act.

This resulted in a projected shortfall in expenditure coverage of roughly 20.5 billion Euro for the health insurance funds in 2022. On the basis of the anticipated income subject to contributions, this results in a calculated additional contribution rate requirement of 1.3 %. The Federal Ministry of Health, which is responsible for the determination, has fixed the average calculated additional contribution rate at 1.3 %. The average additional contribution rate serves on the one hand as a relevant additional contribution rate for calculating

The legislature is called on to already initiate a sustainable reform of the financing of healthcare in the first half of 2022.



The basis for the calculation

The presentation of the financial situation of statutory health insurance is based on the results of the autumn forecast of the statutory health insurance appraisers of 13 October 2021. The financial impact of the 2022 Federal Subsidy Ordinance of 18 November 2021, and of the Act Amending the Infection Protection Act and Other Acts on the Occasion of the Rescission of the Determination of the Epidemic Situation of National Significance of 22 November 2021, was also taken into account. The financial data available at a later date, with the official statistics, in particular the other, non-Health Fund-relevant income and expenditure of the health insurance funds, are not yet taken into account here.

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Social Guarantee 2021

According to the Federal Government's "Social Guarantee 2021", the contribution rates to social insurance, financed on a parity basis, were not to rise above 40 % in total in 2021. The contribution rates for pension, unemployment, health and long-term care insurance added up to 39.95 % as per 1 January 2021, taking into account the average additional contribution rate of the health insurance funds of 1.3 %.

contributions for specific groups of members, e.g. for recipients of unemployment benefit II, and on the other hand as a benchmark for the health insurance funds.

Outlook

Despite all the vagaries of further developments in both the epidemic and the economy, it can be stated at this point in time that it was only possible to secure the financing of statutory health insurance in 2020 to 2022, years which were characterised by the coronavirus pandemic, by substantially depleting the financial reserves of the health insurance funds and of the Health Fund, with considerable supplementary financial transfers from the Federation, as well as moderate contribution rate increases at the beginning of 2021 and 2022. In view of the now diminished reserves, the reduced income base of health insurance due to the pandemic, as well as the foreseeable increase in expenditure, which is markedly higher than developments in basic wages, the need for reform is obvious. The legislature is called on to already initiate a sustainable reform of the financing of healthcare from 2023 onwards in the first half of 2022. Funding through contributions must be retained as the core element of statutory health insurance. At the same time, there must be a proper, consistent division of responsibility for tasks and for financing between the State and self-governing health insurance. The development of expenditure on benefits must be limited by introducing resource-efficient structural reforms.



zeitdaten

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EU cooperation on Health Technology Assessment

The Regulation on Health Technology Assessment was adopted by the European Parliament in December 2021. The European Commission submitted the underlying proposal as early as 2018. The aim is to make cooperation between national authorities in the scientific assessment of medicinal products and medical devices mandatory, and thus to further develop the work of the European network on health technology assessment.

The National Association of Statutory Health Insurance Funds welcomes the reorganisation

The National Association of Statutory Health Insurance Funds considers that there is now a sound basis for cooperation, with a strong role to be played by the relevant national institutions: The key decisions will be taken in a coordination group of the Member States, and not by the European Commission. The latter will only provide administrative support for cooperation.

The National Association of Statutory Health Insurance Funds particularly emphasised the need for high-quality joint assessments: These will follow

international standards of evidence-based medicine in future. The methods are to be reviewed regularly. The demand voiced by statutory health insurance for the greatest possible transparency in the evaluation processes and results was also met. The documents for the evaluation

processes and the results of all stages will be published on a publicly-accessible website.

It was possible to avert the complete harmonisation of clinical assessments for fundamentally all new medicinal products that are subject to the central approval procedure of the European Medicines Agency, as well as for specific medical devices. In addition, the originally rigid obligation to use the joint clinical evaluations as the sole basis for national decisions on pricing and reimbursement, without any evaluations of their own, was transformed into a binding regulation that is sufficiently flexible for the national healthcare systems.

Maximum benefit for insured persons

The National Association of Statutory Health Insurance Funds published a statement on the proposal for a regulation back at the beginning of 2018, and has been involved in the consultation process, also together with the German Social Insurance European Representation and the European Social Insurance Platform (ESIP). Talks were for instance held with the European Commissioner for Health, Vytenis Andriukaitis, and specialist events were organised. The National Association of Statutory Health Insurance Funds will also guide implementation with the aim in mind of ensuring the greatest possible benefit for insured persons.

The joint Health Technology Assessment will follow international standards of evidence-based medicine in future, whilst maintaining the greatest possible transparency.

A secure European Data Space

Better use is to be made in future of public sector data and of health data throughout Europe. In order to create a European Data Space, the European Commission has proposed a first step consisting of a legal framework, namely the Data Governance Act. Sector-specific regulations for the Health Data Space are to follow in 2022. The aim is to use more data for research and innovation, for example to develop new products and services. The data are also to be used to optimise healthcare systems and care, and to improve regulatory decisions.

Finding and using public sector data

Protected data that are held by public authorities are to be re-used as a matter of principle. The European Commission's proposal is that the data should also be used by third parties for commercial purposes. The Data Governance Act does not contain any obligation to disclose such data. If they are however made available, then this should be done comprehensively and according to clear rules. Exclusivity agreements are only permitted if they are necessary in the public interest. The Member States are obliged to create central bodies that bundle all available information and receive requests as to the continued use to which data may be put.

The EU would also like to increase the potential of health data. National and European health institutions such as medicines authorities, assessment bodies and the European Medicines Agency, for example, should have access to data in order to be able to make evidence-based decisions.

The funds as key players

German Social Insurance and the European Social Insurance Platform (ESIP) have contributed position papers, as well as participating in expert groups at EU level. They support the goal of enhancing access to data, as well as their usability and interoperability. At the same time, insured persons must be able to rely on the secondary use of data within the framework of a clearly-defined, delimitable care and governance mandate.

The data are to be used to optimise healthcare systems and care, and to improve regulatory decisions.

The health insurance funds should be considered not only as data providers, but also as key players in the Health Data Space, and should be involved from the outset. This includes having a say in the decentralised provision of anonymised data for research with actual added value in care and benefits for society as a whole.

Fighting cancer in Europe

The EU must pursue the financial sustainability of health systems as a goal in its medicinal product strategy.

"Europe's Beating Cancer Plan" is one of the European Commission's priority projects. It aims to take action in various policy areas at European level in order to improve disease prevention, diagnostics and treatment of oncological diseases, and to help improve the quality of life for EU citizens. Together with the German Social Insurance European Representation, the National Association of Statutory Health Insurance Funds has taken up the topic in an online conference.

Statutory health insurance is strongly committed to disease prevention, early detection and cancer treatment. According to the National Association of Statutory Health Insurance Funds, the EU can make an important complementary contribution here. The disease prevention programmes of statutory health insurance promote exercise, healthier nutrition and reducing tobacco and alcohol consumption. The EU has rightly set itself ambitious goals in this area too. According to the motto "tobacco-free generation", less than 5 % of the population are to use tobacco by 2040.

Higher taxes, less advertising

German Social Insurance also welcomes the first implementation steps taken by the initiative. At the same time, it has called for a clear EU framework and effective measures in tobacco and alcohol taxation, as well as for advertising for unhealthy food to be curbed, in particular to protect children and juveniles. During the panel debate, the European Commission's

Directorate-General for Health emphasised the impact that advertising has on children in particular. The European Commission will therefore critically review the Audiovisual Media Services Directive in respect of advertising for unhealthy products.

