

1. Introduction

In 1992, the legislative institutions of the European Union (EU) adopted regulatory measures in the field of health insurance.¹ The mechanism affirming the free movement of health insurance services – the Third Non-life Insurance Directive² – does not apply to health insurance that forms part of a social security system. But all other forms of health insurance, which we refer to as ‘private health insurance’, fall within the Directive’s scope. This chapter examines the implications of the Directive, and some aspects of EU competition law, for the regulation of private health insurance in the European Union. The EU-level regulatory framework created by the Directive imposes restrictions on the way in which governments can intervene in markets for health insurance. However, there are areas of uncertainty in interpreting the Directive, particularly with regard to when and how governments may intervene to promote public interests. As in most spheres of EU legislation, interpretation largely rests on European Court of Justice (ECJ) case-law, so clarity may come at a high cost and after considerable delay.

The chapter also questions the Directive’s capacity to promote consumer and social protection in health insurance markets. In many ways, the Directive reflects the health system norms of the late 1980s and early 1990s, a time when boundaries between ‘social security’ and ‘normal economic activity’ were still relatively well defined

¹ This is an extensively revised and updated version of an article that originally appeared as S. Thomson and E. Mossialos, ‘Regulating private health insurance in the European Union: the implications of single market legislation and competition policy’, *Journal of European Integration* 29 (2007), 89–107. The authors are grateful to Rita Baeten, Tamara Hervey and Willy Palm for their comments on an earlier draft of the chapter.

² The third ‘Non-life Insurance’ Directive, Council Directive 92/49/EEC on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance, OJ 1992 No. L228/23. From here on we refer to this as ‘the Directive’.

in most Member States.³ Today, these boundaries are increasingly blurred – the new health insurance system in the Netherlands is a case in point. As governments look to private health insurance to ease pressure on public budgets or to expand consumer choice, uncertainty about the scope of the Directive and concerns about its restrictions on regulation are likely to grow.

We base our analysis on discussion of private health insurance-related ECJ rulings and cases of infringement of the Directive or other EU rules. Where actual examples are lacking, the analysis is, inevitably, more speculative. In the following sections, we provide a brief introduction to private health insurance in the European Union; summarize the main changes brought about by the Directive and its initial impact on regulation of private health insurance in EU Member States; examine uncertainty as to when and how governments can intervene in health insurance markets; and conclude with a summary of key points.

2. Private health insurance in the European Union

Private health insurance is often defined as insurance that is taken up voluntarily and paid for privately, either by individuals or by employers on behalf of individuals.⁴ This definition recognizes that private health insurance may be sold by a wide range of entities, both public and private in nature. Organizations involved in providing private health insurance in the European Union include statutory ‘sickness funds’, non-profit mutual or provident associations and commercial for-profit insurance companies. In practice, however, the distinction between statutory and voluntary coverage is not always useful in determining what counts as private health insurance. Three examples illustrate this point. In 2006, the Netherlands introduced a universal health insurance scheme that is both statutory (it is compulsory for all residents) and private (operated by private insurers and governed by private law). The universal scheme replaced a system in which higher earners were excluded from statutory cover and could only obtain cover from private insurers. Conversely, higher-earning

³ R. White, *EC social security law* (Harlow: Longman, 1999).

⁴ E. Mossialos and S. Thomson, ‘Voluntary health insurance in the European Union: a critical assessment’, *International Journal of Health Services* 32 (2002), 19–88.

employees in Germany can join the statutory health insurance scheme on a voluntary basis – making them voluntarily but publicly insured – or choose to be covered by a private insurer. In Belgium, a mutual association recently began to provide what was traditionally seen as voluntary cover (of non-publicly-reimbursed hospital costs) on a compulsory basis. By extending this form of cover to all its members, it was able to offer it at a cheaper rate.

These developments stretch standard definitions of private health insurance. It may therefore be more constructive to focus on the role private health insurance plays in relation to public – or statutory – health coverage. Understanding this relationship is also important in light of the Third Non-life Insurance Directive, as we discuss below. Most EU Member States provide universal or near universal public coverage for health as part of a wider system of ‘social protection’. Due to the dominance of public coverage, private health insurance generally plays a modest role. For example, many Member States have a market for private health insurance that supplements public coverage by giving people greater choice of provider – often access to care in the private sector – and enabling them to bypass public waiting lists (see Table 10.1). This form of ‘supplementary’ private health insurance tends to be purchased by wealthier and better-educated people.⁵ Because it covers individuals and services already covered by the statutory health system, it rarely contributes to social protection.⁶

There are contexts in which private health insurance plays a more significant role. For example, ‘complementary’ private health insurance can cover services that are excluded from the statutory benefits package (outpatient visits, occupational therapy, dental care, etc.), as in Ireland, where it is combined with supplementary insurance and covers about

⁵ E. Mossialos and S. Thomson, *Voluntary health insurance in the European Union* (Copenhagen: World Health Organization, 2004).

⁶ It could be argued that supplementary private health insurance contributes to social protection if those who rely on private insurance do not make use of publicly-financed health care, freeing up public resources to be spent on those without private cover. However, there is little evidence in support of this argument. There is more evidence to suggest that supplementary private health insurance can actually distort public resource allocation in favour of richer groups – for example, where doctors are allowed to work in the public and the private sector and can generate waiting lists for publicly-financed care in order to boost their private activity. See J. Yates, *Private eye, heart and hip* (Edinburgh: Churchill Livingstone, 1995).

Table 10.1. Functional classification of private health insurance markets

Market role	Driver of market development	Nature of cover	EU examples
Substitutive	Public system inclusiveness (the proportion of the population to which coverage is extended)	Covers population groups excluded from or allowed to opt out of the public system	Germany, the Netherlands (prior to 2006)
Complementary (services)	Scope of benefits covered by the public system	Covers services excluded from the public system	Belgium
Complementary (user charges)	Depth of public coverage (the proportion of the benefit cost met by the public system)	Covers statutory user charges imposed in the public system	France, Slovenia, Denmark
Supplementary	Consumer satisfaction (perceptions about the quality of publicly-financed care)	Covers faster access and enhanced consumer choice	United Kingdom

Source: adapted from E. Mossialos and S. Thomson, 'Voluntary health insurance in the European Union: a critical assessment', *International Journal of Health Services* 32 (2002), 19–88; and T. Foubister *et al.*, *Private medical insurance in the United Kingdom* (Copenhagen: World Health Organization, 2006).

50% of the population.⁷ Or it may reimburse the costs of statutory user charges, as in Slovenia⁸ and France,⁹ where it covers over 70% and 92% of the population, respectively. In other Member States, private health insurance provides ‘substitutive’ cover for people excluded from some aspects of the statutory health system. This was the case for higher-earning households in the Netherlands prior to the introduction of statutory universal coverage in 2006. The 2006 reforms effectively abolished substitutive private health insurance in the Netherlands (or extended it to cover the whole population, depending on your perspective). Self-employed people in Belgium were also excluded from statutory cover of outpatient care prior to 2008, and wealthier households in Ireland were excluded from publicly-financed hospital care prior to the introduction of universal hospital cover. In addition, substitutive private health insurance may cover people who are allowed to opt into and out of the statutory scheme, such as higher-earning employees in Germany.

Differences in market role are reflected in the contribution private health insurance makes to spending on health care – both total levels of expenditure and levels of private expenditure. Table 10.2 shows how this contribution is very small in most Member States, only exceeding 5% of total spending and 20% of private spending in Austria, France, Germany, the Netherlands (prior to 2006) and Slovenia. However, spending through private health insurance has grown over time in many countries, particularly in the newer Member States of central and eastern Europe, where health insurance markets were more or less non-existent in the early to mid-1990s.¹⁰

3. Regulation and the Third Non-life Insurance Directive

Health insurance attempts to alleviate some of the uncertainty around ill health. We do not usually know if or when we might fall ill; nor

⁷ The Competition Authority, *Competition in the private health insurance market* (Dublin: The Competition Authority, 2007).

⁸ *Ibid.*

⁹ I. Durand-Zaleski, *The health system in France* (New York: The Commonwealth Fund, 2008).

¹⁰ S. Thomson, ‘What role for voluntary health insurance?’, in J. Kutzin, C. Cashin and M. Jakab (eds.), *Implementing health financing reform: lessons from countries in transition* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2009).

Table 10.2. Private health insurance (PHI) in the EU: contribution to total and private expenditure on health, 1996 and 2005

Country	PHI as a percentage of total expenditure on health		PHI as a percentage of private expenditure on health	
	1996	2005	1996	2005
Austria	9.0	8.2	19.9	21.3
Belgium	1.8	3.5	8.5	12.1
Bulgaria	0.0	0.1	0.0	0.3
Cyprus	1.7	4.3	2.6	7.6
Czech Republic	0.0	0.2	0.0	2.1
Denmark	1.4	1.6	7.7	9.2
Estonia	0.0	0.1	0.0	0.3
Finland	2.4	2.3	9.9	10.2
France	12.4	12.8	51.7	61.1
Germany	7.5	9.1	42.1	39.7
Greece	2.0	2.1	4.3	4.3
Hungary	0.0	0.9	0.2	3.4
Ireland	9.2	6.4	32.1	33.0
Italy	1.0	0.9	3.6	3.8
Latvia	0.7	0.8	1.8	1.7
Lithuania	0.0	0.4	0.1	1.1
Luxembourg	0.7	1.6	10.1	17.6
Malta	1.1	2.1	3.7	9.8
Netherlands*	19.5	20.1	57.7	58.5
Poland	0.0	0.6	0.0	2.1
Portugal	1.3	3.8	4.0	13.8
Romania	0.0	4.5	0.0	18.2
Slovakia	0.0	0.0	0.0	0.0
Slovenia	12.3	12.7	55.3	51.3
Spain	3.5	4.7	12.8	15.8
Sweden	0.0	0.3	n/a	2.0
United Kingdom	3.3	1.0	19.2	7.9

* Figures supplied for the Netherlands refer to the period prior to the reforms introduced in 2006. Private expenditure on health is usually made up of PHI and out-of-pocket payments (including user charges).

