Who bears the burden of the law on stabilising contribution rates in statutory health insurance?

A joint effort or a burden on patients?

The Statutory Health Insurance Contribution Rate Stabilisation Act is – provided the draft legislation remains unchanged – a comprehensive restructuring programme, whereby the focus is almost exclusively on cost-cutting rather than reforms for the time being. The main burden of the reform falls on service providers and the industry, who are being forced to improve efficiency through strict price caps (basic wage rate) and the removal of privileges (tariff refinancing). However, patients are also feeling the strain.

>> This burden is reflected primarily in higher co-payments and a slight reduction in wage replacement benefits. At the same time, the Act seeks to improve the quality of medical care by eliminating ineffective treatments (homeopathy) and avoiding unnecessary operations (second opinions). For high-income insured persons and for married couples covered by family insurance, direct contribution or surcharge burdens are also increasing. Overall, this is a “joint effort” to avert the impending collapse of the statutory health insurance (GKV) finances. The aim of the draft is, in view of a dramatic financial situation, to stabilise contribution rates in the long term and to close a looming funding gap of up to 40 billion euros in 2030.

The starting point is more than dramatic: the system is at breaking point. Statutory health insurance (GKV) faces its greatest financial test in decades. In 2024, health insurance funds and health funds recorded a deficit of just under 10 billion euros. Whilst revenue is set to rise by only around 3 per cent per year in the medium term, expenditure has recently grown by just under 8 per cent – a trend that has become decoupled from general wage growth. Without statutory countermeasures, the total contribution rate would rise to over 19 per cent by 2030, which would pose a massive threat to Germany’s economic development and the net incomes of employees.

At the heart of the reform lies the guiding principle and, furthermore, the reintroduction of a strictly revenue-oriented spending policy. This means that price and remuneration increases in almost all areas of healthcare provision will in future be capped by the so-called basic wage rate (the annual rate of change in contributory income per member). To accelerate consolidation, this rate will be further reduced by one percentage point between 2027 and 2029.

Stakeholder analysis: Who bears the brunt of the burden?

Analysis of the draft makes it clear that the financial burden is spread across many shoulders, but the intensity of the burden varies greatly.

1. The main burden-bearers are service providers, manufacturers and health insurance funds.

This group bears by far the largest share of the financial consolidation. In 2027, around €12 billion (60% of the total volume) will be accounted for by this sector; by 2030, this contribution will rise to €31 billion, corresponding to 72% of the total relief effect.

• **Hospitals:** Remuneration (state-level base case values) and even care budgets will be strictly linked to the reference value or the basic wage rate. The previous full refinancing of collectively agreed wage increases will be abolished, which will massively increase the pressure on hospitals. In addition, the audit quota system will be tightened to impose stricter penalties for incorrect billing.

• **Doctors and dentists:** In addition to budgeting via the basic wage rate, numerous special payments are being scrapped. These include TSVG surcharges for rapid appointment booking, payments for organ donation counselling and surcharges for short-term psychotherapy.

• **Pharmaceutical industry**: A newly introduced dynamic manufacturer's discount obliges the industry to make contributions if expenditure on medicines rises faster than the statutory health insurance scheme's (GKV) revenue. This is expected to save around €5.5 billion in 2030 alone.

• **Employers and high earners**

Employers will be burdened by the increase in the flat-rate contribution rate for mini-jobbers to the level of employees subject to compulsory insurance (14.6% plus additional contribution), as well as by an extraordinary increase in the contribution assessment ceiling. These measures will generate additional revenue of approximately €3 billion annually by 2030.

• **Family-insured** persons**and members**

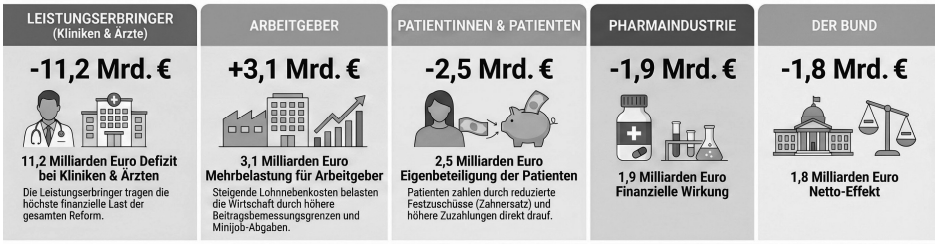
The previously contribution-free family insurance for spouses will be severely restricted. Anyone who cannot prove they have care responsibilities (children under 7, disability) or nursing care responsibilities and has not yet reached the age limit will in future have to pay a contribution surcharge of 3.5%. This is intended to relieve the statutory health insurance system (GKV) of 2.2 billion euros annually from 2028.

