

“The Main Features of German Private Health Insurance”

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Summary

Germany has a system of private health insurance which is unique. It connects the advantages of a market economy with the long-term reliability of a governmental system. This goal is achieved by a comprehensive legal framework, which includes actuarial techniques. The paper deals with the position of private health insurance in the German system of social security, the problem of increasing health expenditures, the calculation of premiums and reserves, premium adjustments, cancellation and dividends to policyholders.

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Zusammenfassung

Deutschland besitzt in der privaten Krankenversicherung ein System, das einzigartig ist. Es verbindet die Vorteile einer marktwirtschaftlichen Versicherungswirtschaft mit der langfristigen Zuverlässigkeit eines staatlichen Systems. Dieses Ziel wird durch umfassende gesetzliche Rahmenbedingungen erreicht, die spezielle actuarielle Verfahren einschließen. Der Beitrag befasst sich mit der Stellung der privaten Krankenversicherung im deutschen Sozialversicherungssystem, dem Problem wachsender Gesundheitsausgaben, der Berechnung von Beiträgen und Rückstellungen, Beitragsanpassungen, Kündigung und Überschussbeteiligung.

“The Main Features of German Private Health Insurance”

Erich Schneider

In Germany a private health insurance system has evolved which is unique. This paper is meant as an introductory essay which makes it easy to understand the main features of the system. Therefore some aspects have been simplified, many details have been omitted. A comprehensive detailed presentation would be beyond the scope of this paper. It is the goal of this essay to illustrate the main requirements for the system, describe the components which have been developed to fulfil the requirements and show the connections between these components.

1. German health insurance: two systems

Health insurance in Germany is characterised by the fact that two systems exist side by side: statutory health insurance and private health insurance. The statutory system is much larger than the private system. In the year 2000 the payments of the statutory system were EUR 126 billion, while the benefits of the private system amounted to EUR 13 billion. Normally the statutory system is in the centre of social policy. Therefore the private system cannot be understood without the latter. So we first turn to the statutory system.

1.1 Statutory health insurance

In statutory health insurance each employee is insured compulsory, if his salary does not exceed a certain limit (“contribution assessment ceiling”). The insurance coverage is almost completely standardized by the legislator. It comprehends a wide range. The main benefits are: outpatient and inpatient medical treatment, dental care, drugs, appliances, sickness benefit. As a contribution a certain percentage of the salary respectively the social insurance pension (up to the contribution assessment ceiling) has to be paid. Thus the contribution does not depend on the age of the insured person. The spouse and children of the employee are insured without additional contribution, if their income can be neglected. The employee himself pays only one half of the contribution, the other half has to be paid by the employer or by the pension insurance carrier. The system is financed completely by these contributions.

It is evident that this insurance cannot be achieved by a market system: Since the contribution has to be a fixed percentage of the salary , the insurance coverage must be standardized, i.e. it cannot depend on individual requirements. Moreover each applicant must be accepted. So the claims cannot be influenced by means of underwriting. Therefore competition is nearly impossible in this system. According to this the system is managed by health insurance funds (under public law).

A short look at the organisation: The patient can choose his physician and hospital nearly unrestrictedly. Almost all physicians and hospitals have a contract with the statutory system. The patient gets no bill. The accounts are settled directly with the fund.

The statutory system goes back to the introduction of social insurance in the 19th century. In the following time it has been extended more and more. Today about 90% of the population is insured in this system. The contribution ceiling is adjusted every year. In 2001 it amounts to EUR 3,336 per month. The contribution differs between the funds. On average it is 13.5%. So the average maximum contribution is EUR 450 per month.

The sum of contributions rises automatically with the general increase of the salaries and with the increase of the contribution assessment ceiling, which is linked to the development of the salaries. Moreover the contribution percentage had to be raised in the last decades because of increasing health expenses. For a long time all German governments have been fighting against the increase of this percentage.

If the salary of an employee exceeds the contribution assessment ceiling, he can either leave the system or continue his membership in statutory health insurance voluntarily. The same applies if he gets self-employed or enters the civil service. According to the rules mentioned above a voluntary member pays the maximum contribution resulting from the assessment ceiling.

1.2 Private health insurance

The following persons (including family members who are not compulsory members of the statutory health insurance) can apply for a private comprehensive health insurance:

- employees with a salary exceeding the contribution assessment ceiling
- self-employed persons
- civil servants

Civil servants are not assigned to the statutory health insurance in Germany. A certain percentage of their health expenses (mostly 50% or more) are covered by the support fund of the civil service. For the rest the private insurance offers according tariffs. Almost all civil servants have private health insurance.