Source: World Health Organization, *World Health Statistics 2007* (Geneva: World Health Organization, 2007).

do we always know how severe an illness will be or how much it will cost to treat it. By pooling health risks (across groups of people) and resources (over time), health insurance provides protection from the financial risk associated with ill health. In this way, it makes a valuable contribution to social welfare. However, markets for health insurance require regulation to protect consumers and insurers from the potentially negative effects of market failures, such as adverse selection and risk selection.¹¹ Without government intervention to correct market failures, health insurance would not be easily accessible to people at high risk of ill health, people already in ill health and people with low incomes. Governments in most high-income countries therefore ensure that health insurance is compulsory for the whole population, that contributions are based on income, and that publicly-financed ‘insurers’ (whether sickness funds, private insurers or a national health service) cannot deny cover to any individual.

In contrast to the rules applied to statutory health insurance, the principles of which are broadly convergent across the European Union, there is considerable variation in the regulation of private health insurance. Prior to the introduction of the Third Non-life Insurance Directive in 1992, the extent to which EU governments intervened in markets for health insurance was largely determined by the role private cover played in the health system (see Table 10.1). Thus, substitutive private health insurance in Germany and the Netherlands tended to be relatively heavily regulated,¹² mainly to ensure access to private cover for older people and people in poor health, but also to protect the finances of the statutory health insurance scheme, which in both cases covered a disproportionate amount of higher-risk households.¹³ The extent of regulation was also influenced by aspects of market structure, such as the number and mix of insurers in operation – particularly, markets dominated by mutual associations – and political ideology.

¹¹ N. Barr, *The economics of the welfare state*, 3rd ed. (Oxford: Oxford University Press, 1998).

¹² S. Thomson and E. Mossialos, ‘Choice of public or private health insurance: learning from the experience of Germany and the Netherlands’, *Journal of European Social Policy* 16 (2006), 315–27.

¹³ This is partly due to the way in which these systems are (were, in the Dutch case) designed and regulated. For example, in Germany, the statutory health insurance scheme is attractive to families because it covers dependants for free, whereas private insurers charge separate premiums for all family members. It is also due to risk selection by private insurers.

Two broad approaches to regulation prevailed: minimal financial or prudential regulation focusing on solvency levels, or material regulation emphasizing control of prices and products. While both approaches aimed to protect consumers from insurer insolvency,¹⁴ material regulation also endeavoured to ensure access to health care through access to health insurance. Under the subsidiarity principle – established in EU law through the European Community Treaty (Article 5 EC) – governments were free to decide on the appropriate form of regulation required in a given context. Over the last thirty years, the EU legislature has restricted this freedom by introducing a series of directives aimed at creating an internal market in insurance services.¹⁵ Grounded in the principle of the free movement of services (enshrined in Articles 43–49 and 50 EC), the internal market in insurance services was intended to enhance competition and consumer choice. EU competence in this area comes from the fact that insurance is considered to be an economic activity.

The Third Non-life Insurance Directive created, for the first time, an EU-level framework for regulating health insurance. The first and second generation of insurance directives had been limited to the cover of ‘large risks’ of a commercial nature, such as aviation or marine insurance and reinsurance (which were considered small enough, in relation to the size or status of their policy holders, not to require special protection).¹⁶ ‘Mass risks’ involving individuals and small businesses were excluded on the grounds that they required special protection because their policy holders would not normally have the ability to judge all the complexities of the obligation they undertook in

¹⁴ Financial or prudential regulation focuses on ex post scrutiny of an insurer’s financial returns on business. Material or contract regulation involves ex ante scrutiny of an insurer’s policy conditions and premium rates on the grounds that this eliminates the potential for insolvency.

¹⁵ First Council Directive 73/239/EEC on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct insurance other than life assurance, OJ 1973 No. L228/3; Second Council Directive 88/357/EEC on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC, OJ 1988 No. L172/1; Council Directive 92/49/EEC, above n.2.

¹⁶ R. Merkin and A. Rodger, *EC insurance law* (London: Longman, 1997); D. Mabbett, ‘Social regulation and the social dimension in Europe: the example of insurance’, *European Journal of Social Security* 2 (1997), 241–57.

an insurance contract.¹⁷ The third generation of insurance directives extended the application of internal market legislation to all types of risks, including mass risks such as health insurance.

As a result of the Directive, insurers have full freedom to provide services throughout the European Union, with or without a branch presence. The mechanisms facilitating free movement are ‘home country control’ (Article 9), a single system for the authorization and financial supervision of an insurance undertaking by the Member State in which the undertaking has its head office; the mutual recognition of systems of authorization and financial supervision; and the harmonization of minimum solvency standards (Article 17). ECJ case-law confirms that insurance activities fall under the scope of the Directive (Article 2) when they are carried out by insurance undertakings at their own risk, following insurance techniques, and on the basis of contractual relationships governed by private law.¹⁸ ECJ case-law more broadly (not relating to the Directive) also suggests that activities with an exclusively social purpose involving solidarity are beyond the scope of internal market and competition rules.¹⁹

To protect the freedoms outlined above and to prevent barriers to competition, the Directive brought about two key changes for private health insurance. First, the Directive accords primacy to the financial approach to regulation: the requirement for governments to abolish existing product and price controls (Articles 6(3), 29 and 39) renders material regulation redundant and, in some cases, illegal. Second, it requires governments to open markets for private health insurance to competition at the national and EU levels (Article 3).

Material regulation in the form of national rules requiring the prior approval or systematic notification of policy conditions, premium rates, proposed increases in premium rates and printed documents insurers use in their dealings with policy holders are no longer permitted (Articles 6(3), 29 and 39). Such rules played an important regulatory function in several countries – notably, France, Germany and Italy. However, most

¹⁷ K. Nemeth, ‘European insurance law: a single insurance market?’, EUI Working Paper LAW No. 2001/4 (2001).

¹⁸ Case C-238/94, *José García* [1996] ECR I-1673; Case C-296/98, *Commission v. France* [2000] ECR I-3025.

¹⁹ Joined Cases C-159/91 and C-160/91, *Poucet and Pistre* [1993] ECR I-637; Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01, *AOK Bundesverband* [2004] ECR I-2493.

Member States amended existing laws or passed new laws to comply with the Directive. Legislative changes generally involved the introduction of tighter solvency controls. Some also resulted in the loosening or outright abolition of prior approval and systematic notification. France proved to be the exception in this respect, contravening the Directive by continuing to insist that insurers notify the supervisory authority when they launched a new product.²⁰ The European Court of Justice ruled against the French Government in May 2000.²¹

Although the Directive prevents governments from introducing regulatory measures that go beyond solvency requirements, Member States do retain limited residual powers to protect policy holders. For example, if the home supervisory authority fails to prevent an insurer from infringing the host country's domestic law, the host supervisory authority may take action (Article 40(5)). More importantly, the host supervisory authority may impose specific measures in the form of restrictions on insurance contracts, in the interest of the 'general good', where contracts covering health risks 'may serve as a partial or complete alternative to health cover provided by the statutory social security system' (Article 54(1)). Where this is the case, the government can require private insurers to 'comply with the specific legal provisions adopted by that Member State to protect the general good in that class of insurance' (Article 54(1)).

Article 54(2) and recitals to the Directive list the types of legal provisions that may be introduced if private cover provides a partial or complete alternative to statutory cover: open enrolment, community rating, lifetime cover, policies standardized in line with the cover provided by the statutory health insurance scheme at a premium rate at or below a prescribed maximum, participation in risk equalization schemes (referred to as 'loss compensation schemes') and the operation of private health insurance on a technical basis similar to life insurance. Measures taken to protect the general good must be shown to be necessary and proportionate to this aim, not unduly restrict the right of establishment or the freedom to provide services, and apply in an identical manner to all insurers operating within a Member State.

²⁰ European Commission, 'Insurance: Commission launches new infringement proceedings against France concerning mutual benefit companies', Press Release IP/00/466, Brussels, 2000.

²¹ Case C-296/98, *Commission v. France*, above n.18.

The German Government has used Article 54(1) to justify intervention in its substitutive market, where risk selection by private insurers has prevented some older people and people with chronic illnesses from buying an adequate and affordable level of private cover.²² Regulatory measures include the provision of lifetime cover, the introduction of policies with mandatory pooling, standardized minimum benefits and guaranteed prices, and the establishment of indirect cross subsidies from those with private to those with public coverage. The same regulatory measures were also present in the Dutch substitutive market prior to 2006. Private insurers in the German substitutive market are subject to further regulation concerning the way in which they fund cover (on a similar basis to life insurance) and the provision of information to potential and existing policy holders.

In contrast, regulation of many markets for complementary and supplementary cover has tended to focus on ex post scrutiny of financial returns on business to ensure that insurers remain solvent. Insurers are often permitted to reject applications for cover, exclude cover of, or charge higher premiums for individuals with pre-existing conditions, rate premiums according to risk, provide nonstandardized benefit packages and offer annual contracts, while benefits are usually provided in cash rather than in kind. However, there are some notable exceptions – many of them recent – particularly where complementary private health insurance is concerned. Relatively heavily regulated markets for complementary cover can be found in Belgium, France, Ireland and Slovenia. It is no coincidence that these are also the countries in which regulation of private health insurance has been most problematic from an EU law perspective (see below).

4. Implications for government intervention in health insurance markets

At first sight, the Directive appears to give governments significant scope for regulating private health insurance under the general good

²² J. Wasem, 'Regulating private health insurance markets', Paper prepared for the Four Country Conference on 'Health Care Reforms and Health Care Policies in the United States, Canada, Germany and the Netherlands', Ministry of Health, Welfare and Sport, Amsterdam, 23–25 February 1995; F. Rupperecht, B. Tissot and F. Chatel, 'German health care system: promoting greater responsibility among all system players', INSEE Studies No. 42 (2000), pp.1–23.

principle, which broadly refers to any legislation aimed at protecting consumers (in any sector, not just the insurance sector). But, on closer examination, interpretation of the principle is shown to be problematic in two areas: first, the issue of what is meant by complete or partial alternative to statutory health insurance; and, second, what types of intervention are necessary and proportionate. These problems arise because there is no agreed definition of the general good; interpretation relies on ECJ case-law. Following complaints about the absence of a definition, the European Commission²³ tried to clarify when and how the general good might be invoked in the insurance sector, but its Interpretive Communication failed to provide new information.²⁴ Calls for further clarification persist on the grounds that the lack of a definition creates legal uncertainty, while the process of testing questionable use of the general good through the courts is prohibitively lengthy and expensive.²⁵ We discuss interpretation of the general good in relation to when and how governments can intervene in markets for private health insurance.

