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Communication from the Commission: "Consultation regarding Community action on health services" of 26 September 2006

Joint opinion of the German Social Security Umbrella Organizations

presented on 20 December 2006

Preliminary remark

In February 2006, the European Parliament established that healthcare is excluded from the scope of the European services directive[1]. In doing so, it rightly took account of the fact that health services are special services which may not be subject to the rules of the free market without protection. What is more, the health sector is subject to the principle of subsidiarity in accordance with Article 152 (5) EC, and hence falls within the sovereignty of the Member States. The Communication on Consultation regarding Community action on health services[2] thereupon announced by the Commission and presented on 26 September 2006 once more gives rise to the question of the degree to which there is a need of supporting measures at Community level for the area of cross-border healthcare. The central German social insurance associations do not consider that there is a need to create further sources of law in addition to national law and Council Regulation (EC) No 1408/71[3] and (probably from 1 January 2009) Council Regulation (EC) No 883/04[4]. Open issues on patient mobility can be regulated on within these possibilities. This does not negate the rights of EU citizens to which they are entitled within the meaning of the case-law of the European Court of Justice (ECJ). Rather, the central German social insurance associations explicitly support the Commission's call for the adoption of these rights in those Member States which have not yet transposed them.

The European Commission's Communication focuses primarily on the lack of or perceived lack of legal certainty in the area of patient mobility as an argument for the need for Community action. The Commission already had a large number of studies carried out on patient mobility in preparation for this Communication. The results however do not stand up to a balanced overall view. The Commission hence gives the impression that most cases of patient mobility – the scope of which it estimates at around 1% of overall public expenditure on healthcare in the EU – take place without the necessary legal certainty, in particular as to subsequent cost refunds. This interpretation is incorrect. The lion's share of patient treatment in other EU countries has successfully been carried out for decades on the basis of Council Regulation (EC) No 1408/71 and of implementing Regulation (EC)

1 Position of the European Parliament adopted at first reading on 16 February 2006 with a view to the adoption of Directive 2006/.../EC of the European Parliament and Council on services in the internal market (EP-PE_TC1-COD(2004)0001)

2 Communication from the Commission Consultation regarding Community action on health services of 26 September 2006

3 Council Regulation (EC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community

4 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems

No. 574/72[5]. The EC regulations generally form the basis, even if separate agreements have been concluded for cross-border healthcare in areas close to borders in the context of Euregio projects or bilateral treaties.

The case-law of the ECJ on patient mobility[6] has already been transposed into German law as on 1 January 2004 in the shape of Health Modernisation Act (Gesundheits-modernisierungsgesetz)[7]. Accordingly, members of statutory health insurance funds can also avail themselves of non-institutional services on a cost-refund basis in other EEA countries, this also applying to hospital treatment, albeit contingent on prior approval. At the same time, the legislature has created the possibility for the statutory health insurance funds to conclude contracts with service-providers in other EEA countries directly.[8]

The undersigned associations therefore support the call for the adoption of these rights in those Member States which have not yet done so. The procedure selected by the Commission of a broad, open-ended consultation is expedient in order to lend concrete shape to the arising questions and problems in the Member States, as well as to systematise them and finally – if necessary – to suitably find a solution for them in a proportionate manner, i.e. where possible in the context of the existing set of regulations (e.g. Council Regulation (EC) No 1408/71).

[5] Council Regulation (EEC) No 574/72 of 21 March 1972 laying down the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons, to self employed persons, to self-employed persons and to their families moving within the Community

[6] in particular the judgments of the ECJ in Cases C-158/96 & C-120/95 (*Kohl/Decker*) of 26 April 1998; C-157/99 ("Smits/Peerbooms") of 12 July 2001; C-385/99 ("Müller-Fauré/van Riet") of 13.05.2003; C-372/04 *("Watts") of 16 May 2006*

[7] cf. section 13 subsections 4 – 6 of Book Five of the Social Code (Sozialgesetzbuch Fünftes Buch – SGB V)

[8] cf. section 140e of Book Five of the Social Code

Methods used when answering the questions

The questionnaire distinguishes between three categories of cross-border healthcare. This distinction is largely accommodated in answering the questionnaire. Further, the item "patient mobility" is broken down into three sub-categories in order to better accommodate the various motivations and resulting solutions. The questions have hence been answered in the following order:

1. Patient mobility

    1.a within Council Regulation (EC) No 1408/71
    1.b With healthcare in border areas
    1.c Other types of care – in particular in application of ECJ case-law

2. provider mobility

3. mobility of goods and services (telemedicine service, labour, etc.)