The private health insurance is based on a contract between the insured person and the insurance company. The policyholder can freely choose the coverage he wants. The companies have split the coverage in different tariffs so that a lot of different combinations are possible.

The private health insurance is offered by health insurance companies, which are either stock companies or mutuals. About 50 companies compete in this market. Since nobody is forced to leave the statutory system, there is additionally a competition between statutory and private insurance.

A return from the private system to the statutory system is possible only in exceptional cases, i.e. if an employee is still younger than 55 years and his salary decreases under the contribution assessment ceiling. So a return is possible neither for self-employed nor for all persons who are older than 55, especially retired persons cannot return. By this rule it is prevented that the statutory system is burdened by elder persons returning from the private insurance system

Henceforth in German health insurance we have the principle: "Once private, ever private." Persons who have decided on private health insurance once are dependent on the lasting reliability of this system. Based on this requirement in Germany a private health insurance system has evolved which guarantees a lasting financial protection against sickness costs, but which also shows the advantages of competition.

The organisation differs from the statutory insurance: The patient can choose freely the physician and the hospital. He gets a bill and then applies for an reimbursement of his insurer. There is no contract between the insurer and the physician or the hospital.

The features of this private health insurance system partly result from the competition with the statutory system: Since the statutory system is prevailing in Germany, it determines what people expect from each kind of health insurance. For the greater part the features rely on legal regulations. Social security is of great importance in Germany. Since the legislator permits a private system as an alternative to statutory insurance, it supposes the liability to guarantee the reliability of the system by government measures.

In order to clarify the domain of private health insurance which is regulated, the legislator has developed the expression of "substitutive health insurance": Substitutive health insurance is private health insurance which may serve as a partial or complete alternative to health cover provided by the statutory social security system. The special tariffs for civil servants are classed to the substitutive health insurance too. Substitutive health insurance is offered only by pure health insurance companies. 7.5 million persons were insured in the substitutive health insurance in the year 2000.

In the substitutive health insurance system the employer or the pension insurance carrier has to pay one half of the premium too, but not more than he would have to pay in the statutory system.

This paper is mainly restricted to the substitutive health insurance. Non substitutive health insurance is essentially insurance which supplements the statutory insurance. This is above all insurance for inpatient private medical treatment, better hospital accommodation, hospital daily allowance, loss of income and foreign travel insurance.

The legal regulations refer not only to the insurance industry, but also to the health care market in Germany.

2. The regulation of the health care market

For physicians there exists a government fee scale for the treatment of patients which are not in the statutory health insurance. This scale has a long tradition, which goes back to the 19th century, and its application is obligatory. The scale gives the billing rates for a detailed list of medical services (about 2,400 positions). The fee for a personally given medical service can vary between the 1- and the 3.5-fold of this billing rate according to the difficulty of the service. A multiplier over 3.5 requires a special agreement between the physician and the patient, which is rarely made. If the multiplier exceeds 2.3 the physician has to give an explanation in his bill. In fact less than 10% of all bills show a multiplier less than 2.3. Exactly the multiplier 2.3 is used in more than 80% of all outpatient treatments and in more than 60% of all inpatient treatments. For a certain group of private insured patients a reduced

upper limit is valid (see chap. 9.5). For dentists' bills a similar regulation applies. In the statutory health insurance there is a different regulation for the prices of medical treatment. Therefore a direct comparison of the prices is not possible. But as a rule of thumb one can say that the prices in the statutory system correspond to the application of the multiplier 1 in the private system.

The operating cost rates of hospitals are not determined by the hospitals, but by committees under government regulation. Furthermore it is not allowed that extra costs for better hospital accommodation exceed certain limits.

For drugs there is a retail price maintenance. For important kinds of drugs the statutory insurance has even set upper limits for the reimbursement. This has an influence on the prices of these drugs.

It is the goal of these governmental regulations to restrict the sickness costs (regardless of the insurance system) without endangering the high health level in the country. So one could say that to some extent we have a governmentally managed care in Germany. For the private health insurance these cost regulations lead to a high safety of calculation, because for all German policyholders the same price situation is valid and because an abrupt change of the price level is not likely.

