

## HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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## LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

### 1. Please provide a bird's eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Austria has a very complex health system with responsibilities for governance split between the federal and state levels. The federal government is primarily responsible for health-related legislation, for example, for social health insurance, health professionals, pharmaceuticals and medical devices, and sets the basic framework for hospital care legislation. The nine federal states, on the other hand, regulate and plan hospital care in their jurisdiction and are responsible for the implementation, organisation and financing of inpatient and outpatient care in hospitals, as well as for investments in hospitals. Municipalities play only a minor role in the healthcare system and are therefore not involved in the regulation. However, they organise and deliver long-term care, such as nursing homes and home care services, along with other social support services for vulnerable groups.

In Austria, the principle of mandatory insurance applies, which means that insurance cover is provided for all persons who are employed or self-employed in Austria, as well as for certain relatives, automatically by virtue of the law. In Austria there are three social health insurance funds, that is, Österreichische Gesundheitskasse (ÖGK), Versicherungsanstalt öffentlich Bediensteter und Eisenbahnen und Bergbau (BVAEB), and two social security funds, that is, Allgemeine Unfallversicherungsanstalt (AUVA) and Pensionsversicherungsanstalt (PVA), that are grouped together in the Umbrella Organisation of the Social Insurance Carriers (Dachverband). Social health insurance funds and Dachverband, as well as their institutions and facilities, are subject to supervision by the Federal Ministry of Labour, Social Affairs, Health and Consumer Protection (Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz or BMSGPK). In addition to mandatory health insurance, anyone in Austria is free to conclude private supplementary insurance contracts with an (health) insurance company of their choice. Unlike social health insurance funds, these insurance companies must comply with the provisions of the Insurance Contract Act (Versicherungsvertragsgesetz or VersVG) subject to supervision by the Financial Market Authority (FMA).

Healthcare services, in general, are provided without additional cost to the insured. However, some insured groups, for example, the insured persons of Sozialversicherung der Selbständigen (SVS) and BVAEB, have to make a copayment in the case of medical care.

**2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.**

The financing of the Austrian healthcare system, as well as reimbursement, are governed by a number of laws, regulations and agreements that ensure that resources are allocated efficiently, fairly and sustainably. The Federal General Social Security Act (*Allgemeines Sozialversicherungsgesetz* or ASVG) is the central legal basis for social insurance and thus for financing and reimbursement of healthcare services in Austria. It regulates health insurance for employees and certain self-employed workers, and defines medical services covered by statutory social healthcare insurance funds, for example, physician's visits, medication and hospital stays. Furthermore, it determines the amount of insurance contributions, and how the costs are borne by employees and employers. By contrast, health insurance for all other self-employed persons, farmers and public servants is regulated by the Commercial Social Security Act (*Gewerbliches Sozialversicherungsgesetz* or GSVG), Farmers' Social Security Act (*Bauernsozialversicherungsgesetz* or BSVG), and Public Servants' Healthcare and Accident Insurance Act (*Beamten-, Kranken- und Unfallversicherungsgesetz* or B-KUVG).

Besides the ASVG, there are different frameworks for the reimbursement of medical treatment and medicinal products. If treatment is administered outside a hospital setting, that is, in a physician's office, group practice or primary healthcare facility, reimbursement is governed under private law by overall agreements (*Gesamtverträge*) between social health insurance funds (or *Dachverband*) and the Physicians' Chambers for each Austrian province on the one hand, and by individual agreements (*Einzelverträge*) between social health insurance funds (or *Dachverband*) and individual physicians on the other hand. The reimbursement of costs for treatment provided or medicinal products used in public hospitals or private hospitals, which are contractual partners of the patient's social health insurance fund, is governed under private law agreements between hospital operators (or the competent professional association for hospitals at the Chamber of Commerce) and the social health insurance fund (or *Dachverband*). The statutory content of the overall contracts is again determined by the ASVG.