A. When can governments intervene?

There is uncertainty about when the general good can be invoked to justify material regulation, mainly because the Directive does not define what it means by partial or complete alternative to statutory health insurance. How then can we distinguish between private cover that falls into this category and private cover that does not? Circumstantial factors suggest that the distinction may hinge on whether or not private health insurance plays a substitutive role. For example, Article 54 was inserted during negotiations prior to the drafting of the Directive at the instigation of the German, Dutch and Irish Governments.²⁶ Perhaps as a result of lobbying by Member States with substitutive markets, the regulatory measures outlined in Article 54(2) are an exact match of

²³ From here on we refer to the European Commission as ‘the Commission’.

²⁴ European Commission, ‘Interpretative Communication on the freedom to provide services and the general good in the insurance sector’, OJ 2002 No. C43/5.

²⁵ Mossialos and Thomson, ‘Voluntary health insurance’, above n.5.

²⁶ Association Internationale de la Mutualité (AIMS), ‘Towards a fourth generation of European insurance directives?’, Newsletter No. 5 (1999), pp. 1–3.

those that were in place in Germany, Ireland and the Netherlands when the Directive was being negotiated. To date, the regulations applied to private insurers in these three countries have not been challenged by the Commission.²⁷ In addition, a summary of the Directive dating from 2006 and available on the Commission's web site refers to the Directive having 'specific rules for health cover serving as a *substitute* for that provided by statutory social security systems'.²⁸

Recent policy developments in the Netherlands shed further light on how we might make this distinction. Dissatisfaction with the dual system of statutory cover for lower earners and voluntary private cover for higher earners had led successive Dutch governments to consider the introduction of a single, universal system of health insurance. Some governments favoured a public system, others preferred private options, in spite of concerns about the applicability of internal market rules to a private system.²⁹ In 2006, a universal and compulsory privately-operated system governed under private law came into force. Regulatory measures under the new system include open enrolment, lifetime cover, government-set income-based contributions deducted at source, additional community-rated premiums set by each insurer, a package of minimum benefits in kind or cash defined by the government and a risk equalization scheme.³⁰

Prior to the introduction of the new system, the Dutch Government asked the Commission to clarify whether or not Article 54 could be relied on to justify such extensive regulation.³¹ The Commission's response came in the form of a letter to the Dutch Minister of

²⁷ Although some aspects of the regulatory environment in Ireland have recently been questioned by the Commission (see below).

²⁸ Council Directive 92/49/EEC, above n.2; European Commission, 'Financial services: insurance', Activities of the European Union: Summaries of Legislation (2006), <http://europa.eu/scadplus/leg/en/s08012.htm> (emphasis added).

²⁹ H. Maarse, 'Health insurance reform (again) in the Netherlands: will it succeed?', *Euro Observer* 4 (2002), 1–3.

³⁰ G. J. Hamilton, 'Private insurance for all in the Dutch health care system?', *European Journal of Health Law* 10 (2003), 53–61. Ministry of Health Welfare and Sport, 'Do you have compulsory or private health insurance? A single new-style health insurance for everybody as of 1 January 2006'. Brochure of the Ministry of Health, Welfare and Sport (2005).

³¹ H. Hoogervorst, 'Letter from the Dutch Minister of Health, Welfare and Sport to the European Commissioner for the Internal Market', Ministry of Health, Welfare and Sport, 8 October 2003.

Health from the (then) Commissioner for the Internal Market Frits Bolkestein.³² In the letter,³³ Bolkestein states that the privately-operated system falls within the scope of the Directive, even though it is compulsory, because the insurers involved are carrying out ‘an insurance activity’. However, he notes that the regulatory measures can be justified under Article 54 for two reasons: first, the system, though private, can be construed as constituting a ‘complete alternative’ to statutory health insurance; and, second, the regulations (with some caveats, see below) ‘appear necessary to ensure legitimate objectives pursued by the Dutch government’.³⁴ The Commission supported this position in response to written questions put forward by Members of the European Parliament in 2005.³⁵ It also stated that the new Dutch system was ‘to be considered as a statutory sickness insurance scheme’.³⁶

Bolkestein’s letter goes on to point out that it would not be proportionate to apply the proposed regulatory measures to ‘any *complementary* insurance cover offered by private insurers *which goes beyond the basic social security package of cover* laid down by the legislation’.³⁷ The letter therefore suggests that ‘partial or complete alternative’ can be understood in terms of the benefits provided by a particular insurance scheme. Substitutive private health insurance constitutes an alternative to statutory cover because it replaces statutory benefits for those who are excluded from some aspects of the statutory system (higher earners in the Netherlands prior to 2006 and Ireland) or those who are allowed to choose statutory or private cover (higher earners in Germany). Whether the substitutive cover is a partial or

³² F. Bolkestein, ‘Letter from the European Commission to the Dutch Minister of Health, Welfare and Sport’, European Commission, 25 November 2003.

³³ The legal status of Bolkestein’s letter is not clear.

³⁴ Bolkestein, ‘Letter from the European Commission’, above n.32, p. 2.

³⁵ C. McCreevy, ‘Answer given by Mr McCreevy on behalf of the Commission’, European Parliament, Doc. No. E-3829/05EN, 12 December 2005; C.

McCreevy, ‘Answer given by Mr McCreevy on behalf of the Commission’, European Parliament, Doc. No. E-3828/05EN, 5 January 2006; C.

McCreevy, ‘Answer given by Mr McCreevy on behalf of the Commission’, European Parliament, Doc. No. E-3830/05EN, 24 January 2006.

³⁶ V. Špidla, ‘Answer given by Mr Špidla on behalf of the Commission’, European Parliament, Doc. No. E-1274/06EN, 25 April 2006.

³⁷ Bolkestein, ‘Letter from the European Commission’, above n.32, p. 3 (emphasis added).

complete alternative depends, presumably, on whether the benefits it provides are 'partial' (for example, cover of mainly outpatient care in Ireland) or 'complete' (cover of outpatient and inpatient care in Germany and the Netherlands). Conversely, complementary and supplementary cover cannot be construed as alternatives to statutory cover because they offer benefits in addition to those offered by the statutory system.

On the basis established in Bolkestein's letter, material regulation would only be permissible where private health insurance covers the same benefits as those provided by statutory health insurance. But 'partial alternative' could be interpreted in other ways. The logic behind allowing governments to intervene in substitutive markets implies that purely financial regulation of solvency levels will suffice for the purposes of consumer protection but will not be enough to ensure social protection (access to health care). Bolkestein's letter implicitly assumes that only substitutive private health insurance provides social protection. But what if other forms of private health insurance also contribute to social protection? For example, where the statutory benefits package (the 'basic social security package of cover' mentioned by Bolkestein) is relatively narrow – and/or subject to extensive co-payments – it could be argued that individuals do not have adequate protection from the financial risk associated with ill health unless they purchase complementary private health insurance covering excluded (and effective) services and/or statutory user charges. In such cases, complementary cover provides a degree of social protection. Material regulation to prevent private insurers from selecting risks might therefore be justified. Under the Directive, however, rules to ensure affordable access to complementary private cover would be illegal.

The implications of outlawing material regulation of complementary cover depend on various factors, not least the extent to which this form of cover does, in practice, contribute to social protection. This issue may become more serious in future if markets for complementary cover develop and expand in light of constraints on public funding. For example, in recent years, policy-makers across the European Union have intensified efforts to define statutory benefits packages, often putting in place explicit criteria (including cost-effectiveness) to determine whether or not certain procedures should be publicly

financed.³⁸ Such efforts may implicitly assume that statutory benefits packages can be complemented by voluntary take-up of private insurance covering less effective and/or non-cost-effective services. In practice, however, efforts to set priorities and measure cost-effectiveness tend to be limited by technical, financial and political considerations, making it easier for governments to exclude whole areas of service, such as primary care, outpatient drugs or dental care, than single interventions of low cost-effectiveness.³⁹ This means that complementary insurance often covers a range of necessary and cost-effective services. Similarly, in some countries, governments have introduced or raised statutory user charges to supplement public resources, again under the assumption that complementary cover will bridge the funding gap. Complementary cover of statutory user charges in France has grown from covering 33% of the population in 1960 to 85% in 2000.⁴⁰ It now accounts for about 13% of total expenditure on health (see Table 10.2). Complementary cover of statutory user charges introduced in Slovenia in 1993 now covers over 90% of the population eligible to pay user charges (about 70% of the total population) and accounts for over 11% of total health expenditure.⁴¹

However, greater reliance on complementary cover can create or exacerbate inequalities in access to health care. In France, the likelihood of having complementary cover and the quality (generosity) of that cover have been highly dependent on social class, age, employment and income levels.⁴² Research from France and Spain shows that

³⁸ B. Gibis, P. Koch and J. Bultman, 'Shifting criteria for benefit decisions', in R. Saltman, R. Busse and J. Figueras (eds.), *Social health insurance systems in western Europe* (Maidenhead: Open University Press, 2004), pp. 189–206; J. Schreyögg *et al.*, 'Defining the "health benefit basket" in nine European countries: evidence from the European Union Health BASKET Project', *European Journal of Health Economics* 6 (2005), Supp: 2–10.

³⁹ C. Ham and G. Robert (eds.), *Reasonable rationing: international experience of priority setting in health care* (Buckingham: Open University Press, 2003).

⁴⁰ S. Sandier, V. Paris and D. Polton, *Health care systems in transition: France* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004).

⁴¹ T. Albreht *et al.*, *Health care systems in transition: Slovenia* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2002).

⁴² N. Blanpain and J.-L. Pan Ké Shon, 'L'assurance complémentaire maladie: une diffusion encore inégale', *INSEE Première* 523 (1997); A. Bocognano *et al.*, *Which coverage for whom? Equity of access to health insurance in France* (Paris: CREDES, 2000).

those who do not have complementary cover do not consult doctors and dentists as frequently as those with cover.⁴³ In Slovenia, there are concerns about the affordability of complementary cover and its effect on access to publicly-financed health care.⁴⁴ Anecdotal evidence suggests that doctors may be reluctant to provide publicly-financed care to people without private cover in case they are unable to pay the necessary user charges.⁴⁵ There are also concerns for market stability, as complementary private health insurance covers a disproportionately high number of older people.

