Balázs Tőkey

HEALTH INSURANCE CONTRACT

Theses

Supervisor:
Lajos Vékás
professor emeritus

2014
I. Brief summary of the research task

The questions of health care reform and health insurance are constantly on the agenda not only in Hungary but also worldwide. The discussions mostly revolve around two issues: first, how the continuous increase of health costs could be stopped, second where additional sources for health care could arise from, and what could help to reach a balance between income and expenses.

The discussions about private health insurance are connected to both issues mentioned above: the appearance of private insurance companies can increase the competition among health care providers and the efficiency of their management. Private insurance can also be a tool to give a rational frame to the private health expenditure of the population and the enterprises. The actual role of private health insurance depends on the structure of the whole health care system in each country. The states are very different in this aspect, therefore the function and importance of private health insurance are diverse in each health care system.

It is not clear yet which role the private health insurance will have in the coming years and decades in Hungary. The reform process of the health care system in the 2000s, which intended to involve private insurers in the health insurance system failed before its implementation because of the resistance of the medical profession and the society. Apart from this fact, some private insurers offer health insurance products, but the Hungarian market is quite small.

We agree with those opinions which state that the expansion of private health insurance could help to decrease the corruption and the inequality of health care in Hungary by offering a regulated frame to the private health expenditure. The model that would be closest to our conviction would offer less health services in the frame of the social security system, with regards to the limited resources, while providing these services following strict standards for everyone equally. Private health insurance would have a more important role beside this type of social security in the health care system and the private health insurance products would cover those services which are not

---

1 It is also often mentioned as an additional benefit of the private health insurances that they can increase the range of services and they can better meet the individual needs than the social security systems, see Sarah THOMSON and Elias MOSSIALOS (ed.): Private health insurance in the European Union – Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities (24th June 2009, LSE Health and Social Care, London School of Economics and Political Science) http://ec.europa.eu/social/BlobServlet?docId=4216&langId=en 18.

2 Some Hungarian opponents of the private health insurance say that the equality would disappear in the health care with the expansion of private health insurance. In our opinion this right only exists on paper now: the quality of the available health care (in the social security system) depends on the luck (or in worse cases on money or social capital) in the practice. See for the problem SÍNKÓ Eszter: „Értékrend váltás az egészségügyben avagy az átalakuló félben lévő egészségügy” [Changes of Values in Health Care or Health Care in Transition] Esély 2006/6. 30.

available in the social security system.\textsuperscript{4}

We might think that these changes are impossible in Hungary in the close future due to the lack of support from the society (which was demonstrated by the recent reform attempts). This is, however, not necessarily true: a recently published survey\textsuperscript{5} shows that a significant part of the Hungarian population (over 60\%) would pay for medical services under controlled conditions,\textsuperscript{6} if it was associated with higher quality. Therefore the legislature should establish his concept of the private health insurance as soon as possible, and the detailed rules could be elaborated on this basis.

It is a banality today, that the Hungarian health care system is in deep crisis, and it is not sustainable on the long run. Therefore, the role of private health insurance will probably increase in Hungary sooner or later, and this is the reason that confirms the relevance of the chosen topic. If our expectation is realized, the development of the detailed regulation of health insurance contract will be inevitable, which was impossible during the preparation of the new Hungarian Civil Code\textsuperscript{7} (hereinafter referred to as NHCC) because of lack of political will and social consensus on the role of private health insurance.

Therefore the aim of our thesis is to give an overview about the health insurance contract, which is missing in the Hungarian jurisprudence, and a starting point to the evolution of a consumer-friendly legal practice regarding the lack of detailed regulation. To reach this aim, we start the introduction of the dissertation with the distinction of private and public health insurance and the presentation of the types of the private health insurances with regard to their role in the health care system. At the end of the introduction we describe some national health insurance systems, which represent the most important models, focusing on the function of private health insurance.

The second part of the thesis is the “general part”, which deals with general issues relating to the health insurance contract. First we explain why we use the term “health insurance contract” and we attempt to define this legal relationship.\textsuperscript{8} Then we present those particularities of the health insurance contract which distinguish it from other insurance agreements, these are the following: long term, the continuous increase of risks, the importance of “in kind services”, the involvement of personal rights, more significant information asymmetry and moral hazard. Thereafter, we try to find the place of the health insurance contract among other insurance contracts: we also examine


\textsuperscript{6} The majority of the Hungarian population also pays today for health services in the form of parasolvency (a kind of mandatory gratuity).

