CROATIAN MEDICAL JOURNAL
CMJ

43(4):425-432,2002

PUBLIC HEALTH

Low Demand for Substitutive Voluntary Health Insurance in Germany

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Aim. To examine why the demand for substitutive voluntary health insurance in Germany is low.

Method. A comparison of the benefits and costs of statutory and voluntary health insurance in Germany, based on a review of literature published in academic journals and books as well as gray literature.

Results. Employees in Germany with gross earnings over 40,500 a year can choose to opt out of the statutory health insurance scheme (Gesetzliche Krankenversicherung, GKV) and purchase substitutive voluntary health insurance instead. Only a quarter of these employees and their dependants actually choose to opt out; the majority remain in the GKV. Substitutive voluntary health insurance does not generally afford greater benefits than the GKV in terms of services provided or choice of insurer and only affords marginal benefits in terms of choice of provider. It is also more expensive than the GKV for people with dependants, elderly people and people in poor health. Consequently, the choice to opt out and purchase substitutive voluntary health insurance is more likely to be taken by young, healthy or single people or couples with double incomes.

Conclusion. Our analysis suggests that the demand for substitutive voluntary health insurance in Germany is low because the costs of opting out of the GKV are, in general, higher than the benefits afforded by purchasing substitutive voluntary health insurance. In the long term substitutive voluntary health insurance does not appear to provide good value for money when compared to the GKV, particularly for people with dependants, elderly people, and people in poor health.

Key words: *Germany; insurance, health; health services; private sector; rate setting and review*

Employees in Germany with gross earnings over 40,500 a year can choose to opt out of the statutory health insurance scheme (Gesetzliche Krankenversicherung) and purchase substitutive voluntary health insurance instead. Only a quarter of these employees and their dependants actually choose to opt out; the majority remain in the statutory health insurance scheme.

The aim of this paper was to examine why many high-earning German employees choose to stay in the statutory health insurance scheme rather than opting out and purchasing substitutive voluntary health insurance. Key features of statutory and voluntary health insurance were analyzed and the two types of health insurance compared in terms of their benefits and costs to members or policyholders. We reviewed the literature on voluntary health insurance in Germany available from a range of databases, including the International Bibliography of the Social Sciences, PubMed, EconLit, and Decomate II. As database searches elicited only a few relevant, original papers published in peer-review journals, we also undertook hand and Internet searches to identify gray literature, such as reports prepared by public and private health insurers, international organizations, and research institutes. We did not make use of individual-level data on German employees' preferences for one type of health insurance over another, nor did we use statutory sickness funds' and private health insurers' survey data.

Voluntary Health Insurance in the European Union

Voluntary health insurance does not play a significant role in funding health care in any member state of the European Union (EU) (1). As a proportion of total expenditure on health care, spending on voluntary health insurance in 1998 accounted for less than 5% in most member states (2). The exceptions to this were Germany (7.1%), Austria (7.3%), Ireland (8.3%), France (12.5%), and the Netherlands (17.5%). Voluntary health insurance markets in the European Union are relatively small because most member states require mandatory participation in the statutory health care system and continue to provide comprehensive benefits to the whole, or almost the whole, population.

Some literature on voluntary health insurance distinguishes between insurance that duplicates statu-

tory insurance and insurance that constitutes the principal means of protection for sections of the population (3). In the context of the European Union, we find it more appropriate to classify voluntary health insurance according to whether it substitutes for the statutory health care system, provides complementary cover for services excluded or not fully covered by the state, or provides supplementary cover for faster access and increased consumer choice. The distinction between complementary and supplementary voluntary health insurance is not always clear and in some member states the crossover between them may be significant.

Although the existence of near-universal coverage reduces most consumers' need for any type of voluntary health insurance, the exclusion of certain health services and the rise of co-payments for statutory health care in many member states have led to the development of a market for complementary voluntary health insurance. This is particularly evident in France, where the market for complementary voluntary health insurance to cover the cost of co-payments in the statutory health care system has grown rapidly, covering a third of the population in 1960, 50% in 1970, 70% in 1980, and 85% in 1998 (4).

