



Spitzenverband



**Together we are 90 percent**

Annual Report 2016



## **Imprint**

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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 the 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 2016.

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# Foreword by the Chairmen of the Administrative Council

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Dear Readers,

After intensive discussions and a large number of statutes, the legislative period is coming to an end. We can say looking back that some of the right incentives have been established for patient-orientated care. These include the mandate given to the self-government bodies to establish a Quality Institute, the unambiguous signal sent out by policy-makers for the introduction of the telematics infrastructure, and should enable health insurance funds and hospitals to conclude quality agreements. At the same time, it nonetheless comes to note that opportunities for real structural change have not been taken up.

Patients still have to slash their way through a jungle of highly-diverse medical care services. There is a need to expand interdisciplinary and inter-professional cooperation. Both out-patient registered contract care and in-patient care are typified by surplus capacities, especially in urban areas. Considerable potential therefore remains for more efficient and effective care. Appropriate further development is therefore needed, bearing in mind the need for action which has already been ascertained, as well as the foreseeable challenges due to socio-demographic developments.

We continue to be absolutely convinced that these challenges can only be tackled in unison with the self-government bodies. The determination that was expressed in the Coalition Agreement that self-government should be enhanced therefore initially kindled our optimism. The experience has however been sobering, given that the draft Bill that is entitled Act to Enhance Self-Government in Statutory Health Insurance (GKV-Selbstverwaltungsstärkungsgesetz) does not measure up to its

promises. Quite the contrary: We were primarily concerned in the legislative procedure to prevent the situation from turning from bad to worse. The Administrative Council has taken great pains to ensure that plans were thwarted to introduce a specialist supervision body, which would have constituted a massive encroachment on self-government on the part of the Ministry. These and other changes can be considered as a major success for the National Association of Statutory Health Insurance Funds. Having said that, a stale aftertaste has been left behind by some of the provisions which quite obviously do not enhance self-government.

There is no doubt that the essence of self-government includes also working together under difficult conditions in a solution- and consensus-orientated manner. This has also not changed at all in this Parliament. In the interest of insured persons and employers, the scope available to the self-government bodies should be expanded instead of increasingly restricted. This also constitutes a motivation to become engaged in this important voluntary office. Such a signal would be particularly significant with regard to the social elections being held this year.

Yours faithfully,

Uwe Klemens

Dr. Volker Hansen



## Foreword by the Board

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Dear Readers,

By the time you read this Annual Report, the end of the legislative period will be in sight. This causes us to not only sum up the past year at this point, but also to reach a conclusion with regard to the past four years. All in all, even for systems such as healthcare and long-term care insurance, which have undergone a multiplicity of reforms, these have been four comparably intensive years. A large number of reforms have been launched, frequently packaged as “Strengthening” and “Structural” Acts. They were intended to place the focus on achieving qualitative improvements in all areas of care, or at least that was the promise contained in the Coalition Agreement.

This goal has been reached in some instances: By transferring to the new levels of long-term care at the beginning of 2017, for the first time long-term care insurance deals with physical and mental as well as cognitive impairments on an equal footing and calculates the benefit requirement by measuring the degree of independence.

Having said that, the reform efforts in out-patient and in-patient care are much less positive. The legislature has failed to come up with sustainable solutions for urgent structural issues. Despite the intention of reducing expensive, unneeded surplus capacities, the reforms are virtually ineffective be-



cause of their construction defects. This is shown most clearly in the hospital reform: It is the Länder which decide on the money that contributors are to provide for structural change, and they neither pay the ongoing costs of the clinics, nor do they have a serious interest in closures. As will become clear at many points in this report, it can unfortunately also be observed all in all with regard to the many laws that have been enacted with regard to prevention, remedies and medical aids as well as medicinal products: Many things will become more expensive, but only a few things will get better!

The contribution rate will nonetheless remain stable in the election year 2017. This is due to the ongoing good economic situation, as well as to the fact of the legislature helping itself to the reserves of the Health Fund. It should be unequivocally stressed here that the decisive contribution to stability is being paid by the contributors themselves, given that the additional 1.5 billion Euro disbursed from the Health Fund to the health insurance funds comes from contributions. This one-off measure only puts off an increase in the additional contribution rate to the years to come. What is more, the expenditure-driving policy pursued in recent years has exacerbated the problem that expenditure will continue to rise faster than income. Policy-makers

will be called upon in the next Parliament to once more pay greater attention to the affordability of care.

It is inherent in the system that there will also be reforms in the next Parliament, especially in healthcare. The fact of there being still much to do is giving rise to particular urgency. Measured particularly against the extremely favourable financial circumstances, many opportunities have been missed in the past four years to already initiate the necessary structural change and achieve greater efficiency, and above all to impact on supra-sectoral forms of care.

The National Association of Statutory Health Insurance Funds will continue to cooperate closely with its member funds in making sure that the voice of statutory health insurance comes over crystal clear, setting the stage for the necessary changes and for sustainable solutions. 90 percent of the population in Germany has statutory health insurance. This guarantees them comprehensive, high-quality healthcare. The National Association of Statutory Health Insurance Funds creates the framework for healthcare and long-term care for more than 70 million people. This Annual Report will provide you with an attractive overview of the diversity of topics and the results that have been attained in the past year.

Yours faithfully,



Dr. Doris Pfeiffer  
Chairwoman of the Board



Johann-Magnus v. Stackelberg  
Deputy Chairman of the Board



Gernot Kiefer  
Member of the Board

# The report from the Administrative Council

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The National Association of Statutory Health Insurance Funds takes on a central role when shaping healthcare and long-term care in Germany. The focus here is equally on securing a high quality of care and conserving economic efficiency. The resolutions and positions of its Administrative Council determine and guide actions in the work of the National Association of Statutory Health Insurance Funds. Within the established structure of bodies and advice, the Administrative Council took up positions in the year under report 2016 on health and long-term care topics, provided an important impetus and formulated arguments for health policies in the interest of patients, care recipients and carers as well as contributors. The perspectives of the social partners form an integral element of this multi-faceted process of opinion forming and weighing up for the Administrative Council as a body of social self-government.

As well as drawing up positions on telemedicine, on the quality of the supply of remedies or on improving quality and economic efficiency in the supply of biological medicinal products, the self-government bodies also repeatedly took up current developments in the healthcare system and its environment by making statements and declarations.

## Further developments in long-term care training

Against the background of the extensive transformation of long-term care insurance on the benefit side, the Administrative Council expressed a conviction that there was a need to appropriately refine long-term care training. The long-term care

**The reform of long-term care training must be strictly measured by the goal of guaranteeing high-value long-term care in future with sufficient specialist staff.**

training reform which the legislature submitted in this regard should hence be strictly measured by the goal of guaranteeing a high standard of long-term care with sufficient specialist staff in future. Under no circumstances was this to trigger a suction effect into nursing care from geriatric

care. In the view of the Administrative Council, a closer convergence within training should also not be allowed to lead to a loss of specific training contents. With regard to the funding system for the new training, the abolition of the tuition fees was wholeheartedly welcomed, given that they had been an obstacle to entering the nursing profession. The Administrative Council was however also highly critical of the resurfacing tendency to cross-subsidise school expenses through the social insurance institutions. The legislature was therefore called on to extensively involve the Länder in school expenses within the law as it stands, as also takes place with regard to the vocational schools.

## Showing solidarity

The topic of refugees, which is of major importance within society, was repeatedly taken up by the Administrative Council from a perspective orientated towards medical requirements. Given the still highly varied levels of access to medical benefits available to asylum-seekers, the Administrative Council renewed the appeal that it made to the Federation, the Länder and the local authorities back in September 2015 to create an arrangement which would apply nationwide enabling asylum-seekers to receive uniform, appropriate healthcare. It undertook to shoulder shared responsibility with the community of solidarity, and emphasised the willingness of statutory health insurance to place itself at the service of the Länder and local authorities as a reliable cooperation partner with its know-how and existing infrastructure.

## Accelerating developments

The Administrative Council welcomed the fact that some of the demands which the National Association of Statutory Health Insurance Funds had repeatedly advanced in the past, which are intended to advance progress towards the introduction of the telematics infrastructure, have been included in the eHealth Act (E-Health-Gesetz). Having said that, the sanctions which have been provided for here are not designed to reflect



the balance of responsibility in some cases. For instance, where deadlines are missed related to the testing of insured persons' master data management (VSDM), amongst other things the budget of the National Association of Statutory Health Insurance Funds is also to be cut. This failed to take into account the fact that there is nothing else that gematik's shareholders can do about supply delays on the part of their partners in industry. The Administrative Council therefore approached the legislature once more, calling on it to reorganise the sanctioning mechanisms in such a manner as to reflect the balance of responsibility and to adjust the deadlines in line with the availability of the necessary components such as card-readers and connectors. As the sole funding institution, the National Association of Statutory Health Insurance Funds in any case has the greatest motivation to ensure rapid implementation. The Federal Ministry of Health availed itself of its power to extend the deadline with a legal ordinance at the end of the year. This obviated the need for cuts in the budget of the National Association of Statutory Health Insurance Funds. In addition to this positive signal, there was also reason to take a more confident view of the future than in previous years: The Administrative Council valued the first testing phase of the insured persons' master data management as a gratifying development, but

at the same time confirmed its previous critical and consistent line: The considerable potential of a uniform telematics infrastructure in high-tech Germany must at last become fully useable.

### **Fighting corruption**

By accepting the 4th report on the work and the results achieved by the Anti-Malpractice Office for the Healthcare System (Stelle zur Bekämpfung von Fehlverhalten im Gesundheitswesen), the Administrative Council drew positive conclusions with regard to the activities that have been developed by the National Association of Statutory Health Insurance Funds. With regard to the anti-corruption legislation that was completed in the middle of the year under report, it praised the fact that the National Association of Statutory Health Insurance Funds had drawn up tenable proposals for such action and submitted decisive signals.

### **Strengthening self-government**

The discussion regarding the strengthening of self-government, which had been announced in the Coalition Agreement by the CDU and the SPD, enjoyed considerable scope in the ongoing period of office of the Administrative Council. In the past, the Administrative Council has repeatedly criticised efforts on the part of policy-makers

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## Farewell to Christian Zahn

Christian Zahn, who had been the Chairman of the Administrative Council for the insured parties since 2010, resigned from his office in March 2016 at the meeting of the Administrative Council and passed the baton as the head of the self-government bodies on to Uwe Klemens. With his major experience of social and system policy, Christian Zahn contributed in the Administrative Council towards establishing and shaping a considerable asset of solidarity-based statutory health insurance as a guarantor for a first-class healthcare system and to define its shape for the future. He sent out many signals which particularly shaped the debates in the Association's bodies. In order to reward the achievements of Christian Zahn, Federal Minister Hermann Gröhe also accepted the invitation of the National Association of Statutory Health Insurance Funds. Attending the meeting of the Administrative Council, Minister Gröhe expressed his thanks for Christian Zahn's many years of untiring commitment to self-government.

ers to expand their influence on the self-government bodies and to encroach on their rights. Given the expectation of suitable legislation in the next Parliament, the members of the Administrative Council already prepared for the upcoming reform discussion at a workshop that was held in 2015. In the course of this, the existing competences of the self-government bodies were discussed and previous strategies and positions were illustrated, but handed-down methods were also critically reflected on. The aim was to create a foundation for an argument in order to make clear vis-à-vis policy-makers the potentials of confident, tenable self-government. Difficulties encountered in the Coalition however caused the reform of self-government to be postponed to the next Parliament.

For quite different reasons - namely the events which were revealed in the National Association of Statutory Health Insurance Physicians -, in 2016 the Federal Ministry of Health then submitted a draft departmental Bill to Enhance Self-Government in Statutory Health Insurance, which however fell far short of its ambitious title. The planned arrangement regarding the determination of the content was regarded as particularly serious, as this would have enabled the Federal Ministry of Health as the supervisory

body to determine the content of undetermined legal terms. This would have completed a decisive step from legal supervision to specialist supervision. Loud protests and a critical communication on all levels of activity of both joint and social self-government led the legislature to delete this provision without a replacement and to reduce the scope of the draft Bill as a whole. A number of decisive provisions which had triggered particularly vociferous criticism during the process were ultimately removed. This related for instance to the concrete statutory determination of the contents of the statutes which would have considerably restricted the autonomy of the Administrative Council. Even if the impact and consequences of the law which has now been adopted on the existing system of social and joint self-government will not be as weighty as had been initially anticipated, it can nonetheless be observed that self-government is to be restricted by a new density of control and instructions on the part of the supervisory bodies. The Act therefore does not actually lead to the strengthening of self-government that has been repeatedly postulated, including in the Coalition Agreement.

**Massive encroachment on the activities of the self-government bodies has been prevented and restrictions on the autonomy of the self-government bodies for the actions of the Administrative Council have been reduced.**



# State or private?

## Self-government can do it better

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On 16 March 2016, the Administrative Council of the National Association of Statutory Health Insurance Funds elected Uwe Klemens as its new Chairman representing the insured parties. He thus followed on from Christian Zahn, who had resigned from the Chairmanship for reasons of age. Uwe Klemens was ver.di's regional district leader in the Land Rhineland-Palatinate from 2001 to 2014, and after the merger he held the same position in the Rhineland-Palatinate/Saarland Land district until 6 February 2015. He has been committed to the self-government of the health insurance funds for more than 20 years, so that he has extensive experience. He is a member of the Administrative Council of the Techniker health insurance fund, and has been an ordinary member of the Administrative Council of the National Association of Statutory Health Insurance Funds since 25 February 2015. Florian Lanz, the spokesperson of the National Association of Statutory Health Insurance Funds, spoke with him about his goals, the significance of self-government and his expectations of policy-makers.

**Mr Klemens, you trained as a specialist social insurance employee, and learned the trade from the bottom up. Does this make the work in the Administrative Council simpler?**

It certainly doesn't do any harm to have worked in the "engine room" of social insurance. What this leaves you with is a profound understanding of how an administrative apparatus works, and the Social Code has also accompanied me since then as an everyday work tool. Whether it was during my time working in pensions insurance, at the trade union or indeed the many years I spent in statutory health insurance - social security provided by the social insurance institutions was always of central significance.

**I'd like to take that point up. Why the social insurance institutions in particular? Things also work fine in other countries which for instance have state healthcare systems.**

A system which is steered by the State and funded through taxation would lose a lot in terms of its inner dynamics and creativity. Imagine that the health insurance funds and their associations were combined together in a gigantic administrative apparatus. I very much doubt that such an apparatus could do justice to the individual needs of insured persons. Any form of benefits would depend on changing political majorities. We have seen in the USA that these can sometimes also change abruptly and turn in the opposite direction. I would rather not entrust the social security of the individual against the ups and downs of life to a state authority, but I know that it is in good hands with the social partners. Self-government can do it better!

**The Administrative Council represents the members of the National Association of Statutory Health Insurance Funds. How do you see the relationship between the Administrative Council and its 113 members, the health insurance funds?**

The colleagues on the Administrative Council represent the 113 members of the Association in their diversity and in all their different interests. It is still an exciting, challenging task to chair the Administrative Council, even though I have been working in social security for more than 30 years. It is therefore particularly important for me to work to achieve a consensus without denying my own attitude here. Dr. Hansen and I share the task of always ensuring that everything remains shipshape and that we ultimately also achieve results. The IKK, BKK, AOK, the Substitute Funds, farmers and the Miners' Insurance Institution, the 113 funds all have their own positions which they contribute and their own approaches. All this is reflected in the Administrative Council.

**You just mentioned the search for a consensus, which can be difficult at times. Is the National Association of Statutory Health Insurance Funds actually able to act de-**



**cisively for the statutory health insurance system as a whole towards policy-makers, but also vis-à-vis the healthcare providers in joint self-government as a central player?**

Yes! There is naturally a variety of interests in the funds and types of funds, as well as rather different perspectives among insured persons and employers which they input in their role as representatives. But at least since I have been playing a role, we have almost always taken the really important decisions unanimously. This is an expression of the ability to act, and hence is a wholeheartedly affirma-

supply of medical aids, solve questions related to benefits and take up a position on specific political and statutory initiatives. The fact that this works so well is an expression of the collective creative drive of all the members of the Administrative Council. Please permit me to add something at this juncture: I am highly grateful to the staff of the Association for their committed work and for the high level of specialist skills that I can see in all the Association's departments. It is a joy to be able to rely on this!



tive answer to your question. We can do it. Policy-makers could take an example by this sometimes. Not to be misunderstood: I don't want a mishmash, but we have real issues to resolve. For instance, we need to organise the

**The National Association of Statutory Health Insurance Funds heads self-government within the fund system. Does this mean that the Association has a special responsibility per se, or indeed for you personally?**

I have always thought that nothing could impress me any more. The first time many years ago when I helped adopt a budget of the German pensions insurance in Rhineland-Palatinate, it was for four billion Euros. Statutory health insurance operates on a different scale altogether. If we take into account the fact that the statutory health insurance funds, which ultimately form the National Association, take care of roughly 70 million people, then this certainly inspires respect. To come back to your question, shouldering responsibility at an important place for the healthcare of 90 percent of the population is a major challenge, both for the Administrative Council as a whole and for me personally.



# Looking forward: Shaping reforms and providing sustainable finance

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A new Bundestag will be elected in Germany in the autumn of 2017: This makes it a good time to assess the healthcare and long-term care policy to date and to take a look at the challenges that the new Parliament will have to face. The Grand Coalition will be working to implement the Coalition Agreement up to the end. It has already given legislative form to a large part of its healthcare and long-term care policy manifesto. In doing so, it has addressed each major care sector, for instance hospital care, out-patient care and not lastly long-term care insurance. Medicinal products as well as remedies and medical aids are to follow in 2017.

## Filling the reforms with life

For the National Association of Statutory Health Insurance Funds, 2016 was typified by the implementation of the many tasks imposed on it by the legislature. For instance, the Care Improvement Act (Versorgungsstärkungsgesetz) is intended to improve the organisation of out-patient care. New regulations to promote the registration of doctors in undersupplied areas where structures are weak, or to improve out-patient psychotherapeutic care, needed to be filled with life.

A major challenge is posed by the implementation of the Hospital Structure Act (Krankenhausstrukturgesetz). Roughly two dozen new tasks needed and in some cases still need to be dealt with. Despite the contrary positions of the negotiating partners that were already evident in the legislative procedure and the frequently short deadlines, it was possible to tick off a great number of these tasks by the end of 2016.

The implementation of the Second Act to Strengthen Long-term Care (Pflegerstärkungsgesetz) with the introduction of the new definition of need for long-term care has also entailed a large number of tasks. The priority goal for all involved was to make the transition from the previous long-term care system to the new one seamless and transparent for the roughly three million persons in need of long-term care. The

introduction of the new definition of need for long-term care in 2017 will mark a milestone in long-term care insurance.

## Countering undesirable developments

Considerable attention is rightly attached to the legislative procedures which were launched in 2016, already completed at the beginning of 2017, or which are still planned to be completed in the current year. There have been positive developments with regard to the Medicinal Products Care Improvement Act (Arzneimittelversorgungsstärkungsgesetz), since the planned confidentiality of the refund amounts was prevented. This lack of transparency would have benefited neither contributors nor patients. Having said that, the opportunity was missed to eliminate arbitrary price fixing for new medicinal products in the first year after market launch. This serves the pharmaceutical industry alone, and means a cost risk for contributors. There is a need for the refund amount to have an across-the-board impact.

**The confidentiality of the refund amounts in the Medicinal Products Care Improvement Act was prevented at the last moment.**

When it comes to the Remedies and Medical Aids Supply Act (Heil- und Hilfsmittelversorgungsgesetz), the critical points are above all the suspension of the principle of the stability of contribution rates, as well as the blank prescription of remedies. Whilst the decoupling from the basic wage will continue to further amplify the already galloping developments in expenditure, the "blank prescription" raises the question of why the results of the ongoing pilot trials cannot be awaited and a sound decision then taken on the basis of the knowledge available. There is much that needs to be done here. It looks for medical aids as if solutions could be found which guarantee a high-quality supply of medical aids under conditions which are tenable in financial terms.

With regard to the "Act to Enhance Self-Governance", it has been possible during the legislative procedure to achieve important corrections as

requested by the National Association of Statutory Health Insurance Funds and to reduce the threat of more grievous encroachments on the rights of social the self-government bodies. The title of the Act is nonetheless clearly a case of fraudulent labelling, given that all in all the provisions restrict the abilities of the self-government bodies to act on its own responsibility. And that in a year in which social elections are being held. The National Association of Statutory Health Insurance Funds considers this Act to be unnecessary.

**Ensuring finance, continuing to improve care**

The reforms of the closing Parliament will increase the expenditure of the health insurance

funds, and hence lead to increases in the additional contributions in the long term. The focus must therefore be on the affordability of healthcare once more. The healthcare

**The title of the Act to Enhance Self-Government is clearly a fraud, given that all in all its provisions restrict the ability of the self-government bodies to act on its own responsibility.**

system has a structural defect: Expenditure is growing faster than income. The goal must be to sensibly distribute the limited financial resources. Existing and proven surplus capacities must be reduced, both in out-patient and in in-patient treatment. More needs to be done in order to tackle the phenomenon that there are more and more doctors in Germany, but that they are very

unevenly spread throughout the country. There is a need to examine the current structures of suprasectoral cooperation in healthcare, given that there is a crunch between out-patient and in-patient care. Patients experience this when they are for instance subject to unnecessary double examinations.

A topic for the future remains emergency patient care, even if initial solutions are in sight from the Care Improvement Act and the Hospital Structure Act. The almost two dozen different legal bases and financing systems for out-patient treatment at clinics need to be placed on a new conceptual foundation.

In addition to these concrete examples of the need for legislative action, the challenge exists in general terms to adjust the healthcare system in line with ever accelerating economic, social, technical and medical change processes. This will not be possible overnight and for all time, but needs to take place on an ongoing basis and in many steps. Demographic change, medical progress, the digitalisation of communication and the workplace, the rural exodus and migration, as well as the change of the panorama of disease, typify developments. The National Association of Statutory Health Insurance Funds and its member funds thus await the new Coalition Agreement, and the legislation of the 19th German Bundestag which will build on it, with great anticipation.



We are unbeatable as a team.

We are strategists.

We are game makers.

We have statutory insurance.

Together we are 90 percent.

# The subject of criticism: The Act to Enhance Self-Government

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The Act to Enhance Self-Government in Statutory Health Insurance has come into force. This was preceded by intensive discussions regarding the direction and shape of the Act. Especially the Administrative Council of the National Association

**Important corrections were made to the Act over the last metres, and encroachments on the rights of social self-government were reduced. The selected approach of restricting self-government rights through control rights and the rights to give instructions of the supervisory body is nonetheless wrong.**

of Statutory Health Insurance Funds vociferously expressed its proposal to do away with the massive encroachments on the actions of the self-government bodies. It was possible at the very closing stages to

remove major restrictions on the autonomy of the self-government bodies. These changes are also to be regarded as a major success for the National Association of Statutory Health Insurance Funds.

## **The introduction of a specialist supervision body averted**

The starting gun for the legislative procedure was sounded by a key issues paper of the Federal Ministry of Health which came to light in March 2016. In essence, the key issues and the draft departmental Bill of the Federal Ministry of Health, which was drawn up on the basis of the paper, provided for the further development of the control rights and the rights to give instructions vis-à-vis the self-government bodies on the part of the national organisations in the healthcare system, so

that the Federal Ministry of Health would have become a specialist supervisory body, especially with the aid of a "Content determination for undefined legal terms". This would have meant a caesura for the rights of social and joint self-government, and would have sustainably weakened their independent responsibility. At the same time, the departmental draft Bill provided for further new rights of encroachment for supervision on the autonomy in statutes and in administrative actions.

Against the background of such unacceptable interference, the Administrative Council has done much to see to it that these were deleted and to maintain the ability of social the self-government bodies to take their own decisions. The protests were gratifyingly successful, and the draft Bill that was adopted by Cabinet no longer provided for the content-related provisions that had been planned for undefined legal terms. This considerably reduced the risk of a specialist supervision body, and successfully prevented the core attack on the autonomy of the self-government bodies. What is more, the provisions on the statutory stipulations regarding statutes and the new provisions for the appointment of a "Representative for special matters" were partly lent concrete form and reduced in scope.

## **Draft Bill initially continuing to have a considerable need of improvement**

An urgent need for action continued to exist after the changes had been made: The draft Bill had ini-

tially provided for the supervisory body to be able to mandate a representative to carry out tasks at the National Association of Statutory Health Insurance Funds and to largely freely determine the actions which that person was to take. What would have been unacceptable with such actions would have been the fact that the responsibility in terms of liability would have remained with the bodies of the National Association of Statutory Health Insurance Funds. The remaining stipulations with regard to statutes were also incomprehensible for the Administrative Council.

The chairs of the Administrative Council therefore repeatedly made it clear in the entire legislative procedure in talks with those bearing political responsibility, at the public hearing of the Bundestag's Committee on Health, as well as in public declarations and at events, that no such legislation is needed for the National Association of Statutory Health Insurance Funds. Its work has provided neither a legal nor a content reason for the envisioned encroachments on self-government rights. The mistrust that has been expressed vis-à-vis self-government is neither comprehensible, nor is it justified.

### **Major changes in the final sprint**

It was only shortly before the Act's adoption by the Bundestag that the Coalition agreed on further important changes to the draft Bill. For instance, the minimum stipulations for the statutes were

deleted. Furthermore, the area of activity of the representative was restricted. He or she may thus only advise, support, supervise and examine compensation claims. The prerequisites for an encroachment were also made more precise.

All in all, this led to major corrections being carried out and to encroachments on

the rights of social self-government being reduced, so that this can be regarded as a major success for the National Association of Statutory Health Insurance Funds. There is nonetheless a need to note that the approach that has been selected of restricting self-government rights through control rights and the rights to give instructions on the part of the supervisory body is wrong. Instead, the legislature should have expanded self-government rights much more extensively. In order to facilitate a real strengthening of self-government, a renewed drive will be needed on the part of the legislature in the upcoming Parliament to bring about a reform which also deserves to be called a reform.

**Self-government needs a greater range of possibilities once more.**



We have travelled a long way.

We are planners.

We are works council members.

We have statutory insurance.

Together we are 90 percent.

# New definition of need of long-term care introduced: The Second Act to Strengthen Long-term Care

With the Second Act to Strengthen Long-term Care (PSG II), the legislature introduced a new definition of need of long-term care as per 1 January 2017. This meant that the second stage of the reform for the further development of long-term care insurance came into force. Since the beginning of the year, the need of long-term care has no longer been orientated towards the need of assistance in repeated everyday activities measured in minutes. The only basis is now to what degree an individual's independence is impaired when it comes to dealing with their everyday lives, and to what extent they rely on the assistance of others. This altered focus leads to the equal treatment of individuals with physical, cognitive or mental impairments and to their being categorised into the five levels of long-term care. Their assessment covers not only the classical areas such as personal care or nutrition, but also aspects including communicative skills, the shaping of

their everyday lives or social contacts. In order to ensure the introduction of the new definition of need of long-term care and the concomitant transitional provisions as well as provisions related to safeguarding acquired rights by 1 January 2017, the National Association of Statutory Health Insurance Funds already started preparing for the transition in 2015.

### New assessment guidelines

A new assessment tool was also introduced with the new definition of need of long-term care, which fundamentally changes the determination of need of long-term care. The assessors of the Health Insurance Medical Service (MDK) have to determine in a more differentiated manner than was previously the case what an individual can do and where

**People with physical, cognitive or mental impairments are treated equally when it comes to being categorised into the five levels of long-term care.**

Aspects of determining the level of long-term care percentage weighting

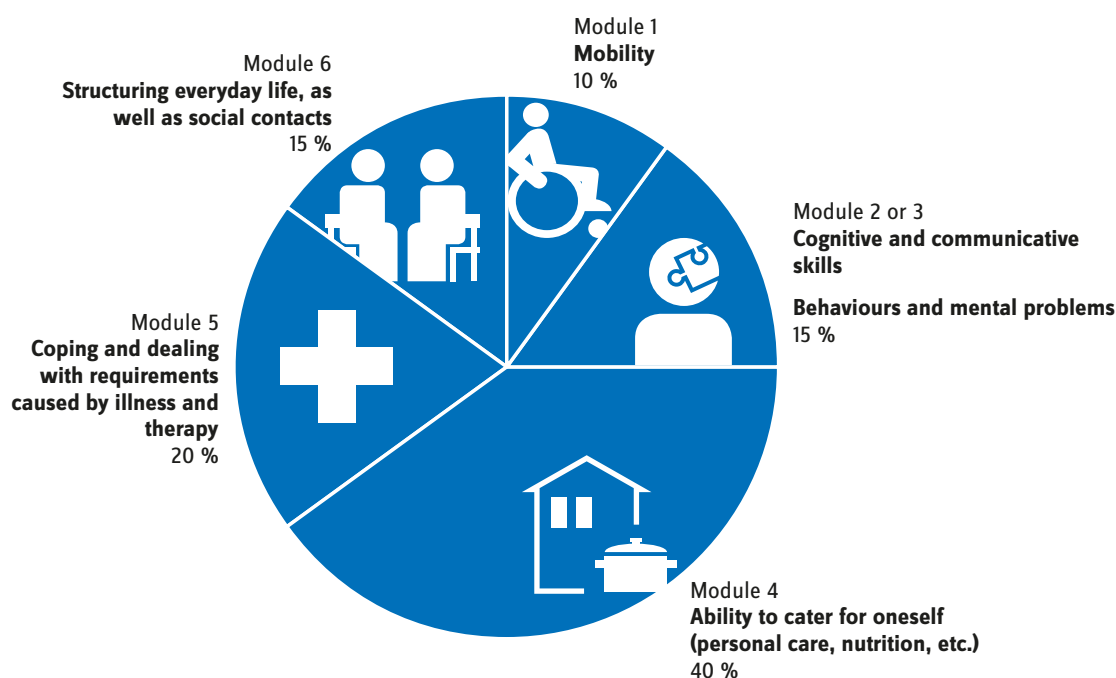


Illustration: National Association of Statutory Health Insurance Funds

they require assistance. They assess the degree of dependence on third-party assistance and support in the areas of life which are vital to long-term care and support.

