

VOLUNTARY HEALTH INSURANCE IN BULGARIA – LEGAL FRAMEWORK AND ITS ROLE WITHIN THE HEALTH INSURANCE SYSTEM

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Abstract

This paper examines voluntary health insurance in Bulgaria as a specific complementary element within the mandatory health insurance system. It aims to analyse the legal framework governing voluntary health insurance, which operates on market-based and contractual principles, and to clarify its role and functions within the existing health insurance model, founded on compulsory and universal participation.

The study seeks to clarify the legal nature of voluntary health insurance by tracing the historical development of the relevant legislation and its transformation into an insurance-based legal relationship. Particular attention is devoted to the relationship between voluntary and mandatory health insurance, with a view to ensuring that the core package of healthcare services remains guaranteed within the public system and that mandatory health insurance is neither replaced nor undermined by private-law mechanisms.

The paper further examines data on the current state and development of the voluntary health insurance market, as well as the applicable supervisory and control mechanisms. Special attention is given to the role of the Financial Supervision Commission and to the control powers of the Executive Agency “Medical Supervision” in relation to insurers offering voluntary health insurance products.

The analysis demonstrates that voluntary health insurance has a legitimate but limited role as a complementary mechanism within the Bulgarian health insurance system. This necessitates clearly defined legal boundaries and effective protection of the rights of insured persons, while safeguarding the central role of mandatory health insurance in guaranteeing access to essential healthcare services.

Keywords: *Voluntary health insurance, Mandatory health insurance, Health Insurance Act, Insurance supervision, Health insurance market.*

1. Introduction

Voluntary health insurance in Bulgaria forms part of the health insurance system and was introduced as a complementary mechanism to the public system of mandatory health insurance. This study examines the current legal framework governing this institution and its systemic position within the health insurance model, while also analysing statistical data on the development of the voluntary health insurance market in 2023 and 2024.

In the international literature, voluntary health insurance is regarded as a specific mechanism for financing healthcare services that may perform different functions depending on the structure of the national health system. Depending on the manner in which it interacts with public financing of healthcare, it may assume a complementary, supplementary, or substitutive role in relation to the public healthcare system. These differences are determined by the historical development of national health systems, the characteristics of the national legal framework, and the level of public financing of healthcare¹.

Comparative studies of voluntary health insurance across European countries demonstrate that its development is strongly influenced by the historical characteristics of national health systems, as well as by the applicable legal framework and the scope of public financing of healthcare. In most European states, voluntary health insurance performs primarily a complementary function in relation to public health systems, while the

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¹ See E. Mossialos, S. M. Thomson, Voluntary Health Insurance in the European Union: A Critical Assessment, in International Journal of Health Services, vol. 32, no. 1/2002, pp. 19–88;

See S. Thomson, T. Foubister, E. Mossialos, Financing Health Care in the European Union: Challenges and Policy Responses, WHO Regional Office for Europe, Copenhagen, 2009, available at <https://iris.who.int/handle/10665/326415>, last time consulted on 16.03.2026.

size of the market and the significance of private health coverage vary considerably across different national models².

Bulgaria has been included in several comparative European studies on voluntary health insurance, as well as in reports examining the structure of healthcare financing in European countries. In these analyses, the Bulgarian model is usually addressed in a comparative or descriptive context, with particular emphasis on the relatively limited penetration of voluntary health insurance and its small share in total healthcare expenditure³. An analysis of the Bulgarian health system is also provided in a report of the European Observatory on Health Systems and Policies, which examines the organisation and financing of the health system and likewise notes the limited role of voluntary health insurance⁴. However, these studies address the Bulgarian model primarily in descriptive or comparative terms and do not offer a comprehensive analysis of the legal framework and institutional development of voluntary health insurance in Bulgaria.

In a broader European context, it may be observed that there is still no comprehensive and up-to-date study specifically devoted to the legal framework and institutional development of voluntary health insurance in Bulgaria. Existing research tends to address the Bulgarian model mainly from a comparative or descriptive perspective and does not sufficiently examine its normative content or its systemic position within the health insurance system. This gap in the literature underlines the relevance of the present study. In the context of the growing involvement of the private sector in the provision and financing of healthcare services, a clear distinction becomes necessary between the public guarantee of access to the basic package of healthcare services and the possibility of contracting additional health protection through private-law mechanisms.

The purpose of this study is to analyse the legal framework governing voluntary health insurance in Bulgaria, tracing its development from the introduction of the Health Insurance Act in 1998 to the current regime, under which the voluntary element is implemented through a medical insurance contract. Through doctrinal, systematic, and historical legal analysis, the study traces the development of the institution, clarifies its legal nature, and evaluates its relationship with mandatory health insurance. The research also includes an analysis of statistical data on the voluntary health insurance market in Bulgaria for 2023 and 2024, making it possible to assess the actual significance of the voluntary element within the structure of healthcare financing.

The analysis demonstrates that voluntary health insurance plays a limited role within the health insurance system as a complementary mechanism to mandatory health insurance. It cannot replace the public guarantee of access to healthcare services, but instead operates as a private-law instrument for the provision of additional health protection.

2. Development and legal framework of voluntary health insurance in Bulgaria

2.1. Transition from a state-funded healthcare system to an insurance-based model

At the end of 1944, Bulgaria entered a period of political transformation that gradually led to significant changes in the organization and financing of healthcare. The period from 9 September 1944 to 17 March 1951 may be regarded as a transitional phase in the development of the model of health protection, as the health insurance system that had existed until that time—based on insurance mechanisms for financing medical care—was progressively replaced by a state-funded healthcare system.

² See A. Sagan, S. Thomson (eds.), *Voluntary Health Insurance in Europe: Country Experience*, European Observatory on Health Systems and Policies, Copenhagen, 2016, available at https://www.euro.who.int/__data/assets/pdf_file/0005/310838/Voluntary-health-insurance-Europe-country-experience.pdf, last time consulted on 1|6000000000000000.03.2026;

See M. Čurak, D. Kovač, K. Poposki, *The Drivers of Voluntary Private Health Insurance Demand in European Countries*, in *Economic Thought and Practice*, vol. 30, no. 2/2021, pp. 457–474.

