The German health insurance model

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Dual health insurance system

- Social health insurance (GKV) – covers 85 % of the population (mandatory for ca. 73%) – ca. 200 sickness funds with non-profit status

- Substitutive private health insurance (PKV) – 10% of the population – 46 insurance companies

- Complementary private health insurance (reimburses health services not covered by the GKV and/or co-payments) – ca. 18 mio (2006)

SHI sickness funds

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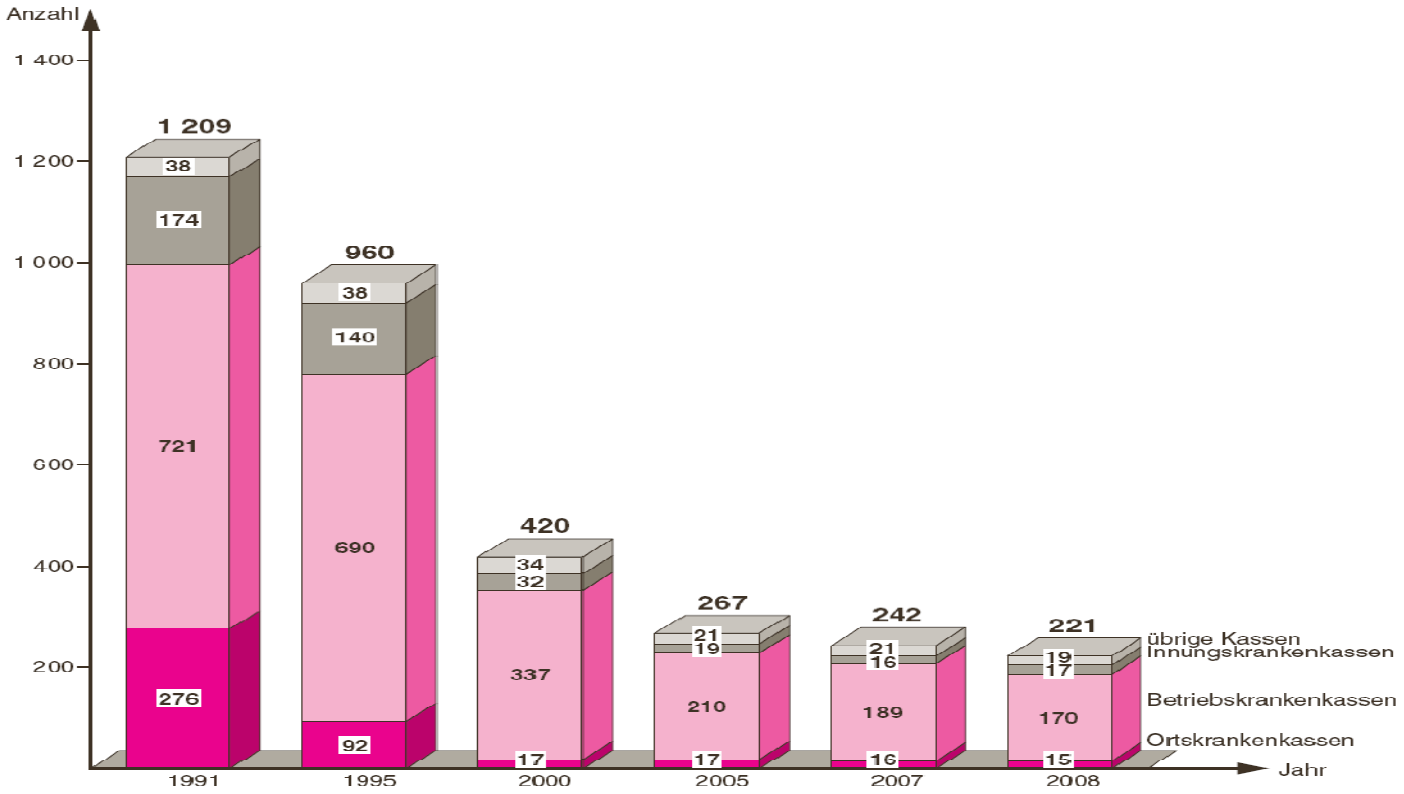
V. 15 Anzahl der gesetzlichen Krankenkassen im Januar des jeweiligen Jahres



Quelle: BMG (KM 1)
Übrige Kassen sind Landwirtschaftliche Krankenkassen, Seekrankenkasse, Bundesknappschaft, Arbeiter- und Angestelltenersatzkassen.