The uniform basis for this procedure is formed by the Assessment Guidelines of the National Association of Statutory Health Insurance Funds, which have been approved by the Federal Ministry of Health, and which also came into force as per 1 January 2017. They were drawn up in close cooperation with the Medical Service of the central association of the health insurance funds at federal level (MDS), as well as with the Health Insurance Medical Service and the associations of the long-term care insurance funds at federal level, with the involvement of representatives of those concerned.

**Insured persons are informed in a concise, comprehensible manner of the most important new developments in the assessments of long-term care with a leaflet.**

**Transition from care categories to levels of long-term care**

Insured persons receiving benefits from long-term care insurance on 31 December 2016 were transferred as per 1 January 2017 from the previous care categories to the new levels of long-term care without a fresh application and without being re-assessed. Persons in need of long-term care with

only physical restrictions receive the next higher level of long-term care in place of the previous care category. Persons in need of long-term care who were ascertained as having restricted day-to-day life skills are assessed two levels of long-term care higher. The persons in need of long-term care were bindingly informed by their respective long-term care insurance fund with a notice of the level of long-term care and the new benefits.

**Guiding the implementation of the law on benefits**

So that persons in need of long-term care who were already receiving benefits prior to 1 January 2017 are not placed at a disadvantage by the introduction of the new definition of need of long-term care, the legislature has provided for mechanisms to safeguard acquired rights. In order to ensure that these provisions on benefits are implemented uniformly, the National Association of Statutory Health Insurance Funds, together with the associations of the long-term care insurance funds at federal level, explained the provisions on benefits in a "Joint Circular". Since a heightened demand for assessments was anticipated in the phase of the conversion from care categories to levels of long-term care, the legislature suspended the statutory assessment deadline for 2017 other than in cases of a particularly urgent need for a decision. Corresponding to the statutory mandate, the National Association of Statutory Health Insurance Funds developed criteria for the existence of such an urgent need for a decision.

**From care categories to levels of long-term care**

Care category 0	with PEA*	▶	<b>Level of long-term care 2</b>
Care category I	without PEA	▶	<b>Level of long-term care 2</b>
Care category I	with PEA	▶	<b>Level of long-term care 3</b>
Care category II	without PEA	▶	<b>Level of long-term care 3</b>
Care category II	with PEA	▶	<b>Level of long-term care 4</b>
Care category III	without PEA	▶	<b>Level of long-term care 4</b>
Care category III	hardship case	▶	<b>Level of long-term care 5</b>

\*Persons with considerably-restricted day-to-day life skills

**Information for the insured persons**

The National Association of Statutory Health Insurance Funds established a working party in order to ensure optimally uniform communication on the introduction of the new definition of need of long-term care and of the new assessment procedure. With the involvement of the relevant organisations and associations of long-term care insurance at federal level as well as of the Medical Service of the central association of the health insurance funds, this working party developed information collections that were accessible to the



layman, including a list of FAQs, as well as illustrations on the new assessment procedure, on the evaluation system, on the transitional regulations as well as recommendations on medical aids, prevention and rehabilitation. Furthermore, the National Association of Statutory Health Insurance Funds worked with the associations of the long-term care insurance funds at federal level to draw up the leaflet entitled "The reform of long-term care 2017 - An overview". This leaflet informs insured persons in a concise, comprehensible form of the most important new developments related to the introduction of the new assessments.

### Disease prevention in in-patient long-term care

The Disease Prevention Act (Präventionsgesetz), which came into force in 2015, placed the long-term care insurance funds under an obligation to provide benefits to prevent disease and promote health in long-term care facilities, as well as in day and night care facilities. This enables the health potential of people in need of long-term care to be promoted despite their physical, cognitive or mental impairments.

On the basis of an expert research report, the National Association of Statutory Health Insurance Funds drew up a guideline stating areas of activity and criteria for disease prevention in in-patient long-term care. The guideline supports the long-term care insurance funds in developing and implementing disease prevention and health promotion. The fields of activity cover the areas nutrition and physical activity. Further topics include strengthening cognitive resources, psychosocial health and violence prevention.

**It makes sense to link preventive measures for persons in need of long-term care with measures of in-company health promotion for the carers.**

The strengthening of disease prevention and health promotion in in-patient long-term care facilities is contingent on sustainably improving the living conditions of persons in need of long-term care in residential homes. Disease prevention in in-patient long-term care must hence be consistently orientated in line with the "setting" method, that is health-promoting, preventive interventions must take place in the geographical and social environment (setting) of the persons in need of long-term care. Given the fact that home residents are highly dependent on the actions of the staff in long-term care facilities, it makes sense to link preventive measures for persons in need of long-term care with measures of in-company health promotion for the carers. This includes the implementation of health-suitable leadership principles or the shaping of an environment that nurtures exercise. It also appears advisable to involve residential homes' advisory councils, relatives and legal guardians.

The statutory long-term care insurance funds are spending approx. 21 million Euro per year on such special offers nationwide.



# Quality control and assurance: Reforms in long-term care

The Quality Committee on Long-Term Care was launched at federal level on the basis of the Second Act to Strengthen Long-term Care (PSG II). The contracting parties in long-term care, that is the funding institutions and healthcare providers,

**Annual audits of invoices of long-term care facilities have been made mandatory against the background of cases of invoicing fraud by out-patient care services which have come to light.**

are represented there on an equal basis. Seven out of 20 places are held by the National Association of Statutory Health Insurance Funds. The Quality Committee adopts resolutions and reaches agreements to ensure and further develop the quality of long-term care which are binding on all long-term care facilities. The goal being pursued by the legislature is to tighten up the decision-making structures and processes with this new body. The Quality Committee took up its work in June 2016.

Within its activities, the Quality Committee on Long-Term Care awards commissions to scientific facilities or experts. These particularly relate to the development of tools for quality control and quality presentation, which are to replace the current "care ratings" ("Pflegeroten"). An independent unit has been supporting the body in research since August 2016.

### Auditing invoices in quality control

Since the beginning of the year, the legislature has prescribed mandatory auditing of invoices in quality control in long-term care facilities which have to be carried out on an annual basis. This especially took place against the background of cases of invoice fraud committed by out-patient care services which had come to light. The Guidelines of the National Association of Statutory Health Insurance Funds regarding the Auditing of

## The composition of the Quality Commission, as well as of the Expanded Quality Committee 2016

### Quality Committee section 113b of Book XI of the Social Code

Resolutions and agreements on sections 37, 113, 113a and 115 of Book XI of the Social Code through the unanimous agreement of all members

- Should no agreement be reached
- At the request of a member, of a contracting partner in accordance with section 113 of Book XI of the Social Code, or of the Federal Ministry of Health

### Expanded Quality Committee

- Expanded to include a non-partisan chairperson and two more non-partisan members
- Decisions taken by majority resolution

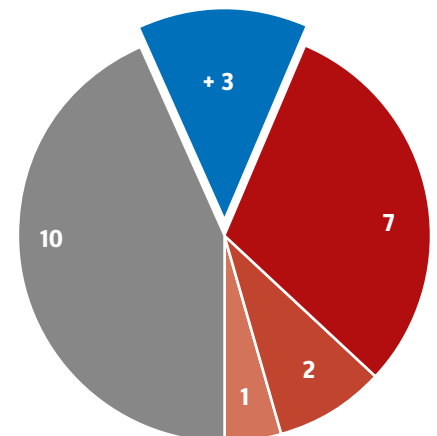
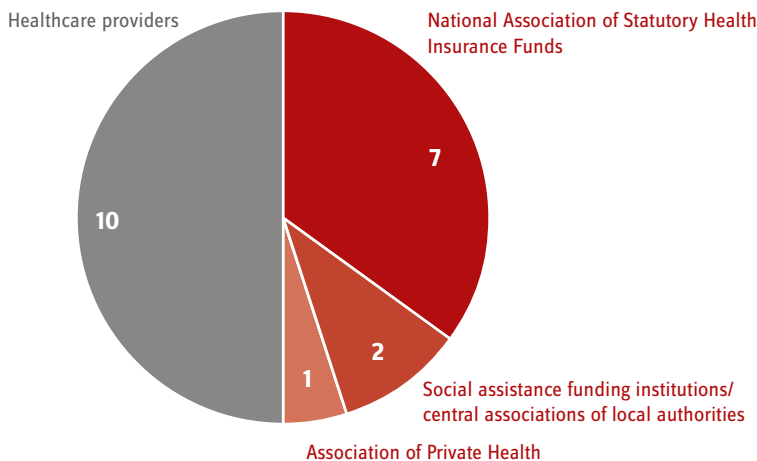


Illustration: National Association of Statutory Health Insurance Funds

the Services provided in Long-term Care Facilities and their Quality in accordance with section 114 of Book XI of the Social Code (SGB XI) (Quality Control Guidelines) form the foundation for the examinations to be carried out by the Health Insurance Medical Service (MDK). Due to the statutory stipulation, these Guidelines needed to be adjusted accordingly. To this end, the National Association of Statutory Health Insurance Funds, in cooperation with the Medical Service of the central association of the health insurance funds at federal level, the Health Insurance Medical Service, the associations of long-term care insurance funds at federal level as well as with the auditing service of the Private Long-Term Care Insurance Association, drew up provisions and criteria for the implementation of the auditing of invoices. The organisations of those concerned that are relevant at federal level contributed in an advisory capacity. The adjusted Quality Control Guidelines came into force on 15 October 2016, after having been approved by the Federal Ministry of Health. The examinations of the long-term care facilities have taken place since then on the basis of the adjusted Guidelines.

#### **Personnel allocation in long-term care**

The Second Act to Strengthen Long-term Care, which came into force in 2016, placed the National Association of Statutory Health Insurance Funds, the Federal Association of Regional Social

Assistance Agencies, the central associations of local authorities at federal level and the Associations of the funding bodies of the long-term care facilities at federal level, jointly as contracting parties in long-term care, under an obligation to develop and test by mid-2020 a scientifically sound procedure for the uniform assessment of the personnel requirement in long-term care facilities. To this end, the contracting parties, in agreement with the Federal Ministry of Health and the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, have to award contracts to scientific institutes. The procedure must be based on the definition of need of long-term care which applies from 2017, and is to continue to take into account the appropriateness of long-term care in terms of content, as well as the different qualifications of carers. The National Association of Statutory Health Insurance Funds considers the commission to constitute an opportunity to develop a standard national personnel allocation procedure to provide the opportunity to critically examine the regional differences existing in staffing. More attention should be attached in the future to aspects of supply quality as a measure for suitable staffing in long-term care, general care and house-keeping care.

**A scientifically sound procedure for the uniform assessment of the personnel requirement in long-term care facilities is to be developed and tested by mid-2020.**

# Organising the supply of long-term care in accordance with needs: The Third Act to Strengthen Long-term Care

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The Third Act to Strengthen Long-term Care (PSG III) takes up three topics: The new definition of need of long-term care in social assistance, strengthening the role of local authorities, as well as invoicing fraud in long-term care.

The new definition of need of long-term care, as well as the new assessment procedure, are to be transferred to social assistance. This is necessary so that the same foundation applies to the supplementary benefits of social assistance, assistance for long-term care, as to the limited benefits from long-term care insurance.

What is more, the Act provides to strengthen the role of local authorities in long-term care with the aim in mind of expanding local authorities' steering and planning responsibilities. A Federation-Länder working party had previously drawn up proposals on this. In June 2015, the Administrative Council of the National Association of Statutory Health Insurance Funds already adopted core positions on these proposals and on the 2016 legislative procedure, and submitted proposals to improve cooperation between local authorities and long-term care insurance funds.

The Administrative Council pointed out that the Länder and local authorities are responsible for making available an adequate long-term care supply infrastructure. In terms of services of general interest and local geriatric assistance, this includes the requirements analysis and long-term care needs planning. If capacity shortfalls are identified, the measures of infrastructure promotion apply. These promotion possibilities are already available, and are also to be implemented consistently. The Länder are responsible for funding.

## **Local governance of long-term care at the expense of contributors**

The provisions which are now embedded in the Act shift long-term care advice by the long-term care insurance funds, which had previously received a

positive reception among insured persons, to up to 60 local authorities. To start with, the latter will be able to provide long-term care advice for a limited period of five years on a pilot basis. The National Association of Statutory Health Insurance Funds repeatedly criticised the fact that this one-sidedly assigns responsibilities from health and long-term care insurance funds to local authorities. As well as establishing dual advisory structures, this will also increase costs since statutory long-term care insurance finances the provision of long-term care advice by local authorities on a pilot basis. Problems will also occur when it comes to the different organisation of the pilot local authorities.

In contrast, the National Association of Statutory Health Insurance Funds proposed joint, equal action on the part of the Länder, local authorities and funds within their respective competences. This would have enabled in concrete terms pilot projects to be implemented from funds available from the equalisation fund of long-term care insurance, and applications to be lodged jointly by local authorities and funds. There is justified concern that the construction that has now been selected will focus less on providing advice and care to those concerned as they require it, and focus primarily on the funding of the local authorities from long-term care insurance contributions.

## **Invoicing fraud in long-term care, expanding the right to audit**

According to information from the Federal Criminal Police Office, which came to light in the spring of 2016, invoicing fraud in out-patient long-term care has now become a nationwide phenomenon. Offenders are primarily concentrating on business with intensive long-term care patients, as this is where the biggest profits can be made. Reports which were also received by units of the statutory health and long-term care insurance funds responsible for countering misbehaviour in the healthcare system have shown that the statutory framework needs to be refined and expanded in order to detect invoicing fraud in long-term care earlier and to prevent it.

**Competences of the health and long-term care insurance funds are unilaterally transferred to the local authorities. This will lead to both the establishment of dual advice structures and to additional costs.**

In order to be able to counter irregularities in the invoicing of long-term care benefits better in future, the PSG III was also to include new provisions relating to the prevention, detection and combating of invoicing fraud in Book V of the Social Code (SGB V), as well as in Book XI of the Social Code, and existing ones added. At the public hearing, the National Association of Statutory Health Insurance Funds wholeheartedly welcomed the new provisions, and called for further changes to be made to the law. In the view of the National Association of Statutory Health Insurance Funds, for instance, there is a need for the law to make it clear that the time of commencement and completion of the provision of the benefits will also need to be stated when invoicing in future. Recording the time of commencement and completion of each deployment in out-patient long-term care is a sine qua non for reaching an understanding of whether the benefits invoiced could actually have been plausibly provided in the time stated. This is the only way in which it can be proven in a manner that can be presented in court that benefits have been invoiced which were not provided.

**Invoicing fraud in out-patient long-term care has now become a nationwide phenomenon. Offenders are primarily concentrating on business with intensive long-term care patients.**



### **New provisions for dealing with invoicing fraud**

- new rights for the Health Insurance Medical Service to audit domestic nursing care benefits on behalf of the health insurance funds
- further development of existing quality assurance tools in long-term care insurance
- additional preconditions for contracts and for completion of contracts in the Länder framework agreements



We are early-risers.

We are farmers.

We are hosts.

We have statutory insurance.

Together we are 90 percent.

# Taking stock after a year: The Innovation Fund

The Statutory Health Insurance Care Improvement Act created the statutory provisions for the introduction of the Innovation Fund. The Fund aims to improve care quality through innovative care models and to minimise the much-lamented interface problems in suprasectoral treatment. Furthermore, projects are to be promoted in care research which lead to better care. 300 million Euro are available every year for project promotion from 2016 up to and including 2019. The funding will be provided in equal halves by the liquidity reserve of the Health Fund and directly by the health insurance funds. Three-quarters of the funding can be spent on new forms of care (225 million Euro per year) and one-quarter on care research (75 million Euro per year).

A new body, the Innovation Committee, has been established at the Federal Joint Committee to implement the promotion. The Innovation Committee, on which both the National Association of Statutory Health Insurance Funds, with three representatives, and the other national organisations of the German healthcare system, as well as two Federal Ministries, have seats and votes, started operations in October 2015. Moreover, a ten-member Expert Advisory Council was appointed in January 2016, which is to provide additional academic as well as practical care-related expertise for the deliberations of the Innovation Committee.

## Publishing the promotion announcements and evaluating the applications

After constituting the bodies, the Innovation Committee decided on the first promotion announcements in the spring of 2016. The spectrum of topics for which applications had been requested in the funding area "New forms of care" was broad-based, for instance including treatment of vulnerable patient groups and care in rural regions, as well as questions regarding the optimisation of the safety of drug therapies. Project applications were invited concerned with telemedicine, which received fresh thrust not lastly with the eHealth Act, which came into force in 2016.

## The composition of the Innovation Committee

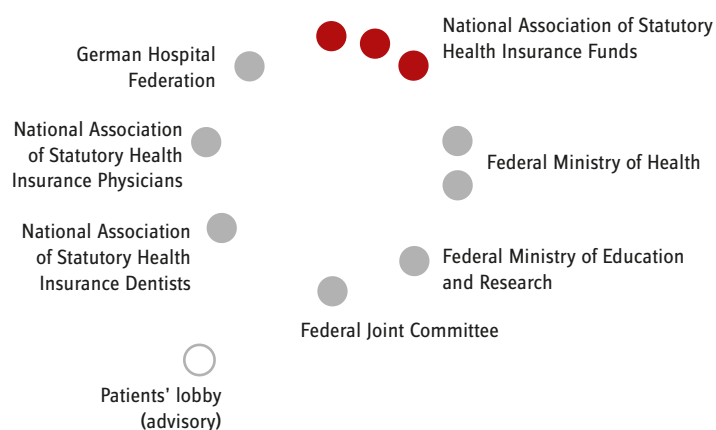


Illustration: National Association of Statutory Health Insurance Funds

The application deadlines for the two promotion announcements "New forms of care" ended in July 2016. A total of more than 220 applications for funding were submitted. As had been expected, this meant that the funding budget available for 2016 was considerably oversubscribed. As a result, 29 funding projects were selected in the Innovation Committee in a consensus, spanning funding institutions and taking the votes of the Expert Advisory Council into account. These accounted for a funds budget of approximately 210 million Euro. Detailed information on these projects is available on the homepage of the Innovation Committee. The roughly 100 project applications of the second wave of promotions will be decided on in the first Quarter of 2017.

More than 300 outline applications were submitted in "care research", and these needed to be evaluated in a two-tier procedure. After examining and evaluating the outlines, the Innovation Committee called on 142 applicants to describe their projects in detail in a fully-fledged application. 55 project applications ultimately prevailed. Furthermore, projects are also being financed from the funding "care research" budget to evaluate the Federal Joint Committee's Guideline on

## Projects funded in "New forms of care" in the 1st wave of promotion

	No.	Volume
<b>Topical area 1:</b> Care models in structurally-weak and rural areas	4	35.6 million €
<b>Topical area 2:</b> Pilot projects for drug therapy, as well as for the safety of drug therapies	4	43.4 million €
<b>Topical area 3:</b> Care models using telemedicine, telematics and eHealth	6	40.9 million €
<b>Topical area 4:</b> Care models for specific groups of patients	10	65.2 million €
Funding applications from a call for tenders without thematic restrictions	5	25.7 million €
<b>Total*</b>	<b>29</b>	<b>210.7 million €</b>

\* Totals may differ because of rounding

## Promoted projects in "care research"

	No.	Volume
<b>Topical area 1:</b> Further development of quality assurance and/or patient safety in care	15	27.5 million €
<b>Topical area 2:</b> Improving instruments to measure quality of life for specific groups of patients	5	2.9 million €
<b>Topical area 3:</b> Innovative patient-orientated long-term care concepts, with particular consideration of the division of tasks and the interfaces, as well as of the integration of recognised foreign specialist long-term term carers into everyday long-term care	2	2.5 million €
<b>Topical area 4:</b> Improving the distributive justice and/or economic efficiency of statutory health insurance care	10	7.7 million €
<b>Topical area 5:</b> Causes, extent and impact of administrative and bureaucratic requirements in the healthcare system on patient care	1	0.4 million €
<b>Topical area 6:</b> Use and linking of routine data	12	14.4 million €
Funding applications from a call for tenders without thematic restrictions	10	8.8 million €
Evaluation and assessment of selective contracts	4	2.6 million €
Evaluation of the Guideline of the Federal Joint Committee on specialised out-patient palliative care	3	3.7 million €
<b>Total</b>	<b>62</b>	<b>70.5 million €</b>

specialised out-patient palliative care, as well as projects to evaluate selective contracts.

It should be ensured when selecting the projects that the funding is applied in a manner that is economical and expedient. The goal is to transfer successfully-tested projects into standard care. It was therefore important for instance to only fund those eHealth solutions in telemedicine which can be integrated into gematik's telematics infrastructure.

### The interim result as seen by the National Association of Statutory Health Insurance Funds

All types of health insurance funds have taken part in the calls for tenders, and many of them were able to put forward convincing project approaches in the selection procedures. The majority of all the projects that were funded are now being implemented with the involvement of health insurance funds. However, the other national organisations of the German health-care system have also contributed constructive proposals relating to the further development of care. A tool has been created in the shape of the Innovation Fund which can be used to provide a major impetus and methods to improve suprasectoral care and care provided between institutions in statutory health insurance. In order to be able to make the best gain in terms of knowledge from the various conceptual approaches that were contributed to the funding procedure, the National Association of Statutory Health Insurance Funds favours making the results even more transparent in future. When it comes to "care research", more than 300 outline applications were submitted, and these needed to be evaluated in a two-tier procedure.



We are on a discovery trip.

We are boys and girls from school.

We are pathfinders.

We have statutory insurance.

Together we are 90 percent.



# Trying out the first online application: The telematics infrastructure

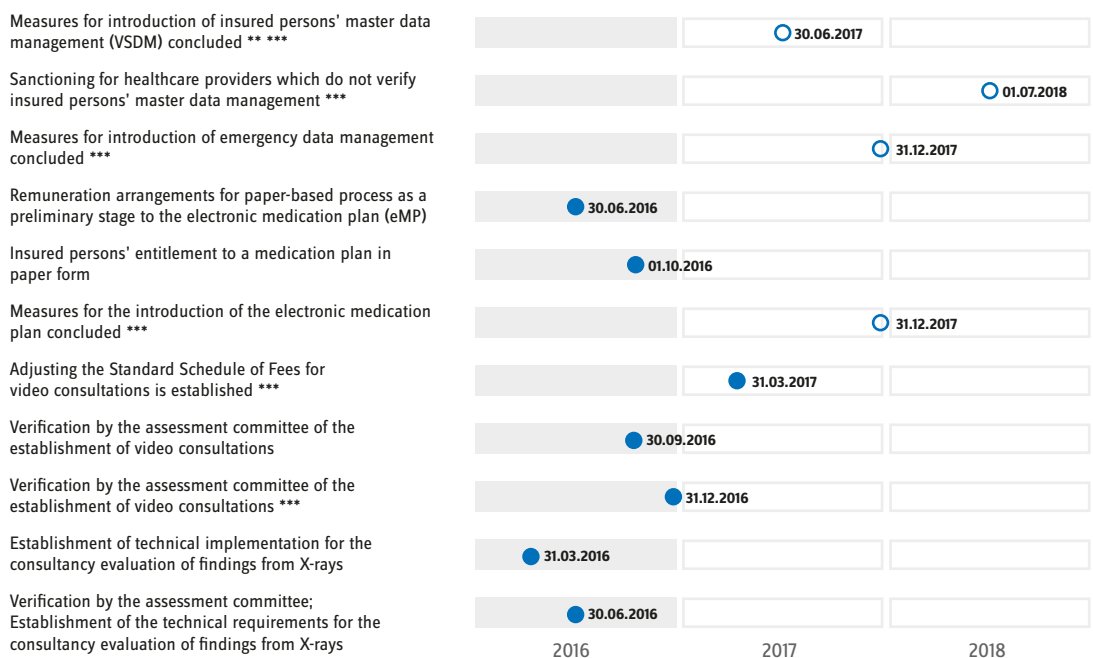
The establishment of the telematics infrastructure in the healthcare system continued to be a determining topic in 2016. Networking the players enables the secure electronic exchange of information to improve treatment quality. A major development goal was reached at the end of 2016: The testing of the online updating of the insured persons' data (insured persons' master data management) as the first online application in the telematics infrastructure has been launched.

Whilst the central telematics infrastructure and the specialist services of the health insurance funds were largely on time, the industrial consortia responsible for the availability of the components and services required in the test regions continued to have massive problems in 2016. One of the two consortia managed in the autumn to provide part of the contractually-agreed com-

ponents at the quality needed for the test. They were brought online in November. A first group of doctors' surgeries was connected to the telematics infrastructure immediately after this important milestone had been reached. This "pilot phase" helped to identify and remedy potential shortcomings in the real care environment. All the participating healthcare provider institutions in the test region North West (Schleswig-Holstein, Rhineland-Palatinate and North Rhine-Westphalia) will be connected in the next step.

By contrast, it was not possible for the testing to be launched in the test region South West (Bavaria and Saxony) in 2016. The launch will undergo further considerable delays since the necessary components from the industrial enterprise that has been commissioned have yet to reach a stage at which they could be approved.

## Deadlines for the eHealth Act\*



\* excerpt  
 \*\* extended to 30 June 2017 by legal ordinance  
 \*\*\* sanctioned deadline  
 Illustration: National Association of Statutory Health Insurance Funds

### Allotting the sanctions in such a way as to reflect the balance of responsibility

The Act on Secure Digital Communication and Applications in the Healthcare System (eHealth Act), which came into force at the end of 2015, is to accelerate the introduction of the telematics infrastructure in the healthcare system with the help of incentives, deadlines and sanctions. The Administrative Council of the National Association of Statutory Health Insurance Funds wholeheartedly welcomed the goal being pursued by the eHealth Act in a declaration that it made in March 2016, and came out fundamentally in favour of sanctions in combination with deadlines. In order to achieve the desired effects, however, the deadlines also need to be based on realistic periods. And instead of punishing individual shareholders of gematik for delays or technical problems caused by the industry, sanctions should affect the parties that are actually responsible. Cutting the budget of the National Association of Statutory Health Insurance Funds only means that the tasks assigned to it by the legislature can no longer be carried out in full.

When it comes to the first online application, the eHealth Act provides that the necessary measures to introduce insured persons' master data management had to be carried out by 30 June 2016. It was not possible to achieve this objective as a result of the problems that industry had encountered with regard to providing the product. In a legal ordinance, the Federal Ministry of Health extended the deadline to 30 June 2017 - also at the repeated insistence of the self-government bodies -, so that the cuts to the budget of the National Association of Statutory Health Insurance Funds provided as a sanction were not applied.

Beyond the provisions on the insured persons' master data management, the eHealth Act provides for further deadlines, some of which are subject to sanctions, such as on emergency data management and on the electronic medication plan. The necessary measures for the introduction of these two applications are to be created by 31 December 2017, and are currently still at the

stage of drafting the documents. It is however already extremely questionable whether the deadline can be adhered to.

Already as a result of the statutory mandate from the eHealth Act, the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians (KBV) have decided to include

**Industry has caused the massive delays to the project with its supply problems.**

benefits in connection with the drawing up and updating of paper-based medication plans in the Standard Schedule of Fees by 1 October 2016 as a first step towards the electronic medication plan. In the process of passing the resolution by the assessment committee on the adjustment of the Standard Schedule of Fees, a provision was also enacted with the National Association of Statutory Health Insurance Physicians on the prerequisites for insured persons' entitlement to a medication plan in the Federal Skeleton Agreement for Physicians.

### The state of the agreement on the teleconsult and on video consultations

The eHealth Act tasked the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds with reaching agreements on the requirements as to the technical procedures on the provision of a consultancy-based evaluation of findings from X-rays (teleconsult) and with agreeing on the technical procedures for video consultations. A teleconsult is a procedure in which findings from X-rays are evaluated between individual healthcare providers in different places using an electronic communication service. This can improve the quality of care, especially in rural regions with few physicians and a paucity of expert experience. In a video consultation, healthcare providers in different places communicate with patients using video technology. This care provided with the aid of telemedicine suggests itself with existing therapy and its continuation, or when carrying out follow-up examinations on for instance immobile patients. Both agreements were concluded on time.



We've been doing it for a long time.

We are masters.

We are amateur chefs.

We have statutory insurance.

Together we are 90 percent.

# From the Act to reality: The hospital structural reform

The essential parts of the Hospital Structure Act came into force on 1 January 2016. This introduced a large number of provisions relating to hospital funding, the hospital structure and inpatient quality assurance. There are virtually no measures here which have a direct impact. The majority of the statutory stipulations do not take effect until after being lent concrete form by the self-government partners. Many of the newly-established tasks are implemented in bilateral agreements with the German Hospital Federation, and arbitration tribunals rule on conflict cases. When it comes to the topic of "Out-patient hospital services", the National Association of Statutory Health Insurance Physicians is involved as a third partner. There is a need to take important decisions on the Federal Joint Committee, especially with regard to quality assurance.

The figure shows the diversity of the topics relating to the hospital reform, albeit there is a need to bear in mind that both the new arrangements on release management and the reorganisation

of University out-patient clinics do not constitute provisions of the Hospital Structure Act in formal terms. They were already brought forward in the Statutory Health Insurance Care Improvement Act, after the discussions in the Federation-Länder working party on the hospital reform. The legislature stipulated very short deadlines with regard to many of the tasks. Even if these deadlines were frequently missed because of the complexity of the topics, it was possible to conclude a large number of the agreements in 2016.