³ See OECD, *Private Health Insurance in OECD Countries*, OECD Publishing, Paris, 2004, available at <https://www.oecd.org/health/health-systems/private-health-insurance-in-oecd-countries-9789264007451-en.htm>, last time consulted on 16.03.2026;

See A. Dimova, M. Rohova, S. Koeva, E. Atanasova, L. Koeva-Dimitrova, T. Kostadinova, A. Spranger, *Bulgaria: Health System Review*, in *Health Systems in Transition*, vol. 20, no. 4/2018, European Observatory on Health Systems and Policies, Copenhagen, 2018, available at https://www.euro.who.int/__data/assets/pdf_file/0006/372348/bulgaria-hit.pdf, last time consulted on 16.03.2026.

⁴ See A. Dimova, M. Rohova, S. Koeva, E. Atanasova, L. Koeva-Dimitrova, T. Kostadinova, A. Spranger, *Bulgaria: Health System Review*, in *Health Systems in Transition*, vol. 20, no. 4/2018, European Observatory on Health Systems and Policies, Copenhagen, 2018;

See European Observatory on Health Systems and Policies, *Bulgaria: Health System Summary*, 2022, available at <https://www.euro.who.int>, last time consulted on 16.03.2026.

This transformation formed part of the broader process of strengthening the role of the state in social relations under the socialist system⁵ and of establishing a centralized system for the governance of healthcare. With the adoption of the Decree on Universal Free Medical Care (1951), health insurance relations were abolished, and the financing of medical services, as well as of the healthcare system as a whole, was assumed entirely by the state.

Following the nationalization carried out in the healthcare sector between 1946 and 1949, ownership of healthcare resources in Bulgaria remained entirely state-controlled until the beginning of the 1990s. As a result of the socialist restructuring of the healthcare system after 1950, a model based on centralized state administration and budgetary financing was introduced. The free choice of physician and healthcare provider was replaced by an administratively organized system of medical services based on the territorial principle and administrative-territorial division.

Throughout this prolonged period, healthcare functioned as a system characterized by a state monopoly, in which medical services were provided at the expense of the state budget, financed through tax revenues and other public funds. This model may therefore be described as a system of public healthcare protection based entirely on budgetary financing.

The political changes that began on 10 November 1989 marked the beginning of profound transformations in all spheres of social and economic life. In this context, the need arose to reconsider the mechanisms governing the organization and financing of healthcare. Bulgaria was once again confronted with the choice between preserving the budget-based model and restoring the insurance principle in the financing of healthcare services.

Discussions on the introduction of health insurance began in the first years following the political changes. During the 1990s, in connection with the preparation of healthcare reform, a number of policy concepts and reform programmes were developed, the experience of other countries was examined, and foreign experts were involved in the reform process. Nevertheless, with the exception of certain partial measures, no substantial legislative steps towards the establishment of a new model of healthcare financing were undertaken until the mid-1990s.

The normative turning point occurred with the adoption of the Health Insurance Act (promulgated in the State Gazette, No. 70 of 1998, in force as of 1 January 1999), which restored health insurance relations in the Republic of Bulgaria. After almost five decades of a budget-funded healthcare system, Bulgarian legislation once again introduced the insurance-based model as the foundation of public healthcare protection, thereby laying the foundations of the contemporary health insurance system.

The restoration of health insurance relations through the Health Insurance Act of 1998 was not limited to the introduction of mandatory health insurance as the principal mechanism of public healthcare protection. The legislator also provided for the possibility of voluntary participation in supplementary health insurance schemes operating alongside the mandatory system. Thus, from the very outset of the legislative framework, a dual structure of the health insurance model emerged—public-law in relation to the guaranteed package of medical services and contractual in relation to supplementary health protection.

It is precisely this second component—voluntary health insurance—that raises the question of the relationship between the solidarity-based nature of the mandatory system and the market-based principles on which supplementary mechanisms for health protection are built. This issue becomes particularly significant in the context of the subsequent development of the legal framework and the transformation of voluntary health insurance into a model implemented through a medical insurance contract.

2.2. Initial model of voluntary health insurance (1998–2012)

With the adoption of the Health Insurance Act of 1998, the Bulgarian legislator established a new model for the financing of healthcare based on mandatory participation in a public health insurance system administered by the National Health Insurance Fund. Alongside this principal mechanism, the Act also introduced the possibility of voluntary health insurance as a complementary element. Pursuant to Article 2 of the Act, health insurance is carried out in two forms—mandatory and voluntary.

Under the initial legal framework, voluntary health insurance was entrusted to specialized joint-stock companies incorporated under the Commerce Act and licensed in accordance with the conditions and procedures laid down in the Health Insurance Act. A specialized licensing authority was also established—the

⁵ See *Istoriya na meditsinata v Bulgaria*, Medicina i Fizkultura Publishing House, Sofia, 1980 (in Bulgarian), p. 220.

National Commission for Voluntary Health Insurance, whose composition and rules of operation were determined by the Council of Ministers. In order to ensure the protection of the rights of insured persons, the Act also provided for specialized supervision over both mandatory and voluntary health insurance, entrusted to the Minister of Health.

The legal regulation of voluntary health insurance is set out in Chapter Three of the Act (Articles 81–99). From the outset, the legislator sought to position voluntary health insurance within the health insurance system through both a clear distinction and a functional relationship with the mandatory model. According to Article 81, voluntary health insurance provides insured persons with medical and other services both within the scope of activities agreed under the National Framework Contract and outside the scope of mandatory health insurance. In this way, even at the initial stage of the reform, the voluntary element was conceived as a complementary mechanism to the public system.

In the initial structure of the Act, voluntary health insurance was implemented through specific packages of healthcare services. These included activities related to prevention and health promotion, outpatient medical care, inpatient medical care, services related to accommodation and other supplementary conditions in the provision of medical care, as well as reimbursement of incurred expenses. A separate licence was issued for each package, reflecting the legislator's intention to establish a detailed regulatory framework governing the scope of voluntary health insurance activities.

In the late 1990s, the development of voluntary health insurance formed part of the broader process of institutional development of the system of supplementary social insurance in Bulgaria. With the adoption of the Supplementary Voluntary Pension Insurance Act (State Gazette, No. 65 of 20 July 1999), the State Agency for Insurance Supervision was established under the Council of Ministers. The newly established authority was responsible for licensing and supervising insurance companies carrying out activities in the field of supplementary social insurance, including pension, health, and unemployment insurance. This institutional concept was subsequently abandoned.

A significant change in the regulation of voluntary health insurance occurred in 2003 following amendments to the Health Insurance Act (State Gazette, No. 107 of 15 November 2002). A detailed legal framework governing health insurance companies was introduced, including provisions concerning their legal status and licensing regime. State supervision over voluntary health insurance activities was entrusted to the Insurance Supervision Agency.