Medicinal products that are prescribed by a physician and subsequently dispensed to the patient by a pharmacy are included in the Reimbursement Code (*Erstattungskodex*) issued by the *Dachverband*. The procedure for including medicinal products in the *Erstattungskodex* is also regulated in the ASVG.

According to the ASVG, GSVG, BSVG and B-KUVG, social health insurance funds and the *Dachverband*, as well as their institutions and facilities, are subject to supervision by the BMSGPK. Insurance companies that provide supplementary health insurance must comply with the provisions of the VersVG and are subject to supervision by the FMA.

**3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?**

Social health insurance is generally administered by self-governing bodies. However, the federal government, that is, the BMSGPK, is responsible for supervising health insurance funds and the *Dachverband*. The BMSGPK is responsible for monitoring the management of social health insurance funds and the *Dachverband*, and ensuring that no legal provisions are violated in doing so. It can extend its supervision to include questions of expediency, efficiency and economy. In such cases, the BMSGPK should, however, limit itself to

important questions and not unnecessarily interfere with the autonomy and responsibility of the social health insurance fund and *Dachverband*. In exercising its supervisory authority, BMSGPK can also rescind the resolutions of managing bodies.

In addition, the Federal Ministry of Finance (Bundesministerium für Finanzen or BMF) is entitled to send a representative to meetings of the *Dachverband's* administrative bodies in order to safeguard the financial interests of the federal government.

In order to facilitate the planning, management and overall financing of the healthcare system across regions and sectors, the Federal Health Agency (Bundesgesundheitsagentur or BGA) and, at the provincial level, provincial healthcare funds (Landesgesundheitsfonds or LGF) have been set up in Austria. The latter manage the financing of public hospitals at the provincial level. The BGA, in turn, defines the financial compensation mechanisms and distributes funds from taxpayers' money and flat-rate payments from social health insurance funds to the LGFs in accordance with legally defined quotas. The BGA is subject to supervision by the Austrian Court of Audit.

Insurance companies that provide supplementary health insurance are subject to supervision by the FMA. Its tasks are essentially solvency supervision, and market and conduct supervision as defined in the VersVG and Insurance Supervision Act (Versicherungsaufsichtsgesetz or VAG).

A Federal Arbitration Commission (Bundesschiedskommission) was established for disputes between the Austrian Physician's Chamber, *Dachverband* or social health insurance funds regarding the conclusion or termination of an overall agreement governing the reimbursement of medical services by social health insurance funds. The commission may determine the content of a terminated collective agreement or a collective fee agreement for a maximum of three months from the date of its decision for the parties. In addition, there are arbitration commissions with equal representation (*Paritätische Schiedskommissionen*), as well as federal state arbitration commissions (*Landesschiedskommissionen*) established in the federal states to arbitrate and decide, on the one hand, on disputes that are legally or factually related to an individual contract concluded between a health insurance provider and a physician and, on the other hand, on disputes between the parties to an overall agreement regarding the interpretation or application of an existing collective agreement. Decisions of the aforementioned arbitration commissions may be challenged before the Federal Administrative Court (Bundesverwaltungsgericht or BVwG).

The decision of the *Dachverband* regarding the inclusion of a medicinal product in the Erstattungskodex and thus on reimbursement by social health insurance funds can also be challenged before the BVwG. The BVwG can amend the decision of the *Dachverband* to the effect that a medicinal product is to be included in the Erstattungskodex and thus reimbursed by social health insurance funds.

#### **4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?**

The pandemic has not changed the general system of healthcare financing. Reimbursement for Covid-19 tests and vaccinations was provided by the federal government via the Covid-19 Crisis Management Fund. This fund was set up as a state fund under the Covid-19 Act and was initially limited to a maximum volume of €4bn. Under the third Covid-19 Act of 4 April 2020, this amount was increased to €28bn. Covid-19 tests and vaccinations were provided

