

The Role of Voluntary Health Insurance in EU Countries

This paper provides an overview of markets for voluntary health insurance (VHI) in the European Union (EU). It examines their role in providing access to health care; analyses recent trends and future challenges for voluntary health insurers and policy-makers at the national level.

VHI markets in the European Union are diverse. This diversity arises from different historical patterns of development, variations in the rules and arrangements of statutory health care systems and discrepancies in national regulatory regimes. These factors underline the wide range of types of VHI on offer, levels of expenditure on VHI, levels of population coverage, types of insurer, mechanisms for premium-setting, selection criteria, policy conditions, benefits provided, premium prices, tax incentives, loss ratios, administrative costs, levels of access and equity implications.

VHI does not play a significant role in funding health care in the European Union, as it does in countries like the United States and Australia. Public policy in EU countries has generally aimed to preserve the principle of health care funded by the government or social insurance and made available to all citizens, regardless of ability to pay. This has led to the development of health care systems broadly characterized by near universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure. These characteristics have been important determinants of the scope and size of the market for VHI in the European Union.

The existence of near universal coverage by the statutory health care system reduces consumers' need for additional coverage through VHI in many countries. Because health care services in the European Union are mainly financed through taxation or contributions from employers and employees, participation in the statutory health care system is usually mandatory. Governments in most EU countries provide their citizens with comprehensive benefits, however, the exclusion of certain health services from statutory coverage, particularly dental care and pharmaceuticals, and the rise in co-payments for statutory services have led to the development of a market for complementary VHI. Supplementary VHI has developed to increase consumer choice and access to different health services. It is particularly prevalent in countries with national health services where it is often referred to as "double coverage".

The types of VHI on offer in a particular country reflect both the historical development and the current rules and arrangements of that country's social health care system. As a general rule, public policy in EU member states has aimed to preserve the principle of health care funded by the state or social health insurance and made available to all citizens, regardless of ability to pay. As a result, statutory social health care systems in the European Union are broadly characterized by near-universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure.

These characteristics have been important determinants of the scope and size of VHI markets in the European Union, and the voluntary nature of such markets means that they generally operate in areas that the state does not cover. Therefore, VHI in the EU could be classified according to whether it:

- Substitutes for cover that would otherwise be available from the social health insurance (substitutive VHI)
- Provides complementary cover for services excluded or not fully covered by the social health insurance, including cover for co-payments imposed by the social health insurance system (complementary); or
- Provides supplementary cover for fast access and increased consumer choice (supplementary)

Complementary and supplementary VHI are open to the whole population and some form of complementary and/or supplementary VHI is available in every EU member state. In contrast, substitutive VHI is limited to specific population groups in a handful of EU states. It is usually purchased by:

- Those who are excluded from participating in some or all aspects of the social health insurance scheme (high-earners in the Netherlands and self employed people in Belgium and Germany); and
- Those who are exempt from contributing to the statutory health insurance because they are allowed to opt out of it (high-earning employees in Germany and some self-employed people in Austria).

The proportion of the population covered by VHI varies among EU countries. Levels of substitutive VHI cover range from 0.2% of the population in Austria to 24.7% in the Netherlands. Data on levels of complementary and supplementary VHI coverage are less comparable, partly because they do not always distinguish between the two types of coverage and partly due to variation in the quality of coverage. In countries where complementary VHI predominates, levels of coverage range from about 20% to 70%. Since the introduction of free complementary VHI cover for people on low incomes in France in 2000, coverage has risen from 85% to 94%. Where supplementary VHI predominates, it generally covers around 10% of the population.

Information about the characteristics of VHI subscribers suggest that those who purchase supplementary VHI are more likely to come from higher income groups, have higher occupational status and live in wealthier regions. The characteristics of complementary VHI subscribers are more varied, but those most likely not to have complementary VHI coverage include people in low incomes and people without employment (such as students, some women, the unemployed and elderly people). Because access to substitutive VHI is determined by income or employment status, those with substitutive VHI tend to be high earning or self-employed people.

VHI does not play a significant role in funding health care in the European Union. Spending on VHI as a proportion of total expenditure on health care is low. In 1998 it accounted for less than 10% of total expenditure in every EU country except France (12,2%) and the Netherlands (17.7%) and well under 5% of total expenditure in Belgium, Denmark, Greece, Italy, Luxembourg, Portugal, Spain, Sweden and United Kingdom. Although the last 20 years have seen some growth in levels of private expenditure as a proportion of total expenditure on health care, this growth has been influenced more by increases in cost-sharing through user charges than by rising demand for VHI. However, sustained economic growth and cutbacks in public expenditure on health care during the 1980s did increase demand for VHI in many EU countries. Demand for VHI continued to grow throughout the 1990s in some member states, but the pace of growth was much slower. The fact that levels of VHI coverage in many EU countries have remained fairly stable for some time now suggests that the market for VHI may have reached saturation point (within current health care system structures).

