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Insurance in Health Care, Part II

Voluntary Health Funds

At the time of adoption of the Act, health funds already had the potential that is in the highest demand in the health care system: to allow a broad spectrum of individuals to obtain higher-standard health care services in an organised framework and making use of a tax benefit.

Mutual funds are organisations which, in accordance with the operating principles set out in the Mutual Funds Act, organise and provide to their members or to their close relatives social or health protection services supplementary to, or, under conditions set out in a separate act, replacing social insurance or other social benefits. Along the lines of the three pillars the state regime, voluntary funds may serve one of three objectives. The key feature of all three is self-care; that is, the services available through the voluntary fund are strictly tied to contributions paid; no funding in excess of the contributions is available on a 'charity' basis.

This follows from the fact that funds can be established by 15 natural persons, without any requirement for founding capital or solvency. Accordingly, the fund finances its operations from member contributions and may provide services exclusively up to the amount held on the individual member accounts.

The pension fund is meant to supplement the state pension, the health fund supplements or replaces social security services, while voluntary mutual funds may be useful in unexpected financial difficulties in the family (e.g. unemployment, child birth). Importantly, if the fund member dies, the entire sum on his individual account can be inherited.

These two factors (the capacity to be inherited and the close link between the benefits used and contributions paid) is the main difference between the operational principles of the social security system and of health funds

The act, passed unanimously by Parliament in 1993, introduced a new legal concept into the Hungarian legal system, that of the institution of voluntary mutual insurance funds. It was modelled after the *mutalité*, which has a history of several hundred years in France, and which has become an organic part of the social security system in several areas of service, relying on the principle of self-governance. This was one of the motives of the legislators at the time to adopt the fund concept, defining the concept of recognised funds in the law. As is known, the pension reform of 1997 made this concept a reality when modelling the second pillar of the state pension system on voluntary pension funds, creating private pension funds.

Place of the voluntary health funds in the management of social risks

The place of social security, sickness insurance and health funds in the five-pillar Hungarian health-care financing regime

The Parliamentary Resolution No 60/1991 (X.29) adopted 20 years ago declared that in the best case scenario the pensions, health and accident benefits and social benefits of citizens should come from five sources, as listed below.

- The first one is the dominant element of social security: the mandatory and universal social insurance, with a significant part of the Hungarian population being direct 'members' as insured persons or relatives of insured persons. It has the function of providing the so-called 'fundamental services' dependent on the payment of contributions as required in uniform regulations. Compliance with and enforcement of this principle is one of the key elements of the current reform.
- The second source, meant to satisfy primarily social needs, is the social benefit system provided by the central and local governments.
- The third source consists in the 'supplementary' private insurance products offered, in addition to the SS system, by private (and non-profit) insurance undertakings.
- The fourth source consists of self-organised, provident institutions such as foundations, associations and clubs.
- Act XCVI of 1993 created the fifth source: the voluntary mutual supplementary health fund.

Institutional forms of access to health care benefits in Hungary

The institutions managing the risks arising from altered health conditions and their main characteristics are summarised in Table 1. It allows for the clear definition of the place and role of voluntary health mutual in the financing of health care services.

In this paper, we understand health mutual to mean the voluntary mutual health funds operating pursuant to Act XCVI of 1993 on voluntary mutual insurance funds. The purpose of health funds is to supplement or replace the social security services of the time with a view to preserving the health of fund members and their relatives.

Figure/Table 1
Institutions of access to health care benefits

Institution managing the risk	*benefit*	*scope of eligible/insured persons*	*Cost bearer*	*does the service recipient contribute to the costs of service*
1. provision of welfare benefit through the state institutions specified in the Social Act	social assistance	Specified in law	State	No
2. Charities	social assistance	in accordance with the objectives of the charity	charity (or NGOs in the broader sense)	No
3. financing of a specific part of sickness risks	Sick leave paid by employer	employees of the employer	employee	yes, with the part of the health

Institution managing the risk	*benefit*	*scope of eligible/insured persons*	*Cost bearer*	*does the service recipient contribute to the costs of service*
directly by the employer (e.g., sick leave for the first 15 days of illness)		concerned		benefit not financed by the employer - a grey area
4. management of sickness risks within the mandatory social security system	Curative-preventive services of social security	Specified in law	employee and employer	contribution payers: yes, non-payers: no
5. voluntary health funds	health services supplementary or additional to, or replacing, current social security services	Fund members	employer and/or employee	Employer funding: no; employee funding: yes
6. management of sickness risks based on contractual relationship within the framework of commercial sickness insurance	sickness insurance purchased from commercial insurer	insured person specified in the policy	employer and/or employee	Employer funding: no; employee funding: yes