Keeping medicinal products affordable

Medicinal products play a central role in the fight against cancer. The European Parliament believes that high prices for medicinal products without a proven additional benefit are a problem in all EU Member States. The regulation on cooperation in Health Technology Assessment, which was adopted in December 2021, can help remedy this situation.

The National Association of Statutory Health Insurance Funds points out that the EU shares responsibility for ensuring an affordable supply of high-quality medicinal products: The EU must pursue the financial sustainability of health systems as a goal in its medicinal product strategy. Supply shortages of oncological and other medicinal products are unacceptable. Statutory health insurance is therefore calling for a joint digital reporting system and effective response capabilities in the EU. It welcomes the initiative to strengthen the European Medicines Agency by extending its powers.

Dr. Doris Pfeiffer, Chairwoman of the Board of the National Association of Statutory Health Insurance Funds, talking to presenter Frederike Gramm (left).



International exchange in response to the pandemic

The International Social Security Association (ISSA) is considered the world's largest and most important international organisation for social security institutions. It offers its members a good platform for networking, knowledge transfer and exchange of experience worldwide. Germany is represented in the ISSA by the National Association of Statutory Health Insurance Funds, the Pension and Accident Insurance, and the Social Insurance for Agriculture, Forests and Gardening. The National Association of Statutory Health Insurance Funds is represented on the ISSA's Board by Manfred Schoch, member of the Administrative Council of the National Association of Statutory Health Insurance Funds.

Cooperation on social and health protection

The coronavirus pandemic spotlighted the massive importance attaching to international cooperation in social and health protection, as pandemics do not stop at national borders. The ISSA has responded to this crisis with various measures: The ISSA established a COVID-19 monitor when the first wave of infections hit, and this was used to present the anti-pandemic measures taken by individual countries. ISSA members from all regions of the world reported to their colleagues on challenges, good practice and innovative solutions in some 80 webinars. More than 40 ISSA articles with in-depth analyses examined the wide range of measures taken by countries, and kept members up to date on strategies and approaches in the interest of monitoring best practice.

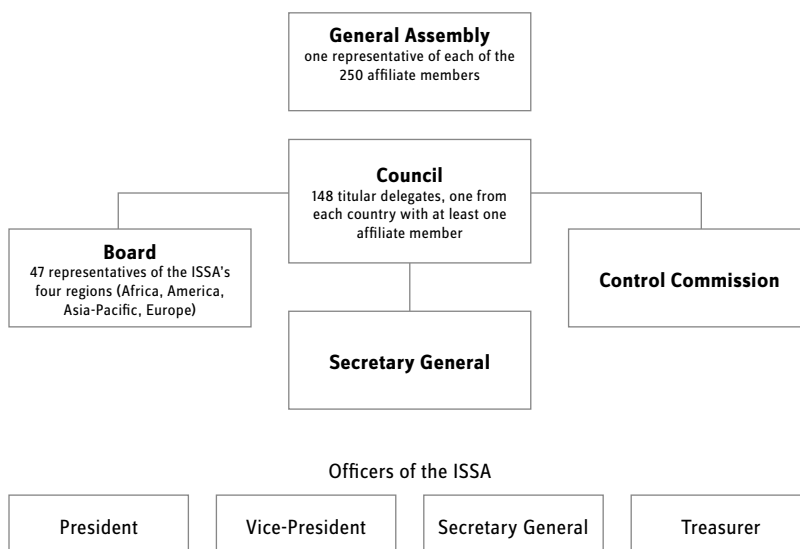
A strong international network

At the same time, the ISSA was able to intensify cooperation with the International Labour Organization, the Organisation for Economic Co-operation and Development, and the World Health Organization, on issues related to the economic, societal and social consequences of the pandemic and of pandemic response. New partnerships were established with the United Nations University and with the Institution of Occupational Safety and Health.

The National Association of Statutory Health Insurance Funds is a much sought-after partner at international level. It has received numerous requests from ISSA member organisations seeking to exchange experiences on topics such as long-term care insurance and long-term care, as well as digitalisation and system-related issues.

Massive importance attaches to international cooperation in social and health protection, as pandemics do not stop at national borders.

Structure of the ISSA



Digitalisation of cross-border claim settlement

The health insurance funds and the National Association of Statutory Health Insurance Funds, DVKA, have worked together in a two-year project to introduce electronic national settlement processes.

Most social security information at European level is now exchanged electronically within standardised processes and messages (Electronic Exchange of Social Security Information - EESSI). The National Association of Statutory Health Insurance Funds, German Liaison Agency Health Insurance - International (DVKA), has been able to send and receive electronic claim settlement messages within the EESSI procedure since December 2021.

Until now, only the actual invoice for the reimbursement of costs of cross-border assistance in terms of benefits in kind was exchanged electronically. Downstream operations such as complaints, credit notes or payment notices still had to be passed on in paper form between the Member States' liaison agencies.

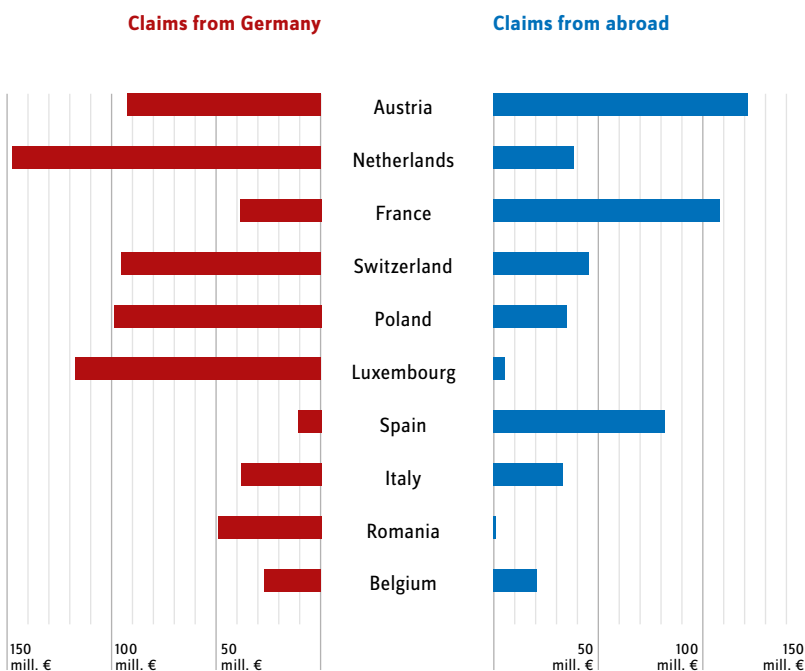
Better security, faster processing

Against this background, it is a considerable step forward in development to now be able to handle all the processes electronically. This also applies in particular to the complex "contestation procedure", as well as to payment processing. EESSI will significantly increase process reliability overall, and will reduce the processing time at the National Association of Statutory Health Insurance Funds, DVKA. This acceleration benefits compliance with the deadlines that are to be observed with regard to claim settlement, which is of particular importance in view of the cash flow of approx. 1.3 billion Euro per year.

Processes in Germany also modified

The introduction of cross-border electronic claim settlement processes goes hand in hand with the modernisation of the corresponding national processes. The exchange of data with the health insurance funds in claim settlement is now also carried out in electronic form. The health insurance funds and the National Association of Statutory Health Insurance Funds, DVKA, have worked together very successfully in a two-year project to achieve the major goal of introducing electronic national settlement processes together.

Claims in 2021
10 countries with the largest claims



Source and illustration: National Association of Statutory Health Insurance Funds

This means that it will be possible to exchange approx. 30 % of all future cost invoices electronically by the end of 2021. This share is expected to grow to more than 90 % by the end of 2022. For this to happen, it is necessary for the standardised EESSI procedures to also be implemented promptly by all other EU Member States.