One should notice another political issue here: By the fee scale and by the contribution assessment ceiling the legislator has two instruments to influence the volume of the private health insurance sector. This refers to the number of the insureds as well as to the average health costs per insured.

3. The main requirements for substitutive health insurance

Since the statutory health insurance is the leading system in Germany, it determines the expectations of the population towards health insurance in general.

Therefore private health insurance has to fulfil the following three requirements:

- Lifelong insurance guarantee: It must guarantee the coverage agreed upon till the end of the life.
- Similarity to the statutory insurance: The insurance coverage must be similar to the coverage of the statutory health insurance.
- Level premium: The premium rates must not increase because of increasing age.

Let us take a closer look at these requirements:

3.1 Lifelong insurance guarantee

The statutory system offers the lifelong insurance guarantee. In health insurance this is extremely important. A health insurance coverage has a value only if the insurer is tied to the contract just when the physical condition changes for the worse or when the insured gets older and therefore increasing sickness costs must be expected.

Thus private health insurance has to offer the lifelong insurance guarantee if it wants to find acceptance. Accordingly also the legislator requires that a substitutive insurance offers this guarantee. How this goal is achieved, is described in chapter 4.

3.2 Similarity to the statutory insurance

In Germany private health insurance can only be an acceptable alternative to the leading statutory system if the private health insurance coverage offers the same main items as the statutory system:

- the outpatient medical coverage including drugs and appliances
- the hospital-surgical coverage
- the dental care coverage

Accordingly the classical private medical expense insurance consists of three tariffs.

Corresponding to the statutory system the expense coverage usually is accompanied by a sickness benefit in form of a daily allowance insurance. As elimination period for the daily benefit one chooses six weeks for employees, because for the first six weeks they get a continued pay by their employers in Germany. One chooses a shorter period for self-employed persons. The sickness benefit in private health insurance is paid as long as the sick person is temporarily unable to work. If the person is constantly unable to work, the daily allowance insurance ends. This case cannot be insured in the private health insurance in Germany, it is a matter of the occupational disability insurance which is offered by the statutory pension insurance system and by private life insurance.

Even if the main items of the statutory and the private coverage are the same, the latter usually includes a lot of benefits which exceed the standardized catalogue of the statutory insurance. Part of these benefits are particularly inpatient treatment by the head physician, better hospital accommodation, higher benefits for dentures and crowns, treatment by lay medical practitioners.

The higher benefits together with the better compensation for physicians (see chap.2) in principle lead to higher benefits and accordingly to higher premiums than in the statutory system. On the other hand the private insurance industry uses opportunities which the statutory system does not have: It offers deductibles. The most important form is the general deductible. In this case the insured is reimbursed in full of all medical expenses in excess of the deductible agreed upon. The general deductible can be chosen as a percentage, but usually it is defined as a fixed amount per year.

Deductibles have a considerable impact on the attitude of the insureds. They develop a consciousness of the costs and so the claims are influenced positively. Moreover the administration costs for the settling of small claims drop out. This is reflected in the premiums.

Compared with the statutory insurance different extensions of the coverage are possible. For the general deductible the insurers offer different amounts between about EUR 50 and EUR 5,000 per year. Moreover deductibles and maxima are possible for certain areas of benefits or for special benefits (e.g. spectacles). Therefore most German health insurers offer a wide range of different tariffs.

Comparing the level of benefits and premiums between the two systems one furthermore has to notice that under some conditions family members have a contribution-free insurance in the statutory system (see chap.1.1), whereas in the private system a just premium has to be paid for each insured person.

3.3 The level premium

The model of the statutory insurance exerts also an influence on the design of the premiums: The contributions in the statutory system depend on the salary, not on the age, so that the insureds can value their financial burden. Accordingly the private insurers offer no premiums which increase with increasing age.

But of course the private insurers need the equivalence of the expected premiums and the expected claims (principle of equivalence). Therefore the premium depends on the entry age. Thus one calculates level premiums as in life insurance. Accordingly a reserve is set up for increasing age. So the private insurance is based on the funding principle, whereas the statutory system is financed on a pay-as-you-go basis.

If a premium rate is determined for a person, besides the chosen tariff and the entry age all facts are relevant which are given at the time of application and which could have an influence on the expected claims, i.e. particularly sex and physical condition. Given diseases are taken into account by an extra premium or by an exclusion rider.