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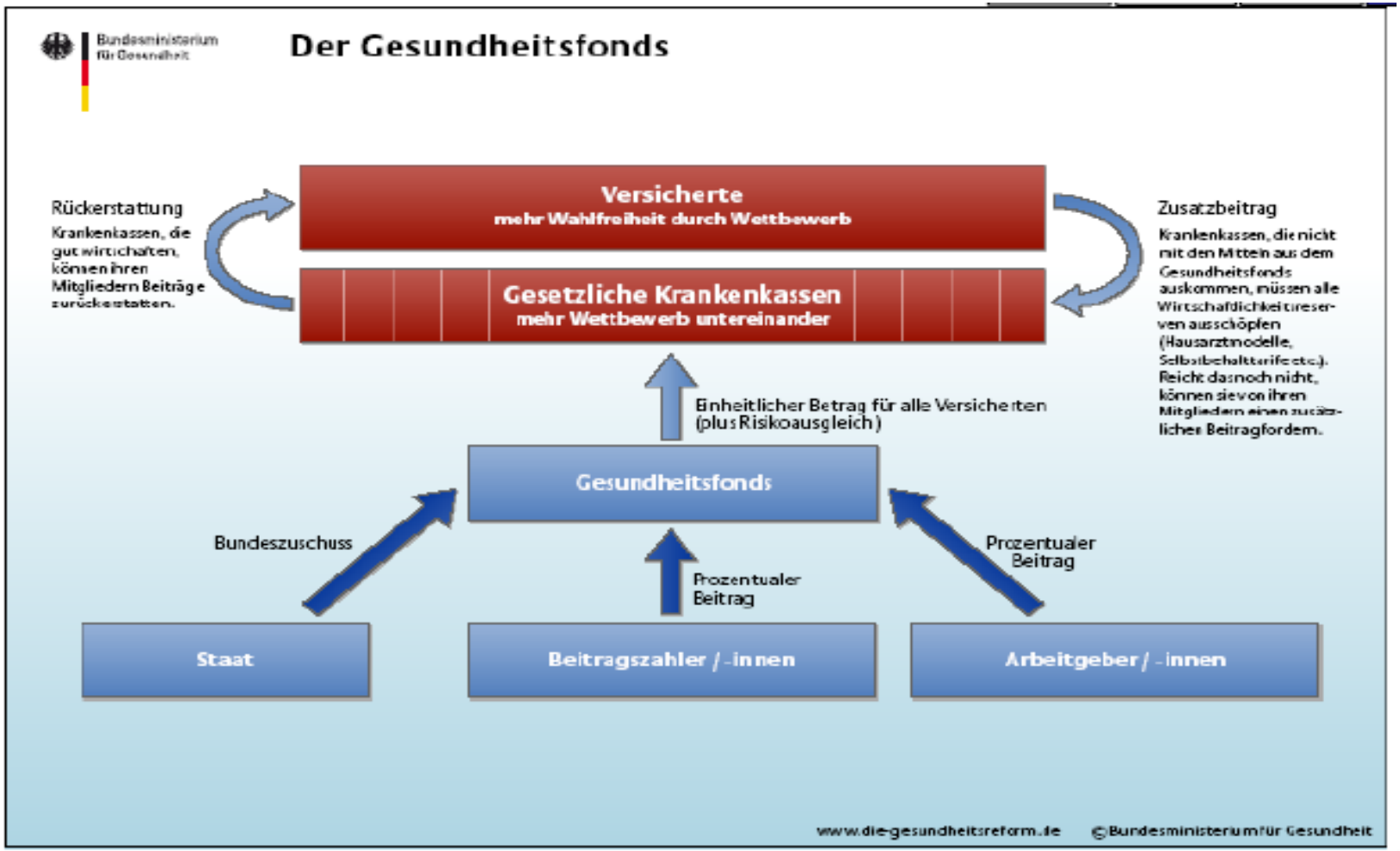
Social health insurance