Including partners outside the EU

The German health insurance funds and the National Association of Statutory Health Insurance Funds, DVKA, have successfully completed the electronic connection in European social security. It is now to be examined with the partners outside the EU, and with the Serbian and Turkish liaison bodies in particular, by when comparable procedures can be implemented.

Focus of communication in 2021

COVID, the Bundestag elections, and the financial situation, are the three key issues that characterise the central topics of the Association's communication, the common features of which being the various issues related to digitalisation.

The coronavirus pandemic

Special regulations on COVID had to be communicated and explained. Questions relating to responsibilities for the organisation and financing of tests and vaccinations were repeatedly the subject of media enquiries, and the question of long-COVID care also played an increasingly important role. The National Association of Statutory Health Insurance Funds repeatedly advocated COVID vaccinations via various press statements and in the social media.

Positions for the new legislative period

The National Association of Statutory Health Insurance Funds engaged in communication work alongside the position paper for the 20th legislative period 2021–2025 that it published in the summer, including press work and a focus page on the Internet. After the Bundestag elections, media attention focused on the plans of the new "traffic light" coalition. The National Association of Statutory Health Insurance Funds gave initial assessments of the Coalition's plans for healthcare and long-term care policy in a press release from the Administrative Council, as well as in interviews with board members and by answering journalists' enquiries.

Funding of statutory health insurance and social long-term care insurance

Funding of statutory health insurance statutory health insurance and social long-term care insurance was also a common theme in communications last year. The looming massive financial shortfall, caused by pandemic-related additional expenditure and falling income from contributions, but also by previous cost-driving reforms, was the reason for intensive press work. This was successful: A supplementary federal subsidy of 14 billion Euro was allocated for statutory health insurance for 2022. A federal subsidy for social long-term care insurance was also decided on for the first time.

Digital event formats

It was not possible for in-person "GKV Live" ("Statutory health insurance live") events to take place due to the pandemic. Instead, the Association offered a large number of specialist events in the form of hybrid online conferences which were streamed live. Two press conferences focusing on in-patient care were also held as hybrid events. The focus was placed on the findings from the first 14 months of the coronavirus pandemic, and on "Three pillars for good nursing care in hospitals".

Digitalisation

The three core elements of digitalisation – e-prescriptions, electronic medical records and electronic certificates of incapacity for work – reached major milestones in 2021, and these were accompanied both constructively and critically in the form of press releases, statements and tweets.

The need for long-term care

Measures to improve the home environment can help people stay in their own homes despite needing long-term care. A list of these measures that has been integrated into the homepage of the National Association of Statutory Health Insurance Funds shows the possibilities offered by long-term care insurance.

The looming massive financial shortfall was the reason for intensive press work. This was successful.

The budget and personnel work of the National Association of Statutory Health Insurance Funds

The annual financial statement for 2020

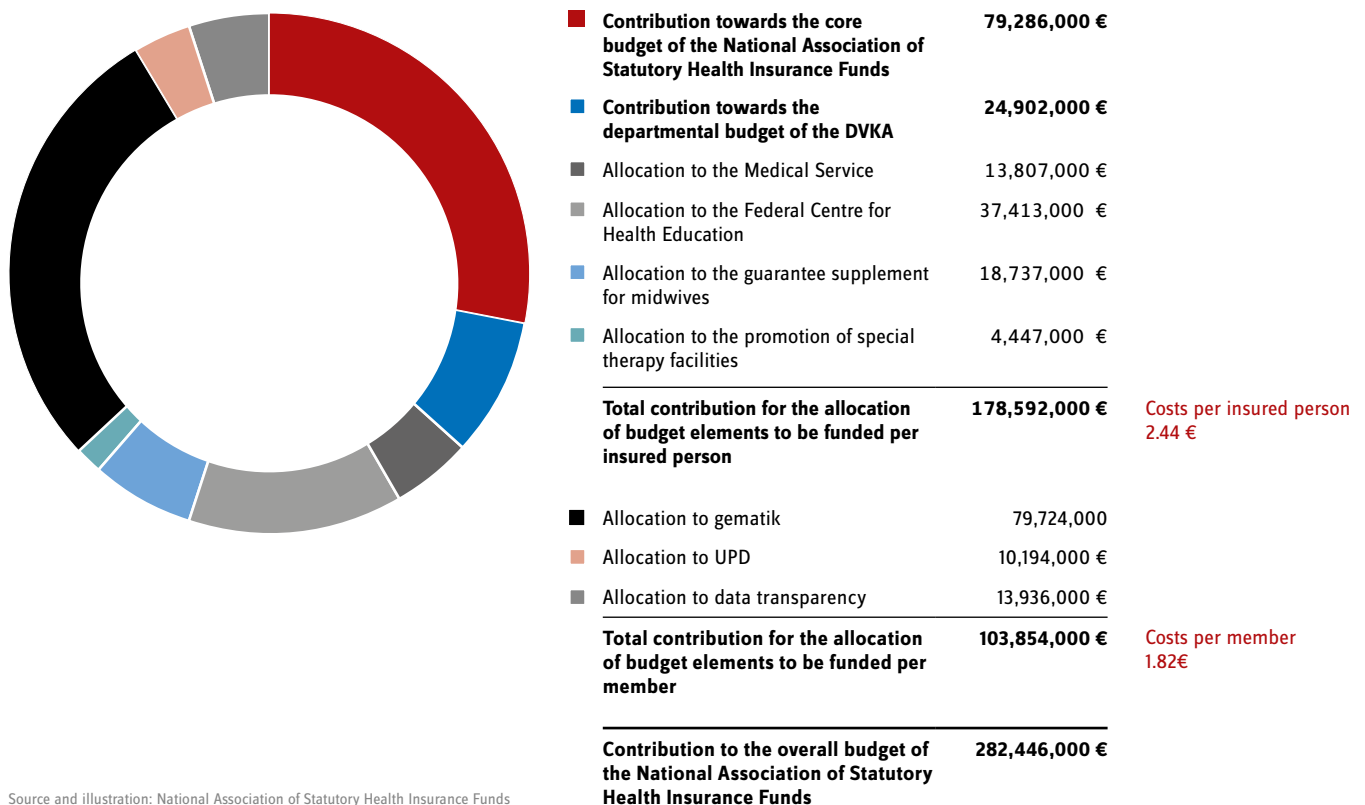
The annual financial statement of the National Association of Statutory Health Insurance Funds for 2020 was drawn up in April 2021. The audit, including the departmental budget of the German Liaison Agency Health Insurance - International (DVKA), was carried out by the KPMG AG firm of auditors. The planning and method for the implementation of "Physical Accessibility in the Administration Building of the National Association of Statutory Health Insurance Funds" were also audited. KPMG issued an unqualified audit report. The Administrative Council thereupon unanimously approved the 2020 annual financial statement and approved the activities of the Board in July 2021 in a written resolution procedure.