**Important decisions, especially in quality assurance, are to be taken by self-government partners on the Federal Joint Committee.**

The following four areas in particular were worked on in the implementation of the hospital reform in 2016:

1. diagnosis-related group adjustment
2. quality orientation
3. hospital landscape
4. University out-patient clinics and release management

## Deadlines for the implementation of the Hospital Structure Act

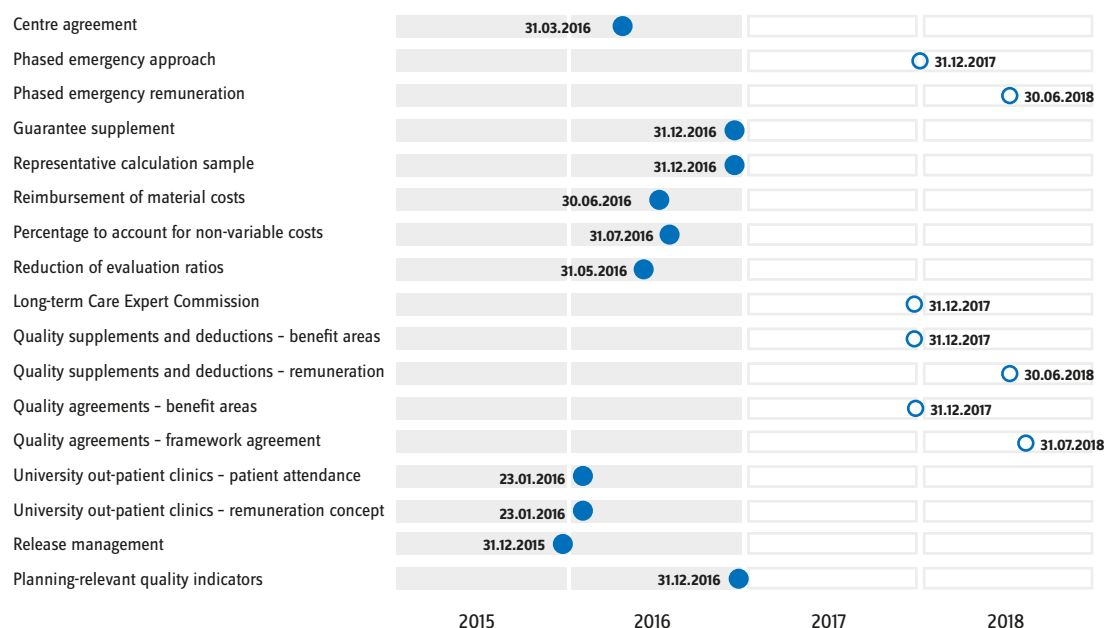


Illustration: National Association of Statutory Health Insurance Funds

A particular focus of the hospital reform was placed on the adjustment of the diagnosis-related groups remuneration system. The Hospital Structure Act remedies several undesirable developments:

- The basis for calculation is to become more representative.
- There will be no more over-evaluation of the material costs.
- Where volume developments occur which are doubtful in medical terms, joint self-government is instructed to correct the empirically-calculated relative weights.

**Representative calculation sample**

Roughly 250 hospitals per year voluntarily take part in the diagnosis-related groups calculation, thus enabling the Institute for Hospital Remuneration Systems (InEK) to undertake a highly-professional further development of the relative weights in the diagnosis-related groups remuneration system. The private hospitals and some benefit areas have however been underrepresented in the calculation for many years. These distortions in the calculation sample led the legislature to task

the self-government partners with concluding an agreement to make the calculation sample more representative. It was possible

to sign a suitable agreement in September 2016, before the statutory deadline expired (31 December 2016). On this basis, the Institute for Hospital Remuneration Systems, presided over by a notary, drew the first 40 hospitals by lots on 31 Octo-

ber 2016, and these are obliged to take part in the diagnosis-related groups calculation for five years from 2017 onwards. This is a major step towards placing the calculation on a broader footing.

**Reducing the material costs**

Reducing the material costs tackles an imbalance in the diagnosis-related groups system when it comes to the remuneration of material costs. Material cost-intensive benefits were previously remunerated differently in the diagnosis-related groups system. If a benefit is funded via an additional fee, the cost data transmitted by the Institute for Hospital Remuneration Systems in the calculation correspond to the amount of the additional fee in euros. If the same benefit is funded via diagnosis-related group flatrate case remuneration, an average of 15 % more is paid in material costs because of the multiplication of the evaluation ratios listed in the diagnosis-related group list by the respective base rate in the Länder (LBFW). Because of this leverage effect, remuneration at flat rates for cases leads to a systematic overpayment of the material costs. The Institute for Hospital Remuneration Systems has developed a concept to correct the leverage effect, and this shifts funds to the staff costs shares. Whilst this does not actually deny any funding to hospitals in toto, it is however redistributed between the hospitals.

After intensive negotiations, the contracting parties reached an agreement in August 2016 to remedy the systematic overpayment. It was ultimately agreed to implement 50 % of the concept of the Institute for Hospital Remuneration

**The political core of the reduction in material costs is the staffing costs revaluation. Especially long-term care is to be weighted more heavily in the remuneration system.**

**From material to staffing costs**

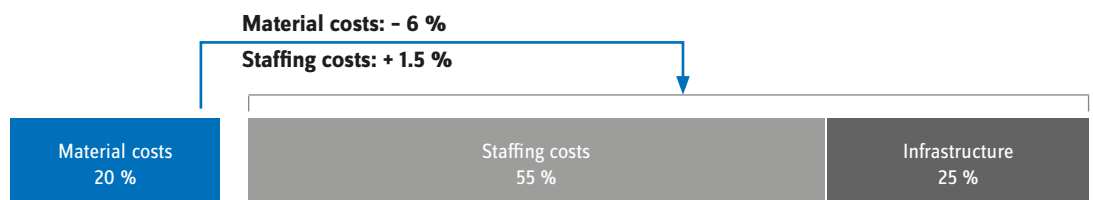


Illustration: National Association of Statutory Health Insurance Funds

Systems in 2017. The concept will be implemented on a pro rata basis at 60 % in 2018 for the diagnosis-related groups system. From 2019, the contracting parties will agree on the extent of the further implementation. If the agreement is not terminated, 60 % will continue to apply.

The political core of the reduction in material costs is the staffing costs revaluation. Especially long-term care is to be weighted more heavily in the remuneration system. The diagram shows the shifts in the diagnosis-related groups adjustment which were carried out from material costs towards personnel expenditure.

### Deliberately reducing evaluation ratios

A further adjustment of the diagnosis-related group system was carried out by deliberately reducing evaluation ratios, as is mandatorily prescribed by the Hospital Structure Act with effect for 2017. This means that benefits appearing to indicate that their volume expansion is economically induced are deliberately reduced. It was also possible to reach an agreement with the German Hospital Federation on this difficult point at the end of August 2016. This was a major step, since this agreement was also vital to publishing the diagnosis-related group system in 2017. Both reductions for diagnosis-related groups in the operative benefit areas "disc surgery" and "hip endoprosthetics", and the downgrading of conservative spine diagnosis-related groups, were carried out as an outcome of the negotiation). The reduction arrangement distinguishes between hospitals above and below the median: The reduced relative weight only applies to half of the hospitals which frequently carry out this operation.

### Percentage to account for non-variable costs (Fixkostendegressionsabschlag, FDA)

A major new arrangement contained in the Hospital Structure Act relates to the price negotiations in the diagnosis-related group system. The Hospital Structure Act shifts the economies-of-scale effect from Land to hospital level. Falling case costs with a volume expansion are also no longer taken

into account at the base rate in the Länder, but as a percentage to account for non-variable costs (FDA) in the individual hospitals. This constitutes a departure from the fundamental principle of benefit-orientated remuneration "equal prices for equal benefits".

The contracting parties at federal level concluded an implementation agreement in September 2016 for the negotiations at hospital level. In addition to greater detail on the implementation of the percentage to account for non-variable costs in situ, this particularly included a definition of the catchment area of a hospital, as well as a list of non-quantity-relevant benefits. The catchment area is significant to the "case of a shift", and hence to any volume constellation in which a hospital or wing closes and the neighbouring hospital takes on the cases. In this case, only half

## Reduced and downgraded diagnosis-related groups

### Diagnosis-related groups flat-rate case remuneration which is to be reduced:

DRG	Designation (list of diagnosis-related groups 2017)
I10D	Other operations on the spine with complex operation on the spine or existing discitis without intervertebral Cage 1 segment, without existing spinal canal stenosis, without existing damaged discs, without occlusion of a defective spinal disk with implant
I10E	Other moderately complex operations on the spine
I10F	Other moderately complex operations on the spine, without specific operations on the spine
I10G	Other non-complex operations on the spine, more than one day of hospitalisation
I10H	Other operations on the spine without non-complex operations or a day of hospitalisation
I47C	Review or replacement of the hip joint without complicating diagnosis, without arthrodesis, without extremely serious CC, age > 15, without complicating operation, without complex diagnosis of the pelvis/thigh or without specific endoprosthetic operation

### Diagnosis-related groups-flat-rate case remuneration which is to be downgraded:

DRG	Designation (list of diagnosis-related groups 2017)
I68D	Non-operated diseases and injuries to the spine, more than one day of hospitalisation, or other femoral fracture, except with discitis or infectious spondylopathy, without fracture of the sacral bone
I68E	Non-operated diseases and injuries to the spine, one day of hospitalisation

the percentage to account for non-variable costs is applied. The agreement on the percentage to account for non-variable costs at federal level now stipulates that the catchment area of a hospital is the area from which more than 70 % of the patients of this hospital come. In accordance with the statutory provisions, non-quantity-relevant benefits are also to only be subject to half the percentage to account for non-variable costs. The self-government partners at federal level have agreed on a list of non-quantity-relevant benefits (88 of the total of 1,255 flatrate case remunerations), consisting of different benefit areas and especially covering benefits with a large share of emergencies (such as strokes and heart attacks). The agreement will serve from the budget year 2017 onwards as the basis for the negotiations on the percentage to account for non-variable costs in hospitals.

It can be observed with regard to the diagnosis-related group adjustment that the self-government partners have really given their best to conclude all the agreements relevant for the 2017 diagnosis-related groups system on time.

### **Regulation relating to University out-patient clinics**

University out-patient clinics are a further focus of the hospital reform - even though they do not constitute part of the Hospital Structure Act in

formal terms, but were regulated shortly before that in the Statutory Health Insurance Care Improvement Act. The Federation-Länder working party ad-

dressed this at an early date because the shortcomings of the Universities flow so to speak directly into the Land budgets.

It is a long time since University out-patient clinics were there only for research and teaching, even though the previous law stated this to be the case. There is therefore a provision to define the broad-

er function of such institutions of higher education in out-patient care in greater detail. The National Association of Statutory Health Insurance Funds, the National Association of Statutory Health Insurance Physicians and the German Hospital Federation have been called upon to establish the group of those patients who need to receive care from the University out-patient clinics because of the nature, seriousness or complexity of their illness. The regulatory area is highly contentious and non-transparent. After unsuccessful rounds of negotiation, a three-year evaluation phase has been provided for in a procedure of the Federal Arbitration Office, intended to create an empirical foundation. There was no precise delimitation of the group of patients at first. Instead, requirements were formulated as to the provision of benefits: Diagnosis and leading therapy decisions are to be taken by a specialist physician who has concluded further training (specialist physician status).

What is more, the German Hospital Federation and the National Association of Statutory Health Insurance Funds have to agree bilaterally on nationwide principles, especially on the documentation of benefits and on the remuneration structure, which suitably portray the particularities of University out-patient clinics. After unsuccessful negotiations, there was an arbitration tribunal solution here too. According to this, in place of an undifferentiated flatrate over all out-patient units of an institute of higher education, up to 50 different treatment flatrates are to be invoiced in future. Components of quantitative control still need to be agreed on. The decision of the arbitration tribunal also provides that University out-patient clinics must document in future whether the services provided constitute research and teaching or patient groups with complex symptoms. The doctor's identification number of the physician in attendance at the University out-patient clinic is however not documented. It can be foreseen that both arbitration tribunal rulings are only the beginning of a further chain of regulatory provisions for University out-patient clinics.

**It is a long time since University out-patient clinics were only there for research and teaching. The further function of higher education institutes in out-patient care is to be defined in greater detail.**



# Greater transparency: The Transplantation Register Act

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The Act on the Establishment of a Transplantation Register (Gesetz zur Einrichtung eines Transplantationsregisters), which came into force as per 1 November 2016, is intended to improve and further develop transplantation medical care in Germany, as well as to increase transparency. The Act corresponds to the direction of the system, creating a solution to the urgent need to bring donors' and recipients' data together in order to be able to organise the allocation of organs better. One positive aspect is that the demand of the National Association of Statutory Health Insurance Funds to make use of existing data was incorporated into the Act.

A central demand of the National Association of Statutory Health Insurance Funds to make it mandatory to provide data in place of a "consent-based solution" was however disregarded. Making absolute the right to informational self-determination leads to fears that the Register will remain incomplete and be unable to provide relevant results. Furthermore, the lack of mandatory data provision will make it virtually impossible to answer questions such as that of any possible preferential treatment of privately-insured patients when allocating organs. There was also no consideration of the demand of the National Association of Statutory Health Insurance Funds to mandatorily involve private health insurance companies in the funding. The Act only provides for them to take part on a voluntary basis.

## Preparing for implementation

Until the Register has been set up, and until the Transplantation Register Agency starts operations, there is a need for considerable preparatory work to be carried out by the contracting authorities in accordance with the Transplantation Act (Transplantationsgesetz - TPG), namely the German Medical Association, the German Hospital Federation and the National Association of Statutory Health Insurance Funds.

Against this background, the contracting partners under the Transplantation Act have agreed to appoint a commissioner for the establishment of the Transplantation Register in order to advance at an early date the Europe-wide call for tenders for the Transplantation Register and Confidence Agency. The first task of the establishment commissioner will be to draw up the description of performance for the call for tenders and to guide it until the contract is awarded.

Parallel to this, the data pertaining to the organ donors as well as to the recipients which need to be reported to the Transplantation Register and the corresponding transmission channels need to be determined by the contracting authorities under the Transplantation Act. In order to support the work of the contracting authorities under the Transplantation Act, the Federal Ministry of Health commissioned the Robert Koch Institute (RKI) at the end of 2015 with drawing up an initial proposal for a dataset that would be standard nationwide. To this end, the RKI, together with experts, has already evaluated the data that have been collected by the German Organ Transplantation Foundation, Eurotransplant, and the Institute for quality assurance and transparency in the healthcare system (IQTIG), and has drawn up an initial proposal for a nationwide dataset. The latter is now being developed further by the contracting authorities under the Transplantation Act.

**The Act corresponds to the direction of the system, creating a solution to the urgent need to bring donors' and recipients' data together in order to be able to organise the allocation of organs better.**

# Handed-down budgets, Lack of equitableness in benefit: The PsychVVG

The Act on the Further Development of Care and Remuneration for Psychiatric and Psychosomatic Benefits (PsychVVG), which came into force as per 1 January 2017, constitutes a fundamental amendment of the new remuneration system

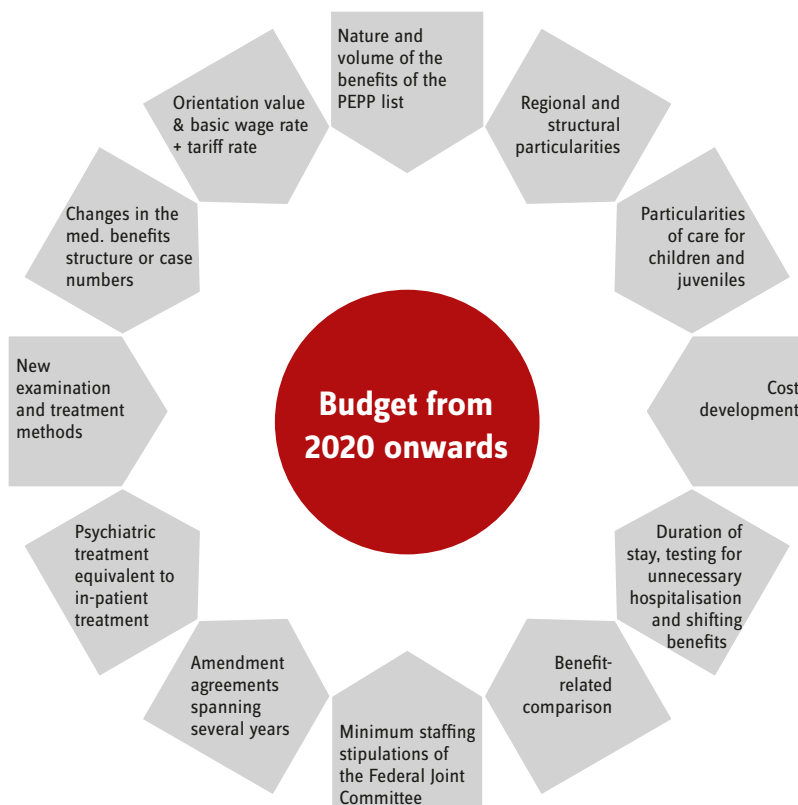
**Instead of the originally-envisioned equitableness in benefits, it can be predicted that historically handed-down budgets will be continued.**

(PEPP). The goal originally aimed for in the Coalition Agreement of CDU/CSU and SPD to entrench greater transparency and benefit orientation in psychiatry

has hence not been achieved. The new remuneration system is now not to be introduced in a budget-neutral manner until 2018. The originally-envisioned equitableness in benefits will be replaced from 2020 onwards with a new

budget finding mechanism. As this is only to be covered by a vague, non-binding comparison of hospitals, it can be predicted that historically handed-down budgets will be continued. In light of twelve different influencing factors, the determination of the budget is completely unclear. The mandate of the Federal Joint Committee to develop stipulations as to staffing has been retained. These binding minimum stipulations are to replace the out-of-date Psychiatric Staff Ordinance (Psychiatrie-Personalverordnung) of 1991. The National Association of Statutory Health Insurance Funds welcomes the implementation of its demand for a binding obligation of proof from the agreement year 2016. The lack of implementation of existing staffing stipulations is caused less by a lack of funding, and more by the inadequate occupation of posts in the hospitals.

## Determining factors of the budgets from 2020 onwards



## New care sector and better documentation

Psychiatric treatment equivalent to in-patient treatment is to be added to the roughly two dozen provisions on out-patient hospital services as a new care sector. The National Association of Statutory Health Insurance Funds considers that the further development of the psychiatric out-patient clinics that have already been established with the stipulation of a nation-wide remuneration system for out-patient treatment in hospitals and treatment involving home visits to patients would have facilitated more promising promotion of suprasectoral treatment.

The impetus provided for in the Act for a better depiction of the benefits must be used to structure the list of more medically-substantial procedures. This is the only way to achieve the still lacking transparency in benefits. The National Association of Statutory Health Insurance Funds has developed proposals for this, and has repeatedly incorporated them into the proposal for a procedure of the German Institute of Medical Documentation and Information (DIMDI).

Illustration: National Association of Statutory Health Insurance Funds

# Realistic simulation of needs: The statutory health insurance clinic simulator

It was realised at the latest with the hospital reform that not all hospitals contained in the hospital plan are actually needed. The legislature has yet to answer the question as to which of the many clinic locations in Germany it may be possible to close or reassign. This topic will therefore continue to dominate the health policy agenda.

Central importance attaches to there always being a hospital available, including in less densely-populated regions which can be easily reached. Anyone who wishes to lend concrete form to and implement the structural improvements in the in-patient sector therefore needs to know what impact the closure of a hospital location has on care. Otherwise, any hospital could be declared to be absolutely necessary. The National Association of Statutory Health Insurance Funds has acted here by launching its new Internet simulator, which is available at [www.gkv-kliniksimulator.de](http://www.gkv-kliniksimulator.de).

## Greater transparency regarding the hospitals that are needed

The statutory health insurance clinic simulator shows the distance from roughly 80,000 residential areas to the closest hospital providing primary care with basic surgery and internal medicine departments. This makes it roughly ten times

more precise than traditional analyses based on postcode districts. The car driving time is measured, which is highly reliable thanks to navigation systems. The simulator also shows how the distances change if the insured persons travel to the closest neighbouring hospital in the event of a closure. This simulation can be carried out for any primary care hospital in Germany, thus creating greater transparency regarding the hospitals that are needed on the one hand, and those which could exit the market on the other.

Chains of clinics have long since had software to simulate changes on the hospital market. Such simulations now need to also be used by the decision-makers on the ground and for the public debate.

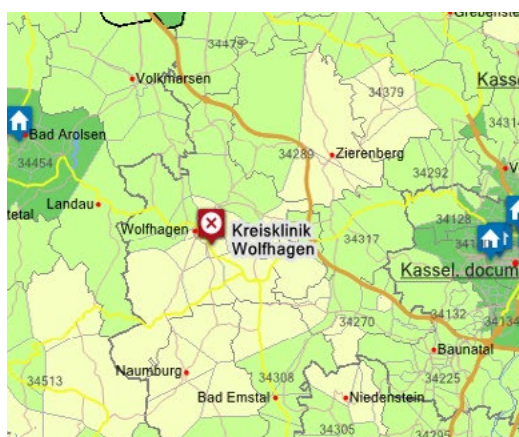
The clinic simulator has already been significant in the discussions on the guarantee supplement in the Federal Joint Committee. If a clinic is making a loss, a supplement can be paid if a clinic closure in a less densely-populated region would cause an additional more than 5,000 insured persons to need to drive more than half an hour by car to the closest hospital providing primary care. According to the evaluation of the simulator, this applies to almost 100 institutions.

## Clinic simulator: Status quo in terms of reachability and after closure (example)

Reachability status quo



Reachability subsequent to closure



### Car driving time

- >40 mins
- 30-40 mins
- 20-30 mins
- 10-20 mins
- 0-10 mins

Hospital

Closed hospital (simulation)



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# Little added value for insured persons: The Care Improvement Act

The Statutory Health Insurance Care Improvement Act (Gesetz zur Stärkung der Versorgung in der gesetzlichen Krankenversicherung, GKV-VSG), which came into force in July 2015, was one of the central legislative procedures in health policy in 2015. Various provisions of the Statutory Health Insurance Care Improvement Act were intended to make a contribution towards ensuring asneeded, universal, easily-reached medical care. Some core elements of the Act which were implemented by the self-government partners in 2016, or which are in the process of implementation, are presented below.

## Appointment service points start operations

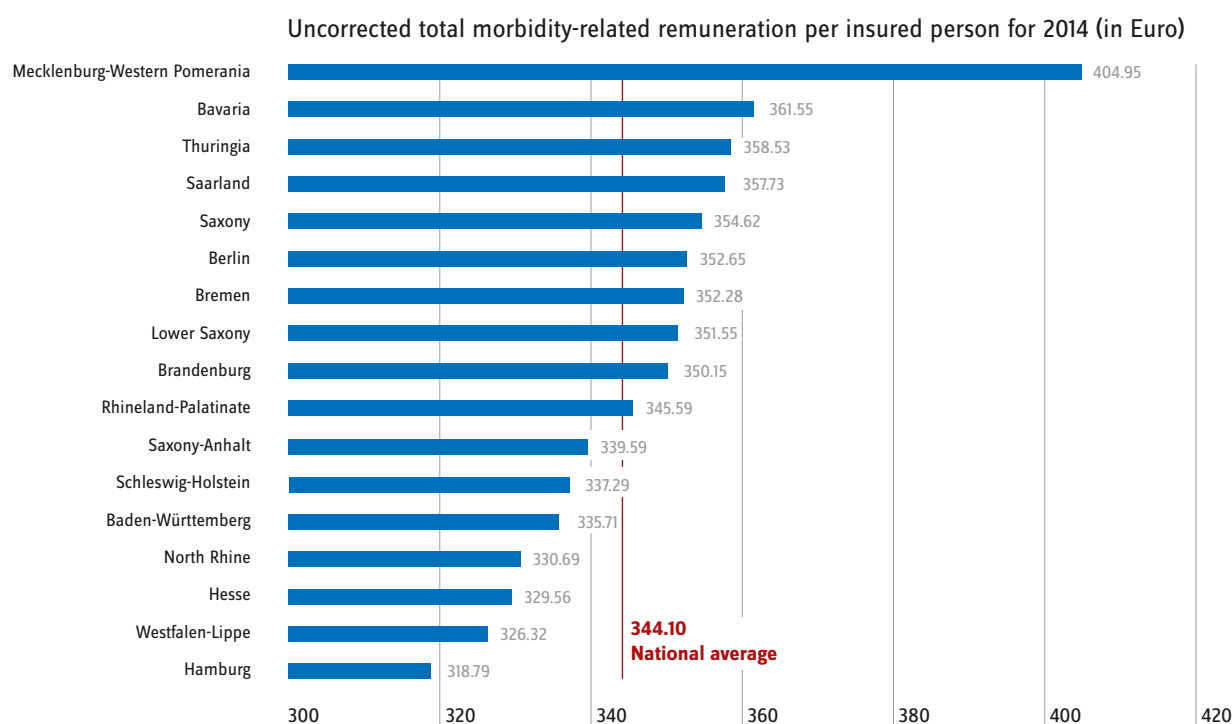
The National Association of Statutory Health Insurance Funds concluded the agreement on the establishment of appointment service points, together with the National Association of Statutory Health Insurance Physicians (KBV). Insured persons who have statutory health insurance have

been entitled since the beginning of 2016 to have specialist physician appointments provided to them by the Associations of Statutory Health Insurance Physicians within one week. The waiting time for a specialist physician's appointment may not exceed a period of four weeks. If no treatment appointment with a specialist physician can be provided within this period, the appointment service point at the Association of Statutory Health Insurance Physicians is to offer to the insured person a treatment appointment in an approved hospital within one more week. The waiting time may not exceed four weeks in this case either, meaning that the insured person is given an appointment within five weeks of the request to be provided with an appointment becoming known.

With the exception of ophthalmology and gynaecology, the provision of a specialist physician's appointment by the appointment service points is conditional on a specially-signed referral being

**Insured persons are given an appointment with a specialist physician within five weeks of their request for placement becoming known.**

## Convergence arrangement on the basis of existing differences in remuneration between individual Associations of Statutory Health Insurance Physicians



Source: Form 3, Calculations: Institute of the assessment committee, Illustration: National Association of Statutory Health Insurance Funds

provided. At the same time, acceptable distance and time stipulations for attending a specialist physician in general specialist physician care and specialised and separate specialist physician care were defined. The obligation to provide appointments that is incumbent on the Associations of Statutory Health Insurance Physicians does not apply to examinations which can be postponed, or to minor diseases. These include screening examinations, follow-up examinations with illnesses which are not medically urgent, as well as examinations to determine physical or mental performance. The impact of the activity of the appointment service points will be evaluated by the National Association of Statutory Health Insurance Physicians. The results are to be reported to the Federal Ministry of Health every year, for the first time as per 30 June 2017.

### **Convergence of the total morbidity-related remuneration**

With the convergence provided for in the Statutory Health Insurance Care Improvement Act between the total morbidity-related remuneration, the legislature intends differences in remuneration to be reduced in the registered contract care sector by virtue of below-average remuneration in individual Associations of Statutory Health Insurance Physicians being increased to an average national value. This provision enables roughly half the Associations of Statutory Health Insurance Physicians to agree for the first time during the fee negotiations for 2017 on an extraordinary increase in the registered contract care remuneration.

Such a one-off adjustment affecting the basis is only possible if the partners to the overall contract unanimously agree during the negotiations that the benchmark value was unjustifiably set too low in 2014. The extent of the adjustment of total morbidity-related remuneration per insured person depends on the total morbidity-related remuneration per insured person falling below the national average between the partners to the overall contract which has been detected and was not materially justified. Total morbidity-related

remuneration per insured person can be increased up to the national average at most. If no agreement on the increase is reached between the partners to the overall contract on the ground, it may be set by the competent Regional Conciliation Board. This extraordinary increase in doctor's fees may cost contributors up to an additional 500 million Euro.

With this arrangement, the legislature complied with the demands of the medical profession for a tangible fee increase. The National Association of Statutory Health Insurance Funds has always rejected such encroachments on the regional remuneration structures since the existing differences in remuneration can largely be justified by considerable regional differences in the care and benefits structure. Increasing the total remuneration does not eliminate these. There is concern that the major additional expenditure will not entail any qualitative improvement in care for contributors.

### **Promoting further training**

The stipulations of the Statutory Health Insurance Care Improvement Act on the further development of the promotional programme were largely implemented in 2016. The agreements in question came into force on 1 July 2016. This increases the number of promoted further training assistants in general medicine from 5,000 to 7,500 posts. In out-patient care, the amount of the promotion was increased from 3,500 Euro to 4,800 Euro per month per promoted post. Added to this was the promotion of 1,000 posts for specialist physicians providing primary care. The eligible groups of specialist physicians are agreed regionally, taking the care situation into account. The focus is placed here on the specialist physician groups of paediatrics and adolescent medicine, gynaecology and midwifery, as well as ophthalmology. The private health insurance companies will also be contributing to the promotional programme to the tune of 7 % of the costs.

Even though the promotion of young physicians constitutes a major contribution towards ensuring adequate, universal care near people's homes in

**There are concerns that the considerable additional expenditure for contributors will not entail any qualitative improvement in care.**

future, criticism does arise with regard to the fact that the further training of doctors is not one of the tasks of statutory health insurance. The further training of physicians is an original task of the medical profession. The medical profession is a liberal profession. The contents of further training are determined by the medical associations. It is fundamentally not conceivable why contributions made by insured persons are to be used to provide doctors with further training who can then decide freely on how they exercise their professions.