The implementation of voluntary health insurance presupposes the existence of two types of contractual relationships. The first type is the health insurance contract concluded between the insured person and the voluntary health insurance company. This contract determines the type and scope of medical and other services guaranteed to the insured person, as well as the amount of the health insurance premium. The second type consists of contracts concluded between the voluntary health insurance company and healthcare providers. Through these contracts, the prices of medical services are determined, as well as the conditions and procedures governing their provision to insured persons.

The legislator abandoned the initial concept of separate types of health insurance contributions and introduced two principal forms of voluntary health insurance—reimbursement of expenses and subscription-based services. Under the reimbursement model, the voluntary health insurance company reimburses, in whole or in part, the expenses incurred for healthcare services upon the occurrence of the cases provided for in the contract. Reimbursement may be made either to healthcare providers or to insured persons for healthcare services and goods paid for by them. The subscription-based model represents a form in which, upon the occurrence of the cases provided for in the contract, the voluntary health insurance company organizes the provision of specific healthcare services and goods through healthcare providers with whom it has concluded contractual agreements.

Within these legal parameters, voluntary health insurance functioned in Bulgaria until 2012. From the very introduction of health insurance in the country, parallels were frequently drawn with the pension system, which is structured on the basis of a combination of mandatory and supplementary pillars. Unlike supplementary pension insurance, however, voluntary health insurance does not include a mandatory component, which has had a significant impact on its development.

Statistical data confirm the limited scope of this mechanism. According to data from the Financial Supervision Commission, as of 31 March 2012 the number of insured persons in universal pension funds reached 1,630,025. By comparison, at the end of February 2012 the number of persons covered by voluntary health

insurance amounted to 189,427. The claims paid by voluntary health insurance companies by the end of the first quarter of 2012 totalled BGN 6,217,733 (approximately EUR 3,179,076 at the fixed BGN–EUR exchange rate)⁶.

These data demonstrate that, despite more than a decade of existence, voluntary health insurance remained limited in scope and relatively marginal within the system of healthcare financing. The existence of nineteen licensed voluntary health insurance companies did not lead to a substantial expansion of the market. In this sense, the initial model of voluntary health insurance may be characterized as functionally underdeveloped and unable to fulfil its intended purpose—namely, to provide individuals with an additional level of health protection beyond that guaranteed by the National Health Insurance Fund.

2.3. Transition from voluntary health insurance to medical insurance – the regulatory reform of 2012

The infringement procedure No. 2010/2156⁷, initiated by the European Commission against the Republic of Bulgaria, represents a significant turning point in the development of the legal regime governing voluntary health insurance. In the course of the procedure, the Commission concluded that the existing regulatory framework under the Health Insurance Act excluded voluntary health insurance companies from the scope of the EU directives on non-life insurance and introduced restrictions on the free movement of capital under Article 63 TFEU.

As a result, the Bulgarian model of voluntary health insurance was found to be incompatible with the requirements relating to a unified prudential framework, solvency, technical provisions, and financial supervision applicable to insurance undertakings within the European Union. The procedure raised not only the issue of the formal transposition of EU law but also necessitated a conceptual reconsideration of the nature of voluntary health insurance—from a health insurance model to a medical insurance model.

In this respect, the intervention of the Commission acted as an external corrective to national regulatory autonomy and accelerated the institutional transformation of the sector, with a view to ensuring a level playing field for market participants and a higher level of consumer protection.

In this context, the legislative amendments to the Health Insurance Act (State Gazette, No. 60 of 7 August 2012) should be regarded as a direct response to the inconsistencies identified by the European Commission. Among the principal reasons for their adoption, the legislator expressly referred to “the removal of inconsistencies between the regulatory framework governing voluntary health insurance activities in the Republic of Bulgaria and EU law in the field of insurance, as well as the termination of the infringement procedure No. 2010/2156 initiated by the European Commission against the Republic of Bulgaria.” In this way, the national legislator undertook a conceptual reorientation of the model by subjecting voluntary health insurance to the regulatory regime of insurance law.

The current legal framework contains an internal systemic tension. On the one hand, Article 81 of the Health Insurance Act provides that the relevant chapter regulates voluntary health insurance as part of the health insurance system. On the other hand, Article 82 expressly stipulates that voluntary health insurance is carried out on the basis of a medical insurance contract within the meaning of the Insurance Code. In this way, the legislator simultaneously preserves the terminology of social security law while subjecting the substantive content of the legal relationship to the regime of insurance law.

The conceptual tension between these provisions becomes even more pronounced in the Bulgarian linguistic context. In the national legal tradition, the concepts of “social security” (*osigurjavane*) and “insurance” (*zastrahovane*) have a distinct historical origin and perform different social functions, although in English-language terminology they are often rendered by the common term “insurance.” This duality is not new—as early as the beginning of the twentieth century, Bulgarian legislation clearly distinguished between the public social security system and private insurance activity⁸, each of which developed on the basis of a different normative and economic foundation.

⁶ See M. Radeva, *Pravna ramka na dobrovolnoto zdravno osiguryavane*, in *Proceedings of the Rousse University*, 2012, vol. 51, series 7, p. 241 (in Bulgarian).

⁷ See European Commission, *Internal Market: Commission acts to protect policy-holders and to ensure level playing field in the Bulgarian health insurance sector*, Press Release IP/12/72, available at https://ec.europa.eu/commission/presscorner/detail/en/ip_12_72, last time consulted on 16.03.2026.

⁸ At the end of the nineteenth century, the development of insurance in Bulgaria was influenced by the presence of foreign companies. Among the first pioneers of insurance activity were the Romanian companies *Dacia* and *Naționala*, later joined by the American *New York Life* and the Austrian *Anker*. The first Bulgarian insurance company was established in 1891 in Ruse.

The concept of “social insurance” (Ger. Sozialversicherung, Fr. assurances sociales, Eng. social insurance) historically emerged as a response to the social risks associated with industrialization and the development of wage labour. It reflects the societal need to protect workers in situations of adverse social and economic circumstances. Its origins may be traced, on the one hand, to the mutual aid societies established by workers themselves (*sociétés de secours mutuels*, *Hilfskassen*, friendly societies), and, on the other hand, to the gradual recognition by the state of employers’ liability for damages arising from occupational accidents. In Bulgaria, social insurance developed as one of the early manifestations of social policy as early as the first decade of the twentieth century, laying the normative foundations for the distinction between the public social security system and private insurance activity.