free of charge to the Austrian population, that is, not only to those with health insurance.
<p><b>5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?</b></p> <p>Social health insurance services are available to all insured persons. There is no rejection due to the high risk and resulting expected expenses, which means the social health insurance providers may neither reject the insured persons assigned to them by law nor terminate an insurance relationship prematurely. Therefore, every insured person can claim the same social health insurance services.</p> <p>The prerequisites for being insured are set out in the ASVG, GSVG, BSVG and B-KUVG, and are essentially based on a person's employment status, that is, whether the person is an employee or self-employed, works in agriculture or is employed in the public sector. In addition, unemployed persons receiving unemployment compensation and relatives of compulsorily insured persons are also entitled to statutory health insurance coverage. The remaining (small) group of people who do not have statutory health insurance, for example, job seekers without entitlement to unemployment compensation, or those in marginal employment, can obtain self-insurance from social health insurance funds.</p> <p>In the area of supplementary private insurance, there is full contractual freedom, that is, the insurer may refuse to accept a person as an insured and may also include reservations in the individual insurance policy.</p> <p>The establishment and operation of hospitals and outpatient clinics is regulated jointly by the Federal Hospital Act (Krankenanstalten und Kuranstalten or KAKuG) and relevant implementing legislation of the federal states. The federal states are responsible for the licensing of hospitals and outpatient clinics based on the prerequisites set out in the hospital regulations of the federal states. To obtain a license for a hospital or an outpatient clinic that provides services that are to be reimbursed by social health insurance funds, a prior needs assessment on the basis of the Regional Structural Plans for Healthcare is mandatory.</p> <p>In extramural care, any licensed physician registered with the Austrian Physician's Chamber has the right to open a practice. However, only practices included in the location-based staffing plan and with an individual agreement (<i>Einzelvertrag</i>) with the relevant social health insurance fund based on an overall agreement (<i>Gesamtvertrag</i>) are allowed to bill services to social health insurance funds. Besides an individual agreement with social health insurance funds, the establishment of group practices of physicians under the Austrian Physicians Act (<i>Ärztegesetz</i> or <i>ÄrzteG</i>) requires a license issued by the federal states and, if services are to be reimbursed by social health insurance funds, a prior needs assessment.</p> <p>If a person with statutory health insurance is on a business trip abroad, that person's employer will cover the costs of the health insurance services that the person would normally receive from its health insurance provider. This also applies to family members who are also on the business trip abroad. The insurance provider reimburses the employer for the costs. For each calendar day of treatment, the maximum reimbursable costs are 1/30 of the maximum contribution base for therapeutic appliances and 1/20 of the maximum contribution base for medical treatment. The maximum reimbursable costs for therapeutic aids correspond to the costs that would have been reimbursed by the insurance carrier if the services had been provided in Austria. In the case of hospitalization, the insurance carrier</p>

<p>pays a care cost contribution.</p> <p>Health insurance services may also be provided to any uninsured persons. However, these persons have to pay for the services themselves afterwards according to the applicable fee rates and tariffs.</p>
<p><b>HEALTH INSURANCE FINANCING AND COVERAGE</b></p>
<p><b>6. How are health insurance carriers financed? How are premiums determined?</b></p>
<p>The Austrian healthcare system is financed through a mix of income-related health insurance contributions and general taxation. Taxes are collected at the federal level and distributed to the federal states and municipalities through a fiscal sharing mechanism to finance the healthcare services. Premiums for health insurance are based on income and not health risks. They are set by law and can only be changed by the Austrian legislator. The health insurance contribution rate is essentially split almost equally between the employee and employer. However, employers pay both the employee and employer share directly to health insurance funds.</p> <p>The BGF pools those portions of tax revenue at the federal level earmarked by law for healthcare and distributes them to the LGF in fixed amounts for hospital financing. To consider specific characteristics of individual federal states (eg, federal states with a high volume of tourism) or imbalances arising from patient flows between federal states, in addition, the BGA distributes lump-sum grants to some LGFs.</p> <p>Because the financing of the Austrian healthcare system and, in particular, the rates of social health insurance contributions are set by law, there are only very limited possibilities for judicial review. These essentially relate to whether the legal provisions have been enacted in compliance with the Austrian constitution and/or whether they interfere with the fundamental rights of the contributors.</p>
<p><b>7. How is the coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?</b></p>
<p>The legal purpose of social health insurance is to provide protection in the event of illness, an inability to work and maternity, as well as the provision of healthcare and cash benefits. The ASVG contains a range of compulsory services that are to be provided by the social health insurance institution. The overall agreements between the Austrian Physicians' Chamber and social health insurance funds (or <i>Dachverband</i>) and the individual agreements between the contracted physicians and social health insurance funds (or <i>Dachverband</i>) specify the services covered by social health insurance. However, they do not contain a list of services or products that must be covered by social health insurance funds. Likewise, there are no lists of services and products that must not be reimbursed by social health insurance funds. Whether a medical service is to be paid for by social health insurance funds therefore depends on whether the respective service serves a legally defined purpose, that is, in particular, the treatment of an illness. Apart from mandatory health insurance services, social health insurance funds are also authorised by law to provide voluntary supplementary services, for example, certain cosmetic treatments or health-promoting and disease-preventing measures. However, the insured have no legal claim to these services.</p>

