

The Private Health Insurance: Demarketization of a Welfare Market?

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Abstract

This article examines to what extent the German private health insurance (PHI) is undergoing a process of “demarketization”. Whereas newly established welfare markets (e.g. in the field of pension, long-term care, health care, labor market etc.) can be regarded as a result of “marketization”, the substitutive PHI looks back on a centennial tradition as the market-based counterpart of the statutory health insurance (SHI). Even though the PHI generally assures a high level of insurance protection, the market-based organization of this insurance led to an increase in socio-political regulations in the past two decades. These social liabilities did not transform the PHI business model radically. Nevertheless, an incremental transformation as well as a partial convergence is taking place between SHI and PHI. These developments will be analyzed in this article.

Zusammenfassung

In diesem Beitrag geht es um die Frage, inwieweit die private Krankenversicherung (PKV) in Deutschland einem Prozess der “Entmarktlichung” unterliegt. Während viele neu geschaffene Wohlfahrtsmärkte (z.B. in den Bereichen Rente, Pflege, Gesundheit, Arbeitsmarkt etc.) das Resultat von Vermarktlichungsprozessen sind, blickt die substitutive PKV auf eine über hundertjährige Tradition als marktwirtschaftliches Pendant zur gesetzlichen Krankenversicherung (GKV) zurück. Obwohl die PKV im Allgemeinen ein hohes Schutzniveau gewährleistet, hat die marktförmige Organisation dieses Versicherungszweiges in den vergangenen zwei Jahrzehnten zu einer Verstärkung sozialpolitisch motivierter Regulierungen geführt. Bisher haben die sozialen Verpflichtungen das Geschäftsmodell der PKV zwar nicht grundlegend verändert, allerdings vollzieht sich eine allmähliche Transformation und partielle Konvergenz zwischen gesetzlicher und privater Krankenversicherung. Diese Entwicklungen werden im vorliegenden Beitrag analysiert.

1 Introduction

The German health care system with its coexistence of statutory and private health insurance (SHI/PHI) is characterized by a peculiarity, which differs substantially from other European health care systems. However, this peculiarity results less from the general existence of private health insurances, but rather from its substitutive character. Therefore, the PHI is not only suitable as supplementary insurance but also as a substitute full-cover of SHI. In spite of this substitutive function, many fundamental differences exist between these systems. The past years have witnessed a tendency of convergence of PHI and SHI systems. In the SHI, a development of marketization took place, whereas the PHI faced a growing influence of regulatory state intervention. While changes in the SHI—due to their relevance for a predominant part of the population—are often analyzed in detail, reforms of PHI normally play a subordinate role. This article will focus on recent develop-

ments of Germany's private health insurance and tries to analyze, if this process can be described as "demarketization" of a welfare market.

In Chapter 1, some general considerations of health insurance and the role of welfare markets are outlined. Chapter 2 gives a brief overview of historical path dependencies and the exceptional position of the German PHI in Europe, where the Third Non-Life Insurance Directive (Dritte Richtlinie Nichtlebensversicherung) of the European Union exerts a relevant influence on national state interventions. The most important regulations are represented and analyzed in the following sections: the introduction of the standard tariff in 1994 and its replacement by the basic tariff in 2009 (Chapter 3), the implementation of consumer protection concepts (Chapter 4), as well as fixing the funding principle as a sociopolitical adjustment to protect older private insured (Chapter 5). Against the background of these developments, Chapter 6 analyses the modified relationship of PHI and SHI regarding the principles of solidarity and competition. Finally, the results are summarized and alternatives for the future organization of health insurance are proposed.

2 Health insurance and the role of welfare markets

The past decades have witnessed a tendency towards marketization in many fields of social policy. Looking at the German welfare state and especially health care policies, it seems that these changes run counter to its constitutive characteristics, which were often identified as conservative or corporatist (Esping-Anderson 1990; Pierson 2001). Even if many of these comparative studies focused on pension systems as well as labor market and family policies, for a long time, most notably the self-government of "Bismarckian" statutory health insurance was one of the central pillars of the German health care system. Self-administration became predominantly a field for corporatist representatives with relatively little transparency and democratic rights for SHI-insured. Political discourses of the 1980s and early 1990s have tended to focus on "reform blockades", "structural constancies", and "institutional stickiness" of corporatist decision-making and mutual self-government institutions (Mayntz 1990; Rosewitz/Webber 1990; Alber 1992; Pierson 2001). Yet the German health care system was much more market-based than was highlighted in welfare state research (e.g. the double-role of office-based physicians as associated doctors *and* freelancers with strong economic interests; the existence of private health insurances, to a certain extent hospitals in private ownership, a mainly market-based pharmaceutical sector etc.).

Since the early 1990s, however, the role of markets has grown in social policy. Issues of health policy have been analyzed under a variety of headings over the last 20 years. A range of health policy dichotomies like "State vs. Market" or "Regulation vs. Competition" have been discussed. Each was often presented as a choice between opposites, between incompatible concepts for constructing a health care system. When looking across German health care institutions, however, one sees no dichotomies, but rather a va-

riety of traditional and new models. They incorporate key elements of both aspects of theoretical dichotomies into pragmatic health care systems (Saltman 2001: 60). Already in the 1990s, the concept of “quasi markets” was used to analyze reforms of the National Health Service (NHS) in Great Britain (LeGrand 1991; Bartlett et.al. 1998). The “quasi-market” debates had in common a weak understanding of market elements on the supply and demand side. They considered that service suppliers are not necessarily out to maximize their profits, that they are not necessarily private owned, and that consumer purchasing power is not expressed in monetary terms (LeGrand 1991: 1260). Building on this, actual debates on social policies are strongly influenced by the concept of “welfare markets” (Taylor-Gooby 1999; Nullmeier 2001, Leisering et al. 2002). Especially the (German) welfare market research until today has tended to focus on pension reforms (“Riester-Rente”) and labor market reforms (“Hartz-Reformen”) established under the red-green government (1998-2005) rather than developments reached by recent health care reforms (Nullmeier 2001; Leisering et al. 2002; Berner 2004). Following a large tradition in policy research, the debate is dominated by a focus on the changing role of the state as well as new impacts of social-policy regulation:

“Welfare markets include all kinds of market-like structures aimed at the production or distribution of goods and services traditionally connected with the welfare state. But “welfare markets” still remain under the specific regulations of social politics to maintain social justice and social security” (Nullmeier 2006: 387).

The concept of welfare market obviously refers to an institutional arrangement as a consequence of recent welfare state reforms. What all concepts of welfare market have in common, however, is that market structures, such as competition, price elements, profit orientation, private ownership etc., are used to reach social-policy goals. From this point of view, social politics can not only be seen as “social politics *against* markets”, where national political activity protects the population against basic risks of markets, but rather as “social politics *with* markets”, where different kinds of regulated welfare markets are used as an instrument of social politics (Nullmeier 2001). In this context, the interdependencies of both (welfare) market structures and (socio-political) state interventions were highlighted in recent studies (Berner 2004; Bode 2005). These interventions might include different forms of socio-political regulations, such as social legislation, special forms of earmarked subventions, redistribution to a certain extent, as well as different forms of consumer protection and limitation of supplier’s market power.