### The right to a second opinion

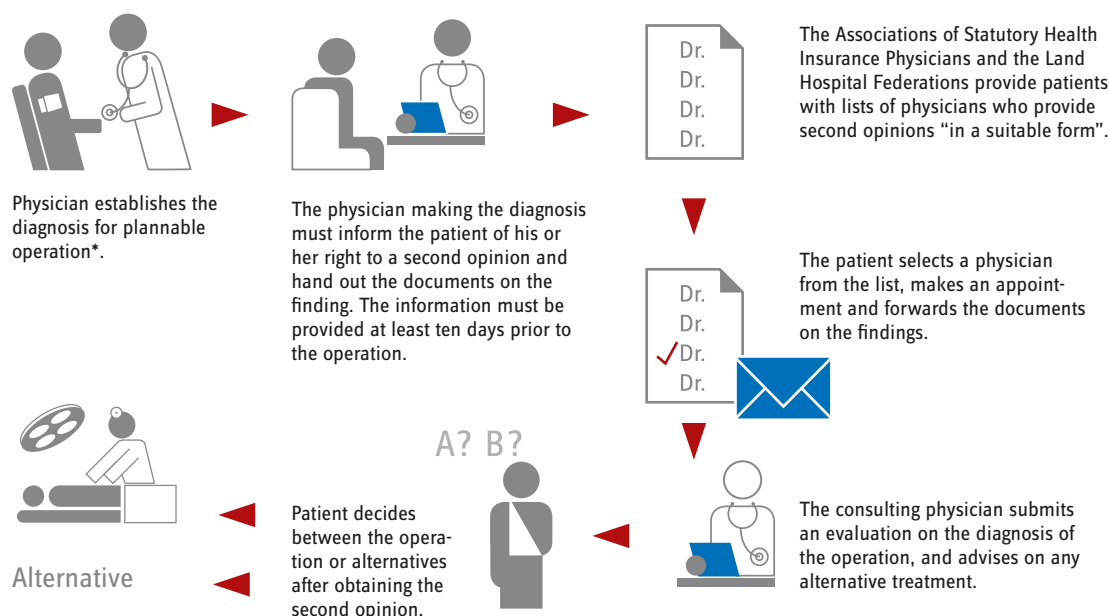
This new provision contained in the Statutory Health Insurance Care Improvement Act has entitled insured persons to obtain a second medical opinion in future before certain plannable operations are carried out. At the same time, doctors who first establish the diagnosis for an operation are obliged to inform insured persons of this entitlement to a second opinion. This enables insured

persons to obtain an independent examination of whether an operation that has been recommended is actually medically necessary. The Federal Joint Committee established in a guideline for which operations the right to a second opinion and an obligation to provide information exists, how the second opinion procedure is to work, and what stipulations those doctors need to satisfy who are consulted to obtain a second opinion.

In the deliberations of the Federal Joint Committee, the National Association of Statutory Health Insurance Funds has striven to see to it that operations are selected as a matter of priority for which less incisive, non-operative alternatives are available. It has also called for unambiguous provisions to be included stating that physicians giving second opinions must have an above-average level of qualification, and that they must be independent. This guideline can be expected to come into force in the spring of 2017.

**Insured persons are afforded the opportunity to have an independent review carried out of whether an operation that has been recommended is actually medically necessary.**

### The second opinion procedure in accordance with section 27b of Book V of the Social Code



\* The right to a second opinion only applies to operations designated by the Federal Joint Committee. Illustration: National Association of Statutory Health Insurance Funds

# Successful agreement: Registered contract remuneration 2017

The fee negotiations that were held at federal level between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians concentrated on the adjustment of the orientation value as per 1 January 2017, and on the remuneration for the drafting and updating of the medication plan.

### Compromise reached on the orientation value

The resolution passed by the assessment committee on the orientation value provides for it to be increased by 0.9 % (approx. 315 million Euro) as per 1 January 2017. The medical profession had called for the orientation value to be increased by 1.4 % (approx. 490 million Euro) plus a structural component of approx. 0.3 % (approx. 120 million Euro) of the total remuneration.

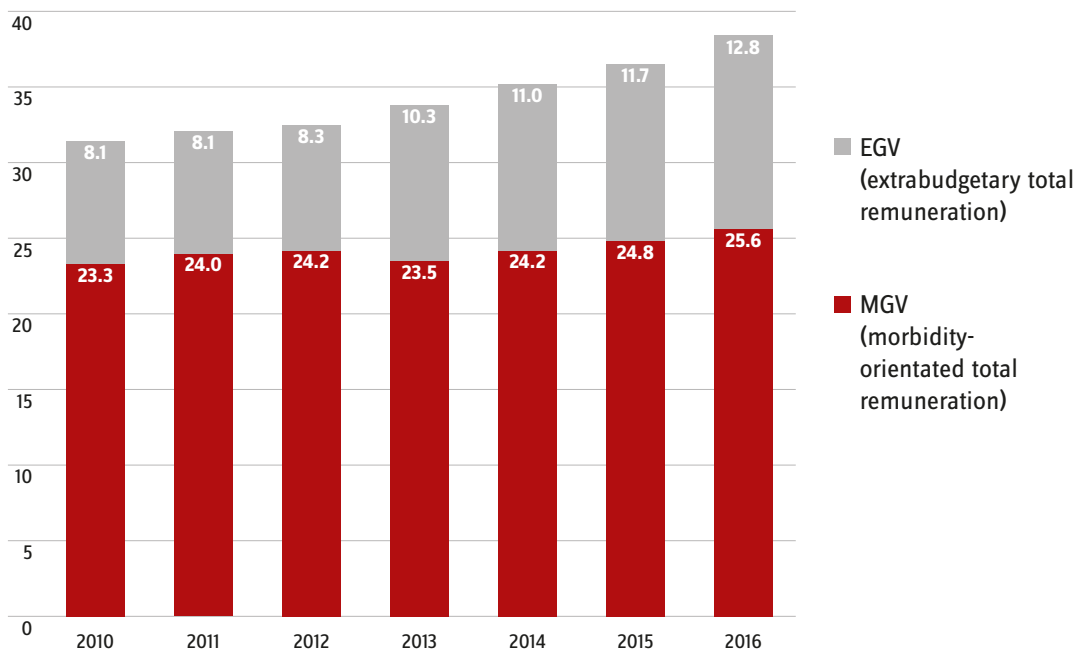
**The surpluses among registered doctors increased by an average of 3.8 % in 2015.**

By contrast, the National Association of Statutory Health Insurance Funds was strongly in favour of retaining the existing orientation value, referring to surgery costs falling whilst surpluses rose. The surpluses of registered doctors rose by an average of 3.8 % in 2015.

Given the different starting positions, the decision of the assessment committee constitutes a justifiable compromise between the positions of the two sides. In comparison to the results that were achieved in the previous years - most recently 1.6 % for 2016 - this is a significantly lower rate of increase in the orientation value for 2017. As was already the case in the previous year, no additional increases in remuneration were agreed because of coordinated structural measures.

The adjustment of the orientation value was adopted in a package of resolutions, together with the provisions on the introduction of the

### Expenditure development in 2010-2016



Source: Form 3 (uncorrected total remuneration), extrapolation for 2016, Illustration: National Association of Statutory Health Insurance Funds



medication plan. With regard to the drafting and updating of the medication plan, to which insured persons have been legally entitled since 1 October 2016, the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians agreed on an additional funding volume of approx. 163 million Euro.

### Objective morbidity measurement necessary

Furthermore, the assessment committee adopted recommendations on the demographic and diagnosis-related change rates of the morbidity-related treatment requirement. The Land level negotiates on diagnosis-related changes in the morbidity structure on this basis. The demographic change rates averaged 0.19 %, and the diagnosis-related change rates were 1.17 %. Whilst it has been possible to observe a continuous, slightly downward trend in demographic rates in the last five years, the level of the diagnosis-related rates corresponds to the median value of the past four years. The National Association of Statutory Health Insurance Funds is holding to its fundamental criticism that the morbidity measurement on the basis of the diagnoses documented by registered doctors themselves is not suitable for the further development of the out-patient treatment requirement. Instead, there is a need to adjust the statutory stipulations in order to be able to implement the morbidity measurement on the basis of criteria which can be viewed objectively.

### Statutory stipulations as a driver for expenditure

An increase in expenditure by approx. 1 billion Euro, or 2.6 %, emerges for the statutory health insurance funds from the resolutions of this year's round of fees for 2017. Approx. 315 million Euro of this is accounted for by the adjustment of the orientation value, approx. 170 million Euro by development in morbidity, approx. 163 million Euro by the medication plan, and approx. 330 million Euro by the anticipated increase in the volume of the extra-budgetary benefits.

Because of the negotiations on the overall contract, and of the statutory stipulations which are still to be concluded at Land level, as well as of considerable increases in expenditure which still need to be implemented, further pronounced increases in expenditure must be anticipated. With the latter in particular, the expenditure development in the registered contract area will be higher than the change rate forecast of income subject to contributions of 2.5 % for 2017.

**The morbidity measurement on the basis of self-documented diagnoses is not suitable for the further development of the out-patient treatment requirement.**

### Results of the remuneration negotiations

	Expenditure in million Euro
Adjustment orientation value 2017	315
Morbidity development (weighting: 50/50)	170
<b>Sub-total 1</b>	<b>approx. 485 (+ 1.3 %)</b>
plus medication plan	163
<b>Sub-total 2</b>	<b>approx. 650 (+ 1.7 %)</b>
plus EGV expenditure increase (Extrapolation)	330
<b>Sub-total 3*</b>	<b>approx. 980 (+ 2.6 %)</b>
for information purposes: increase in expenditure not incl. medication plan	approx. 820 (+ 2.1 %)

\* Sub-total 3 does not yet include additional expenditure expected to result from legal amendments (with the exception of the medication plan).

# A comprehensive reform: Rewording the Psychotherapy Guideline

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With the Statutory Health Insurance Care Improvement Act, the legislature mandated the Federal Joint Committee to adopt by 30 June 2016 provisions on making the therapy on offer more flexible. The Federal Joint Committee adopted the new version of the Psychotherapy Guideline after intensive deliberations.

## **The psychotherapeutic consultation is newly introduced**

As had been called for by the health insurance funds, the revision of the Guideline has introduced a psychotherapeutic consultation as a new benefit. Each patient must take this up before starting to undergo psychotherapeutic treatment. Psychotherapists must also offer consultations as a matter of principle. In order to avoid bottlenecks, the Guidelines include regulations on the availability of all psychotherapists (by telephone).

After the consultation, the patient receives a recommendation for further treatment, from which the transition to the psychotherapy according to the Guideline can take place via the obligatory assessment sessions. Once more there are two possibilities here: The patient can take up a first short-term psychotherapy (T1) of a maximum of twelve hours of treatment via a simplified application procedure. The assessment sessions can however also be followed by long-term psychotherapy; then as before, an assessor needs to be consulted.

## **Urgent treatment as a low-threshold offer**

As an alternative to treatment with psychotherapy according to the Guideline, the patient may also be offered urgent psychotherapeutic treatment after the consultation for a maximum of twelve hours. The goal is to relieve patients of acute symptoms and to prevent their conditions becoming chronic. It is however possible to change to psychotherapy according to the Guideline during or after the urgent treatment, whilst crediting

the hours that have been taken up so far. The implementation of at least two hours' assessment sessions prior to the treatment with a procedure according to the Guideline is obligatory in such cases.

In addition to the above treatment possibilities, patients may however also be recommended in the consultation to attend a self-help group if treatment in the professional medical-psychotherapeutic system is not regarded as being necessary. The advice and treatment requirement may ultimately be met by the consultation to such a degree that no further activities are needed.

## **Stabilisation in relapse prevention**

The short-term therapy T1 (twelve hours) may be followed on application by a further short-term therapy T2 consisting of twelve more hours. For further treatment, an application, which must be submitted via an assessor, can be made for conversion to a long-term therapy. The maximum number of treatment hours which have previously been possible in terms of the procedure has not been changed. The relapse prevention called for with the Statutory Health Insurance Care Improvement Act has been integrated into the course of the treatment with long-term therapies. Once a long-term therapy has been completed, it may make sense to carry out further treatment with the hours remaining within the contingent that has been approved in order to maintain the goals that have been drawn up and achieved. The hours that are to be used for relapse prevention form a component of the overall contingent that has been approved.

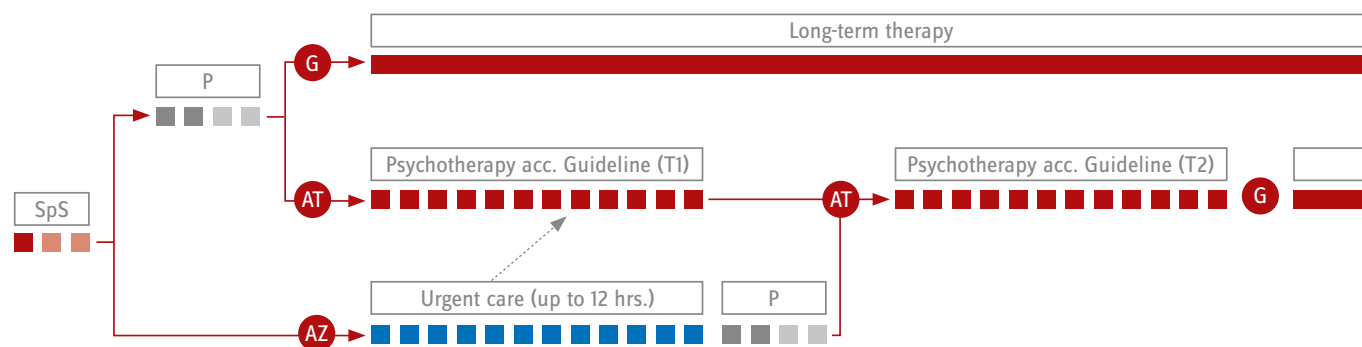
Over and above this, the reform includes a variety of steps to make it easier to provide group therapy, such as making the groups smaller and abolishing the obligation to involve an assessor for the short-term therapy.

## **Out-patient psychotherapy reorganised**

The National Association of Statutory Health Insurance Funds took as an orientation in the

**The goal of the urgent treatment is to offer patients initial psychotherapeutic assistance, to relieve patients' acute symptoms and to prevent their conditions becoming chronic.**

## New procedure in psychotherapy



- SpS** Consultation (one hour obligatory, two hours optional)
- P** Assessment sessions (2 hours obligatory + 2 optional)
- G** Application and assessor obligation
- AT** Obligation to apply without minimum waiting period
- AZ** Obligation to report

Illustration: National Association of Statutory Health Insurance Funds

negotiations in the Federal Joint Committee the positions which it adopted in its Administrative Council in 2013. It was not possible to lend concrete form to the demand on the part of statutory health insurance to generally replace the application procedure with an obligation to report. The compromise that has been achieved in this item provides to structure the short-term therapy as an application procedure with no obligatory assessor procedure.

The structural reform that has been adopted introduces new care elements with which it is possible to achieve psychotherapeutic treatment at short notice and on a low-threshold basis. Illnesses requiring treatment are clarified at an

early date with a diagnosis. Interventions can be organised quickly and unbureaucratically with acute mental symptoms. The Federal Joint Committee will evaluate within five years whether the goals of the reform have actually been achieved. All in all, joint self-government has been successful with regard to the reform of the Psychotherapy Guideline in terms of the furthest-reaching reform of the set of regulations for the range of out-patient psychotherapeutic services since the introduction of the Act on Psychotherapists (Psychotherapeutengesetz).

**The structural reform that has been adopted introduces new care elements with which it is possible to achieve psychotherapeutic treatment soon and on a low-threshold basis.**

# The disbursal is ongoing: The guarantee supplement for midwives

**Statutory health insurance appropriately funds the share of liability costs accounted for by ensuring that obstetric services are provided in statutory health insurance.**

With the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der gesetzlichen Krankenversicherung), the legislature obliged the contracting partners at federal level to agree on contractual provisions concerning the disbursement of a "guarantee supplement" for midwives providing obstetrics services. The latter is to compensate for the high costs of professional liability insurance (Euro 6,274 from 1 July 2015, Euro 6,843 from 1 July 2016) in the long term. The arbitration tribunal established the provisions and the calculation formula for the guarantee supplement at the end of 2015.

## Applying for the guarantee supplement

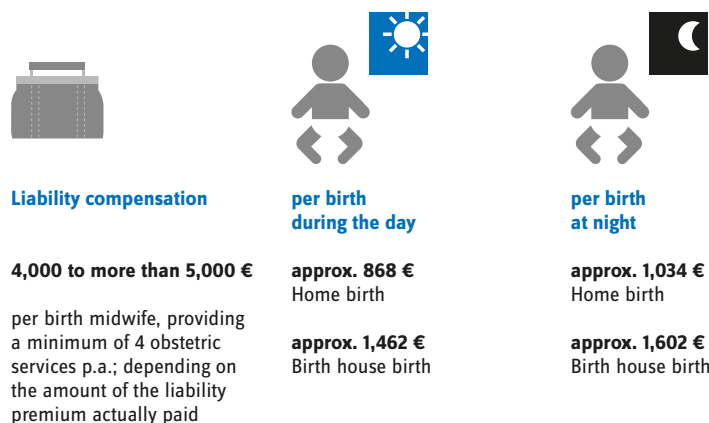
Each midwife working in obstetrics can apply twice per year to the National Association of Statutory Health Insurance Funds to have her professional liability insurance costs disbursed – retroactively from 1 July 2015. This is contingent on the applying midwife having provided at least one obstetric service per quarter, or four in the insurance year, and on her being able to prove her liability insurance costs. The National Association of Statutory Health

Insurance Funds then calculates the compensatory amount to be transferred, which is to be corrected for specific amounts, such as the liability cost elements which have remained in the fee items, and those for persons with private insurance or for private professional liability insurance policies. Statutory health insurance appropriately funds the share of liability costs accounted for by ensuring that obstetric services are provided in statutory health insurance.

## More than 7 million Euro disbursed

The National Association of Statutory Health Insurance Funds set the stage early in January 2016 for a database-assisted application procedure, so that the first applications from self-employed midwives providing midwifery services could be processed and the guarantee supplement disbursed. 3,584 applications had been submitted by 2,171 midwives as per 31 December 2016. It has already been possible to effect 3,080 disbursements on the basis of these applications, as all the documentation was complete in these cases. The total of the overall disbursement had been more than 7 million Euro by then. The amounts that were paid by the National Association of Statutory Health Insurance Funds are funded by the health insurance funds on a pay-as-you-go basis.

## Expenditure incurred by statutory health insurance for a homebirth or a birth in a birth house



Example calculation of possible midwifery services during a non-clinic birth in accordance with section 134a of Book V of the Social Code  
Illustration: National Association of Statutory Health Insurance Funds

We are easily inspired.

We are founders.

We are mothers.

We have statutory insurance.

Together we are 90 percent.



# Care improved: The Hospice and Palliative Care Act

**The framework agreement on the promotion of out-patient hospice services has been reorganised, and was already being fully applied in 2016.**

Once the Act to Improve Hospice and Palliative Care (Gesetz zur Verbesserung der Hospiz und Palliativversorgung) in Germany had been adopted in 2015, the following year was dominated by its implementation. For the National Association of Statutory Health Insurance Funds, this was linked with some new tasks and some expanded ones. The core concern of the law is to refine the framework conditions for hospice and palliative care in such a way that insured persons are cared for and accompanied where they spend the last phase of their lives, that is when they are dying.

## **Expanding the quality and scope of the benefits**

With this aim in mind, the National Association of Statutory Health Insurance Funds has reorganised the framework agreement on the promotion of out-patient hospice services with the relevant national organisations. It was already possible to apply the expanded foundation for promotion in its entirety in 2016. Moreover, the deliberations were initiated with the relevant central organisations of in-patient hospices, including on separate framework agreements for adults' and children's hospices, with which nationally-applicable standards are regulated with regard to the scope and quality of the hospice services.



Together with the National Association of Statutory Health Insurance Physicians, the statutory mandate for an agreement on particularly-qualified, coordinated palliative medical care by contract doctors was implemented in accordance with section 87 subsection (1b) of Book V of the Social Code. The National Association of Statutory Health Insurance Funds has campaigned in the relevant self-government bodies in favour of the necessary further developments in other benefit areas such as in domestic nursing care. Moreover, deliberations were commenced with the relevant national organisations regarding the conception and design of healthcare planning in the last stage of life in fully in-patient long-term care facilities and facilities

of assistance for persons with disabilities. Given the complex nature of the provisions, it will be necessary in some cases to also continue the various deliberations in 2017.

In order to create a sound foundation in the health insurance funds for approaching and informing their insured persons, information was prepared by the National Association of Statutory Health Insurance Funds regarding the possibilities to personally provide for the last stage of life. This relates for instance to living wills, precautionary powers of attorney and guardianship directives.

## **Recommendations for action within a National Strategy**

Back in 2013, the National Association of Statutory Health Insurance Funds started intensively contributing to deliberations regarding recommendations for action in a National Strategy on the basis of the Charter for Care of Severely-III and Terminally-III People (Charta zur Betreuung schwerstkranker und sterbender Menschen) in Germany. The Administrative Council is in favour of the "Recommendations for Action within a National Strategy", and has come out in favour of submitting the consent of the National Association of Statutory Health Insurance Funds to the Charter's Secretariat.

		
<b>The Charter for Care of Severely-III and Terminally-III People in Germany</b>		
Principle 1: Socio-political challenges - Ethics, the law and public communication		
Principle 2: The needs of those affected - Demands on the care structures		
Principle 3: Demands on basic and further training		
Principle 4: Development perspectives and research		
Principle 5: The European and international dimensions		

We are a good team.

We are world travellers.

We are reading coaches.

We have statutory insurance.

Together we are 90 percent.



# Steering instruments are going unused: The Statutory Health Insurance Medicinal Products Care Improvement Act

The Pharma Dialogue between the Federal Government and the pharmaceutical industry ended in April 2016. In this dialogue, the Federal Government agreed with representatives from the pharmaceutical industry, Academia, research and trade unions on the framework conditions for the pharmaceutical industry in Germany in the fields of research and development as well as production and care. Several meetings were held from 2014 to 2016, chaired by the Federal Ministries of Health, of Economic Affairs as well as of Research and Education. Essential results of the Pharma Dialogue were input into the subsequent legislative procedure to the Statutory Health Insurance Medicinal Products Care Improvement Act. The Bundestag however still carried out important changes shortly before adopting the Act.

## **Waiver of public listing of the refund amount deleted from the draft Bill**

The draft Bill at one time provided that refund amounts were no longer to be publicly listed in future. The National Association of Statutory Health Insurance Funds loudly and repeatedly rejected this provision. Not publicly listing the refund amount unavoidably leads to additional expenditure for the community of insured persons, and to more bureaucracy. If the refund amount is not known to all players who carry out price-fixed statutory tasks, then the functionality of central steering instruments is considerably restricted. Against this background, it is to be welcomed that the legislature has ultimately deleted confidentiality from the draft Bill.

## **No turnover threshold for refund amounts**

Together with confidentiality, the turnover threshold from the draft Bill was waived. It was initially planned for the refund amount to apply from the first day of the next month after the surplus if expenditure of 250 million Euro is exceeded within twelve months of a medicinal product being placed on the market for the first time.

The turnover threshold would have constituted a first, hesitant step towards establishing fair prices from the first day onwards. The fact that this has now been deleted is accommodating towards the manufacturers of particularly expensive, high-turnover medicines. The National Association of Statutory Health Insurance Funds will continue to lobby for realistic prices with new medicinal products from the first day on which they are placed on the market. Fair prices for medicinal products will only be brought about if the refund amount is generally retroactively applied from the first day on which they are placed on the market.

## **Pharmacists' remuneration**

The draft Bill provides for an increase in pharmacists' remuneration in the segment of formulations although there is no reliable evidence of underfunding here. This leads to an additional annual funding burden of approx. 115 million Euro per year for statutory health insurance. The envisioned increase in remuneration counters the project of the Federal Ministry for Economic Affairs and Energy to remedy the grievous shortcomings in a research project as to authoritative figures on the cost and income situation among pharmacists in Germany. On the basis of this research project, for the first time evidence-based decisions should be taken on the adjustment of the Medicinal Products Price Ordinance (Arzneimittelpreisverordnung). Adjusting individual elements of the Ordinance without evidence places the meaningfulness of the research project as a whole in question.

## **Extending the price moratorium to 2022**

The planned extension of the price moratorium is a necessary step, and makes a major contribution towards the financial stability of statutory health insurance as long as there is no possibility of benefit evaluation or of negotiations on the refund amount for patent-protected medicinal products of the established market. The price moratorium hence aims at the market segment in which other regulatory tools of Book V of the Social Code do not apply and the medicinal

**Fair prices for medicinal products will only be achieved if the refund amounts are generally applied retroactively from the first day on which they are placed on the market.**



product prices can be determined uncontrolledly by the pharmaceutical companies. Were the price moratorium not to be continued, one would have to anticipate considerable increases in expenditure on medicinal products. This in turn would be highly relevant to the contribution rates, and hence especially to the additional contributions made by insured persons.

### **Benefit evaluation of established market medicinal products**

The National Association of Statutory Health Insurance Funds is fundamentally in favour of the possibility of benefit evaluation also for medicinal products with active ingredients which were placed on the market for the first time prior

to 1 January 2011. The restriction to medicinal products with a fresh approval and new data exclusivity, or to medicinal products with ongoing data exclusivity, is however to be rejected. This reduces the possibility of benefit evaluation to extremely rare case constellations, so that a benefit evaluation of medicinal products of the established market is practically ruled out. In the interest of quality-assured, economical care, each new field of application, especially also changes in the patient population and lines of therapy or new combinations available, should as a rule entail a new evaluation of additional benefit.

**If the price moratorium is not continued, there will be considerable increases in expenditure on medicinal products.**



### **Key aspects of the Statutory Health Insurance Medicinal Products Care Improvement Act**

- The results of the benefit evaluation of new medicinal products are to be input into the doctors' information system in the future in order to provide them with a better basis for making a decision on prescriptions. The Federal Joint Committee is to correspondingly prepare the results of the benefit evaluation one month after the resolution has been adopted.
- The possibilities open to the health insurance funds to safeguard the supply of individually-produced parenteral preparations from finished medicinal products in oncology for direct administration by physicians to patients through contracts with pharmacies are being abolished.
- The health insurance funds will be banned in future from concluding vaccine discount contracts with pharmaceutical manufacturers.
- A period of six months will apply in future to medicinal product discount contracts until they are implemented.
- The price moratorium is to be extended to the end of 2022.
- The remuneration of the pharmacies for the manufacture and sale of formulations, as well as for benefits to which a duty of documentation applies, is considerably increased.

# Benefit-orientated reimbursement of medicinal products: A new concept

Access to new medicinal products is available very early in Germany in a European comparison. As soon as they are approved, medicinal products can be reimbursed without any restrictions for the entire approved patient population. The result of the benefit evaluation that is prescribed by law for these medicinal products however does not have any direct influence on the quality of care for patients. Because of the results of the Pharma Dialogue, the Administrative Council of the National Association of Statutory Health Insurance Funds has adopted a promising concept on benefit-orientated reimbursement.

The concept is aimed at increasing care quality for patients: Enabling doctors to gain better access to the results of the benefit evaluation from the Federal Joint Committee, patients too can be more confident that they are receiving the right therapy. At the same time, this enables the

health insurance funds to orientate their benefits for insured persons in line with the quality of care and the economical use of the contributions.

Benefit-orientated reimbursement is also intended to make it possible to agree several billing prices for an active ingredient in order to portray the different benefit evaluations in the price, depending on the care situation. This ensures that the use of the active ingredient in subindications in which the active ingredient does not have any additional benefit for the patient does not cause any additional costs, whilst with those groups of patients to whom an additional benefit applies, a higher billing price is incurred in accordance with the extent of the additional benefit that has been identified. Moreover, it should be able to rule out a reimbursement for sub-indications which are allotted a lower benefit by the Federal Joint Committee, or for which no dossier was submitted.

## Concept on benefit-orientated reimbursement

**The problem:**

**Mixed prices do not permit a differentiated depiction of the refund amounts where several sub-populations have different additional benefit manifestations.**

**The solution:**

**Differentiated pricing depending on the additional benefit**

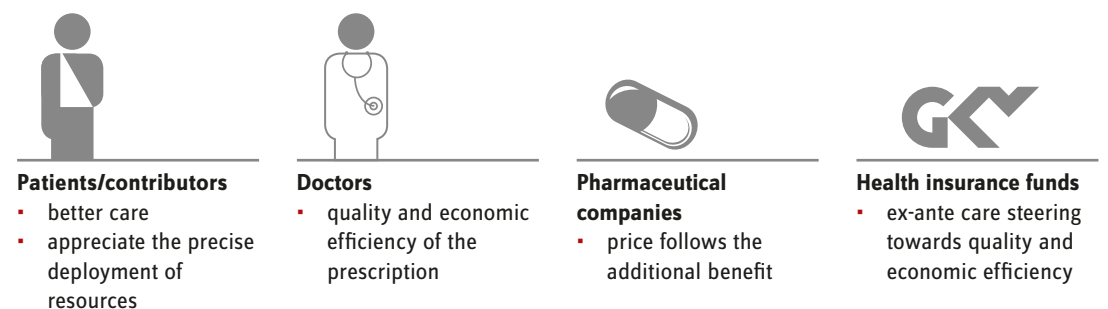


Illustration: National Association of Statutory Health Insurance Funds

# Negotiations successful: Taking stock of the Act on the Reform of the Market for Medicinal Products (AMNOG)

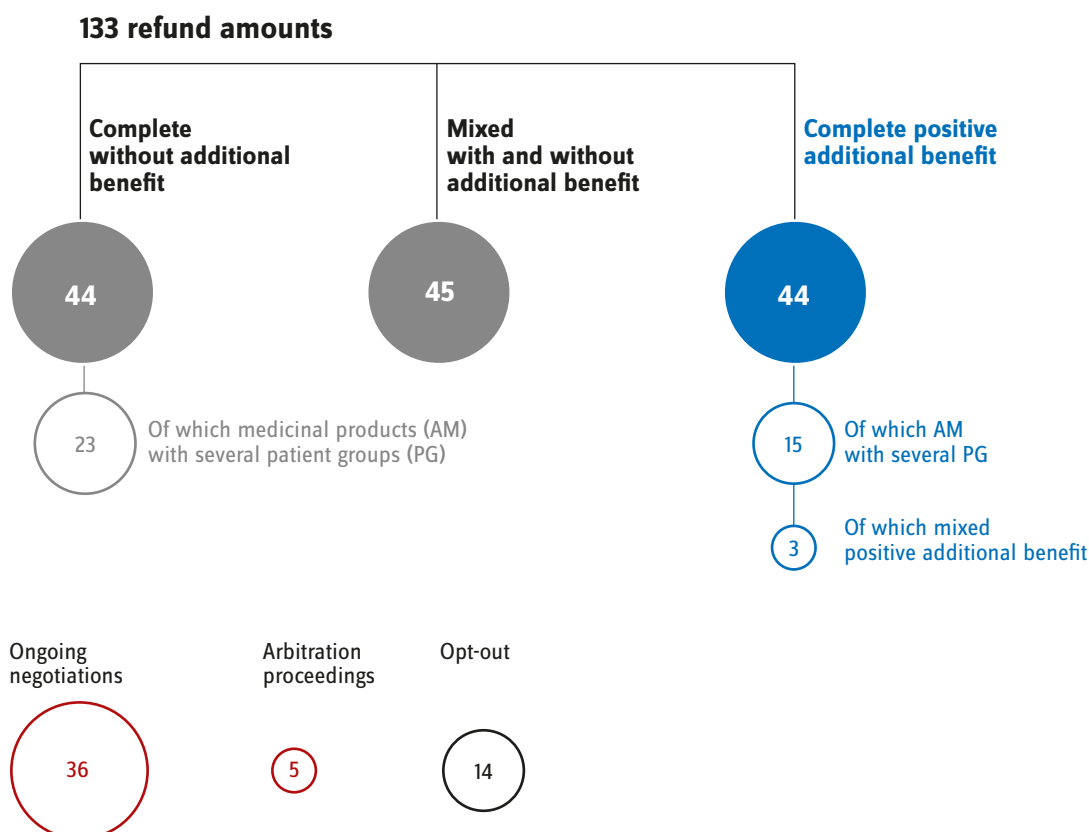
The Federal Joint Committee carried out 272 sets of proceedings on the early benefit evaluation of medicinal products from the new and established markets and more than 746 sets of advice proceedings between 1 January 2011 and 1 January 2017. 27 medicinal products were exempted from the benefit evaluation. Refund amounts were agreed on a total of 133 active ingredients. 114 of these sets of proceedings were concluded through an agreement that was reached between the contracting parties and 19 with a ruling by the arbitration tribunal. Four medicinal products have so far been directly attributed to existing fixed-amount groups. 36 sets of refund amount negotiations and five sets of arbitration proceedings were pending

as per 31 January 2017. 18 sets of pending refund amount negotiations constitute new negotiations necessitated by new resolutions of the Federal Joint Committee in conjunction with new areas of application, because of the expiry of a deadline or of the termination of existing refund amount agreements.