\textsuperscript{7} Act V of 2013 on the Civil Code

\textsuperscript{8} We also give a definition for insurance agreement, because we have to make a distinction between the health insurance contract and other insurance contracts.
where national acts (e.g. the German, the Austrian or the Spanish act on insurance contracts and the NHCC) can find a place for the health insurance contract in the governing regulation.

The subtypes of health insurance contracts are also discussed among the general issues based on the German and Spanish model. At the end of this part we deal with discrimination which has an increasing importance in insurance agreements. We examine in separate sections the genetic, racial, sex-based discrimination and ageism.

The particular questions related to the health insurance contract are discussed in the third part. In this context we deal with the following issues: the subjects, the conclusion and the effective date of the contract, the commencement of the insurance coverage, the insured risk and event, the performance of the insurer’s service (and its terms and limitations), the insurance premium, other obligations of the parties, the amendment of the agreement because of the increase of risks, the termination and the change to an other health insurance.

After a brief summary we publish the “fruit” of our research in the fourth and final part: it is a sample of health insurance terms and conditions for individual clients. The appendix of the dissertation is the Hungarian translation of the section governing the health insurance contract in the German and Austrian act on insurance contracts, which is a positive spin-off of our work.

It should be mentioned that we attempted to present the health insurance contract and the related issues thoroughly in our thesis, because the theoretical elaboration of this agreement is still missing in the Hungarian jurisprudence.

II. A brief summary of the studies, analyses and scientific methods

1. First we would like to emphasize that the comparison of some health insurance contract models in different countries was not intended in our dissertation, because primarily we attempted to give a basis to the development of good legal practice, the further contemplation on the regulation and the theoretical elaboration of the topic in Hungary. We do not see the sense of a comparative analyses which exceeds the parallel presentation, because the health insurance systems of the individual states are very different, the role of private health insurance is quite diverse, so we should compare solutions on different needs and answers for dissonant questions.

Thus we primarily aimed to search such foreign solutions and models which can also be used among the Hungarian conditions. We tried to select some countries for a brief overview in the introduction with the goal to show the most important national models. We hope that these snapshots can explain why our dissertation focuses just on a few of them (the German, the Austrian and the Spanish regulation and practice).
2. We would like to give just some examples why certain countries stayed in the background in the thesis. The Dutch and the Swiss health care systems are based on a mandatory private health insurance system, but the realization of such model seems to be very unlikely in the near future in Hungary. While private health insurance is not mandatory in France, it has a quite different role there than in Hungary: it aims to cover the co-payments of the public health care. In the United States of America the state provides access to health services just for the elderly and most vulnerable population groups, it is provided by private health insurance for other people, and this situation is not comparable with the Hungarian conditions. We can find both the public and the private health care system in Ireland, but the voluntary private health insurance is highly regulated: the open enrollment,\textsuperscript{9} the lifetime cover\textsuperscript{10} and the community rating\textsuperscript{11} are also prescribed by the legislator. The introduction of this strict regulation for the voluntary private health insurance market is not likely in Hungary, either. Finally, we just mention that we did not want to explore the governing regulation of those countries with legal systems very distinct from ours (e. g. the United States of America, the United Kingdom and Canada).

In contrast to the countries mentioned above – we deal with the German, Austrian and Spanish private health insurance regulation and practice in detail. Germany was chosen because the German regulation of private health insurance is one of the most detailed regulations and it is associated with a developed jurisprudence. The concerning Austrian legal regulation is also quite deep, and the role of private health insurance is closer to the Hungarian situation in Austria than in Germany. The significant influence of these countries (Germany and Austria) on the development of the Hungarian legal system was also an important argument in our choice. Spain came in the focus of our investigation, because it has one of the most important European market of the “in kind model”\textsuperscript{12} which is also prevalent in Hungary. Our focus on these three\textsuperscript{13} legal systems does not mean that we do not mention in some questions the remarkable solutions of other countries. It does not mean either, that we present the regulation and the practice of these three countries in all the investigated questions, because in some cases these issues are not relevant in all the three legal systems.\textsuperscript{14}

The concerning regulation and judicial practice of the European Union is discussed by the dissertation in just those cases, where they are relevant in context with the regulation and practice of