The burden on patients

The draft addresses the issue of the burden on patients with a two-pronged approach: direct additional financial costs and moderate cuts to benefits. The financial contribution from patients is estimated at €3.8 billion in 2027 and €4.4 billion in 2030. However, under the draft bill, patients do not directly 'save' any money; instead, through additional burdens and service reductions, they make a financial contribution towards stabilising the health insurance funds, which is expected to amount to €3.8 billion in 2027. By 2030, this contribution is set to rise to around €4.4 billion annually.

According to the draft bill, this total contribution from patients comprises two equally weighted areas:

• **Co-payments:** The draft now provides for a one-off increase of approximately 50%. By raising theco-payment limits and amounts (e.g. for medicines, therapeutic products and inpatient care), which have not been adjusted for over 20years, patients will face an additional burden of 1.9 billion euros in 2027. The minimum co-payment is set to rise from €5 to €7.50, and the maximum amount from €10 to €15. In future, inpatient treatments and remedies will also cost €15 per day or per prescription, instead of the current €10. From 2028, these costs are set to increase by a further €100 million per year through annual indexation linked to the basic wage rate.



• **Benefit adjustments:** Further savings for the statutory health insurance system at the expense of patients, amounting to €1.9 billion (2027) and €2.2 billion (2030) respectively, result from benefit cuts.

The specific measures relating to benefit adjustments include, in particular:

• **1. Sick pay:** The level of sick pay will be reduced moderately by 5 percentage points. In addition, potential for abuse will be eliminated through a stricter block period rule of 78 weeks within three years (regardless of the type of illness). The 5 percentage point reduction in the level of sick pay is expected to lead to a reduction in expenditure by the statutory health insurance (GKV) of €1.3 billion in 2027 (rising to €1.5 billion in 2030).

• **2. Dental prostheses:** Fixed subsidies will be reduced by 10 percentage points to the 2020 level (50% standard care). However, hardship provisions will remain in place. The reduction of fixed subsidies to the 2019 level is expected to save health insurance funds around €590 million in 2027.

• **3. Homeopathy:** These services are to be completely removed from the statutory health insurance catalogue, as, according to the draft, there is insufficient scientific evidence of their effectiveness. The exclusion of homeopathic and anthroposophic services is expected to save approximately 50 million euros annually.

• **Second opinion procedure:** For certain ‘high-volume’ operations (e.g. on the knee or spine), obtaining a second opinion will become a mandatory prerequisite for cost coverage.

The aim

Whether the burden is perceived as socially balanced can be assessed on the basis of the following safeguard mechanisms and distribution principles enshrined in the draft:

1. The main burden lies with service providers and industry

A key argument for social balance is that patients and the insured do not bear the main burden of the reform.

• 72% of the total cost-saving effect (approx. €31 billion in 2030) will be achieved through savings made by service providers (doctors, hospitals), manufacturers and health insurance funds.

• Insured persons and employers, on the other hand, will be spared massive increases in additional contributions, which could rise to around 4.7% by 2030 without this reform.

2. Solidarity contribution from high earners and employers

To strengthen contribution fairness, the draft provides for measures specifically targeting financially stronger stakeholders:

• Increase in the contribution assessment ceiling: Through the exceptional increase of €300 per month, individuals with higher incomes will make a 'solidarity contribution'.

• Employer contribution for mini-jobs: The flat-rate contribution rate for those in marginal employment will be raised to the level of jobs subject to compulsory insurance to avoid distortions of competition and generate additional revenue.

3. Social safety nets for patients

Despite the increase in co-payments and benefit cuts, the draft contains specific clauses designed to prevent financial hardship:

• Financial limits remain in place: The rule that co-payments are capped at 2% of annual gross income (1% for the chronically ill) remains unchanged.

• **Hardship provisions for dental prostheses:** Whilst fixed subsidies are generally being reduced, a 100% fixed subsidy remains in place for hardship cases to ensure access to care for low-income groups.

• **Protection for children:** Children remain fully covered under family insurance without having to pay any contributions.