Over the last 20 years the demand for VHI in several EU countries has been fuelled by an increase in policies purchased by groups (usually employers, as a fringe benefit for their employees). Stagnant or falling levels of individual demand for VHI have forced insurers to rely even more heavily on sales to groups. Group policies gained an increasing share of the VHI market in many EU countries during the 1990s and currently account for almost all VHI policies in Sweden, Ireland, Portugal, Greece and the United Kingdom, more than half of all policies in the Netherlands, and about half of all policies in France. Group policies usually benefit from group-rated premiums, discounted prices and less stringent policy conditions. The price of group policies has also increased at a much slower rate than the price of individual policies.

It was expected that the framework for a single market for VHI established in 1994 would increase competition among insurers, leading to greater choice and lower prices for consumers. However, increased competition does not appear to have reduced the price of VHI premiums, particularly for policies purchased by individuals. In fact, the price for individual VHI policies has often risen at a faster rate than health care expenditure in general. Since 2000, insurers offering substitutive VHI in Germany have been required by law to inform potential subscribers of the likelihood and magnitude of premium increases. The competition watchdog in the United Kingdom has asked insurers to do the same, also suggesting that they should publish figures showing applicants how much premiums have risen in previous years. Some industry commentators predict that future growth in the market for VHI is more likely to come through increases in price than increases in population coverage.

However, VHI markets in certain EU countries are characterized by a high level of product differentiation, perhaps as a result of the abolition of national price and product controls for complementary and supplementary VHI in 1994, which suggests that insurers may employ strategies other than price increases to sustain profitability by keeping existing subscribers and attracting new subscribers. While product differentiation can benefit consumers by increasing the range of product available to them and by providing them with products that are tailored to meet their needs, it can also be used to segment the

market, giving insurers greater opportunity to distinguish between “good” and “bad” risks. Either way, the presence of multiple insurance products may reduce price competition unless it is accompanied by a level of information sufficient to permit consumers to compare products in terms of value for money. EU consumers in many countries now have a wide choice of VHI products, but it is not clear that choice always works in their advantage. Evidence from many EU countries suggests that consumers may not have sufficient access to comparable information about VHI products, to the possible detriment of consumers. The competition watchdog in the United Kingdom and consumer associations in some EU countries have noted that consumers can be easily confused by multiple VHI products and may therefore purchase inappropriate policies.

Information asymmetry between insurers and consumers arising from the proliferation, variability and complexity of VHI products can be mitigated by the use of standardized terms, the existence of a standard package of benefits, an obligation for insurers to inform potential and existing subscribers of all the options open to them and accessible sources of comparable information on the price, quality and conditions of VHI products. However, in the absence of product controls, insurers have little incentive to reduce consumer confusion by introducing standardized terms or standard benefit packages. Late in 2001 the British government announced that general insurance sales (including the sale of VHI) would now come under the statutory regulation of the Financial Services Authority. In making its decision the government stated that statutory regulation of general insurance would help true competition to flourish in this area, because it would help correct the information asymmetry that presently exists against the consumer.

Insurers operating in a competitive environment may have strong incentives to lower their costs by risk selection, encouraging custom from individuals with below average risk and discouraging or refusing custom from individuals with above average risk. Risk selection may raise concerns equality (particularly where substitutive VHI is concerned) and also presents serious efficiency problems, lowering the optimal level of competition in an insurance market. Risk selection is likely to occur where voluntary health insurers are able to reject applications, exclude pre-existing conditions and cancel contracts. Incentives to risk-select can be addressed to some extent by obliging all insurers to guarantee access to coverage (open enrolment), provide automatic renewal of contracts and limit exclusions for pre-existing conditions. This type of intervention would radically alter the nature of VHI markets in many countries. At present, open enrollment policies in EU countries are rare among voluntary health insurers in the European Union, most insurers exclude pre-existing conditions (the norm) or charge higher premiums for them, short-term contracts are the most common form of VHI contract and lifetime cover is the exception rather than the rule. Furthermore, VHI premiums in many EU countries rise with age and most insurers set a maximum age limit for purchasing VHI, while some actually cancel contracts when people reach retiring age. Incentives to risk-select can also be reduced by the introduction of sophisticated risk-adjustment mechanisms, but these are only found in Ireland (where risk equalization scheme is in place but has not yet been activated) and Belgium (for substitutive VHI provided by mutual associations).

For largely historical reasons, some of the most extensive VHI markets in the European Union are currently dominated by non-profit mutual or provident associations. Many of these non-profit insurers adhere to solidarity principles in their provision of VHI. In recent years their share of the VHI market has declined in some countries, and in the future they may lose further market share to for-profit commercial insurers.

The extent to which VHI affects access to health care depends, in part, on the characteristics of the statutory health care system. Access to VHI may concern policy-makers in so far as VHI provides primary protection against the consequences of ill health. While this is usually the case for substitutive VHI, it may also apply to complementary VHI covering co-payments imposed by the statutory health care system and necessary and effective health services not provided or only partially provided by the government social health insurance. The high price of VHI premiums in some EU countries (particularly for individual policies), the absence of open enrollment, lifetime cover and community rating, and the imposition of stringent selection criteria and policy conditions present barriers to VHI for those on low incomes, people with pre-existing conditions, elderly people and people without employment.