## **New framework agreement in accordance with section 130b subsection (9) of Book V of the Social Code**

The arbitration tribunal established the content of the new framework agreement for the AMNOG procedure with effect as per 1 July 2016. Corresponding to the application of the National Associ-

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



As per: 31 January 2017, Illustration: National Association of Statutory Health Insurance Funds

ation of Statutory Health Insurance Funds, the essential content of the framework agreement was confirmed by the arbitration ruling. The resolution handed down by the Federal Joint Committee on the benefit evaluation continues to form the central basis for the negotiations. As previously,

**The patient-relevant additional benefit in comparison to the expedient comparison therapy is the decisive criterion for agreeing on the refund amount.**

the refund amount with medicinal products with an additional benefit is agreed as a supplement to the therapy costs of the expedient comparison therapy. The patient-relevant additional benefit in comparison to the expedient comparison therapy remains the decisive criterion for agreeing on the refund amount. By contrast, the annual therapy costs of the comparable medicinal products and the actual sales prices in other European countries are only to be taken into account. What has changed are the conditions under which the manufacturers are able to remove their medicinal product from the market without a refund amount being set for the medicinal product (opt-out). Manufacturers will have the possibility to decide to opt-out, not only in accordance with the first benefit evaluation, but also in accordance with further benefit evaluations of a medicinal product, for instance because of the approval of new areas of application. Furthermore, they previously only had up to four weeks after the resolution taken by the Federal Joint Committee to remove the

medicinal product from the market. They may now take the decision up to 14 days after the first negotiation.

**The economic efficiency of the Act on the Reform of the Market for Medicinal Products 2014 to 2016**

In 2016, the National Association of Statutory Health Insurance Funds, the Federal Joint Committee and the Institute for Quality and Efficiency in Health Care (IQWiG) examined the economic efficiency of the implementation of the Act on the Reform of the Market for Medicinal Products. The comparison of the overall administrative costs on the one hand, and the savings which were made between 2014 and 2016 by the refund amounts on the other, revealed that the total cost of the three institutions is small in comparison to the overall savings, and can be regarded as highly economical.

**Participation by the health insurance funds in the refund amount negotiations**

Each health insurance fund which opts to participate has been actively included in the negotiations on refund amounts since January 2015. In the now third survey of mid-2016, 30 health insurance funds stated their willingness to take part in the negotiations. The first allocations based on this list of 64 series of negotiations were carried out back in October 2016.

# Fair prices: Medicinal product fixed amounts 2016

Fixed amounts for medicinal products remain a guarantor for stable medicinal product prices. As maximum limits for reimbursement, they promote competition for low prices. The arrangement comprises both generic and patent-protected active ingredients where these are comparable with other active ingredients and do not signify any therapeutic improvement vis-à-vis other active ingredients in the same group. When determining the fixed amounts, the National Association of Statutory Health Insurance Funds makes sure that a number of medicinal products is available for the necessary medical care for which insured persons do not have to make any additional payments.

## Changes in fixed amounts in 2016

The National Association of Statutory Health Insurance Funds examines the medicinal product market on a regular basis and adjusts the fixed amounts as required to any changes in the market situation. It changed the fixed amounts for a total of 53 fixed-amount groups in 2016:

- reductions in 28 groups
- increases in 13 groups
- repeals in ten groups
- established for the first time in two groups

In addition to the fixed amounts, the National Association of Statutory Health Insurance Funds is able

to exempt particularly reasonably-priced medicinal products from the statutory co-payment of at least 5 Euro and at most 10 Euro. This too is to promote price competition on the fixed amount market. The situation with regard to medicinal products which are exempted from co-payments is to be taken into account when adjusting fixed amounts.

In 2016, therefore, the fixed amounts were only moderately reduced for six groups with medicinal products which are exempted from co-payments in order to continue to guarantee after the adjustment an adequate supply of medicinal products without any co-payments.

**The annual potential for savings is now 7.7 billion Euro.**

## The future perspective of fixed amounts

Fixed amounts promote competition in the interest of fair medicinal product prices. All in all, the arrangement encompasses roughly 34,000 finished medicinal products as per 1 January 2017. Fixed amount medicinal products account for a share of 81 % of prescriptions and a turnover share of 37 % of the total statutory health insurance medicinal products market. The annual savings potential is now 7.7 billion Euro. With the planned Medicinal Products Care Improvement Act (AM-VSG), the fixed amounts arrangement remains largely unchanged. This also means that fixed amounts will continue to make a contribution towards supplying affordable medicinal products in the long term.

## The fixed amounts market in 2016

	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Total</b>
<b>Grouping in accordance with section 35 of Book V of the Social Code</b>	<b>Identical active ingredients</b>	<b>Pharmacological therapeutic comparable active ingredients</b>	<b>Therapeutic comparable effect</b>	
<b>Fixed-amount groups with</b>	314	64	63	441
	205 active ingredients	175 active ingredients	168 combinations of active ingredients	
<b>Turnover in Euro</b>	5.7 billion	4.9 billion	2.3 billion	12.9 billion
<b>Prescriptions</b>	234.4 million	226.2 million	70.8 million	531.4 million
<b>Packages</b>	16,957	10,719	5,980	33,656

Illustration: National Association of Statutory Health Insurance Funds

# Higher quality and economic efficiency: Biological medicinal products

The large share of generic medicinal products in Germany in comparison with other European countries avoids uneconomically high expenditure on medicinal products which are no longer patented. Starting with the rheumatism medicine Infliximab in February 2015, more biological medicinal products which currently have a very high turnover will become patent free in the years to come.

Biological medicinal products are among the most expensive, and hence highest-turnover medicines prescribed at the expense of statutory health insurance. In comparison to the segment of chemically-synthesised generics, biological generic preparations (biosimilars) – especially also medicinal products manufactured by biotechnological means – have by contrast only played a subordinate role so far. The Administrative Council set out its central demands in June 2016 in its position paper entitled “Improving quality and economic efficiency in the supply of biological medicinal products”. The goal is to create incentives for the further development of the market segment.

**Biological medicinal products are among the most expensive and hence highest-turnover medicines.**

Share of biosimilars in the active ingredient Infliximab in Percent

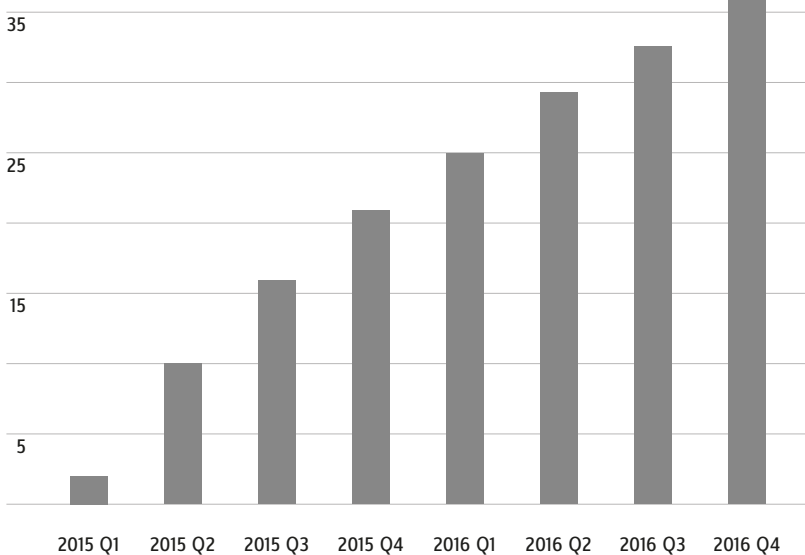


Illustration: National Association of Statutory Health Insurance Funds

Initial results taking the example of Infliximab show that especially the incentives to prescribe economically, which were created by regionally-agreed goals and discount contracts, can lead to the rapid diffusion of biosimilars on the market. According to the figures from the statutory health insurance rapid medicinal product information system, biosimilars for instance already accounted for a share of almost 37 % in the 4th quarter of 2016.



## Core demands of the National Association of Statutory Health Insurance Funds

- Increase competition between suppliers**  
The possibility should be created to define the prescription of biological medicinal products with regard to which the sale price is far below the reference price at the expense of the community of insured persons as “cost-effective biologicals”. The existing framework conditions to conclude selective contracts should be maintained without restrictions.
- Incentives to accept biosimilars and to prescribe biological medicinal products economically**  
Mandatory economic efficiency goals and target rates are to be agreed for biological medicinal products which are classified as “cost-effective biologicals” or for which selective contracts exist.
- Expansion of pharmacists' obligation to substitute with regard to active ingredient expanded to include biological medicinal products**  
The Federal Joint Committee should be tasked with regulating in the Medicinal Products Guideline which biological medicinal products may be inter-substituted at pharmacies. Pharmaceutical companies should be obliged to improve the situation as to studies on the interchangeability of biosimilars.

# Pharmacies' remuneration entitlements: Arbitration ruling on prescription bill auditing

The legislature has commissioned the German Pharmacists' Association and the National Association of Statutory Health Insurance Funds via the Statutory Health Insurance Care Improvement Act with regulating in what cases of a complaint regarding billing by the health insurance funds, especially with regard to formal errors, prescription bill auditing is to be completely or partly foregone. Both contracting partners should take into account here both recent case-law and aspects of the safety of drug therapies, as well as guaranteeing that the stipulations contained in the Framework Agreement avoid misincentives and do not cause any disproportionate administrative effort for the health insurance funds.

The contracting parties to the framework agreement were unable to reach a consensus in the negotiations. It was therefore agreed to call on the arbitration tribunal, which worked out in four sessions a new version of the framework agreement which was acceptable for all the members of the arbitration tribunal.

**The stipulations contained in the framework agreement are to avoid misincentives and not to create any disproportionate administrative effort for the health insurance funds.**

## Provisions on the remuneration entitlement

The arbitration tribunal found that, despite improper prescription by a registered contract physician or sale by the pharmacist, the entitlement to remuneration nonetheless exists where

- a contract supplementing the framework agreement in accordance with section 129 subsection (5) of Book V of the Social Code lawfully provides for the creation of an entitlement to remuneration despite a violation.
- beyond the requirements of the information to be stated in the prescription (e.g. life-long doctor's identification number, establishment number, institution ID number of the health insurance fund) provided for in the Medicinal Products Prescriptions Ordinance (Arzneimittelverschreibungsverordnung) and the Narcotics Prescriptions Ordinance (Betäubungsmittelverschreibungsverordnung), contracts require information to be provided in accordance with section 129 subsection (5) of Book V of the Social Code, and this obligation was complied with by the pharmacy. If the pharmacy has not done so, the remuneration entitlement nonetheless comes about unless the contracts in accordance with section 129 subsection (5) of Book V of the Social Code explicitly provide for prescription bill auditing if such information is missing or erroneous.
- it is an insignificant error not essentially affecting medicinal product safety and the economic efficiency of care, particularly an error of form. Constellations are described in the arbitral ruling in which this is the case.

The contracting parties agreed on the basis of the arbitration ruling to adopt further changes in a second agreement to amend the framework agreement on which consensus had been reached. A complete editorial version of the framework agreements has been published for better comprehensibility.

# Safety vulnerabilities: European approval process for new medicinal products

**The principle of proven effectiveness and safety as a precondition for the market approval of medicinal products may not be watered down any further.**

Companies need approval under the law on medicinal products in order to place medicinal products on the market, and this is issued by the European Commission in most cases. The basis for approval is formed by an assessment report by the European Medicines Agency (EMA). The EMA launched a pilot project in March 2014 entitled "Adaptive Licensing" (now "Adaptive Pathways"), which is to enable those patients to have faster access to medicinal products who are

most likely to benefit. Adaptive Pathways are to rebalance rapid availability with suitable knowledge of the potential benefit and harm emanating from the medicinal product. The goal is said to be not to create a new channel for approval, but to make better use of existing channels.

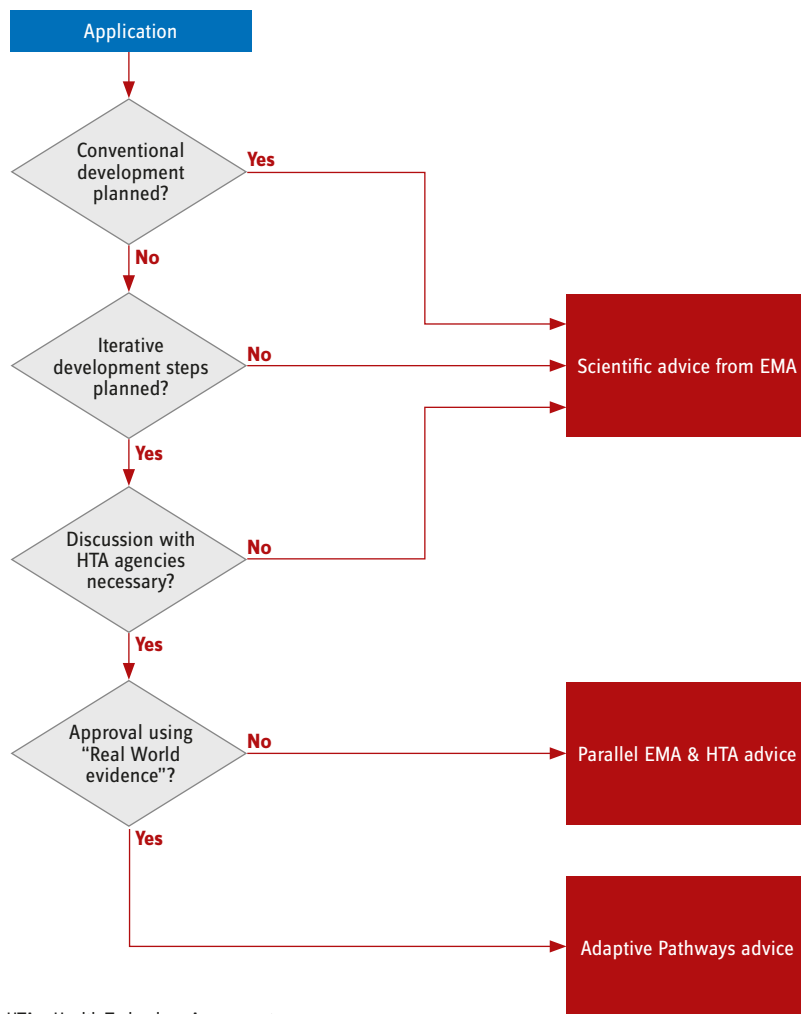
### High safety standards needed

The National Association of Statutory Health Insurance Funds expressed criticism of the pilot project in the final report that was submitted to the EMA in July 2016: Hope of healing or relieving a disease through new medicinal products alone should not lead to a partial departure from the principle of safety as a condition for market approval. The regulations applicable to approval today were not created as a means in themselves, but came about as a reaction to a lack of safety standards, or inadequate safety standards, and to their consequences such as the Contergan® scandal in the 1970s or contaminated blood products in the 1980s. It may also not be forgotten that many medicinal products fail shortly before approval because their presumed effectiveness cannot be proven.

Medicinal products can also be approved more quickly today in order to treat diseases that are caused by life-threatening or serious invalidity. Such approval is given subject to the proviso that missing data on effectiveness and safety be subsequently submitted. According to recent studies, the companies concerned are complying with this requirement to an inadequate degree and too late.

Against this background, accelerated approvals of medicinal products must remain the exception where there are real gaps in medical care. Only in such cases can it be justified that the very early market launch of new medicinal products does not lead to any misassessments regarding their effectiveness, risks and side-effects occurring because of the relative lack of data.

## The suitability of a product for Adaptive Pathways



HTA = Health Technology Assessment  
 Illustration: National Association of Statutory Health Insurance Funds acc. to EMA 2016





We are forging ahead.

We are apprentices.

We are friends for life.

We have statutory insurance.

Together we are 90 percent.

# A reform with light and shadows: The Remedies and Medical Aids Supply Act

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**Departing from the principle of contribution rate stability also sends a signal to other benefit areas, and will further accelerate the expenditure dynamic in remedies.**

The draft Remedies and Medical Aids Supply Act (HHVG), which was submitted in 2016, provides amongst other things to suspend the basic wage rate as an upper limit for remuneration agreements with remedy suppliers for three years. The arbitration procedure and the designation and appointment of arbitrators are also to be accelerated in this context. The draft furthermore provides for nationwide pilot projects across different types of insurance fund regarding the "blank prescription". This is to test within three years greater decision-making powers and therapy responsibility of the remedy suppliers and with regard to taking on into standard treatment. It is a characteristic of the blank prescription that therapists are able to determine for themselves the nature, duration and frequency of the remedy therapy on the basis of a diagnosis and indication for treatment with remedies made by a registered contract doctor.

## **Improving the quality of the supply of medical aids and keeping it financeable**

The National Association of Statutory Health Insurance Funds considers the decoupling of the remuneration for remedies from the basic wage rate as critical, given the fact that the lower price limits for remedies were only recently introduced in the Statutory Health Insurance Care Improvement Act. These will already lead to considerable increases in remuneration in 2016 to 2022. Departing from the principle of contribution rate stability, even only briefly, also sends a signal to other benefit areas, and will further accelerate the expenditure dynamic in remedies.

What is more, a further arrangement for pilot projects with regard to greater therapeutic responsibility on the part of remedy suppliers is not necessary as this can already be tested in pilot projects today. The clarification in the draft Bill of the possibility of approval procedures for remedy suppliers across different types of insurance fund can be regarded positively since this promotes unbureaucratic administrative procedures.

To accompany the current political debate in the field of remedies, the Administrative Council of the National Association of Statutory Health Insurance Funds adopted a position paper back in June 2016 entitled "Improving the quality of the supply of medical aids and keeping it financeable". Amongst other things, this tackled the need for reform in the laws regulating the respective occupations, especially given the inadequate level of qualifications acquired in physiotherapy training as well as the greater therapy responsibility for remedy suppliers, which has been discussed. With regard to the latter, there are no clear, uniform provisions of professional law for responsibly planning and implementing the remedy therapy. The position paper also points to the risks of the abolition of the mandatory basic rate of pay in remuneration for remedies with regard to the long-term financeability of this benefit area. Furthermore, a more evidence-based design of the list of remedies, the evaluation of telemedicine therapies, as well as changes in the further training, are proposed.

## **Ensuring high-quality bandages**

The legislature furthermore intends to create a legal definition of bandages in the Remedies and Medical Aids Supply Act. The National Association of Statutory Health Insurance Funds welcomed the definition provided for in the departmental draft Bill, which was however watered down in the Cabinet draft under the influence of the medical device manufacturers. The original wording of the provision would have enabled clarity regarding the delimitation of classical and moist wound dressings vis-à-vis products promising characteristics over and above this such as having antimicrobial or disinfectant effects. The benefit of these non-classical bandages was to be evaluated in the Federal Joint Committee before they became a part of the standard treatment. The definition that has now been selected will continue to prevent a distinction being made between economical, expedient and evidence-based care and the uneconomical supply of additional benefit that is alleged but not proven. It will not

be possible to make real improvements in wound care quality under these conditions.

### Keeping the list of medical aids up to date

The Remedies and Medical Aids Supply Act also contains a comprehensive bundle of measures aiming to further develop the existing quality tools in medical aids, enhancing patient rights and the principle of benefits in kind, as well as rendering the supply of medical aids financially sustainable. The statutory provisions are welcome on the whole, and are largely based on the proposals and statements previously submitted by the National Association of Statutory Health Insurance Funds on the further development of the supply of medical aids.

The medical aids reform focuses on the stipulation that the list of medical aids is to be systematically examined over the next two years as to its topicality, and continued where necessary. The National Association of Statutory Health Insurance Funds itself already recognised this need in individual areas of medical aids and took it into account by continuing the following product groups in 2016:

- radiation therapy equipment
- insoles
- incontinence products
- nursing care articles
- nursing aids to facilitate long-term care

In this context, especially the technical product requirements were adjusted in line with the current technological state-of-the-art and with requirements as to the care processes. All in all, the focus was placed on needs-based, high-quality care, also as to the quantity and the selection available between several products with no additional payment. Comparable objectives are provided for all future updates of the product groups yet to be covered.

**The benefit of non-classical bandages should be evaluated in the Federal Joint Committee before they become part of the standard treatment.**

The National Association of Statutory Health Insurance Funds will be detailing the procedure to continue the list of medical aids and the product listing until the end of 2017 in a code of procedure which will require the approval of the Federal Ministry of Health. This code of procedure will also establish updating intervals for all continu-



#### Core aspects of the Remedies and Medical Aids Supply Act in medical aids

- Revision of the list of medical aids by 31 December 2018
- Possibility of the multiple contracting partner model also with procurement contracts
- Insured persons entitled to an adequate selection of products
- Defined weighting of non-price quality criteria in the award of contract with calls for tenders
- Expanded obligations to provide information, advice and documentation for healthcare providers, especially with regard to care alternatives provided at no extra cost
- Stricter monitoring of the quality of the results by the health insurance funds on the basis of framework recommendations of the National Association of Statutory Health Insurance Funds
- Further development of the pre-qualification procedure, especially the transfer of the nomination and monitoring of the prequalification units to the German accreditation body

ations after 31 December 2018. These may differ for the individual product groups. The statutory obligation that is incumbent on manufacturers to notify product changes and discontinuations provided for by law will also help to keep the list of medical aids up to date.

Updating the list of medical aids is however not enough by itself to ensure that insured persons actually receive the benefits. The important thing is for the requirements of the list of medical aids

**The focus is placed on needs-based, high-quality care, also as to the quantity and the selection available between several products with no additional payment.**

to be implemented quickly in the care agreements and for the contract monitoring which is obligatory on the basis of the

Remedies and Medical Aids Supply Act to also be established. Only then will the provisions create the necessary conditions for insured persons to also have the required medical aids at their disposal in the long term and in the necessary quality and quantity.

### Benchmarks on the list of medical aids

**Products are included in the list of medical aids at the request of the manufacturer if they meet the quality requirements defined in the product sub-groups. This is examined in detail in an administrative procedure in the National Association of Statutory Health Insurance Funds.**

No. of product groups	39
No. of product sub-groups	more than 650
No. of product types	approx. 2,000
No. of listed medical aids	approx. 30,000
No. of inclusion and change applications submitted in 2016	more than 4,500



We are full of plans.

We are students.

We are trainees.

We have statutory insurance.

Together we are 90 percent.

# Adjusting remedy prices: Implementation of the Statutory Health Insurance Care Improvement Act

**Remuneration differences are to be eliminated by gradually adjusting the remedy prices over a period of five years.**

The Statutory Health Insurance Care Improvement Act empowered the National Association of Statutory Health Insurance Funds to identify price thresholds for remedies. These are to be used as a foundation for the agreements between the health insurance funds and the associations of the healthcare providers as minimum prices. The background is formed by differences in remuneration between the Substitute Funds and the other health insurance funds; these have a historical background, and unlike doctors' and dentists' remuneration have not yet been reduced with the remedies. These differences in remuneration, as well as the distortions of competition that they entail, are now to be eliminated by gradually adjusting remedy prices over a period of five years.

In order to calculate the price thresholds, the funds are required to transmit to the National Association of Statutory Health Insurance Funds, annually as per 1 April, the prices that are applicable at that time to each remedy that is provided. In accordance with the calculation method that is stipulated by law, the lowest price of the respective remedy benefit is added to two-thirds of the difference between the lowest and the highest price of

the Federal Land in question. In order to facilitate a simple calculation procedure and to include the most important price agreements, only maximum prices are considered which have been agreed between health insurance funds and the healthcare providers' associations. Agreements with individual healthcare providers are not considered.

### The statutory health insurance remedies information portal

The National Association of Statutory Health Insurance Funds received the prices reported by the insurance funds in the period under report 2016 in a standardised data supply procedure via the data receipt and transmission unit. The reported data were checked for their completeness and plausibility in an ensuing quality assurance phase, and necessary corrections were taken into account in a correction supply procedure. Furthermore, the recommendations to take individual remedy items into consideration were implemented in a price committee that was established by the insurance funds. In order to calculate the price thresholds, the existing "GKV-HIS" topical portal was developed to become a "GKV remedies information portal" ([www.gkv-heilmittel.de](http://www.gkv-heilmittel.de)) and expanded to include a module for "remedy price thresholds".

## Establishing the price thresholds for remedies

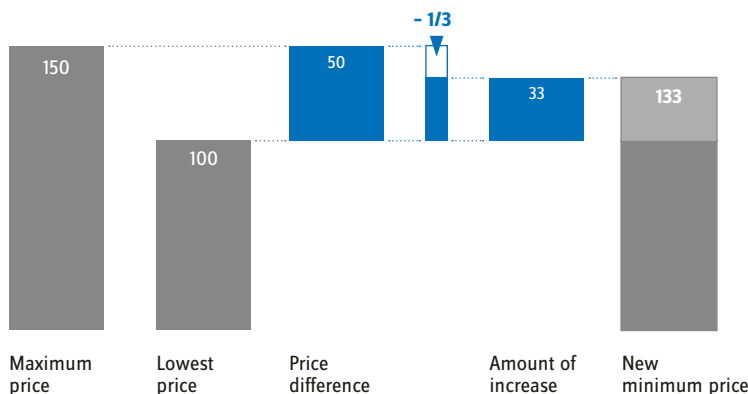



Illustration: National Association of Statutory Health Insurance Funds



We are experts.

We are trainers.

We are fathers.

We have statutory insurance.

Together we are 90 percent.

# Quality assurance and transparency: The IQTIG delivers its first results

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**In September 2016, the IQTIG presented its first quality report containing the results of external quality assurance in hospitals for the reporting year 2015.**

With the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der gesetzlichen Krankenversicherung), the legislature

mandated the Federal Joint Committee with establishing a professionally-independent scientific Institute for Quality Assurance and Transparency in the Healthcare System (IQTIG). After the Federal Joint Committee had launched the "Foundation for Quality Assurance and Transparency in the Healthcare System" in August 2014, the new Quality Institute was formally established at the constituting meeting of the Foundation's Council on 9 January 2015 and Dr. med. Christof Veit appointed as its director. The initial phase in 2015 and into 2016 was characterised by the activities for recruiting staff, establishing the premises at the Berlin location and taking them into operation, planning the IT infrastructure and defining the work and organisational structures. Furthermore, the incorporation of the datastocks and evaluation software from the predecessor institute (AQUA Institute) was planned and prepared, so that the routine tasks could be continued seamlessly from 1 January 2016 onwards.

## **The focus of the work of the IQTIG**

The focus of the work is clearly outlined by the law. As well as implementing the roughly 30 quality assurance procedures in hospitals, they particularly include the further development of data-based suprasectoral quality assurance, as well as the implementation of the new possibilities emerging from the Hospital Structure Act. This Act offers a great deal of new tools which are suitable for the quality-orientated steering of the healthcare system:

- promotion (quality agreements)
- transparency (quality report understandable to the layman, illustration of the results of quality assurance enabling a hospital comparison)
- regulation (quality indicators that are relevant to planning, supplements and deductions)

The IQTIG is preparing the implementation of the stipulations of the Hospital Structure Act for the Federal Joint Committee by developing the tools and methods with its scientific competence.

The IQTIG submitted the first quality report which it drafted independently, as commissioned by the Federal Joint Committee at the QA conference in September 2016. The report has roughly 200 pages, and presents the results of external quality assurance in hospitals for the reporting year 2015, as well as a comparison with the results of the previous year. The quality report is published annually, and provides detailed quality information on various medical care sectors, such as vascular surgery, cardiology, gynaecology or transplants. The IQTIG has also completed its first development commission on time: the development of initial indicators which can be used for hospital planning. They were presented to the Federal Joint Committee in October 2016. These indicators were adopted by the Federal Joint Committee on 16 December 2016, within the period stipulated by the legislature, as a component of a new guideline on quality indicators that are relevant to planning.