Contribution to the overall budget of the National Association of Statutory Health Insurance Funds 2021

The overall budget 2021 of the National Association of Statutory Health Insurance Funds shows an overall contribution of 282.4 million Euro which needs to be financed. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds and to the departmental budget of the DVKA, as well as the following pay-as-you-go arrangements which need to be financed:

- the Medical Service of the National Association of Statutory Health Insurance Funds (MDS)
- the Federal Centre for Health Education (BZgA) in accordance with section 20a of Book V of the Social Code
- the guarantee supplement for midwives in accordance with section 134a subsection (1b) of Book V of the Social Code

Contribution components of the overall budget of the National Association of Statutory Health Insurance Funds 2021



- the promotion of special therapy facilities in accordance with section 65d of Book V of the Social Code
- gematik GmbH in accordance with section 316 of Book V of the Social Code
- the promotion of consumer and patient advice facilities in accordance with section 65b of Book V of the Social Code
- data transparency in accordance with sections 303a to 303f of Book V of the Social Code

The overall budget for 2022

The overall budget for 2022 that was drawn up by the Board on 8 November 2021 was unanimously adopted by the Administrative Council on 10 December 2021 in a written resolution procedure, and approved by the Federal Ministry of Health, as the supervisory authority of the National Association of Statutory Health Insurance Funds, on 15 December 2021. The overall budget of the National Association of Statutory Health Insurance Funds for 2022 shows a contribution of

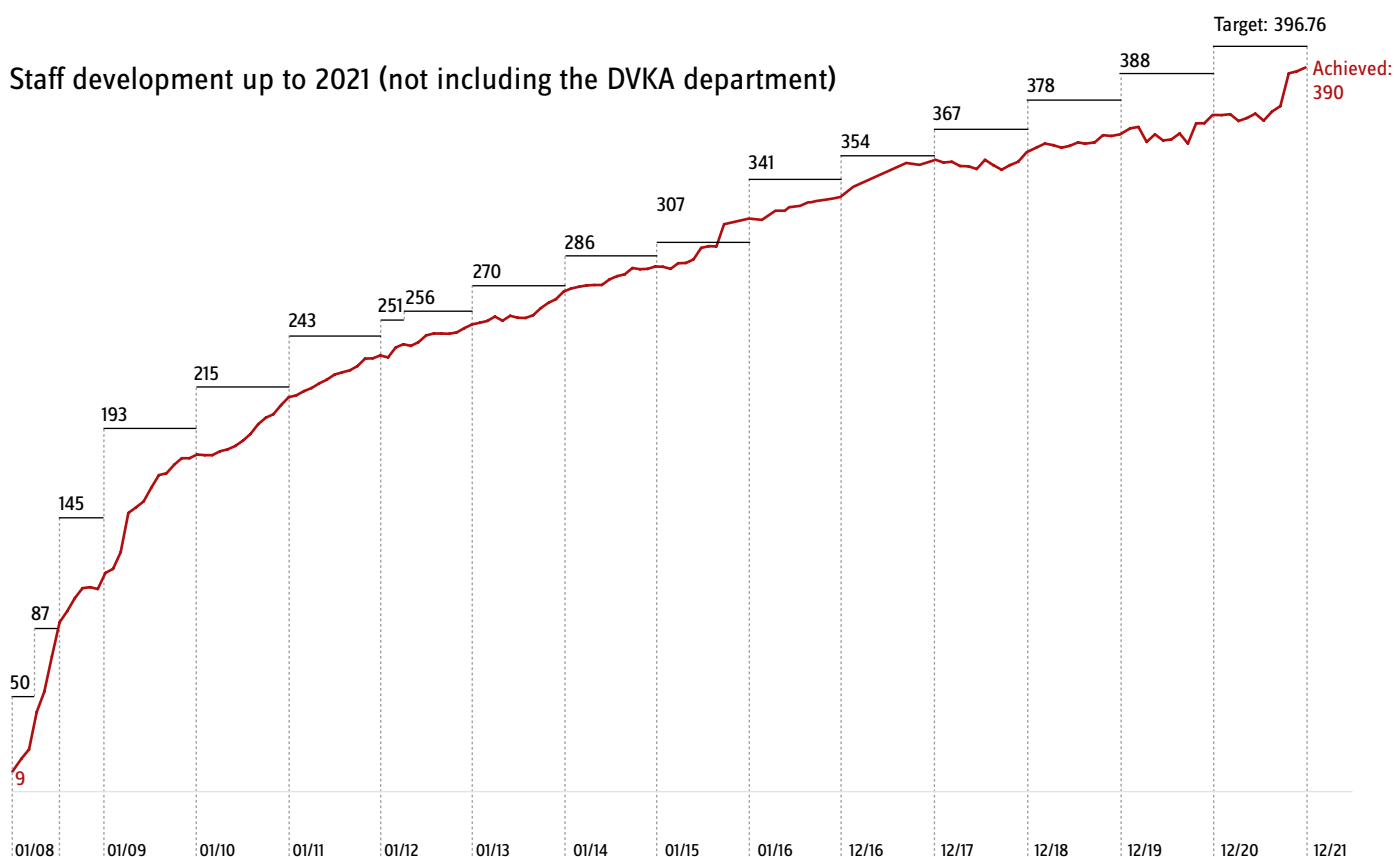
237.2 million Euro which is to be allocated to the member funds, and is thus 45.2 million Euro lower than in the previous year. This is primarily a result of the pay-as-you-go arrangement to fund the Federal Centre for Health Education and for the Medical Service which did not apply in the overall budget for 2022.

The personnel work of the National Association of Statutory Health Insurance Funds

The staff budget for 2021 totalled 519.62 established posts. 387.76 target posts were accounted for by the Berlin location, and 122.86 target posts by the DVKA.

505.29 posts were occupied on 1 December 2021, 389.85 of which at the Berlin location and 115.44 at the DVKA. The occupancy rate was 97.2 % for the Association as a whole. The occupancy rate at the Berlin location is 98.3 %, and 94.0 % at the DVKA.

Staff development up to 2021 (not including the DVKA department)



Source and illustration: National Association of Statutory Health Insurance Funds

The members of the National Association of Statutory Health Insurance Funds in 2021

- | | |
|--|--|
| 1. AOK - Die Gesundheitskasse für Niedersachsen | 44. BKK Public |
| 2. AOK - Die Gesundheitskasse in Hessen | 45. BKK Rieker.RICOSTA.Weisser |
| 3. AOK Baden-Württemberg | 46. BKK Salzgitter |
| 4. AOK Bayern - Die Gesundheitskasse | 47. BKK Scheufelen |
| 5. AOK Bremen/Bremerhaven | 48. BKK Schwarzwald-Baar-Heuberg |
| 6. AOK Nordost - Die Gesundheitskasse | 49. BKK STADT AUGSBURG |
| 7. AOK NordWest - Die Gesundheitskasse | 50. BKK Technoform |
| 8. AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen | 51. BKK Textilgruppe Hof |
| 9. AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse | 52. BKK VDN |
| 10. AOK Rheinland/Hamburg - Die Gesundheitskasse | 53. BKK VerbundPlus |
| 11. AOK Sachsen-Anhalt - Die Gesundheitskasse | 54. BKK Verkehrsbau Union (BKK VBU) |
| 12. Audi BKK | 55. BKK Voralb HELLER*INDEX*LEUZE |
| 13. BAHN-BKK | 56. BKK Werra-Meissner |
| 14. BARMER | 57. BKK Wirtschaft & Finanzen |
| 15. BERGISCHE Krankenkasse | 58. BKK Würth |
| 16. Bertelsmann BKK | 59. BKK ZF & Partner |
| 17. Betriebskrankenkasse Mobil | 60. BKK_DürkoppAdler |
| 18. Betriebskrankenkasse PricewaterhouseCoopers | 61. BKK24 |
| 19. BIG direkt gesund | 62. BMW BKK |
| 20. BKK Akzo Nobel Bayern | 63. Bosch BKK |
| 21. BKK B. Braun Aesculap | 64. Continentale Betriebskrankenkasse |
| 22. BKK BPW Bergische Achsen KG | 65. Daimler Betriebskrankenkasse |
| 23. BKK Deutsche Bank AG | 66. DAK-Gesundheit |
| 24. BKK Diakonie | 67. Debeka BKK |
| 25. BKK EUREGIO | 68. energie-BKK |
| 26. BKK EVM | 69. Ernst & Young BKK |
| 27. BKK EWE | 70. Handelskrankenkasse (hkk) |
| 28. BKK exklusiv | 71. Heimat Krankenkasse |
| 29. BKK Faber-Castell & Partner | 72. HEK - Hanseatische Krankenkasse |
| 30. BKK firmus | 73. IKK - Die Innovationskasse |
| 31. BKK Freudenberg | 74. IKK Brandenburg und Berlin |
| 32. BKK GILDEMEISTER SEIDENSTICKER | 75. IKK classic |
| 33. BKK Groz-Beckert | 76. IKK gesund plus |
| 34. BKK Herkules | 77. IKK Südwest |
| 35. BKK KARL MAYER | 78. Kaufmännische Krankenkasse - KKH |
| 36. BKK Linde | 79. KNAPPSCHAFT |
| 37. BKK MAHLE | 80. Koenig & Bauer BKK |
| 38. bkk melitta hmr | 81. Krones BKK |
| 39. BKK Miele | 82. Merck BKK |
| 40. BKK MTU | 83. mhplus Betriebskrankenkasse |
| 41. BKK PFAFF | 84. Novitas BKK |
| 42. BKK Pfalz | 85. pronova BKK |
| 43. BKK ProVita | 86. R+V Betriebskrankenkasse |
| | 87. Salus BKK |
| | 88. SECURVITA BKK |
| | 89. Siemens-Betriebskrankenkasse (SBK) |