Question 1: What is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

1. Patient mobility

1.a Within Council Regulation (EC) No 1408/71

Council Regulation (EC) No 1408/71 on the coordination of social security schemes has successfully regulated cross-border healthcare on the entire territory of the European Economic Area (EEA) and Switzerland for more than 30 years. In case of a temporary stay in another EEA State or in Switzerland, insured parties are placed on the same footing as if they were insured there. A risk to the financial balance of the host state is avoided here by refunding the respective costs at the prices of the latter. What is more, no risk to the financial stability of the sending States has been observed since the patient volume, at ±1% of overall expenditure, has not reached significant dimensions.

Patient mobility particularly impacts the services offered and the demand for medical care in tourist conurbations, where much higher demand for medical services may occur on a seasonal basis which cannot be covered by the normal service which is sufficient for the residential population. Reductions in quality and accessibility may be the result. These problems can however not be remedied by European regulations since the problems must be solved in line with the individual circumstances, and these differ from one location to another.

1.b With healthcare in border areas

With healthcare in border areas it has been possible to bring about an improvement in accessibility to care for insured parties through cooperation between the regions in question in the so-called Euregios. Cooperation in the Euregios has no negative impact on the financial stability of the healthcare systems involved since cooperation entails individual agreements between those concerned, and any higher care costs incurred in the neighbouring country may be compensated for by savings made by combining resources.

The major advantage of this form of cooperation is the local care approach which can be tailored to different regional needs, thus benefiting patients in terms of both access and quality. Such approaches, which the Commission is happily promoting by awarding Interreg III funds, should continue to be supported in the view of the central German social insurance associations. It is however not advisable to standardise such a regional care approach across Europe since this would go beyond what is needed and also restrict the

necessary flexibility of those involved. Support in exchanging information on the establishment cross-border cooperation could however be promoted by the European Commission since this would constitute a European added value.

1.c Other types of care – in particular in application of ECJ case-law

The judgments of the ECJ on patient mobility have enabled citizens to avail themselves of medical services abroad[9]. Whilst in the field of institutional treatment in most respects only the question of the costs arrangement has been reformed, the patients now on principle have the right to avail themselves of any medical service in the non-institutional area without previously obtaining approval. So far, however, they have made little use of this. If one presumes 1% of patient mobility among overall public expenditure on healthcare as estimated by the Commission, the lion's share of this is accounted for by payment flows within Council Regulation (EC) No 1408/71, and only a small part by expenditure on the basis of the ECJ's case-law.

The ECJ judgments increased the accessibility of medical services in formal terms for all EU citizens. The cost refund procedure could however exclude the socially more vulnerable from healthcare systems since they are unable in most cases to advance the incurred costs; in particular this causes problems if healthcare systems do not provide for measures to alleviate the burden this entails. This could lead to a situation in which the socially vulnerable are excluded from medical care.

In practical terms, the central German social insurance associations hence regard patient mobility based on the cost refund procedure described by the ECJ only as an addition to the existing procedure under Council Regulation (EC) No 1408/71 – but not as an equivalent alternative. The procedure by which the benefit invoicing method is selected by the respective Member State in conjunction with Council Regulation (EC) No 1408/71 is to be preferred in principle. This all the more so given that in some Member States health services are not provided or funded only by the health insurance funds, but also by the statutory pensions insurance and statutory accident insurance organisations. The undersigned associations hence consider the primary goal with patient mobility to lie in implementing Council Regulation (EC) No 1408/71, as well as in analysing and remedying the difficulties occurring here in practice.

2. Provider mobility

Directive 2005/36/EC on the recognition of professional qualifications, which came into force on 30 September 2005, makes it easier – as did its predecessors – for service-providers to have their qualification formally recognised in the respective Member State,

[9] in particular judgments of the ECJ in the Cases C-158/96 & C-120/95 (*"Kohll & Decker") of 26 April 1998;* C-157/99 *("Geraets-Smits/Peerbooms")* of 12 July 2001; C-385/99 *("Müller-Fauré/van Riet")* of 13 May 2003

but also ensures that the level of quality customary in the country of destination is not disregarded. The temporary and long-term provision of services takes place in principle according to the regulations of the respective State in which the service is provided.