Supplementary voluntary health insurance to increase consumer choice and facilitate faster access to treatment has expanded in countries with national health service-type systems, although it is available in every EU member state and usually guarantees superior accommodation and amenities in hospital.

In many countries, however, certain groups of people are either excluded from the statutory health care system or exempt from contributing to it, leaving them free to purchase voluntary health insurance as a substitute for statutory protection. Substitutive voluntary health insurance is available to specific population groups in Austria (priests, vets, and notaries) and Belgium (self-employed people), and most prevalent in Germany (self-employed people and high-earning employees) and the Netherlands (high-earners) (5).

Statutory and Voluntary Health Insurance Coverage in Germany

Health insurance in Germany is mainly provided by the statutory health insurance scheme. Membership of one of the 420 competing statutory sickness funds is compulsory for employees with gross earnings under an annual ceiling of 40,500. The contribution ceiling for statutory health insurance has been index-linked to the contribution ceiling for pensions since 1971, and is now the same in the old and the new Länder, ie, the western and eastern parts of Germany. Before 2001, the ceiling was approximately 500 lower in the new Länder.

Compulsorily enrolled in the statutory health insurance scheme, irrespective of their income, are also pensioners who were covered by the statutory health insurance scheme before retiring, students, recipients of unemployment benefits, people in continuing education programs, and specific occupational groups, such as farmers and maritime workers (6). The statutory health insurance scheme covers 89% of the population, mandatory and voluntary members alike. Employees with earnings above the ceiling (4.5%), permanent civil servants and self-employed (4.5%), the police and the military (2.0%), and a few others (for example, those covered by the European Union) are exempt from compulsory membership of the statutory health insurance scheme (7). Less than 0.2% of the population is uninsured.

Substitutive voluntary health insurance is provided by about 50 private health insurance companies, members of the German Association of Private Health Insurers (Verband der privaten Krankenversicherung, PKV). It can be purchased by two groups of people: the self-employed, who are excluded from the statutory health insurance scheme unless they have been members previously, with the exception of those who fall under compulsory statutory health insurance scheme cover, such as farmers and maritime workers; and employees with gross earnings above the statutory health insurance scheme contribution ceiling of 40,500 a year and their dependants.

Employers inform employees when their earnings rise above the contribution ceiling of statutory health insurance scheme, and offer them a clear choice: they can either stay where they are and continue to be covered by the statutory health insurance scheme (but as voluntary members with slightly different rights) or they can opt out of the statutory health insurance scheme and purchase substitutive voluntary health insurance (8). Those who opt out cannot return to the statutory health insurance scheme unless their gross earnings fall below the ceiling. The decision to opt out has been irreversible for individuals over 65 since 1994, and for those over 55 years of age since 2000.

Only a quarter of employees with earnings above the ceiling and their dependants choose to opt out of the statutory health insurance scheme. The majority (76%) choose to remain in the statutory health insurance scheme as voluntary members. As a result, 16% of those insured by the statutory health insurance scheme and their dependants are voluntary members who have decided to stay where they are rather than opt out and purchase substitutive voluntary health insurance (7,8).

A small number of people in Germany has no health insurance at all (<0.2%) and it is highly unlikely that any of these uninsured people are high-earning employees (7). Although the purchase of substitutive voluntary health insurance is voluntary, individuals that opt out and do not take out a substitutive voluntary health insurance policy would forego their employers' contribution to the cost of the policy.

