

# Project Report on Cross-region Medical Insurance Management in Germany and Poland

Under the EU-China Social Security Co-operation Reform Project, the delegation of 9 members from the Department of Medical Insurance of MOHRSS, National Information Center, Social Insurance Center and medical insurance agencies in Tianjin, Liaoning, Jiangsu, Zhejiang, Fujian and Hubei provinces makes an investigation on medical insurance system and cross-nation insurance management in Germany and Poland from May 10 2009 to 22 2009. During the stay in Germany, representatives have visited the Department of International Cooperation of the Ministry of Health, AOK Health Insurance Funds, AOK Telephone Enquiry Center and its sub-branch in Aachen, Affiliated Hospital to the University of Aachen; while in Poland, they have paid a visit to Polish Ministry of Health, National and Krakow Medical Insurance Funds (NFZ), as well as St. Paul's Hospital. Relevant institutions in both countries pay more attention to this study tour, and have made every preparation while providing many valuable materials which give us a very good chance to get familiar with the medical insurance system in both countries. This study tour is supported by EU-China Social Security Co-operation Project, and accompanied by the international expert Mr. Hubert and Ms. Fei Jing from the Project Office. Their thoughtful arrangements have led to a focused, comprehensive and fruitful investigation. Through the study tour, representatives have a deepened understanding of the medical insurance

system and its management in Germany and Poland, and get familiar with EU member states' cross-border and cross-region medical insurance practices and service management which are of great importance.

Please find the detailed project report:

## I Germany

### i Basic information on medical insurance system

Germany is the world's first nation formulating social security system by law. German regulated medical insurance is a compulsory insurance initiated and promoted by the Federal Government. At present, there is around 90% of the total population (i.e. 72 million) joining this system. The contribution rate reaches 14.5% of the total income which is shared by both employers and employees. Besides, the employee should contribute another 0.9% sick allowance. This kind of insurance runs under the principle of "giving relief to both poor and rich, being jointly insured by family".

The contribution rate for German medical insurance is regulated by the Ministry of Health with unified standard. Contributions are collected by professional institutions within certain period, and then formed as health funds. Federal Health Affair Administration Bureau works according to the same principle and regulations under the criteria of age group and the condition of incidence which are provided by the regional insurance agencies, and establishes "risk buffer funds" for the purpose of avoiding the deliberate selection of the insured people to keep equality and social justice. The unified health funds are established at the beginning of 2009.

German government has reformed on social security policies in recent years to cover the deficits which are caused by inadequate contribution and excessive payment, such as making limitation on the medical insurance coverage, raising employees' contribution rate, etc. to control the rapid grow of medical expenses; meanwhile, the Government has increased medical insurance allowance of € 4 billion as the annual investment to medical insurance funds, and the investment should be increased by € 1.5 billion per year and finally reach € 14 billion by 2016. The Government has put € 3.2 billion one-shot investment as the starting fund for health; governmental financial subsidies take 8% of the total contributions which are unprecedented. Consequently, the regulated contribution ratio has lowered by 0.6% and therefore helped employers' contribution alleviation under global financial crisis so as to improve investment environment and increase their international competitiveness.

German private medical insurance is a vital supplement to regulated

medical insurance, and the insured takes about 10% of Polish population. The private insurance plays a positive role in meeting civil and public servants', self-employed and decent-income earners' demand. Different from the regulated contribution ratio of the regulated medical insurance, private medical insurance should make confirmation on possible diseases of the insured and then fix the contribution. In addition, this insurance works under the principle of the equality of rights and duties, that is, one contributes, he gets the returns.

#### ii Medical Insurance Management

German medical insurance is jointly managed by governmental and autonomous administration organizations. Federal Ministry of Health is in charge of making law and regulations on fund collection and medical services, and it as well makes nationwide supervision over medical insurance management. Autonomous organizations including National Medical Insurance Committees at all levels, national insurance institutions (e.g. AOK), Hospital Association and Insurance Certificated Doctors' Association are responsible for the implementation of related law and regulations, compilation and completion of the medical service list, consultation and supervision of the price, quantity and quality of insurance services. From the perspective of graded control, federal, state and district governmental and autonomous departments have different rights and obligations. National departments and institutions are in charge of making policies; and state governments also play a part in policy-making and conducting medical insurance and management policies under the same criterion.

German government pays more attention to medical cost audit and the academic research on normalized medical services. Financed by hospitals and medical insurance funds, the specific research center studies on medicine economics, health economics and so on, fixes and revises DRG contribution terms, makes arbitrations on medical expenses disputes, provides professional support to technical problems. The above methods pave the way for enhancing the scientificness of medical service management and of the standardized administration.