A negative impact of temporary or long-term provider mobility on the quality and financial sustainability of the respective Member States is not to be expected as long as the Member States are permitted in accordance with the country-of-destination principle to define quality without discrimination and to apply volume management tools in order to restrict the burden on the health systems which are based on the principle of solidarity resulting from supply-induced demand.

3. Mobility of goods and services (telemedicine service, labour, etc.)

The mobility of goods and services, without the patient or provider having to be mobile themselves, is one of the growth markets in the field of cross-border healthcare. This area concentrates on telemedicine services, laboratory services, as well as the supply of therapeutical agents and aids, as well as drugs. For instance, 1 % of drug sales[10] in Germany are already carried out from abroad via the Internet. In this case it is the national legislation – which permits greater mobility than is required by the ECJ's case-law – which ensures the quality and financial stability of supply.

This is however not as simple in all areas as in the field of drugs. Whilst the mobility of goods and services in particular ensures access to these services, which previously were not offered either because of a lack of specialists or because there was too little demand, this however gives rise to new questions which are as yet unresolved, such as with regard to data security and the quality standards which are to be applied. The proportionality of quality requirements which are applied in order to assure public health by imposing market access restrictions is to be examined in individual cases. High-quality, reliable services must however take top priority because of the vital significance of health, which is why national sovereignty to enact quality assurance measures in the healthcare sector is a central point in the present European legal framework.

[10] own survey

Question 2: What specific legal clarification and what practical information is required by whom (eg; authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

1. Patient mobility:

1.a Within Council Regulation (EC) No 1408/71

Patient mobility largely takes place today on the basis of the European Health Insurance Card (EHIC) and of form E 112 for planned medical treatment abroad. Here, the patient may only consult physicians who are approved in the social insurance system of the host country. Patients however generally do not know which physicians these are. It would be possible to publish this information in lists on the Internet, but such a system would be costly to maintain and create considerable additional administrative costs, for instance for translation into all languages. Furthermore, this would marginalise persons with no Internet access. It would be simpler to affix a symbol, for instance the EHIC, in entrance area of the service-provider (similar to credit cards in shops and restaurants) showing patients that their EHIC will be accepted here in line with the regulation. This would also further commit physicians to accept the EHIC and not to invoice privately as is evidently frequently the case in many countries. A corresponding basis could be created in implementing regulation (EC) No. 574/72.

The Member States themselves must take and execute the necessary steps to ensure that the EHIC, form E 112, etc., are accepted by service-providers and that the regulation is applied in a legally-valid manner. The Commission may also examine transposition and where appropriate initiate infringement proceedings in accordance with Article 226 EC.

1.b With healthcare in border areas

Consumers and service-providers in areas close to borders are generally aware of the additional services which are on offer there. Any regional or local requirement which is in need of improvement can only be examined in individual cases, and does not require any measures at European level.

1.c Other types of care – in particular in application of ECJ case-law

The Commission had already attempted in its proposal for a directive on services on the internal market to codify the case-law of the ECJ on patient mobility in Article 23 of the European service directive. The central German social insurance associations do not consider this to be necessary.

The ECJ has provided detailed clarified on the question of cost refunds in its case-law. It has made a statement on when treatment requires prior approval (for instance on principle with hospital services), when a service must be approved (when it cannot be offered at home within a period taking into account the overall medical condition of the patient), how high the refund amount of the service is and to what services a right exists. The ECJ further stated that national access requirements, such as the obligatory consultation of a GP prior to consulting a specialist physician or the obligatory submission of a treatment plan for dental protheses, may also be maintained with cost refund procedures. The ECJ has repeatedly emphasised the original competence of the Member States in shaping and organising their healthcare systems in accordance with Article 152 EC.

The central German social insurance associations however take seriously the statement of the European Commission that these claims emerging from the EC Treaty have not yet been transposed into national law in some Member States, and that the EU citizen is frequently not sufficiently informed of his or her rights. The Commission could hence use a communication to summarise the case-law of the ECJ in a systematic manner, and hence support any national legislation.