- **Enrolment compulsory** for non-public sector employees earning less than 48,600 Euro a year (in 2008), some self-employed people (farmers, artists, jounalists), students, those receiving unemployment benefits, people with a disability, retired people who were members of GKV prior to retirement;
- **free coinsurance** for family members
- **Pay-as-you go priciple**, wage-based contributions, not (health) risk-related;
- since 2009 **uniform contribution rate** 14,9% (7% employer, 7,9% employee)
- „**health fund**“ (pooling and allocation of funds)
- morbidity-oriented risk structure compensation scheme (**Morbi-RSA**)


Bundesministerium für Gesundheit
Der Gesundheitsfonds
Rückerstattung
Krankenkassen, die gut wirtschaften, können ihren Mitgliedern Beiträge zurückerstatten.
Versicherte
mehr Wahlfreiheit durch Wettbewerb
Gesetzliche Krankenkassen
mehr Wettbewerb untereinander
Zusatzbeitrag
Krankenkassen, die nicht mit den Mitteln aus dem Gesundheitsfonds auskommen, müssen alle Wirtschaftlichkeitsreserven ausschöpfen (Hausarztmodelle, Selbstbehalttarife etc.). Reicht das noch nicht, können sie von ihren Mitgliedern einen zusätzlichen Beitrag fordern.
Einheitlicher Betrag für alle Versicherten (plus Risikoausgleich)
Gesundheitsfonds
Bundeszuschuss
Prozentualer Beitrag
Prozentualer Beitrag
Staat
Beitragszahler / -innen
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Morbi-RSA