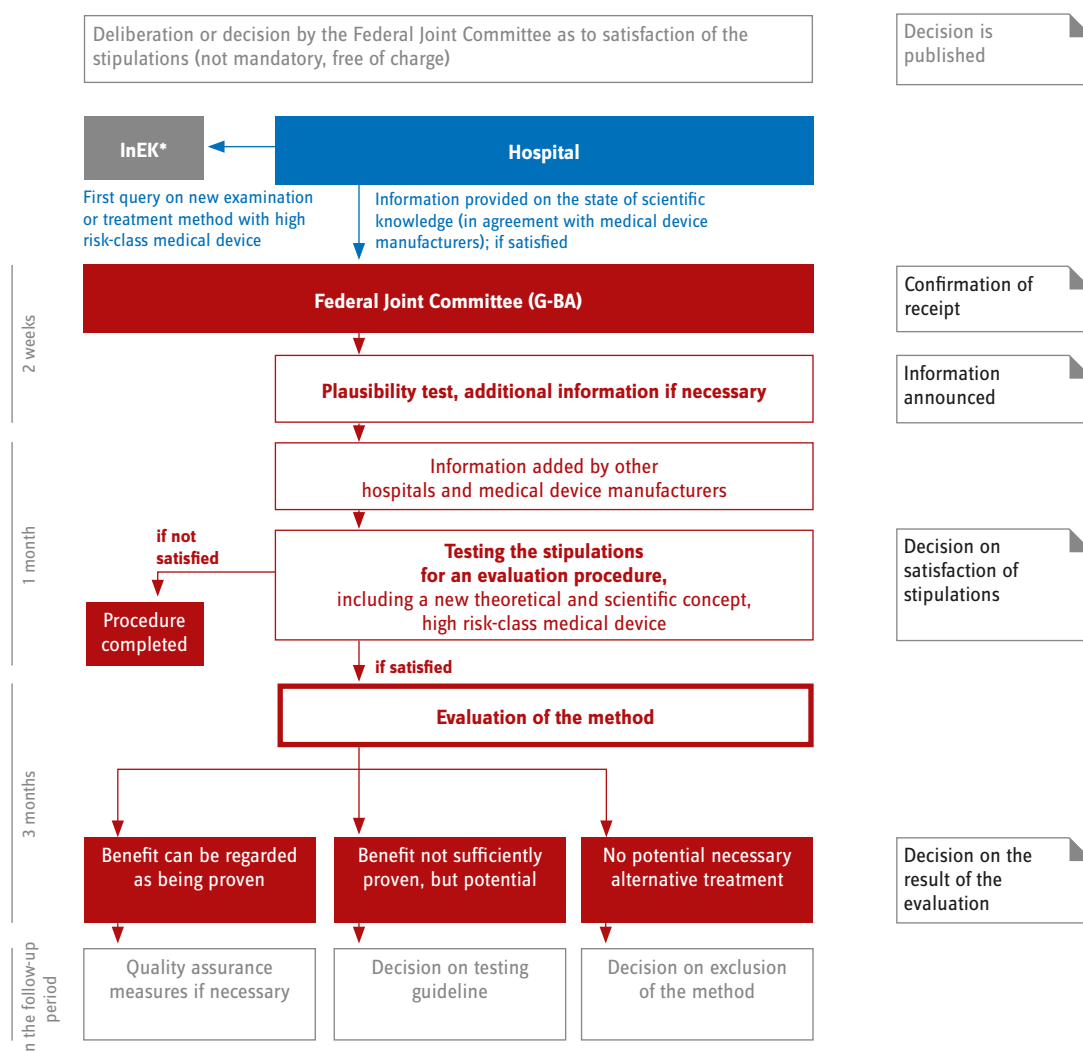
# Ensuring safety: High risk-class medical devices

The National Association of Statutory Health Insurance Funds has been pointing out for quite some time that innovations based on high risk-class medical devices need to be tested better prior to being broadly administered. This demand has been partly taken up by the policy-makers: The legislature adopted such a provision in July 2015 in the shape of the Care Improvement Act. Accordingly, methods which are materially based on the use of a particularly invasive high

risk-class medical device and which show a new theoretical and scientific concept must be subject to a benefit evaluation by the Federal Joint Committee.

A major condition for triggering the procedure is for a hospital to wish to agree on special remunerations for the application of the method, so that it submits a request to the Institute for Hospital Remuneration Systems for the first time.

## The evaluation procedure for high risk-class medical devices



\* INEK: Institute for Hospital Remuneration Systems  
Illustration: National Association of Statutory Health Insurance Funds

If the Federal Joint Committee concludes in the context of the three-month evaluation that the method has the potential to constitute a necessary alternative treatment, it is to decide on its testing. Hospitals which wish to apply the method must take part. Details on the procedure were regulated by the Ministry of Health in a separate legal ordinance, which came into force on 1 January 2016.

### **The provisions do not go far enough**

The statutory provisions are welcomed in principle by the National Association of Statutory Health Insurance Funds, but they fall short of expectations:

1. The stipulations contained in the legal ordinance restrict the scope of application to a very small number of methods. Only three sets of information have been sent to the Federal Joint Committee by hospitals for 2017. One of the methods in question was already requested in the previous year. The Federal Joint Committee is therefore unable to carry out an evaluation although the method satisfies all the criteria in other respects and the underlying product was not even marketable at the time the query was made. It is obvious that not all high-risk innovative methods are indeed evaluated.
2. In accordance with the will of the legislature, each method which has potential is already to be applied and paid for before testing by the Federal Joint Committee has commenced. During the actual testing study, furthermore, all hospitals are to be afforded the opportunity to universally apply the innovation in unnecessary accompanying studies. This runs counter to all the efforts to carry out the actual testing quickly and successfully.

The National Association of Statutory Health Insurance Funds has pointed to these short-comings several times, and has contributed with regard to the design of the code of procedure of the Federal Joint Committee to the legal loopholes being closed in some instances. This path will also be continued in future: constructive guidance where possible – constructive criticism and improvement proposals where necessary.

**Methods which are largely based on the use of a particularly invasive high risk-class medical device and which show a new theoretical and scientific concept must be subject to a benefit evaluation by the Federal Joint Committee.**



We are at home here.

We are neighbours.

We are carers.

We have statutory insurance.

Together we are 90 percent.

# Tackling disease prevention together: Implementation of the Disease Prevention Act

The Disease Prevention Act came into force in July 2015, and is to enhance disease prevention and health promotion for all age groups and in many spheres of life. On the basis of the statutory stipulations, the National Association of Statutory Health Insurance Funds worked in 2016 to create good framework conditions for the targeted, quality-assured expansion of prevention and health promotion.

## National framework recommendations

The National Disease Prevention Conference adopted for the first time in February 2016 the

national framework recommendations on disease prevention and health promotion required by the Disease Prevention Act. They are to help safeguard and refine the quality of disease prevention and health promotion related

to settings and workplaces. Moreover, cooperation between the social insurance institutions is to be promoted in these fields.

The recommendations that have been adopted are subdivided into three goals orientated along the course of life addressed by the institutions of statutory health, accident, pension and social long-term care insurance in line with their respective statutory mandate:

- growing up healthily
- living and working healthily
- ageing healthily

The national framework recommendations are implemented in the Länder and local authorities on the basis of the Land framework agreements. The latter are to be concluded by the Land associations of the health insurance funds and the Substitute Funds with the institutions of statutory pension and accident insurance, as well as with the agencies that are responsible in the Federal Länder. Land framework agreements had been signed in twelve Federal Länder by the end of October 2016.

## Commissioning of the Federal Centre for Health Education

As provided in the Disease Prevention Act, after intensive negotiations the National Association of Statutory Health Insurance Funds concluded an agreement with the Federal Centre for Health Education on 8 June 2016 on support for the health insurance funds in the provision of health promotion and disease prevention benefits in settings. In close cooperation with the associations of the health insurance funds at federal level, a total of nine individual commissions were awarded to the Federal Centre for Health Education. Priority was allotted here to the model project on the interlinking of work and health promotion, as well as on the quantitative and qualitative expansion of the coordination units on equality of healthcare opportunities. The first result is the expansion of measures on the support of the health of unemployed people to cover almost 60 locations all over Germany from the fourth quarter of 2016. The topping up of the coordination units on equality of healthcare opportunities in the Federal Länder to an average of two statutory health insurance-funded posts started in October. They are to support the health insurance funds in the implementation of the Land framework agreements, amongst other areas.

The court action lodged by the National Association of Statutory Health Insurance Funds with Berlin-Brandenburg Regional Social Court, with which the funding of the Federal Centre for Health Education as a state authority by contributions from health insurance is to be reviewed as to its lawfulness, is being pursued in the meantime.

**In commissioning the Federal Centre for Health Education, priority was given to the model project to link work and health promotion, as well as to the quantitative and qualitative expansion of the coordination units on equality of healthcare opportunities.**





We are always on the ball.

We are class representatives.

We are daughters and granddaughters.

We have statutory insurance.

Together we are 90 percent.

# On the way to greater participation: The Federal Participation Act

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The legislature is pursuing the goal with the Federal Participation Act (Bundesteilhabegesetz) of further developing integration assistance on the basis of the UN Convention on the Rights of Persons with Disabilities to become a modern law on participation. This concern is supported by the National Association of Statutory Health Insurance Funds. Integration assistance is being completely reorganised in the legislative procedure and transferred into Book IX of the Social Code (SGB IX). Health and long-term care insurance are particularly affected by two regulatory fields.

## **Binding procedures in the law on rehabilitation and participation**

In order to identify needs and grant benefits in care constellations spanning funding institutions more quickly, the procedures are to be tightened up in the structured rehabilitation and participation law. This goal is wholeheartedly welcomed from the point of view of those concerned. The procedure that has now been chosen, in which a funding institution is able to make binding decisions on benefits for another funding institution, and hence can encroach on decision-making sovereignty with direct financial effect, is likely to prove to be prone to conflicts. This is not lastly because the periods which have been chosen for the rehabilitation funding institutions which are to be involved are not viable in practice.

## **Equal treatment for long-term care insurance and integration assistance**

Against the background of the new definition of need of long-term care, even greater overlaps will arise than was previously the case, especially in the field of care services, in the relationship between social long-term care insurance and integration assistance. The effect of the provision on the priority of social long-term care insurance that had still been selected in the draft Bill would have been that, without recognisable improvements in benefits, only the funding institutions change and the public budgets are relieved of the burden of integra-

tion assistance at the expense of the contributors of social long-term care insurance.

The National Association of Statutory Health Insurance Funds made it clear in this context that people with disabilities who are at the same time in need of long-term care require as a matter of principle both long-term care benefits and integration assistance benefits in order to comprehensively ensure their participation. The need for both benefits, as well as for a clear delimitation, already emerges from the different goals of the two social benefit systems. Recent changes retained the previous equal ranking of social long-term care insurance benefits and integration assistance. When both benefits apply, the funding institution of integration assistance is now to provide the long-term care insurance benefits and a claim a reimbursement from the long-term care insurance fund. This separation between responsibility for implementation and for funding is criticised by the National Association of Statutory Health Insurance Funds, as it leads as a rule to problematic, laborious reimbursement procedures in practice.

The National Association of Statutory Health Insurance Funds will continue to endeavour to ensure that a policy which does justice to persons with disabilities and ensures participation is understood as a task for society as a whole.

**The public budgets of the funding institutions of integration assistance may not be relieved at the expense of the contributors of social long-term care insurance.**



We are loyal to ourselves.

We are bankers.

We are colleagues.

We have statutory insurance.

Together we are 90 percent.

# Standardising provisions: Care of asylum-seekers

**The health insurance funds take on the medical treatment of asylum-seekers after the 15-month statutory waiting period has expired, in return for the reimbursement of their costs.**

The organisational, social and financial challenges are also a matter for statutory health insurance as a central sociopolicy topic. In line with the statutory mandate, the health insurance funds take on the medical treatment of asylum-seekers after the 15-month statutory waiting period has expired. They then receive an electronic health card and can use it to largely claim the same benefits as persons with statutory health insurance. The expenditure to which this leads is reimbursed to the health insurance funds by the competent funding institutions, in addition to an administrative costs share.

## **Framework recommendation for standard procedures**

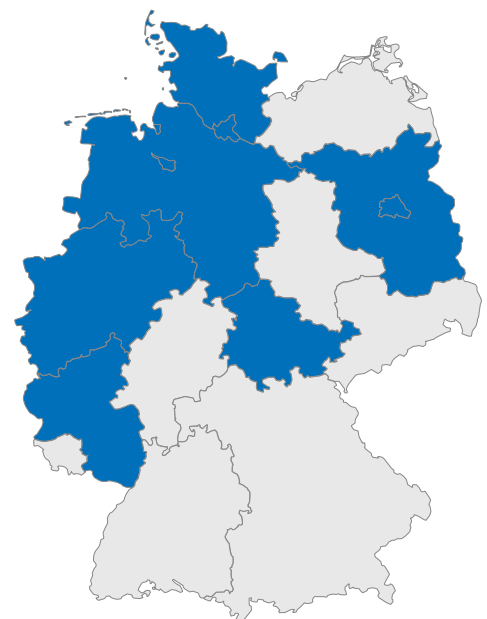
As part of the Asylum Procedure Acceleration Act (Asylverfahrensbeschleunigungsgesetz), which was adopted in an emergency procedure, an expanded statutory basis was created in 2015 in accordance with which the health insurance funds can also be obliged to assume the healthcare of asylum-seekers during the waiting period. This is conditional on the respective Federal Land requiring this and on agreements being reached at least at the level of the rural districts or non-district towns. This means that the question of the structure of medical care during the waiting period continues to be decided on in the Länder and local authorities. In order to nonetheless achieve as standard a structure in the regional agreements as possible, the National Association of Statutory Health Insurance Funds concluded a framework recommendation in 2016 with the central organisations of the authorities that are competent at federal level in accordance with the Asylum-Seekers' Benefits Act (Asylbewerberleistungsgesetz).

The wording of the recommendation particularly addresses the implementation of the provisions under the law on benefits, the billing and auditing of invoices for benefits, as well as compensation for expenditure and the administrative costs of the health insurance funds. Despite intensive talks on the design of the framework recommendation,

it was impossible to establish joint positions on some points. The framework recommendation is nonetheless used as a basis for the above agreements and for the Land framework agreements. It is to minimise the administrative effort with regard to the conclusion of the agreements, and provide a concrete orientation to support the negotiations.

All in all, asylum-seekers do not have standard access to healthcare benefits during the first 15 months of their stay in Germany, and this also cannot be achieved in light of the statutory stipulations, as well as of the federal framework conditions. More stringent standardisation of medical care is also made more difficult by the fact that for the Länder, the involvement of the health insurance funds on a commission-by-commission basis and for a large number of the local authorities accession to any Land agreement which may be in existence is optional.

## **Land agreements on the care of asylum-seekers**



As per January 2017  
Illustration: National Association of Statutory Health Insurance Funds





We have our hearts in it.

We are volunteers.

We are studying together.

We have statutory insurance.

Together we are 90 percent.

# A decisive step: The Anti-Corruption Act

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The Act to Combat Corruption in the Healthcare System (Gesetz zur Bekämpfung von Korruption im Gesundheitswesen) came into force in 2016. The National Association of Statutory Health Insurance Funds has lent considerable support to the legislative procedure, given that it was not possible to effectively counter corruptive practices in the healthcare system with the existing prohibitions regulated in social law alone. The units investigating misconduct can now also inform the competent public prosecution office where there is initial suspicion of corruption in the healthcare system. The new criminal offences will now also indirectly protect the property interests of statutory health insurance, and hence of the community of solidarity.

## **Passive and active corruption are now criminal offences**

What is important here is that the new criminal offences will not be "offences prosecuted on application", but actual criminal offences. The public prosecution offices will therefore always have to prosecute corruption in the healthcare system "ex officio" in future. Anonymous informants can thus file criminal charges and pass on relevant insider knowledge directly and without taking detours.

The Act takes a first decisive step in the fight against corruption in the healthcare system. However, others will have to follow since the Act does not cover all the variants of the offence. This

particularly applies to violations of obligations under professional law to maintain the independence of the medical profession. The Act ultimately causes allocations of monopolies not to

be punished. This however denies the reality of the healthcare system. New, innovative medicinal products to which there is no comparable alternative on the market are only one example of this. Potential unauthorised exerting of an influence on the manner in which pharmacists dispense medi-

cations also goes unpunished under criminal law. This is relevant for instance if health insurance funds have concluded discount contracts for the same active ingredient with several pharmaceutical companies and these are in competition with one another.

## **More detailed provisions on the work of the units investigating misconduct**

In order to guarantee the activity of the units to counter misconduct in the healthcare system among its members in accordance with comparable standards, the National Association of Statutory Health Insurance Funds was obliged to issue more detailed provisions regarding the organisation, work and results of the units on the fight against misconduct in the healthcare system for the first time as per 1 January 2017. Given the major significance attaching to anti-misconduct measures in the healthcare system, the legislature has made it clear that all the health and long-term care insurance funds are to do their share in terms of their size and financial resources to combat misconduct. The National Association of Statutory Health Insurance Funds has shouldered the statutory task of defining minimum standards without encroaching on the organisational sovereignty of its member funds in doing so.

**The new offences will also indirectly protect the property interests of statutory health insurance, and hence of the community of solidarity of insured persons.**



We are completely in our element.

We are development aid workers.

We are motivation artists.

We have statutory insurance.

Together we are 90 percent.

# Under a new funding institution: The Independent Patient Counselling for Germany

UPD gGmbH (Independent Patient Counselling for Germany), as the new provider for a period of seven years (2016–2022), has been advising persons in search of advice on issues related to health and the law on health since 1 January 2016. Statutory health insurance has set aside funding of 9 million Euro per year for the advice. Especially the availability of the independent information and advice service by telephone and in person is to be improved in the new promotion phase. As was to be expected, the first year of the new standard period was dominated by the establishment of the new mechanism.

**Three advice mobiles complement the existing advice at 30 fixed locations.**

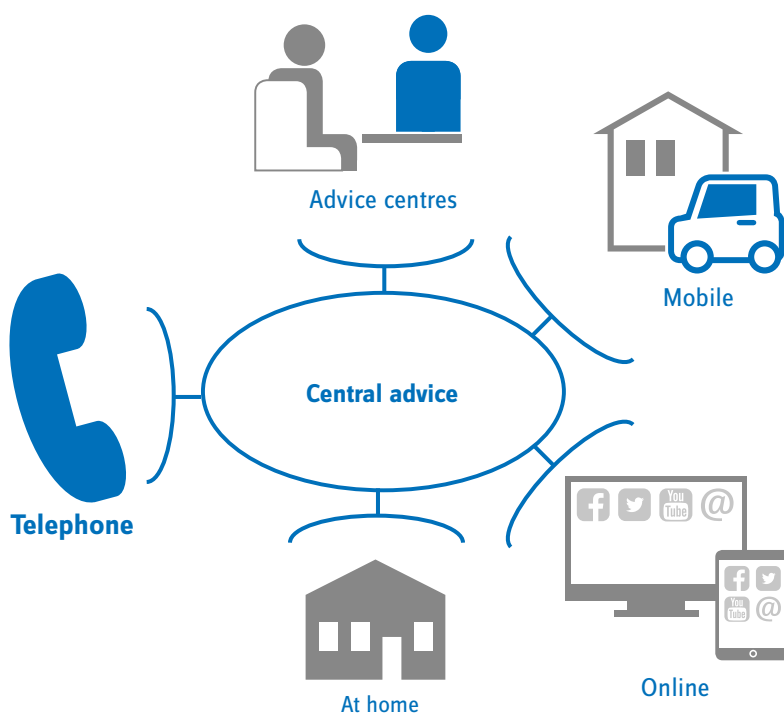
## Access channels successively expanded

A seamless transition of the telephone advice service was guaranteed with the launch of the free nationwide telephone hotline on 2 January 2016. Three advice mobiles have visited 100 towns and cities since 1 April 2016 in order to reach people seeking advice in regions with a weaker structure once per quarter. They supplement the existing advice at 30 fixed locations. Online advice was established as a further access channel.

## Scientific support has started operations.

The new UPD will also be evaluated in the current promotion phase. Prognos AG, which was commissioned by the National Association of Statutory Health Insurance Funds after a Europe-wide call for tenders, has been analysing the structures and processes of the new UPD, as well as the quality of their results, since August 2016. The research questions are the result of a comprehensive description of performance which was coordinated with the advisory council of the UPD.

The advice structure of the new UPD



## Auditor verifies neutrality and independence

In addition to scientific support, gsub GmbH as the auditor has been verifying the neutrality and independence of the advice service since September 2016. The auditor assists the Patients' Rights Commissioner and the advisory council. It is not bound by instructions, has access to all documentation and quality assurance tools, and an unrestricted right to information from the UPD.



We are full of hope.

We are salaried employees.

We are life planners.

We have statutory insurance.

Together we are 90 percent.

# Health insurance funds in the black, Sharp fall in the liquidity reserve: The financial situation of statutory health insurance

At first sight, 2016 was a good year for statutory health insurance in fiscal terms. Whilst the Health Fund had a shortfall of roughly 1.2 billion Euro, the Fund's liquidity reserve was able to compensate for this without falling back on the minimum statutory reserve. At the same time, the health insurance funds can expect a positive result at a level of more than 1 billion Euro with the outstanding accounting results for 2016 as a whole. Against the background of many positive annual results in 2016, the vast majority of health insurance funds was able to keep the additional contribution rates stable until the end of the year. The average additional contribution rate set as a benchmark by the Ministry of Health also remained unchanged at 1.1 %. All in all, therefore, 2016 was a good year with good prospects for 2017. At second sight, however, the judgment must be more differentiated given the fall in the Fund's reserve and other financial developments after 2017.

## Financial development in 2016

The assessable income of statutory health insurance members increased by 3.9 % in the year under report to 1.291 trillion Euro (2015: +4.1 %). This meant that the increase was 0.3 percentage points, or 5.5 billion Euro, less than the appraisers had anticipated in the autumn of 2015. With a general contribution rate of 14.6 %, which has been fixed by law since 1 January 2015, income from contributions was approx. 188.6 billion Euro. Including the net contributions from marginal employment (roughly 3.0 billion Euro) and the contribution from the Federation, reduced by the share accounted for by farmers' health insurance (approx. 13.9 billion Euro), the total income of the Health Fund was about 205.4 billion Euro. The Health Fund was unable to finance the allocations which had been assured to the health insurance funds of 206.2 billion Euro in full with this income. As a result, this led to an annual shortfall of the Health Fund of 752 million Euro. Taking into account the further flow of funds to the Innovation Fund

(149 million Euro) and to the Structural Fund (99 million Euro), prescribed by law as well as to compensate for the shortfall in the income equalisation of the additional contributions (220 million Euro), the liquidity reserve fell from 10.0 billion Euro (31 December 2015) to 8.8 billion Euro (31 December 2016) in the year under report.

Revenue from allocations to the health insurance funds of 206.2 billion Euro compared to fund-relevant expenditure of 218.4 billion Euro. The expenditure of the health insurance funds hence increased by 9.3 billion Euro in comparison to the previous year. This corresponds to expenditure growth of 3.4 % per insured person. The income-related shortfall of the health insurance funds was 12.3 billion Euro in the year under report, which primarily needed to be made up by charging additional contributions. The additional contribution rates charged in 2016 varied between 0.3 % and 1.9 %; only one of the 117 health insurance funds which existed in 2016 (as per: 31 December 2016) was able to completely avoid charging an additional contribution during the year under report.

## The financial forecast for 2017

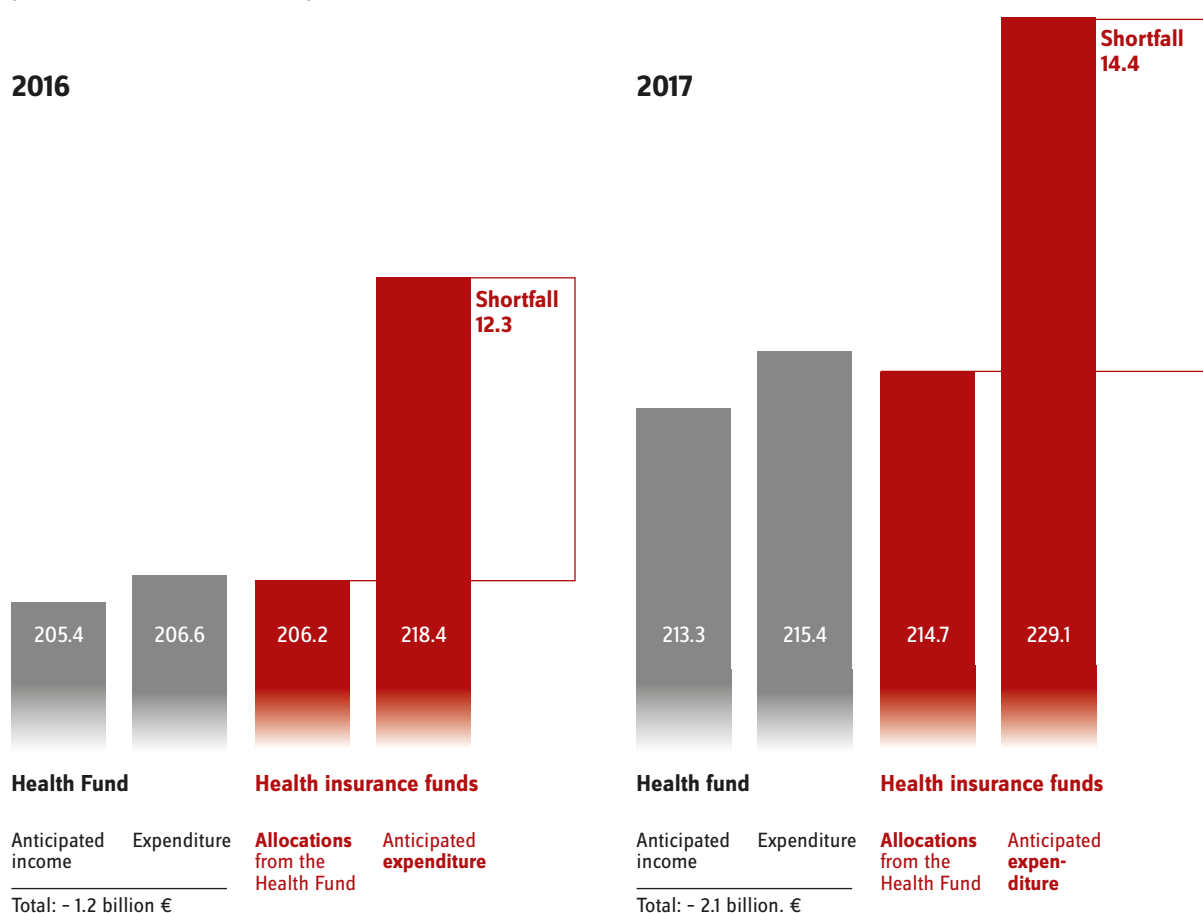
The contribution income for 2017, including contributions from marginal employment, was estimated by the statutory health insurance appraisers to be approx. 198.9 billion Euro. In addition to income from contributions, the Fund is also able to expect the contribution from the Federation to be increased by 0.5 billion Euro year-on-year to about 14.4 billion Euro, so that the estimated revenue totals 213.3 billion Euro. An additional amount of 1.5 billion Euro is available to determine the allocation volume for 2017, and this will be withdrawn from the Fund's liquidity reserve on a one-off basis as stipulated by law. The total income of approx. 214.7 billion Euro increased in this manner is guaranteed for the health insurance funds as allocations for 2017.

All in all, the Fund will achieve a financial result of approx. 2.1 billion Euro. In addition to

**The Health Fund was unable to fully finance the allocations assured to the health insurance funds of 206.2 billion Euro with this income.**

## Income and expenditure of the Health Fund and of the health insurance funds

Major estimation values of the statutory health insurance appraisers of 13 October 2016 plus estimation of income equalisation, in billion Euro



\*Allocations to the health insurance funds plus payments to the Innovation Fund/Structural Fund, as well as compensation for the shortfall of the income equalisation. Values rounded, so that arithmetic deviations are possible

Illustration: National Association of Statutory Health Insurance Funds

the withdrawal of 1.5 billion Euro in favour of the health insurance funds, the Fund will also be burdened in 2017 by the funding shares for the Innovation Fund (149 million Euro) and the Structural Fund (297 million Euro), as well as by the income equalisation (200 million Euro). The liquidity reserve will therefore fall from roughly 8.8 billion Euro to approx. 6.6 billion Euro by the end of 2017. This permits one to anticipate that the politically-convenient phase in which the funds from the liquidity reserve could be

drawn on to finance rising benefit expenditure and for new funding tasks is coming to an end. Even in 2017, the minimum reserve, which constantly increases with the expenditure volume of the Fund, is roughly 4.8 billion Euro. There will also be further obligations incumbent on the Fund beyond 2017 to finance the Innovation Fund and the Structural Fund, as well as the shortfall in the income equalisation. This means that the "available" latitude for funding from the Reserve is all but exhausted.

**The politically-convenient phase in which the funds from the liquidity reserve could be drawn on to fund rising benefit expenditure and for new funding tasks is coming to an end.**

The anticipated fund-relevant expenditure of the health insurance funds in 2017 was estimated at 229.1 billion Euro (+3.9 % percent per insured person). This consequently leads to a shortfall of 14.4 billion Euro on the part of the health insurance funds. Where the health insurance funds are unable to fall back on reserves, this amount is to

be raised through additional contributions made by the insured persons. The shortfall, related to the estimated base rate of pay for 2017, corresponds to a theoretical average additional contribution rate of 1.1 percent. The

Federal Ministry of Health has therefore set the theoretical average additional contribution rate for 2017 to remain unchanged at 1.1 %.