Furthermore, it is important to note that welfare market debates in Germany solely gain importance as a result of marketization (“welfare markets still remain under specific regulations of social politics”). This predominant perspective relies on the theoretical deconstruction of the “traditional” social insurance. This academical one-sidedness can obviously be ascribed to some far-reaching reforms such as the Riester pension reform of 2001 and the Hartz labor market reform of the red-green government’s second legislative period. For the concept of welfare markets, however, it is hardly rele-

vant, whether “traditional” welfare state institutions (like statutory health insurance, statutory pension insurance etc.) are undergoing a process of marketization, or “traditional” market institutions (like private health insurance) receive new—and potentially stronger—socio-political interventions. Especially the German PHI with its centennial tradition was at all times an integral part of the social security system, but never a genuine component of the welfare *state* in a narrower sense.

From a general perspective, health care systems should be primarily intended to benefit the insured, patients and their dependants. Health is considered as a “conditional good”, whose “possession must be assumed”, so that humans can successfully exist and master their life (Kersting 2005: 144). The human desire for a long and healthy life reflects not least the social consensus that equal and need-related access to primary health care is guaranteed for everyone. These general findings might be shared by a predominant majority of humans. If access to primary medical care has to be need-related, the exclusive access by means of ability to pay a market price is excluded. Thus, a pure market-based system of access is refused by nearly all political forces. However, this normative approach encounters two fundamental difficulties: Firstly, the criterion of need has to be substantiated and secondly, the extent of distributive elements for primary health care has to be negotiated. Thus, a substantial disagreement exists about the extent of “basic” care and the amount of distributive elements in financing health insurance. Proponents of free market economy normally plead for minimalistic basic care with little redistribution, whereas proponents of solidarity usually favor an expansion of the benefit package including a high level of distribution.

According to this cleavage, each society has to define a common understanding of health and sickness. Without any doubt, terms like health and disease contain always a cultural, political and historical variability. They also depend on economic frameworks and progress in medical technology. Even if these factors are constant at a certain time in a society, the individual perception of health and disease will cause a subjective need of health care. Due to the fact that subjective needs have an “all embracing character” (Kersting 2005: 148), the objectification and standardization of “health” and “disease” is essential at the latest in terms of financing. Therefore, the individual subjective need has necessarily to be transformed into a common benefit package financed by the society. This procedure is always characterized by contingent results. Based on a common benefit package physicians will decide on health and disease by diagnosis. At last they receive a definition monopoly of social acceptance of individual diseases (Hajen/Paetow/Schumacher 2006: 18-19).

In Germany, substantiation of the relevant disease and the definition of need are given by the Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA). Based on the Social Code Book V (Sozialgesetzbuch V, SGB V) representatives of the Federal Association of SHI Physicians (Kassenärztliche Bundesvereinigung, KBV) and representatives of the SHI Associations negotiate the main health care budget and the statutory insurance benefits. According to §12 Social Code Book V, the benefit package has to

be sufficient, appropriate and efficient. This requirement is affirmed in §70 Social Code Book V and extended insofar as sickness funds and physicians have to guarantee a health care, which is needs-related, consistent, and which is commensurate with the (current) generally accepted medical expertise. Thus, the SHI benefit package has an indirect effect on the benefit package of the substitutional PHI. Due to the fact that PHI services have to be geared to the SHI benefit package, the Federal Joint Committee also determines the relevant conception of disease and need for private insured. To a certain extent, however, private insurers are allowed to offer a larger variety of benefit packages, cost-sharing tariffs, and differentiated premiums.

In spite of the general consensus that access to primary health care should not depend on income of a sick person, welfare markets are frequently used as a favorable institutional arrangement. In this context, great value is attached to the role of competition. Economic competition—as a necessary condition of functioning market processes—can be regarded as rivalry between participants of one market side. Hence, competition exists among different suppliers (e.g. insurance companies) and among different consumers (e.g. insured) (Nullmeier 2005: 109). Both sides can be separated analytically and provided with different competition intensities. There are also conceptions conceivable, where competition prevails on one side, whereas competition can be completely excluded on the other side. However, one of the basic conditions is that market participants of each side find uniform competitive conditions and an equal legal framework (Fuchs 2000: 43). By means of competition, market participants obtain different options and therefore freedom benefits. The freedom of choice can potentially protect from economic power, bad service achievements and low performance quality on the supplier's side (Olten 1995; Knieps 2001; Kerber 2003). Though the market-like arrangement of health insurance obviously only makes sense under the condition that insurance companies face a certain level of competition. Admittedly, competition develops merely the assumed advantages, if insurance companies have the right to create different products. If an equal access to primary medical care is desired (which needs necessarily a common benefit package), different contracts cannot be a parameter of competition. Thus, competition in this segment is limited to a relatively manageable field of product development.

3 Historical path dependency—the PHI as a German peculiarity

The coexistence of the dual insurance system can be regarded as a result of historical path dependencies. The origins of Germany's health care system date back to 1883, when the parliament passed a law that made health insurance mandatory for certain employees (mainly blue-collar workers of industries with low incomes) (Deppe 2005: 13). Those, who did not receive a mandatory insurance cover, were constrained to look for insurance alternatives. For this reason private health insurances were set up. Also after World War II, these dual structures of the German health care system have been retained. Until today the existence of substitutive PHI is a German character-

ristic (until 2006, only the Netherlands had a comparable health care system with a full insurance protection by statutory and private health insurances, for further information see Leiber/Manouguian 2009).

PHI generally follows different principles than SHI. The system of PHI includes a full insurance cover for approximately 10% of the population and a supplementary health insurance for another 9% of the population with SHI coverage. In 2006, approximately 8.5 million insured had private full-cover insurance (Verband der privaten Krankenversicherung 2007a: 16). People with full-cover consist of mainly three groups with usually the whole families falling into the respective category:

- Active and retired civil servants (teachers, university professors, employees in ministries etc.); members of this group are excluded from SHI protection as they are reimbursed by the government for at least 50% (up to 70% for retired civil servants, 70% for spouses, and 80% for children) of their private health care bills (allowance for civil servants). They have to purchase private insurance protection to cover the remaining sum. PHI companies are obliged to offer special suitable tariffs for civil servants.
- Self-employed people; they are free to choose statutory or private health insurance and may opt to become voluntary SHI members or fully PHI members.
- Employed people with an income above the annually adjusted threshold for compulsory insurance (3.975 Euro per month in 2007) are allowed to opt out of social health insurance.