The design of the application and opposition proceedings for asserting these rights however does not require a European regulation since this is already regulated in the respective social law systems for comparable legal situations. The introduction of additional procedures would be more likely to lead to greater legal uncertainty.

2. Provider mobility

There is currently no requirement for further legal clarification in the field of provider mobility. It should merely be stated that in particular with services provided directly to the patient the legal and quality standards of the country apply in which the patient receives the service. This does not prevent service-providers from agreeing higher quality levels among themselves, as well as in direct relations with the patient.

3. Mobility of goods and services (telemedicine service, labour, etc.)

In particular in the field of telemedicine service, there is a need for legal clarification as to the degree to which patient data may be sent over the Internet and what preconditions are to prevail as to data protection, as well as the compatibility of the data. It is also unresolved whether the patient must explicitly approve if for instance a physician is consulted to draft an expert report or evaluate X-ray pictures who is subject to another legal order. What is also unclarified is the liability and recourse claims of a patient in such a situation.

The question also arises of what rights the patient has towards the service-provider if the latter addresses a third party established in another EU country for a partial service. In the

majority of EU Member States, the patient will exclusively have a claim against the provider, who in turn can claim against the provider of the partial service in the other State. This procedure should however be examined since it may be that a deviation from this principle could give rise to a requirement to report to the patient.

An explanatory note from the Commission could create clarity here. On principle – as in all cases of cross-border service provision - the regulations of International Private Law apply (IPR; Rome I+II). The organisations of German social insurance do not consider a need to exist for legislation derogating from this.

Question 3: Which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

1. Patient mobility

On principle, specialist medical supervision, as well as safeguarding blanket, quality-assured medical care, must be provided in accordance with national regulations by the competent authorities and facilities of the country in which the service is provided. In particular, it is unrealistic and impracticable to expect the prosecution of any conduct on the part of service-providers of one Member State which may be at fault by authorities or facilities of another Member State. The corresponding facilities of each Member State are also competent for ensuring that patients from other EU countries are treated without discrimination.

As the ECJ confirms (cf. Q 2 No. 1c), national service conditions (such as treatment by a consultant only when transferred by a GP) are to be adhered to and complied with by insured parties if they wish to avail themselves of health services in other EEA countries by means of cost refunds on the basis of the principle of the free movement of goods and services. This principle must particularly apply where the national social security systems have legal prerequisites and practical possibilities to manage the medical care of insured parties in order to ensure a high quality of care in the interest of the patients (for instance by concluding contracts with foreign service-providers).

This concerns in addition to statutory health insurance organisations also the insurers of statutory accident and pensions insurance since these provide their health services amongst other things in order to avoid pensions for reduction of earning capacity or for incapacity for earning.

In this case, the provider who bears the financial risk of the failure of a medical measure must also be enabled to influence the success of its services by setting high qualitative standards and by effective management of the course of the care. In order to guarantee high care quality in the interest of the patients, the principle must apply here that responsibility for funding and for management must go hand-in-hand.

The management of medical procedures is also particularly significant and worth maintaining from a point of view of social compensation for interests. In particular in self-administrated social security systems, the principle has proven its worth that the relevant decisions on ensuring and refining the quality of care are taken by the self-administration partners themselves. The management and optimisation of medical services by the employers who fund the system on the one hand and the insured parties as potential service recipients on the other has led in the past to a just compensation between the qualitative and economic requirements as to healthcare and the provision of high-quality services when they are needed.

2. Provider mobility

The principle that the applicable law, as well as checks and supervision of suppliers, is to be determined by the country of destination also applies to temporary service provision and to establishment. The country-of-origin principle is to be rejected for mobile providers in the health system. It would create additional legal uncertainty for the patient, who is in a vulnerable position at the time of availing himself or herself of the service. Furthermore, this would undermine the quality and volume management tools of the social insurance systems and place their financial stability at risk.

3. Mobility of goods and services (telemedicine service, labour, etc.)

cf. on this answer to Q 2 No. 3.

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

On principle, the respectively competent authorities and facilities of the country in which the service is provided are competent for safety and for supervising service-providers. The recourse available to the patient is defined by the respective national administrative and social law, as well as by International Private Law. (cf. on this also answer re Q 3)

Question 5: What action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries)?