4. Differentiated adjustment of family insurance

The newly introduced additional contribution for co-insured spouses (3.5%) is linked to exceptional social circumstances. Those who perform family duties or cannot readily take up gainful employment are exempt:

• Caring for children under the age of 7

• Caring for relatives (care level 2 or higher)

• Disability of the child or the spouse reaching the standard retirement age. <<

by: MVF Editor-in-Chief Peter Stegmaier

Reactions to the Statutory Health Insurance Contribution Rate Stabilisation Act

Mostly negative stakeholder response to statutory health insurance plans

In the health policy debate surrounding the planned Statutory Health Insurance Contribution Rate Stabilisation Act (BStabG), a deep divide is evident between the expectations of the payers and the fears of the service providers. Whilst the federal government is responding to the looming deficit of up to 40 billion euros in 2030 with the draft bill of 16 April 2026, associations representing the medical profession, hospitals and the pharmaceutical industry are warning of a massive deterioration in the quality of care. On the one hand, health insurance funds see the draft as a necessary means of stabilising contribution rates; service providers, on the other hand, view it as a mere cost-cutting measure lacking structural foresight. The shared concern of almost all stakeholders – with the exception of the health insurance funds – is that the reform will be at the expense of patients, whether through longer waiting times, hospital insolvencies or the withdrawal of innovations from Germany.

>> Former Federal Health Minister Jens Spahn once said, or something to that effect, that the quality of a healthcare reform could be gauged by the opposition it faces; and if there were none from the pharmaceutical industry, something had probably gone wrong. Judging purely by the mostly negative reactions to the Statutory Health Insurance Contribution Rate Stabilisation Act so far, this appears to be one of the better reform proposals. Here is a summary of the reactions, broken down by stakeholder group:

Medical profession/psychotherapists

Practising doctors and psychotherapists have reacted with open indignation to the draft. The National Association of Statutory Health Insurance Physicians (KBV) and professional associations such as SpiFa view the bill as a “head-on attack on outpatient care”.

• **Reactions:** Particular criticism is directed at the removal of extra-budgetary remuneration for TSVG services (e.g. walk-in consultations and appointment booking). The KBV warns that this will remove the incentives for prompt appointment allocation, which will inevitably lead to longer waiting times. The Central Institute for Statutory Health Insurance Medical Care (Zi) describes the law as “the first step towards a system of waiting lists and rationing”.

• **Specific burdens:** The panel doctor sector is expected to contribute around €2.7 billion to consolidation by 2027. According to Zi calculations, this represents an average loss of fees of €24,000 per practice; for specialist groups such as radiology, the losses could even amount to €68,000 per year.

Hospitals and university hospitals

The inpatient sector feels disproportionately burdened and sees its very existence under threat.

• **Reactions:** The German Hospital Association (DKG) and regional associations such as the Hessen Hospital Group criticise the fact that hospitals must shoulder over 40% of the savings in the provider sector, even though their share of total statutory health insurance expenditure is only around 33%. The Association of University Hospitals (VUD) warns that the 'one-size-fits-all approach' would drastically exacerbate structural deficits at all university medical centres. The return to only half the standard rate of reimbursement is described as a 'cost-revenue gap' that could drive many hospitals into insolvency.

• **Specific burdens:** The hospital sector will face a burden of around €4.6 billion in 2027. Key factors include the capping of care budgets, the abolition of the flat-rate payment for care-relieving measures (approx. €700 million) and the tightening of billing audits.

Existential fears and accusations of bureaucracy

Hospitals feel disproportionately burdened by the austerity package and see their economic foundations under threat.

• **Association of German University Hospitals (VUD):** The VUD warns urgently that the reform could further weaken highly specialised university medicine financially. Whilst the

need to consolidate statutory health insurance finances is recognised, the association sees the current plans primarily as a dangerous burden on maximum-care providers. Prof. Jens Scholz, Chairman of the VUD, describes the short-term cost-cutting measures envisaged in the draft bill as merely "treating the symptoms". He criticises the fact that political decisions ignore the actual structural causes of the financial crisis and instead forcefully widen the "cost-revenue gap" for hospitals once again. This, he argues, undermines the recently agreed stabilisation measures and jeopardises hospitals on which the country relies in crisis situations such as pandemics.

The VUD is particularly critical of the cuts to the innovation fund. It argues that this fund is necessary to develop ideas for the healthcare of tomorrow; an austerity package in this area would therefore jeopardise the long-term sustainability of the system. With regard to the care budget, the association expresses understanding for stricter efficiency controls, but warns against rigid requirements or new "bureaucratic pitfalls". The association views the planned reorientation of the approach to new examination and treatment methods (NUB) as one of the few promising approaches. It welcomes the concentration of these services in specialised innovation centres within the framework of clinical trials, as university hospitals are the ideal location for this due to their scientific expertise and high standards of patient safety.