Thus the insurance is operated on a technical basis similar to that of life insurance. The increase of expected costs with increasing age is already reflected in the level premium. Therefore the requirement mentioned above – which is also a requirement of the legislator for the substitutive insurance - is fulfilled: The premiums do not increase because of increasing age. If there however is a general increase of health expenses (inflation of health expenses), it is necessary – like in the statutory insurance - that the premiums are raised (see chap. 8).

4. The achievement of the lifelong insurance guarantee

As explained above the private health insurance must give a lifelong insurance guarantee, i.e. in the insurance contract it cannot be provided that the insurance ends when a certain age is reached, if a certain sickness occurs or high costs emerge. Moreover in the substitutive health insurance the insurer has to renounce the right to cancel the contract, provided the premiums continue to be paid. He does not have the possibility to reduce the coverage either.

These features have far-reaching consequences for the design of the whole system.

In the first place the insurer must have the right to adjust the premium to the inflation of health expenses he observes in his portfolio (see chap. 8). In the second place the system must be structured in a way that the insurer constantly has a well balanced portfolio. Only by the premiums of a well balanced portfolio the costs of the not healthy part of the insureds can be financed.

Therefore it has to be prevented that healthy persons leave, while persons with bad physical condition remain. In principle this peril exists: Ill persons normally will not leave, because

they have to pay an extra premium to the new insurer. Healthy persons have a reason to go if another insurer seems more favourable to them. Each of the fore-mentioned premium adjustments can bring the policyholders to compare the premiums. If many healthy persons leave, the insurer will have to raise the premiums again and even more insureds would have a reason to leave. So it is clear that a continuous process of adverse selection is threatening.

The logical solution of the problem of adverse selection is evident: It is the preclusion of termination by the policyholder. This would correspond to the abstention from termination by the insurer. But this is impossible because of juridical reasons.

Therefore the change of the insurer is made unfavourable by the following procedure: Premiums depend on the entry age. Thus one can expect that the premium of the new insurer is higher in any case if the old contract has lasted some years. This disadvantage is not compensated by a reimbursement of the reserve. In contrast to life insurance a surrender value is not paid in health insurance.

The missing reimbursement of the reserve has again and again been subject of public discussions in Germany. The experience shows that it is very difficult to convey that this is an arrangement which is necessary to ensure the financing of the lifelong insurance guarantee.

The fact that with increasing duration it is more and more unfavourable to change the insurer could have a considerable impact on the competition in the insurance market: The competition in private health insurance could focus completely on the new customers. The legislator has taken this problem into account. It is its goal to put the existing customers on par with the new ones. Therefore it demands for the substitutive health insurance:

- equal bases of calculations for old and new customers
- the right of tariff switch
- rules for new founded health insurance companies

4.1 Equal bases of calculations for old and new customers

The operation similar to life insurance requires that the claims expected in old age are included in the premium calculation of a young customer. The insurer is not allowed to estimate these claims freely: He must presuppose just the claims he observes in his existing business in force. Therefore the insurer can offer favourable premiums only if his claim expenses for the elder insureds and with it the premiums for the elder insureds are low.

The insurer is obliged to compare yearly according to a prescribed procedure the assumed claims with the actually occurred claims, in order that the premiums of the new business are always in accordance with the actual claims of the business in force. If the deviation exceeds a certain limit, he has to adjust his premiums. This adjustment refers to the new business and to the business in force as well (see chap. 8).

4.2 The right of tariff switch

Thus the required equality of the bases of calculations for business in force and for new business impedes too low premiums in the latter. But of course this equality cannot be demanded if the insurer introduces a new tariff. In this case no according business in force

exists. In order that in this case too the old insureds benefit by the competition , all insureds of a company have the right to switch to every other tariff – particularly to the new tariff - of the same company. At a switch account must be taken of the rights which the insured person has already acquired, in particular of the reserve for increasing age. A new medical examination and an extra premium may be required only for increased cover. Therefore the insurer must take the expected claims of the already insured persons into account, even if he calculates a new tariff.

A second effect of this arrangement is that also the already insured persons can take advantage of the competition by innovation.

4.3 Rules for new founded health insurance companies

Even if a new health insurance company is founded so that there are no insureds who could switch within the company, an arrangement has been found to take the expenses of old customers of the private health insurance into account (see chap. 5.2).

5. The calculation of new business premiums

5.1 The method of calculation

The premiums have to be calculated individually. So group insurance with not individually calculated premiums is not allowed. The rates have to be scaled according to the single entry ages (no grouping of ages).