Any problems of this nature which may occur are caused by a wide variety of causes, and must hence be solved by different means and at regional level.

1. Patient mobility

1.a Within Council Regulation (EC) No 1408/71

The special seasonal burden on holiday regions may well constitute a logistical challenge for the regions in question. As a rule, it is however restricted to the necessary initial care of the patients and – depending on the holiday location – to certain selected specialist areas such as surgery in ski areas or internal medicine and surgery in regions of the Mediterranean.

The cost of treatment is covered via Council Regulation (EC) No 1408/71. The distribution of the payments from the compensation system to the region under Council Regulation (EC) No 1408/71 must be assured by the respective Member State itself. The additional costs for the provision of staff and infrastructure must be borne by the respective Member State or the region itself. This is appropriate since the region in question has corresponding additional income from tourism. If the regional authorities consider this to be is insufficient, they are free to levy and appropriately spend a visitors' tax. There is no need for European action.

The situation is similar when it comes to pensioners who only spend part of the year in another EU country – in most cases in Southern regions. Here too, it is incumbent on the Member States to ensure that these people register in the respective system in accordance with Council Regulation (EC) No 1408/71 and that the appropriate funds are distributed to the regions in question.

1.b With healthcare in border areas

The problem of insufficient access of the domestic population does not apply to healthcare in border areas insofar as it is based on cooperation agreements. Cooperation arrangements are agreed in particular in order to use available resources jointly and reduce unnecessary excess capacities on both sides of the border.

1.c Other types of care – in particular in application of ECJ case-law

Somewhat different than in No. 1a and No. 1b is the situation with medical care provided on a cost-refund basis (cf. here the example of dental care mentioned in the Communication. This must as a rule be carried out on a cost refund basis or be paid for by the patient directly since many social systems or national health systems make little or no provision for dental protheses.) Here, in particular the possibilities for a cost refund, as well as the possibility of higher income for treating foreigners, may constitute incentives for the service-providers to give foreigners preferential treatment.

Since the system of Council Regulation (EC) No 1408/71 is not applicable in such cases, it is incumbent on the respective Member State to ensure that foreigners and own nationals pay the same prices, and hence to reduce the incentive for preferential treatment of foreigners. On principle, foreigners may not be discriminated against by charging higher prices.

Question 6: Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

1. Patient mobility

The Member States have the right to exclude services from the list of social insurance services, or to completely prohibit their provision on their sovereign territory in accordance with their national values and standards. The providers cannot be obliged to approve such services on a cost-refund basis within the meaning of the ECJ case-law.

2. Provider mobility

There is no need at present for further regulations as to freedom of movement of service-providers.

Question 7: Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

cf. Q 6.

Question 8: in what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

1. European Networks of Centres of Reference (ENCR)

Particularly also in an enlarged European Union where there are increasing differences among the Member States as to size, economic resources and resulting funding potential, guaranteeing highly-specialised medical care in the EU is a major task. A European initiative could help to realise this interest, whilst not overstepping the EU's competences. Freedom of movement in accordance with Art. 42 EC and the freedom to receive services in another member state in accordance with Art. 49-55 EC, as well as Council Regulation (EC) No 1408/71, offer legal a foundation for the cross-border use of health services.

The initiative to establish European Networks of Centres of Reference however still requires unresolved issues to be clarified, in particular:

- definition of the tasks and goals,
- establishing quality criteria,
- clarifying competences,
- the contribution to standard care,
- patient access to the centre,
- funding of the network,
- funding of patients' treatment costs,
- dealing with services not contained in all Member States' benefit lists,
- safeguarding the independence of political considerations in selecting the centres,
- ensuring that no overcapacities are created through the establishment of Centres of Reference,
- ensuring the autonomy of the Member States in capacity planning and volume management.

It should be examined whether national competence networks existing in the area of statutory accident insurance (e.g. on serious accidents and accident-related illnesses) could be integrated into the concept.

In principle, each Member State must initially ensure standard care of its population. Over and above this, the concept of bilateral cooperation is to be preferred in the view of the central German social insurance associations as against the idea of European Networks

since this can be precisely tailored to the needs and circumstances of the contracting parties. This applies in particular to the patients' cultural and linguistic environment, which is closely connected to patient mobility, as well as to geographic proximity and accessibility.

