NATIONAL HEALTH INSURANCE SERVICE

Korea's Long-Term Care Insurance: Policy and Practice

ADB-NHIS Technology Solutions to NCDs & Mental Health Training

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About me

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Why LTCI?
Origins & Policy Context

Demographic Crisis & Rapid Aging Policy Context

Korea: World's Fastest Aging Pace

Korea's family-based care model collapsed rapidly under pressure from smaller households and rising female labor participation. Shifting care responsibility from families to social insurance became vital.

2008
Long-term Care Insurance Launch
10.3% Elderly share

37.3%
65+ SHARE BY 2045
Projected highest in the world

Rapid Super-Aging Milestones

2008 - LTCI Launch **10.3%** Elderly Share

2017 - Aged Society **14.0%+** Elderly Share

2024 - Super-Aged Society **20.0%+** Elderly Share

The Policy Problem

- Family-based care collapsed under demographic pressure — smaller households, women entering the workforce, unsustainable caregiver burdens.
- Institutionalization was costly and inconsistent in quality; no public framework existed for home-based professional care.
- LTCI (2008) shifted responsibility from individual families to a collective social insurance mechanism — decoupling care access from family wealth or geography.

Why Korea Chose Social Insurance Strategic Choice

Korea's Insurance-Based System

- **Mandatory Contributions:** Explicit legal entitlement right, securing benefits from political budget cuts.
- **Automatic Enrollment:** All NHI insured automatically join LTCI—universal coverage.
- **Unified Administration:** Joint contribution collection with zero additional infrastructure costs.
- **NHIS single-payer:** Unified eligibility, claims review, and quality control under one public insurer — efficiency by design.

Tax-Based Systems (Limitations)

- **Discretionary Benefits:** Subject to budget pressure and political cycles.
- **Means-Tested Gaps:** Target poverty limits, excluding middle-income citizens.
- **Unpredictable Planning:** Coverage limits fluctuate according to fiscal years.

PART 02

How LTCI Works: Benefits, Stakeholders, & Financing

Ecosystem & Stakeholder Roles Operational Flow

Ministry of Health & Welfare

Role: Formulates national policy, establishes the LTCI Master Plan.

Legal Oversight

National Health Insurance Service

Role: Acts as the single Insurer, Payer, Assessor, Auditor

Core Operating Engine

Local Governments

Role: Manages administrative provider licensing and Field Audits.

Regional Regulation

LTC Beneficiary
Aged 65+ or with geriatric disease

LTC Institution
Provider

Direct Operational Loop:

① Pays LTCI contributions
② Assessment application
③ On-site investigation
④ Approval & care plan
⑤ Claims reimbursement
⑥ Reimburse & Quality eval.
⑦ Receives services · pays co-payment
⑧ Designates institutions

Eligibility & Rating Distribution Key Beneficiary Data

Who is Eligible?

Citizens aged 65+ or those under 65 with geriatric diseases (such as dementia, stroke) requiring care for at least 6 months.

214K
Approved at launch 2008
(4.2% of elderly)

1.26M
Approved April 2026
(11.2% of elderly)

5.9×
Expansion
over 16 years

Long-Term Care Rating Distribution — April 2026

Rating	Beneficiaries	Share	Primary Benefit Access
Rating I	54,001	4.3%	Institutional Care Benefits or Home Care Services
Rating II	100,557	8.0%	Institutional Care Benefits or Home Care Services
Rating III	330,180	26.2%	Benefits for Home Care Services
Rating IV (largest)	595,191	47.2%	Benefits for Home Care Services
Rating V	150,072	11.9%	Home Care Services (Home Visit Care: cognitive activity type only)
Cognitive Assistant Rating	30,725	2.4%	Day and Night Care (cognitive activity type) only

Core Long-Term Care Benefits Benefit Categories

Benefits for Home Care Services

- Home Visit Care — Physical activity & household support
- Home Visit Bathing — Bathing equipment visit service
- Home Visit Nursing — Nurse-led clinical care at home
- Day and Night Care — Daytime/overnight care at LTC facility
- Short-term Respite Care — Temporary residential care stays
- Welfare Devices — Assistive devices (separate annual cap: 1.6M KRW)

★ Monthly cap: Rating I — 2,512,900 KRW/month
Co-pay: 15% home care · Medical aid beneficiaries: exempt

Institutional Care Benefits

- Nursing Home — 24/7 residential & clinical care (Ratings I–II)
- Group Home — Small-scale shared residential care (Ratings I–II)

★ Monthly cap: Rating I — 2,792,100 KRW/month
Co-pay: 20% institutional · Medical aid beneficiaries: exempt

Care Allowances (Special Cash Benefits)

- Family Care Benefits in Cash
- Exceptional Care / Hospital Nursing — Non-LTCI facility or LTC hospital admission