Insurance (Fr. *assurance*, Ger. *Versicherung*, Eng. *insurance*, It. *assicurazione*) constitutes an autonomous legal and economic institution, the purpose of which is to provide protection against the adverse consequences of future uncertain events through the contractual distribution of risk among a plurality of participants⁹. It operates on a market basis and is founded on the principle of equivalence between the risk assumed and the premium due.

Although both are built upon the common idea of risk transfer¹⁰ and distribution, social security and insurance perform different social functions. The former is based on the principle of solidarity and is governed by public law, whereas the latter is characterized by contractual autonomy and a private-law nature. It is precisely this distinction that gives rise to the particular complexity of the contemporary regulation of voluntary health insurance, which is formally designated as “social security,” yet is materially implemented through an insurance legal relationship.

In public discourse, a parallel is often drawn between pension provision and healthcare as systems structured around a combination of mandatory and supplementary elements. In Bulgaria, the pension system is organized as a three-pillar model: mandatory public social security (as part of the State Social Security system), supplementary compulsory pension insurance, and supplementary voluntary pension insurance. The mandatory pillar is administered by the National Social Security Institute, whereas the second and third pillars are managed by pension insurance companies—private joint-stock companies whose legal framework is governed by the Social Security Code.

The situation in the field of healthcare following the 2012 reform evolved along a different trajectory. While in the pension system private pension insurance companies continue to operate as independent entities, health insurance companies ceased to exist. By 7 August 2013, companies holding licences for voluntary health insurance were required to bring their activities into compliance with the requirements of the Insurance Code and to obtain a licence to carry out insurance activities. Those that failed to meet these requirements were obliged to terminate their operations.

As a result, voluntary health insurance did not develop as an independent “second pillar” of the healthcare system but was institutionally integrated into the general insurance regime. This further confirms its transformation from a social security-based model to an insurance-based model.

In light of the above terminological and systematic clarifications, the question arises whether voluntary health insurance, in its current form, continues to exist as an autonomous social security institution. Following the 2012 reform, its content, subjects, and supervisory regime have been subordinated to the Insurance Code, which effectively aligns it with the model of private health insurance.

Nevertheless, until an explicit legislative amendment is introduced, Bulgarian law formally preserves the two-component structure of healthcare—compulsory and voluntary health insurance. Thus, the normative terminology continues to employ the concept of “insurance” in the sense of social security, even though the substantive legal content of voluntary health insurance is built upon an insurance principle. Alongside this normative and institutional transformation, broader questions also arise regarding the systemic position and the permissible scope of the voluntary component within the healthcare system.

⁹ See Targovski *entsiklopedichen rechnik*, Cooperative Printing House “Tipograf”, Sofia, 1930, pp. 175–176, 345 (in Bulgarian).

¹⁰ See Kr. Sredkova, *Osiguritelno pravo*, Sibi Publishing House, Sofia, 2008 (in Bulgarian), p. 510: “Insured persons receive the medical care to which they are entitled without paying its equivalent. It is paid by the insurance institution – the National Health Insurance Fund or the health insurance company. This reflects the transfer of risk from the insured person to the insurance institution, which constitutes the essence of any social security system.” (author’s translation).

2.4. Attempt at closer integration of voluntary health insurance

In the context of the search for a more sustainable model of healthcare financing in the period following 2012, policies were formulated aimed at increasing efficiency and prioritising public expenditure. The “Health 2020 Goals” Concept, adopted by the Council of Ministers in 2015, places emphasis on the financial sustainability of the system, taking into account pressures arising from demographic trends, technological progress, and limited fiscal resources.

Within this framework, it was proposed to structure healthcare activities into distinct packages: a basic package, guaranteeing prevention, diagnosis, and treatment of socially significant diseases, as well as child and maternal health; a supplementary package, encompassing planned activities for which a waiting-list mechanism may be applied; and an emergency package, financed from the state budget.

It is precisely within the supplementary package that the functional link with voluntary health insurance becomes apparent, as individuals who do not wish to wait for the provision of planned services may obtain access through a medical insurance contract. In this way, the voluntary component is integrated as a parallel mechanism for expedited access, raising the question of the extent to which such a construction is compatible with the principle of equality within the framework of the mandatory system.

The vision for the development of voluntary health insurance is also reflected and further elaborated in the strategic framework of state health policy, as set out in the National Health Strategy 2020¹¹. This strategic document attempts a systematic conceptualisation of the balance between the public solidarity-based system and supplementary financing mechanisms.

The National Health Strategy adopts the logic of prioritisation and structuring of healthcare service packages, while explicitly providing for the creation of appropriate conditions and incentives for the development of voluntary health insurance through medical insurance. Under Priority 2, Policy 2.1, the need for a strategic allocation of resources across healthcare service packages and sources of financing is expressly emphasised. Within the supplementary package, insured persons are envisaged as having the possibility to access services “outside the established mechanisms of financing through public funds.”

This formulation clearly links voluntary health insurance to the supplementary package and positions it as an instrument for alternative access to healthcare services. It is precisely at this point that the central question emerges—whether, and to what extent, the pursuit of closer integration of the voluntary component is compatible with the foundations of the solidarity-based public health system.

It should, however, be emphasised that the National Health Strategy 2020 constitutes a strategic and programmatic document outlining the policy priorities and directions for the development of the system, but does not establish directly applicable legal norms. In this sense, the role attributed therein to voluntary health insurance has the character of a programmatic objective, the implementation of which depends on subsequent legislative measures and on their compatibility with the established principles of mandatory participation, solidarity, and equal access to medical care. In this way, voluntary health insurance is positioned at the level of health policy as a supplementary mechanism, while its institutionalisation and limits remain subject to further normative specification.

The vision formulated at the strategic level does not remain confined to the sphere of programmatic intentions. At the beginning of 2015, the Council of Ministers submitted to the National Assembly a draft law amending and supplementing the Health Insurance Act, seeking to provide a normative implementation of the concept of structuring healthcare services into distinct packages.

It was proposed that the activities financed by the National Health Insurance Fund (NHIF)—that is, those covered within the framework of mandatory health insurance and traditionally regarded as the “basic package”—be divided into a basic and a supplementary package. At the level of legislative technique, this creates the possibility for differentiating access to medical services according to their social significance and temporal urgency.