Nature of risks concerning health status

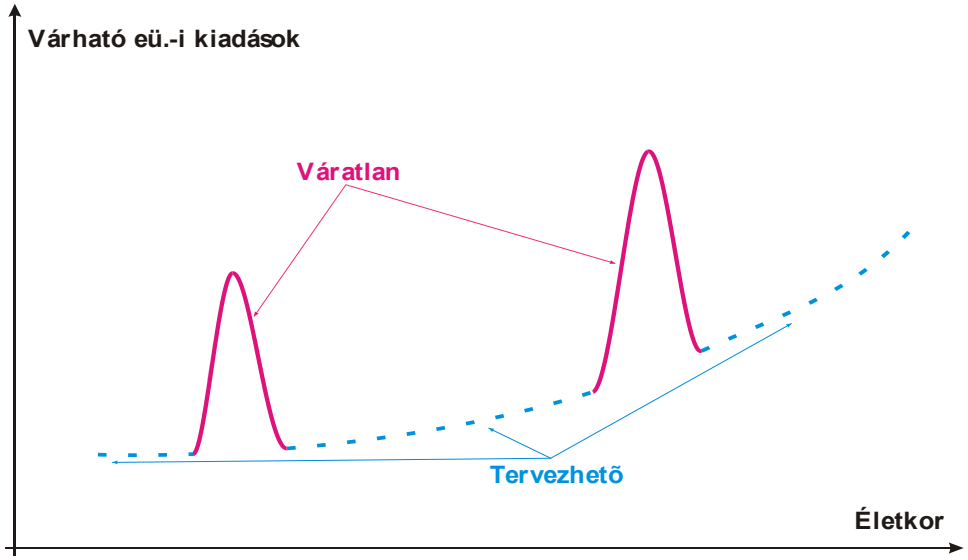
Most people have a high regard for the attainment or preservation of health. This comes to the fore particularly when problems arise: when we are taken ill. As the saying goes: I will spare no costs to recover.

Still, do we know in advance how much we will pay to preserve or restore our health? While some of the costs can be planned, another part is essentially random.

- On the one hand, we are fully aware that as we get older, the chances of getting ill increase, thus the related expenditures will also grow. This foreseeable category contains genetic deceases as well.
- On the other hand, on the level of the individual the onset, timing and severity of illnesses is random, and so is the response of the individual to customary treatments. Consequently, the cost of the treatment as well as the absence from work due to sickness, or other losses resulting from changes in circumstances, are to be considered random.

The figure below shows the change in health care expenditure with age.

Figure/Table 2
Change of health care expenditure as a function of age



Várható eü.-i kiadások	Expected health expenditures
Váratlan	Unexpected
Tervezhető	Plannable
Életkor	Age

Costs and losses cover a broad scale, potentially rising to a level that endangers the livelihood of the sufferer.

We may ask where we get the necessary financial resources in the event of illness? Clearly, individual risks must be distributed or atomised, risk pools must be set up to, more or less, jointly bear individual risks. The question, as always, is that of proportions determining who - the state or the individual - should bear the bulk of the costs in such cases.

The sources of restoration of health may be different country from country. Let us just consider that in most European countries there is a tradition of the welfare state, while the US places responsibility on the individual.

The essential features of the health fund

To put it in easy-to-understand terms: essentially, the individual health fund account is nothing but a special health care bank account, which can be used exclusively to finance health care services (everything that we have covered from our own purses in relation to our health or the health of our relatives). Any remaining amount is invested just as in pension funds, and the yield earned is added quarterly to the sum available to fund members to spend on services.

Health funds are, within the legislative constraints, free to design their package of benefits; that is, they can decide at their discretion which category of benefits supplementary to the social security system to favour (e.g., pharmaceuticals, preventive services, sports, medicinal resort costs or screening).

The primary objective of health funds is health maintenance and the alleviation of financial burdens of the treatment of illnesses. The yield of any sum unused for benefits is added to the sum available to members to finance benefits.

It should be noted that health funds only finance benefits on presentation of an invoice as defined in the accounting act; thus, they have a role in suppressing the black economy and gratuity payments.

