Analysis of the upcoming 2026 statutory health insurance reform

FKG recommendations versus draft legislation

The statutory health insurance (GKV) faces a historic test in spring 2026. Faced with a looming financial deficit of over 40 billion euros by 2030, the Health Finance Commission (FKG), established by Federal Health Minister Nina Warken, presented a catalogue of 66 measures on 30 March 2026 to stabilise contribution rates from 2027 onwards. The draft bill and the Cabinet decision on the Statutory Health Insurance Contribution Rate Stabilisation Act (BStabG) take up these proposals, but show significant differences in implementation and burden-sharing. For instance, the draft bill and the cabinet decision adopt over 75% (approx. 50 out of 66) of the measures identified by the Commission, accounting for a total of around 80% of the potential cost-saving measures identified by the Commission for the starting year 2027.

>> The draft bill and the Cabinet decision focus heavily on the expenditure side (freeze on reimbursement rates, cuts to sick pay, drug discounts) and contribution revenue (raising the contribution assessment ceiling). However, the massive relief through tax revenue (citizen's income contributions, consumption taxes) hoped for by the Commission failed to materialise. Whilst the FKG recommended a radical overhaul of family insurance, the Cabinet opted for a politically more moderate, yet still highly debatable, model in the form of the contribution surcharge. According to the Federal Government's plans, the Statutory Health Insurance Contribution Rate Stabilisation Act is to be passed in the near future in order to limit further increases in contribution rates expected from 2027 onwards. The timeline: The draft was approved by the Cabinet on 29 April 2026. The aim is to get the bill through the Bundestag by the 2026 summer recess, with the final reading currently scheduled for 9 July 2026.

This leaves very little time for the necessary discussions in the political process, although many stakeholders have already voiced criticism, some of it sharp. The main criticisms concern benefit cuts, high additional burdens on insured persons and employers, and a lack of structural reforms. Supporters, however, see the proposed Contribution Rate Stabilisation Act as a necessary measure to stabilise contributions.

Objectives and tasks

The Health Finance Commission (FKG), established by Federal Health Minister Warken, had identified the decoupling of expenditure and revenue since 2019 as a key cost driver in its report . The most important recommendation was therefore a blanket cap on remuneration increases across all sectors at the so-called basic wage rate, supplemented by a one-percentage-point reduction for the years 2027 to 2029.

The draft bill and the cabinet decision adopt this principle almost in its entirety. Price and remuneration increases for contract dentists, providers of therapeutic services, midwives, preventive care facilities and emergency services will be strictly linked to the basic wage rate. The administrative costs of health insurance funds will also be capped according to this benchmark. The draft justifies this with the need to curb price dynamics as a key factor in the financial difficulties.

Outpatient sector and medicines: consistent implementation

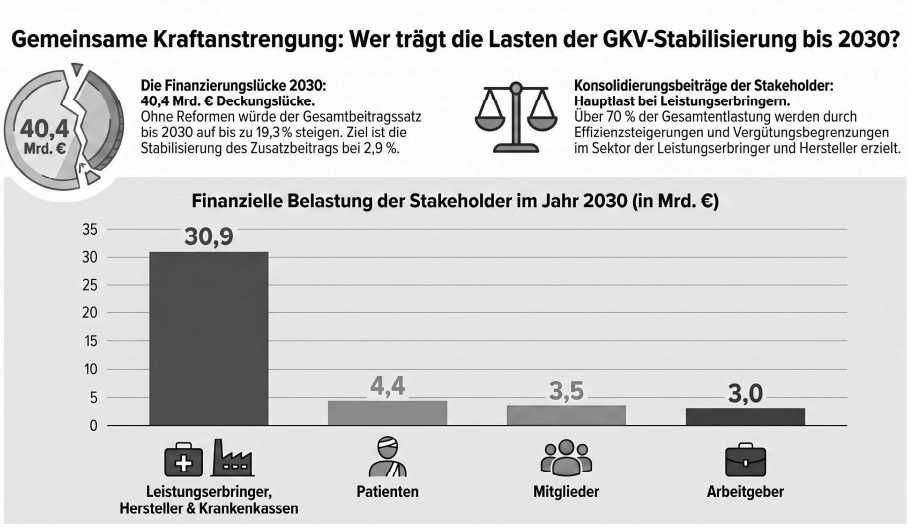
In the area of outpatient care, the legislator largely follows the Commission's recommendations. The surcharges for appointment booking (TSVG arrangements), which according to the evaluation have not improved patient access, are being abolished. Similarly, the separate remuneration for the initial completion and updating of the electronic patient record (ePA) is being abolished, as this is considered part of standard documentation following the introduction of the opt-out procedure. The adoption of the recommendations is particularly evident in the reimbursement of homeopathic services. The draft legislation follows the FKG's recommendation to remove these from the catalogue of statutory benefits due to a lack of scientific evidence.