The number of people with substitutive voluntary health insurance has risen from 4.2 million in 1975 to 7.5 million in 2000 (9% of the population, Table 1) (9). Between 1991 and 1999, the number of people with substitutive voluntary health insurance increased by 16%. About half of the increase resulted from people in the new Länder (formerly East Germany) subscribing to substitutive voluntary health insurance for the first time, since coverage had not been available before 1991. The increase in the old Länder

Table 1. The number of people with substitutive voluntary health insurance in Germany, 1975-2000[a]

Year	No. of people
1975	4,176,000
1980	4,843,000
1985	5,241,000
1990	6,614,000
1991	6,333,000[b]
1992	6,686,000
1993	6,829,000
1994	6,934,300
1995	6,945,200
1996[c]	6,977,400
1997	7,065,600
1998	7,205,700
1999	7,356,400
2000	7,522,400

[a]Source: German Association of Private Health Insurers, PKV 2001 (11).
[b]Elimination of duplicate counting; the net increase in 1991 was 262,000 persons.
[c]New counting method introduced; 6,945,800 persons according to the old method.

(formerly West Germany) was much less pronounced, from 9% to 10% of the population (10). Approximately half of all those with substitutive voluntary health insurance are high-earning employees, whereas the rest are the self-employed and active or retired civil servants. Active and retired civil servants are excluded from the statutory health insurance scheme because the government directly reimburses most of their health care costs. They only need to purchase voluntary health insurance to cover remaining costs. Although we consider the type of voluntary health insurance they purchase to be complementary rather than substitutive, they are included in the figures for substitutive voluntary health insurance compiled by the German Association of Private Health Insurers.

Private health insurers argue that the demand for substitutive voluntary health insurance is low due to major increases in the contribution ceiling of the statutory health insurance scheme, which are sometimes higher than increases in wages. This means that the number of people eligible to switch from statutory to voluntary health insurance does not increase as much as it should from year to year (11). But others argue that it is these regular increases in the contribution ceiling that provide a market of high stability for private health insurers (10).

In spite of regular increases in the statutory health insurance scheme contribution ceiling, the number of people who switch to substitutive voluntary health insurance every year since 1975 has been higher than the number of people lost to the statutory health insurance scheme because their incomes have fallen below the contribution ceiling (Table 2). In the mid 1990s, the number of people switching to substitutive voluntary health insurance declined in comparison to previous years. Only 66,000 people switched in 1996, compared with a peak of 515,000 in 1989 and 329,000 in 1992 (11). Since 1997, however, there has been a stronger increase in the number of people switching from statutory to voluntary health insurance, which the German Association of Private Health Insurers argues is partly due to benefit cutbacks in the statutory health care system (11).

Table 2. People switching between substitutive voluntary health insurance (SVHI) and the statutory health insurance scheme (GKV), 1975-2000[a]

Year	Switches to SVHI	Losses to the GKV	Net gain to SVHI
1975	170,000	152,000	18,000
1980	217,000	109,000	108,000
1985	243,000	98,000	145,000
1986	206,000	86,000	120,000
1987	368,000	103,000	265,000
1988	352,000	112,000	240,000
1989	664,000	149,000	515,000
1990	310,000	112,000	198,000
1991	356,000	125,000	231,000
1992	483,000	154,000	329,000
1993	307,000	175,000	132,000
1994	195,000	103,000	92,000
1995	271,000	186,000	85,000
1996	247,000	181,000	66,000
1997	315,700	144,400	171,300
1998	327,800	154,800	173,000
1999	324,800	149,200	175,600
2000	325,000	148,600	176,400

[a]Source: German Association of Private Health Insurers, PKV 2001 (11).

Annual losses to the statutory health insurance scheme that resulted from increases in the contribution ceiling partly explain why the number of substitutive voluntary health insurance policyholders does not increase dramatically every year. However, they do not explain why so many of those eligible to switch to substitutive voluntary health insurance stay in the statutory health insurance scheme.

Benefits and Costs of Substitutive Voluntary Health Insurance

Statutory Health Insurance Continues to Provide Comprehensive Benefits

The low level of demand for complementary and supplementary voluntary health insurance suggests that the statutory health insurance scheme continues to provide comprehensive benefits. Estimates of the number of people covered by complementary and supplementary voluntary health insurance in Germany vary from 7.5 million to 13.7 million, but the higher figure includes double-counting (10). Microcensus data show that this type of voluntary health insurance was purchased by about 7.5 million people (9% of the population) in 2000 (9).