However, it is noteworthy that the explanatory memorandum¹² to the draft law in this respect is extremely concise. It merely states that “the package of medical services financed by the NHIF is divided into a basic and a supplementary package,” while the specific medical activities included in each package are to continue to be

¹¹ See National Assembly Decision of 17 December 2015, SG No. 101 of 22 December 2015 (Bulgaria).

¹² See National Assembly of the Republic of Bulgaria, Draft Law amending and supplementing the Health Insurance Act, available at <https://www.parliament.bg/bg/bills/ID/15200>, last time consulted on 16.03.2026.

regulated by an ordinance of the Minister of Health. A more in-depth justification is lacking with regard to the relationship between the two packages, the criteria for their differentiation, and the place of supplementary voluntary insurance. This laconic approach raises the question of whether the legislative solution constitutes merely a technical restructuring of financing or introduces a deeper transformation in the logic of the mandatory health insurance model.

Following the adoption of the law, a group of Members of Parliament referred the matter to the Constitutional Court, seeking a declaration of unconstitutionality of the adopted amendments. The applicants argued that the division of the package of healthcare services into a basic and a supplementary package is contrary to the principle of the social state.

The principles of social justice, security, solidarity, and mutual assistance require that health insurance solidarity operate both in the payment of health insurance contributions and in access to medical care, which must be ensured on an equal basis. The establishment of two packages, subject to different conditions and procedures for access, is perceived as an impermissible differentiation of access and as a form of discrimination.

In its decision, the Constitutional Court does not, in principle, deny the possibility of structuring healthcare services into distinct packages. The Court holds that such an approach may be compatible with the model of mandatory health insurance, including in the presence of supplementary mechanisms such as medical insurance contracts. The main issue, according to the Court, arises from the manner in which this concept has been implemented legislatively.

A lack of clear criteria for distinguishing between the “basic” and the “supplementary package” was identified, as well as deficiencies in the regulation concerning the financial coverage of the respective activities. The direct authorisation of the Minister of Health, by means of an ordinance, to determine the content of the packages was regarded as an impermissible delegation of legislative powers and as a violation of the principle of separation of powers.

Following the delivery of the decision—which does not, in essence, exclude the possibility of differentiating packages within the framework of mandatory health insurance, but rather sanctions the chosen regulatory approach—the legislator did not undertake a new attempt at a comprehensive normative implementation of this concept. As a result, the idea of closer integration of the voluntary component into the health insurance system remains at the level of a strategic vision, without receiving stable legislative concretisation.

The current National Health Strategy 2030¹³, while preserving the overall logic of pursuing financial sustainability and reducing out-of-pocket payments, places voluntary health insurance in a less prominent position compared to the previous strategic document. Among the policy objectives up to 2030, it is indicated that the share of out-of-pocket payments and informal expenditures in the system should be reduced through the creation of incentives for the development of voluntary health insurance.

The wording is indicative: more than a decade after the normative transformation of the institution and its definitive positioning within the framework of insurance law, reference is once again made to the need to “stimulate” its development.

However, this rhetoric of encouragement is not accompanied by consistent and comprehensive legislative measures capable of establishing a sustainable model of interaction between the mandatory and the voluntary components of the system. Normative incentives remain limited and fragmented. By way of example, reference may be made to Article 28(1)(2) of the Personal Income Tax Act, which provides for a reduction¹⁴ of the annual tax base by the amount of personal contributions paid during the year for voluntary health insurance, subject to certain conditions. While such measures have an incentivising effect, they do not constitute an independent policy for the structural integration of voluntary health insurance into the healthcare system.

In this context, particular importance attaches to the analysis of the applicable legal framework, which determines the actual legal parameters of voluntary health insurance in Bulgaria.

¹³ See National Assembly Decision of 18 April 2024, SG No. 37 of 26 April 2024 (Bulgaria).

¹⁴ See V. Panteleeva, *Praven rezhim na mestnite danatsi*, Mediatech Publishing House, Pleven, 2023 (in Bulgarian), p. 4: “The tax reliefs provided for in the legislation constitute an instrument for achieving a fair distribution of the tax burden” (author’s translation).

2.5. Applicable legal framework of voluntary health insurance

Beyond the strategic documents and the unsuccessful legislative attempt, it is necessary to examine the applicable legal framework within which voluntary health insurance currently operates, as well as its practical dimensions.

Voluntary health insurance is defined as an activity involving the assumption of risks related to the financial coverage of specific healthcare services and goods in exchange for the payment of premiums, on the basis of insurance contracts (Article 3 of the Health Insurance Act). Voluntary health insurance is carried out on the basis of a medical insurance contract within the meaning of Chapter Forty, Section IV of the Insurance Code.

Chapter Forty of the Insurance Code regulates classes of non-life insurance, while Section IV is entitled “Health (medical) insurance.” In this way, the legislator unequivocally positions voluntary health insurance within the framework of general insurance, rather than as an autonomous social security institution.

The medical insurance contract, regulated in Article 427 of the Insurance Code, defines the specific legal content of the legal relationship through which the voluntary element of health protection is effectively implemented. Under this contract, the insurer undertakes to cover expenses for healthcare goods and services arising from illness or accident, as well as other agreed risks, including those related to prevention, pregnancy and childbirth, or temporary loss of income due to illness or accident, as well as combinations of such cover. The law allows for different forms of indemnification, including the payment of fixed monetary sums, reimbursement of actual expenses incurred, or a combination of both mechanisms. In addition, ancillary services such as transport, specialised care, and palliative care may also be covered. An essential element of the contract is the possibility to determine a maximum limit of the insurer’s liability, either through a sum insured or by limiting the scope and extent of services for a specified period. These characteristics—contractual freedom in determining the scope of cover, limited liability, and the premium-based principle—confirm that the substantive content of voluntary health insurance follows the logic of a classical insurance legal relationship.

The Health Insurance Act does not merely define voluntary health insurance; it also expressly delineates its boundaries by identifying activities which—although closely related in subject matter—do not fall within its scope. These include medical insurance contracts concluded in connection with travel outside the territory of Bulgaria. Also excluded is the activity of healthcare providers under contracts with natural or legal persons for the provision of medical services with predefined types, scope, and prices.

Through this distinction, the legislator clearly separates voluntary health insurance within the meaning of the Health Insurance Act from other forms of health coverage or contractual arrangements in the field of medical services. These constitute independent insurance products or service contracts that do not form part of the health insurance framework.