In the pharmaceutical market, the draft relies on the package proposed by the Commission comprising dynamic manufacturer discounts and a tightening of price-volume regulations. To strengthen price competition for patent-protected medicines, the legislator is also introducing the possibility of discount agreements covering multiple active substances.

An interesting detail, however, is that whilst the Commission recommended abolishing the orphan drug privilege in order to subject these medicines to a regular benefit assessment, the draft bill seeks to implement this by removing the relevant special provisions in Section 35a of the Social Code, Book V.

Hospital sector: Increased efficiency through audit pressure

In the inpatient sector, the draft bill adopts the FKG's proposals to abolish flat-rate funding for measures relieving the burden of care and to require repayment for unfilled staff positions in the PEPP sector, in order to prevent double funding and the misuse of funds. With regard to auditing, however, the legislator has opted for a more moderate approach than that envisaged by the Commission's recommendations: Whilst the FKG called for the complete abolition of audit quotas, the draft version merely provides for an increase in thresholds and audit quotas. This is justified on the grounds of maintaining the reduction in bureaucracy for institutions that bill in accordance with the rules. Nevertheless, the automatic extension of the Medical Service's (MD) audit mandate is being implemented to strengthen cost-effectiveness controls.



Sick pay and patient contributions: painful adjustments

Both the FGK recommendation and the draft bill emphasise that a contribution from insured persons is unavoidable. Consequently, the draft version implements the FGK recommendation to reduce the level of sick pay by five percentage points (to 65% of gross or 85% of net pay). To compensate, partial incapacity for work and partial sickness benefit are being introduced to make the return to work more flexible – a key demand of the expert group.

Regarding the financing of dental prostheses, the legislator is reverting, as recommended, to the pre-2020 status quo and reducing the fixed subsidies to 50%. The indexation of co-payments (raising the minimum amount to €7.50 and the maximum amount to €15) is also reflected in the draft.

Discrepancies: the ‘missing billions’ and the revenue side

Despite the high degree of alignment between the recommendations and the legislative texts, there are three key areas where the Commission’s recommendations have been deviated from or are completely ignored without any explanation:

• **Citizens’ income contributions:** The FKG strongly recommended that contributions for citizens’ income recipients be financed by the federal government on a cost-covering basis, which would have relieved the statutory health insurance funds (GKV) of around €12 billion. This proposal is not included in the draft bill. Instead, the federal government contributes to stabilisation merely by deferring loan repayments.

• **Excise duties (prevention):** The Commission proposed that additional revenue from increases in tobacco and alcohol duties, as well as a new sugar tax, be channelled directly into the health fund. These measures are completely absent from the draft bill.

• **Family insurance:** Whilst the FKG recommended the complete abolition of non-contributory co-insurance for spouses without children under the age of 7, the draft bill envisages a less radical approach: it introduces a contribution surcharge of 3.5 percentage points for this group. This is intended to strengthen the financial basis without fundamentally

dismantling the family insurance system.

Where do the differences come from?

An analysis of the FGK's recommendations and the draft bill, which was drawn directly from them and published very shortly afterwards, reveals clear differences between two divergent agendas: that of academia and that of politics. The content of the draft bills from the Federal Ministry of Health can be attributed primarily to purely political considerations, fiscal constraints of the federal budget, and the attempt to somehow maintain social acceptance despite the increasingly apparent burdens of reform. The Commission, on the other hand, follows strictly scientific and systematic logic. The draft bill thus represents a political compromise attempted as early as the draft stage, without seizing the opportunity to act more boldly.

Here are the likely key reasons for the discrepancies:

1. Federal fiscal constraints (citizen's income contributions)

Recommendation: The FKG called for the federal government to provide cost-covering funding for statutory health insurance contributions for basic income recipients, which would have meant a reduction in costs of approximately €12 billion.

Draft: The RefE completely dispenses with this system-appropriate tax financing. Instead, the federal government merelycontributes to liquidity by deferringloan repayments (approx. €5.6 billion).

Nature of the difference (assessment): Purely political. The Commission argues, on regulatory grounds, that non-insurance benefits must be financed from taxes. However, the draft reflects the reality of the federal budget, in which no funds are available for such a massive increase in the federal subsidy.

2. Social acceptance vs. labour market incentives (family insurance)

Recommendation: The expert group recommended the complete abolition of non-contributory co-insurance for spouses without children under the age of 7, in order to create incentives to work and adapt the system to modern lifestyles.