Governments in several Member States recognize that complementary cover of statutory user charges can contribute significantly to social protection. In 2000, the French Government introduced free complementary cover for people with low incomes,⁴⁶ raising the proportion of the population covered to over 92%.⁴⁷ In 2006, it extended favourable fiscal treatment to any private insurers offering open enrolment and community-rated premiums (see below). Since 2005, the Slovenian Government has required private insurers to offer open enrolment and community-rated policies accompanied by a risk equalization scheme.⁴⁸ In 2007, the Belgian Government also introduced open enrolment and other rules to ensure access to health insurance, particularly for people in poor health and disabled people.

The lack of a definitive interpretation of partial or complete alternative creates further uncertainty when we consider what happens if a particular market for health insurance changes from playing a substitutive to a complementary role. In Ireland, for example, private health insurance developed at a time when entitlement to publicly-funded inpatient and outpatient care was restricted to low and middle-income households. A significant proportion of the population could only

⁴³ P. Breuil-Genier, 'Généraliste puis spécialiste: un parcours peu fréquent', *INSEE Première* 709 (2000); L. Rajmil *et al.*, 'The quality of care and influence of double health care coverage in Catalonia (Spain)', *Archives of Disease in Childhood* 83 (2000), 211–4.

⁴⁴ Albrecht *et al.*, *Health care systems in transition*, above n.41.

⁴⁵ Thomson, 'What role for voluntary health insurance?', above n.10.

⁴⁶ Through a scheme known as *Couverture Maladie Universelle-Complémentaire*.

⁴⁷ Durand-Zaleski, *The health system in France*, above n.9.

⁴⁸ A. Milenkovic Kramer, 'Health insurance in Slovenia', unpublished report (2006).

access health services by paying out of pocket or buying private cover, which may partly explain why, when the Irish market was liberalized in 1994, private insurers were subject to quite stringent regulation involving open enrolment, minimum benefits, community-rated premiums and a risk equalization scheme⁴⁹ (see below). However, the level of public benefits has gradually increased so that low-income households and all those aged seventy and over have free access to all types of care, while non-elderly higher-income households have access to services that are predominantly publicly-funded but subject to co-payments.⁵⁰ In 2006, the government further increased the number of people eligible for free primary care.⁵¹ The regulatory framework originally justified under Article 54(1) could now be questioned on the grounds of whether or not private health insurance in Ireland still constitutes a partial or complete alternative to statutory health insurance. In other words, it is debatable whether the Irish market for private health insurance continues to play a significant role in providing social protection.

In the past, the Commission has avoided formally addressing what might or might not constitute a partial or complete alternative where the issue has not been absolutely clear cut. When it approved the Irish risk equalization scheme, for example (see below), it deliberately abstained from commenting on the compatibility of the regulatory framework with the Directive. The recent *BUPA*⁵² ruling on the Irish regulatory framework did not address the issue either (see below). Informally, however, the Commission has acknowledged that there is a need for further clarification.

Beyond its potential impact on social protection, the restriction of material regulation of non-substitutive cover may have implications for consumer protection. Examples include the possibility of conditional sale and consumer detriment arising from product differentiation.

⁴⁹ In effect, these were the regulations already in place prior to 1994 (with the exception of the risk equalization scheme, which had not been necessary when VHI Healthcare was the only insurer).

⁵⁰ D. McDaid and M. M. Wiley, *Ireland: health system review* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2009).

⁵¹ Department of Health and Children, 'Tánaiste announces increase in means test for GP Visit Card', Department of Health and Children, 26 June 2006, www.dohc.ie/press/releases/2006/20060626.html.

⁵² Case T-289/03, *BUPA and Others v. Commission* (not yet reported).

Where voluntary cover is offered by the same entities responsible for providing statutory cover, insurers can take advantage of the absence of open enrolment or lifetime cover requirements for voluntary cover to terminate a voluntary contract when an individual moves to a rival insurer for statutory cover. This 'conditional' sale is a form of risk selection that is particularly likely to deter older people or people in poor health from switching from one statutory insurer to another, for fear that a new insurer might reject their application for cover, a new voluntary contract might be too expensive (taking into account the person's current age) and/or might exclude pre-existing conditions (that had developed since the signing of the original voluntary contract and were therefore covered by that contract). Conditional sale poses a barrier to competition among statutory health insurers. If construed as abuse of dominant position, it could breach EU competition rules. However, although there is evidence to suggest that conditional sale prevents fair competition in Belgium, Germany, the Netherlands and Switzerland,⁵³ we are not aware of any ECJ case-law in this area. We discuss the issue of product differentiation in the following subsection.

B. How can governments intervene?

The second area of uncertainty concerns the types of intervention that might be considered necessary and proportionate. Article 54(2) and recitals to the Directive list the legal provisions governments can introduce where private cover provides a partial or complete alternative to statutory cover. But it is not clear if the list should be understood as being exhaustive, in which case unlisted interventions would contravene the Directive. And, again, there is the problem of interpreting partial or complete alternatives. In this subsection, we discuss interventions that have been disputed under internal market or competition legislation, or that may be contentious in future.

Financial transfers (risk equalization schemes)

Risk equalization schemes are a direct form of intervention typically involving financial transfers from insurers with a lower than average

⁵³ F. Paolucci *et al.*, 'Supplementary health insurance as a tool for risk selection in mandatory basic health insurance markets: a five country comparison', *Health Economics, Policy and Law* 2 (2007), 173–92.

risk profile to insurers with a higher than average risk profile. They are an essential component of health insurance markets with open enrolment and community rating, where they are introduced to ensure access to health insurance and fair competition among insurers.⁵⁴ Risk equalization measures aim to lower insurers' incentives to compete through risk selection, and to encourage insurers to compete in terms of cost and quality. As such, they are widely applied to public or quasi-public entities involved in the provision of statutory health insurance (for example, in Germany and the Netherlands).⁵⁵ More recently, governments have applied them to private health insurers in Ireland (2006) and Slovenia (2005). Internationally, risk equalization schemes are also applied to private health insurers in Australia, Chile and South Africa. Wherever risk equalization has been introduced in the European Union, it has been subject to legal challenge by private insurers and/or infringement proceedings⁵⁶ initiated by the Commission in response to complaints.

The legal challenges in Ireland⁵⁷ and the Netherlands⁵⁸ have focused on the potential for financial transfers made under a risk equalization scheme to breach competition rules on state aid. There has been less emphasis on whether or not they breach internal market rules in the

⁵⁴ W. P. van de Ven and R. C. van Vliet, 'How can we prevent cream skimming in a competitive health insurance market? The great challenge for the 90s', in P. Zweifel and H. Frech III (eds.), *Health economics worldwide (developments in health economics and public policy)* (Amsterdam: Kluwer, 1992), pp. 23–46; J. Puig-Junoy, 'Managing risk selection incentives in health sector reforms', *International Journal of Health Planning and Management* 14 (1999), 287–311.

⁵⁵ W. P. van de Ven *et al.*, 'Risk adjustment and risk selection in Europe: six years later', *Health Policy* 83 (2007), 162–79.

⁵⁶ Infringement proceedings based on the Article 226 EC procedure are triggered by complaints to the European Commission. Following an informal process (informal contacts with the Member State concerned to provide the Commission with more information) and failure to reach a settlement, the formal process involves three stages. First, the Commission writes a letter of infringement to the Member State government asking it to submit its observations on the alleged infringements. Second, if the Commission considers that the Member State has not satisfactorily responded, it delivers a 'reasoned opinion', setting out the formal reasons why the Member State has failed to comply with its obligations under the Treaty and asking the government to redress the breach, usually within two months. Third, if the Member State does not respond satisfactorily, the Commission refers the matter to the European Court of Justice.

⁵⁷ Case T-289/03, *BUPA*, above n.52.

⁵⁸ Case T-84/06, *Azivo Algemeen Ziekenfonds De Volharding v. Commission* (case withdrawn from the register October 2008).

form of the Directive. An unsuccessful domestic legal challenge in Slovenia also focused on unfair competition, but did not refer either to EU competition or internal market rules.⁵⁹ However, the Commission's current infringement proceedings against the Slovenian Government do focus on breach of the Directive. One of the issues at stake seems to be whether or not the risk equalization scheme in Slovenia can be justified by Article 54. In the following paragraphs, we briefly outline the legal challenges in the three countries.

The Netherlands

Bolkestein's letter to the Dutch Minister of Health raised concerns that the Dutch Government's risk equalization scheme, part-financed from public funds, might contravene EU rules about state aid.⁶⁰ However, in 2005, the Commission issued a decision authorizing the transfer of public funds as, in its opinion, the aid did not unduly distort competition.⁶¹ Despite further assurances from the European Commissioner for Competition,⁶² Dutch analysts and politicians continued to question the legality of the risk equalization scheme, noting that the ECJ would have the final say on whether or not the scheme was both necessary and proportionate.⁶³ In 2006, a Dutch insurer brought a case before the ECJ, challenging the Commission's 2005 authorization of the risk equalization scheme primarily on the grounds that the scheme breached EU rules on state aid.⁶⁴ The insurer also argued that the new Dutch health insurance system was incompatible with the Directive and Articles 43

⁵⁹ Milenkovic Kramer, 'Health insurance', above n.48.

⁶⁰ Bolkestein, 'Letter from the European Commission', above n.32, p. 3.

⁶¹ European Commission, 'State aid: Commission endorses €15 billion public funding for new Dutch health insurance system', Press Release No. IP/05/531, 3 May 2005. McCreevy, 'Answer', above n.35.

⁶² A. Reerink and E. Rosenberg, 'Neelie Kroes over staatssteun aan nieuwe zorgstelsel', NRC Handelsblad, 5 October 2005.

⁶³ A. den Exter, 'Blending private and social health insurance in the Netherlands: challenges posed by the EU', in C. M. Flood, K. Roach and L. Sossin (eds.), *Access to care, access to justice: the legal debate over private health insurance in Canada* (Toronto: University of Toronto Press, 2005), pp. 257–77; E. Meijer and K. Liotard, 'Written question to the European Commission: entry into force in 2006 of a new Care Insurance Act in the Netherlands and its relationship with competition policy and the common market. II. Acceptance and equalisation', European Parliament, Doc No. E-3829/05, 11 October 2005.

⁶⁴ Case T-84/06, *Azivo Algemeen Ziekenfonds*, above n.58.

and 49 EC (on freedom of establishment and free movement of services respectively). It accused the Commission of failing to provide reasons to substantiate its view that the risk equalization scheme did not contravene either the Directive or competition rules on state aid. The CFI ordered that the case be removed from the register in October 2008.