Reimbursement Rates

Home Care Services - per Visit / Day

Benefit Type	Service Basis	Total (KRW)	Co-payment (15%)
Home Visit Care ★	180 min / visit	57,020 KRW ($36.9/€32.6)	8,553 KRW ($5.5/€4.9)
Home Visit Bathing	With vehicle, 60+ min / visit	74,470 KRW ($48.2/€42.5)	11,171 KRW ($7.2/€6.4)
Home Visit Nursing	60+ min / visit	57,610 KRW ($37.3/€32.9)	8,642 KRW ($5.6/€4.9)
Day & Night Care	Rating 4, 8–10 hrs / day	47,230 KRW ($30.6/€27.0)	7,085 KRW ($4.6/€4.0)
Short-term Respite	Rating 4, per day	52,680 KRW ($34.1/€30.1)	7,902 KRW ($5.1/€4.5)

Institutional Care – per day

Type	Daily Rate	30-Day Total
Nursing Home (Rating 3–5)	81,540 KRW/day ($53/€47)	2,446,200 KRW ($1,583/€1,397)
Group Home (Rating 3–5)	63,800 KRW/day ($41/€36)	1,914,000 KRW ($1,239/€1,093)

Total Revenue
16.97T KRW ($10.98B / €9.69B)

Total Expenditure
16.77T KRW ($10.85B / €9.58B)

LTC Benefit Payments
16.34T KRW ($10.58B / €9.33B)

Admin & Operating
0.43T KRW ($0.28B / €0.25B)

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Financing Architecture LTC Financing Sources Breakdown

65.7%
KRW 11.1T
($7.2B / €6.3B)

LTCI Contributions

- Rate: 0.9448% of health insurance contribution (2026)
- Employee-insured (salaried workers): auto-deducted from salary; employer bears 50% of combined contribution
- Self-employed insured (self-employed): calculated on income, property & vehicle composite score

13.4%
KRW 2.3T
($1.5B / €1.3B)

Government Subsidies

- 20% of estimated LTCI contribution revenue annually (statutory target; maintained 2021–2026)
- Borne by the central government and transferred to NHIS as annual subsidy

19.5%
KRW 3.3T
($2.1B / €1.9B)

Medical Aid Burden

- Borne jointly by central government and local governments
- Covers full LTC benefit costs for medical aid beneficiaries — equivalent to National Basic Livelihood Security recipients
- These beneficiaries pay zero co-payment and zero LTCI contributions

Total Revenue **16.97T KRW** **($10.98B / €9.69B)**	Total Expenditure **16.77T KRW** **($10.85B / €9.58B)**
LTC Benefit Payments **16.34T KRW** **($10.58B / €9.33B)**	Admin & Operating **0.43T KRW** **($0.28B / €0.25B)**

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PART 03

Strategic Direction: Integrated Home & Community based Care

Transition to Integrated Care New Paradigm

LTCI Act (January 2024): Formally declares that a designated institution may provide Integrated Home and Community based Care Services — an enabling provision that recognizes and incentivizes multi-service coordinated care.

Conventional Model

- Beneficiaries arrange each service type independently — home visit care, nursing, and day care treated as separate benefit streams
- No coordinated care plan across service types — providers operate without visibility into each other's services
- Care gaps arise when needs span multiple benefit types with separate provider schedules
- Caregivers bear the coordination burden, often unaware of full service options available

Integrated Model (Integrated Home and Community based Care Services)

Two integrated service configurations:

Type A	Home Visit Care + Home Visit Nursing
Type B	Home Visit Care + Day and Night Care

- Single institution delivers a coordinated care plan tailored to each beneficiary's daily needs across both service types
- Financial incentive: 110% monthly cap supplement — making the model viable for providers
- Goal: 700 integrated providers by 2027 — to delay and prevent premature institutionalization

Cap Supplements for Dementia Care Aiding Families

15+ days

per month use of Dementia-Dedicated Day & Night Care
to trigger the expanded cap

50%

Extra monthly cap supplement
on top of the standard rating cap

How It Works

- Applies specifically to Dementia-Dedicated Day and Night Care institutions — not all day and night care providers.
- When a dementia beneficiary uses dementia-dedicated day and night care for more than 15 days per month, their monthly spending cap is expanded by up to 50% — with additional co-payment obligation.
- Allows substantially more service hours to address the intensive supervision and cognitive programming needs of dementia patients.
- Purpose: relieve family caregiver burnout and sustain cognitive well-being at home — and prevent the cascade: burnout → care crisis → emergency institutionalization.