Individual accounts

Pension funds keep individual accounts about the payments received on behalf of members and the benefits used as well as the yields credited; in this regard they are different from the record keeping systems of the social security and health insurance systems.

The law requires an annual account statement to be sent to fund members: they must be informed, at least once a year, about their contributions paid, benefits used and the balance of their individual account. This means that since their inception, health funds have been functioning as a primary health care data collector, with bank-like record-keeping systems that satisfy the strictest of requirements.

Health services organised and contracted by the health fund for the benefit of members, with price discounts

With a few exceptions, the entity financing health services is obliged to enter into contract with the service providers of the health fund (Mutual Funds Act, Section 2(2)(e)) "health fund service provider: health care service provider as defined in the Act on health care that has a contract with, is owned or operated by the health fund as well as any natural person, legal person or economic association without legal personality that, pursuant to a contract with the fund, provides actual health fund benefits to fund members".

In practice this means that after the conclusion of the contract the fund, having regard to the best service to its members, guarantees prices and monitors the quality and standard of health services. Health funds have been collecting relevant information for almost a decade now; therefore, we can safely say that, in possession of tens of thousands of contracts, this is the only sector that has extensive experience in such negotiations. (As is known, the contract between the National Health Insurance Fund and the financed institutions is not negotiated but is concluded based on the territorial service obligation as required by law, without the possibility of choice.)

Due to the membership of the health funds, sometimes in the tens of thousands, they achieve discounts from the list prices of service providers, just as a purchasing club, which may bring thousands of forints of savings annually to the average fund member.

The overwhelming majority of health funds finance their services through health fund cards, which considerably simplify the rather cumbersome reimbursement process, along the lines of the social insurance principle of in-kind benefits.

The principle of in-kind benefits is reflected in the work of health funds in that members are eligible to fund benefits by virtue of their health insurance card. The health fund pays the costs incurred in the course of providing the benefit directly to the service provider based on the contract with such service provider, the card of the member and its own records. Essentially, the insured need not advance the costs of services twice (first when paying into the health fund

account, then when using the service), which would be an unrealistic expectation most of the time in light of the financial situation of the member. In the course of payment for the service, there is a single cash movement between the health fund and the service provider.

Investment of moneys temporarily not used for benefits

As another important feature of the health fund arrangement, moneys temporarily not used for benefits are invested by the funds. At the time of the inception of the sector in 1994 it was impossible to foresee the role of the asset management function; however, it has become evident by now that the tens of billions of assets must be managed with the same discipline as required from pension funds.

In the forthcoming decades this issue will become particularly relevant as health funds are well placed to cover the health care expenses foreseeably increasing with older age, let alone a nursing fund to be potentially set up, where the amounts paid into the fund may not be used for decades.

Who is the intended membership of health funds?

Health funds are designed for self-caring families who consider it important to preserve their own and their families' health and who are willing to pay for this, making use of benefits available in an organised format. Employers may also pay into the individual health fund accounts of members, while families may provide for the cover for foreseeable as well as unpredictable health care expenditures (pharmaceuticals, therapeutic equipment, medical services, medicinal resort costs, fitness, sports equipment) by making one-off payments into the account.

The role of health funds in collecting funds to cover future unforeseeable health care expenditures is also worth noting.

Health fund membership, alongside pension fund membership, will become increasing important in forthcoming years but the health care reform is certain to bring about the narrowing of available services and the 'whitening' of access to available services (making access to social security services contingent upon contribution payment, termination of the practice of jumping the waiting list upon payment of gratuity and of the purchase of higher-quality services). This means that in the future services that used to be available by mobilising social capital will be accessible through financial capital, and the health fund provides an operational institutional background for this.

Key operating principles of health funds, legislation governing their operation

The operation of health funds is governed by the Mutual Funds Act and the relevant government decrees, while contracts with service providers and employers are covered by the provisions of the Civil Code.

Rules governing the legal relationship of fund membership and the process of becoming a member

Establishment of membership

Membership in a fund is initiated by the member (employee) by completing the application for membership and its endorsement by the fund. Pursuant to the membership thus created, the member has the obligation to pay contributions, which the employer may assume, based on a contract with the health fund (see Section 6.2: employer members of health funds).

The membership of a fund member commences when the fund endorses the application for membership containing the information necessary for the records of the fund. Conditions of a membership relationship:

- not less than 16 years of age,
- acceptance of the provisions of the articles of association,
- undertaking to pay the membership contribution.