Ireland

The risk equalization scheme in Ireland has also been challenged as breaching competition rules on state aid. In 1994, the Irish market was opened up to competition to comply with the Directive. Prior to this, private health insurance was almost exclusively provided by Vhi Healthcare, a quasi-public body under the jurisdiction of the Department of Health. By 1994, Vhi Healthcare covered about 37% of the population.⁶⁵ After the market was opened up to competition, the Irish Government relied on Article 54 to maintain the informal rules that applied to Vhi Healthcare, involving open enrolment, community-rated premiums, minimum benefits and lifetime cover. The Irish Government also passed new legislation allowing it to establish a risk equalization scheme to be activated by the government at the request of the independent Health Insurance Authority (HIA) if it became evident that private insurers were competing through risk selection rather than on the basis of administrative efficiency and quality.⁶⁶ In 2006, the government triggered the risk equalization scheme on the advice of the HIA.

In 1998, BUPA Ireland, a branch of the United Kingdom insurer BUPA that set up in Ireland in 1996, complained to the Commission that the (not yet triggered) risk equalization scheme was a form of state aid that distorted competition and discouraged cost containment in the health sector.⁶⁷ In response, the Irish Government argued that the Directive allowed Member States to exercise reasonable discretion with respect to the general good and that the scheme had particular regard for the need for proportionality.⁶⁸ Five years later, the

⁶⁵ Department of Health and Children, 'Private health insurance', White Paper, Department of Health and Children (1999).

⁶⁶ *Ibid.*

⁶⁷ BUPA Ireland, 'Risk equalisation', BUPA Ireland (2003), previously available from www.bupaireland.ie/whatsnew/RiskEqual.pdf.

⁶⁸ Department of Health and Children, 'Submission to the European Commission's study on voluntary health insurance in the European Union', Department of Health and Children (2001).

Commission issued a decision⁶⁹ stating that financial transfers made under the scheme would not constitute state aid for two reasons.⁷⁰ First, the scheme would legitimately compensate insurers for obligations they faced in carrying out a service of general economic interest (Article 86(2) EC). Second, the compensation was limited to what is necessary and proportionate to ensure stability in a community-rated market for private health insurance. The decision also noted that the scheme would not distort competition, penalize efficiency or create perverse incentives that might lead to cost inflation, nor was it likely to deter insurers from entering the market, as new entrants could exclude themselves from the scheme for up to three years. Even if financial transfers were to be considered a form of state aid, the Commission pointed out that this aid would not, by itself, amount to a violation of the Directive.

The Commission's decision is as noteworthy for what it abstains from commenting upon as for what it confirms. It explicitly states that it assessed the risk equalization scheme's compatibility with state aid rules 'without prejudice to the analysis of its compatibility with other relevant EU rules, and in particular with [the Directive]', emphasizing that it was made independently of any consideration as to whether the Irish market could be regarded as a partial or complete alternative to cover provided by the statutory system.⁷¹ BUPA Ireland subsequently challenged the Commission's reluctance to consider whether the scheme infringed the Directive. Asking the ECJ to suspend the decision in 2003,⁷² it accused the Commission of misapplying the public service compensation test and wrongly identifying open enrolment, community rating, minimum benefits and lifetime cover as public service obligations when they actually represent rules generally applied to all insurers offering private health insurance. It also accused the Commission of failing to consider whether these obligations imposed a financial burden on Vhi Healthcare and whether the risk equalization scheme would affect the

⁶⁹ Unlike Bolkestein's letter, above n.32, a Commission decision is binding and judicially reviewable at the suit of the addressee or those directly and individually concerned (Article 230 EC). Article 88(2) EC and Regulation 659/99/EC give the Commission the power to make such decisions.

⁷⁰ European Commission, 'Ireland – risk equalisation scheme in the Irish health insurance market', State Aid Decision No. 46/2003, European Commission (2003).

⁷¹ *Ibid.*, p. 8.

⁷² Case T-289/03, *BUPA*, above n.52.

development of trade contrary to the interests of the Community, and of failing to initiate a formal investigation procedure, given the complexity of the arguments and the economic analysis required. The Dutch and Irish Governments and Vhi Healthcare joined the legal proceedings in defence of the Commission. BUPA Ireland also launched a domestic challenge to the risk equalization scheme in 2006 (see below). The following year, it pulled out of the Irish market and its business was bought by Quinn Healthcare, an Irish company. Quinn Healthcare has also challenged the risk equalization scheme (within Ireland).

In 2008, the Court of First Instance (CFI) dismissed BUPA's application, finding its claim inadmissible.⁷³ The CFI used the criteria⁷⁴ laid down in *Altmark*,⁷⁵ finding that the Commission had been right to conclude that the risk equalization scheme did not contravene EU state aid rules. It is worth going into the CFI's decision in some detail, since the arguments involved are revealing. BUPA had argued that private health insurance in Ireland could not constitute a service of general economic interest (SGEI) since there was no obligation of general interest imposed on insurers to provide certain services and those services were not available to the whole population. Rather, they were optional – even 'luxury' – financial services and not intended to replace the public social security system. BUPA also argued that the decision of whether or not SGEIs were being carried out was a decision for European Community institutions and not to be delegated to national authorities. In contrast, the Irish Government contended that the definition of SGEIs falls primarily within the competence and discretion of the Member States and that private health insurance is 'an important instrument of the social and health policy pursued by Ireland ... and an important *supplement* to the public health insurance system, although it does not *replace* that system'.⁷⁶ It added that, because the obligations of open enrolment and community rating ensure that

⁷³ *Ibid.*

⁷⁴ These are as follows: (a) the recipient undertaking must have public service obligations to discharge and the obligations must be clearly defined; the service must also be of a universal and compulsory nature; (b) the parameters on the basis of which the compensation for carrying out the SGEI mission is calculated must be established in advance in an objective and transparent manner; (c) the necessity and proportionality of the compensation must be provided for; and (d) comparison with an efficient operator must be established.

⁷⁵ Case C-280/00, *Altmark Trans GmbH* [2003] ECR I-7747.

⁷⁶ Case T-289/03, *BUPA*, above n.52, para. 164 (emphasis added).

private health insurance is available to all, it is not necessary that it should be universal, compulsory, free of charge, economically accessible to the whole population or constitute a substitute for the public social security system.

Responding to these claims and counterclaims, the CFI confirmed that Member States have a wide discretion to define what they regard as SGEIs. Moreover, the definition of such services by a Member State can only be questioned by the Commission in the event of a manifest error.⁷⁷ It found that there had been an act of public authority creating and entrusting an SGEI mission in Ireland. It also found that the compulsory nature of the SGEI mission could lie in the obligation on insurers to offer certain services to every citizen requesting them (open enrolment) and was strengthened by other obligations, such as community rating, lifetime cover and minimum benefits.⁷⁸ According to the CFI, these obligations guarantee that the Irish population has 'wide and simple access' to private health insurance, which entitles private health insurance to be characterized as universal within the meaning of Community law.⁷⁹ The CFI went on to note:

[T]he criterion of universality does not require that the entire population should have or be capable of having recourse to it in practice ... the fact that approximately 50% of the Irish population has subscribed to PMI [private medical insurance] cover indicates that, in any event, the PMI services respond to a very significant demand on the Irish PMI market and that they make a substantial contribution to the proper functioning of the social security system, in the broad sense, in Ireland.⁸⁰

The CFI further found that the parameters used to calculate the risk equalization payments were sufficiently clearly defined and that the scheme itself was necessary and proportionate to the costs incurred. In addition, it found that insurers operating less efficiently than their competitors would not be able to gain undue advantage from the risk equalization scheme, because the scheme compensated insurers based on average costs.⁸¹ Finally, the CFI concluded that the risk equalization scheme was necessary and proportionate for the purposes of

⁷⁷ *Ibid.*, para. 165. ⁷⁸ *Ibid.*, paras. 188–91.

⁷⁹ *Ibid.*, para. 201. ⁸⁰ *Ibid.*, para. 201.

⁸¹ See Chapter 9 in this volume for further discussion of this aspect of the Court's ruling.

Article 86(2) EC. It noted that the Commission had been right to support the risk equalization scheme as a measure necessary to prevent destabilization of the community-rated Irish market caused by active risk selection on the part of Vhi Healthcare's competitors.⁸²

The comments by the CFI on the nature of the Irish market are particularly revealing. Paragraph 204 states:

In the light of the foregoing, the applicant's [BUPA's] very general argument concerning the optional, complementary and 'luxury' nature of the PMI services cannot succeed. Apart from the fact that the applicants disregard, in this context, the various levels of PMI cover available, they have not submitted a detailed challenge to the argument put forward by the defendant [the Commission] and by Ireland that Irish PMI constitutes, alongside the public health insurance system, the second pillar of the Irish health system, the existence of which fulfils a mandatory objective of social cohesion and solidarity between the generations pursued by Ireland's health policy. According to the explanations provided by Ireland, PMI helps to ensure the effectiveness and profitability of the public health insurance scheme by reducing pressure on the costs which it would otherwise bear, particularly as regards care provided in public hospitals. Within the framework of the restricted control that the Community institutions are authorised to exercise in that regard, those considerations cannot be called in question either by the Commission or by the Court. Accordingly, it must be accepted that the PMI services are used by Ireland, in the general interest, as an instrument indispensable to the smooth administration of the national health system and they must be recognised, owing to the PMI obligations, as being in the nature of an SGEI.

These comments and the ruling as a whole suggest three things. First, not only do national governments have considerable discretion in deciding what is in the general interest, but the regulations in place themselves contribute to the definition of a particular service as being in the general interest. In other words, if the Irish Government defines a service as being in the general interest, regulations such as open enrolment and community rating can only strengthen the government's case, although the necessity and proportionality tests would still apply. This apparently circular argument reflects the complexity of determining what is and is not an SGEI in the absence of a central

⁸² Case T-289/03, *BUPA*, above n.52, paras. 285–86.

definition, but it reinforces the significant scope for Member State autonomy in this area. Second, the Irish Government claims that, even though private health insurance in Ireland plays a supplementary rather than a substitutive role, it is an important instrument of Irish social and health policy – ‘the second pillar of the Irish health system’ – and helps to sustain the public health insurance scheme by relieving pressure on public hospitals. The ruling notes that these claims cannot be questioned by the Commission or the CFI. Consequently, if a government says that private health insurance is a key component of the national health strategy, the European Union’s legislative institutions must accept it as being the case. Third, the CFI makes much of the fact that private health insurance in Ireland covers about half of the Irish population and takes this as evidence that it makes a ‘substantial contribution to the proper functioning of the [Irish] social security system’. Thus, the degree of population coverage might bolster arguments about the contribution of private health insurance to the ‘national health strategy’.