\textsuperscript{9} Open enrollment: the insurer shall accept all applicants.
\textsuperscript{10} Lifetime cover: the insurance provides coverage until the death of the insured person.
\textsuperscript{11} Community rating: the insurer shall offer the insurance services at the same price to all persons regardless of their health status, age etc.
\textsuperscript{12} See later.
\textsuperscript{13} These three countries mean just two different models, because the Austrian regulation follows the German one in several issues: therefore the Austrian commentaries refer the German judicial practice. This is the reason why the Austrian legal practice does not appear in the dissertation.
\textsuperscript{14} E.g. the responsibility of the insurer for the defective performance of the health care provider can be relevant just in the in kind model when the insurer has a contractual relationship with the health care provider. These health insurances are typical just in Spain and not in Germany or Austria. This is the reason why we only deal with the Spanish model in this issue.
the health insurance contract in Hungary. Therefore, we do not deal in detail with the EU Directives regulating the insurance industry because they contain mainly public law rules. However, we put emphasis on the antidiscrimination legislation of the EU, because it has an important influence on the health insurance contracts. We follow similar principals during the presentation of the practice of the Court of Justice of the European Union: we just mention those decisions which have less relevance, but we give priority to the Test-Achats Case (C-236/09), which has a significant effect on the insurance market of the EU (especially on the market of life and health insurances).

We also analyze the concerning Hungarian regulation and practice in detail with an emphasis on the interpretation of the NHCC. The analysis of the NHCC is not placed in a separate chapter, but its concerning provisions and solutions are presented in that part of the dissertation where the specific issue is discussed – to build up a clearer structure.

The presentation of the concerning Hungarian practice is limited to the interpretation of the general terms and conditions of the Hungarian insurers due to the lack of the judicial practice. As we know – nine insurers offer health insurance products in Hungary, and we tried to obtain all of their concerning general terms and conditions for our research. We had to take in consideration that the market is very small: the annual premium income of the whole industry barely exceeded six billion forints (approx. 20 million euro) in 2012, and the number of the contracts was around thirty-four thousand. On the other hand, the Hungarian health insurance products are extremely heterogeneous, we can find important differences between their services. In addition, those products are not typical which cover all important health risks. Most of them just cover a narrow segment: e.g. one insurance covers the treatment carried out abroad in case of a serious illness, and those indemnity insurances which offer a wider coverage do not comprise inpatient care services. Other insurers just offer insurances of fixed sums. Regarding this situation it was not possible to give a statistical analysis of the available general terms and conditions. Therefore we chose to shortly present the solutions of general terms and conditions during the examination of the particular issues, and we just refer to which are frequently used and which are exceptionally applied.

We always tried to find and present the best solution at the end of the discussion of the particular issues, that was based on the studies and analysis described above (the interpretation of foreign regulatory models with the concerning practice and the Hungarian regulation and practice) and we

---

15 See e.g. the case T-289/03 which sais that the risk equalisation scheme introduced by Ireland on the private health insurance market is compatible with the Community law. The application of a risk equalisation scheme is needed in the model based on community rating but its introduction is not a real opportunity in Hungary so this issue is not relevant for us.

16 We know just one Hungarian case which has relevance to the health insurance but it is a travel insurance case (but we interpret this case in the dissertation).


18 The health care provider partner of the most insurers which offer in kind products is the same.
attempted to make proposals in some cases on how we could find a better regulation or practice.

III. A brief summary of the scientific results and their possible exploitations

1. First we deal with the name of the relationship in the general part of the dissertation. There are two options in Hungarian language: “health insurance contract” or “illness insurance contract”. We prefer the first one for several reasons. On one hand, not only an illness can be the insured risk, but healthy people can also use the services provided by a health insurance (e.g. during pregnancy). On the other hand, the use of the word “health” has a more positive content then the use of the word “illness”: the health insurance contract expresses more clearly the main goal of this legal relationship which is the preservation of health or the helping of recovery (as soon as possible) in case of an illness. It is also true that the majority of the Hungarian insurance companies offer their products under the name of health insurance.