The application of persons who satisfy the criteria set out above may not be turned down.

The membership of the fund member is created when the application for membership is endorsed, with retroactive effect to the day of expressing the intention to join.

By virtue of his membership, a fund member is entitled to use the services of the health fund, except where the health fund provides for a waiting period in its articles of association (this is not common in the practice of funds, but the law provides this option).

Employer members of health funds

The Mutual Funds Act allows employers to assume the obligation of contribution payment from the member as an employer contribution, with tax benefits attached; this is agreed by the parties in a separate contract.

The employer contribution is either the same sum for every employer or the same percentage of their respective salaries. Employers operating a cafeteria regime are exempt from this requirement because in such a regime the individual may use his quota at his discretion, thus the voluntary fund contribution may differ from employee to employee.

Importantly, the employer may not exclude any employee from the employer contribution as long as they have been in its employment for no less than six months.

Minimum monthly contribution

Fund membership is contingent upon regular contribution payment, which is defined in the articles of association of the fund. Members should select the regularity of contribution payment (annual, semi-annual, quarterly or monthly) depending on the expected outlays in the health care budget of the family.

There is no ceiling on contributions; however, when selecting the maximum payments, the limits of tax benefits are worth considering. Still, a higher sum may be reasonable if the health fund generates yields higher than those available elsewhere on the market (as is known, the yields of funds are not subject to interest taxes), or a high price discount in excess of 20% is offered by service providers.

One-off contribution payments

In addition to the individual contribution payments and the employer contributions, members may also make additional one-off payments as allowed by the family budget, or may undertake regular monthly payments in addition to the employer contribution, thus the payment of health fund membership by the company also leaves room for individual self-care alongside the payments of employers.

Distribution of health fund contributions by fund

Pension funds are required to set up coverage, operational and liquidity reserves from their revenues and to use such funds in accordance with legislative provisions. Within the coverage reserve, the individual and service accounts must be maintained separately.

The coverage reserve serves to finance the health fund benefits, the operational reserve covers operating costs while the liquidity reserve collects the temporarily unused funds and guarantees the liquidity of the fund, as a general reserve underlying the other two reserves. The law specifies the types of payments that can be made from each reserve and delegates the detailed regulation of the distribution of revenues between the reserves to the scope of responsibility of the articles of association.

Fund members may use the services of the fund from the sum available in the coverage reserve. The operational reserve serves to cover the operation of the fund, while the balance of the liquidity reserve, the tip of the scale between the other two reserves, can be reallocated to either reserve.

Eligibility criteria for the use of health fund benefits

Eligibility for the use of health fund benefits is conditional upon a current membership and the existence of cover for the benefit used on the individual account.

As a special feature of the health fund arrangement, deriving from the rights of the member, his close relatives and cohabiting partner are also entitled to use the health fund benefits under identical terms. In other words, the legislator has created the possibility to care for the health of the entire family.

Determination of the health fund contribution

The health fund contribution is adapted to the benefits intended to be used by the member as well as the willingness of the member and his employer to make payments.

The maximum of the contribution is determined by the combination of

- the tax benefits available,
- the discounts offered by service providers and
- the yield achieved on investments by the fund.

Taxation environment of health funds (in 2011)

The recruitment of members in pension funds is promoted by a taxation environment that is highly favourable both for employers and employees. In short: subject to certain limits, payments by companies can be offset against the tax payment obligation of the company (19.04%), while individual payments benefit from a PIT allowance.

Employers achieve a saving in that the entire employer contribution paid on behalf of the member is deductible expense, with a reduced 19.04% tax rate up to HUF 23,400 per month per employee. The employer contribution is not considered income on the side of the fund member (and no tax benefit is available in its regard).

Key indicators of the health fund sector

Membership, revenue, services used (2002-2010 period)

The membership of voluntary health mutual increased from the initial 151 thousand in 2002 to 958 thousand by end-2010, while their revenues rose from HUF 9 billion to HUF 52 billion, a five-fold increase. Benefit expenditures are worth noting in particular, amounting to HUF 56 billion in 2010, which corresponds to 3.8% of total expenditures of the National Health Insurance Fund.

At the end of 2010, ten thousand employers had an interest in the operation of health funds.