Pharmaceutical industry

For pharmaceutical manufacturers, the law represents a massive setback for Germany as a business location.

• **Reactions:** The vfa and Pharma Deutschland criticise the new "dynamic manufacturer discount" as a tool that makes investment unpredictable. vfa President Steutel emphasises that linking the discounts to statutory health insurance (GKV) revenue means companies lose all planning certainty. Furthermore, the introduction of discount agreements for patent-protected, "therapeutically comparable" medicines is rejected as a paradigm shift in which price will in future take precedence over medical benefit.

• **Specific burdens:** The pharmaceutical industry will face a burden of approximately €1.9 billion in 2027. Its contribution is set to rise to 22% of the total share borne by service providers by 2030. Added to this are burdens arising from new price-volume regulations and discounts on vaccines.

Providers of medical treatments and aids

Smaller sectors such as orthopaedic technology and physiotherapy are also sounding the alarm.

• **Reactions:** The Federal Guild Association for Orthopaedic Technology (BIV-OT) and the association "Wir versorgen Deutschland" (WvD) strongly reject the flat-rate 3% discount on medical aid prices provided for in the draft bill. This penalises, of all sectors, one that has already, in the past, strictly adhered to the basic wage rate.

• **Specific** financial **burdens:** The medicinal products sector will face a burden of €0.3 billion in 2027, and the medical aids sector €0.4 billion.

Health insurance funds and their associations

Whilst the health insurance funds welcome the guiding principle of a revenue-oriented expenditure policy, they criticise the lack of federal government involvement.

• **Reactions:** The GKV-Spitzenverband and the AOK praise the attempt to limit the rise in expenditure, but see a "fairness gap". The main criticism is that the federal government is not addressing the shortfall in contributions for citizens receiving basic income (approx. €12 billion). AOK Rheinland/Hamburg describes the distribution of the burden as "unfair", as the state is almost entirely shirking its responsibility.

• **Specific burdens:** Health insurance funds must cap increases in their administrative costs at the rate of basic wage growth and cut their advertising budgets per member by 50%. Furthermore, the funding volume of the Innovation Fund will be permanently halved to €100 million.

Employers and members (contributors)

The government describes the burden on contributors as “moderate”, but those affected view it critically.

• **Reactions:** The Private Health Insurance Association criticises the extraordinary increase in the compulsory insurance threshold as an “attack on freedom of choice” and “citizens’ insurance for employees through the back door”.

• **Specific burdens:** a) Employers: Will contribute around €3.1 billion in 2027, mainly due to the increase in the mini-job contribution rate to 17.5% and the rise in the contribution assessment ceiling (BBG). b) **High-earning members:** Will pay approx. €25 more per month due to the increase in the BBG (by €300 per month). c) **Families:** From 2028, a separate contribution surcharge will be levied for co-insured spouses (excluding children under 6), which will relieve the statutory health insurance system (GKV) of €1.5 billion. << by: MVF Editor-in-Chief Peter Stegmaier

Structural reform not until late 2026

The Health Finance Commission (FKG) is pursuing a two-stage approach to reforming statutory health insurance (GKV), with the focus on ensuring long-term financial sustainability whilst maintaining a high standard of care. Whilst the first report, due in March 2026, will contain short-term measures to close the funding gap from 2027 onwards, the Commission will present a second report by the end of 2026, which is intended to contain detailed recommendations for structural reforms effective in the medium and long term. The key areas of action for these planned structural reforms include:

• **Digital transformation:** Measures are to be developed for a comprehensive digital transformation of healthcare in order to tap into efficiency reserves.

• **Shifting care to the outpatient sector:** Services that have hitherto been provided primarily on an inpatient basis are to be increasingly shifted to the outpatient sector.

• **Improved patient management:** A focus is on the coordination and management of patient pathways, in particular through the reform of emergency care and the introduction of a primary care system.

• Service structures and team-based approach: The Commission plans fundamental changes to service structures, particularly in the inpatient sector, as well as a stronger team-based approach involving various professions.

• **Reorganisation of remuneration systems:** A systematic review of the allocation of services to extra-budgetary (EGV) versus morbidity-based total remuneration (MGV) in the contract-based medical sector is planned.

• **Representative cost surveys:** In the medium to long term, the foundations for cost surveys across all service sectors are to be established in order to create automated cost indices as a basis for fair and cost-effective remuneration negotiations.

• **Strengthening prevention:** In addition to fiscal measures, further recommendations are to be put forward to strengthen prevention and health promotion, covering areas of action beyond the scope of SGB V.