-
- | | |
|--|------------------------------|
| 90. SKD BKK | 95. VIACTIV Krankenkasse |
| 91. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG) | 96. vivida bkk |
| 92. Südzucker BKK | 97. WMF Betriebskrankenkasse |
| 93. Techniker Krankenkasse | |
| 94. TUI BKK | |

cut-off date: 1 January 2022

Mergers

Merged fund

vivida bkk

BIG direkt gesund

VIACTIV Krankenkasse

bkk melitta hmr

Novitas BKK

BKK VerbundPlus

energie-BKK

BERGISCHE Krankenkasse

Merger partners

Schwenninger BKK
atlas BKK ahlmann

BIG direkt gesund
actimonda BKK

BKK Achenbach Buschhütten
VIACTIV Krankenkasse

BKK Melitta Plus
BKK HMR

Novitas BKK
BKK Siemag

BKK VerbundPlus
BKK Wieland

energie-BKK
BKK RWE

BERGISCHE Krankenkasse
BKK der Grillo-Werke AG

cut-off date: 1 January 2022

Ordinary members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 3rd period of office (2018-2023)

Representatives of insured persons

Name	Health insurance fund
Auerbach, Thomas	BARMER
Balser, Erich	Kaufmännische Krankenkasse - KKH
Beier, Angelika	AOK - Die Gesundheitskasse in Hessen
Berking, Jochen	BARMER
Breher, Wilhelm	DAK-Gesundheit
Brendel, Roland	BKK Pfalz
Date, Achmed	BARMER
Ermler, Christian	BARMER
Firsching, Frank	AOK Bayern - Die Gesundheitskasse
Hamers, Ludger	VIACTIV Krankenkasse
Holz, Elke	DAK-Gesundheit
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER
Keppeler, Georg	AOK NordWest - Die Gesundheitskasse
Klemens, Uwe	Techniker Krankenkasse
Kloppich, Iris	AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen
Kolsch, Dieter	AOK Rheinland/Hamburg - Die Gesundheitskasse
Lambertin, Knut	AOK Nordost - Die Gesundheitskasse
Lersmacher, Monika	AOK Baden-Württemberg
Linnemann, Eckehard	KNAPPSCHAFT
Märtens, Dieter F.	Techniker Krankenkasse
Müller, Hans-Jürgen	IKK gesund plus
Roer, Albert	BARMER
Römer, Bert	IKK classic
Schoch, Manfred	BMW BKK
Schröder, Dieter	DAK-Gesundheit
Schuder, Jürgen	HEK - Hanseatische Krankenkasse
Schultze, Roland	Handelskrankenkasse (hkk)
Stensitzky, Annette	Techniker Krankenkasse
Strobel, Andreas	Siemens-Betriebskrankenkasse (SBK)
Tölle, Hartmut	AOK - Die Gesundheitskasse für Niedersachsen
Wiedemeyer, Susanne	AOK Sachsen-Anhalt - Die Gesundheitskasse

Representatives of the employers

Name	Health insurance fund
Avenarius, Friedrich	AOK - Die Gesundheitskasse in Hessen
Bley, Alexander	SIEMAG BKK
Dohm, Rolf	pronova BKK
Empl, Martin	SVLFG
Hansen, Dr. Volker	AOK Nordost - Die Gesundheitskasse
Heß, Johannes	AOK NordWest - Die Gesundheitskasse
Jehring, Stephan	AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen
Landrock, Dieter Jürgen	AOK Baden-Württemberg
Leitl, Robert	BIG direkt gesund
Meinecke, Christoph	AOK - Die Gesundheitskasse für Niedersachsen
Nicolay, Udo	Techniker Krankenkasse
Parvanov, Ivor	AOK Bayern - Die Gesundheitskasse
Reyher, Dietrich von	Bosch BKK
Ries, Manfred	BKK ProVita
Ropertz, Wolfgang	AOK Rheinland/Hamburg - Die Gesundheitskasse
Neumeyer, Ronald-Mike	Handelskrankenkasse (hkk)
Thomas, Dr. Anne	Techniker Krankenkasse
Vogler, Dr. Bernd	AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse
Wegner, Bernd	Techniker Krankenkasse
Wollseifer, Hans Peter	IKK classic

Deputy members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 3rd period of office (2018-2023)

Representatives of insured persons

Name	Health insurance fund
Adrian, Quentin Carl	Techniker Krankenkasse
Aichberger, Helmut	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Balzer-Wehr, Dr. Alexandra	Kaufmännische Krankenkasse - KKH
Berger, Silvia	IKK Südwest
Böntgen, Rolf-Dieter	BERGISCHE Krankenkasse
Böse, Annemarie	DAK-Gesundheit
Brück, Peter	Kaufmännische Krankenkasse - KKH
Coors, Jürgen	Daimler Betriebskrankenkasse
Dehde, Klaus-Peter	BARMER
Dorneau, Hans Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Faber, Werner	AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse
Frackmann, Udo	Techniker Krankenkasse
Fritz, Anke	Kaufmännische Krankenkasse - KKH
Fritsch, Herbert	BARMER
Funke, Wolfgang	BARMER
Gosewinkel, Friedrich	Techniker Krankenkasse
Grellmann, Norbert	IKK classic
Hauffe, Ulrike	BARMER
Hindersmann, Nils	KNAPPSCHAFT
Hippel, Gerhard	DAK-Gesundheit
Huppertz, Claudia	BAHN-BKK
Johannides, Meinhard	DAK-Gesundheit
Karp, Jens	IKK - Die Innovationskasse
Klemens, Luise	DAK-Gesundheit
Korschinsky, Ralph	BARMER
Krause, Helmut	BIG direkt gesund
Kuklenski, Mirko	AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse
Lohre, Karl Werner	BARMER
Löwenstein, Katrin von	BARMER
Markiwitz, Diana	AOK Nordost - Die Gesundheitskasse
Nimz, Torsten	Handelskrankenkasse (hkk)
Plaumann, Karl-Heinz	BARMER
Roloff, Sebastian	DAK-Gesundheit
Schäffer, Lutz	AOK NordWest - Die Gesundheitskasse
Schmidt, Günther	BARMER
Schönewolf, André	AOK - Die Gesundheitskasse Hessen
Scholz, Jendrik	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg
Schümann, Heinrich Joachim	HEK - Hanseatische Krankenkasse
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse

