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The uncertain and differentiated impact of EU law on national (private) health insurance regulations

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Abstract – The present chapter seeks to analyze the impact of EU law on private health insurance at national level. Does EU law have a vertical impact leading to a rather standardized situation or can we observe a more contrasted landscape? The chapter proposes a two-sided approach: on the one hand, a study of EU internal market law that frames and aims to regulate the health insurance market; on the other hand, a comparative overview of various national arrangements as far as health insurance marketization is concerned. Two main results are brought out. First, though EU law appears to be a “matrix” for private health insurance activity, it is actually rather flexible so that there is latitude for national regulation of the PHI market. This generates some uncertainty. Second, there are various forms of arrangements at national level relating to health coverage, and this is why the impact of EU law is differentiated.

Introduction

Private health insurance (PHI) is fairly well developed in Europe, though in a very heterogeneous way. National backgrounds and environments play a prominent role (Sagan and Thomson, 2016). Comparative studies show that the scope of private health coverage in each country – assessed as a share of the population covered by a private/voluntary plan – varies widely; the function or role of PHI, which can be substitutive, duplicative, complementary (user charges or services) or supplementary, depends on the very structure and organization of the statutory health insurance scheme or national health system in each country (see Fig. 4.1). Health insurers also operate under various legal forms: for-profit companies and non-profit organizations (mutual benefits societies, provident institutions, welfare institutions, etc.), and this has often led European countries to adopt and apply specific regulations, depending on the legal status and purpose of these different sorts of insurers. The generic term “private health insurance” or “voluntary health insurance” includes a wide variety of actors and techniques. In fact, PHI is a galaxy.

Fig. 4.1 – Overview of the different functions of private health insurance (PHI)

Duplicative PHI	Substitutive PHI	Complementary PHI	Supplementary PHI
Provides access to services that are already available within the publicly financed health insurance scheme (presumably affording faster access, greater choice, or other amenities)	Covers specific categories of the population who can “opt out” of the statutory scheme (employees with a salary exceeding the contribution assessment ceiling; self-employed persons; civil servants)	Private health insurance that complements coverage of government/social insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., cost sharing, co-payments)	Generally offers services that are not covered under the statutory scheme

In the light of this complex and heterogeneous reality, European Union law appears to be a simplified or simplistic framework. PHI is regarded as non-life insurance under the EU legislation – the non-life insurance directives – which aims to harmonize national legislations in order to establish an internal market for insurance, governed by the principles of freedom of establishment and freedom to provide services (this includes solvency rules). Health insurance is considered as an economic activity and health insurers as undertakings, which are the criteria for the applicability of EU competition law. So there is a kind of European “legal matrix” which shapes voluntary health insurance and imposes its own rules over national regulations.

At first glance, one could think that when private bodies or actors provide healthcare coverage, this leads automatically to a uniform application of European economic law, i.e., the non-life directives and competition law (art. 101 to art. 109 TFUE). From this point of view, a clearly identifiable impact of EU law is to be expected, according to the model: private health insurances imply a free and competitive market. In other words, though the EU law in itself does not command the marketization of healthcare, it tends to impose the application of market and competition rules when health coverage is provided by private insurers. Nevertheless, a closer examination of the situation leads to the observation that there is no uniform application of EU law. European law leaves a margin of discretion to the member States so they can arrange the health insurance market and limit competition to a certain extent. Sagan and Thomson (2016) note: “The EU-level regulatory framework created by the non-life Insurance Directive imposes restrictions on the way in which governments can intervene in markets for PHI. There are areas of uncertainty in interpreting the directive, particularly with regard to when and how governments can intervene to promote public interests. As in most spheres of EU legislation, interpretation largely rests on ECJ case law, so clarity may come at a high cost and after considerable delay”.