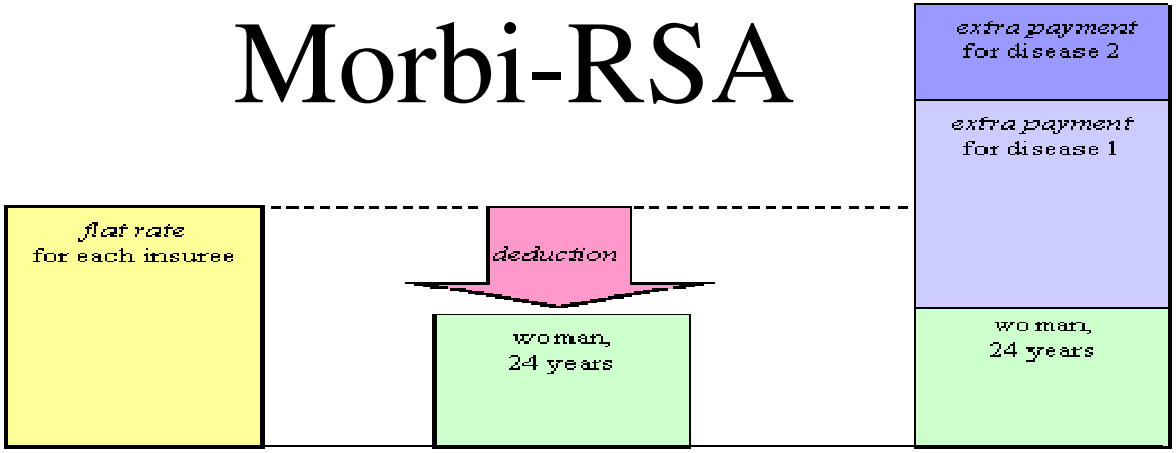

fig. 1: allocations for mandatory benefits of sickness funds

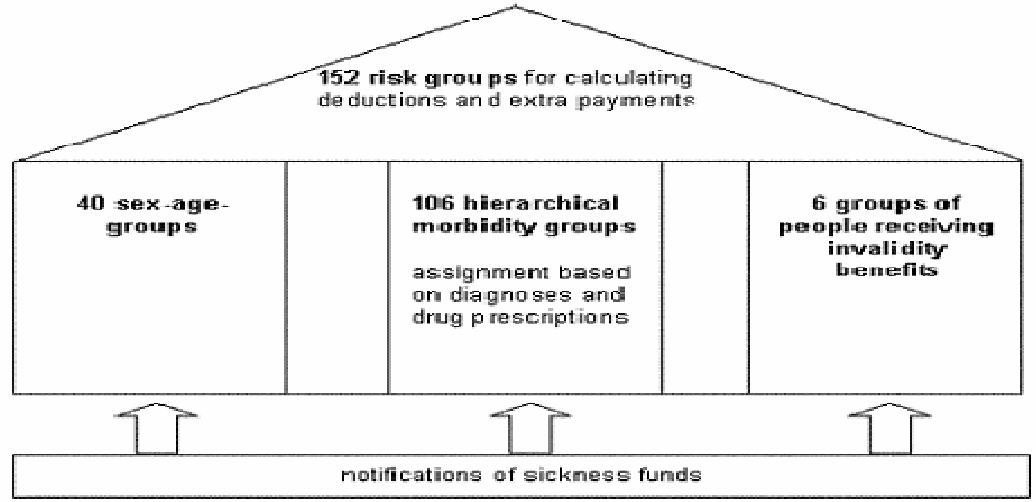

fig. 2: risk groups of the reformed risk structure compensation scheme

Source: Schang 2009

Substitutive private health insurance

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- Employees who have earned above the threshold of 48,600 Euro a year for three consecutive years and their dependents (about 20% of the population) have two options: 1) remain in the GKV (voluntary GKV membership) 2) opt out for substitutive private health insurance

- Self-employed people not eligible for GKV – substitutive private health insurance. Civil servants - purchase private health insurance to complement the health benefits „Beihilfe“ they are eligible to.

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Substitutive PHI

- insurance premiums based on an individual‘s risk, vary by age, sex and medical history (cost of the premium typically shared with the employer); dependants not automatically covered as in the SHI (separate premiums)
- capital cover; obligation to build „old age reserves“, additional 10% of the costs of the premium; since 2009 „old age reserves“ portable to increase competition
- private insurers can reject applications and exclude pre-existing conditions or charge a higher premium
- from 2009 on obligation to accept any applicant who is eligible for a „basic policy“ (cannot exclude cover for preexisting diseases)
- basic tariff covers the same set of services as the SHI for a premium that varies based on age and sex (not medical history), capped at the level of the maximum SHI contribution (533 Euro in 2008)

Substitutive PHI

- „Model policy conditions“ (developed by the private insurers‘ association) - subscribers should be offered free choice of any physician and hospital in the country (as in the SHI)
- Recently – „preferred provider networks“ e.g. for dental care (restricted choice in return for a reduction in or exemption from cost sharing)

Complementary insurance plans

cover additional services fully or partially excluded from the GKV reimbursement such as:

- spectacles
- hearing aids
- some health checks and diagnostic services,
- co-payments for dental services and pharmaceuticals
- service ‚top ups' in hospital including accomodation in single or two-bed rooms
- treatment by the chief consultant

Current discussion and reforms

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Risk segmentation – „low risks“ (young and healthy insurees) in the PHI, „high risks“ in the SHI

Equity problems – high-income earners can opt out of the SHI based on income and risk solidarity (rich, young, healthy → poor, old, sick) → decreases the financial sustainability of the SHI;

inequity in access to healh care (providers prioritize private patients e.g. outpatient doctors charge higher fees to private patients)

→ 2007 Reform Act - restricts the eligibility for substitutive cover, requires open enrolment and capped premiums for certain groups, facilitates choice of private insurer