Treuter, Uta	BARMER
Vieweger, Birgitt	BARMER
Wagner, Dieter	AOK Bayern - Die Gesundheitskasse
Wagner, Christine	mhplus Betriebskrankenkasse
Weilbier, Thomas	AOK Rheinland/Hamburg - Die Gesundheitskasse
Weinschenk, Roswitha	AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen
Wiedemann, Andrea	BARMER
de Win, Thomas	pronova BKK
Witte, Michael	Kaufmännische Krankenkasse - KKH
Wonneberger, Klaus	HEK - Hanseatische Krankenkasse
Zierock, Carola	AOK Nordost - Die Gesundheitskasse

Representatives of the employers

Name	Health insurance fund
Breitenbach, Thomas	Techniker Krankenkasse
Bußmeier, Uwe	Techniker Krankenkasse
Dick, Peer Michael	AOK Baden-Württemberg
Fitzke, Helmut	Techniker Krankenkasse
Franke, Dr. Ralf	Siemens-Betriebskrankenkasse (SBK)
Gural, Wolfgang	AOK Bayern - Die Gesundheitskasse
Heins, Rudolf	SVLFG
Heymer, Dr. Gunnar	BKK BPW Bergische Achsen KG
Hoffmann, Dr. Wolfgang	BKK Verkehrsbau Union (BKK VBU)
Japing, Kim Nikolaj	Techniker Krankenkasse
Kastner, Helmut	IKK - Die Innovationskasse
Kittner, Susanne	BAHN-BKK
Kruchen, Dominik	Techniker Krankenkasse
Lotz, Anselm	IKK Brandenburg und Berlin
Lübbe, Günther	Handelskrankenkasse (hkk)
Lunk, Rainer	IKK Südwest
Nobereit, Sven	AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen
Reinisch, Dr. Mark	BKK VerbundPlus
Runge, Uwe	IKK gesund plus
Schomburg, Uwe	AOK Sachsen-Anhalt
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg - Die Gesundheitskasse
Söllner, Wolfgang	AOK - Bremen/Bremerhaven
Stehr, Axel	AOK NordWest - Die Gesundheitskasse
Stollenwerk, Elmar	AOK Nordost - Die Gesundheitskasse
Strichertz, Stephan	AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse
Winkler, Walter	Techniker Krankenkasse
Wolff, Michael	AOK Niedersachsen

cut-off date: 1 December 2021

Ordinary and deputy members of the specialist committees of the Administrative Council

Specialist committee on fundamental issues and health policy

Chaired by: Stephan Jehring/Hans-Jürgen Müller (alternating)

Ordinary members

Employers' representatives

1. Jehring, Stephan (AOK)
2. Stehr, Axel (AOK)
3. Nicolay, Udo (EK)
4. Empl, Martin (SVLFG)
5. Dohm, Rolf (BKK)
6. Kastner, Helmut (IKK)

Representatives of insured persons

1. Märtens, Dieter F. (EK)
2. Balsler, Erich (EK)
3. Auerbach, Thomas (EK)
4. Schultze, Roland (EK)
5. Lersmacher, Monika (AOK)
6. Lambertin, Knut (AOK)
7. Müller, Hans-Jürgen (IKK)
8. Hamers, Ludger (BKK)

Deputy members

Employers' representatives

- Söllner, Wolfgang (AOK)
- Meinecke, Christoph (AOK)
- Breitenbach, Thomas (EK)
- Heins, Rudolf (SVLFG)
- Ries, Manfred (BKK)
- Leitl, Robert (IKK)
- Wollseifer, Hans Peter (IKK)

Representatives of insured persons

- Hippel, Gerhard (EK)
- 1st deputy on the list for insured persons 1-4
Breher, Wilhelm (EK)
- 2nd deputy on the list for insured persons 1-4
Korschinsky, Ralph (EK)
- 3rd deputy on the list for insured persons 1-4
Schümann, Heinrich J. (EK)
- 4th deputy on the list for insured persons 1-4
Kolsch, Dieter (AOK)
- 1st deputy on the list for insured persons 5-6
Weinschenk, Roswitha (AOK)
- 2nd deputy on the list for insured persons 5-6
Linnemann, Eckehard (Kn)
- 1st deputy on the list for insured persons 7-8
Strobel, Andreas (BKK)
- 2nd deputy on the list for insured persons 7-8
Scholz, Jendrik (IKK)
- 3rd deputy on the list for insured persons 7-8

Specialist committee on organisation and finance

Chaired by: Bernd Wegner/Andreas Strobel (alternating)

Ordinary members

Employers' representatives

1. Wegner, Bernd (EK)
2. Landrock, Dieter Jürgen (AOK)
3. Ropertz, Wolfgang (AOK)
4. Reyher, Dietrich von (BKK)
5. Ries, Manfred (BKK)
6. Lunk, Rainer (IKK)

Representatives of insured persons

1. Roer, Albert (EK)
2. Fritz, Anke (EK)
3. Stensitzky, Annette (EK)
4. Dreisbusch, Bernd (AOK)
5. Kloppich, Iris (AOK)
6. Tölle, Hartmut (AOK)
7. Baer, Detlef (IKK)
8. Strobel, Andreas (BKK)

Deputy members

Employers' representatives

- Lübbe, Günther (EK)
- Nobereit, Sven (AOK)
- Meinecke, Christoph (AOK)
- Bley, Alexander (BKK)
- Leitl, Robert (IKK)
- Wollseifer, Hans Peter (IKK)

Representatives of insured persons

- Schröder, Dieter (EK)
- 1st deputy on the list for insured persons 1-3
Balzer-Wehr, Dr. Alexandra (EK)
- 2nd deputy on the list for insured persons 1-3
Wiedemann, Andrea (EK)
- 3rd deputy on the list for insured persons 1-3
Firsching, Frank (AOK)
- 1st deputy on the list for insured persons 4-6
Lersmacher, Monika (AOK)
- 2nd deputy on the list for insured persons 4-6
Grabietz, Katharina (AOK)
- 3rd deputy on the list for insured persons 4-6
Brendel, Roland (BKK)
- 1st deputy on the list for insured persons 7-8
Berger, Silvia (IKK)
- 2nd deputy on the list for insured persons 7-8
N. N. (BKK)
- 3rd deputy on the list for insured persons 7-8

Specialist committee on disease prevention, rehabilitation and long-term care

Chaired by: Dietrich von Reyher/Eckehard Linnemann (alternating)

Ordinary members

Employers' representatives

1. Parvanov, Ivor (AOK)
2. Ropertz, Wolfgang (AOK)
3. Söller, Wolfgang (AOK)
4. Thomas, Dr. Anne (EK)
5. Reyher, Dietrich von (BKK)
6. Kastner, Helmut (IKK)

Representatives of insured persons

1. Date, Achmed (EK)
2. Holz, Elke (EK)
3. Gosewinkel, Friedrich (EK)
4. Düring, Annette (AOK)
5. Kolsch, Dieter (AOK)
6. Firsching, Frank (AOK)
7. Linnemann, Eckehard (Kn)
8. Schoch, Manfred (BKK)