The activity of voluntary health insurance may be carried out exclusively by joint-stock insurance companies licensed for the classes of insurance referred to in item 2, or in items 1 and 2 of Section II, letter “A”, of Annex No. 1 to the Insurance Code. Annex No. 1 sets out the classes of insurance, with Section II covering non-life insurance classes. Letter “A” contains a classification of risks according to the relevant insurance class. In this way, voluntary health insurance is positioned within the system of non-life insurance.

Under the “Accident” risk, the insurer may provide fixed monetary sums, indemnities, or a combination of both mechanisms. Under the “Sickness” risk, analogous forms of indemnification are provided.

The regulatory framework governing voluntary health insurance also predetermines the nature of the control mechanisms applicable to its operation. These may be broadly distinguished into two areas—general insurance supervision and specialised oversight. This two-tier control framework reflects the dual nature of the institution—on the one hand, as an insurance activity, and, on the other, as a mechanism aimed at financing and securing access to medical services.

Insofar as voluntary health insurance is carried out by joint-stock insurance companies, a key role is played by the Financial Supervision Commission (FSC). Under its governing statute, the Commission constitutes a specialised state authority responsible for the regulation and supervision¹⁵ of supervised entities in the non-banking financial sector¹⁶. In this capacity, the Commission exercises state insurance supervision under the

¹⁵ See S. Penov, *Kurs po finansovo pravo – spetsialna chast*, University Press “St. Kliment Ohridski”, Sofia, 2021 (in Bulgarian), pp. 409–428.

¹⁶ Within the meaning of the Financial Supervision Commission Act, financial markets include the securities market and the market for insurance and social security services.

Insurance Code, including in relation to companies licensed for the classes of insurance through which voluntary health coverage is provided. Its supervisory powers encompass both the granting and withdrawal of licences, as well as ongoing control over solvency, investment policy, and the protection of insurance service users, among other aspects.

The Health Insurance Act provides for the so-called “medical control”—a term that may raise certain reservations¹⁷ from a systematic perspective, yet has been adopted by the legislator. This control is exercised by the Executive Agency “Medical Supervision” and concerns not the financial stability of insurers, but the lawfulness and the actual provision of healthcare services agreed under medical insurance contracts. The Agency monitors whether the insurers referred to in Article 83(1) of the Health Insurance Act ensure the provision of healthcare services in accordance with the terms of the insurance contract. It also prepares an annual report to the Minister of Health on the state and overall functioning of health insurance, including voluntary health insurance. In this sense, medical control performs the function of sector-specific monitoring aimed at safeguarding the public interest in the field of health protection.

The law also provides for coordination between the Executive Agency “Medical Supervision” and the Financial Supervision Commission (FSC). The Agency provides the Deputy Chairperson of the FSC, in charge of the Insurance Supervision Division, with information obtained in the exercise of its powers, including information concerning natural and legal persons or healthcare establishments carrying out activities related to voluntary health insurance without the required licence. Upon explicit request, it prepares opinions on the content and enforceability of medical insurance contracts. This framework demonstrates a functional interaction between financial supervision and the so-called medical control.

For the purpose of exercising its powers, the Agency is entitled to request and examine contracts concluded between insurers and healthcare providers. The National Health Insurance Fund and insurers are required to submit semi-annual reports containing data on the number of persons served, as well as the type and scope of services provided. Insurers must also provide a list of the healthcare providers with whom they have concluded contracts, along with information necessary for health statistics and for monitoring the health status of the population. Access to personalised data is granted exclusively to Agency officials, who may use such data solely for the performance of their supervisory functions.

Officials of the Executive Agency “Medical Supervision” are vested with powers to conduct on-site inspections at insurers and healthcare establishments and may request the necessary documents and information. Insurers and healthcare establishments are obliged to cooperate. Thus, alongside financial supervision, a specialised mechanism is established to ensure the lawfulness and quality of medical services within the framework of voluntary health insurance.

The regulatory framework delineates the institutional boundaries of voluntary health insurance but does not provide a complete picture of its actual position within the structure of payments for medical services. It is therefore also necessary to examine statistical data on the development of the voluntary health insurance (medical insurance) market, which make it possible to assess the actual scope and significance of the voluntary component.

2.6. Scope, structure and dynamics of voluntary health insurance in Bulgaria (2023–2024)

The present analysis is based on data from the Annual Report on the State and Overall Activity of Health Insurance in the Republic of Bulgaria for 2023, prepared by the Executive Agency “Medical Supervision”, as well as on the data for 2024 contained in the subsequent annual report of the Agency. On the basis of these sources, an analysis is carried out of the scope, structure and dynamics of voluntary health insurance in Bulgaria.

According to data from the Financial Supervision Commission, as of the end of 2023, 24 insurance undertakings were carrying out non-life insurance activity in Bulgaria, of which 14 offered sickness insurance. Within this class of insurance, seven types of health insurance packages are offered: “Health improvement and disease prevention”, “Outpatient medical care”, “Inpatient medical care”, “Reimbursement of expenses”, “Dental services / dental care”, “Services related to accommodation and other additional conditions in the provision of medical care”, and “Other health insurance packages”.

¹⁷ See M. Radeva, *Printsipi na zadalzhitelnoto zdravno osiguruvane*, Academic Publishing House “Ruse University”, Ruse, 2025 (in Bulgarian), p. 187.

The data for 2024 indicate that the number of insurance undertakings offering sickness insurance remains unchanged, while a similar range of health insurance packages is maintained. This points to a relative stability of the market in terms of participants and the product framework of voluntary health insurance. Both in 2023 and in 2024, insurers offering between five and six packages prevail, with the packages “Other health insurance packages” and “Services related to accommodation and other additional conditions in the provision of medical care” being the least frequently offered. This reveals a high degree of structural similarity in the insurance coverage provided and confirms the relative stability of the product model on the voluntary health insurance market.

The data for 2023 show an expansion of the voluntary health insurance market. The total number of insured persons under sickness insurance increased from 439,999 in 2022 to 486,839 in 2023, representing a growth of 10.65%. This increase indicates a clear upward trend in the demand for voluntary health insurance. The data for 2024 confirm the continuation of this upward dynamic, with the total number of insured persons reaching 498,383, which represents an increase of 2.37% compared to 2023. At the same time, a significant slowdown in the growth rate is observed—from 10.65% in 2023 to 2.37% in 2024—which may be regarded as an indication of a transition to a more moderate phase of market development.