PART 04

Critical Structural Challenges:

Fiscal pressure, market structure, family care dependency, and workforce vulnerability

Financial Sustainability vs. Super-Aging Demographic Pressures Long-Term Pressures

7 yrs
Korea: Aged → Super-Aged
(world's fastest)

37.3% ?
Projected elderly share
by 2045 — world highest

2031 ?
LTCI reserves projected
to be depleted

The Fiscal Challenge

- Total LTCI expenditure reached 16.77 trillion KRW in 2025; beneficiaries projected to exceed 1.45 million by 2027 — sharply steepening the expenditure curve.
- LTCI financial balance expected to turn negative from 2026?; accumulated reserves projected to be depleted by 2031?
- Beneficiary pool expanding faster than contribution revenue — requires periodic adjustment of contribution rates, co-payments, and government subsidy baselines.
- Without productivity gains or proactive Aging in Place transitions, fiscal sustainability becomes a medium-term policy imperative.

Private Provider Dominance in Korea's LTCI Market Market Structure

29,886
Total designated LTC institutions (Apr 2026)

85.7%
Privately operated by individual for-profit operators

Institution Type	Total	Government / Local	Corporation	Private Individual
All LTC Institutions	29,886	330 (1.1%)	3,957 (13.2%)	25,599 (85.7%)
Home Care Services	23,512	191 (0.8%)	2,544 (10.8%)	20,777 (88.4%)
Institutional Care	6,374	139 (2.2%)	1,413 (22.2%)	4,822 (75.6%)

Policy Implications

- Market grew from 8,444 institutions (2008) → 29,886 (2026) — a 3.5× increase driven almost entirely by private entrants responding to the new market opportunity.
- Inconsistent quality standards and limited public accountability at scale — 85%+ private individual ownership makes direct regulatory enforcement difficult.
- Primary levers: 5-tier public quality evaluation ratings, financial incentives for top performers, joint field audits with local governments, and mandatory public disclosure of violations.

The Family Caregiver Paradox Policy Constraints

190K
Beneficiaries receiving family care (2025)

26.7%
Share of Home Visit Care workers who are family members

$718M / €634M
Family care payments (1.11T KRW = 19.4% of visiting care spend)

Limitations of the Family Caregiver Support Structure

- Financial compensation is provided — but the rate paid to family caregivers is lower than what regular long-term care workers receive for equivalent care hours, creating an implicit undervaluation of family-based care.
- Only 60- or 90-minute care sessions per visit are eligible for reimbursement. The reimbursable duration depends on the caregiver's relationship to the beneficiary (e.g., spouse) and whether the beneficiary has dementia.
- There is significant negative social sentiment around compensating family caregiving through social insurance contributions — raising equity and moral hazard concerns that constrain policy expansion in this area.

Care Workforce Crisis: An Aging and Shrinking Workforce Workforce Status

2.91M
Total certified long-term care workers (2024)

22.8%
Currently working (665,780 of 2.91M)

67.1 yrs
Average age of active long-term care workers (2023)

Statutory Mandate vs. Reality

- The LTCI Act mandates that the Government shall fully endeavor to improve the welfare and status of long-term care workers — and requires the 5-year Master Plan to address worker treatment.
- Yet: only 22.8% of 2.91 million certified workers are actively working — a strikingly low activation rate reflecting how challenging working conditions are in practice.

Structural Vulnerability

- 66.1% of active workers aged 60+ (July 2024); average age 67.1; workers in 70s+ have nearly tripled since 2019 — virtually no new generation entering the profession.
- Low pay near minimum wage, irregular hourly employment, high physical demands, and social undervaluation drive high attrition and burnout.
- By 2027, supply is projected to fall short of demand by approximately 75,000 workers.

PART 05

Technical Solutions & Mental Health Support

Assistive Devices: Standard Benefit + Pre-Authorization Extension Pre-Authorization Scheme

Standard Benefit — Welfare Devices

- Dedicated annual cap: 1,600,000 KRW — independent of monthly service caps.
- Covers: adjustable safety beds, pressure-relief mattresses, mobility aids, bath support equipment.
- Enables physical Aging in Place support without depleting monthly care budget.

Pre-Authorization Scheme

Newly developed devices not yet formally listed can be provisionally covered while undergoing clinical effectiveness review.
Balances innovation access with cost control — creates a structured pipeline:

Pilot → Effectiveness Review → Permanent Benefit Listing

Now Standard benefit: Diaper Sensor

Smart diaper sensors detect moisture and alert long-term care workers in real time — reducing skin injury risk and caregiver burden in home and institutional settings

Pre-Authorization in Practice: Digital Medication Reminder System

Digital medication systems use LED lights and audible alarms to prompt timely dosage — tracking adherence and reducing caregiver burden through automated mobile logging.

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Mental Health: NHIS Family Counseling Service Mental Health Support

Who & Where

NHIS-deployed counselors conduct in-person home visits to family members of long-term care beneficiaries — not a telephone or drop-in service.