**Developments in additional contribution rates**

Thanks to the additional funding of 1.5 billion Euro made available to the health insurance funds in 2017 to fund recurring expenditure, 85 out of 112 health insurance funds were able to avoid increasing their additional contribution rates at the end of the year. The average of the additional contribution rates actually charged, weighted according to members, which, at 1.08 %, was slightly less in the year under report than the prospectively-calculated average additional contribution rate of 1.1 % that had been set, increased only slightly in the new year (1.099 %, as per: 10 February 2017).

The National Association of Statutory Health Insurance Funds wholeheartedly welcomes the fact that the Health Fund is disbursing a part of the liquid funding, which is in excess of the minimum reserve of 25 % of a month's expenditure of the Fund, to the health insurance funds, and hence benefiting the insured persons. The additional funding by no means constitutes generous allocations on the part of the Federation. In fact, the contributors themselves have primarily successfully increased the reserves of the Health Fund in the years from 2011 onwards which have been

used for the allocations. These are now rightly being used in order to reduce the burden on them. As gratifying as the legislative measure is, it must be said that it only entails a one-off alleviating effect for 2017. Such relief of the need for an additional contribution on the part of the health insurance funds – with 1.5 billion Euro or 0.11 contribution rate points in 2017 – is unlikely to take place in 2018. Since the Federation is also not planning to further increase its contribution for 2018, as far as can be seen at present, increases in the contribution rate can also not be prevented for the end of 2017/beginning of 2018. Whether and to what degree the additional contributions are raised will depend on the financial situation of the individual funds and on the respective decision as to the degree to which the financial reserves are used to cushion increases in the contribution rate.

**Low flat-rate contributions of the Federation for beneficiaries of Unemployment Benefit II**

The National Association of Statutory Health Insurance Funds considers there to be no fundamental need for a specific justification in order to gradually reduce the surplus liquidity of the Health Fund to the health insurance funds. The reduction in burdens on contributors is reason enough. The declaration that has nonetheless been put forward by the legislature that the health insurance funds should have their burden reduced for the healthcare of persons entitled to asylum who are subject to compulsory insurance once they have received a residence title, as well as for their investment in the establishment of the telematics infrastructure on the part of the healthcare providers, can only be understood to a certain degree. There is actually a need for the contribution payments of the Federation for the beneficiaries of Unemployment Benefit II to be orientated at least towards the average expenditure of the health insurance funds. Since these payments are much too low today, a suitable, long-term increase in the health insurance contributions of the Federation for this group of members would be appropriate.

Because of the early publication of the Annual Report, the illustration of the financial situation of statutory health insurance in the year under report was carried out largely on the basis of the results of the appraisers' autumn prognosis (appraisal table of 13 October 2016); the illustration does therefore not include the additional financial data arising at the level of the funds and in the official statistics at later dates, especially the Other income and expenditure of the health insurance funds.



Spread of the health insurance funds in accordance with additional contribution rates

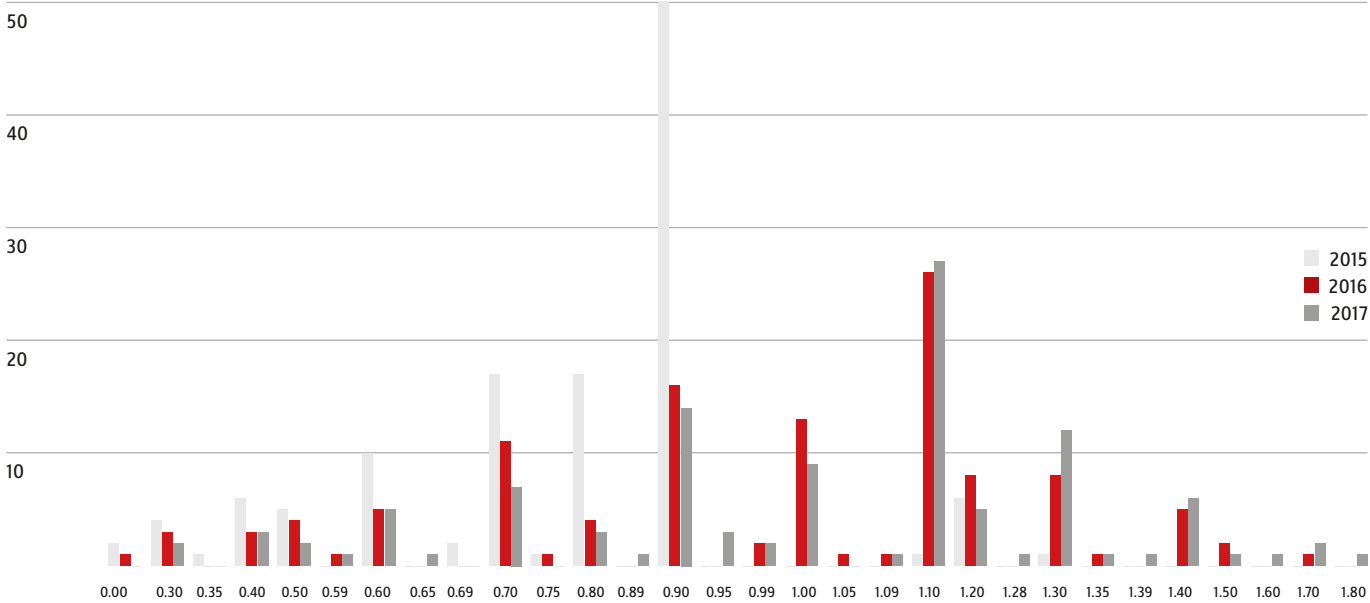


Illustration: National Association of Statutory Health Insurance Funds

We are on the way to the top.

We are starting school.

We are young talent.

We have statutory insurance.

Together we are 90 percent.



# The reorganisation of the European Representation of the National German Social Insurance Associations

Ilka Wölfle is the new Director of the European Representation of the National German Social Insurance Associations in Brussels. She is a lawyer. She worked for the German Statutory Accident Insurance in the European Representation from March 2007 onwards, and had previously worked for the Brussels Office of the German Bar Association. She succeeds Dr. Franz Terwey as Director, who had headed the European Representation since it was opened in 1993, and who retired in November 2016.

The European Representation of the National German Social Insurance Associations in Brussels has been reorganised not only in terms of staffing. Since 2016, it has provided information with a new website on activities and current developments in the European Union concerned with the topic of social security. At the same time, it has been presented in a new design since last year, with a new logo and other media. The new presentation aims to heighten the profile of the European Representation of the three branches of German social insurance and to make them more recognisable.

## New communication channels

Major joint position papers and statements on relevant European topics can be found at [www.dsv-europa.de](http://www.dsv-europa.de), as can current information. Interested readers, as well as the expert public, can sign up to a newsletter. There will also be a regular newsletter in future going into more detail on current developments.

The European Representation of the National German Social Insurance Associations will be positioning itself even more prominently as a competent partner for

topics related to the German social insurance system with the new communication tools.

The new communication concept was drawn up jointly by the European Representation and the German Federal Pension Insurance, the central associations of health and long-term care insurance, as well as German Statutory Accident Insurance.

**The European Representation of the National German Social Insurance Associations is the competent partner for topics related to the German social insurance system.**



Deutsche Sozialversicherung  
Europavertretung

The new logo of the European Representation is one of the stars of the European flag, which is known as a symbol of the European unification process. "The German Star" was given a stylised eagle's head, and therefore symbolises the strengths and particularities of German social insurance, which is also represented by the European Representation in Brussels.

# There's a lot left to do: Health policy in Europe

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The European Union pursued several existing initiatives in 2016 and launched new ones which influence German health policy and statutory health and long-term care insurance. The National Association of Statutory Health Insurance Funds accompanies these initiatives with the aim in mind to place the focus on patient and contributor benefit.

## **Medical devices**

The trilogue negotiations between the Council of the EU, the European Parliament and the European Commission on the new Medical Devices Regulation were concluded in May 2016 with an agreement. The Council and the European Parliament still need to agree to the draft Bill. It is expected that it will be concluded in the first half of 2017. There will be a three-year transitional phase once it has come into force.

The National Association of Statutory Health Insurance Funds considers the draft to constitute progress vis-à-vis the status quo, even though one central demand of the health insurance funds was not taken up: There will still be no independent, central official approval procedure for high-risk products at European level. Instead, the designated agencies are to be reduced in number and made more independent. The specialist responsibility of the designated agencies is also to be improved, and they are to be made more highly specialised. The Regulation introduces a new control tool in the shape of the "Scrutiny System" (expert evaluation of the respective conformity assessment procedures of the designated agencies).

There has been progress when it comes to transparency. A European database is to contain information on the products that are available on the market and their suppliers, and will be open to the public to a considerable degree. The introduction of a standard product identification system (Unique Device Identification - UDI) is to make medical devices easier to trace once they have been placed on the market. There has been no recognisable progress when it comes to product

liability. The negotiating partners have not agreed on obligatory professional liability insurance.

## **Standardisation**

The National Association of Statutory Health Insurance Funds, together with the national organisations of accident and pension insurance, has repeatedly criticised the standardisation of healthcare and long-term care benefits at European level. Should such standardisation take place, the benefits provided by social insurance might only have to comply with a single European standard.

The National Association of Statutory Health Insurance Funds does not consider the standardisation of healthcare services to be suited to bring about greater patient safety when gaining access to high-quality care. It might actually lead to the opposite. The National Association of Statutory Health Insurance Funds points as an example to quality assurance in long-term care and in medical care. Germany has several established self-government procedures in these areas which are geared to the specific conditions of the national care situation. European standardisation might lead to parallel or even competing structures. Since the EU Member States' healthcare and social systems differ widely, it is to be feared that a joint standard can only present a minimum consensus. The European Commission has been able to commission the standardisation of services since 2012. The European Standardization Institute (CEN) already addresses specific standardisation initiatives. The CEN should however restrict itself to technical specifications.

## **A high level of social protection for Europe**

The Administrative Council of the National Association of Statutory Health Insurance Funds welcomed the goal of the European Commission to achieve greater equalisation of social security in the Member States of the European Union at a high level. A high level of social protection and the reduction of inequalities in social services and healthcare in all Member States form the basis

for the Union's long-term economic and political cohesion.

The assessment of the National Association of Statutory Health Insurance Funds is that the States of the EU are faced by common challenges in in-company health promotion, healthcare and sickness benefits, as well as in long-term care in topical terms, but that these differ very widely in practice. These should therefore largely also be countered at nation-state level. Systematic comparisons and a voluntary exchange of experience between the Member States can help them to learn from one another and to modernise the long-term care and healthcare systems in Europe.

The appropriate tools are already available in the EU, so that there is no need to fundamentally recast EU law in healthcare and long-term care. Only in the regulations on the coordination of the social security systems should explicit provisions be included for the risk of long-term care in order to guarantee the effectiveness of these regulations.

The European Commission launched a public consultation on this pillar in 2016. It intends to submit a final proposal in the spring of 2017. The pillar institutes a number of social policy principles which are to serve as a reference framework for "benefit screening" in the Member States in employment and social affairs.

**The standardisation of healthcare services is not suited to achieve greater patient safety in access to high-quality care. The opposite might even be the case.**

## Health policy topics at EU level in 2016

Topic	Contents
<b>Benefit evaluation by the EMA</b>	<ul style="list-style-type: none"> <li>• Along with the amendment to the Regulation laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use, the European Parliament would like to see an assessment of the effectiveness of medicinal products in comparison to existing medicinal products in the context of approval by the EMA.</li> <li>• The Member States must therefore take this evaluation into account when deciding on reimbursements and on pricing. This would lead to a considerable reduction of value in the early benefit evaluation by the Federal Joint Committee.</li> <li>• The National Association of Statutory Health Insurance Funds and the European Social Insurance Platform (ESIP) consider that it will have to be ensured that evaluations and price negotiations are perceived as a national responsibility and as being part of the national reimbursement systems. This is the only way in which national particularities of care can be taken into account.</li> </ul>
<b>European cooperation on patient safety</b>	<ul style="list-style-type: none"> <li>• The European Commission had been tasked by the Council of Ministers with creating a permanent EU network for cooperation on patient safety and healthcare quality in order to work together on a voluntary basis and to learn from one another.</li> <li>• Even though the topic attracted considerable attention at European level in recent years, the Commission did nothing.</li> <li>• Because of the considerable significance which the statutory health insurance funds attach to patient safety, the National Association of Statutory Health Insurance Funds called for cooperation within the EU in this area, which has already been commenced, to be continued within a new network and to include funding organisations in this in future.</li> </ul>
<b>Consultation on Health Technology Assessment (HTA)</b>	<ul style="list-style-type: none"> <li>• The European Commission has launched a consultation on strengthening EU-wide cooperation in the Health Technology Assessment in order to prepare further initiatives at EU level. The spectrum of its considerations ranges from long-term, voluntary cooperation through to jointly drawing up complete HTA reports at EU level and making their use binding in the Member States.</li> <li>• The evaluation procedures and the underlying methods differ widely from one Member State to another in some cases. These differences reflect varying preferences, social framework conditions and particularities of the healthcare systems.</li> <li>• Statutory health insurance and the ESIP consider that cooperation at EU level should be gradually stepped up. Participation in individual evaluation projects and the application of the results of the evaluation should remain voluntary until mutual trust and agreement have been established as to the methods.</li> </ul>

# Transfer of knowledge and exchange: International commitment

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The National Association of Statutory Health Insurance Funds was also active in the international transfer of knowledge and exchange in 2016. The focus here was on contributing in the International Social Security Association (ISSA), as well as on organising and implementing the conference of the German-Austrian Commission (DÖK).

## The German-Austrian Commission

The 45th meeting of the German-Austrian Commission was held in Potsdam in May 2016 in order to deliberate on matters related to social health insurance. The conference, which is held every two years, alternating between Germany and Austria, has been an established institution for decades. It provides the opportunity for a senior-level exchange on major issues related to the healthcare systems over national borders. Representatives were invited who work in the Austrian and German health insurance funds and


**With more than 330 member institutions in over 160 countries, today the ISSA is a leading organisation in international cooperation between social security institutions.**

in their associations on a full-time and voluntary basis. The 82 participants spent two days discussing a variety of topics from the areas of safeguarding medical care, anti-fraud measures and medicinal products. A particular highlight was the talk by Prof. Dr. Ferdinand Gerlach, Chairman of the council of experts on the assessment of developments in the healthcare system, on the prospects for the further development of the healthcare system.

## The International Social Security Association

The National Association of Statutory Health Insurance Funds has been a member of the ISSA for three years, as have the respective organisations responsible for pension insurance, for accident insurance and for social insurance for agriculture, forests and gardening. Established almost 100 years ago, today the ISSA, with its more than 330 member institutions in over 160 countries, is a leading organisation in international cooperation between social security institutions.

The ISSA holds its "World Forum" every three years. This is where the General Assembly, as the highest constituent body, and the Administrative Council as a voting and control body, come together. The "World Forum" is also regarded as the largest meeting of social security experts in the world. Having taken place in Qatar in 2013, it was held in Panama City from 14 to 18 November 2016 at the invitation of the Government of the Republic of Panama, and was hosted by the Social Insurance Fund of Panama. More than 1,000 participants from over 150 countries attended the World Forum, including Ministers, decision-makers from national institutions and agencies, as well as representatives from the United Nations, the International Labour Organisation, the Organisation for Economic Cooperation and Development and other international organisations. Statutory health insurance was represented by Manfred Schoch, a member of the Administrative Council of the National Association of Statutory Health Insurance Funds, in his function as Board member of the ISSA. The Director General of German Statutory Accident Insurance, Dr. Joachim Breuer, was elected as the new ISSA President at the 2016 World Forum.



We are real country people.

We are nature lovers.

We are club champions.

We have statutory insurance.

Together we are 90 percent.

# Investment for the future: The digitalisation of the DVKA

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On the basis of international and national statutory stipulations, as well as of continually-increasing case numbers in the specialist operative areas, more serious challenges arise for the German Liaison Agency Health Insurance - International (DVKA) when it comes to the cross-border tasks of the National Association of Statutory Health Insurance Funds.

**Previously paper-based data and messages will be exchanged internationally by electronic means in future.**

Tried-and-tested modern standards and procedures in information technology are setting the stage for an efficient, economical redesign of major core business sectors. The digital transformation of the DVKA's overall business processes is projected over a period of several years. It is primarily those processes which have the greatest added value and benefit for the health insurance funds that are being digitalised. The first item here is the cross-border cost refund for insured persons within the EU.

## **Legal stipulations and economic requirements**

The European Commission sets the legal framework as well as the IT system for the uniform exchange of messages and data between institutions of social security in the Member States. The processes, interfaces and software components provided by the EU enable the Member States to make considerable savings when establishing and operating the cross-border electronic exchange of data. The Member States retain responsibility for the connection of their national systems to the central components, so that in future extensive business procedures can run from institution to institution over national borders in completely digital form.

For instance, it is to be possible for a claim for reimbursement from a health insurance fund to be transmitted seamlessly via the National Association of Statutory Health Insurance Funds, DVKA department, to the billing system of the debtor institution abroad. The health insurance

fund abroad can directly process the standard, translated request and pay the refund amount much more quickly than was previously the case. The high quality of the verified data, which are transmitted to the recipient in seconds in encrypted form and in a secure transaction, further accelerates the process.

## **The impact on the health insurance funds**

Before the health insurance funds are actually able to benefit from the advancing digitalisation of the processes, they need to invest in new interfaces and specialist applications. The Europe-wide project entitled Electronic Exchange of Social Security Information coordinates the national measures in line with international work in order to be able to start with the standard productive operation in roughly three years. From that time on, many types of data and messages which today remain paper-based will be exchanged internationally by electronic means. The National Association of Statutory Health Insurance Funds, DVKA, is developing the data formats and message structures necessary for this in close coordination with the health insurance funds and their associations at federal level.





We are well networked.

We are advisors.

We are creative.

We have statutory insurance.

Together we are 90 percent.

# At a glance: The “Social insurance for employers” information portal

In December 2014, the Federal Cabinet adopted in a bureaucracy-reduction project the establishment and operation of an information portal for obligations incumbent on employers to report under social insurance law. Small and medium-sized enterprises in particular are to use this portal as a source of information.

## The goal of the portal

The details on the implementation of the portal were entrenched in 2016 in the Sixth Act Amending the Fourth Book of the Social Code and other Acts (6. SGB IV-Änderungsgesetz). The “Social insurance for employers” information portal, which has been implemented as an online portal, is to present the major obligations that are applicable under social insurance law.

**The online portal is to show the major obligations under the law on social insurance.**

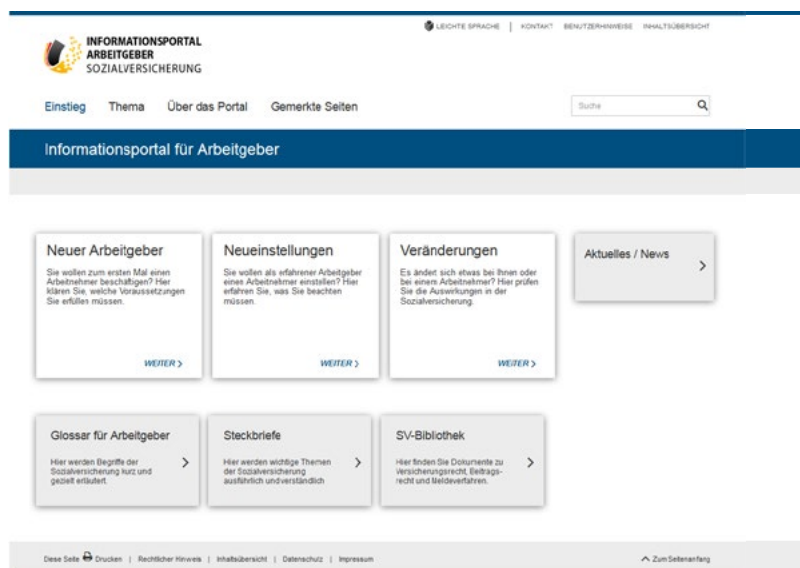
The following requirements were formulated:

- easy-to-follow but highly functional
- low-threshold graphic interface
- users navigate via an information assistant with simple decision-making questions
- portal can be used as a store of knowledge by establishing a library for circulars, discussion results and generally-accessible information

As a matter of principle, the information portal is not intended to replace the existing services from the institutions of social insurance, but should bundle the existing information mechanisms on the Internet. This will save employers time, and the hotlines of the individual social insurance institutions be less occupied.

## The conceptual implementation and launch of the portal

The Federal Ministry for Labour and Social Affairs commissioned the Informationstechnische Servicestelle der Gesetzlichen Krankenversicherung GmbH (ITSG) with the technical implementation and with drawing up an organisation manual for the operation. The technical implementation comprises the establishment of a development and quality assurance system and the preparations for the transition into the production system between November 2015 and December 2016. The national organisations of social insurance, the health insurance funds, as well as other institutions involved, have helped set up the information portal, supported the ITSG in the content-wise orientation of the individual processes, as well as ensuring that the results which were established were quality assured in terms of their specialist content. In January 2017, the information portal was activated by State Secretary Yasmin Fahimi, together with the Chairperson of the Board of the National Association of Statutory Health Insurance Funds Dr. Doris Pfeiffer. It is available at [www.informationsportal.de](http://www.informationsportal.de). The operation and the further development are taken on by the National Association of Statutory Health Insurance Funds with the assistance of the other social insurance funding institutions.





We are ready to answer all questions.

We are sales assistants.

We are experts in arithmetic.

We have statutory insurance.

Together we are 90 percent.

# Keeping the channels open: Focus of communication in 2016



The large number of health policy topics for 2016 was reflected both in the large number of press releases, statements and interviews, as well as in the event series entitled "GKV Live" ("Statutory health insurance live"). In addition to one event each on the prescription of medical devices and on the supply of medical aids, the need to reform the AMNOG procedure was also discussed, and was debated on in the spring during the now completed Pharma Dialogue, but was not addressed in detail.

## **90 Prozent - the e-magazine of the National Association of Statutory Health Insurance Funds**

The Association expanded its communication services in 2016: The e-magazine "90 Prozent" ("90 percent") has been informing the target group of the expert public in the healthcare system at regular intervals since the early summer about interesting facts from health and long-term care policy. This group of individuals, ranging from long-term care managers through the Chairman of the Association of Statutory Health Insurance Physicians, to staff at health insurance funds and midwives, is to be supplied with information that is relevant for them in future. This illustrates not lastly the wide range of topics dealt with by the National Association of Statutory Health Insurance Funds.

The first edition of the magazine appeared in June, with amongst other things an interview with the Chairwoman of the Board of the National Association of Statutory Health Insurance Funds, Dr. Doris Pfeiffer, on health-policy topics such as the finances of the funds and the reform of the Act on

the Reform of the Market for Medicinal Products. "90 Prozent" appears four times per year. A subscription function informs interested parties when a new edition has appeared.

## **From the Cancer Register to the clinic simulator: Press events in 2017**

The presentation of the IGES report on the state of the establishment of the clinic cancer register, which was commissioned by the National Association of Statutory Health Insurance Funds, had a resounding public echo. The report reveals that considerable commitment is still required in the Federal Länder so that the Cancer Registers can work on time and in compliance with the stipulated promotion criteria.

The supply of hospitals providing primary care within the geographical reach of the population is a major concern. But which hospitals are really needed, and which could be closed without endangering the quality of care of the population? The National Association of Statutory Health Insurance Funds has presented an online tool in the shape of the statutory health insurance clinic simulator with which anyone can find out how necessary hospitals providing primary care actually are in terms of their reachability.

The National Association of Statutory Health Insurance Funds, finally, pointed to the major changes which have been brought about by the longterm care reform, which came into force as per 1 January 2017, at a press conference, together with its Medical Service.

**The e-magazine "90 Prozent" ("90 percent") illustrates the range of topics addressed by the National Association of Statutory Health Insurance Funds.**



We are there when we are needed.

We are rescue workers.

We set an example.

We have statutory insurance.

Together we are 90 percent.

# Well positioned: The budget and personnel work of the National Association of Statutory Health Insurance Funds

## The annual financial statement for 2015

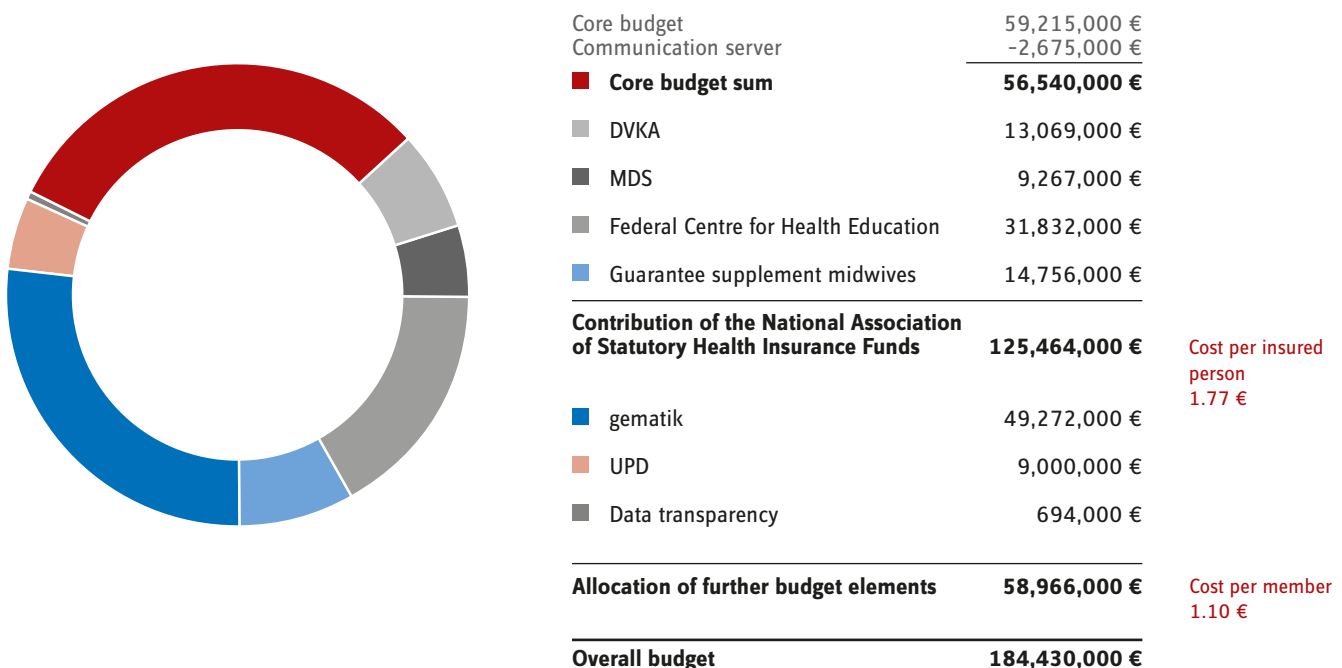
The financial statement of the National Association of Statutory Health Insurance Funds for 2015 was drawn up in April 2016. The audit of the annual financial statement, including the departmental budget of the German Liaison Agency Health Insurance - International (DVKA), was carried out by the BDO firm of auditors. "Claims Management and Accounting" within the DVKA department of the National Association of Statutory Health Insurance Funds was also audited. The firm of auditors issued an unqualified audit report. At its session that was held in June 2016, the Administrative Council thereupon approved the activities of the Board and approved the 2015 annual financial statement.

## The Association's budget for 2016

The 2016 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 184.4 million Euro. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds (56.5 million Euro), minus the refunds from the refinancing of the start-up funding for the statutory health insurance communication server. The following pay-as-you-go financing arrangements are also included:

- German Liaison Agency Health Insurance - International (DVKA departmental budget)
- The Medical Service of the central association of the health insurance funds at federal level (MDS e. V.)
- Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik)

## Elements of the overall budget 2016



- Data transparency in accordance with sections 303a to 303f of Book V of the Social Code
- Promotion of facilities for consumer and patient advice (UPD)
- The guarantee supplement for midwives in accordance with section 134a subsection (1b) of Book V of the Social Code
- Federal Centre for Health Education in accordance with section 20a of Book V of the Social Code

hence increased by 10.5 million Euro year-on-year. This is especially a result of the pay-as-you-go arrangement to promote special therapy facilities amounting to 5 million Euro in accordance with section 65d of Book V of the Social Code, which was incorporated into the overall budget of the National Association of Statutory Health Insurance Funds for the first time in the budget year 2017, and to the increase in the 2017 departmental budget of the DVKA of 5.6 million Euro, which is to be financed on a pay-as-you-go basis.

**The budget for 2017**

The budget plan for 2017 that was drawn up by the Board on 11 November 2016 was adopted by a majority of the Administrative Council of the National Association of Statutory Health Insurance Funds on 30 November 2015. The Association's overall budget was set at 194.9 million Euro. It

**Personnel work**

The staff employment plan provided for a total of 443.63 established posts for 2016. 102.5 of these were accounted for by the German Liaison Agency Health Insurance - International (DVKA) in Bonn. The rate of occupied posts was 98.1 % in December.