The present chapter seeks to analyze and discuss the impact of EU law on private health insurance at national level. From a legal point of view, the question of the impact or the influence of EU law on national legislation is rather classical. Due to the supranational nature of EU law, an impact can be observed and assessed when national law is forced to transform or adapt itself through a legal process such as the transposition of a directive or the application of an ECJ ruling. This is the “vertical” or “top down” dimension of European integration. Nevertheless, in this particular area, some national arrangements may challenge the EU legal framework and produce a kind of feedback effect. In many cases, the confrontation between national regulation (of the PHI market) and EU law is provoked by a stakeholder that challenges this regulation and aims to impose perfect competition. It happens that the outcome of this process is the evolution of EU law itself (through ECJ case law).

Two main ideas will be developed here. First, though EU law appears to be a “matrix” for PHI activity, it is actually rather flexible and open to interpretations so that there is latitude for national regulation of the PHI market. This generates some uncertainty. Second, there are various forms of arrangements at national level as far as health coverage is concerned, and this is why the impact of EU law is differentiated. In some countries, the frontier between the public healthcare system and the private health insurance market is well defined and quite impervious. This is generally the case when private health insurance plays a duplicative role, according to pure market mechanisms: people purchase private health insurance in order to get better and faster access to healthcare; they have a choice among a plurality of insurers who offer and supply health coverage and services in a competitive environment. In these countries - Spain, for instance- the impact is rather “soft” insofar as the member States only have to make sure

that private health insurers comply with the provisions of the EU insurance directives. In other countries, private health insurance is integrated into the universal statutory scheme (Belgium, Czech Republic, Germany, The Netherlands, Slovakia) or is closely connected to it and plays a complementary role in social protection (France, Ireland, Slovenia). These are the two faces of health coverage marketization: the adoption of “the methods and values of the market” in the non-profit sector to make it “more market-like in their actions, structures, and philosophies” (Eikenberry and Kluver 2004); the idea of using market forces to finance and provide *health* services. Those kinds of arrangements are potentially more problematic from the EU law perspective.

1. Health insurance and the internal market: the European matrix

Examining the impact of European Union law on national legislation is common practice, irrespective of the field in question. However, the extent of this impact largely depends on the breakdown of competencies between the European Union and Member States in the field under consideration.

Health insurance is undeniably part of social policy, which is dealt with in Title X of the Treaty on the Functioning of the European Union (hereinafter, TFEU). In particular, this Title provides that with respect to social security and the social protection of workers, the Union shall support and complement the activities of the Member States (art. 153§1, c). However, there are two constraints on the action of the EU in this domain. Firstly, while European legislation may implement measures designed to encourage cooperation and the exchange of information and best practice, it cannot implement any harmonisation measures of the laws and regulations of the Member States (art. 153§2 a); on the other hand, *the provisions adopted “shall not affect the right of member States to define the fundamental principles of their social security systems and must not significantly affect the financial equilibrium thereof”* (art. 153§4).

From this it follows that the configuration of social protection systems falls within the remit of Member States, as stated very clearly by the CJEU in 1987, in its *Duphar* ruling: “*Community law does not detract from the powers of member states to organize their social security systems*¹”. The Court has had the opportunity to reiterate the rules of competency in a number of rulings, including the *Sanres* ruling, which states the following: “*in the absence of harmonization in social security matters, the Member States remain competent to define the conditions for granting social security benefits*”². From this it follows that Member States decide on the characteristics of their social security systems in every respect; this leads to a very high degree of diversity in these systems. National choices in this respect are therefore not constrained by the European Union, within which there are not only national health systems, but also social insurance schemes; these may exist side-by-side with various forms of privatisation, including private insurance schemes.