Overall, there are few differences in the level of benefits provided by statutory and voluntary health insurance. Some private health insurers may offer a wider range of benefits than the statutory health insurance scheme, particularly for services such as mammography, pharmaceutical prescriptions, and expensive dental care, but in other areas statutory health insurance scheme benefits may be more generous than those provided by private health insurers (e.g., for psychotherapy) (10).

A key difference between the benefits provided by statutory and voluntary health insurance is that to obtain a comprehensive package of benefits, the employee opting for substitutive voluntary health insurance has to buy more than one policy. Private health insurers offer outpatient and dental benefits separately from inpatient benefits, so while employees

with substitutive voluntary health insurance usually enjoy the same benefits as those insured by the statutory health insurance scheme, their level of cover depends on the amount of policies they buy (10).

This may not be problematic where inpatient care is concerned, as inpatient benefits are clearly defined and there is not much variation between inpatient policies. But policies offering outpatient benefits do vary, particularly with regard to marginal benefits, such as psychotherapy, alternative treatment, rehabilitation, and transport. Some substitutive voluntary health insurance outpatient policies offer lower levels of coverage than would be provided by the statutory health insurance scheme (10). Consumer associations have recently noted that people find it increasingly difficult to distinguish between necessary and superfluous voluntary health insurance products (12).

Substitutive Voluntary Health Insurance Does Not Provide Much More Choice

Since 1996, most employees have had a free choice of statutory sickness fund, but once they have switched to a new fund, they are required to remain in it for at least 18 months (7). Statutory sickness funds compete on the basis of the contribution rate, which can vary substantially. In some regions, employees are able to choose between funds with a contribution rate of 11.2% and funds with a contribution rate of 15% (13). Estimates of the share of statutory health insurance members who switch from one sickness fund to another each year range from 3% to 5% (13). Those who switch tend to be young and healthy (7). There is also a clear correlation between switching and price (13).

In theory, there are fewer restrictions for substitutive voluntary health insurance policyholders who want to switch to another private health insurance company. In practice, however, recent reforms to substitutive voluntary health insurance have removed policyholders' incentives to change insurer. Since January 2001, the government has imposed a surcharge of up to 10% of the gross premium on all new substitutive voluntary health insurance policies, to address the problem of inaccurate premium calculations and inadequate ageing reserves. Existing policyholders face additional premium increases of 2% a year for five years (12). Funds raised from the surcharge are paid into a shared reserve, but as these reserves cannot be transferred from one insurance company to another, substitutive voluntary health insurance policyholders who change insurer face higher entry premiums with the new insurer (10).

Where providers are concerned, there is little difference between the choice provided to statutory health insurance scheme members and substitutive voluntary health insurance policy holders, as only about 3% of hospital beds and 3% of ambulatory physicians are not contracted by the statutory health insurance scheme (8). In terms of access and quality of care, the claim that substitutive voluntary health insurance policyholders receive better services has not been substantiated, and in the absence of waiting lists, faster access to treatment is not an issue (10).

Statutory Health Insurance Covers Dependants

Whereas the statutory health insurance scheme automatically covers its members' dependants, substitutive voluntary health insurance policies only cover individuals; dependants must buy separate policies and pay separate premiums. This makes family size a critical factor when choosing between statutory or voluntary health insurance (13,14). As a result, substitutive voluntary health insurance is more attractive to young people without dependants (8), which leaves the statutory health insurance scheme to insure a disproportionately high number of elderly people, people with large families, and those in poor health (6).

According to a recent industry report, high-earning employees purchasing substitutive voluntary health insurance are mostly young and single people or couples with double incomes (15). Another industry report notes that substitutive voluntary health insurance is growing in popularity among young and affluent Germans (12).

In 1999, men accounted for 52.7% of those with substitutive voluntary health insurance, whereas women accounted for only 32%, and children (≤15 years of age) for 15.3% (16). The low proportion of women among those with substitutive voluntary health insurance may be attributed to the lower rate of employment for women and the fact that women have lower earnings than men (9).