<p>In contrast to possible medical treatments and medical products, Erstattungskodex provides an exhaustive list of the medicinal products for which health insurance funds have to bear the costs.</p> <p>Coverage for in-person visits and telemedical appointments is essentially the same, that is, by law, they are not billed differently.</p> <p>If certain conditions are met, mandatory health insurance may reimburse the cost for pharmaceuticals in individual cases, even if they are not (yet) included in the respective List of Specialties, such as novel orphan drugs or pharmaceuticals used off-label.</p>
<b>HOSPITAL SECTOR</b>
<p><b>8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?</b></p> <p>In the inpatient sector, all public hospitals and most private hospitals have agreements with health insurance funds. Therefore, the patient covered by social insurance does not have to pay for treatment or medicinal products used in the hospital; the costs are borne by hospital operators and reimbursed to them under private law agreements.</p> <p>In the outpatient sector, regular negotiations on overall agreements take place between the Austrian Physician's Chamber and provincial chambers of physicians, representing physicians in outpatient care, and <i>Dachverband</i>, representing health insurance funds. Thus, each health insurance fund negotiates its own overall agreement. These agreements set out in detail the range of services covered, number of services that can be charged for some services, corresponding fees and remuneration mechanisms, and number of contracted physicians.</p> <p>Private physicians do not have any contractual relationship with social health insurance funds and are therefore not subject to any general agreements. They are therefore free to charge higher fees than those set in the overall agreements and choose their place of residence. However, the Austrian Physician's Chamber provides non-binding fee recommendations in which fee rates for the respective medical services are listed. Patients in turn can apply for a reimbursement of 80 per cent of the fee of a contracted physician from social health insurance funds. The difference between the fee of a contracted physician and the reimbursed fee can be covered by private health (supplementary) insurance.</p>
<p><b>9. How are the prices of such services determined? How is economic efficiency controlled?</b></p> <p>In essence, the law allows for time-tariffs, per-service tariffs and flat-rate tariffs. Tariffs and prices are set in accordance with the principle of contractual freedom. Tariffs are primarily agreed in contracts between insurers and service providers.</p> <p>Overall agreements (<i>Gesamtverträge</i>) are concluded between social health insurance funds (or <i>Dachverband</i>) and the physicians' chambers for each Austrian province on the one hand, and by individual agreements (<i>einzelverträge</i>) between social health insurance funds (or <i>Dachverband</i>) and individual physicians on the other hand. Agreements regarding services in hospitals are concluded between hospital operators (or the competent professional association for hospitals at the Chamber of Commerce) and the social health insurance fund (or <i>Dachverband</i>).</p>