Since there are no designated medical insurance agencies in Germany, the market-oriented mechanism leads to the fierce competition among these agencies. There were over 12,000 approved insurance agencies in 1989; however, this number is sharply shrunk to about 250 by 2004 mainly due to enterprise merging. At present, there are 193 agencies under 6 categories, and this number is still shrinking; it is estimated that there would be only 50 institutions by 2015, and the insured people who join compulsory insurance may arbitrarily choose any agency. Insurance institutions sign agreements with Hospital Association, Insurance Certificated Doctor Association, Pharmacists' Federation, etc. rather than with medical institutions. Hence, there are little differences in service

quality, and these medical institutions make competence in terms of price and quality. The doctor could provide medical treatment to the insured patients and get payment from medical insurance funds after becoming a member of the National Medical Technicians' Federation which is entitled according to medical insurance law or regulations.

In Germany, outpatient and hospitalized services, medical care and medicine-selling are provided by different sectors. Basic outpatient service can be achieved by family doctor and local clinics which are conducted under the direction of National Medical Insurance Technicians' Federation. In case a patient needs further medical treatment in specialty hospital, the therapist should at first make appointment at another hospital; the patient could to after getting the approval; therefore, problems such as long-time waiting, failing to wait till the booked time lead to the turning to private clinics and more un-reimbursed expenses. The insured could take the description to the pharmacy for medicine; specialty hospital only provides medicines for hospitalization.

Outpatient expenses are extracted from the total budget with certain amount of state installment without specific regulation on every clinic or doctor, which means that the insured person could choose the clinic and doctor he wants to visit. Hospitalization expenses are paid according to DRG regulations. At present, Germany is among the top nations running under DRG management regulations after setting up the scientific and feasible DRG regulations for over 1100 categories.

### iii Cross-region(cross-nation) Medical Care Management

Coordination related to the receiving of medical treatment for the insured person is headed by German Ministry of Labor and Social Security; however, the implementation of such specific issues is made by the International Liaison Office. German Medical Insurance Liaison Office (DVKA) is now a sub-branch of National Medical Insurance Committee (also called National Medical Insurance Federation, Supreme Federation, Federal Commission), and responsible of the payment and coordination of medical insurance, medical care insurance and child-birth insurance for the cross-nation migrant beneficiaries, publicity of the new medical insurance policies of other nations; and the medical insurance agencies; beneficiaries could get all information from the website. The Liaison Office has over 1000 staff and signs co-operation agreements with 40 nations. Cross-border medical expenses clearance only provides balance sheets rather than materials relevant to medical services to avoid complicated procedures and to promote mutual trust. German Medical Insurance International Liaison Office deals with around 1 million cross-border patient' cases per year, which takes 1.39% of the total number of legally insured population and costs about € 500 million; among these, there are only 5% have different ideas on the issue, and these cases could be solved by submitting relevant statements.

Cross-border medical care management runs under the supervision of the 1408 Regulation (1408/71) in 1971 and the 574 Enforcement Regulation (574/72) in 1972, which have regulated that the insured person could move freely, and expense reimbursement should be in line with working state's law. The Regulation has made every detailed explanation on how could migrant workers get medical insurance, old-age insurance, injury insurance, unemployment insurance as well as family allowance. Cross-border insured people could get medical treatment in the working state while his residence is in another state (except for transference) and receive reimbursement by local medical institutions.

We have also found the fact that, the EU health insurance card which we are quite familiar with has restriction on holders and relevant medical services. This card is firstly in use within 13 EU member states on June 1 2004 and followed by other 14 nations; till 2008, there are 173 million people become beneficiaries. The purpose of issuing this card is to lead to more convenient medical services within EU members for card holders, and to simplify expense reimbursement. This card is issued by corresponding medical insurance organizations in the state where he is insured, and has validity restriction mainly on the period of short-stay in other nations, such as working, study etc., the regulated medical treatment only covers emergency treatment for beneficiaries.

German medical insurance card has two main functions: one is to claim for domestic medical expenses, the other is to clear cross-border medical expenses within EU member states as the EU medical insurance card. The insured could apply for the temporary opening of the EU medical insurance card which leads to accessible medical services within EU states; and the expenses could be cleared by the Medical Insurance International Liaison Offices.

#### Chart of Cross-border Medical Expenses Clearance (e.g. Short-term Stay)

( 1 ) EU patient shows his EU medical insurance card while visiting a German doctor →(2) the doctor sends the detailed balance sheet to KV (National Medical Insurance Approved Medical Technicians' Association)→ ( 3 ) KV sends relevant documents to local medical insurance institutions for reimbursement → ( 4 ) The institution checks the claiming form, and transfers money to KV (i.e. advance payment), then fills E125 form and sends it to DVKA (German Medical Insurance International Liaison Office) → ( 5 ) DVKA sends the form to the

International Liaison Office in the insured state → ( 6 ) the Liaison Office in the insured state applies for reimbursement to relevant agencies → ( 7 ) agencies transfer the money to the International Liaison Office in the insured state → ( 8 ) the International Liaison Office in the insured state transfers to DVKA → ( 9 ) DVKA transfers to German institutions who have paid advance payment.

