Private health insurance in the European Union

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List of abbreviations

ABC1 upper middle class, middle class and lower middle class (demographic classifications in the UK and Ireland)
ABI Association of British Insurers
AIM Association Internationale de la Mutualité
CAM complementary and alternative medicine
C2DE skilled working class, working class, those at lowest level of subsistence (demographic classifications in the UK and Ireland)
CEA Comité Européen des Assurances
CEE central and eastern Europe
CFI Court of First Instance
CMU *Couverture Maladie Universelle*
CMU-C *Couverture Maladie Universelle Complémentaire*
COBRA Consolidated Omnibus Budget Reconciliation Act (US)
C(S) complementary PHI cover of excluded services
C(UC) complementary PHI cover of user charges
DKK Danish *kroner*
DRG diagnosis-related group
EC European Community
ECJ European Court of Justice
EHIF Estonian Health Insurance Fund
ERISA Employment Retiree Income Security Act (US)
EU European Union
FFS fee for service
FFSA Fédération Française des Sociétés d'Assurances
FMA Financial Market Authority (Austria)
FSA Financial Services Authority (UK)
GDP gross domestic product
GKV *Gesetzliche Krankenversicherung*
GP general practitioner
HF Hungarian *forint*
HHS Health and Human Services (US)
HIA Health Insurance Authority (Ireland)
HIPAA Health Insurance Portability and Accountability Act (US)
HMO Health maintenance organisation
IPT insurance premium tax
IVF in-vitro fertilisation
MCO managed care organisation
MISSOC Mutual Information System on Social Protection in the Member States of the European Union
MSA medical savings account
NHS National Health Service (UK) or National Health System (Greece, Italy, Portugal, Spain)
NICE National Institute for Health and Clinical Excellence (UK)
NIMES non-insured medical expenses scheme (UK)

OECD	Organisation for Economic Co-operation and Development
OFT	The Office of Fair Trading (UK)
OOP	out of pocket
PD	*per diem*
PHI	private health insurance
PKV	Verband der privaten Krankenversicherung/German Association of Private Health Insurers
PMI	private medical insurance
POS	point of service
PPN	preferred provider network
PPO	preferred provider organisation
SCHIP	State Children's Health Insurance Program (US)
SGEI	services of general economic interest
SIC	social insurance contributions
TEH	total expenditure on health
UC	user charges
VHI	voluntary health insurance
WHO	World Health Organization

Country abbreviations

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HU	Hungary
IE	Ireland
IS	Iceland
IT	Italy
LI	Liechtenstein
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	Netherlands
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
UK	United Kingdom
US	United States

Executive summary

This report provides an overview and analysis of markets for private health insurance (PHI) in the European Union (EU). Part 1 reviews market role, size, structure and conduct and public policy towards PHI. Part 2 focuses on the impact of EU law on public policy towards PHI. Part 3 examines the policy implications of PHI. It looks at the impact of PHI on health policy objectives within the market and on the wider health system. It also discusses barriers to market development and public debate about the current and future role of PHI.

Every country in the European Union allows PHI to operate alongside publicly-financed (statutory) health insurance, but there is enormous diversity in the role PHI plays within the health system and in the size and functioning of different markets for PHI. It is difficult to think of PHI in isolation from statutory health coverage, particularly in the European Union, where PHI is never the only or even the main source of coverage. The dominance of statutory coverage means that markets for PHI are heavily shaped by the rules and arrangements of the publicly-financed part of the health system. It also means that PHI generally plays a modest role, although there are notable exceptions.

Market role
Many member states have a market for private health insurance that supplements public coverage (for example, Poland, Romania, Spain, the UK). A **supplementary** market usually offers access to health services that are already covered by the statutory health system, but gives subscribers greater choice of provider (often private providers) and enables them to bypass waiting lists for publicly-financed treatment. There are contexts in which PHI plays a more significant role. For example, **complementary** PHI can cover **services** that are excluded from the statutory benefits package (Denmark, Hungary, the Netherlands), or it may reimburse the costs of statutory **user charges** and extra billing by doctors (Belgium, France, Latvia, Slovenia). Complementary markets for PHI aim to improve access to health care that is either not covered or not fully covered by the statutory health system. In other member states PHI provides **substitutive** cover for people not eligible for some of all forms of statutory health coverage (the Czech Republic, Estonia) or for those who are not required to be statutorily covered and can opt into or out of the statutory scheme (Germany). Understanding these differences is important because market role is closely linked to market size, largely determines the way in which a market is regulated and may indicate the likely effect of the market on public policy goals.

PHI markets in the newer member states mainly play a supplementary role. The key exceptions are the large market for complementary cover of statutory user charges in Slovenia and the very small substitutive markets in the Czech Republic and Estonia. The most significant changes in market role have occurred in the older members states. Expansion of statutory health insurance in Belgium and the Netherlands has effectively abolished two markets for substitutive PHI, while the Irish market has developed over time from substitutive PHI to a mixture of supplementary and complementary PHI. An emerging market for supplementary PHI in Denmark has experienced rapid growth in the last five years.