Private health insurance is offered by 49 insurance companies, united in the Association of Private Health Insurance (Verband der privaten Krankenversicherung). The PHI Association is a powerful lobby group for various reasons. *Firstly*, the private insured normally are “good risks” in terms of income, professional status, educational level, and health status. These well organized groups (especially the German Association of Civil Servants (Deutscher Beamtenbund, DBB) and Confederation of German Employers (Bundesvereinigung der deutschen Arbeitgeberverbände, BDA)) have strong interests to defend their privileges in terms of health care protection. *Secondly*, the PHI Association keeps numerous lobbyist contacts with politicians, judges, and university professors. Most notably, the Christian Democratic Party/Christian Social Party (Christlich Demokratische Union/Christlich Soziale Union, CDU/CSU) and the Liberal Democratic Party (Freie Demokratische Partei, FDP) were always loyal allies, when it comes to defending the private health insurance sector against solidarity-orientated health care reforms in terms of financing and redistribution.¹ *Thirdly*, even the physicians—a further well organized and powerful lobby group—are interested in the continuance of the PHI. Due to the fact that private insured

¹ The unification of both SHI and PHI under the condition of more solidarity is predominantly forced by the Social Democratic Party (Sozialdemokratische Partei Deutschlands, SPD), the Greens (Bündnis90/Die Grünen), and the Left (Die Linke) under the catchword “citizens’ insurance” (“Bürgerversicherung”).

persons have to pay higher charge rates for medical treatment, these private patients are always welcome in every surgery (for details see Chapter 6).

In spite of the substitutive character of PHI, there are some structural differences between both systems. This concerns the legal structure (public bodies vs. insurance associations based on reciprocity/publicly listed companies), the mode of financing (pay-as-you-go principle vs. funding principle), the calculation of contributions (income-related vs. risk-related) as well as different provisions of services (in-kind-benefits vs. cost reimbursement) and remuneration of services (budgeted and non-budgeted fee-for-services). The SHI-typical inclusion of non-earning spouses and children up to a certain age, the obligation to conclude contracts, and the risk compensation scheme do not exist for PHI companies. According to this institutional arrangement, the German health care system holds an exceptional position: Although the substitutive character of PHI refers to the common benefit catalogue and therefore need is to be standardized, the fundamental principle of all citizens' equity in terms of financing is denied. Whereas for a vast majority of the population a certain level of solidarity is fixed, approximately 10% of all citizens are entitled to opt out of mandatory health insurance.

The relationship between SHI and PHI was frequently changed and regulated by law over the years. In the early 1970s, certain social groups were integrated into the statutory scheme, e.g. well-earning white collar workers (1970), farmers (1972) and students (1975). At the same time the statutory benefit catalogue was enlarged (Bandelow 2006: 161). The expansion of mandatory SHI insured limited the potential group of private insured with full cover protection, whereas the increasing entitlement to benefits restricted the business with supplementary insurance. Even the successive uprating of the income threshold for compulsory insurance had limited the potential clientele for substitutive private insurance (Rosenbrock/Gerlinger 2006: 103). Already in 1970, the income threshold for compulsory (health) insurance was fixed at the level of 75% of the assessable income limit of the statutory pension insurance. This agreement led to a preservation of the status quo and assured the durable coexistence of both insurance systems. However, this legislative agreement did not cause the end of state interventions. When the Health Care Reform Act (Gesundheitsreformgesetz, GRG) of 1988 came in force, the possibilities of returning from PHI to SHI were limited. A changeover from PHI to SHI was only permitted, if the annual income fell below the income threshold for compulsory insurance (Deppe 2005: 37). Thus the intention is to avoid people being privately insured while they are young, healthy and rich, and later on—as their health perhaps deteriorates with old age—returning to the solidarity-based SHI. The Competition Strengthening Act (Wettbewerbsstärkungsgesetz, WSG) of 2007 intervened again in the relationship of SHI and PHI. In the past, the insured person was allowed to change immediately from SHI to PHI, if the income threshold was exceeded. Now, the income of a voluntarily SHI insured has to exceed the income threshold in three successive years (Simon 2008: 161).

In spite of the political commitment to the dual insurance system, the past two decades have witnessed a tendency of convergence. For the SHI, this

development was characterized by the weakening of corporatist arrangements and a simultaneous strengthening of market-like *and* regulative instruments (Wasem 2005; Böckmann 2007). The era of cost containment already began in 1977, but at first without any structural reforms. From the early 1990s, various path-breaking reforms were implemented. The largest and strictest reform was the Health Care Structure Act (Gesundheitsstrukturgesetz, GSG) of 1992 (for further discussions see Lamping 1994; Döhler/Manow 1997; Kania/Blanke 2000; Bandelow 2004; Noweski 2004; Gerlinger 2009). The key elements of this reform act were the introduction of sectoral budgets and the implementation of free choice for almost all SHI insured and, consequently, competition between SHI sickness funds. Due to the fact that sickness funds were still obliged to conclude contracts with all mandatory and voluntarily SHI-insured people, a risk compensation scheme (Risikostrukturausgleich) to redistribute contributions among sickness funds was implemented. The mechanism of this risk compensation scheme should compensate disparities in income, age, sex and disabilities and the number of non-contributory insured dependents (Busse/Riesberg 2004: 195-196).² According to expert recommendations, the Act to Reform the Risk Structure Compensation Scheme in Statutory Health Insurance (Gesetz zur Reform des Risikostrukturausgleichs in der Gesetzlichen Krankenversicherung) of 2001 added further categories (namely the chronically ill persons enrolled for disease management programs) for risk adjustment. The recent Competition Strengthening Act of 2007 finally introduced a morbidity orientated risk compensation scheme in addition to the other criteria.

In the early 1980s, initial restrictions of the benefit package, such as co-payments for dentures, pharmaceuticals, and remedies were introduced. The health care reforms of the following decades led to an increasing amount of co-payments³. Presently, co-payments are implemented for dentures, pharmaceuticals, rehabilitative care, inpatient care, medical aid and, since the Health Care Modernization Act (Gesundheitsmodernisierungsgesetz, GMG) of 2004, for out-patient care. The “office-fee” of 10 Euro per quarter must be paid for the first consultation at a physician’s office and each consultation with other physicians without referral during the same quarter. Due to the fact that especially for patients with multi-morbidities or chronic diseases the increasing role of co-payments and benefit cuts can lead to serious problems, annual co-payments are limited to 2% of annual gross household income (1% for chronically ill patients). Additionally, the SHI sickness funds received further market-based possibilities to conclude contracts. One of these options for sickness funds is the introduction of “no-claim” bonuses

² Due to the fact that these criteria do not cause any expenditure *per se*, a major criticism of the current risk compensation scheme was the failing consideration of differences in morbidity (Lauterbach/Wille 2001; Jahn et.al 2009). With some empirical evidence it was demonstrated that even under the condition obligatory contract conclusion, risk selection is one of the most important strategies of SHI sickness funds (Höppner et.al. 2005)

³ Some of the co-payments and other market-based instruments were abolished with the *Act to Strengthen Solidarity in Statutory Health Insurance* (Solidaritätsstärkungsgesetz) of 1998 and the *Reform Act of Statutory Health Insurance* (GKV-Gesundheitsreformgesetz) of 2000. In 2004, most of these financial burdens were reintroduced, partly extended to further sectors and fixed on a higher level.

and deductibles as well as the right to offer private medical treatment with reimbursement tariffs.