Operation similar to life insurance means that for the entry age x the yearly net premium is calculated as follows:

$$P_x = A_x / \ddot{a}_x$$

with the present value of an annuity

$$\ddot{a}_x = \sum_{t=0}^{w-x} D_{x+t} / D_x$$

and the present value of the benefits

$$A_x = \sum_{t=0}^{w-x} K_{x+t} * D_{x+t} / D_x$$

K_{x+t} designates here the expected yearly benefits of an insured who is $x+t$ years old.

Thus the calculation does not rely on entry probabilities and expected claims for diseases. This would be a very troublesome procedure. It relies on the benefits which are expected on average per year regardless of the diseases which may underlie.

It should be noted that the expected benefits K_{x+t} depend only on the reached age $x+t$, not on the duration t . Since only persons who are completely healthy are insured using the standard rates of the tariff, the assumed benefits K_{x+t} are too high in the early years of the contract. The selection profits resulting from this are used to cover initial expenses.

According to the usual terminology we have

$$D_x = l_x * v^x, v = 1 / (1 + i),$$

with assumed interest rate $i..$

Since there is no benefit in the case of termination, terminations can be taken into account like the cases of decease. Therefore we have

$$l_{x+1} = l_x * (1 - q_x - s_x)$$

with

q_x = mortality rate at age x

s_x = lapse rate at age x .

It turns out that terminations do not lead to profits of the insurer, if the assumed lapse rates meet the reality.

This kind of calculation applies to the health cost insurance and to the insurance of a daily allowance as well. In the latter case the expected benefits K_{x+t} refer to an allowance of amount EUR 1 and the resulting premium is multiplied according to the chosen allowance.

5.2 The bases of calculations

There are very strong requirements for the safety of the calculation. All bases have to rely on sufficient statistical data and have to be set cautiously. 3.5% is the upper limit for the interest rate. In addition to the implicit margins a contingency margin of at least 5% of the premium is obligatory.

If the calculation cannot be based on an existing business in force, the calculation has to be based on the tables published regularly by the supervisory authority. These tables refer to expected benefits, mortality and termination and reflect the experience of the whole industry.

The appointed actuary is responsible for the appropriateness of all bases. Moreover the bases have to be submitted to the supervisory authority

6. The claims reserve

Since it is difficult to distinguish one illness from another one, a special definition for the insured event is given in the terms of health insurance. There it is said: "The insured event is the necessary medical treatment because of an illness or an accident."

This definition leads to some differences between normal casualty insurance and health insurance. In health insurance all claim payments are assigned to the date of treatment, not the begin of illness. Consequently there is no reimbursement for a treatment received after the termination of the contract, even if the illness has occurred before it. The premium of a year is assigned to the treatments in that year, not to the illnesses occurring in the year. Therefore a claims reserve is set up only for the treatments in the accounting year which will lead to payments in the following year.

So there are no long tail problems to be solved. The claims reserve can easily be determined by looking at the payments in the first weeks after the end of the accounting year which are made for treatments in the accounting year. This amount is increased according to the experiences of the three preceding years.

7. The reserve for increasing age

If P is the net premium which is paid for an insured person, then

$${}_mV_x = A_{x+m} - P * \ddot{a}_{x+m}$$

is the corresponding reserve at age $x+m$. According to the rules of the substitutive health insurance the present values A_{x+m} and \ddot{a}_{x+m} have to be calculated here with the same bases as the new business premiums of the tariff.

These reserves for increasing age are taken into account in the case of a tariff switch and in the case of a premium adjustment (see chap. 8). The aggregate of this reserves is the reserve for increasing age which is shown in the balance sheet. This means in particular: The bases of calculations and the bases of valuation are identical.

It is worth noting that the individual reserves of a healthy and of an ill person do not differ. Nevertheless the aggregate reserve of the business in force is sufficient, because the assumptions always have to be chosen in such a manner that they are appropriate for the business in force of the tariff as a whole (see chap. 4.1).

The net premium P which occurs in the reserve formula given above can be loaded by initial expenses according to the method of Zillmer. However the regulations provide an upper limit for this loading to impede that the reserves stay negative too long. The aggregate reserve of the company has the lower limit zero anyway.