In spite of the CFI’s ruling, which BUPA decided not to appeal against, the Irish regulatory framework has continued to be questioned in the domestic courts. In 2006, the Irish High Court ruled against BUPA’s legal challenge to the risk equalization scheme. BUPA appealed and, in 2008, the Supreme Court upheld its appeal on procedural grounds, finding that the risk equalization scheme was based on an incorrect interpretation of the meaning of community rating in the relevant law and would therefore have to be abandoned.⁸³ However, the Supreme Court did not question the risk equalization scheme on other grounds, so a change in legislation may be sufficient to secure the scheme’s domestic legitimacy. In the meantime, the scheme has been set aside.

Slovenia

The CFI ruling came after the Commission had initiated infringement proceedings against Belgium and Slovenia, but may have some bearing on both of these cases. In this subsection, we discuss the case against Slovenia. The case against Belgium is discussed in a subsequent subsection. In 2005, two of the three insurance companies

⁸³ *BUPA Ireland Limited and Anor v. Health Insurance Authority and Others* [2008] IESC 42.

operating in the Slovenian complementary private health insurance market (covering statutory user charges) challenged legislation establishing a risk equalization scheme. The largest insurer, Vzajemna⁸⁴ (a mutual association), argued that the scheme would favour the two other (commercial) insurers and encourage risk selection, while the larger commercial insurer, Adriatic,⁸⁵ argued that the scheme would distort competition. Neither challenge referred to EU law, and the Slovenian High Court ruled in the government's favour.⁸⁶ However, in 2007, following a complaint from Vzajemna, the Commission initiated infringement proceedings against the Slovenian Government, arguing that the risk equalization scheme could not be justified under Article 54(1) of the Directive because complementary private health insurance in Slovenia does not constitute a partial or complete alternative to statutory health insurance. The Commission's letter of formal notice, the contents of which have not been made publicly available, may also have noted that the requirement for insurers involved in the complementary market to inform the regulator of changes to policy conditions and premiums breaches the Directive (Articles 6, 29 and 39) and that the requirement for insurers to put 50% of any profits generated back into the private health insurance scheme is problematic.⁸⁷

The Slovenian Government responded by arguing (in May 2007) that the complementary market is a part of the broader social security system and has been defined in legislation as a service of general interest.⁸⁸ It also drew to the Commission's attention the similarities between the Irish market and the Slovenian market. Previously, the Commission had rejected the government's claim that the Slovenian market represented a partial or complete alternative to compulsory health insurance, arguing instead that the market played a supplementary role. While it

⁸⁴ Vzajemna, 'Dispute put forward to High Court regarding the new Health Care and Health Insurance Act No. U-I-277/05', Vzajemna, 22 December 2005.

⁸⁵ Adriatic, 'Dispute put forward to High Court regarding the new Health Care and Health Insurance Act No. U-I-282/05-1', Adriatic, 10 October 2005.

⁸⁶ S. Toplak, 'Constitutional Court failed to please Vzajemna and Adriatic', *The Finance Business Daily Newspaper*, 17 September 2005, www.finance-on.net/show.php?id=137526; Milenkovic Kramer, 'Health insurance', above n.48.

⁸⁷ A. Rednak and T. Smrekar, 'Evropa žuga Sloveniji zaradi zdravstvenih zavarovanja', *Finance*, 4 May 2007.

⁸⁸ Slovenia Business Week, 'Government responds to EU's warning over health insurance', *Slovenia Business Week* 18 (2007), p. 10.

seems clear that the Slovenian Government will need to address potential breaches of the Directive's ban on systematic prior notification of policy conditions and premiums, it is less clear, following the *BUPA* ruling, whether the risk equalization scheme breaches the Directive or EU state aid rules. The CFI's rationale for upholding the Commission decision in favour of the risk equalization scheme in Ireland could apply, with even greater force, in the Slovenian case. First, there is an act of public authority creating and entrusting an SGEI mission (given in the Slovenian Health Care and Health Insurance Act), which, along *BUPA* lines, is both compulsory and universal in nature. Second, complementary private health insurance covers an even greater proportion of the population than in Ireland (70%), strengthening the government's claim that the complementary market is part of the social security system. And, third, following *BUPA*, does the Commission have the right to question the claims of the Slovenian Government? The Commission is due to respond.

In our view, both the Dutch and Slovenian cases for risk equalization seem stronger than the Irish case, in the Netherlands because the 'private' health insurance scheme *is* the statutory health insurance scheme, and in Slovenia because the complementary market makes a more significant contribution to social protection than the predominantly supplementary market in Ireland. For example, the extent of statutory cost sharing has increased in Slovenia⁸⁹ in recent years, whereas it has gone down in Ireland.⁹⁰ Reflecting this, private health insurance in Slovenia accounts for over half of all private spending on health (the second highest proportion in the European Union after France), but only a third of private health expenditure in Ireland (see Table 10.2).

Benefits

Governments can regulate the benefits offered by private insurers by specifying a minimum level or standard package of benefits and/or requiring benefits to be provided in kind rather than in cash. The first intervention aims to facilitate price competition, while both aim to lower financial barriers and ensure access to a given range of health services.

⁸⁹ Milenkovic Kramer, 'Health insurance', above n.48.

⁹⁰ McDaid and Wiley, *Ireland: health system review*, above n.50.

Minimum or standard benefits

The question of whether or not regulators should be able to specify minimum or standard benefits – as they do in Germany, Ireland and the Netherlands (prior to 2006 and now) – has not yet been legally challenged as a form of material regulation that contravenes the Directive or as an intervention that impedes the free movement of services. Nevertheless, we raise it as an issue that has implications for consumer protection. The issue is also pertinent since a key objective underlying the introduction of the internal market in insurance was to stimulate competition among insurers, precipitating efficiency gains and bringing consumers the benefits of wider choice and lower prices.⁹¹ The preamble to the Directive states that it is in policyholders' interest that they should have access to 'the widest possible range of insurance products available in the Community so that [they] can choose that which is best suited to [their] needs' (Recital 19).⁹²

In theory, product differentiation benefits consumers by providing policies tailored to meet particular needs. It benefits insurers by allowing them to distinguish between high and low risk individuals. But, in practice, it may be detrimental to consumers in two ways. First, it gives insurers greater opportunity to select risks, leading to access problems for high risk individuals. Second, making consumers choose from a wide range of highly differentiated products restricts competition, which only operates effectively where consumers find it easy to make informed comparisons about price and quality.

To encourage competition based on price and quality (rather than risk selection), regulators can require insurers to offer a standard package of benefits, use standardized terms when marketing products, inform potential and existing policy holders of all the price and product options open to them and provide consumers with access to centralized sources of comparable information. However, the Directive specifically outlaws product and price controls, except where private health insurance constitutes a partial or complete alternative to statutory cover. Even in these circumstances, control is limited to offering benefits standardized in line with statutory benefits – that is, the primary aim is to ensure that the privately insured have access to

⁹¹ European Commission, 'Liberalisation of insurance in the single market: update and questions', *Single Market News* 11 (1998), 1–8.

⁹² Council Directive 92/49/EEC, above n.2.

the same services as the publicly insured, rather than to facilitate price competition. For example, governments in Germany and the Netherlands have required private insurers to offer older policy holders benefits that match statutory benefits.⁹³

In the absence of product regulation, liberalization of health insurance markets in some Member States has been accompanied by rising levels of product differentiation, with evidence suggesting that consumers may be confused by the proliferation of products on offer.⁹⁴ For example, an official investigation into information problems in the market for supplementary private health insurance in the United Kingdom found that increased product complexity did not benefit consumers; rather, consumers sometimes paid more than they should and often purchased inappropriate policies.⁹⁵ An OECD study noted that as the diversity of schemes in the United Kingdom market rose, consumers faced increasing difficulty in comparing premiums and products, a concern echoed by consumer bodies in other Member States.⁹⁶

Perhaps due to limited price competition and private insurers' limited ability to control costs, prices appear to have gone up rather than down in many Member States. Research based on data from several Member States shows that, during the 1990s, the compound annual growth rate of private health insurance premiums rose much faster than the average annual growth rate of total spending on health care.⁹⁷

Benefits in kind

The provision of benefits in kind enhances social protection by removing financial barriers to accessing health care. Bolkestein's letter to the Dutch Minister of Health suggests that the Dutch Government's requirement for insurers to provide a basic package of benefits in kind could infringe the free movement of services by creating barriers for non-Dutch insurers entering the market and might need to be assessed for proportionality and necessity.⁹⁸ This raises concerns not only

⁹³ Mossialos and Thomson, *Voluntary health insurance*, above n.5.

⁹⁴ *Ibid.*

⁹⁵ Office of Fair Trading, 'Health insurance: a second report by the Office of Fair Trading', Office of Fair Trading (1998).

⁹⁶ Organisation for Economic Co-operation and Development, 'Private health insurance in OECD countries: compilation of national reports', OECD (2001).

⁹⁷ Mossialos and Thomson, *Voluntary health insurance*, above n.5.

⁹⁸ Bolkestein, 'Letter from the European Commission', above n.32, p. 3.

for the new Dutch system, but for statutory and substitutive private health insurance in other Member States. However, the issue has not yet been subjected to legal challenge.

Differential treatment of insurers

Under the Directive, governments can no longer influence market structure (by restricting the provision of private health insurance to a single approved insurer or to statutory health insurance funds) or discriminate against particular types of insurer. For example, Recital 25 outlaws regulations preventing non-specialist or composite insurers from providing health insurance. When the German Government transposed the Directive, it had to abolish its rule excluding non-specialist insurers from entering the private health insurance market, but used its social law to prohibit employers from contributing to policies offered by composite insurers, leading the Commission to refer Germany to the European Court of Justice.⁹⁹ Germany amended its legislation and the case was removed from the register in December 2003. Other areas in which the Directive affects differential treatment of insurers concern solvency requirements and tax treatment.