All these developments are typical for private health insurance markets. For the SHI, this process of marketization means a successive approach to the PHI system. However, not only the SHI but also the PHI is undergoing significant changes. As one consequence of the European Third Non-Life Insurance Directive, the influence of socio-political state intervention has grown. The EU directive determines that an insurance company is allowed to pursue its business in the whole European Union without a separate permission of each member state. Consequently, an insurance company needs only the business permission of the relevant authority in the member state of the company's head office ("single license principle"). However, exceptions apply for mandatory insurances and substitutive health insurances (Glaeske/Rothgang 2005: 13-14). Thus, §54 of the European directive contains some special rules, which allow member states to enact special national regulations.

4 Decreed solidarity—from risk premiums to the basic tariff

The right to enact national regulations was initially used by the German legislator with the enlargement of §257 SGB V. This paragraph determines the employers' contribution for voluntary SHI insured and private insured. Since 1994, the receipt of the employers' contribution for private insured is linked with certain requirements. Therefore, these contributions can only be paid, if

- the insurance business is practised "according to the type of life-insurance" ("nach Art der Lebensversicherung")
- insurance companies participate in revenue sharing in case of high financial burdens
- private health insurances use a certain part of their profits for the benefit of the insured persons
- they waive their ordinary right of cancellation ("Verzicht auf das ordentliche Kündigungsrecht")
- they respect the principle of specialisation ("Gebot der Spartentrennung")
- they offer a so-called standard tariff for elderly private insured.

As a result of this regulatory framework, each European insurance company, which would like to transact business, has to follow the German rules of SGB V, otherwise they would not obtain the employers' contribution for private insured. These premiums would be twice as much as "normal" premiums and consequently, the European insurance companies were not competitive.

According to the increasing convergence of SHI and PHI, first and foremost the standard tariff is important. Since premiums still rise with age, and entry into SHI is not permitted in ordinary circumstances, private insurers

are obliged to offer the standard tariff. People with a continuous private coverage for at least 10 years, who are at least 65 years old or who are more than 55 years old and have an income below the threshold for compulsory insurance, are allowed to opt for this tariff. This option includes the standard benefit package of statutory health insurance combined with a premium no higher than the maximum contribution paid under statutory health insurance (Wendt/Rothgang/Helmert 2005: 16; Verband der privaten Krankenversicherung 2002). For married couples and civil unions, the highest payable premium is fixed at the maximum level of 1.5 of the maximum contribution paid under statutory health insurance. According to the allowance for active and retired civil servants, PHI companies are obliged to offer suitable standard tariffs for this subgroup (Verband der privaten Krankenversicherung 2002: 10-12). In 2006, about 25,000 private insured used the benefits of the standard tariff (Verband der privaten Krankenversicherung 2007a: 30).

With the Competition Strengthening Act of 2007, a general compulsory coverage was introduced by the grand coalition of CDU/CSU and SPD, even though the dual structure of SHI and PHI was retained. Therefore, all PHI companies are obliged to offer a new “basic tariff”, which supersedes the standard tariff from 2009. Nevertheless, the PHI companies have the continuing ability to calculate normal risk-related premiums. According to the former standard tariff, even the new basic tariff will offer a SHI-like protection and a maximum premium comparable to SHI maximum contribution. The main innovation involves abolishing all age limits regarding access. The new basic tariff is available for voluntarily SHI-insured, all PHI-insured, and all those, who “belong”—according to the German health care system—to PHI and currently do not have any insurance (e.g. former PHI insured self-employed people, who lost protection as a consequence of insolvency). Any kind of risk adjustment like age, sex or medical history at the time of concluding a PHI contract is forbidden by law. The basic tariff reflects only the average morbidity risks of all insured of one single PHI company- limited by the obligation that the tariff has to be cut at the level of maximum SHI contribution. With the basic tariff, all PHI companies have the duty to conclude contracts. The formation, organization and realization will be monitored by the Federal Authority for Financial Services Supervision (Bundesanstalt für Finanzdienstleistungsaufsicht, BaFin). Both the standard tariff and its replacement by the new basic tariff can be seen as an act of de-marketization and a perceived state responsibility to achieve defined social policy goals (for further information see Sodan 2006: 71-72; Kingreen 2007: 35-36; Simon 2008: 168-170).

With the obligation to offer a basic tariff, solidarity-based elements are partly introduced into the PHI system: The premiums are explicitly geared to the statutory contribution level, as well as the private remuneration for medical services is likewise related to statutory health care contracts. Within the limits of the basic tariff, no risk relations exist in terms of age, sex and state of morbidity (Kingreen 2007: 36). Furthermore, an obligation to conclude contracts including a financial risk compensation scheme comes in force. This development of socio-political regulation can be seen as a process of demarketization, because the basic tariff repeals the market-based

criterion “ability to pay” and weakens the principle of equivalence. Therefore, solidarity exists between private insured of the same company, because a comparable access to a standard benefit package without risk related premiums for a certain part of private insured has to be financed by all insurance members. Owing to the financial risk compensation scheme in terms of the basic tariff, solidarity also occurs among private insurance companies. Apart from prospective demands, the obligation to offer such a basic tariff according to SHI rules represents a strong state intervention.

5 Limitation of market power- socio-political consumer protection

Within the implementation of the European insurance directives the Insurance Contract Act (Versicherungsvertragsgesetz, VVG) was modified. The VVG generally rules the contractual relationship between insurers and insured. When the European directive came into force, the PHI was not explicitly mentioned by the VVG. Nevertheless, the general regulations (§§1-80 VVG) were applied for private health insurances (Thielbeer 1999: 36). The European directive induced the German legislator to renew the established VVG rules for substitutive PHI. The modernization came into force with some additions to §§ 178 VVG. Aim of the added articles §§ 178a-o VVG is to protect consumers from asymmetric market power. Thus, all included regulations are influenced by socio-political intentions. In 2008, the VAG was once again renewed and the former §§ 178 a-o VAG were transformed into §§ 192-208 VAG. It is regulated that substitutive private health insurance is for an unlimited period (§195; formerly §178a) and that the ordinary right to cancellation by the insurance company is excluded (§206; formerly §178i), whereas the insured are entitled to withdraw from an insurance contract (§195; formerly §178h). Waiting periods may last no longer than three months before coverage begins (§197; formerly §178c) and newborns of private insured are covered immediately, regardless of their health status (§198; formerly §178d). Additionally, insured persons are allowed to switch within the same PHI company, if cheaper tariffs are offered. Accrued rights and old age provisions have to be transferred to the new insurance tariff (§204; formerly §178f). Further rules are related to the duty of transparency (§202; formerly §178m) or to protect surviving dependents (§ 207; formerly §178n).

These regulations can be regarded as a socio-political consumer protection, which prescribes a minimum of distribution as well as limits the suppliers’ market power. With the determination of perpetual substitutive insurance cover and the protection against cancellation, the specific character of morbidity risk is considered. Therefore, a lifelong and constant insurance protection should be guaranteed even for private insured. From an economic point of view, market-based insurance protection is subjected to insolvency risks and cut-throat competition so that insurance companies potentially are not able to fulfill their contracts (Eilfort 1997: 30). Thus, the main goal of consumer policy is to regulate insurance contracts in a way that the life-long fulfillment of contracts is given. However, the current arrangement is cha-

racterized by an obvious contradiction: A successful market system is based on the principle of competition. This means, on the one hand, that non-competitive and inefficient suppliers have to drop out of the insurance market. On the other hand, insolvencies cannot be a desired result of market processes as long as a non-discriminatory changeover to another insurance company is not possible. Due to these findings, the right to switch within the same PHI company, provided that accrued rights are accepted and old age provisions are transferred (§204, formerly §178f), is too weak. This shortcoming might become increasingly important if health insurance in the future is based on market principles.