The distribution of insured persons by age groups shows a strong concentration within the active age group of 18–64 years. In 2023, this group included 447,934 persons, representing over 90% of all insured persons. In 2024, this structure is preserved, with the number of insured persons in the 18–64 age group reaching 457,058, or approximately 91.7% of the total number of insured persons. This proportion clearly indicates that voluntary health insurance is used predominantly by the economically active population.

The reason for this lies in the mechanism of product distribution. A significant share of insurance contracts is concluded as group corporate contracts, whereby employers provide voluntary health insurance for their employees. The data for 2024 confirm the persistence of this trend, with group contracts remaining the main distribution channel. Consequently, the majority of insured persons belong to the working-age population.

At the same time, an increase is observed in the number of insured persons in the group of children and young people (0–17 years). Their total number increased from 24,753 in 2022 to 29,178 in 2023, and reached 31,004 in 2024 (approximately 6.2% of all insured persons). This trend may be explained by the inclusion of family members of insured employees in corporate contracts.

An increase is also observed in the age group above 65 years, although its relative share remains low. The total number of insured persons in this group rose from 8,124 in 2022 to 9,727 in 2023, reaching 10,321 in 2024 (approximately 2.1% of all insured persons). The limited participation of persons in this age group may be explained both by the financial burden of the product and by the fact that, in most cases, health insurance contributions for persons over 65 are covered by the state.

Despite the increase in the number of insured persons, approximately 7.5% of the population of Bulgaria¹⁸ was covered by voluntary health insurance in 2023. According to current demographic data, the population of the country at the end of 2024 was 6,437,360¹⁹, which implies that the coverage of voluntary health insurance reached approximately 7.7%. This indicates a slight increase in the relative share of insured persons. Despite this positive dynamic, the share remains low, demonstrating that voluntary health insurance continues to occupy a limited position within the structure of healthcare financing, covering less than one tenth of the population. In this sense, voluntary health insurance functions primarily as a complementary mechanism to the system of mandatory health insurance, used mainly by economically active individuals included in group corporate contracts.

The data show a clear concentration of insured persons in several main health insurance packages. In 2023, the most widely used package was “Outpatient medical care”, covering 381,411 persons, followed by “Inpatient medical care” with 359,604 persons and “Reimbursement of expenses” with 288,020 persons.

In 2024, however, a restructuring is observed in the distribution of insured persons across health insurance packages. The largest number of insured persons is recorded under the “Inpatient medical care” package—377,896 persons, representing an increase of 5.09% compared to 2023. The “Outpatient medical care” package

¹⁸ According to data from the National Statistical Institute, the population of Bulgaria at the end of 2023 was 6,445,481 persons.

¹⁹ National Statistical Institute, Population of the Republic of Bulgaria as of 31 December 2024, available at https://www.nsi.bg/file/28603/Population2024_F59F6N4.pdf, last time consulted on 16.03.2026.

ranks second with 370,499 persons, showing a decrease of 2.86%. The “Reimbursement of expenses” package remains in third place with 268,329 persons, reflecting a decline of 6.84% compared to the previous year.

These data indicate a shift in the structure of demand for insurance coverage, expressed in the increasing relative importance of inpatient medical care at the expense of outpatient care and reimbursement of expenses. This dynamic may be interpreted as an indication of increased sensitivity to more serious health risks or as a result of the adaptation of insurance products to the needs of insured persons.

The analysis of the data for the period 2023–2024 makes it possible to outline the main patterns in the use of the different health insurance packages within voluntary health insurance, as well as the relationship between the scope of coverage and the intensity of healthcare service utilisation.

Under the “Outpatient medical care” package, in 2023, medical services were used by 153,070 insured persons, while the total number of claims paid reached 660,996. On average, approximately four claims per insured person were recorded for the year. The number of persons using the service increased by 1.88% compared to 2022. The data for 2024 show a significant expansion in the scope of utilisation of this package. The number of insured persons who used medical services reached 172,230, representing an increase of 12.52% compared to 2023. The total number of claims paid increased to 802,066, while the average number of claims per insured person remained at approximately four per year.

This dynamic shows that the increase in the number of users is not accompanied by a change in the intensity of service utilisation, which suggests a relatively stable pattern of consumption. Outpatient medical care thus emerges as one of the most widely used components of voluntary health insurance, characterised by broad coverage and a predictable frequency of use. This conclusion should be considered in conjunction with the structure of insurance coverage in 2024, in which the “Inpatient medical care” package occupies a leading position. This points to a distinction between the structure of coverage and the actual use of healthcare services—while inpatient care is more widely included in insurance products as protection against risk, outpatient care remains the most frequently used type of medical service.

Under the “Inpatient medical care” package, in 2023, medical services were used by 11,326 insured persons. The total number of claims paid amounted to 17,994, corresponding to an average of approximately 1.6 claims per insured person for the year. The data for 2024 show an increase in the number of persons using inpatient medical care, reaching 18,181. This represents a significant increase compared to the previous year. The total number of claims paid also increased to 21,311, resulting in an average of approximately 1.2 claims per insured person. This dynamic indicates an expansion in the scope of utilisation of inpatient medical care combined with a decrease in the intensity of use. The increase in the number of users may be interpreted as an indication of broader access or more active use of this type of service, while the lower average number of claims reflects the specific nature of inpatient care as a service with lower frequency but higher severity per event.

In comparison with outpatient medical care, a clear distinction in the consumption model emerges—while outpatient care is characterised by high frequency and regularity of use, inpatient medical care is used significantly less often but is associated with more serious health events. This confirms the role of the inpatient package as an instrument for covering higher health risks rather than as a means of financing routine medical services.

Under the “Reimbursement of expenses” package, in 2023, medical services were used by 51,886 persons, with the number of claims paid reaching 111,338. On average, approximately two claims per insured person were recorded, while the total number of claims paid under this package increased by 15.54% compared to 2022. The data for 2024 show a continuation of the upward trend. The number of insured persons who used medical services increased to 59,640, while the number of claims paid reached 128,826, representing an increase of 15.71% compared to the previous year. The average number of claims per insured person remained at approximately two per year. This dynamic indicates both an expansion in the scope of utilisation and stability in the intensity of use. Compared to the other packages examined, the “Reimbursement of expenses” package is characterised by a lower frequency of use but a clear upward trend, reflecting its flexible function in covering individual healthcare expenditures.