Solvency requirements

National laws often distinguish between non-profit and for-profit institutions, sometimes resulting in preferential treatment of non-profit institutions. This usually favours mutual associations, which have a long history of involvement in statutory and private health insurance in many Member States and traditionally operate in different areas of the market from commercial insurers.¹⁰⁰ The special status accorded to mutual associations has given rise to difficulties under the Directive. For example, French mutual associations operate under a special *Code de la Mutualité*, which means they were subject to less rigorous solvency rules than commercial insurers or provident associations.¹⁰¹ In 1999, the European Court of Justice ruled against France for its failure to transpose fully the Directive with regard to mutual associations.¹⁰² However, the French Government failed to

⁹⁹ Case C-298/01, *Commission v. Germany* (not yet reported).

¹⁰⁰ W. Palm, 'Voluntary health insurance and EU insurance directives: between solidarity and the market', in M. McKee, E. Mossialos and R. Baeten (eds.), *The impact of EU law on health care systems* (Brussels: PIE-Peter Lang, 2002).

¹⁰¹ *Ibid.* ¹⁰² Case C-239/98, *Commission v. France* [1999] ECR I-8935.

act and the Commission was forced to begin fresh infringement proceedings under Article 228 EC the following year, which eventually resulted in the adoption of a revised code tightening the solvency requirements for mutual associations and bringing French law in line with the Directive.¹⁰³

Solvency rules have also led to controversy in Belgium and Ireland. Mutual associations in Belgium engaged in selling a mixture of complementary and supplementary private health insurance operate under separate solvency rules from commercial insurers. Both types of insurer competed to provide cover for self-employed people, who were excluded from statutory cover of outpatient care. More recently, they also began to compete to provide complementary cover of some hospital costs. For example, the Mutualité Chrétienne, which is one of several statutory health insurers, also provided its members with compulsory complementary cover of all hospital costs above a deductible per inpatient stay.¹⁰⁴ Previously, this type of cover had been exclusively offered by commercial private insurers. In 2006, the European Commission began infringement proceedings against the Belgian Government on the grounds that differential treatment might distort the market.¹⁰⁵

The issue regarding self-employed people in Belgium has been addressed by extending statutory cover of outpatient care to them from 2008. However, the issue of complementary private health insurance has been more problematic. The Belgian Government has argued that the Directive does not apply to mutual associations because the cover they provide is part of the social security system, their activity is based on solidarity rather than being economic in nature and, if the complementary cover they provide were to be viewed as an economic activity, it would be a service of general economic interest and exempt from competition rules under Article 86(2) EC. In 2008, the Commission rejected this defence and sent a

¹⁰³ European Commission, 'Insurance', above n.20. European Commission, 'Insurance: infringement proceedings against France concerning mutual societies and the requirement of a marketing information sheet', Press Release No. IP/00/876, 28 July 2000.

¹⁰⁴ Mutualité Chrétienne, 'L'Hospi Solidaire, parce que l'hospitalisation ne doit pas être un luxe', www.mc.be/fr/100/campagne_hospi/index.jsp.

¹⁰⁵ European Commission, 'Commission scrutinises Belgian law on supplementary health insurance provided by private sickness funds', Press Release No. IP/06/1781, 13 December 2006.

reasoned opinion to Belgium, asking it to amend its national rules so that mutual associations are no longer governed by separate solvency and supervisory rules.¹⁰⁶ As shown in the discussion of France (below), the Commission is unlikely to consider this type of differential treatment of insurers to be necessary or proportionate to the costs incurred in carrying out SGEI activities.

In the 1970s, the Irish Government had obtained a derogation from the First Non-life Insurance Directive's solvency requirements for its quasi-state insurer Vhi Healthcare.¹⁰⁷ This meant that Vhi Healthcare was not subject to the same solvency requirements as its commercial competitors and was not regulated by the same regulatory body. In January 2007, the Commission began infringement proceedings against Ireland in response to a claim made by Vivas (a commercial insurer that entered the Irish market in 2004) that Vhi Healthcare had breached the conditions of its derogation from the Directive by carrying out business in addition to its core health insurance activity.¹⁰⁸ The Irish Government subsequently brought forward plans to change the status of Vhi Healthcare. It has announced that, by the end of 2009 (not 2012 as originally stated), Vhi Healthcare will be a conventional insurer authorized by the financial regulator.¹⁰⁹

Some of these solvency issues may change in the future, with the introduction of new economic risk-based solvency requirements in 2012 (the so-called 'Solvency II' framework).¹¹⁰ The Commission is proposing to move away from a 'one-model-fits-all' method of estimating capital requirements to more entity-specific requirements, which would be applied to all entities regardless of their legal status. However, as yet, the implications of this new framework for health insurance are not clear.

¹⁰⁶ European Commission, 'Internal market: Commission requests Belgium to amend law on supplementary health insurance provided by private sickness funds', Press Release No. IP/08/691, 6 May 2008.

¹⁰⁷ The Competition Authority, *Competition*, above n.7.

¹⁰⁸ European Commission, 'Insurance: Commission scrutinises exemption of Irish Voluntary Health Insurance Board from EU rules', European Commission (2007).

¹⁰⁹ Department of Health and Children, 'Government approves reform measures for private health insurance market', Department of Health and Children, 25 April 2007.

¹¹⁰ European Commission, 'Solvency II: frequently asked questions', MEMO/07/286, 10 July 2007.

Tax treatment

Tax incentives in France, Luxembourg and Belgium have traditionally favoured mutual or provident associations over commercial insurers. In Luxembourg, the existence of a 'gentleman's agreement' between mutual associations and commercial insurers has prevented the latter from complaining about preferential tax treatment.¹¹¹ The agreement rests on the understanding that mutual associations will not encroach on commercial insurers' dominance of the market for pensions and other types of insurance. Prior to 2008, Belgian mutual and commercial insurers competed to cover outpatient care for self-employed people. Mutual associations providing this cover benefited from state subsidies, whereas commercial insurers did not. The commercial insurers tried to challenge this in the Belgian courts, but lost their legal challenge. In 2006, the Commission began infringement proceedings against this preferential treatment, but the issue is no longer relevant, as the Belgian Government now extends statutory outpatient cover to all self-employed people.¹¹²

Preferential tax treatment of mutual insurers has been most problematic in France, where mutual and provident associations have been exempt from health insurance premium tax since 1945. In 1992, the French Federation of Insurance Companies (FFSA) lodged two complaints against the French Government for this discriminatory tax policy, arguing that it contravened EU rules on state aid. Their complaints were eventually upheld by a Commission decision in November 2001 and the French Government was asked either to abolish the tax exemptions in question or to ensure that the aid did not exceed the costs arising from the constraints inherent in a service of general economic interest.¹¹³ At the same time, the Commission noted that it did not regard the provision of private health insurance by these associations to be a service of general economic interest explicitly provided for in their articles. The French Government responded

¹¹¹ Mossialos and Thomson, *Voluntary health insurance*, above n.5.

¹¹² European Commission, 'Commission scrutinises Belgian law on supplementary health insurance provided by private sickness funds', European Commission (2007); European Commission, 'Internal market', above n.106.

¹¹³ European Commission, 'State aid: Commission calls on France to put an end to certain tax exemptions for mutual and provident societies', Press Release No. IP/01/1575, 13 November 2001.

by removing the health insurance premium tax exemption for mutual and provident associations¹¹⁴ and, instead, applying it to two types of private health insurance contract: those based on ‘solidarity’ (*contrats solidaires*) – in this case, contracts concluded without a prior medical examination or other reference to an individual’s risk of ill health – and ‘responsible’ contracts (*contrats responsables*), in which private health insurers agree not to cover new co-payments intended to encourage patients to obtain a referral for specialist care and to adhere to protocols for the treatment of chronic illnesses. At first, the Commission agreed that this new exemption was compatible with EU rules on state aid.¹¹⁵ However, in 2007, it launched a formal investigation into the new *contrats*, to find out if they are indeed non-discriminatory and how much consumers really stand to benefit from the advantages granted to insurers.¹¹⁶ The results of this investigation have not yet been published.

Some argue in favour of treating mutual associations differently on the grounds that they provide better access to health services because they generally offer open enrolment, lifetime cover and community-rated premiums, whereas commercial insurers usually restrict access by rejecting applications, excluding the cover of pre-existing conditions and risk rating premiums.¹¹⁷ In a market where mutual associations and commercial insurers operate side by side, the latter may be able to undermine the former by attracting low risk individuals with lower premiums, leaving mutual associations to cover high risks. However, while the distinction between non-profit and for-profit insurers is important

¹¹⁴ In 2006, in response to a further decision from the Commission, the French Government abolished the exemption from insurance premium tax for mutual and provident associations on non-health insurance business. European Commission, ‘State aid: Commission calls on France to put an end to certain tax exemptions for mutual and provident societies’, Press Release No. IP/05/243, 2 March 2005.

¹¹⁵ European Commission, ‘Exemption from tax on health insurance contracts’, OJ 2005 No. C126/10; European Commission, ‘France – exonération de la taxe sur les contrats d’assurance maladie’, State Aid Decision No. E 46/2001, European Commission (2001).

¹¹⁶ European Commission, ‘State aid: Commission opens formal investigation into French plan to grant tax aid to insurers’, Press Release No. IP/07/1692, 14 November 2007.

¹¹⁷ M. Rocard, ‘Mission mutualité et droit communautaire: rapport de fin de mission’, Government of France (1999); Palm, ‘Voluntary health insurance’, above n.100, pp. 195–234.

in so far as an insurer's profit status determines its motivation and influences its conduct, in practice there is considerable variation in the way in which mutual associations behave; in some Member States, their conduct may be indistinguishable from the conduct of commercial insurers. As it is not possible to make assumptions about an insurer's conduct on the basis of its legal status, it would be more appropriate to discriminate on the basis of conduct, favouring insurers who offer greater access to health services or, where appropriate, penalizing those who restrict access. This was the approach taken by the French Government in 2004 and again in 2006, when it expanded the remit for exemption from insurance premium tax to any insurer agreeing to abide by specific rules intended to promote access to health care.¹¹⁸

5. Conclusions

In some ways, the EU regulatory framework established by the Directive places limits on national competence in the area of private health insurance. It relies on financial regulation to protect consumers, prohibiting material regulations such as price and product controls, except where private cover constitutes a complete or partial alternative to statutory health insurance and so long as any intervention is necessary, proportionate and non-discriminatory. We have argued that the Directive is not sufficiently clear about when governments can justify material regulation of private health insurance. This is mainly because there is no explicit consensus about the meaning of partial or complete alternative, leading to uncertainty and confusion among policy-makers, regulators and insurers. Where the Commission and, more recently, the European Court of Justice (in *BUPA*), have had opportunity to clarify this aspect of the Directive, they have tended to sidestep the issue, relying instead on rules about services of general economic interest to authorize (Ireland) or prohibit (France) government intervention. Key exceptions are Bolkestein's letter, in which he argues that Article 54(1) of the Directive should not be used to justify material regulation of complementary private health insurance, and a description of the Directive on the Commission's web site, which refers to 'substitutive' private health insurance.