Due to the fact that the German PHI covers predominantly good risks, the problem of insolvencies has currently no empirical evidence. Despite this empirical argument, the theoretical contradiction—and at least in consideration of financial crisis the factual menace—cannot be overseen. For this reason, the PHI companies built up private and mutual insolvency insurance (the so-called Medicator AG) in 2003. The cause of this voluntary agreement was the incipient deterioration of stock markets and the cutback of interest rates, which leads to distinct problems in the whole class of insurance (Sahmer 2006: 40). The constitution of this security fund was also an important strategy of the PHI Association to demonstrate that a potential insolvency would not lead to a breach of private health insurance contracts. In 2006, the German legislator passed a law that makes the membership of a (statutory or private) security fund compulsory. As expected, the PHI Association decided to retain the Medicator AG as a private solution.

6 The PHI—a market without competition

The Insurance Supervision Act (Versicherungsaufsichtsgesetz, VAG) governs the relationship between the supervision authority and the PHI companies. It contains instructions for business operations as well as terms of premium calculation. When the European directive came into force, the VAG was implemented to substitute former national regulations, which were no longer acceptable. Even in this case, the opportunity to renew the national regulatory framework according to §54 of the EU directive was extensively used by the German legislator (Präve 2005: 283).

Private health insurance follows the *principle of equivalence*: Risk-related premiums vary with age, sex and medical history at the time of concluding a PHI contract. Consequently, high risks are encountered by higher premiums due to risk adjustment, exclusion of services, and in some cases by denial of contracts (Rothgang/Cacace 2005: 12). It is important to notice that insurers assess the insured's risk once at the beginning of the contractual relationship. However, insurers are not allowed to reassess the individual health risk during the insurance contract or to cancel the contract. Private health insurance contracts are generally intended to cover protection for the whole of the insured's lifetime. According to this consumer policy regulation, the private insurance, as well as the statutory insurance, has to waive its right of cancellation. The VAG determines that insurance business has to

be practiced “according to the type of life-insurance” (“nach Art der Lebensversicherung”). Therefore, the calculation of premium has to be made on actuarial basis. The required statistical data have to be provided by the Federal Authority for Financial Services Supervision (Bundesanstalt für Finanzdienstleistungsaufsicht, BaFin). Another aspect of VAG regulation is that premiums must be calculated using the capital funding method. Whereas SHI is financed on a pay-as-you-go basis, PHI is financed on both pay-as-you-go and funded systems. Due to the fact that under the condition of age-related premiums and “total equivalence” PHI premiums would rise immensely with age, private health insurers are obliged to accumulate old age provisions. Hence, premiums are higher than the risk when insured persons are young, (but they are still lower than comparable contributions of SHI) and lower than the risk when insured persons are old (Meyer 1997). The obligation to accumulate old-age-provisions is a kind of market-based, but socially motivated regulation of the German PHI to keep the premiums for elderly as low as possible (combined funding method instead of pure pay-as-you-go principle). In theory, premiums are not supposed to increase in later life. However, in fact they have to be adjusted on occasion in terms of increasing health care expenditures in general.

In the context of welfare market and the politically forced health care target “free choice of insurance company”, a further yet unsolved problem can be identified. Owing to the principle of equivalence, especially the elderly face not only serious problems of rising premiums but also competitive restrictions. It is a political desire, that welfare markets are based on competition between suppliers. Thus, it has to be a constitutional right of the insured to change the insurance company at any time. Due to risk related premiums, private health insurances face de facto a serious lack of competition: After a short period, a changeover to another PHI company does not make any sense or is almost impossible for those privately insured. Due to increased age and a possible lower health status, each insurance company will implement a new medical risk assessment, which leads necessarily to higher premiums or at worst the denial of contracts. Thus, older insured persons normally have no alternatives if they wish to change to another private health insurance company.

This lack of competition is intensified by another problem. Currently, neither an individual nor an average old age provision is transferable to a normal risk-related tariff of another health insurance company in case of a desired changeover. In recent years, a number of expert commissions tried to find a satisfactory solution to this problem, so far without any proper results (for further detailed information see: Deutscher Bundestag 1996; Kommission zur Reform des Versicherungsvertragsrechts 2004; Meyer 2004; Depenheuer 2006; Thüsing/Kämmerer 2006). Consequently, after a short time of PHI membership, a free choice of PHI companies is not possible. This “defect” leads to a paradox situation: While every SHI insured is allowed to change a statutory sickness fund, PHI insured face a situation without choice and, consequently, without competition between “market-based” private health insurance companies.

With the Competition Strengthening Act of 2007, the PHI companies were initially obliged to make old age provisions transferable in general. Under the influence of strong lobbyist interventions by the PHI Association, the German legislator implemented some important exceptions: PHI members with contracts existing before 2009 are allowed to change. A potential changeover, however, is only permitted for a scheduled period of six months (from 01.01.2009 to 30.06.2009). Additionally, a desired change leads automatically and solely to the new (and relatively expensive) basic tariff, whereas a changeover with an individual old age provision to another “normal” risk-related tariff is not accepted. Thus, a changeover is definitely not a rational choice. In summary, the new regulation will remain without a serious competitive effect.

In spite of these improvements for the insurance companies achieved by lobbyist interventions, the PHI Association has filed a complaint of unconstitutionality against all regulations of the 2007 Competition Strengthening Act concerning the PHI:

- the new basic tariff in general
- the obligation to make old age provisions transferable
- the clause that the income of a voluntarily SHI insured has to exceed the income threshold in three successive years.

In June 2009, the whole complaint of unconstitutionality was dismissed by the Federal Constitutional Court (Bundesverfassungsgericht, BVerfG).

7 Convergence and difference—continuous risk selection between SHI and PHI

Even if both health insurance systems face a development of convergence, the separation of PHI and SHI was retained (Leiber 2007: 17). In spite of the partial approximation “good risks” will continue to switch into PHI. SHI membership is still mandatory for employees whose gross income does not exceed a level of 3,975 Euro per month in 2007 and voluntary for those above that level. Even self-employed are not compulsory insured, but they are allowed to choose whether to stay voluntarily in SHI or opt out into PHI. All voluntary insured have to pay their contributions according to their economic ability up to the assessable income limit. According to the income-related SHI system, this group pays a relatively high amount of contributions compared to people with lower incomes. Due to the fact that PHI premiums are risk-related (and not income-related), especially the healthy voluntary insured face a strong incentive to opt out and transfer to PHI. However, the exacerbated conditions for change-over (e.g. waiting period of three years since 2007) do not convert the general incentives of risk selection.