Substitutive voluntary health insurance coverage also varies by geographical location. Data from 1992 and 1993 show that only 4.4% of those with substitutive voluntary health insurance (and 0.8% of those with complementary and supplementary voluntary health insurance) were from the new Länder (17). This discrepancy is still marked. In April 1999, overall coverage was 8.9%, with 10.1% coverage in the old Länder and only 3.6% coverage in the new Länder (18).

A comparison of the average annual substitutive voluntary health insurance premium (about DM3,500 in 1999) and the average annual maximum statutory health insurance scheme contribution (DM10,688 average: DM10,805 in the old Länder, and DM10,570 in the new Länder) gives some indication of how much an individual without dependants might save by opting for substitutive voluntary health insurance (10,19). However, an individual's actual annual substitutive voluntary health insurance premium is likely to be considerably higher than the average, as the average also includes the premiums paid by civil servants and children, which are substantially lower than the premiums paid by employees and self-employed people.

Substitutive Voluntary Health Insurance Premiums Rise Steeply with Age

Another reason why people may be reluctant to opt out – or want to return to the statutory health insurance scheme if they have already opted out – is that substitutive voluntary health insurance premiums have risen steeply in recent years, and have also tended to increase with age. Although the private health insurers' main marketing strategy is to high-

light the better facilities they provide, many people regard substitutive voluntary health insurance as expensive compared with the statutory health insurance scheme (20).

Not only is the statutory health insurance scheme better value for money in terms of providing comprehensive benefits and covering dependants, it is also cheaper in the long term. Statutory health insurance scheme contributions are community-rated and levied as a proportion of gross earned income up to an annual ceiling of 40,500. The average contribution rate has not increased significantly over time; in 1975 it was 10.5%, rising to 12.3% in 1991, 13.6% in 2000, and 14.0% in 2002 (7,11).

In contrast, substitutive voluntary health insurance premiums are calculated on the basis of individual risk, age at entry, sex, health status at the time of underwriting, and the extent and level of cover required. Pre-existing conditions are excluded if they were known at the time of underwriting and were not disclosed by the insured, whereas declared pre-existing conditions are covered but generally result in higher premiums (10).

Between 1993 and 1999, gross written voluntary health insurance premiums (for all types of voluntary health insurance) grew in real terms at a compound annual growth rate of 5.2%, a trend that is expected to continue to 2004 (12,15). Total expenditure per capita on health care grew at the much slower annual rate of 4.5% (calculated in national currency units at current prices) (21). Since 1994, the real compound annual growth in premiums for substitutive voluntary health insurance has been lower – 2.9%, compared with a growth rate of 8.8% for all other types of voluntary health insurance (12). According to an industry report, this is primarily due to the fact that many private health insurers were forced to subsidize increases in substitutive voluntary health insurance premiums from their own reserves to continue to attract new business, rather than to raising existing premiums too high and risk repeating the adverse publicity that surrounded the market in the early to mid 1990s, when they were criticized for charging unreasonable premiums for older policy holders (12).

In theory, substitutive voluntary health insurance premiums should not increase as policyholders age, since private health insurers operate on a technical basis similar to that of life insurance, as required by the German government. This involves setting up aging reserves, with the specific objective of preventing premiums from increasing with age, and effectively prohibits insurers from terminating contracts. However, an adjustment clause allows private health insurers to increase premiums where there is a discrepancy between the costs used as a basis for calculating premiums and the actual costs of providing benefits, and in the past this clause has been used to introduce sharp premium rises as policyholders have aged. The discrepancy between predicted and actual costs was partly caused by the fact that private health insurers based their premium calculations on average life expectancy, failing to account for the longer than average life expectancy enjoyed by substitutive voluntary health insurance policy holders, who tend to come from higher socio-economic groups (10).