2. After that, we tried to find an appropriate definition for the health insurance contract with the help of the definition of the insurance contract. Regarding the definition of several acts and their commentaries we found that in an insurance contract the insurer shall cover the risk specified in the contract, primarily by exonerating the client from damages caused by unforeseen insured events or by paying a fixed sum; the subscriber shall pay the offset of the risk coverage in the form of the premium. The health insurance contract shall be defined as a special insurance contract: the insurer shall cover the risk specified in the contract, connected to health deterioration primarily by exonerating the client from the damages connected to the threatening or occurred health deterioration caused by the insured event, which can be performed by providing access to health and nursing care and also by covering health preservation costs, or alternatively, a fixed sum shall be paid; the subscriber shall pay the offset of the risk cover in the form of the premium.

3. Our next aim was to find the place of health insurance contract among the other insurance contracts. The health insurance can be an indemnity insurance, or an insurance of fixed sums, too. This makes their regulation difficult, which can also be seen in the NHCC that regulates the indemnity insurances and the insurances of fixed sums in separate chapters. However, the health insurance cannot be integrated in this differentiation, therefore it is placed in a separate chapter which contains referring rules to more norms of the indemnity insurances and the insurances of

---

19 Of course beside the compensation of damages connected to health deterioration.
20 It can also be an event which surely happens but its time is unforeseen (e.g. the death).
21 “Indemnity insurance” means insurance under which the insurer is obliged to indemnify against loss suffered on the occurrence of an insured event.
22 “Insurance of fixed sums” means insurance under which the insurer is bound to pay a fixed sum of money on the occurrence of an insured event.
fixed sums. This forced solution has some negative side effects: on one hand, some references are missing, and the NHCC also contains unnecessary references. On the other hand, it is questionable whether the referred indemnity insurance rules shall apply to all health insurances (or just to the health insurances which are indemnity insurances). In our opinion, it would be a better solution\textsuperscript{23} if each insurance on a person, which are normally insurances of fixed sums, was regulated in a separate chapter, and the act could refer to the norms of the indemnity insurances in each chapter if it is necessary.

4. It is also important to delimitate the subtypes of health insurance contracts because they require different regulation. According to this, we should make a distinction between health insurances which aim to protect and recover health, and health insurances which compensate the indirect disadvantages of the loss of health, because missing to perform the insurance service properly has very different consequences. If the indirect damages remain without compensation, it is just a financial loss for the insured person. However, if the insured person looses his chance to access a health service because the insurer does not perform his service, the insured can also suffer personal injuries: it can endanger his life, health or physical integrity. Therefore the regulation shall give a wider protection to the insured persons in the second case. We should also make a distinction between the contracts following the “in kind model”\textsuperscript{24} and the contracts following the “reimbursement model”\textsuperscript{25} among the health insurances which aim to protect and recover health. In some countries the first, in others the second model is more common. The most important advantage of the reimbursement model is the greater freedom of the insured: it offers a possibility of free choice of health care providers. However, the in kind model can give access to such health services which are normally not available for the insured.\textsuperscript{26} The in kind model also protects the clients from the danger of having to bear the costs of the health services (the insurer cannot refuse his performance after the provision of the health service). Finally, it is an other important difference between the two models, that there is no contractual relationship between the insurer and the health care provider in the reimbursement model, but the health care provider is a contractual partner of the insurer in the in kind model: in the second case the insurer can influence the quantity and quality of health services.

5. The last discussed issue in the general part of the dissertation is the discrimination. As a result of our analysis, we concluded that there are factors (such as race or genetic information) which could

\textsuperscript{23} See e.g. the German, the Austrian or the Spanish insurance contract acts.
\textsuperscript{24} “in kind model”: the benefit of the insurance is not provided in cash, but the insured gets direct access to a health service. Normally the insurance company chooses the health care provider, which is a contractual partner of the insurer.
\textsuperscript{25} “reimbursement model”: first the subscribers shall pay the cost of the health service to the health care providers, and they have to claim back these costs from the insurer later. There is no contract between the insurer and the health care provider.
\textsuperscript{26} e.g. a second opinion by an internationally known expert
influence the risk in a health insurance, but the legislator (in the European Union and in Hungary, too) prohibits to make distinctions among clients according to these factors. We can agree with this regulation in case of race and genetic information: on one hand, it has become the part of public opinion, that no one shall suffer prejudice on the basis of these factors, because it is not acceptable due to the moral principle of equality. On the other hand, these factors probably do not have a significant effect on the risk regarding the whole risk pool.