Simply put, it must be borne in mind that the fact that national options in terms of social security organisation and protection, and, more particularly for our interests, health insurance, are not predetermined at EU level. This means that the degree of vertical integration provided by EU law is relatively minor, although it does have an impact in the event of the existence of private insurance schemes. However, horizontal integration under EU law is worth examining more

¹ ECJ case 28/82, *Duphar*, 7 February 1984, *ECR* 1984, p. 523

² ECJ case C-20/96, *Snares*, 4 November 1997, *ECR* 1997, p. I-6057. See also ECJ case C-158/96, *Kohll*, 28 April 1998, *ECR* 1998, p. I-1931; ECJ case C-247/90, *Xhymshiti*, 18 November 2010, *ECR* 2010, p. I-11845

closely. Indeed, integration may be indirect, potentially brought about by compliance with “transverse” EU rules that, in theory, apply irrespective of the activity in question. This is particularly the case for internal market law, based on the freedom to provide services, and competition law, the provisions of which are enshrined in the TFEU. This law has led to the creation of a kind of matrix, with its own criteriology (Mossialos et alii 2010).

1.1. The relatively minor impact of EU insurance law on vertical integration

Member States retain most responsibility for deciding how to organise and regulate those areas of activity not covered by EU harmonisation in the form of sector-specific Directives³. This applies, for instance, to social protection, in view of how competencies are allocated between the EU and Member States (see above). With respect to health insurance, this means that the EU does not predetermine what should be covered by social insurance (social security)⁴ or private insurance. Legally speaking, it is up to Member States to establish “on-market” and/or “off-market” health insurance and the scope of each type (Thomson and Mossialos 2006 and 2010).

In this respect, national arrangements are often hybrid in nature; this raises specific problems. Indeed, while the EU does not have any remit to harmonise domestic social security, the same is not true of the insurance business, which falls within the scope of the internal market. To create the internal market and make the freedom to establish and provide services a reality, the EU has adopted a great many Directives, in particular sector-specific Directives. As a result, a body of EU insurance law has gradually come into existence. It would therefore be tempting to conclude that, in countries that allow private health insurance, these “Insurance” Directives shape the legal environment applicable to this business, so much so that they constitute vertical integration.⁵ However, this sweeping conclusion does not withstand an analysis of the limits established by the Directives themselves.

1.1.1. Statutory social security schemes: not covered by vertical integration

The Solvency II Directive excludes “*insurance forming part of a statutory system of social security*” (art. 4) from its scope. As a result, the deployment of social insurance to cover sickness falls outside the sphere of EU competition law (see below).

In a case involving France, the issue of this exclusion was brought before the CJEU. In its *García*⁶ ruling, the Court stated that one of the law’s provisions clearly and precisely specified that the Insurance Directive excluded from its scope of application “*not merely social security organizations (undertakings or institutions) but also the types of insurance and operations which they provide in that capacity*”. In its view of national competency to organise social security systems in the light of the scope of application of “Insurance” Directives, the Court

³ This type of Directive relates to certain sectors of business (e.g. transport, banking, and financial markets).

⁴ Member States also decide on the procedures governing state payment for care. Some countries, such as the UK, have opted for a national health system that provides direct access to care; others, such as France, have opted to set up social insurance, covering part of the cost of care.

⁵ Several generations of “Insurance” Directive have been adopted since 1973. They were abrogated by Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance. Known as the Solvency II Directive, this Directive is now a kind of European Insurance Code. Hereafter, reference will be made to this 2009 legislation, of which many provisions are taken from previous Directives (particularly those of 1973 and 1992). See chapter 3.

⁶ ECJ case C-238/94, *García*, 26 March 1999, *ECR* 1996, p. I-1673

ruled that two health insurance schemes could coexist in Member States: a private-sector scheme, subject to “Insurance” Directives, alongside a social security scheme that was not subject to the rules of the internal market (“Insurance” Directives and competition law) (see Fig. 4.2).