Comparable incentives take place if one looks at dependants insurance. While SHI contributions include non-earning spouses and children up to a certain age without any surcharges, PHI premiums have to be paid separately for each family member. Therefore, those insured with children and fami-

ly will tend to remain in the SHI, whereas private insurance cover is especially attractive for single people or double income couples (Busse/Reisberg 2004: 78-79). Finally, risk selection exists between men and women. While SHI contributions make no difference between male and female insured, the calculation of PHI premiums incorporates different health risks in terms of sex. Thus, in 2006 the quota of men (without allowance for civil servants) is about 2.4 times higher compared to women (Verband der privaten Krankenversicherung 2007b: 12).

In terms of solidarity, this kind of risk selection is a serious problem insofar as mainly the strongest statutory insurance members are allowed to abscond from redistribution. Against this criticism, political advocates of PHI often remark that SHI members receive “crosswise subventions” (Niehaus/Weber 2005; Verband der privaten Krankenversicherung 2008: 13-14). They argue that these “subventions” result from private insured’s higher prices for medical treatment for the assumed benefit of statutory insured. In fact, private insured generally have to pay providers such as physicians, dentists or pharmacists directly. This payment is reimbursed by their insurer (principle of cost reimbursement). For privately delivered medical services, a price list exists as an ordinance issued by the Federal Ministry of Health, which is advised by Federal Physicians’ Chamber (Bundesärztekammer). For physicians and dentists, the catalogue for private tariffs is based on fee-for-service. In the Catalogue of Tariffs for Physicians (Gebührenordnung für Ärzte, GOÄ) and in the Catalogue of Tariffs for Dentists (Gebührenordnung für Zahnärzte, GOZÄ), each procedure is given a tariff number and a certain amount of points. Each point has a defined point value. Unlike SHI, there is no budget restriction in these private catalogues. A further important difference is the fact that physicians and dentists are allowed to charge a higher rate, by a factor of 1.7 or 2.3 up to 3.5 for special medical services. The usual charge rate for private liquidations is 2.3.

Contracting partnerships only exist between insurees and private health insurances and privately insured patients and physicians, but—unlike SHI—not between PHI and physicians (Busse/Riesberg 2004: 79-80; 182-183). Consequently, the per-capita-expenditures for private insured persons rose by 43% between 1992 and 2001 (SHI: 30% between 1992 and 2001) (Deutscher Bundestag 2003). The increasing PHI expenditures might hardly be caused by deterioration of private insured’s morbidity. It seems rather that some physicians try to compensate SHI budgets with a strategy of enlargement of services due to asymmetrical information (“supplier-induced demand”). Even if private insured have to pay higher remunerations for medical treatment, two serious problems exist with the argument of “crosswise subventions”: Firstly, there is no possibility to quantify the benefits for statutory insured. Secondly, “crosswise subventions” could possibly, though not necessarily, lead to improved welfare services for statutory insured. The usage of these physicians’ incomes defies control from public, politicians and insurance companies.

Additionally, the argument of “system competition” between both PHI and SHI is often brought forward. This pronouncement suggests that not only insurance companies, but also insurance systems compete. Due to the

undeniable fact of risk selection between statutory and private insurance system, this argument is not convincing. Competition of systems should be characterized by freedom of choice. In reality, most of the insured persons have no choice of sickness funds: All mandatory SHI insured are not allowed to changeover into PHI. Even civil servants have no choice to opt for statutory protection, because they would lose the 50% allowance for civil servants paid by the respective public employer. Moreover, the competition for all those, who are free to choose, proceeds under distorted conditions (Jacobs/Schulze 2004: 8-10). As long as these structures still remain, risk selection will be an ongoing issue.

8 Conclusion

In the past two decades, a development of convergence of SHI and PHI took place. However, this process did not lead to a complete equalization of the German insurance landscape. For the SHI, this convergence exists in a trend of marketization including managed competition and regulated price-elements such as co-payments, no-claim bonuses, or cost-sharing tariffs. For the PHI, this convergence exists in the obligation to implement elements of solidarity and “social” consumer protection. In terms of demarketization, especially the new basic tariff can be regarded as a weakening of market instruments. The governmental obligation to conclude contracts with the relevant group as well as the limitation of premium costs is maybe one of the strictest state interventions in customary business operations of substitutive private health insurances. The order to comply with social consumer protection, however, is a heterogeneous kind of embedding of welfare markets. On the one hand, the VVG regulation is a process of demarketization insofar as the voluntariness of concluding contracts is restricted (e.g. newborns of private insured; the waiving of cancellation etc.) as well as these regulations content, to a certain extent, an obligation of redistribution (protection of surviving dependents; the former standard tariff; the new basic tariff). On the other hand, the startup of the new insolvency insurance Mediator AG can hardly be seen as a process of demarketization.

The non-transferability of old age provisions is maybe the most complicated analysis in terms of welfare markets. First of all the principle of equivalence and the application of risk-related premiums has to be regarded as a welfare market structure with insured on the demand side and insurance companies on the supply side. From an analytical perspective, it is not necessary that risk-related premiums accompany with capital funding. In reality, health expenditures increase over the years, whereas incomes normally decrease with retirement. Therefore, it is a socio-political regulation that private health insurance companies have to accumulate old age provisions. Due to the difficulties of transferability, competition between private insurance companies is hardly realized.

A further lack of competition has to be criticized in terms of the statutory and private insurance system. In this article, it was shown that both SHI and PHI converge to a certain extent. Nevertheless, the asymmetric competition

between SHI and PHI has not been altered. The lack of competition on the supply side is a problem insofar, as the equal access to a defined benefit package is politically desired, but a common responsibility for financing expenditure is not required. Thus, risk selection is still a major problem between SHI and PHI, which systematically contributes to the erosion of the SHI income-related revenues. Competition is contingent on consistent competitive conditions on the supply side; solidarity needs a common responsibility to finance social security.

Even if these results cannot be satisfying, the general tendency to unify both systems has to be approved. Proponents of solidarity will support the abolishment of two-tier medical care, whereas proponents of competition should recommend the standardization of equal competitive preconditions. In spite of this integrative potential, various reasons exist, why different principles such as solidarity and competition should not be unified in a common institutional arrangement. One result of this welfare market analysis might be that wherever welfare markets are used to reach social policy goals, these systems are subject to strong pressure. Maybe more attention should be paid to the following shortcomings:

Firstly, the increasing complexity of differentiated market products and the intensified need for regulation of market failures leads to a decreasing acceptance of welfare state institutions. This argument gains importance, if insured persons have to cope with benefit cuts and additional financial burdens. Certainly, the present welfare state has not to be maintained per se, but most notably the analysis of the German PHI highlights some difficult interdependencies of welfare markets and regulation. *Secondly*, in terms of primary health care and basic insurance protection, the role of welfare markets and competition seems to be overestimated. If one shares the argument of equal access to a common benefit package, the efficiency of competitive welfare markets depends on little scope of product development. *Thirdly*, a further health care target cannot be reached satisfactorily. Under the condition of competition, preventive investment in someone's health is, from an insurance company's perspective, not rational. Due to the fact that prevention causes costs today, but possible positive results of prevention become visible after many years, the investments in prevention of diseases are remarkably low. *Fourthly* and at least, the request for market and competition ignores the fact that even regulation causes some costs. This includes rule-making, monitoring, and enforcement. Even the necessity to gain information results in higher cost, which have to be paid by citizens, contributors or tax-payers. Even if supporters of more market-based coordination will quickly criticize any continuing major role of regulation, especially the health care sector will never go without a minimum of regulation, solidarity and consumer protection.