Market size
PHI does not make a significant contribution to total health spending in the European Union. In 2006 it accounted for under 10% of total health expenditure in every member state except France (12.8%) and Slovenia (13.1%) and for under 5% in two-thirds of member states. The third largest market, in terms of PHI spending, is in Germany (9.3%). Between 1996 and 2006, spending via PHI experienced some growth in two-thirds of member states, but in general market size has remained relatively stable over time. The largest declines in PHI as a proportion of total spending on health care occurred in the Netherlands and the UK. PHI is also relatively low as a proportion of private spending on health care, accounting for less than 25% in 2006 in most member states.

There is large variation in the proportion of the population covered by PHI in different member states. The markets with the highest levels of coverage are those covering statutory user charges in France (92%), Luxembourg (91%), Slovenia (74%) and Belgium (73%). The Netherlands is unique in having a very high level of coverage for its mixed complementary (services) and supplementary market (92%). Ireland also has a relatively high level of coverage (51%), the exception among supplementary markets, which usually only cover up to around 10% of the population. Levels of population coverage have increased significantly in Denmark (largely due to the introduction of tax incentives for group cover in 2002), France (as a result of the introduction of CMU-C in 2000) and Ireland (due to a combination of economic growth, generous tax relief and lack of confidence in the public system). In other countries it has remained stable.

When market size is measured in terms of premium income, Germany has by far the largest market for PHI, accounting for almost half of total premium income in the European Union, followed by France, Spain and the UK.

Buyers
The extent and quality of statutory health coverage are major determinants of demand for PHI. Income is another important determinant. In many countries the typical subscriber is aged 40-50 years old, relatively well off, better educated, employed as a white collar worker (often at management level or higher), working for larger companies or self employed, living in urban areas and male. Group cover purchased (but not always paid for) by employers has maintained (and in some cases gained) a significant share of the market in many member states.

Sellers
Entities providing PHI include mutual and provident associations, commercial companies, statutory health insurance funds and employers. Mutual and provident associations have dominated the PHI market in many western and northern European countries, but their share of the PHI market has declined since the 1990s due to the entry of commercial insurers. In some countries, commercial insurers are the only source of PHI. The number of private insurers operating in each member state varies from five or fewer to around fifty to a hundred; France is the outlier with almost 1,000. The PHI market is highly concentrated in many countries: in 2006 the three largest private insurers had a market share of over 50% in most member states.

Policy conditions and premiums

Access to PHI is usually restricted to people aged under 65 and offered as a short-term (annual) contract. Private insurers offering voluntary cover are generally free to reject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums on the basis of individual health risk, set limits to benefits and impose waiting periods and cost sharing. In recent years tighter regulation has been applied to substitutive PHI in Germany and complementary PHI covering statutory user charges in Belgium, France and Slovenia. The Irish market is also tightly regulated. As a result, these markets are broadly characterised by open enrolment, lifetime cover and regulated premiums. The aim of increased regulation has been to improve access to PHI, particularly for older people, less well off people and people with chronic conditions, all of whom would otherwise find it difficult and/or expensive to obtain PHI cover. Group cover also often benefits from community-rated premiums and less stringent policy conditions.

Consumer choice

Consumers usually have some choice of private insurer, of products or plans, of level of benefits and of provider. However, it may be difficult for older or people with pre-existing conditions to move from one insurer to another, as most new policies will be priced according to current age and health status. Similarly, the lack of standardised benefits and extensive product differentiation may undermine price competition unless centralised sources of information help consumers to compare products in terms of value for money. Consumer and competition authorities have found evidence of consumer detriment due to product differentiation in several countries.

Choice is frequently circumscribed by eligibility criteria (for example, people aged 60 and over are not usually allowed to buy PHI), health status (many private insurers can reject applications if the applicant is considered to be too high risk) or ability to pay (PHI is only available to those who can afford the premium). In addition, the extent of choice available to those who are publicly covered has increased in many countries in recent years. Thus, while it is broadly true that PHI enhances consumer choice, the gap between the level of choice available to publicly and privately insured patients has narrowed over time.

Relations with providers

Some private insurers are integrated with providers. While this is the exception rather than the norm, there has been a move towards greater integration in some countries, as well as increased effort to engage in selective contracting. However, insurers have generally been cautious in attempting to strengthen purchasing as vertical integration and/or selective contracting may be unpopular with subscribers if they restrict consumer choice of provider. Most private insurers pay providers retrospectively on a fee-for-service basis and the fees they pay are usually higher than the fees paid for publicly-financed health care. Private insurers in some countries make use of private beds in public hospitals. In almost every country doctors are allowed to practise in the public and the private sector.