<b>HEALTHCARE PROVIDERS IN PRIVATE PRACTICE</b>
<b>10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?</b>
Healthcare services provided by private practitioners are financed and reimbursed in the same way as for hospitals in the ambulatory/outpatient setting (cf questions 8 and 9).
<b>11. How are the prices of such services determined? How is economic efficiency controlled?</b>
Again, prices of such services are set on contractual bases in the same way as for hospitals in the stationary/outpatient setting (cf questions 8 and 9).
<b>PHARMACEUTICALS AND MEDICAL DEVICES</b>
<b>12. How are pharmaceuticals and medical devices financed and reimbursed?</b>
<p>Only the reimbursement of medicinal products prescribed by a physician and subsequently dispensed to the patient by a pharmacy is governed by a standardised procedure. Medicinal products reimbursed under this framework are included in the Erstattungskodex issued by the <i>Dachverband</i>. Medicinal products that are not included in the Erstattungskodex may only be reimbursed in justified exceptional cases if treatment is necessary for compelling therapeutic reasons and cannot be carried out with medicinal products listed in the Erstattungskodex (also subject to approval of the Chief and Control Medical Service of the Insurance Carriers). If a medicinal product is not included in the Erstattungskodex and there is no justified exceptional case, the patient has to bear the cost.</p> <p>In cases where the medicinal product is directly administered by the physician in non-hospital care from the physician's own supplies (<i>Ordinationsbedarf</i>) and, thus, supplied by a pharmacy to the physician beforehand, reimbursement is governed under private law by overall agreements (<i>Gesamtverträge</i>) between the social insurance funds (or <i>Dachverband</i>) and the physicians' chambers of the federal states, as well as by individual agreements (<i>Einzelverträge</i>) between the social insurance funds (or <i>Dachverband</i>) and the individual physicians as part of medical treatment.</p> <p>In hospital care, medicinal products are usually procured by hospital pharmacies either directly from a market authorisation holder or from wholesalers and then administered to the patient within the hospital. Hospital operators are obligated to set up a Medicines Commission (<i>Arzneimittelkommission</i>) responsible for the selection and use of medicinal products. If added to the hospital's list of medicinal products, the procurement of products is taken care of by the hospital pharmacy. Generally, a patient covered by social insurance does not have to pay for medicinal products used in public hospitals or private hospitals. The costs are borne by hospital operators and reimbursed to them under private law agreements between hospital operators and social insurance carriers (or <i>Dachverband</i>).</p> <p>The reimbursement of medical devices is not standardised in Austria, as there is no overall agreement for reimbursement. It is important to note the distinction between two types of reimbursement: intramural (within the hospital) and extramural (outside the hospital). In general, health insurance providers conclude agreements with medical device companies and distributors. Therefore, reimbursement in the extramural sector depends on the social</p>

insurance fund and concluded contract. Patients generally contribute a defined copayment towards the cost of a product. In some cases, prior authorisation must be obtained from the social insurance provider. For products that are not regulated by a tariff, a cost estimate from the contractual partner is often also required. In the intramural sector, medical devices, generally, are reimbursed as part of payments to hospitals.

### 13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

For products reimbursed under the Erstattungskodex, the price must not exceed the average price in all European Union Member States where the products are authorised and placed on the market, which is regularly determined by the Price Commission (Preiskommission) at BMSGPK. For the inclusion of a medicinal product in the Erstattungskodex, an application must be submitted to the *Dachverband*. As a next step, following consultation with the Medicines Evaluation Committee (Heilmittel-Evaluierungs-Kommission), the *Dachverband* examines whether there are any reasons that would exclude the medicinal product from reimbursement (eg, not suitable for use outside of hospital care and mandatory package size requirements are not met). The *Dachverband* must inform the applicant of any doubts regarding those requirements and request a written statement. If none of the reasons that would exclude reimbursement apply, the *Dachverband* decides on the inclusion of the medicinal product based on its price, additional therapeutic benefit for the patient and/or therapeutic innovation compared to other medicinal products already included in the Erstattungskodex. If no substantial innovation or additional benefit can be found, the medicinal product will only be added to the green box of the Erstattungskodex (ie, the medicinal product can be prescribed without approval of the Chief and Control Medical Service of the insurance fund) if there is a relevant price difference with comparable medicinal products. The decision by the *Dachverband* can be challenged before the BVwG.