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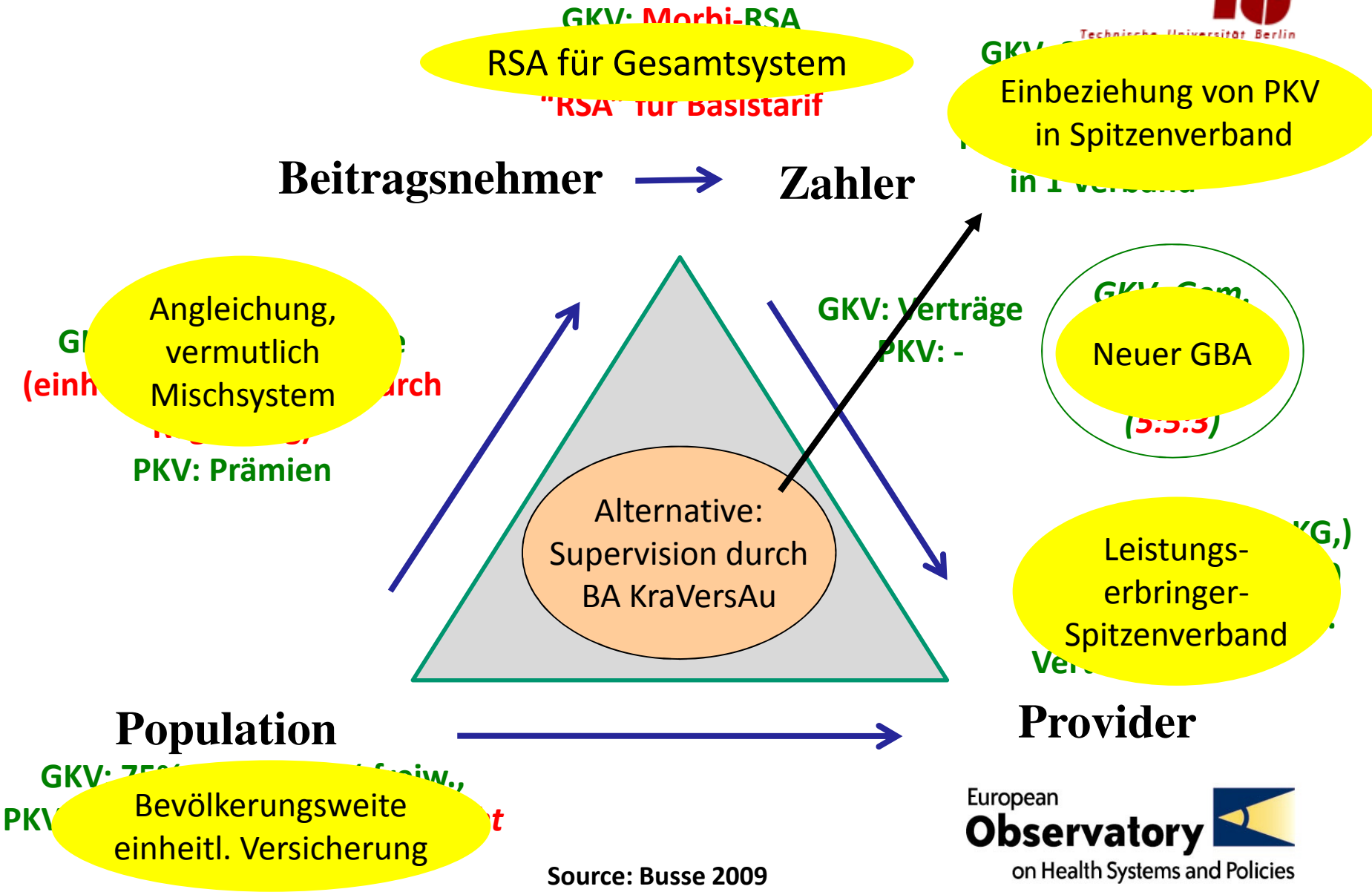
Competition

- **competition between PHI and SHI** – since 2004 sickness funds can offer additional tariffs (Wahltariffe) and coverage for services excluded from the GKV, previously priviledge only for private insurers

- **PHI -** until 2009 no competition among PHI insurers for those insured who are already have a private insurance (because of non-transferrable old age reserves); competition mainly focused on new entrants

- **SHI** - focuses on the benefit and service package (no longer differing contribution rates); new mechanisms to attract customers: additional tariffs (deductibles, no-claim refunds, higher premiums for additional sickness benefits etc.), refunds for participation in certain programmes (family doctor model, DMP, integrated health care), bonuses for participation in programmes aiming at prevention and early diagnosis of disease; high quality services from the sickness funds

Future Reforms



Source: Busse 2009