8. The increase of health expenses

It has already been explained that expected cost increases which are due to the ageing of the insured are accounted for in the calculation of a premium in the new business. The premiums have to be raised only if a general increase of health expenses occurs. Here it does not matter if the increase results from higher prices, from an increasing general demand to health services or from the introduction of health services or medicines which are more expensive.

In contrast to the statutory insurance the premiums are not raised on a pay-as-you-go basis but on the basis of the principle of equivalence. Thus the raised premium of a person already insured results from the premium for the new business at the attained age taking into account the reserve for increasing age. It is the same procedure as in a tariff switch in life insurance. Diseases which have occurred after the beginning of the insurance are not taken into account, neither in the calculation of the reserve nor in the calculation of the additional premium, i.e. the equivalence of the expected premiums and benefits is only valid in the business in force as a whole, not individually. If the insurer calculated individually here, then after a severe worsening of health the following raises of the premium would soon result in an unbearable financial burden for the insured.

This form of calculation of the premium raise is obligatory in the substitutive insurance. It is the extension of the lifelong insurance guarantee to the increase of expenses. Each such premium adjustment of a tariff has to be approved by an independent trustee. So the revision of the bases of calculations of a given tariff is under control of two persons, the appointed actuary and the trustee.

In the following “old” and “new” refer to the bases of calculations before and after a premium adjustment. P is the net premium a given insured has to pay. If q is the rate of inflation of health expenses to apply in the given tariff and x+m the age attained at the time of the premium adjustment, then at this time the reserve is equal to

$$\begin{aligned} & (\text{old}P_{x+m} - \text{old}P) * \ddot{a}_{x+m} = {}_mV_x = \text{new}A_{x+m} - \text{new}P * \ddot{a}_{x+m} = (1 + q) * \text{old}A_{x+m} - \text{new}P * \ddot{a}_{x+m} \\ & = ((1 + q) * \text{old}P_{x+m} - \text{new}P) * \ddot{a}_{x+m} . \end{aligned}$$

Thus the premium rise amounts to $\text{new}P - \text{old}P = q * \text{old}P_{x+m}$.

So the premium is not raised by $q * \text{old}P$ but by $q * \text{old}P_{x+m}$, i.e. the rate of inflation has to be applied to the premium of new business at the attained age. Since the latter is always higher than the hitherto valid premium $\text{old}P$, the rise of the premium is always relatively higher than the increase of the expenses.

In principle this effect cannot be avoided if the calculation is based on the equivalence principle: General increases of expenses which occur far in the future cannot be estimated fairly in advance. They can only be accounted for, when they are recognizable. If this happens, the elder insureds are almost always more affected than younger ones.

It has to be emphasized that this is the main challenge for the private health insurance. Therefore different measures have been developed to mitigate the premium increase for the elder insureds.

9. The premium discharge in old age

The following regulations for the substitutive health insurance have been introduced to achieve a premium discharge in old age.

9.1 The 10%-loading

Up to age 60 there is a 10%-loading on the premium. This loading is used completely to finance a claim of the insured to mitigate premium rises in old age. Accordingly the loading leads to higher reserves.

9.2 The use of profits

On account of the prescribed high safety margins the insurers are committed to reimburse at least 80% of their profits as dividends to policyholders. In fact the average percentage is about 92%. In the allotment the insurers are not free: 90% of the interest profits occurring in the health cost insurance by the low assumed interest rate has to be used to mitigate premium rises in old age. Technically this is achieved by using profits as additional single premiums.

Moreover the whole allotment has to be approved by the fore-mentioned trustee, who is committed to attend particularly that premium rises in old age are bearable.

9.3 The assumption of unit costs

Calculating premiums it is not allowed to assume administration expenses which are proportional to the premiums. Instead of this the insurer has to assume fix costs per insured. So it is guaranteed that the premium of an elder insured is not loaded by higher expenses than the premium of a young insured.

9.4 The switch hint

If the premium of an elder insured is raised and if the insurer has a tariff with equal kinds of benefits and a lower premium, the insurer has to give a hint to this tariff and inform the customer about the premium he had to pay after a switch.

9.5 The standard tariff

The standard tariff is a special tariff, which has been introduced to impede that the financial burden for the elder insureds gets unbearable. For this tariff the net premiums are equal in the whole private health insurance. The benefits are nearly the same as in the statutory insurance, i.e. the insured have to renounce benefits not given by the statutory system. The physicians are obliged to restrict their fees for personally given services to the multiplier 1.7 (cf. chap. 2). If nevertheless for an elder person a premium results which is higher than the maximum contribution in the statutory system (cf. chap. 1.1), the premium to be paid is reduced to this amount. The deficit resulting from this reduction is paid by the aggregate of the private health insurers using a pool. In order to finance this payment, there is a small loading on all tariffs of the substitutive health cost insurance.