If medicinal products are sold outside the Erstattungskodex regime, the price will generally be determined by a marketing authorisation holder (MAH) or wholesaler selling its products to pharmacies. Pharmacies may add a regulated margin to the wholesale price.

According to the Austrian Medicinal Products Act (Arzneimittelgesetz or AMG) granting, offering and promising of 'discounts in kind' (*Naturalrabatte*) to persons entitled to prescribe or supply medicinal products is prohibited if the medicinal products concerned are included in the Erstattungskodex.

The prices for medical devices are either contractually agreed between the medical device manufacturer and social health insurance fund or freely determined by the medical device manufacturer.

## LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

### 14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

An important decision by BVwG of 17 November 2017 (W147 2157682-1) set out the impact of the amendment of section 351c (10) ASVG (Federal Law Gazette No 49/2017, in force since 1 May 2017). The court stated that the new provision means that as soon as a third price reduction has been achieved by a generic product, the previous option ('optional



provision' of section 351c (10) ASVG) to negotiate a new price agreement with the company of the original product had then been replaced by a statutory order (statutory price regulation). Accordingly, the *Dachverband* is obliged to agree a price reduction for the original product to the price of the third generic product, otherwise the latter must be removed from the Erstattungskodex. As a result of this legally stipulated price regulation, the *Dachverband* no longer has any discretionary power – after weighing up the interests of the insured persons and the economic interests – to agree a higher price for the original product than that of the third generic. If the price is reduced to the level of the generic product, triggering the third price reduction, the price of the triggering generic product therefore no longer represents a rebuttable presumption of the economically appropriate price. Rather, by law, this is the economic price to be agreed without exception, otherwise the original product is to be removed from the Erstattungskodex.

Another decision issued by the BVwG, dating from 6 June 2017 (W147 2141725-1), related to reimbursement law, was in favour of MAHs: The BVwG held that the complainant in its complaint rightly criticised the *Dachverband* (then Hauptverband) for fundamentally excluding the provision of section 351c paragraph 10 of the ASVG in the event of the original product being removed from the Erstattungskodex. Rather, in accordance with previous case law, a further health economic evaluation for the price structure would also have to be carried out, taking into account the original product that had since been removed from the Erstattungskodex.

## RECENT DEVELOPMENTS AND TRENDS

**15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes or trends for healthcare financing and reimbursement, and briefly indicate how these may foreseeably affect the medical sector in the near future.**

In Austria, there is an interesting ongoing discussion regarding price adjustment for medicinal products. On 5 December 2024, the Federal Administrative Court (BVwG) asked the Constitutional Court (Verfassungsgerichtshof or VfGH) to invalidate a specific part of the General Social Insurance Act (ASVG). This part of the law, section 351c (11), sentence 5, states that if medicines with the same active ingredient are listed in the Reimbursement Code, their prices must be adjusted within a certain range. If the prices are not adjusted, the medicines will be removed from the Reimbursement Code. Appeals against these removal decisions only delay the removal for 90 days.

The BVwG argues that this 90-day delay is too short and violates the constitutional rights of MAHs because it often takes longer for the court to make a decision. During this time, the medicines generate no revenue, which is unfair to MAHs. Additionally, patients would have to change their medication twice due to reimbursement issues. The Constitutional Court has yet to make a decision on this matter.

In terms of recent trends to be followed in the next few years, so-called 'primary care centres' (*Primärversorgungszentren*) should be mentioned. These centres have been conceived as a means to avoid overstraining hospitals and their staff due to an excessive number of (outpatient) care cases to handle, in particular, in the evenings and during weekends. *Primärversorgungszentren* are physician offices usually staffed with several doctors and other

HCPs where patients can go when they would otherwise need to obtain outpatient hospital care due to the rather restrictive opening hours of doctors' offices in general. *Primärversorgungszentren* are to be set up all over Austria, so they should help to relieve the burden on hospitals in the future, not only from the staff perspective, but also, relevant to the context at issue, from the point of view of their financial balance.