From the above procedure, the migrant insured person could receive convenient medical services in other nations; however, the complicated procedure for money transfer among relevant agencies leads to delayed capital withdrawal.

The insured person who becomes a permanent settler in another state after retirement could receive local medical treatment according to EU regulations; all expenses should be settled by the medical insurance agencies in the insured state and resident state, and be paid under certain criteria to institutions in resident state by insured state and administrated by the medical insurance agencies in residence. During the study tour, AOK's Aachen Office has introduced an example of the Dutch insured persons who move to Aachen after retirement. These Dutch retirees' medical expenses are paid to AOK Aachen Office under the agreement reached by both Netherlands and Germany.

Cross-region medical expenses should be paid in advance by local agencies, and then be cleared among agencies in other regions.

In order to save administration cost and increase work efficiency, some regional medical insurance institutions have signed agreement after negotiation with other nations' relevant institutions so as to simplify cross-border medical expenses reimbursement for the insured. For instance, some agencies have declared that expenses less than € 100 could be claimed directly without filling any form and examination. Border areas in Germany have adopted more flexible mode of clearance, such as simplify or withdraw approval procedure, no restrictions on the receiving of foreign patients by local medical institutions, pre-payment of the medical expenses, cooperative development of information system, sharing the insured persons' information and medical resources, providing high quality and convenient medical services to borderers.

## II Poland

### i General Information on Polish Medical Insurance System

As the closing of the Cold War and the acceleration of European integration, Polish medical insurance system has experienced great reformation to satisfy social development and the insured person's demands for the purpose of providing the most practical and effective

nationwide medical services. Polish parliament has passed *Establishment of National Medical Insurance Funds and General Medical Insurance Law* on January 2003, and it will take into effect by Polish President's approval since April 2003. According to this, Poland has established a new nationwide medical insurance system, which focuses on central administration of national medical insurance funds, elimination of regional and group differences, providing non-discriminatory treatment to all insured people. Establishing National Medical Insurance Funds (NFZ) and carrying out general medical insurance policies are two vital elements for the forming of the new system.

Basic principles of the new medical insurance system are: 1. Everyone has the right to be insured with compulsory insurance, no matter they are poor or rich; the insurance covers 99% of the total population due to Polish government's promotion. The Government also provides relevant protections for the uninsured groups who are poor or have special difficulties to ensure equality and social justice. 2. The insured has the right to choose doctors and hospitals. 3. Everyone receives the same treatment within medical insurance's regulation, including waiting for medical services. 4. Levying certain amount of the income as the contribution which should be withheld by the employer, and the rate should be 9% of employee's total income.

Contributions are collected by 2 social insurance companies (commission for contribution collection is 0.19% of the total premium), and then form the National Health and Medical Funds through the administration of banks which is administrated by National Medical Insurance Funds (NFZ). NFZ takes 1% management expense of the total premium which is 5% to 7% lower than German administration cost and NFZ also thinks that the expense is much lower; due to some political factors, management expenses haven't been raised. The Government reallocates the contribution after making evaluation of the composition of the insured, incidence rate, application of new techniques, medical consumption level, total number of outside-hospital cases, etc. and appropriates the contributions to NFZ sub-branches. However, many NFZ sub-branches are not satisfied with the allocation.

#### ii Medical Insurance Management

National Medical Insurance Funds is a national organization possessing legal personality specifically in charge of national medical insurance cases to ensure the regular operation of the medical benefits. National and provincial Oversight Boards should be set up to monitor medical insurance cases. President of National Medical Insurance Funds should be nominated by the Minister of Health, judged by Oversight Board, designated by Prime Minister; and reported to Ministers of Health and Finance at regular intervals. Each branch should have its own president who is in charge of carrying out national medical insurance

policies, such as the management of medical service contract, medical insurance information management, etc. The main obligations of the Oversight Board are making and monitoring the implementation of national medical insurance scheme, determining and administrating the implementation, evaluating Medical Insurance Funds' work plan and expenditure reports. The Funds is registered as a non-profit organization that has no operating activities, does not open hospital or pharmacy and possess any medical property in any form. Main goals of this organization are: 1. to make clear who the insured person is, that is who has signed medical insurance contract; 2. to sign co-operation agreement with medical institutions. Its headquarter locals in the capital city of Warsaw with 16 provincial sub-branches owning around 4000 staff; there are 250 staff working in primary central organizations. Central organizations do not directly choose partners (i.e. medical institutions). Partnership should be done by 16 provincial organizations. Presidents at provincial levels are nominated by the President of National Funds.