Every supplier of the substitutive health insurance has to maintain this tariff so that the elder insureds can switch to it. In 2000 the tariff had only 3024 insured persons in the whole country. This shows that the other discharging measures have been successful.

10. Miscellaneous

10.1 Premiums for children

If young people begin to practise a profession, they often become a compulsory member of the statutory health insurance. Thus for private insured children it makes no sense to set up a reserve for increasing age. Therefore children are insured by using risk premiums which depend on the attained age. The premium for adults which depends on the entry age (see chap. 3.3) has to be paid if the age of 21 is reached. Accordingly the 10%-loading does not apply for children.

10.2 Underwriting for new born children

New born children whose parents are insured privately cannot enter the statutory health insurance. Therefore these children can get insured privately regardless of their physical condition without any extra premium. They get the same tariff as the parents. In this way even disabled new born children can get an insurance cover at a standard rate.

10.3 Underwriting for civil servants

Since civil servants are dependent on the private health insurance system, the extra premiums for beginners in the civil service are limited to a maximum of 30% of the standard rate.

10.4 Non substitutive health insurance similar to life insurance

The regulations for the substitutive health insurance – with exception of the 10%-loading – are valid also for the non substitutive insurance, if it is operated similar to life insurance, i.e. if there is a level premium which requires an according reserve. In this way these regulations apply also for the biggest part of non substitutive insurance, in particular for the insurance for inpatient private medical treatment, better hospital accommodation, hospital daily allowance and loss of income. This makes sense, since all these types of coverage are also sold as a part of the substitutive health insurance.

About 7.5 million persons which are insured in the statutory system have such an additional private insurance.

10.5 Long-term care insurance

In 1995 in Germany a compulsory long-term care insurance was introduced. In contrast to health insurance this insurance offers benefits for non medical services, i.e. help for the performances of every day life like getting in and out of bed, bathing, eating, etc.

The coverage is given by the health insurance carrier the insured belongs to. This applies to both health insurance systems. The different calculation principles of the two systems are maintained: A percentage of the salary on a pay-as-you-go basis in the statutory system, the principle of equivalence and the funding principle in the private system.

Here the private system had to cope with the problem that a whole part of the population had to be insured, including persons which had already attained a high age and even persons which had a claim on benefits from the beginning.

Since it is a generally interesting question how a private health insurance system can be introduced for a whole part of the society, it is worth looking at how this problem was solved. It was solved by a limitation of the premium to the maximum contribution of the long-term care insurance in the statutory system and by a pool of the private insurers to cover the deficits. At the end the deficits are financed by a loading on the premiums of the private long-term care insurance. So it turns out that the introduction of this new line of business has a strong pay-as-you-go component. But this component will dwindle with the years to come. Eventually the funding principle will prevail.

11. The bases of the German private health insurance system

One could ask if the German private health insurance system could be a model for other countries. Before answering the question one should look at the bases of the system and its consequences. Only if the bases can be developed and if the consequences are accepted, an adoption of the system may be possible.

The German private health insurance is characterized by the following main features:

- it is a market insurance system
- it offers a lifelong insurance guarantee
- the premiums do not increase because of the increasing age

These features are achieved by comprehensive and detailed legal regulations. They refer to:

- the prices on the health care market
- underwriting, tariff switch and termination
- the calculation of premiums and reserves
- the adjustment of premiums
- the use of profits

Obviously such a system requires a legislator who takes the responsibility for its reliability and therefore is prepared to create a legal framework and adapt it constantly to new developments in the health care and in the insurance industry. Furthermore the experience shows that this system requires insurers which on the one hand act as entrepreneurs in competition to each other and on the other hand speak with one voice in a strong association so that the government has a competent trustworthy partner, who can contribute to find feasible solutions for the problems arising with the further development of the system.

Certainly this system has not emerged accidentally in Germany. In the last 50 years in Germany a social market economy has been build up, i.e. a liberal market economy with social commitments set by the legislator. Social commitment in health insurance means: lifelong insurance coverage to a bearable price. So the German private health insurance system is just the realization of the social market economy in the field of health insurance.