Deputy members

Employers' representatives

- Nobereit, Sven (AOK)
- Heß, Johannes (AOK)
- Schomburg, Uwe (AOK)
- Fitzke, Helmut (EK)
- Franke, Dr. Ralf (BKK)
- N. N. (BKK)
- Runge, Uwe (IKK)
- Wollseifer, Hans Peter (IKK)

Representatives of insured persons

- Aichberger, Helmut (EK)
- 1st deputy on the list for insured persons 1-3
Hauffe, Ulrike (EK)
- 2nd deputy on the list for insured persons 1-3
Brück, Peter (EK)
- 3rd deputy on the list for insured persons 1-3
Lambertin, Knut (AOK)
- 1st deputy on the list for insured persons 4-6
Firsching, Frank (AOK)
- 2nd deputy on the list for insured persons 4-6
Wiedemeyer, Susanne (AOK)
- 3rd deputy on the list for insured persons 4-6
Brendel, Roland (BKK)
- 1st deputy on the list for insured persons 7-8
Römer, Bert (IKK)
- 2nd deputy on the list for insured persons 7-8
Scholz, Jendrik (IKK)
- 3rd deputy on the list for insured persons 7-8

Specialist committee on contracts and care

Chaired by: Martin Empl/Knut Lambertin (alternating)

Ordinary members

Employers' representatives

1. Avenarius, Friedrich (AOK)
2. Söller, Wolfgang (AOK)
3. Japing, Kim Nikolaj (EK)
4. Bley, Alexander (BKK)
5. Lotz, Anselm (IKK)
6. Empl, Martin (SVLFG)

Representatives of insured persons

1. Ermler, Christian (EK)
2. Katzer, Dietmar (EK)
3. Johannides, Meinhard (EK)
4. Schröder, Dieter (EK)
5. Lambertin, Knut (AOK)
6. Wiedemeyer, Susanne (AOK)
7. Brendel, Roland (BKK)
8. Römer, Bert (IKK)

Deputy members

Employers' representatives

- Schomburg, Uwe (AOK)
- Stollenwerk, Elmar (AOK)
- Parvanov, Ivor (AOK)
- Wegner, Bernd (EK)
- Reyher, Dietrich von (BKK)
- Runge, Uwe (IKK)
- Lunk, Rainer (IKK)
- Heins, Rudolf (SVLFG)

Representatives of insured persons

- Breher, Wilhelm (EK)
- 1st deputy on the list for insured persons 1-4
Plaumann, Karl-Heinz (EK)
- 2nd deputy on the list for insured persons 1-4
Aichberger, Helmut (EK)
- 3rd deputy on the list for insured persons 1-4
Nimz, Torsten (EK)
- 4th deputy on the list for insured persons 1-4
Lersmacher, Monika (AOK)
- 1st deputy on the list for insured persons 5-6
Tölle, Hartmut (AOK)
- 2nd deputy on the list for insured persons 5-6
Hindersmann, Nils (Kn)
- 1st deputy on the list for insured persons 7-8
Karp, Jens (IKK)
- 2nd deputy on the list for insured persons 7-8
Schoch, Manfred (BKK)
- 3rd deputy on the list for insured persons 7-8

Specialist committee on digitalisation, innovation and the benefit for patients

Chaired by: Robert Leitl/Jochen Berking (alternating)

Ordinary members

Employers' representatives

1. Breitenbach, Thomas (EK)
2. Meinecke, Christoph (AOK)
3. Söller, Wolfgang (AOK)
4. Dohm, Rolf (BKK)
5. Leitl, Robert (IKK)
6. Heins, Rudolf (SVLFG)

Representatives of insured persons

1. Berking, Jochen (EK)
2. Hoof, Walter (EK)
3. Vieweger, Birgitt (EK)
4. Kloppich, Iris (AOK)
5. Grabietz, Katharina (AOK)
6. Hamers, Ludger (BKK)
7. Krause, Helmut (IKK)
8. Hindersmann, Nils (Kn)

Deputy members

Employers' representatives

- Japing, Kim Nikolaj (EK)
- Landrock, Dieter Jürgen (AOK)
- Selke, Prof. Dr. Manfred (AOK)
- Ries, Manfred (BKK)
- Lotz, Anselm (IKK)
- Empl, Martin (SVLFG)

Representatives of insured persons

- Klemens, Luise (EK)
- 1st deputy on the list for insured persons 1-3
Gosewinkel, Friedrich (EK)
- 2nd deputy on the list for insured persons 1-3
Brück, Peter (EK)
- 3rd deputy on the list for insured persons 1-3
Löwenstein, Katrin von (EK)
- 4th deputy on the list for insured persons 1-3
Roloff, Sebastian (EK)
- 5th deputy on the list for insured persons 1-3
Dreisbusch, Bernd (AOK)
- 1st deputy on the list for insured persons 4-5
Wiedemeyer, Susanne (AOK)
- 2nd deputy on the list for insured persons 4-5
Strobel, Andreas (BKK)
- 1st deputy on the list for insured persons 6-8
Grellmann, Norbert (IKK)
- 2nd deputy on the list for insured persons 6-8
Linnemann, Eckehard (Kn)
- 3rd deputy on the list for insured persons 6-8