High premium increases for older substitutive voluntary health insurance policyholders put considerable pressure on the statutory health insurance scheme in the early 1990s, as people would opt for substitutive voluntary health insurance when they were young and then attempt to return to the statutory health insurance scheme when their premiums became too expensive due to increasing age or ill health (22). One of the ways in which they managed to do this was to reduce their working hours before retirement, allowing their incomes to drop correspondingly and thereby regaining access to the statutory health insurance scheme (10).

In 1994, the government took action to put a stop to this trend, announcing that the decision to opt for substitutive voluntary health insurance would be irreversible for those aged 65 years and over, even if their incomes dropped below the statutory health insurance scheme contribution ceiling (8). The recent Social Health Insurance Reform Act 2000 tightened the rules further by reducing the age limit for returning to the statutory health insurance scheme to 54 years (23). The 1994 legislation appears to have had some effect on the numbers switching to substitutive voluntary health insurance, which fell from 307,000 in 1993 to 195,000 in 1994 (Table 2). According to the German Association of Private Health Insurers, the fall in numbers was caused by "an occasionally polemic debate concerning the increase in private health insurance premiums in old age", but in 1995 the numbers went up again and by 1997 they had surpassed their 1993 level, which the German Association of Private Health Insurers argues is partly due to benefit cutbacks in the statutory health insurance scheme (11,12). It will be interesting to see the impact on this trend, if any, of the stringent change introduced in 2000.

At the same time, in 1994, the government required private health insurers to offer substitutive voluntary health insurance policies at a standard rate to individuals who have been privately insured for a qualifying period of at least 10 years and: a) are aged 65 and over (9), and 55 and over since 2000, and have an income below the contribution ceiling of statutory health insurance scheme, and b) receive a premature pension from the statutory pension scheme or under civil service regulations, and have an income below the statutory health insurance scheme contribution ceiling.

Standard rate policies provide benefits that match the benefits of the statutory health insurance scheme and guarantee that premiums will not exceed the average maximum contribution of the statutory health insurance scheme (or 1.5 times the contribution for married couples) (24). To date, however, very few people have chosen this option (only 1,161 people in 1998, 1,407 in 1999, and 3,024 in 2000) (16). This may be because, as with all substitutive voluntary health insurance, it does not cover dependants and, even with the 50% reduction for spouses, it is still more expensive than the statutory health insurance

scheme. It may also be due to lack of information about eligibility for the standard rate. The 2000 Reform Act requires private health insurers to inform existing policyholders of the possibility of switching to another tariff category when their premiums go up and to advise policyholders aged 60 years or over to switch to a standard rate policy or another tariff category that provides the same benefits for a lower premium (19).

In 2000, the government also tackled the problem of inaccurate premium calculations and inadequate aging reserves by imposing a surcharge of up to 10% of the gross premium on all new substitutive voluntary health insurance policies and a premium increase of 2% a year for five years for existing policy holders (15). By paying this surcharge, which goes into a shared reserve, policyholders can ensure that the cost of their premiums will not rise when they reach the age of 65. New policyholders who choose not to pay the surcharge risk paying substantially increased premiums as they grow older. The 2000 Reform Act also stipulates that the surplus obtained by applying the technical interest rate to the extra funds received through this surcharge is to be credited to the insured and used to limit premium increases in older age (19). As we noted above, an important side effect of the requirement to accumulate aging reserves is that privately insured individuals no longer have any incentive to change insurer.

Finally, to protect consumers further, the 2000 Reform Act stipulates that private health insurers must inform potential substitutive voluntary health insurance policyholders of the likelihood of increasing premiums, the possibility of limiting the increase in premiums with old age, and the irreversibility of the decision to opt out of the statutory health insurance scheme (19,23).

Employers' Contributions to Substitutive Voluntary Health Insurance Limited

Employers contribute up to 50% of employees' substitutive voluntary health insurance premiums (as in the statutory health insurance scheme), but this contribution is limited to the average maximum contribution of statutory health insurance scheme, so that the employee bears the full cost of any additional benefits purchased (10,19).