As a result, domestic arrangements for health insurance play a determining role in the extent to which EU law achieves vertical integration. The more the national system leaves room for private health insurance, the greater the vertical integration; on the other hand, in countries where social security covers most of the cost of healthcare, vertical integration is weak. From this it follows that the definition of a statutory social security scheme is key. No such definition is to be found in the “Insurance” Directives, which are silent on the matter. However, EU jurisprudence in the field of competition law does provide some definitional aspects. Indeed, the Court referred to this jurisprudence in its *Garcia* ruling. It cites the landmark *Poucet and Pistre*⁷ rulings, which define schemes founded on the principle of solidarity, and to which affiliation is made mandatory in order to ensure application of the principle of solidarity as well as that of financial equilibrium, as being a solely social (as opposed to economic) activity. The actual wording of the *Poucet and Pistre* ruling states that these schemes have a social purpose, and fulfil the solidarity principle, because they are intended “to provide cover for all the persons to whom they apply, against the risks of sickness, old age, death and invalidity, regardless of their financial status and their state of health at the time of affiliation”. In terms of health insurance, solidarity is expressed in terms of identical services for all social security beneficiaries, with contributions proportional to income, ensuring that the less well-off are not deprived of any social cover their state of health may require.

Fig. 4.2 – Organic scope of EU economic law

	Insurance Directives	EU competition law
Statutory social security schemes	Out of the scope regardless the organization	Out of the scope regardless the organization
Private health insurance	All organizations (for-profit or non-profit insurance undertakings)	All organizations (for-profit or non-profit undertakings)

Source: authors

The off-market nature of “operations” by provident and mutual benefit institutions

Right from the first “Insurance” Directive (1973), a distinction is drawn between insurance activities and “operations of provident and mutual benefit institutions whose benefits vary according to the resources available and in which the contributions of the members are determined on a flat-rate basis” (art. 2§2, cited in article 5 of the Solvency II Directive). Indeed, all such “operations” are excluded from the scope of application of provisions covering insurance other than life insurance.

⁷ ECJ joined cases C-159/91 and C-160/91, *Poucet and Pistre*, 17 February 1993, *ECR* 1993, p. I-637

There is no explanation of this exclusion in the recitals to the Directives, even though it results in part of the activity of a certain category of insurers qualifying as being “off-market”. In view of the definitional elements set out in the legislation and the insurers in question, it would appear that this is a reference to services provided on the grounds of social action (e.g. one-off assistance to a beneficiary having to cope with an exceptionally large excess to be paid for care that they cannot afford due to their low income)⁸. Unlike insurance cover, the insurers in question make no commitment to their policyholders, because the services counting as “operations” may be granted only if resources are available. Moreover, policyholders’ contributions to the funding of operations is on a flat-rate basis; this means that they do not depend on actuarial criteria (the degree of risk the policyholder represents).

However, the definitional criteria do not restrict “operations” to the field of social action. Indeed, “operations” are not defined in terms of their nature or purpose, but in terms of how they are funded. It is therefore in theory possible for part of the activity of insurance companies to fall outside the scope of regulations applicable to the insurance sector, including some activities that are somewhat complementary in nature to the insurance business itself. A reform undertaken in Belgium in 2010 made express use of this distinction between the business of insurance and “operations” to keep part of the top-up healthcare activity carried out by mutual benefits societies out of the insurance market (see chapter 6).

1.1.2. A lack of harmonisation in insurance policy law

The subjects of the harmonisation brought about by the “Insurance” Directives offer some insight into the scope of expression of vertical integration. In substance, the purpose of the “Insurance” Directives is to harmonise the conditions for competition between companies present on the market, securing the commitments made by these operators with respect to policyholders, and allowing the latter to have all the information required to benefit from the existence of competition. EU law governing insurance companies has thus been built up over time, and been applied throughout all Member States via Directives. The law governing the terms of exercise of the business of insurance is highly integrated, in order to achieve an internal insurance market.

However, insurance policy law has for the most part not been included in the harmonisation process. Substantive law covering insurance policies derives mainly from domestic law. The lack of vertical integration regarding the contents of insurance policies grants Member States the scope to influence this content (or choose not to do so)⁹. Each country decides on the regulatory framework governing all or part of the products that may be offered on the market by insurance companies. Applying this to the realm of health insurance, state interventionism is a matter of domestic policy; this may depend largely on the extent to which private health insurance is, explicitly or implicitly, assigned a systemic role in paying for care. In France, for instance, private health insurance is mostly involved as a top-up to the statutory health insurance scheme (social security); it is therefore hardly surprising that regulations structure the relationship between these two levels of payment via configuration constraints that impact health insurance policies¹⁰.