Draft: The legislator has opted for a more moderate approach and is instead introducing a contribution surcharge for this group.

Nature of the difference (assessment): Political-social. Whilst the FKG emphasises the scientific evidence for increasing labour force participation, politicians shy away from a radical overhaul of the system to avoid social hardship and massive resistance among the population.

3. Reducing bureaucracy vs. cost-effectiveness checks (audit quotas)

Recommendation: The FKG advised the complete abolition of audit quotas, as these have demonstrably failed to improve the quality of claims processing and the statutory health insurance funds are missing out on billions in recoveries.

Draft: The RefE retains the system but raises audit quotas and thresholds.

Nature of the difference (assessment): Balancing of political interests. The scientific community regards quotas as an inefficient mechanism. However, politicians place greater weight on maintaining 'peace' with hospitals and the desire to reduce bureaucracy for service providers than on maximising the recovery of payments.

4. Location policy vs. price regulation (drug price caps)

Recommendation: The FKG identified orphan drug privileges and a lack of price-volume control as cost drivers.

Draft: The RefE goes beyond the proposed savings but at the same time removes the 'price caps' for reimbursement amounts (price ceilings for low added value), which were only introduced in 2022, without replacement.

Nature of the difference (assessment): Economic policy. The explanatory memorandum in the draft explicitly cites "attractiveness as a business location" and the rewarding of innovation. This is a political decision in favour of the pharmaceutical industry, which the experts tended to view from the perspective of cost-effectiveness.

5. Avoiding political conflict (excise duties)

Recommendation: Introduction of a sugar tax and an increase in alcohol and tobacco duties, with the revenue flowing directly into the health fund.

Draft: These measures are completely absent from the draft bill.

Nature of the difference (assessment): Purely political. Although the FKG cites strong scientific evidence for the preventive effect of these taxes, new taxes or earmarked levies are often unenforceable within a coalition.

The differences are therefore almost exclusively political in nature. Whilst the Commission designs an 'ideal', scientifically grounded financial architecture, the Federal Ministry of Health (BMG) seeks to take into account the constraints of the federal budget, the interests of stakeholders and, above all, voter support. <<

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Links

Commission report: https://t1p.de/6jfhf

Draft bill: https://t1p.de/y7zny

Cabinet draft: https://t1p.de/qrndr

Gegenüberstellung ausgewählter im Referenten- und Kabinettsentwurf vollständig übernommener FKG-Vorschläge	
Vorschlag der Finanzkommission (FKG)	**Begründung / Details im Entwurf**
Globale Begrenzung der Vergütungsanstiege (Grundlohnrate)	Fokus auf Reduktion der Preisdynamik; Kopplung an die Einnahmenentwicklung ist "unabdingbar"
Erhöhung der Zuzahlungsbegrenzungen um 50%	Anpassung an die Inflation seit 2004 zur "finanziellen Konsolidierung"
Streichung der TSVG-Zuschläge (Terminvermittlung)	Evaluation zeigt keinen verbesserten Patientenzugang; Vermeidung von Mitnahmeeffekten
Rückführung der Psychotherapie in die MGV	Gedeckelte Gesamtvergütung zur Ausgabensteuerung
Streichung der ePA-Erstbefüllungsvergütung	ePA-Befüllung wird nach Opt-out-Einführung als Teil der Regeldokumentation gewertet
Streichung Homöopathie als Satzungsleistung	Fehlende wissenschaftliche Evidenz für die Wirksamkeit
Reduktion Festzuschüsse Zahnersatz (auf Niveau v. 2020)	Rückkehr zu 50% Festzuschuss; Härtefallregelung (100 %) bleibt
Streichung volle Tarifrefinanzierung (Krankenhaus/Pflege)	Volle Refinanzierung hebelt Grundlohnrate aus; Anreiz für wirtschaftliche Tarifabschlüsse
Automatische Erweiterung MD-Prüfauftrag	MD soll alle abrechnungsrelevanten Sachverhalte unabhängig vom konkreten Auftrag prüfen
Dynamisierter Herstellerabschlag (Arzneimittel)	Sicherstellung eines nachhaltigen Beitrags der Pharmaindustrie ohne Querfinanzierung
Abschaffung Orphan-Drug-Privileg	Orphan-Drugs werden regulärer Nutzenbewertung unterzogen
Absenkung Krankengeldniveau (um 5 Prozentpunkte)	Moderater Beitrag der Versicherten angesichts hoher Deckungslücken vertretbar

Table 1: **Comparison of selected proposals adopted in full in the draft bill and the cabinet draft. Own presentation.**