Figure/Table 7
The voluntary health fund sector between 2002 and the first half of 2011
(source: www.pszaf.hu)

	Revenues (HUF million)	Membership (persons)	Benefits (HUF million)	Assets (HUF million)
2002	8,951	151,200	4,553	9,031
2003	12,317	219,067	9,228	13,086
2004	20,667	358,459	15,092	20,599
2005	25,038	490,900	21,800	28,717
2006	35,020	614,715	27,027	37,912
2007	35,097	733,232	34,049	44,024
2008	44,064	842,123	40,080	49,418
2009	50,009	899,444	51,453	53,891
2010	52,193	958,444	56,360	55,509
First half of 2011	22,400	969,642	27,601	54,285

Distribution of services financed by health funds, by type

As is known, 2005 was the first year for which the HFSA published figures about health fund benefits, in the breakdown specified in Government Decree No 263/2003.

2005 to 2006

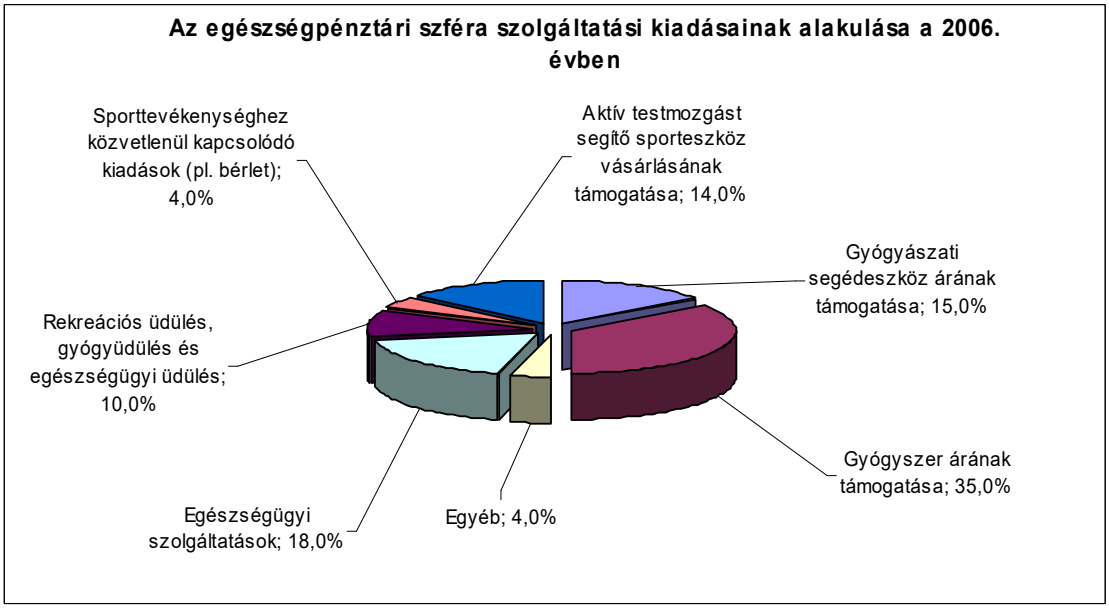
In accordance with the HFSA's past practice, the report on 2006 is expected to be published in May; consequently, at the time of writing we have only the data collection and analyses of the association to rely on.

We should note that in 2006 the health fund sector continued the trend of previous years and produced an annual growth of 40-50% in each segment. Last year, health funds financed HUF 27.0 billion of benefits for their members, an increase of 23.8% over the previous year.

The figure below shows that in 2006 the sector had 624 thousand members and spent the highest amount on contributing to the costs of pharmaceuticals (35%) and of therapeutic equipment (15%).

Within the service portfolio, sports represented 4%, the purchase of sports equipment 14%, recreational and medicinal holidays 10%, while 18% was spent on 'real' health care services.

Figure/Table 8



Az egészségpénztári szféra szolgáltatásainak kialakulása a 2006. évben	Services of the Health fund sector in 2006
Sporttevékenységhez közvetlenül kapcsolódó kiadások (pl. bérlet); 4,0%	Expenditures directly related to sports activities (such as a pass: 4.0%
Rekreációs üdülés, gyógyüdülés és egészségügyi üdülés; 10,0%	Recreational holidays, medicinal and health resort costs: 10.0%
Egészségügyi szolgáltatások; 18,0%	Health care services: 18.0%
Egyéb; 4,0%	Other: 4.0%
Gyógyszer árának támogatása; 35,0%	Contribution to the price of pharmaceuticals: 35.0%
Gyógyászati segédeszköz árának támogatása; 15,0%	Contribution to the price of therapeutic equipment: 15.0%
Aktív testmozgást segítő sporteszköz vásárlásának támogatása; 14,0%	Contribution to the purchase of sports equipment promoting physical activity: 14.0%

2007 to 2010

The services that health and self-help funds are allowed to provide have changed as of 1 June 2007; consequently, funds supply the service tables to reflect the new data content.