Furthermore, employers are only permitted to contribute to substitutive voluntary health insurance policies offered by private health insurers that specialize in health. Traditionally, the German supervisory body has only permitted insurers specializing in health to sell voluntary health insurance products, to protect policyholders from insolvency arising from other business. The legislation transposing the European Commission's third non-life insurance directive into German law formally abolished this rule (Article 5 of the directive), but the German government added a new provision to German social law, prohibiting employees from benefiting from employer-paid contributions if the insurer combined health with other types of insurance (10,25). The European Commission considered this to be an indirect infringement of the directive and sent a so-called "reasoned opinion" to Germany in 1996 (26). In the absence of a satisfactory response from the German government, the European Commission has referred Germany to the European Court of Justice (Case C-298/01) (5). The principle of separation of voluntary health insurance from other types of insurance does not apply to foreign health insurers (19).

Individuals with Substitutive Voluntary Health Insurance Receive Benefits in Cash Rather than in Kind

Substitutive voluntary health insurance may reduce access to health care by providing benefits in cash rather than in kind. Unlike statutory health insurance scheme members, who receive benefits in kind, privately insured individuals generally have to pay providers directly and are subsequently reimbursed by their insurer (19).

Private health insurers also offer a range of reimbursement options that reduce the price of voluntary health insurance premiums, but also reduce levels of coverage. Privately insured individuals may have the option of full reimbursement (100%) or choosing a premium with a deductible. Deductibles are defined as a fixed amount (ranging from DM180 to DM2,740 a year) or a percentage. For example, with an annual deductible of DM900, the premium for an outpatient policy amounts to about 70% of the full premium price (9).

Providers are Permitted to Charge More for Patients with Substitutive Voluntary Health Insurance

Although private health insurers claim that the cost transparency associated with paying patients in cash rather than in kind encourages a more "responsible" attitude to claims for medical benefits, it has not stopped health care costs in the substitutive voluntary health insurance sector from rising (14,24). Over the last 10 years, expenditure for self-employed people and high-earning employees with substitutive voluntary health insurance has increased on average by 40% more than expenditure for those in the statutory health insurance scheme, and by 200-300% more for ambulatory care, dental care, and pharmaceuticals (Table 3) (8).

Table 3. A comparison of changes in per capita expenditure for the statutory health insurance scheme (GKV) and substitutive voluntary health insurance (SVHI) in West Germany between 1989 and 1999[a]

	Increase (%) in expenditure for scheme	
Type of care	GKV	SVHI (ratio to GKV)
Ambulatory care	43	91 (2.1)
Dental care	21	60 (2.8)
Pharmaceuticals	32	74 (2.3)
Hospital care	61	53 (0.9)
Total	48	69 (1.4)

[a]Source: ref. 12.

A possible explanation for this additional growth in substitutive voluntary health insurance expenditure may be that providers are allowed to charge their privately insured patients 1.7 or 2.3 times the reimbursement values (and sometimes even more) set in the fee schedule for private medical services issued

by the Federal Ministry for Health (8). Balance billing may reduce access for some patients, although providers are no longer permitted to charge more than 1.7 times extra for individuals with a standard rate policy (19).

Comment

Our analysis suggests that the costs of opting out of the statutory health insurance scheme are generally higher than the benefits afforded by purchasing substitutive voluntary health insurance, and that these costs are substantially higher for those with dependants, those aged 55 years and over, and those with chronic illnesses. Substitutive voluntary health insurance does not generally provide greater benefits than the statutory health insurance scheme in terms of services provided or choice of insurer and only covers marginal benefits in terms of choice of provider. Whereas the statutory health insurance scheme continues to provide comprehensive benefits, benefits under substitutive voluntary health insurance may be fragmented. Substitutive voluntary health insurance is more expensive than statutory health insurance for people with families because dependants must be insured separately. It is also more expensive for elderly people and those with chronic illnesses because premiums are rated according to individual risk and have tended to rise steeply and with age. Although employers contribute up to 50% of employees' substitutive voluntary health insurance premiums (as in the statutory health insurance scheme), they can only do so up to the average maximum statutory health insurance scheme contribution, so the employee bears the full cost of any additional benefits. Finally, substitutive voluntary health insurance benefits are provided in cash rather than in kind and providers are permitted to charge significantly higher fees to patients with substitutive voluntary health insurance, which may reduce access for policyholders on lower incomes.