The case of gender and age as a risk factor in a health insurance is a much more difficult issue. The “Test-Achats judgment” of Court of Justice of the European Union (1st March, 2011 in case C-236/09) determined the gender issue: it declared, that the Article 5 (2) of Council Directive 2004/113/EC of 13 December 2004, which permitted to the insurers to make proportionate differences in individuals’ premiums and benefits where the use of sex is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data, is invalid. This judgement has been widely criticized. In our opinion the decision does not take into consideration that the situation of women and men – especially in a case of a life or health insurance – is not the same, but the gender is a very important risk in these insurances, and there is no public opinion which could justify equal treatment in all cases.

In addition, the judgement does not generally prohibit the consideration of gender in the assessment of risk according to the interpretation of the European Commission, but it just excludes the gender based differences in individuals’ premiums and benefits. This could mean in exceptional cases that the insurer denies the access of one gender to certain products, leading to further contradictions.

Age is an even more important risk factor in a health insurance than gender: the risk of getting ill and hospitalization is continuously growing after the young adult age. Therefore it is essential to take into account the age of an insured person in the assessment of premiums and benefits. It can lead to the phenomenon that the insurer does not conclude a health insurance with clients over a specified age or the contracts automatically terminate when the insured person reaches a specified age. This is the general practice in Hungary: the insurers do not conclude a health insurance over 60 years of age and the contracts automatically terminate when the insured person reaches 65 years of age. The termination of the contracts is a serious problem for the insured, because they loose the coverage of health risk in the moment when they need it the most. However, it is questionable whether this practice is lawful and how long it can be sustainable, because the proposal for the Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation will probably pass soon. This Directive shall apply in the field of access to and supply of goods and services which are available to the public including insurance as well. If the proposal passes in its last form, which permits only proportionate differences in treatment in just those cases where, for the product in question, the use of age or
disability is a key factor in the assessment of risk based on relevant and accurate actuarial or statistical data or medical facts, it will not be possible to deny or terminate an insurance because of the age of the insured person, because it cannot be seen as a proportionate difference in treatment. In addition, the practice of the Hungarian Equal Treatment Authority\textsuperscript{27} (based on the Hungarian law\textsuperscript{28}) seems also to prohibit those practices in Hungary which exclude persons from an insurance because of their age.

6. This issue leads us to the particular problems connected to the health insurance contract. We will interpret just those (self-)regulation directions which should be followed in the practice of health insurance in Hungary.

Related to the parties of the health insurance contract we would like to emphasize that the regulation and practice shall realize the goal that no one shall be excluded from a health insurance – especially because of their age or health status. As we said before, the current Hungarian practice does not meet these expectations, the exclusion of some potential clients is discriminative, because it cannot be seen as a proportionate difference in the treatment. The insurers shall also offer insurances for those clients who have higher risks, but they can make differences in the premium or the benefit.

Of course, it does not mean that everyone would have a real chance to get a health insurance: if an old person with several illnesses wants to conclude a health insurance contract, the insurer cannot offer it at a reasonable price, because the risk is too high. It means that the goal is not to give private health insurance to everybody, in our opinion it would be enough, if those automatisms disappeared from the health insurance practice which exclude someone or terminate\textsuperscript{29} a contract without an acceptable reason.

The most important issue about the conclusion of a health insurance contract is providing as much information to the clients as possible about the insurance. In our opinion the clients shall be informed not just about what is prescribed by the law, but also about the changes of the premium of the chosen product in the last 10 years and the conditions of renewal in case of a fixed-term insurance. If the conclusion fails because the insurer denies the bid, it shall be justified to avoid the arbitrary decisions. The insurer shall bare the costs (e.g. medical examination), if the conclusion fails except if the client is liable for the circumvention.

If the conclusion of the insurance is successful, it shall enter into force as soon as possible – with regards to the waiting period, but irrespectively of the payment of the premium – because of the characteristics of the insured risk. This starting time could be the arrival of the bid which means that the entry into force is retroactive if the insurance is concluded. However, the insured event can

\textsuperscript{27} See the decision Nr. 1124/2010 of the Hungarian Equal Treatment Authority
\textsuperscript{28} See the Act CXXV of 2003 on the equal treatment and the promotion of equality
\textsuperscript{29} The termination is the more significant problem in the practice.
occur after the arrival of the bid but before its acceptance by the insurer. The conclusion of the insurance should be guaranteed irrespectively of the occurrence of the insured event after the bid. The waiting period also influences the starting time of the risk cover. In our opinion it shall start as soon as possible, the general waiting period shall not be longer than three months and it shall not apply for accidents.