References

- Alber, Jens (1992): Das Gesundheitswesen der Bundesrepublik Deutschland. Entwicklung, Struktur und Funktionsweise. Frankfurt/ New York.

- Bandelow, Nils C. (2004): Akteure und Interessen in der Gesundheitspolitik: Vom Korporatismus zum Pluralismus? In: Politische Bildung 37/2. 49-63.
- Bandelow, Nils C. (2006): Gesundheitspolitik: Zielkonflikte und Politikwechsel trotz Blockaden. In: Schmidt, Manfred G./ Zohlnhöfer, Reimut (Hrsg.): Regieren in der Bundesrepublik Deutschland. Wiesbaden. 159-176.
- Bartlett, Will/ Roberts, Jennifer A./ LeGrand, Julian (1998): A Revolution in social Policy. Quasi-market reforms in the 1990s. Bristol.
- Berner, Frank (2004): Wohlfahrtsmarkt und wohlfahrtsstaatliches Arrangement. Marktstrukturen und sozialstaatliche Einbettung der kapitalgedeckten Altersvorsorge in Deutschland. Bielefeld (REGINA-Arbeitspapier Nr. 6).
- Böckmann, Roman (2007): Von der Selbstverwaltung zum regulierten Gesundheitsmarkt. Der gesundheitspolitische Steuerungswandel im ambulanten Sektor. Diskussionspapier 01/07 der Graduate School of Politics (GraSP) der Universität Münster. Reihe PoliThesis. [URL: www.uni-muenster.de/GraSP/forschung/Polithesis.html] (10.08.2008)
- Busse, Reinhard/ Riesberg, Annette (2004): Health Care Systems in Transition. Germany. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies. Copenhagen.
- Deppenheuer, Otto (2006): Verfassungsrechtliche Grenzen einer Portabilität von Altersrückstellungen in der Krankenversicherung. Köln.
- Deppe, Hans-Ulrich (2005): Zur sozialen Anatomie des Gesundheitswesens. Neoliberalismus und Gesundheitspolitik in Deutschland. Frankfurt.
- Deutscher Bundestag (1996): Unterrichtung durch die Bundesregierung. Gutachten der Unabhängigen Expertenkommission zur Untersuchung der Problematik steigender Beiträge der privat Krankenversicherten im Alter. Bonn.
- Deutscher Bundestag (2003): Schriftliche Fragen mit den in der Woche vom 27. Oktober 2003 eingegangenen antworten der Bundesregierung. Berlin.
- Döhler, Marian/ Manow, Philip (1997): Strukturbildung von Politikfeldern. Das Beispiel bundesdeutscher Gesundheitspolitik seit den fünfziger Jahren. Opladen.
- Eilfort, Susanne (1997): Der Verbraucherschutzgedanke in der deutschen privaten Krankenversicherung nach der Dritten Richtlinie Schadenversicherung- Die Entscheidungsgeschichte der Richtlinie und rechtspolitischer Ausblick. Berlin.
- Esping-Andersen, Gøsta (1990): The Three Worlds of Welfare Capitalism. Cambridge.

- Fuchs, Maximilian (2000): Wettbewerb zwischen privaten und öffentlichen Krankenversicherungen. In: Zeitschrift für Sozialreform (4/2000): Das Gesundheitswesen in der Wettbewerbsordnung. Heft 4; 39-52.
- Gerlinger, Thomas (2009): Wettbewerb und Patientenorientierung in der gesetzlichen Krankenversicherung. In: Böckmann, Roman (Hrsg.): Gesundheitsversorgung zwischen Solidarität und Wettbewerb. Wiesbaden. 19-41.
- Glaeske, Gerd/ Rothgang, Heinz (2005): Differenzierung privater Krankenversicherungstarife nach Geschlecht: Bestandsaufnahme, Probleme, Optionen. Gutachten für das Bundesministerium für Familie, Senioren, Frauen und Jugend. Bremen.
- Hajen, Leonhard/ Paetow, Holger/ Schumacher, Harald (2006): Gesundheitsökonomie. Strukturen-Methoden-Praxisbeispiele. Stuttgart.
- Höppner, Karin/ Greß, Stefan/ Rothgang, Heinz/ Wasem, Jürgen/ Braun, Bernard/ Buitkamp, Martin (2005): Grenzen und Dysfunktionalitäten des Kassenwettbewerbs in der GKV: Theorie und Empirie der Risikoselektion in Deutschland. Bremen.
- Jacobs, Klaus/ Schulze, Sabine (2004): Systemwettbewerb zwischen gesetzlicher und privater Krankenversicherung: Idealbild oder Schimäre? In: Gesundheit und Gesellschaft Wissenschaft 1/2004. 7-18.
- Jahn, Rebecca/ Staudt, Susanne/ Wasem, Jürgen (2009): Verbesserung des Risikostrukturausgleichs als Instrument zur Sicherung der Balance zwischen Solidarität und Wettbewerb. In: Böckmann, Roman (Hrsg.): Gesundheitsversorgung zwischen Solidarität und Wettbewerb. Wiesbaden. 43-61.
- Kania, Helga/ Blanke, Bernhard (2000): Von der „Korporatisierung“ zum „Wettbewerb“. Gesundheitspolitische Kurswechsel in den Neunzigerjahren. In: Czada, Roland/ Wollmann, Hellmut (Hrsg.) (2000): Von der Bonner zur Berliner Republik. 10 Jahre Deutsche Einheit. Wiesbaden. 567-591.
- Kerber, Wolfgang (2003): Wettbewerbspolitik. In: Bender, Dieter (Hrsg.): Vahlens Kompendium der Wirtschaftstheorie und Wirtschaftspolitik. Bd. 2; München. 297-361.
- Kersting, Wolfgang (2005): Kritik der Gleichheit. Über die Grenzen der Gerechtigkeit und der Moral. Weilerswist.
- Kingreen, Thorsten (2007): Europarechtliche Implikationen des Entwurfs eines Gesetzes zur Stärkung des Wettbewerbs in der Gesetzlichen Krankenversicherung (GKV-Wettbewerbsstärkungsgesetz- GKV-WSG). Rechtsgutachten für den Deutschen Gewerkschaftsbund und die Hans-Böckler-Stiftung. Regensburg.
- Knieps, Günter (2001): Wettbewerbsökonomie. Regulierungstheorie, Industrieökonomie, Wettbewerbspolitik. Berlin/ Heidelberg/ New York.