The table reveals that for years the overwhelming majority (97-95%) of benefits have been tax-free curative, that is, supplementary health insurance services. Certainly, the favourable trend was reversed by the unfavourable regulations introduced in 2007 (making health preserving services subject to taxation); at the time, the ratio of curative services was 88%, leaving 12% for the health-enhancing services that were tax-free at the time.

The regrettably increasing ratio of curative services is probably attributable to the inclusion of the health expenditures of families into the fund-financed scope rather than to an increase in consumption. Nevertheless, we may assume that in recent years the sum of health fund expenditures on health-enhancing services per person has also declined in absolute terms.

Significance of health funds in the mutual fund sector (2001-2010)

The data table and graphs published by the HFSA show that the sector, with more than two million members, generated revenues of HUF 136.64 billion in 2010 and financed benefits of HUF 96 billion for its members. The voluntary funds had assets of HUF 868.49 billion at end-2010 at market value.

In the period under investigation health funds had been increasing their weight continuously within the three actors of the mutual fund sector (pension, health and self-help funds). While in 2001 health funds realised 8.2% of the total mutual fund revenues, this ratio had increased to 38.13% by 2010. In respect of benefit expenditures, in 2010 health funds provided 58% of all fund benefits (pension funds: 40%). This means that the health fund sector has become the largest actor in managing social and welfare risks.

Problems of the Hungarian voluntary health fund sector

The annually changing legal environment makes the sector unpredictable for participants

Even though health funds, with their continuously growing revenues, can be regarded as one of the most successful actors in the sector of financial services, it is easy to identify the years when the development of the sector was hindered by the unpredictable legislative changes. On the other hand, certain measured had indisputable positive impacts. Examples include the change in 2003, when the legislator made it possible for health funds to maintain individual accounts similarly to the regime applicable to pension funds, thereby reinforcing the individual responsibility involved in the health fund scheme.

At the same time, there were other definitely negative legislative changes, which restricted the ability of health funds to raise funding on the revenue side and limited the promotion of health enhancing services on the expenditure side. Nevertheless, it is understandable that while the effects of health enhancing programmes launched by the various health funds will be felt in time horizons spanning political cycles, it is difficult to make governments de-emphasise fiscal considerations to protect their budgets, that is, to refrain from measures that reduce payments into the funds.

Still, the sector has produced a number of achievements, proving that healthy persons make less use of social security services as well, thereby contributing to the expenditure cuts promoted by the health care reform. Important partial results include the free Preventive Fund available to all members of Patikapénztár or the research conducted by AXA that provides factual proof that fund members consume less from the National Health Insurance funds.

The predictability of regulations will enhance confidence in the health fund sector, placing health at its just place among social values; furthermore, the several ten billion forints available in the sector finances the general government deficit before it is spent in the health care sector in a regulated manner.

Inadequate willingness of Hungarians for self-care

Research results indicate that two decades after the systemic change citizens are still reluctant to provide for themselves. As an inheritance of state socialism, most people still believe in the nanny state and think that it is cheaper to gain access to social goods as free-riders than to provide for themselves and their families.

This attitude is certain to change slowly; meanwhile, the state has the responsibility to strengthen the institutions of self-care.

The fact that at present 1.3 persons are pension fund members proves that people are afraid that they would be unable to maintain the lifestyle they got used to during their working years once they retire. The changes in OEP financing that will necessarily be introduced in this government term - eligibility for services being made conditional on contribution payment and a higher co-payment to the services of the state fund, the relocation of disability pensions of the OEP and the review of eligibility - will change the attitude of people to self-care radically and in the positive direction in forthcoming years.

The operation of the fund sector in compliance with the legislative principles is not monitored

In general, the development of the mutual fund concept is severely constrained by the fact that most of the funds do not fully comply with the principles set out in the Mutual Funds Act. The long-term viability of the French *mutuel* ideal is guaranteed by self-organisation, independence and competition to provide the best possible services available in the market to members using the services of the organisation.

Now the HFSA has every chance to enforce the legislative provisions in this field as well.

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