In 2023, the largest number of claims—911,002—was paid under the “Health improvement and disease prevention” package. On average, approximately ten claims per insured person were recorded for the year. The data for 2024 indicate a change in the dynamics, although the package remains among those with a high number of claims, being surpassed by outpatient care. A decrease of 2.10% is observed in the number of insured persons under this package compared to 2023. At the same time, the number of insured persons who used medical

services reached 90,852, representing an increase of 2.54% compared to the previous year. The total number of claims paid decreased to 800,703, while the average number of claims per insured person declined to approximately nine per year. This dynamic indicates a simultaneous decrease in the number of insured persons and an expansion in the actual use of services. The increase in the number of users combined with a decrease in the total number of claims suggests broader but more moderate utilisation of services within the package. A full interpretation of this trend would require additional data on the content and conditions of the specific insurance coverage. Despite this change, the importance of the package remains significant, as prevention plays a key role in the early detection and limitation of health risks, as well as in reducing the need for more costly and intensive medical interventions.

The data for 2023 and 2024 show that, despite the differing scope and heterogeneous dynamics of the individual packages, a general trend towards increased utilisation of healthcare services can be identified, while the dynamics of the number of claims paid remain differentiated depending on the nature of the respective package. Within this trend, particular attention should be paid to the data concerning the “Dental services” package, given that the coverage of dental care under the mandatory health insurance system is limited in scope and extent.

In 2023, an increase of 15.52% is observed in the number of insured persons under the “Dental services” package compared to 2022, exceeding the overall growth rate of insured persons under sickness insurance (10.65%). It should also be noted that two of the insurance undertakings do not offer this package. The higher growth rate indicates increasing interest in covering dental services through voluntary health insurance. In 2023, 33,559 insured persons used medical services under this package, while the number of claims paid amounted to 66,282, corresponding to an average of approximately two claims per insured person. Compared to 2022, the number of users increased by 13.73%, and the number of claims by 6.55%.

The data for 2024 confirm and further reinforce this trend. The number of insured persons under the “Dental services” package increased by 12.48% compared to 2023, while again two insurance undertakings did not offer this package. The number of insured persons who used medical services reached 47,698, representing an increase of 24.97% compared to 2023, and the number of claims paid rose to 82,200 (an increase of 24.02%). The average number of claims per insured person remained at approximately two per year.

This dynamic indicates both an expansion in the scope of utilisation and a relatively stable intensity of use. The increase in both the number of insured persons and the actual use of services may be interpreted as an indicator of a growing need for additional financing of dental care beyond the scope of mandatory health insurance. In this sense, the “Dental services” package stands out among the examined packages with a clearly expressed compensatory function, filling the gaps in the coverage of dental services within the mandatory health insurance system.

The data for 2023 and 2024 show that the voluntary health insurance market in Bulgaria continues to develop, albeit with different intensity across the two periods under review. While in 2023 a more pronounced increase is observed both in the number of insured persons and in the use of covered healthcare services, in 2024 the upward dynamic continues but with a significant slowdown in the growth rate. Nevertheless, the scope of voluntary health insurance remains relatively limited, covering less than 10% of the population even in 2024.

Particularly indicative are the differences between the individual health insurance packages, as well as the divergence between the scope of insurance coverage and the actual use of healthcare services. While in 2024 the “Inpatient medical care” package occupies a leading position in terms of coverage, the highest intensity of utilisation is observed in outpatient medical care, which emerges as the leading category in terms of the number of claims.

The most clearly expressed functional specificity is observed in the “Dental services” package, where a high growth rate is maintained both in the number of insured persons and in the actual use of services in 2024. This confirms that voluntary health insurance performs a compensatory role precisely in those segments of healthcare where mandatory health insurance provides more limited coverage or insufficient financing.

In this sense, the statistical data for 2023–2024 clearly outline the functional profile of voluntary health insurance in Bulgaria—relatively limited in scope in relation to the population, but directed towards covering those healthcare services for which public health insurance provides more limited coverage or funding (notably dental services), as well as towards facilitating access to medical care in services with a higher frequency of use, such as outpatient medical care.

3. Conclusions

The development of the legal framework demonstrates that voluntary health insurance in Bulgaria has undergone a significant institutional transformation. Initially introduced by the Health Insurance Act of 1998 as a supplementary mechanism to the mandatory system, following the reform of 2012 it has been gradually integrated into the regulatory framework of insurance law. The current legal regime thus establishes a specific model in which voluntary health insurance is formally positioned within the health insurance system, while the substantive legal relationship is implemented through a contract of medical insurance.

The analysis of strategic documents and legislative initiatives shows that, over the past decade, the voluntary component has consistently been present in health policy as a potential supplementary source of financing. Nevertheless, a coherent and comprehensive legislative concept defining a stable model of interaction between the mandatory health insurance system and voluntary mechanisms of health protection remains absent.

The statistical data for the period 2023–2024 confirm and further specify these findings. Although the market of voluntary health insurance demonstrates growth in the number of insured persons and an expansion in the use of covered health services, its overall scope remains limited, covering a relatively small share of the population. At the same time, a clear distinction emerges between the structure of insurance coverage and the actual use of medical services: while hospital care occupies a leading position within insurance products as protection against risk, outpatient medical care and dental services are characterized by the highest frequency of actual utilization.

This functional differentiation indicates that voluntary health insurance performs predominantly a compensatory role, targeting those segments of healthcare where public financing is limited or access is constrained. In practice, voluntary insurance is primarily used as a corporate benefit for economically active individuals, which further explains its limited overall coverage.

In this context, voluntary health insurance in Bulgaria operates as a supplementary mechanism with a limited scope, aimed at expanding access to specific healthcare services without substituting the public guarantee of the basic healthcare package. The clear normative delineation between these two levels of health protection remains essential for preserving the solidarity-based character and the social function of the Bulgarian health insurance system.

This study contributes to clarifying the legal nature and systemic position of voluntary health insurance by proposing an analytical model distinguishing between the social insurance and insurance law elements within healthcare protection, complemented by an empirical analysis of patterns of service utilization. From a practical perspective, the findings may support the development of a more consistent legislative and policy framework for the voluntary component.

Future research should further explore the interaction between public financing and voluntary mechanisms, including through comparative legal analysis and evaluation of the effectiveness of different models of supplementary health coverage. Particular attention should be given to achieving a normative balance between encouraging voluntary participation and ensuring equal access to healthcare within the solidarity-based system.

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