Medical insurance covers the prevention, diagnosis and medical treatment of all diseases, such as the prevention of diseases and injuries, early detection, diagnosis and medical treatment, avoidance of disability and the inconvenience.

Following medical services are excluded: physical examination which is irrelevant to medical treatment (such as medical examination for driving license), living in sanitarium without prescription, specific dental treatment, optional vaccination, unconventional treatment paid by patient.

Costly expenses for 17 serious diseases such as heart, lung transplantation would be paid by National Special Funds.

Polish primary medical services are provided by family doctor; every insured person has an appointed family doctor, and each doctor has 2500 patients. The insured could change the doctor twice a year, if the exchange frequency is more than 3 times a year, the insured should pay for it. The patient should get the approval for referral service from higher hospitals. Specialty and general hospitals mainly provide medical treatment to hospitalized patients. All medical institutions should sign service agreements after competition and negotiation; the format and criteria of the agreement should be made by NFZ. The agreement lasts for 3 years, and could be revised according to its operation after negotiation. Contract clauses should be comprehensive and in detail covering issues such as requirement for medical service, expenses' clearance, settlement of disputes, etc. NFZ provides appropriation to hospitals and doctors; as to services excluded from the agreement, the Funds would not provide additional appropriation in the same financial year. The hospital and doctor would submit monthly report to the Funds. The management mode of cross-region medical services is almost the same as that of Germany.

### III Enlightenment

i Meeting Migrant workers' need, studying and making cross-region medical treatment policies.

There are specific regulations and clauses on EU cross-border medical treatment, even the application forms have particular format. The insured, service provider and administer work according to the law and regulations, any violation, dispute and controversy should be solved without any ambiguity, which promotes the solving of cross-border medical care in EU.

ii Complying with public demands and making every effort to figure out problems existing in cross-region medical treatment.

The increasing number of insured people, the diversification of the way of employment, severe ageing problem, cross-region retirement pensions and employment, and the increasing number of transferred patients lead to nationwide concern over cross-region medical expenses clearance which is also a difficult problem in medical insurance management. Raising pooling level, founding cross-region medical service co-operation and co-ordination mechanism, improving pension management and simplifying operating procedure could be taken as a good example for cross-region medical treatment implementation.

iii Proposing creative ideas and researching on practical schemes of the implementation of direct pension management in the residence.

It is suggested to study on retirees' cross-region medical insurance treatment and the practical scheme for cross-region expenses management after studying German medical insurance practice. It is suggested that the retiree could have negotiation with local medical insurance institutions, the institutions could have pilot study on the issue in view that the big differences in terms of regional economic development and medical insurance policies.

iv Avoiding risks and selecting pilot-city for clearance promotion such as DRGs.

At present, Chinese medical expenses are claimed under the criteria of medical treatment and expenses, therefore, many problems such as massive intervention, overdose, alteration of received services, separation of expenses and so on which remain incessant after repeated prohibition. DRGs is a world-recognized mode of clearance which is comparatively scientific, reliable, transparent and equal. The lower management cost of the medical insurance agencies and their increased responsibilities would definitely promote the standardization and improvement of medical services. We should wrestle over the selection of pilot-cities in case the refusal of DRGs by medical institutions.

v Rational deployment of medical resources and expense clearance policies gives a feeling of "less expenditure but more returns" to the insured.

In Germany and Poland, every insured person has their own family

doctor. Primary medical services, disease prevention and health care could be gained locally and easily. The agency could not only promote the improvement of doctor's service so as to enroll more insured person, but also effectively monitor medical expenses by adopting the "paid in capita" method which is easy to operate with lower cost for clearance. Level III medical institutions and specialty hospitals could then focus their study and medical treatment on serious diseases, difficult and baffling diseases. We could also take following practice such as promoting alternate experts' outpatient services or cancellation of Level III hospitals' outpatient services into consideration. It is as well adoptable to remove regulations on deductible and ratio of payment as well as reimbursement cap when the insured person visits community hospital.

vi Common and standardized administration to maintain equality.

Through this study tour, we have found the fact that European medical funds management has the tendencies of centralized management and adjustment rather than decentralized management, same standard and management mode of medical services rather than independent operation in different regions by different insurance agencies, which are to the benefit of maintaining equal treatment, lowering management cost and improving service efficiency. Up till now, there are problems in terms of different systems and distributed institutions which lead to big differences in medical treatment, lower minus level and ability to resist risks, high management cost. Therefore, we should positively promote the consolidation of employees' and urban residents' medical insurance, novel rural cooperative medical service, retired and health professionals' medical institutions, approved service institutions and information network, and finally reach to goal of the unified standard of social security returns.

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