2. Realisation of innovation potential (Health Technology Assessment - HTA)

The Commission's project to improve cooperation in HTA between the Member States and to facilitate access to national facilities' HTA reports is basically welcome. The framework conditions of the healthcare systems in the EU do however differ widely. For this reason, HTA reports are always to be understood against the background of the respective system. This also means that HTA results are generally only transferable in the field of medical effectiveness. HTA results are not transferable as a rule in the area of cost effectiveness, as well as with regard to the social and ethical aspects, because of the different nature of the systems. The Commission should take this into account in further promotion of the exchange of information in the HTA area.

3. Joint knowledge base for drafting policies

The expansion of data collection at European level should be temporarily postponed in the healthcare sector in favour of making the data more available and in particular more valid. Cooperation such as the proposed observatory will only lead to an added value where different healthcare systems are at a virtually identical level and are based on a similar healthcare structure, and hence the framework for the survey is comparable. The grassroots healthcare situations in the Union however do not satisfy these prerequisites. The range of variants within the spectrum will expand further with the accession of the new Member States "10+2". The primary goal of "EU health policy" could be instead to support the Member States in improving care at grassroots level. The creation of more "data mountains" which cannot be compared or used would, by contrast, be expensive and counterproductive.

4. Health System Impact Assessment - HSIA

The idea of the HSIA in the context of the Commission's integrated impact assessment guidelines is to be supported. In practice, it still remains to be proven however how information obtained via impact assessment can and should be integrated into the political process.

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

As stated above, the central German social insurance associations do not consider there to be any need at the moment for legislative measures on the part of the Commission. Should the Commission nonetheless consider it to be necessary to codify the case-law of the ECJ in a second attempt, the tools of a communication or guidelines would be preferable for this to those of a directive or regulation. This enables the Member States to appropriately harmonise their healthcare systems – where implementation is necessary at all – without the Commission encroaching on the Member States' freedoms as guaranteed in accordance with Article 152 (5) EC. Over and above this, the central German social insurance associations also consider it to be unnecessary to expand the open method of coordination to include the topics mentioned in this questionnaire.

Summary

- **The organisations of social security in Europe do not consider there to be a need to create further sources of law in addition to national law and Council Regulation (EC) No 1408/71 (or its successor, Regulation (EC) No. 883/04). Patient mobility should be regulated within these mechanisms.**

- **The transposition of the ECJ's case-law into national law is the sole responsibility of the Member States.**

- **Service-providers should show via a "label" that they accept the EHIC and hence provide services in accordance with Council Regulation (EC) No 1408/71.**

- **Provider mobility is regulated by Directive 2005/36/EC on the recognition of professional qualifications and its predecessors. There is no need for any regulation over and above this.**

This position paper has the support of the following German Social Security Umbrella Organizations:

- **AOK-Bundesverband** [National Federation of Local Health Insurance Funds]
- **Bundesverband der Betriebskrankenkassen** [National Federation of Company Health Insurance Funds]
- **Bundesverband der Innungskrankenkassen** [National Federation of Guild Health Insurance Funds]
- **Bundesverband der landwirtschaftlichen Krankenkassen** [National Federation of Agricultural Health Insurance Funds]
- **Verband der Angestellten-Krankenkassen** [Federation of Salaried Employees' Health Insurance Funds]
- **Arbeiter-Ersatzkassen-Verband** [Workers' Private Health Insurance Companies Federation]
- **Knappschaft** [Miners]
- **See-Krankenkasse** [Seamen's Health Insurance Fund]
- **Hauptverband der gewerblichen Berufsgenossenschaften** [Main Federation of Employers' Industrial Liability Insurance Associations]
- **Bundesverband der landwirtschaftlichen Berufsgenossenschaften** [National Federation of Employers' Agricultural Liability Insurance Associations]
- **Bundesverband der Unfallkassen** [National Federation of Accident Insurance Funds]
- **Gesamtverband der landwirtschaftlichen Alterskassen** [National Federation of Agricultural Old-Age Insurance Funds]
- **Deutsche Rentenversicherung Bund** [German Pension Schemes Association]