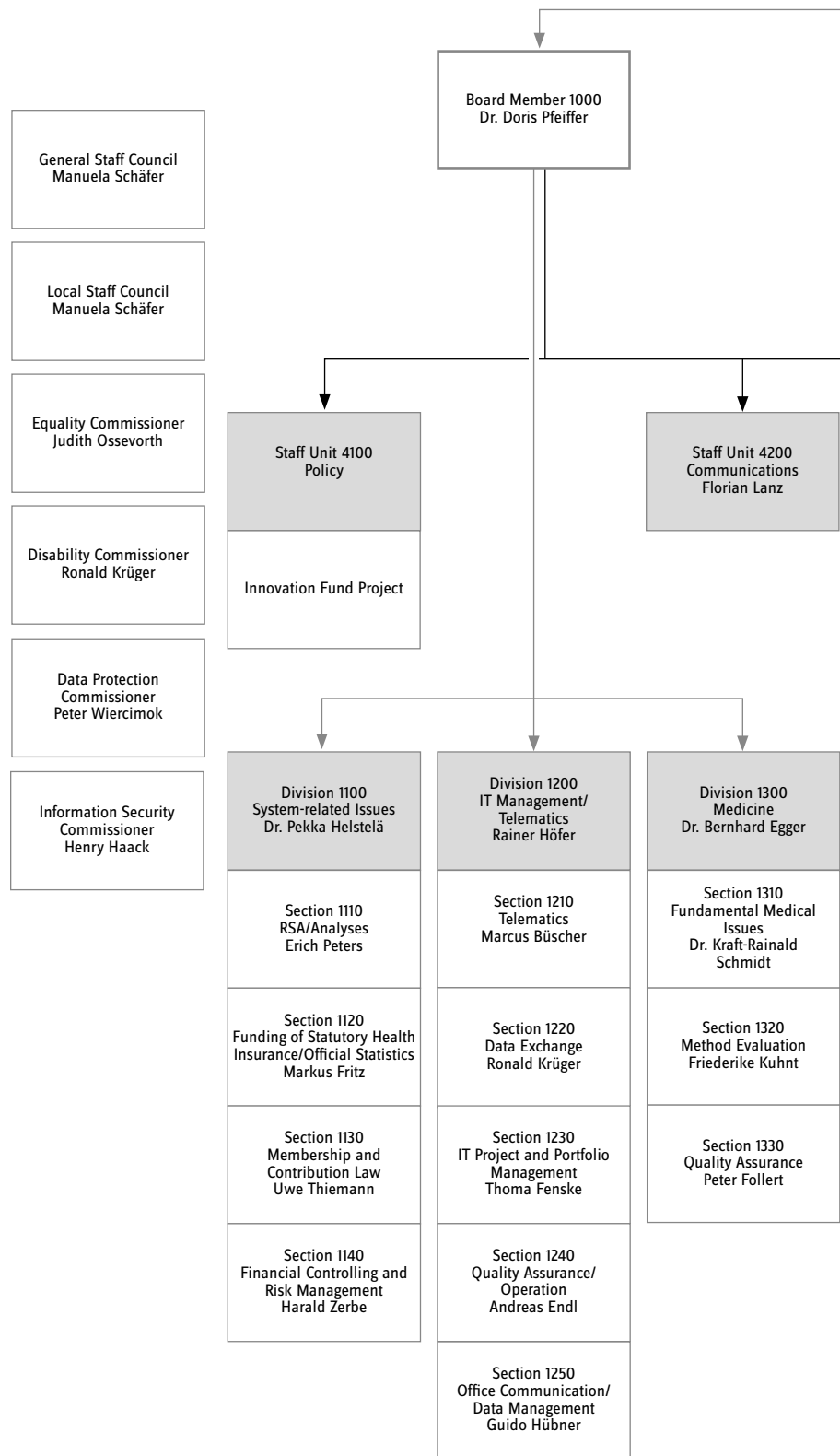
Cut-off date: 1 December 2021

Ordinary members and deputy members of the Steering and Coordination Committee

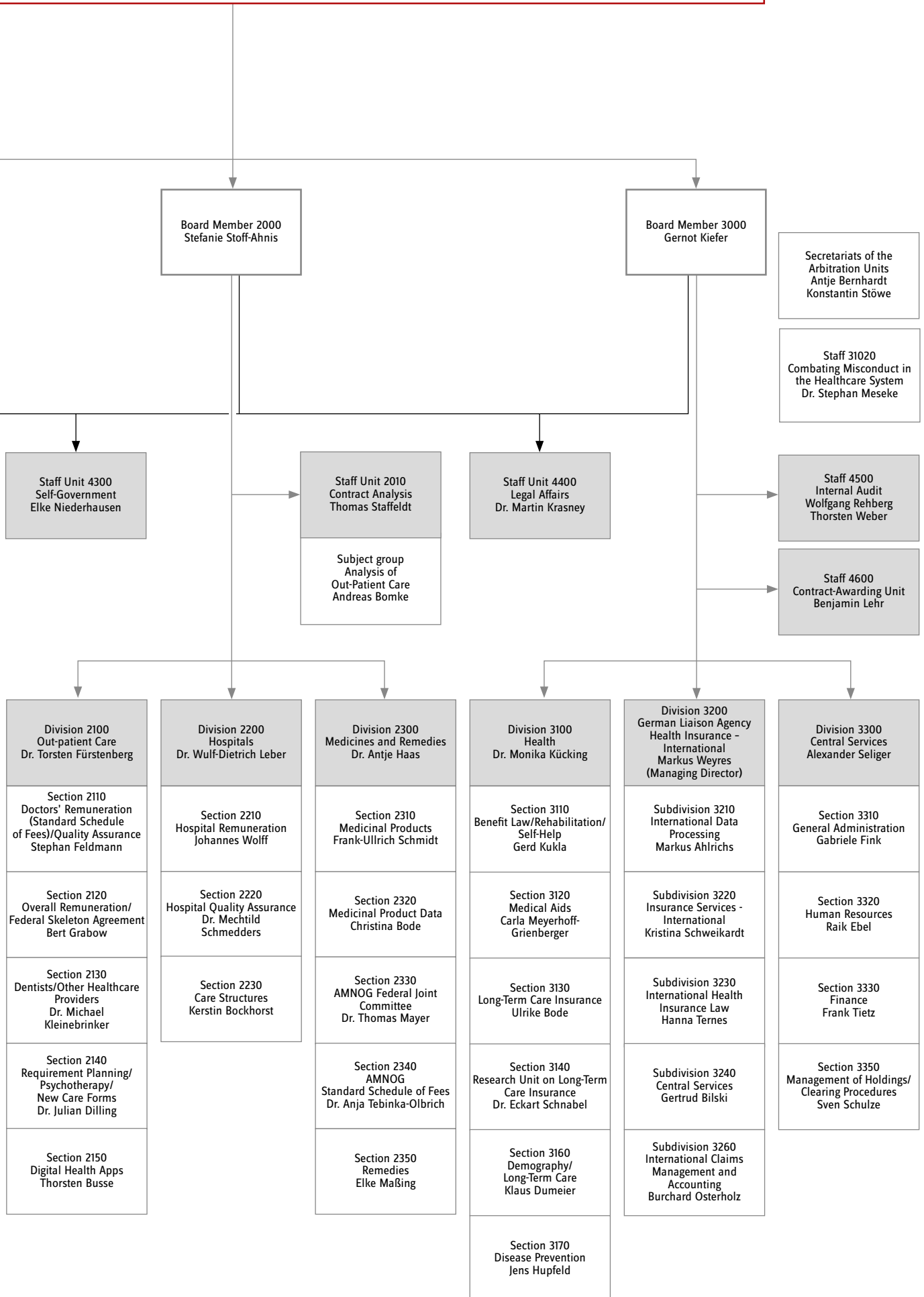
	Ordinary member	Deputy
AOK	Stippler, Dr. Irmgard (AOK Bayern)	Teichert, Daniela (AOK Nordost)
	Ackermann, Tom (AOK NordWest)	Striebel, Rainer (AOK PLUS)
BKK	Galle, Andrea (BKK VBU)	1st deputy Demmler, Dr. Gertrud (SBK) 2nd deputy Stamm, Sabine (BERGISCHE Krankenkasse)
	Fuchs, Gerhard (Audi BKK)	1st deputy Kaiser, Lutz (pronova BKK) 2nd deputy Gerhardt, Jens (BMW BKK)
EK	Walkenhorst, Karen (TK)	no deputy
	Kafka, Torsten (HEK), since 16 Jun 2021 for Dr. Mani Rafii	Bodmer, Thomas (DAK-Gesundheit)
IKK	Hippler, Frank (IKK classic)	1st deputy Kaetsch, Peter (BIG direkt gesund) 2nd deputy Loth, Prof. Dr. Jörg (IKK Südwest)
KNAPPSCHAFT	am Orde, Bettina	Held, Heinz-Günter
SVLFG	Sehnert, Gerhard	Lex, Claudia

Organisational chart

National Association of Statutory Health Insurance Funds



Administrative Council



Publications

Position papers

Author(s)	Title	Publication date
GKV-Spitzenverband	Positionspapier des GKV-Spitzenverbandes für die 20. Legislaturperiode 2021-2025	June 2021
GKV-Spitzenverband	Echte Arzneimittelinnovationen fördern und die Versorgung stärken. Positionspapier des GKV-Spitzenverbandes zu patentgeschützten Arzneimitteln	July 2021

Series of publications on long-term care

Author(s)	Title	Publication date
GKV-Spitzenverband	Schriftenreihe Pflege, Band 19: Forschung für die Pflege. Impulse zur Weiterentwicklung der Pflegeversicherung	December 2021

Other publications

Author(s)	Title	Publication date
GKV-Spitzenverband, MDS	Präventionsbericht 2021. Berichtsjahr 2020	November 2021
GKV-Spitzenverband	Leitfaden Prävention. Handlungsfelder und Kriterien nach § 20 Abs. 2 SGB V	November 2021

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