In the short term, opting out of the statutory health insurance scheme may be financially beneficial to certain groups of people, such as young people with no dependants. In the long term, however, substitutive voluntary health insurance does not appear to provide good value for money when compared to the statutory health insurance scheme. Consequently, the choice to opt out and purchase substitutive voluntary health insurance is more likely to be taken by young, healthy or single people or couples with double incomes, leaving the statutory health insurance scheme to cover a disproportionately high number of elderly people, people with large families, and people in poor health.

This form of risk selection between the statutory and voluntary health insurance sectors put pressure on the statutory health insurance scheme in the early 1990s and eventually led the government to make substantial interventions in the market for substitutive voluntary health insurance, in order to protect elderly people and those with chronic illnesses, and ensure that they had access to affordable substitutive voluntary health insurance coverage.

The reforms that took place in 1994 and 2000 addressed the issue of risk selection between the public and private sectors. It should now be clear to individuals that not only is it difficult to return to the statutory health insurance scheme after opting out, but also that the decision to opt out is genuinely irreversible for those aged 55 years and over. Both reforms also addressed the issue of ensuring access to substitutive voluntary health insurance for older people and people in poor health – including improving potential and existing policy holders' access to information about the options available to them – although substitutive voluntary health insurance is still likely to be more expensive than statutory health insurance for these people, particularly if they have dependants for whom they have to purchase separate policies. Future trends in substitutive voluntary health insurance coverage will therefore depend on whether the statutory health insurance scheme continues to provide comprehensive benefits, whether the statutory health insurance scheme contribution ceiling remains "stable", and whether private health insurers are able to prevent premiums from rising rapidly and with age. The most effective means of increasing the level of substitutive voluntary health insurance coverage might be to require private health insurers to cover dependants automatically, as the statutory health insurance scheme does.

However, neither reform addressed other issues, such as the cost and efficiency implications of substitutive voluntary health insurance for the health care system as a whole. As Table 3 shows, allowing providers to charge higher fees to substitutive voluntary health insurance policyholders has led to substantial cost inflation in certain sectors. Furthermore, private health insurers' administrative costs (10.2% in 1999) are twice as high as those of the statutory health insurance scheme (5.1% in 2000) (10). Given that the marginal benefits of opting for substitutive voluntary health insurance are minimal (except, perhaps, for young and healthy people with no dependants) and the costs appear to be significant, it might be more efficient to abolish the choice to opt out, so that all employees, regardless of their earnings, are insured by the statutory health insurance scheme. The abolition of this element of choice (for high-earning employees) and competition between statutory sickness funds and private health insurers would be countered by the competition between sickness funds introduced in 1996 and the choice of sickness fund made available to all statutory health insurance scheme members at the same time.

A limitation of our approach was that we were not able to make use of individual-level data on German employees' preferences for one type of health insurance over another. Unfortunately, this issue is not covered by the German Socio-Economic Panel Study (27). On the other hand, statutory sickness funds and private health insurers conduct surveys that include questions about individuals' motives for choosing a particular type of insurance. However, the results of these surveys are often considered to be commercially sensitive and are not usually available for public scrutiny (28). In spite of this limitation, we con-

sider our analysis to be useful in highlighting policy implications for statutory and voluntary health insurance in Germany and other European countries.

Further research could survey high-earning employees to find out why some opt out and others do not. We have argued that the demand for substitutive voluntary health insurance in Germany is low because the long-term costs of opting out outweigh any benefits gained, but there may be other factors influencing demand that we have not considered in this paper.

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Received: December 5, 2001
Accepted: May 23, 2002

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