Access to VHI has been an issue of concern to policy-makers in some member states. In recent years governments in Germany, the Netherlands and, to a lesser extent, Belgium have intervened heavily in the market for substitutive VHI to ensure that people on lower incomes, people with pre-existing conditions and elderly people have access to adequate and affordable levels of VHI coverage. The German and Dutch governments have also intervened to prevent or address the consequences of risk selection by statutory and voluntary health insurance schemes.

Other governments have taken steps to increase access to complementary and supplementary VHI. Since 2000, the 1999 law on universal health coverage (CMU) in France has enabled those who do not benefit from any health insurance to be covered by a basic, compulsory, statutory health insurance scheme. The law also provides free complementary VHI coverage for people on low incomes. In Ireland, the government continues to oblige voluntary health insurers to offer open enrollment, lifetime cover, community-rated premiums, maximum waiting periods and minimum level of benefits. It will also subject insurers to a system of risk adjustment through a (not yet activated) risk equalization scheme. Insurers in Sweden have voluntarily agreed to refrain from requesting information about family history of disease, a type of genetic information that is required by insurers in many countries. Genetic testing for insurance purposes may emerge as an issue for VHI in future.

The existence of VHI could present a barrier to access in the statutory health care system for some individuals and population groups if it creates distortions in the allocation of resources. This scenario is most likely where the boundaries between public and private health care are not clearly defined, particularly if capacity is limited, if providers are paid by both the public and the private sector, and if VHI creates incentives for health care professionals to treat public and private patients differently. While research into this

issue is limited, there is evidence to suggest that VHI in some EU countries does create or exacerbate existing inequalities in access to health care services.

Any expansion of VHI markets in the future is likely to depend on developments in statutory health care systems. Expansion is likely to occur as a result of market interventions such as obliging voluntary health insurers to offer open enrolment, but this type of regulatory action would fundamentally alter the nature of VHI markets in most EU countries.

At the present time, EU countries demonstrate commitment in principle to publicly funded health care for all or almost all citizens, but the sustainability of funding health care from public sources continues to be called into question. It is often suggested that factors such as the aging of the population, the high cost of new technology and rising public expectations will increase demand for health care, causing expenditure on health care to escalate beyond the willingness or ability of citizens to pay for it (particularly through collective means such as taxation or social insurance). As a result, governments may no longer be able to provide sufficient levels of health care to the whole population, and citizens maybe forced to rely on additional methods of funding their health care needs. In such a situation, there would be significant opportunity for VHI to play a more substantial role in funding health care.

However, recent studies have shown that population aging is unlikely to put significant pressure on health care expenditure in the future. Expected rises in the number of older people, may have an impact on health care costs in the future, but they are much more likely to affect the costs of long-term care. The impact of new technology on health care costs is not clear and cannot be used as an accurate predictor of future expenditure on health care. Public expectations may increase demand for health care, but it is neither evident nor logical to assume that a country's ability to sustain a given level of expenditure on health care is increased by raising money from one funding source (VHI) rather than another (tax or social insurance). In this respect, it is worth noting that although health care is mainly provided through private health insurance in the United States, the level of public expenditure on health care in the United States is substantial, the level of overall spending on health care, as a proportion of the gross domestic product, is much higher than in any EU country, and a significant proportion of the America population is not covered by any type of health insurance. Therefore, it does not follow that expanding VHI will automatically result in reduced levels of public spending on health care or increased levels of coverage.

Three options open to European Union policy-makers might influence the future expansion of VHI markets in different countries; allowing more individuals to opt out of the statutory health care system, further excluding specific health services from statutory cover, and introducing or increasing tax incentives to purchase VHI.

Allowing people to opt out does not appear to be a growing trend in the EU. Where high-earning individuals are given a choice to opt out, as in Germany, very few actually choose to leave the statutory health insurance scheme. Governments in Belgium and the

Netherlands, where some individuals are excluded from statutory coverage, are currently considering the possibility of extending statutory health insurance to the whole population.

Explicit reduction in statutory coverage of some health services could increase demand for complementary VHI, while less explicit reductions through rationing might increase demand for supplementary VHI. However, increased demand for complementary VHI may not always be met, as VHI to cover the cost of co-payments or products excluded from statutory reimbursement may be less profitable for insurers to provide. Voluntary health insurance may only be able to meet increased demand for supplementary VHI where there is sufficient private sector capacity.

Most EU countries do not use tax incentives to encourage individuals to purchase VHI, although tax incentives to firms have fuelled demand for group-purchased VHI in some countries. The current trend is to reduce or remove existing tax incentives for individuals, as they are not particularly successful in stimulating demand. Resources devoted to tax relief might be better spent on improving the quantity and quality of statutory health care.