- Kommission zur Reform des Versicherungsvertragsrechts (2004): Abschlussbericht vom 19.04.2004.
- Lauterbach, Karl/ Wille, Eberhard (2001): Modell eines fairen Wettbewerbs durch den Risikostrukturausgleich. Sofortprogramm „Wechslerkomponente und solidarische Rückversicherung“ unter der Berücksichtigung der Morbidität. Köln/Mannheim.
- Lamping, Wolfram (1994): Selbstverwaltung und Parafiskalität: Die gesetzliche Krankenversicherung im politischen Ausgleich sozialer Risiken. In: Blanke, Bernhard (Hrsg.) (1994): Krankheit und Gemeinwohl. Gesundheitspolitik zwischen Staat, Sozialversicherung und Medizin. Opladen. 75-109.
- Le Grand, Julian (1991): Quasi-Markets and Social Policy. In: *The Economic Journal*, 101; 1256-1267.
- Leiber, Simone (2007): Paradigmatic Change in Social Insurance Countries? Assessing Recent Health Care Reforms in Germany, the Netherlands and Austria. Düsseldorf (ESPAnet Conference Paper 2007).
- Leiber, Simone/ Manouguian, Maral-Sonja (2009): Vereinbarkeit von Wettbewerb und Solidarität in der sozialen Krankenversicherung? Gesundheitsreformen in den Niederlanden und Deutschland. In: Böckmann, Roman (Hrsg.): Gesundheitsversorgung zwischen Solidarität und Wettbewerb. Wiesbaden. 175-202.
- Leisering, Lutz/ Davy, Ulrike/ Berner, Frank/ Schwarze, Uwe/ Blomeke, Patrick (2002): Vom produzierenden zum regulierenden Wohlfahrtsstaat. Eine international vergleichende und interdisziplinäre Studie des Wandels der Alterssicherung in Europa. Bielefeld (REGINA-Arbeitspapier Nr. 2).
- Mayntz, Renate (1990): Politische Steuerbarkeit und Reformblockaden: Überlegungen am Beispiel des Gesundheitswesens. In: *Staatswissenschaften und Staatspraxis* 1. Jg./Nr. 3; 283-307.
- Meyer, Ulrich (1997): Langfristige Versicherungsverhältnisse in der Privaten Krankenversicherung. In: Männer, Leonhard (Hrsg.): Langfristige Versicherungsverhältnisse. Ökonomie, Technik, Institutionen. Karlsruhe. 177-201.
- Meyer, Ulrich (2004): Sondervotum zum Abschlussbericht der Kommission zur Reform des Versicherungsvertragsrechts bezüglich der Übertragbarkeit der Altersrückstellung in der PKV. Bamberg.
- Niehaus, Frank/ Weber, Christian (2005): Der überproportionale Finanzierungsbeitrag privat versicherter Patienten zum Gesundheitswesen. Köln.
- Noweski, Michael (2004): Der unvollendete Korporatismus. Staatliche Steuerungsfähigkeit im ambulanten Sektor des deutschen Gesundheitswesens. Berlin.
- Nullmeier, Frank (2001): Sozialpolitik als marktregulative Politik. In: *Zeitschrift für Sozialreform* 47 (6). 645-668.

- Nullmeier, Frank (2005): Wettbewerb und Konkurrenz. In: Blanke, Bernhard/ Bandemer, Stephan von/ Nullmeier, Frank/ Wewer, Göttrik (Hrsg.): Handbuch zur Verwaltungsreform. Wiesbaden. 108-120.
- Nullmeier, Frank (2006): Personal Responsibility and it's Contradiction in Terms. In: German Policy Studies. Volume Three, No. 3. 386-399.
- Olten, Rainer (1995): Wettbewerbstheorie und Wettbewerbspolitik. München/ Wien.
- Präve, Peter (2005): Zweiter Teil. Kommentierung. Gesetz über die Beaufsichtigung der Versicherungsunternehmen (Versicherungsaufsichtsgesetz- VAG). I. Einleitende Vorschriften (§§ 1-4) und II. Erlaubnis zum Geschäftsbetrieb (§§ 15-53b). In: Kollhosser, Helmut (Hrsg.): Versicherungsaufsichtsgesetz. München. 21-371.
- Pierson, Paul (2001): Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies. In: Pierson, Paul (ed.): The New Politics of the Welfare State. Oxford. 410-456.
- Rosenbrock, Rolf/ Gerlinger, Thomas (2006): Gesundheitspolitik. Eine systematische Einführung. Bern.
- Rosewitz, Bernd/ Webber, Douglas (1990): Reformversuche und Reformblockaden im deutschen Gesundheitswesen. Frankfurt a.M./ New York.
- Rothgang, Heinz/ Cacace, Mirella (2005): Fair financing in Germany's public health insurance: Income-related contributions or flat-premiums? TransState Working Papers 26. Bremen.
- Saltman, Richard B. (2001): Regulation, Competition, and Governance in European Health Care Systems. In: Henke, Klaus-Dirk/ Dräger, Christian (Hrsg.): Gesundheitssysteme am Scheideweg: Zwischen Solidarität und Wettbewerb. Baden-Baden. 58-67.
- Sahmer, Sybille (2005): Privatversicherte künftig auch bei Insolvenz geschützt. In: PKV Publik 4/2005.
- Simon, Michael (2008): Das Gesundheitssystem in Deutschland. Eine Einführung in Struktur und Funktionsweise. Bern.
- Sodan, Helge (2006): Private Krankenversicherung und Gesundheitsreform 2007. Verfassungs- und europarechtliche Probleme des GKV- Wettbewerbsstärkungsgesetzes. Berlin.
- Taylor-Gooby, Peter (1999): Markets and Motives. Trust and Egoism in Welfare Markets. *Journal of Social Policy* 28, 97-114.
- Thielbeer, Markus (1999): Notwendigkeiten, Möglichkeiten und Grenzen einer Deregulierung in der privaten Krankenversicherung. Eine ordnungsökonomische Analyse. Bayreuth.
- Thüsing, Gregor/ Kämmerer, Jörn Axel (2006): Vertragsfreiheit und Wettbewerb in der privaten Krankenversicherung. Verfassungsrechtliche und europarechtliche Grenzen für die Umsetzung der Gesundheitsreform. Bonn/Hamburg.

- Verband der privaten Krankenversicherung (2002): PKV und Recht. Allgemeine Versicherungsbedingungen (AVB) für den Standardtarif im Sinne des § 257 Abs. 2a SGB V. Köln.
- Verband der privaten Krankenversicherung (2007a): Zahlenbericht der privaten Krankenversicherung 2006/2007. Köln.
- Verband der privaten Krankenversicherung (2007b): Rechenschaftsbericht der privaten Krankenversicherung 2006. Köln.
- Verband der privaten Krankenversicherung (2008): “Zwei-Klassen-Medizin”. Behauptungen und Wahrheit. Ein Beitrag zur Versaachlichung der Diskussion. Köln.
- Wasem, Jürgen (1995): Gesetzliche und private Krankenversicherung—auf dem Weg in die Konvergenz? In: Sozialer Fortschritt 44. Jg., Heft 4. 89-96.
- Wendt, Claus/Rothgang, Heinz/Helmert, Uwe (2005): The self-regulatory German health care system between growing competition and state hierarchy. TranState Working Papers. No. 32. Bremen.