What

Psychological support, caregiver burnout assessment, and care guidance — operating under NHIS's core mandate to provide families with information, guidance, and counseling.

How

Sessions are proactively scheduled — not demand-based. High-risk caregiver households are identified through NHIS case management data and receive targeted outreach.

Proven Impact

NHIS internal program evaluation data (not publicly disclosed): participants showed measurable reductions in depression levels and stress scores compared to baseline — providing internal evidence of program effectiveness.

PART 06

The Core Engine: NHIS End-to-End Operational Role

NHIS End-to-End Operations: LTCI Act Article 48 Single-Insurer Mandate

LTCI Act Article 48 — NHIS manages the full lifecycle from application through quality evaluation as the single insurer.

01

On-site Investigation

Standardized home visit assessing physical/cognitive status and care needs (Art. 48-3)

02

Rating Committee

15-member committee determines LTC rating and issues certification (Art. 48-4)

03

Care Plan Preparation

NHIS prepares standard LTC use plan (Standard LTC Use Plan) based on rating (Art. 48-5)

04

Service Counseling

Utilization support: guidance on benefit selection and service linkage for beneficiaries (Art. 48-7)

05

Post-care Monitoring

Ongoing confirmation of benefit delivery and beneficiary condition management

06

Expense Review

All institution claims verified before payment — RFID-based electronic screening (Art. 48-8)

07

Payment

Reimbursement paid to LTC institutions; cash benefits paid directly to beneficiaries (Art. 48-8)

08

Eligibility management & Imposition and collection of Contributions

Eligibility management of long-term care insurance and Imposition and collection of long-term care insurance contributions

NHIS End-to-End Operations: LTCI Act Article 48 Single-Insurer Mandate

LTCI Act Article 48 — NHIS manages the full lifecycle from application through quality evaluation as the single insurer.

09

Quality Eval. & Audits

5-tier quality evaluation of all institutions
joint field audits with local governments (Art. 48-6, 13)

10

Long-Term Care Development

Investigation, research, **international cooperation**, and public relations regarding long-term care projects

11

Establishment and operation of Long-term care institutions

Develop long-term care benefits criteria and review the appropriateness of long-term care benefit costs

5-tier quality evaluation of all institutions

Evaluation Domains		Rating Results	
01	**Institution Management** — Staffing ratios, facility operations, compliance	A	**Excellent** — Top performers — reimbursement rate supplement applied
02	**Environment & Safety** — Physical environment, infection control, emergency protocols	B	**Good** — Above average
03	**Rights & Responsibilities** — Beneficiary rights protection, grievance handling	C	**Average** — Meets minimum standards
04	**Care Process** — Assessment, care planning, service delivery quality	D	**Below Avg** — Falls below standards
05	**Beneficiary Outcomes** — Functional status, satisfaction, health indicators	E	**Poor** — Significantly below standards — Mandatory follow-up inspection, Denial of renewal

Incentive: Grade A → Enhanced reimbursement rate supplement applied.
Disincentive: Grade E → Reimbursement reduction prescribed — however, enforcement of financial penalty has not yet been implemented in practice.

NHIS End-to-End Operations: LTCI Act Article 48 Single-Insurer Mandate

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Display of Long-term Care Institution Rating Level (Number of Stars) and Converted Scores by Evaluation Domain

Service Type	Category	Total Score	Institution Institution Management	Environment & Environment & Safety	Rights & Rights & Responsibilities	Care Process Care Process	Beneficiary Beneficiary Outcomes
Home Visit	Home Visit Care A (Excellent) 2023 Periodic Evaluation	96.35	★★★★★	★★★★★	★★★★½	★★★★★	★★★★½
			93	100	96	100	90
	Overall Average	81.73	75	89	83	79	85
Home Visit	Home Visit Care A (Excellent) 2023 Periodic Evaluation	91	★★★★★	★★★★★	★★★★☆	★★★★½	★★★★★
			97	90	83	86	98
	Overall Average	83.75	81	87	83	76	97

The NHIS publishes its long-term care evaluation results on its official website to help beneficiaries choose the right care institution
www.longterm.or.kr

NHIS End-to-End Operations: LTCI Act Article 48 Single-Insurer Mandate

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National Health Insurance Service (NHIS) Seoul Nursing Home

The only long-term care institution directly established and operated by the NHIS

Functions as a "test-bed" to develop, evaluate, and disseminate standardized, high-quality care service models

Review the appropriateness of long-term care benefit costs.

Operates Nursing Home, Day & Night Care, Short-term Respite,
Home Visit Care, and Home Visit Bathing

Q&A

Questions?

Thank you for your valuable attention.

Presenter

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