**Staff development in 2016 (not including the DVKA department)**

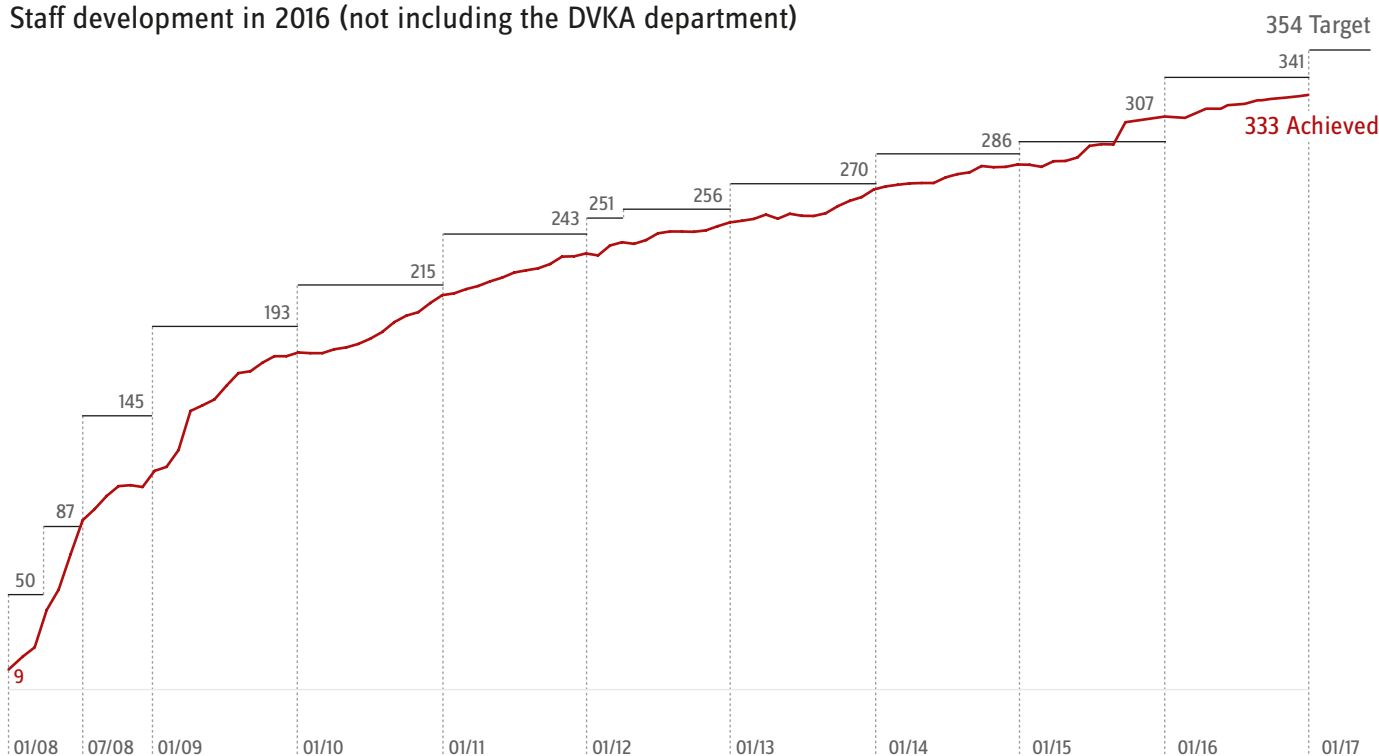


Illustration: National Association of Statutory Health Insurance Funds

# The members of the National Association of Statutory Health Insurance Funds 2016

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- |  |   |
|--|---|
| 1. actimonda BKK   | 42. BKK KARL MAYER                        |
| 2. AOK - Die Gesundheitskasse für Niedersachsen              | 43. BKK KBA                               |
| 3. AOK - Die Gesundheitskasse in Hessen                      | 44. BKK Linde                             |
| 4. AOK Baden-Württemberg                                     | 45. BKK MAHLE                             |
| 5. AOK Bayern - Die Gesundheitskasse                         | 46. BKK Melitta Plus                      |
| 6. AOK Bremen/Bremerhaven                                    | 47. BKK MEM                               |
| 7. AOK Nordost - Die Gesundheitskasse                        | 48. BKK Miele                             |
| 8. AOK NORDWEST - Die Gesundheitskasse                       | 49. BKK MTU                               |
| 9. AOK PLUS - Die Gesundheitskasse für Sachsen und Thüringen | 50. BKK PFAFF                             |
| 10. AOK Rheinland-Pfalz/Saarland - Die Gesundheitskasse      | 51. BKK Pfalz                             |
| 11. AOK Rheinland/Hamburg - Die Gesundheitskasse             | 52. BKK ProVita                           |
| 12. AOK Sachsen-Anhalt - Die Gesundheitskasse                | 53. BKK Public                            |
| 13. atlas BKK ahlmann  | 54. BKK Rieker.Ricosta.Weisser            |
| 14. Audi BKK   | 55. BKK RWE                               |
| 15. BAHN-BKK   | 56. BKK Salzgitter                        |
| 16. BARMER   | 57. BKK Scheufelen                        |
| 17. Bertelsmann BKK  | 58. BKK Schwarzwald-Baar-Heuberg          |
| 18. Betriebskrankenkasse Mobil Oil                           | 59. BKK STADT AUGSBURG                    |
| 19. Betriebskrankenkasse PricewaterhouseCoopers              | 60. BKK Technoform                        |
| 20. BIG direkt gesund  | 61. BKK Textilgruppe Hof                  |
| 21. BKK Achenbach Buschhütten                                | 62. BKK VDN                               |
| 22. BKK advita   | 63. BKK VerbundPlus                       |
| 23. BKK Aesculap   | 64. BKK Verkehrsbau Union (BKK VBU)       |
| 24. BKK Akzo Nobel Bayern                                    | 65. BKK VITAL                             |
| 25. BKK B. Braun Melsungen AG                                | 66. BKK Voralb HELLER*INDEX*LEUZE         |
| 26. BKK BPW Bergische Achsen KG                              | 67. BKK Werra-Meissner                    |
| 27. BKK Deutsche Bank AG                                     | 68. BKK Wirtschaft & Finanzen             |
| 28. BKK Diakonie   | 69. BKK Würth                             |
| 29. BKK EUREGIO  | 70. BKK ZF & Partner                      |
| 30. BKK EVM  | 71. BKK_DürkoppAdler                      |
| 31. BKK EWE  | 72. BKK24                                 |
| 32. BKK exklusiv   | 73. BMW BKK                               |
| 33. BKK Faber-Castell & Partner                              | 74. Bosch BKK                             |
| 34. BKK firmus   | 75. Brandenburgische BKK                  |
| 35. BKK Freudenberg  | 76. Continentale Betriebskrankenkasse     |
| 36. BKK Gildemeister Seidensticker                           | 77. Daimler Betriebskrankenkasse          |
| 37. BKK GRILLO-WERKE AG                                      | 78. DAK-Gesundheit                        |
| 38. BKK Groz-Beckert   | 79. Debeka BKK                            |
| 39. BKK HENSCHEL Plus  | 80. DIE BERGISCHE KRANKENKASSE            |
| 40. BKK Herford Minden Ravensberg                            | 81. Die Schwenninger Betriebskrankenkasse |
| 41. BKK Herkules   | 82. energie-Betriebskrankenkasse          |
|  | 83. Ernst & Young BKK                     |
|  | 84. HEK - Hanseatische Krankenkasse       |
|  | 85. Heimat Krankenkasse                   |
|  | 86. hkk                                   |
|  | 87. IKK Brandenburg und Berlin            |



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88. IKK classic	102. SECURVITA BKK
89. IKK gesund plus	103. SIEMAG BKK
90. IKK Nord	104. Siemens-Betriebskrankenkasse (SBK)
91. IKK Südwest	105. SKD BKK
92. Kaufmännische Krankenkasse - KKH	106. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
93. Knappschaft	107. Südzucker BKK
94. Krones BKK	108. Techniker Krankenkasse
95. Merck BKK	109. Thüringer Betriebskrankenkasse
96. Metzinger BKK	110. TUI BKK
97. mhplus Betriebskrankenkasse	111. VIACTIV Krankenkasse
98. Novitas BKK	112. Wieland BKK
99. pronova BKK	113. WMF Betriebskrankenkasse
100. R+V Betriebskrankenkasse	
101. Salus BKK	

cut-off date: 1 January 2017

## Mergers in 2016

### Merged funds

DAK-Gesundheit

BKK Verkehrsbau Union (BKK VBU)

pronova BKK

energie-Betriebskrankenkasse

BARMER

### Merger partners

DAK-Gesundheit  
BKK Beiersdorf AG

BKK Verkehrsbau Union (BKK VBU)  
Vereinigte BKK

pronova BKK  
BKK Braun-Gillette

energie-BKK  
E.ON Betriebskrankenkasse

BARMER GEK  
Deutsche BKK

cut-off date: 1 January 2017

# Ordinary members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 2nd period of office (2012–2017)

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## Representatives of insured persons

<b>Name</b>	<b>Health insurance fund</b>
Aschenbeck, Rolf-Dieter	DAK-Gesundheit
Balsler, Erich	Kaufmännische Krankenkasse - KKH
Beier, Angelika	AOK Hessen
Bilz, Rosemie	Techniker Krankenkasse
Brendel, Roland	BKK Pfalz
Ermler, Christian	BARMER GEK
Hamers, Ludger	VIACTIV Krankenkasse
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER GEK
Keppeler, Georg	AOK NORDWEST
Kirch, Ralf	BKK Werra-Meissner
Klemens, Uwe	Techniker Krankenkasse
Langkutsch, Holger	BARMER GEK
Lersmacher, Monika	AOK Baden-Württemberg
Linnemann, Eckehard	Knappschaft
Märtens, Dieter F.	Techniker Krankenkasse
Metschurat, Wolfgang	AOK Nordost
Moldenhauer, Klaus	BARMER GEK
Müller, Hans-Jürgen	IKK gesund plus
Reuber, Karl	AOK Rheinland/Hamburg
Roer, Albert	BARMER GEK
Römer, Bert	IKK classic
Schoch, Manfred	BMW BKK
Schösser, Fritz	AOK Bayern
Strobel, Andreas	Siemens-Betriebskrankenkasse (SBK)
Stute, Hans-Peter	DAK-Gesundheit
Tölle, Hartmut	AOK Niedersachsen
Weinschenk, Roswitha	AOK PLUS
Wiedemeyer, Susanne	AOK Sachsen-Anhalt
Wittrin, Horst	HEK - Hanseatische Krankenkasse
Zahn, Christian	DAK-Gesundheit

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**Representatives of the employers**

<b>Name</b>	<b>Health insurance fund</b>
Aust, Michael †	Bertelsmann BKK
Avenarius, Friedrich	AOK Hessen
Blum, Leo	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
Chudek, Nikolaus	IKK Brandenburg und Berlin
Hansen, Dr. Volker	AOK Nordost
Hornung, Ernst	Novitas BKK
Jehring, Stephan	AOK PLUS
Kuhn, Willi	AOK Rheinland-Pfalz/Saarland
Landrock, Dieter Jürgen	AOK Baden-Württemberg
Münzer, Dr. Christian	AOK Niedersachsen
Parvanov, Ivor	AOK Bayern
Reyher, Dietrich von	Bosch BKK
Ropertz, Wolfgang	AOK Rheinland/Hamburg
Schnurr, Hansjürgen	Kaufmännische Krankenkasse - KKH
Schrörs, Dr. Wolfgang	hkk
Schweinitz, Detlef E. von	Siemens-Betriebskrankenkasse (SBK)
Stehr, Axel	AOK NORDWEST
Tautz, Dr. Andreas	Deutsche BKK
Unzeitig, Roland	Techniker Krankenkasse
Wegner, Bernd	Techniker Krankenkasse
Wollseifer, Hans Peter	IKK classic

cut-off date: 31 December 2016

# Deputy members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 2nd period of office (2012–2017)

## Representatives of insured persons

<b>Name</b>	<b>Health insurance fund</b>
Aichberger, Helmut	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Baki, Brigitte	AOK Hessen
Becker-Müller, Christa	DAK-Gesundheit
Berger, Silvia	IKK Südwest
Berking, Jochen	Deutsche BKK
Bink, Klaus-Dieter	AOK NORDWEST
Böse, Annemarie	DAK-Gesundheit
Bumb, Hans-Werner	DAK-Gesundheit
Christen, Anja	BKK Verkehrsbau Union (VBU)
Coors, Jürgen	Daimler BKK
Date, Achmed	BARMER GEK
Decho, Detlef	Techniker Krankenkasse
Dollmann, Klaus	BARMER GEK
Dorneau, Hans-Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Feichtner, Richard	AOK Rheinland-Pfalz/Saarland
Fenske, Dieter	DAK-Gesundheit
Gabler, Heinz-Joachim	Kaufmännische Krankenkasse - KKH
Goldmann, Bernd	BARMER GEK
Gosewinkel, Friedrich	Techniker Krankenkasse
Gransee, Ulrich	AOK Niedersachsen
Hauffe, Ulrike	BARMER GEK
Heinemann, Bernd	BARMER GEK
Hippel, Gerhard	DAK-Gesundheit
Hoppe, Klaus	Siemens-Betriebskrankenkasse (SBK)
Hüfner, Gert	Knappschaft
Jena, Matthias	AOK Bayern
Kaczmarek, Irina	IKK classic
Karp, Jens	IKK Nord
Kemper, Norbert	AOK Rheinland/Hamburg
Kloppich, Iris	AOK PLUS
Knerler, Rainer	AOK Nordost
Knöpfe, Manfred	BKK STADT AUGSBURG
Korschinsky, Ralph	BARMER GEK
Krause, Helmut	BIG direkt gesund
Lambertin Knut	AOK Nordost
Leitloff, Rainer	DAK-Gesundheit
Lubitz, Bernhard	HEK – Hanseatische Krankenkasse
Matthesius, Dr. Rolf-Gerd	BARMER GEK
Muscheid, Dietmar	AOK Rheinland-Pfalz/Saarland

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<b>Name</b>	<b>Health insurance fund</b>
Salzmann, Rainer	BKK B. Braun Melsungen AG
Schmidt, Günther	BARMER GEK
Schneider, Norbert	Techniker Krankenkasse
Scholz, Jendrik	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg
Schröder, Dieter	DAK-Gesundheit
Schuder, Jürgen	HEK - Hanseatische Krankenkasse
Schulte, Harald	Techniker Krankenkasse
Schultze, Roland	hkk
Sonntag, Dr. Ute	BARMER GEK
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland
Stensitzky, Annette	Techniker Krankenkasse
Vater, Birgit	BARMER GEK
Vieweg, Johanna	Techniker Krankenkasse

### Representatives of the employers

<b>Name</b>	<b>Health insurance fund</b>
Beetz, Jürgen	Die Schwenninger Betriebskrankenkasse
Bruns, Rainer	Techniker Krankenkasse
Dick, Peer-Michael	AOK Baden-Württemberg
Diehl, Mario	Kaufmännische Krankenkassen - KKH
Empl, Martin	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
Fitzke, Helmut	Techniker Krankenkasse
Gantz-Rathmann, Birgit	BAHN-BKK
Gemmer, Traudel	AOK Sachsen-Anhalt
Gural, Wolfgang	AOK Bayern
Henschen, Jörg	Techniker Krankenkasse
Heß, Johannes	AOK NORDWEST
Heymer, Dr. Gunnar	BKK BPW Bergische Achsen KG
Kastner, Helmut	IKK Nord
Kreßel, Prof. Dr. Eckhard	Daimler BKK
Kruchen, Dominik	Techniker Krankenkasse
Lang, Dr. Klaus	pronova BKK
Lübbe, Günther	hkk
Lunk, Rainer	IKK Südwest
Malter, Joachim	AOK Rheinland-Pfalz/Saarland
Nicolay, Udo	Techniker Krankenkasse
Nobereit, Sven	AOK PLUS
Reinisch, Dr. Mark	BKK VerbundPlus
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg
Scheer, René	BIG direkt gesund
Schirp, Alexander	AOK Nordost
Söller, Wolfgang	AOK Bremen/Bremerhaven
Steigerwald, Claus	BKK Faber-Castell & Partner
Wadenbach, Peter	IKK gesund plus
Wilkening, Bernd	AOK Niedersachsen
Witt, Axel	Kaufmännische Krankenkasse - KKH

cut-off date: 31 December 2016

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

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## Specialist committee on fundamental issues and health policy

Chaired by: Hans-Jürgen Müller\*, Andreas Strobel\*/Stephan Jehring (alternating)

\* Changing half-way through their period of office

### Ordinary members

#### Employers' representatives

1. Stephan Jehring (AOK)
2. Axel Stehr (AOK)
3. Roland Unzeitig (EK)
4. Leo Blum (SVLFG)
5. Michael Aust (BKK) †
6. Hans Peter Wollseifer (IKK)

#### Representatives of insured persons

1. Dieter F. Märtens (EK)
2. Erich Balsler (EK)
3. Klaus Moldenhauer (EK)
4. Horst Wittrin (EK)
5. Monika Lersmacher (AOK)
6. Fritz Schösser (AOK)
7. Hans-Jürgen Müller (IKK)
8. Andreas Strobel (BKK)

### Deputy members

#### Employers' representatives

- Dr. Christian Münzer (AOK)
- Wolfgang Söller (AOK)
- Udo Nicolay (EK)
- Martin Empl (SVLFG)
- Detlef E. von Schweinitz (BKK)
- Rainer Lunk (IKK)
- Helmut Kastner (IKK)

#### Representatives of insured persons

- Roland Schultze (EK)
- 1st deputy on the list for insured persons 1-4  
Gerhard Hippel (EK)
- 2nd deputy on the list for insured persons 1-4  
Ralph Korschinsky (EK)
- 3rd deputy on the list for insured persons 1-4  
Hans-Peter Stute (EK)
- 4th deputy on the list for insured persons 1-4  
Susanne Wiedemeyer (AOK)
- 1st deputy on the list for insured persons 5-6  
Georg Keppeler (AOK)
- 2nd deputy on the list for insured persons 5-6  
Knut Lambertin (AOK)
- 3rd deputy on the list for insured persons 5-6  
Eckehard Linnemann (Knappschaft)
- 1st deputy on the list for insured persons 7-8  
Roland Brendel (BKK)
- 2nd deputy on the list for insured persons 7-8  
Irina Kaczmarek (IKK)
- 3rd deputy on the list for insured persons 7-8

cut-off date: 31 December 2016

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## Specialist committee on organisation and finance

Chaired by: Holger Langkutsch/Dieter Jürgen Landrock (alternating)

### Ordinary members

#### Employers' representatives

1. Dieter Jürgen Landrock (AOK)
2. Dr. Christian Münzer (AOK)
3. Dr. Wolfgang Schrörs (EK)
4. Leo Blum (SVLFG)
5. Detlef E. von Schweinitz (BKK)
6. Peter Wadenbach (IKK)

#### Representatives of insured persons

1. Holger Langkutsch (EK)
2. Walter Hoof (EK)
3. Rosemie Bilz (EK)
4. Georg Keppeler (AOK)
5. Karl Reuber (AOK)
6. Hartmut Tölle (AOK)
7. Detlef Baer (IKK)
8. Ralf Kirch (BKK)

### Deputy members

#### Employers' representatives

- Sven Nobereit (AOK)
- Wolfgang Ropertz (AOK)
- Günther Lübbe (EK)
- Martin Empl (SVLFG)
- Dr. Andreas Tautz (BKK)
- Helmut Kastner (IKK)
- Nikolaus Chudek (IKK)

#### Representatives of insured persons

- Klaus Moldenhauer (EK)
- 1st deputy on the list for insured persons 1-3  
Erich Balsler (EK)
- 2nd deputy on the list for insured persons 1-3  
Dieter Schröder (EK)
- 3rd deputy on the list for insured persons 1-3  
Richard Feichtner (AOK)
- 1st deputy on the list for insured persons 4-6  
Annette Düring (AOK)
- 2nd deputy on the list for insured persons 4-6  
Wolfgang Metschurat (AOK)
- 3rd deputy on the list for insured persons 4-6  
Angelika Beier (AOK)
- 4th deputy on the list for insured persons 4-6  
Ludger Hamers (BKK)
- 1st deputy on the list for insured persons 7-8  
Silvia Berger (IKK)
- 2nd deputy on the list for insured persons 7-8  
Hans-Jürgen Dorneau (BKK)
- 3rd deputy on the list for insured persons 7-8

cut-off date: 31 December 2016



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

Chaired by: Eckehard Linnemann/Nikolaus Chudek\*, Dietrich von Reyher\* (alternating)

\* Changing half-way through their period of office

### Ordinary members

#### Employers' representatives

1. Ivor Parvanov (AOK)
2. Wolfgang Ropertz (AOK)
3. Hans-Jürgen Schnurr (EK)
4. Dietrich von Reyher (BKK)
5. Dr. Andreas Tautz (BKK)
6. Nikolaus Chudek (IKK)

#### Representatives of insured persons

1. Harald Schulte (EK)
2. Christian Ermler (EK)
3. Rolf-Dieter Aschenbeck (EK)
4. Wolfgang Metschurat (AOK)
5. Roswitha Weinschenk (AOK)
6. Knut Lambertin (AOK)
7. Eckehard Linnemann (Knappschaft)
8. Manfred Schoch (BKK)

### Deputy members

#### Employers' representatives

- Sven Nobereit (AOK)
- Johannes Heß (AOK)
- Helmut Fitzke (EK)
- Ernst Hornung (BKK)
- Michael Aust (BKK) †
- Peter Wadenbach (IKK)
- Helmut Kastner (IKK)

#### Representatives of insured persons

- Achmed Date (EK)
- 1st deputy on the list for insured persons 1-3
- Klaus Dollmann (EK)
- 2nd deputy on the list for insured persons 1-3
- Christa Becker-Müller (EK)
- 3rd deputy on the list for insured persons 1-3
- Susanne Wiedemeyer (AOK)
- 1st deputy on the list for insured persons 4-6
- Angelika Beier (AOK)
- 2nd deputy on the list for insured persons 4-6
- Fritz Schösser (AOK)
- 3rd deputy on the list for insured persons 4-6
- Karl Reuber (AOK)
- 4th deputy on the list for insured persons 4-6
- Roland Brendel (BKK)
- 1st deputy on the list for insured persons 7-8
- Bert Römer (IKK)
- 2nd deputy on the list for insured persons 7-8
- Jendrik Scholz (IKK)
- 3rd deputy on the list for insured persons 7-8

cut-off date: 31 December 2016

## Specialist committee on contracts and care

Chaired by: Angelika Beier/Ernst Hornung (alternating -  
Dietrich von Reyher, acting deputy for E. Hornung)

### Ordinary members

#### Employers' representatives

1. Dr. Volker Hansen (AOK)
2. Friedrich Avenarius (AOK)
3. Wolfgang Söller (AOK)
4. Bernd Wegner (EK)
5. Ernst Hornung (BKK)
6. Rainer Lunk (IKK)

#### Representatives of insured persons

1. Albert Roer (EK)
2. Dietmar Katzer (EK)
3. Hans-Peter Stute (EK)
4. Helmut Aichberger (EK)
5. Angelika Beier (AOK)
6. Susanne Wiedemeyer (AOK)
7. Roland Brendel (BKK)
8. Bert Römer (IKK)

### Deputy members

#### Employers' representatives

- Traudel Gemmer (AOK)
- Alexander Schirp (AOK)
- Ivor Parvanov (AOK)
- Jörg Henschen (EK)
- Dietrich von Reyher (BKK)
- Nikolaus Chudek (IKK)
- Peter Wadenbach (IKK)

#### Representatives of insured persons

- Roland Schultze (EK)
- 1st deputy on the list for insured persons 1-4  
Harald Schulte (EK)
- 2nd deputy on the list for insured persons 1-4  
Ulrike Hauffe (EK)
- 3rd deputy on the list for insured persons 1-4  
Dieter Fenske (EK)
- 4th deputy on the list for insured persons 1-4  
Wolfgang Metschurat (AOK)
- 1st deputy on the list for insured persons 5-6  
Fritz Schösser (AOK)
- 2nd deputy on the list for insured persons 5-6  
Georg Keppeler (AOK)
- 3rd deputy on the list for insured persons 5-6  
Roswitha Weinschenk (AOK)
- 4th deputy on the list for insured persons 5-6  
Ludger Hamers (BKK)
- 1st deputy on the list for insured persons 7-8  
Jens Karp (IKK)
- 2nd deputy on the list for insured persons 7-8  
Gert Hüfner (Knappschaft)
- 3rd deputy on the list for insured persons 7-8

cut-off date: 31 December 2016

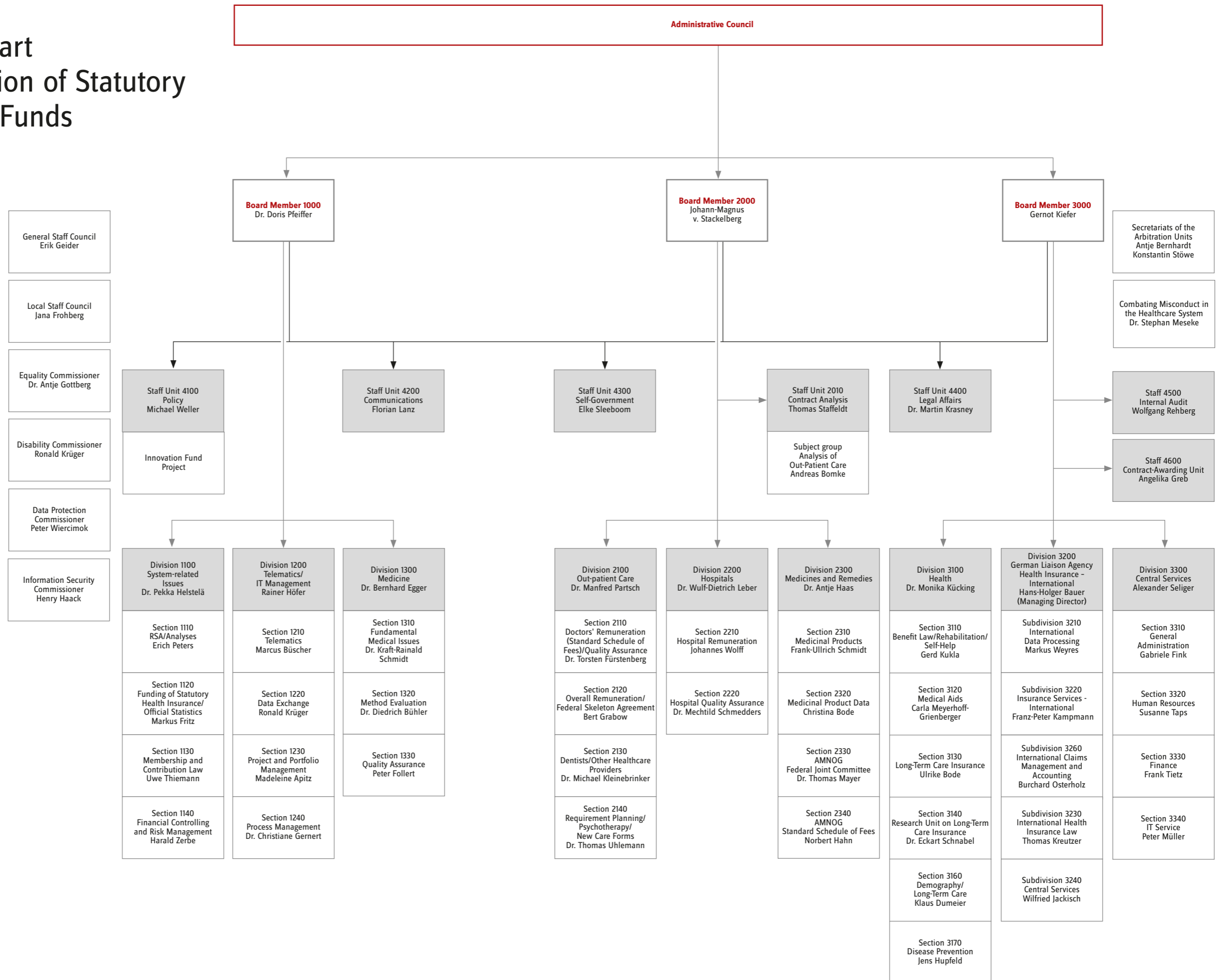
# Ordinary members and personal deputies of the Specialist Advisory Council of the National Association of Statutory Health Insurance Funds

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	<b>Members</b>	<b>Deputies</b>
AOK	1. Martin Litsch (since 15 April 2016) 2. Dr. Helmut Platzer	Jens Martin Hoyer (since 20 June 2016) Dr. Jürgen Peter
BKK	1. Franz Knieps  2. Andrea Galle (since 15 April 2016)	Verena Heinz (since 15 April 2016 for Andrea Galle) Winfried Baumgärtner
Substitute Funds	1. Ulrike Elsner 2. Dr. Jörg Meyers-Middendorf	Boris von Maydell Oliver Blatt
IKK	1. Jürgen Hohnl 2. Uwe Schröder	Frank Hippler Enrico Kreutz
Miners' Insurance Institution	1. Bettina am Orde 2. Gerd Jockenhöfer	Dieter Castrup Jörg Neumann
Landwirtschaftliche Sozialversicherung	1. Claudia Lex  2. Gerhard Sehnert	Dirk Ender (since 16 December 2016 for Reinhold Knittel) Jürgen Helfenritter (since 16 December 2016 for Dr. Erich Koch)

cut-off date: 31 December 2016

# Organisational chart National Association of Statutory Health Insurance Funds



# Publications

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## Position papers

Author(s)	Title	Publication
GKV-Spitzenverband (National Association of Statutory Health Insurance Funds)	Eckpunkte des GKV-Spitzenverbandes zur Weiterentwicklung der Hilfsmittelversorgung	February 2016
GKV-Spitzenverband	Telemedizin in der vertragsärztlichen Versorgung - Vorschläge der gesetzlichen Krankenkassen	March 2016
GKV-Spitzenverband	Qualität der Heilmittelversorgung verbessern und finanzierbar halten	June 2016
GKV-Spitzenverband	Position der Gesetzlichen Krankenversicherungen zur Reform der Psychotherapie-Ausbildung	August 2016

## Further publications

Author(s)	Title	Publication
GKV-Spitzenverband	Leitfaden Prävention in stationären Pflegeeinrichtungen nach § 5 SGB XI	August 2016
Prognos AG	Gutachten zum aktuellen Umsetzungsstand des KFRG	August 2016
GKV-Spitzenverband	Glossar zur Europäischen Gesundheitspolitik	October 2016
GKV-Spitzenverband and MDS (Medical Service of the central association of the health insurance funds at federal level)	Präventionsbericht 2016 Leistungen der gesetzlichen Krankenversicherung: Primärprävention und betriebliche Gesundheitsförderung. Berichtsjahr 2015	November 2016

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