¹¹⁸ Sécurité Sociale, 'Contrat responsable', Sécurité Sociale (2008), www.securite-sociale.fr/comprendre/reformes/reformeassmal/decrets/maitrise/20050930.htm.

Bolkestein's definition of complementary cover fails to recognize that this type of private health insurance increasingly contributes to social protection for those who purchase it, operating in an unofficial partnership with statutory health insurance where it offers reimbursement of statutory user charges and/or provides access to effective health services excluded from the statutory benefits package. In particular, complementary cover of statutory user charges tends to be purchased by a relatively high proportion of the population, making it regressive in financing health care (because it is not restricted to richer groups) and creating or exacerbating inequalities in access to health care.¹¹⁹ If, as we have argued, the logic underlying Article 54(1) is to permit material regulation where private health insurance fulfils a social protection function, then obliging complementary insurers to offer open enrolment, lifetime cover and community rating would be necessary to ensure equitable access to health care, while a risk equalization scheme might be needed to lower incentives to select risks and to encourage competition based on price and quality. The Irish experience highlights the complexity of the issues at stake and the difficulties caused by legal uncertainty.

The Directive has been amended several times since its introduction, most recently in 2007.¹²⁰ None of the amendments has had any direct bearing on private health insurance. In 2008, the Commission circulated a proposal for an amended directive that would repeal and replace the Third Non-life Insurance Directive and several other insurance-related directives under the 'Solvency II' framework.¹²¹ Once again, there are no major changes specifically relating to private

¹¹⁹ A. Wagstaff *et al.*, 'Equity in the finance of health care: some further international comparisons', *Journal of Health Economics* 18 (1999), 263–90; E. van Doorslaer, C. Masseria and X. Koolman for the OECD Health Equity Research Group, 'Inequalities in access to medical care by income in developed countries', *Canadian Medical Association Journal* 174 (2006), 177.

¹²⁰ European Parliament and Council Directive 2007/44/EC 5 September 2007 amending Council Directive 92/49/EEC and Directives 2002/83/EC, 2004/39/EC, 2005/68/EC and 2006/48/EC as regards procedural rules and evaluation criteria for the prudential assessment of acquisitions and increase of holdings in the financial sector, OJ 2007 No. L247/1.

¹²¹ European Commission, 'Amended Proposal for a Directive of the European Parliament and of the Council on the taking-up and pursuit of the business of insurance and reinsurance (SOLVENCY II)', COM (2008) 119 final, 21 April 2008.

health insurance. The only real change seems to be in the wording of Recital 58 (Recital 24 of the original Directive), which now excludes open enrolment, community rating and lifetime cover as possible measures that may be introduced to protect the general good (where private health insurance serves as a partial or complete alternative). It is not clear whether this omission has any particular significance.¹²²

By maintaining the same wording as the Directive ('complete or partial alternative'; Article 204), the proposed new directive has missed a key opportunity to address legal uncertainty. The Commission's reluctance to be explicit about what the phrase means, the importance of the phrase in the infringement proceedings against Slovenia (but its seeming irrelevance in the eyes of the Court of First Instance in *BUPA*), and increasing reliance on the Treaty (Article 86(2) EC) to justify intervention in private health insurance markets (in France and Ireland) suggest that the Commission would have done better to have removed the phrase from the proposed directive. As the Court confirms, whether or not private health insurance requires material regulation to protect the general good should be a matter for national governments. We have argued that the logic underlying Article 54(1) is to ensure access to private health insurance where it contributes to social protection. However, as definitions of social protection may vary from one country to another (and even within a country, over time), deciding what does or does not contribute to social protection is, in our view, a largely political issue. It is therefore a matter best left to the discretion of national political processes.

If, as the Court states in *BUPA*, governments have relative freedom to define private health insurance as being a service of general economic interest, and regulations such as open enrolment can be construed as demonstrating SGEI obligations, then there seems little need for further elaboration of this particular issue in the form of a directive, particularly given the uncertainty created by the current and proposed wording and the fact that proportionality must still be tested, regardless of which process (Treaty or Directive) applies. It

¹²² As before, Recital 58 of the third 'Non-life Insurance Directive', above n.2, states that standardized benefits offered at a premium rate at or below a prescribed maximum, participation in loss compensation (risk equalization) schemes, and private health insurance operated on a technical basis similar to life insurance may be introduced as measures to protect the general good.

remains to be seen whether the *BUPA* ruling will change the position of the Commission in its infringement proceedings against Slovenia (at least concerning the legality of the risk equalization scheme), since the Slovenian Government now has a good legal basis on which to defend the SGEI nature of its complementary private health insurance market. The SGEI argument is unlikely to be much help to the Belgian Government, however, because hard and soft law alike consistently reject differential treatment of insurers based on legal status. A more pragmatic (and effective) approach to influencing the conduct of insurers is to favour those who adhere to specific principles. France has led the way here, with its system of tax exemptions for insurers that uphold *contrats solidaires* or *contrats responsables*, although even this move is under investigation by the Commission.

We have also argued that there is uncertainty about what sort of government intervention in the private health insurance market might be considered to be necessary or proportionate, not just because of the Directive, but also under EU state aid rules. While it is clear that differential treatment of insurers based on legal status will not be tolerated, it is much less clear whether regulatory requirements such as open enrolment and risk equalization schemes are compatible with the Directive – particularly (but not exclusively) where non-substitutive private health insurance is concerned. For example, the Commission's decision to authorize risk equalization in the Netherlands has been challenged by a Dutch insurer,¹²³ even though the new Dutch health insurance system is broadly accepted as being statutory in nature. The Commission has contributed to this uncertainty by approving the risk equalization scheme in Ireland (on the grounds that private health insurance in Ireland constitutes a service of general economic interest), but accusing the Slovenian risk equalization scheme of contravening the Directive – and yet, as we have argued, the case for risk equalization might be stronger in Slovenia than in Ireland. It is possible that the *BUPA* ruling will, in practice, remove some of this uncertainty.

Finally, we have argued that the Directive's regulatory framework may not provide sufficient protection of consumers. In markets where private health insurance does not contribute to social protection, the Directive assumes that financial regulation will protect consumers. But solvency rules alone may not be adequate if health

¹²³ Case T-84/06, *Azivo Algemeen Ziekenfonds*, above n.58.

insurance products are highly differentiated. Information asymmetry exacerbated by product differentiation appears to be a growing problem in markets across the European Union and the Commission has not yet put in place mechanisms for monitoring anti-competitive behaviour by insurers. Communications from the Commission have also raised doubts about the compatibility of certain regulatory measures with competition rules – for example, the provision of benefits in kind.¹²⁴ If a requirement for insurers to provide benefits in kind were to be found to contravene competition rules, there would be implications for statutory as well as private health insurance.

The Directive reflects the regulatory norms of its time. When it was introduced in 1992, the Commission may have been convinced that it would provide ample scope for governments to protect consumers where necessary and would not jeopardize statutory arrangements. Article 54 would protect markets contributing to social protection, while, in markets regarded as purely supplementary, the benefits of deregulation (increased choice and competition resulting in lower prices) would outweigh concerns about consumer protection. These assumptions are more problematic now, partly because there is no evidence to suggest that the expected benefits of competition have, as yet, materialized. Private health insurance premiums in many Member States have risen rather than fallen in recent years, often faster than inflation in the health sector as a whole, while insurers' expansion across national borders has been limited to cross-border mergers and acquisitions, rather than genuinely new entrants to the market.¹²⁵ The new Dutch health insurance system has not yet seen any cross-border activity and the number of insurers in operation has swiftly fallen to about five.

The assumptions are also problematic due to increased blurring of the boundaries between normal economic activity and social security. On the one hand, the case-law reviewed in this chapter shows governments how they might put their health insurance arrangements beyond the scope of internal market law, either by placing them firmly within the sphere of social security or by invoking the general good defence. On the other hand, as the Dutch system shows, the trend seems to be going in the opposite direction. Consequently,

¹²⁴ Bolkestein, 'Letter from European Commission', above n.32.

¹²⁵ Mossialos and Thomson, *Voluntary health insurance*, above n.5.

social security is no longer the preserve of statutory institutions or public finance, a development likely to bring new challenges for policy-makers. Greater blurring of the public–private interface in health insurance gives rise to complexities that neither the existing Directive nor the proposed new directive seem equipped to address. In light of these complexities, only some of which we have attempted to highlight here,¹²⁶ we think it is time for a debate about how best to move forward. A priority for debate should be to find ways of thinking about private health insurance that go beyond ‘partial or complete alternative’ to statutory cover. These terms are unclear and do not reflect the often complicated relationship between public and private cover. At least in the European Union, private health insurance rarely offers a genuine ‘alternative’ to statutory cover.¹²⁷ We also emphasize that financial regulation may not be the only or best means of protecting consumers in health insurance markets. If it is not possible to reach a political consensus about re-examining the need for material regulation of private health insurance under some circumstances, then the Commission and the Member States should consider how best to improve the way in which products are marketed and the quality of the information available to consumers.

¹²⁶ There are other issues that may also be relevant – for example, the introduction of medical savings accounts as part of either private or public coverage. Medical savings accounts (MSAs) involve compulsory or voluntary contributions by individuals to personalized savings accounts earmarked for health care. They do not involve risk pooling (except in so far as they are combined with insurance). Consequently, they do not involve any form of cross-subsidy from rich to poor, healthy to unhealthy, young to old or working to non-working. The only example of MSAs in an EU context is in Hungary, where savings accounts that benefit from tax subsidies are used voluntarily to cover statutory cost sharing or to cover out of pocket payments for services obtained in the private sector.

¹²⁷ S. Thomson, T. Foubister and E. Mossialos, *Financing health care in the European Union: Challenges and Policy Responses* (Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2009).