Insurer costs and profit

PHI is a profitable business in many countries. Although private insurers often incur administrative costs that are much higher as a proportion of total revenue than those found in the statutory health system, they are still able to maintain healthy profit margins; claims expenditure as a proportion of premium income is well under 75% in about half of all member states.

Regulation
In many countries PHI is regulated in the same way as any other financial service, particularly where commercial PHI is concerned and/or in predominantly supplementary markets. National regulation goes beyond general insurance requirements in PHI markets with a strong mutual or non-profit tradition and where the market plays a substitutive role or a complementary role covering statutory user charges. In the last 15 years the degree of regulation in these markets has increased, mainly to improve access to PHI.

The PHI market is typically regulated by some form of national financial market authority or supervision commission under the jurisdiction of the Ministry of Finance. Ministry of Health or Ministry of Social Security involvement in regulation of commercial PHI is rare; it is more common for regulation of non-profit PHI. Non-profit private insurers are often subject to a separate legal framework and overseen by a different regulatory body from commercial insurers.

In 1994 the European Union established a regulatory framework for private health insurance (the Third Non-Life Insurance Directive). This broadly precludes non-financial regulatory intervention in non-substitutive markets and has provoked controversy and national and/or European case law in Belgium, France, Germany, Ireland, the Netherlands and Slovenia.

Fiscal policy
Many countries use tax incentives to encourage the take up of PHI, although these have been abolished or lowered in several countries in the last five to ten years, without much negative effect on demand for PHI. While generous tax subsidies have succeeded in fuelling demand for PHI in a few countries (notably Hungary and Ireland), they are unlikely to be self-financing and lower equity in financing health care. The use of fiscal policy to benefit some types of insurer over others is generally outlawed by EU law.

Policy implications
The way in which PHI operates often undermines health policy objectives within the market (which may differ from policy objectives for the market), notably financial protection, equity in finance and equity of access to health care. However, this is generally only a matter of public policy concern where PHI contributes to financial protection in the wider health system – which explains the much greater degree of government intervention in substitutive markets and markets providing complementary cover of statutory user charges.

In terms of impact on health policy objectives in the wider health system, the effects of PHI are mixed. Substitutive PHI and complementary PHI covering statutory user charges clearly play an important role in providing subscribers with financial protection. At the same time, however, the existence of PHI undermines other health policy objectives, even where the market is carefully regulated. For example, allowing higher earners to choose between statutory and private coverage in Germany has led to risk segmentation and stretches the resources of the statutory scheme, which not only loses the contributions of higher earners but also covers a disproportionately high risk group of people. In countries where PHI covers statutory user charges, the depth of statutory coverage has been eroded over time and there are concerns about the fact that those who do not have PHI may face financial and other barriers to accessing health care. Where the boundaries between public and private provision are not always clearly defined there is some evidence to show that public resources may be used to subsidise faster access to health care for those with PHI, who tend to come from higher income groups.

These problems are often a direct result of public policy rather than problems created by the way in which the PHI market operates. For example, allowing providers to charge higher fees to privately-financed patients creates strong incentives to prioritise these patients at the expense of publicly-financed patients. The use of tax relief to subsidise PHI also lowers equity by drawing resources away from publicly-financed health care. Overall, the argument that PHI will contribute to financial sustainability by relieving pressure on public budgets is not supported by evidence. Furthermore, concerns about the impact of changing demographic and labour market conditions on the financial sustainability of employment-based health care finance do not usually extend to markets for PHI, although they should, since in many member states PHI is partly financed by employers.

Market development and public debate
With one or two exceptions, there seems to be a clear divide between the newer and older member states with regard to market development and public debate about PHI. Markets in the older member states tend to be larger, show more diversity in terms of role and are or have been dominated by mutual associations. In contrast, markets in many of the newer member states have struggled to take off, mainly play a supplementary role and are sometimes exclusively commercial.

In many of the older member states public debate about PHI focuses on concerns about the potential for reductions in statutory coverage and growth in PHI to undermine equity of access to health care. In the newer member states the generosity of statutory health insurance is often blamed for slow PHI market development. Consequently, debate about PHI frequently focuses on the need for better delineation of the statutory benefits package. However, the scope and depth of statutory coverage do not seem to be greater in these countries than in the older member states. In fact, in many of them statutory cost sharing is widespread and has increased over time. This suggests that gaps in statutory coverage are not a sufficient pre-requisite for PHI market development, which may be held back by other barriers such as limited ability to pay for PHI, the presence of informal payments, lack of consumer and employer confidence, lack of private infrastructure and lack of insurance know-how.

The report highlights the diversity of markets for PHI across the European Union and notes the difficulty of generalising (frequently scarce) research evidence from one setting to another. The report also emphasises the importance of understanding each market in terms of the context in which it is situated. Nevertheless, different market roles and the way in which these roles interact with the statutory health system are associated with certain policy implications. The report attempts to outline these to raise awareness among policy-makers of the advantages and disadvantages of encouraging the growth of PHI.