The delimitation of insured risk and insured event is a problematic issue of health insurance contracts. The detailed definition of these notions is only possible in the particular contracts, but it shall be done as clearly as possible. The insured event shall also be distinguished from the service of the insurer (this is a relevant problem of the in kind services).

The insurers prescribe numerous positive and negative criteria which have to be fulfilled by the client in order to be eligible for the insurer's service. However, the insurers shall apply only those criteria which are really necessary and they must not obstruct the clients in exercising their rights (e.g. unnecessary administrative work or too short time limits). These criteria shall also be clearly separated from each other: e.g. if the law prescribes that the insurer must not be exempt from performing its service (e.g. the negligence of the client if it is not gross negligence), the insurer shall not exclude this case from the insurance coverage as a circumvention of the law.

Despite all the specific regulations and criteria mentioned above, disputes between the parties are inevitable about the question whether the insurer shall perform its service in certain situations or not. E.g. it can be a question whether a specific medical treatment is covered by the insurance or if performing it is reasonable in that case. Thus it must be made clear what the parties shall prove during the process, and it would also be useful to have fast, cheap and definitive arbitration methods to solve these situations.

We also discuss the issues connected to the premium in the dissertation. Now we just mention some of our conclusions. The assessment of the premium shall not be discriminative, and continuously increasing it with age shall be avoided (although setting up a reserve for increasing age can be reasonable). The other issue discussed about the premium is the no-claims bonus: it shall not threaten the effect of prevention and mitigation of damages and encumber the social security system in case of parallel services.

The parties have other obligations not just covering the risk (the insurer) and paying the premium (the subscriber). The insurer shall prescribe these other obligations for the clients just in those cases – and just in those forms – if it is really necessary. E.g. the disclosure obligation shall concern just relevant information, and it shall be fulfilled in any form. The insured shall be obliged to submit results of medical examinations only in cases that are unavoidable. Data management by the insurer shall be transparent. The clients should have the right to decide in every case whether they give their consent to the data management and they should also have the right to access these documents.
for review in a reasonable extent.

The *significant increase of the insured risk* is an inevitable factor of the health insurance contracts and it should be regulated in detail at least by the general terms and conditions. If the particular risk (the risk of an insured person) increases, in our opinion the general norms governing significantly increased risk shall not apply for such cases when the reason of the increase is the change in health status. However, if the general risk (the risk of the whole pool) increases, the insurer shall be entitled to (unilaterally) amend the contract (especially the premium) to restore the balance of consideration. This process should be regulated in details: e.g. determining the criteria of amendment, building up an effective monitoring system, providing alternative solutions to avoid the increase of premium. It should also be guaranteed that the insurer shall amend the contract in favour of the clients if the risk decreases.

The *termination* of the health insurance contract – as we mentioned before with relation to the discrimination – is a crucial point. In our opinion the clients should be able to find health insurance with a life-time cover – at least for those services which cover medical costs. To realize this aim the contracts shall be unfixed term agreements, the insurer shall not have the right to voluntary terminate and in case of terminating the contract the clients should be entitled to renew the contract with the same acquired rights if the contract does not terminate because of the unlawful conduct of the client. It would also be a reasonable requirement for the insurer to re-activate the insurance within the specified period if no insured event occurs.

7. Following the regulatory principles discussed above, we prepared a compilation of the most important contractual terms and conditions which should be applied by the insurer in health insurance contracts concluded with individual subscribers. This compilation contains those rules which could protect the rights and interests of the clients. We did not aim to regulate all details of the health insurance contracts with this compilation, because it should be applicable in several types of the health insurance contracts, and the insurer shall also apply their own general terms and conditions anyway, which can be very heterogeneous depending on the different services proved. This compilation is the part of the dissertation which can be of most practical use. Insurers could apply it just as it is provided, or they could use certain parts of it after publication. In our opinion, the future voluntary application of the compilation – or its updated version – by the insurers would not be contrary to competition law, even if all or most of the insurers would do so.
IV. List of publications on the topic of the dissertation