⁸ Traditionally, provident and mutual benefit institutions have social action funds financed by an annual budget that draws on the contributions received. These funds allow aid, assistance, and additional services to be provided to policyholders in the circumstances covered by the insurance policy in question.

⁹ “Horizontal” EU Regulations do however cover some aspects of the contractual relationship in insurance policies (information, non-discrimination, etc.).

¹⁰ See chapter 7.

When private insurance replaces social security – a special case

EU regulations covering insurance do however apply to one type of health insurance policy: policies taken out on an opt-in basis that wholly or partly replace health insurance provided by a social security scheme. This instance of so-called “substitute” insurance generally applies only to a tiny fraction of the population. For instance, in Germany, employees whose income exceeds a given ceiling may approach a private-sector insurer rather than a health insurance fund (Busse and Blümel 2014).

According to recital 84 of the Solvency Directive, “*the particular nature of such health insurance distinguishes it from other classes of indemnity insurance and life insurance insofar as it is necessary to ensure that policy holders have effective access to private health insurance or health insurance taken out on a voluntary basis regardless of their age or risk profile*¹¹”. This may legitimise the maintenance of legislation that is binding in quantitative terms, designed to ensure that the cover in question is a genuine substitute (e.g. including an obligation of non-discrimination). Such legal measures must be made binding, in order to protect the general interest with respect to this branch of insurance in the Member State in question (Solvency Directive art. 206). The State in question may require the insurance policy and the insurer’s practices to comply with the provisions designed specifically to protect the general interest¹², one aspect of which is that nobody should be deprived of health insurance. Again, in Germany, in the case of substitute insurance, this means, for instance, that insurers cannot increase premiums on the grounds of age, or terminate the policy (i.e. their commitment is for life).

From this analysis, it may be concluded that in substantive terms (i.e. policy content, rules governing selection and tariffs, etc.), vertical integration in terms of insurance law is, ultimately, relatively slight. With respect to health insurance, however, closer attention needs to be paid to indirect integration mechanisms. Indeed, transverse EU rules may impact national decisions; in some cases, they may even offer Member States opportunities when it comes to choosing how to organise their social protection system. This is the case not only in view of fundamental rights (e.g. the principle of equal treatment¹³) but also in view of EU competition law.

1.2. Horizontal integration via EU competition law: uncertain criteria and malleable instruments

Competition law makes reference to a body of rules of which the purpose is to prevent competition between companies that intervene or seek to intervene on the same market from being hindered, restricted, or distorted (art. 101-113, TFEU), for instance through the abuse of dominant position or via state aid granted to some operators. Consequently, its principles have a very broad influence on all sectors of activity. They thus constitute horizontal integration processes with an impact in the field of health insurance.

¹¹ On the difficulties of clearly defining the notion of substitute insurance, see Sagan and Thomson (2016, p. 85) and Mossialos *et alii* (2010).

¹² On this concept, see the interpretative communication by the Commission, C (1999) 5046 of February 2, 2000 “Freedom to provide services and the general interest in the insurance sector”.

¹³ For instance, in a landmark ruling, the CJEU ruled against sex-based discrimination in insurance premiums and services. ECJ case C-236/09, *Association belge des consommateurs Test-Achats*, 1st March 2011, *ECR* 2011, p. I-773

However, understanding these processes and their real impact is complicated, for two reasons in particular. Firstly, the precise outline of the criteria governing the legal spaces created by EU competition law (see below) is unclear. Secondly, when Member States configure their health insurance systems, they rarely provide a detailed explanation of how these fit into the spaces in question; the issue of the compatibility of domestic provisions with EU competition law only tends to emerge in the event of litigation.

1.2.1. Legal spaces created by competition law: a broad spectrum for (non)-marketization of health insurance.

Introductory identification of the legal spaces created by EU competition law. Irrespective of the sector of activity in question, examination of CJEU jurisprudence reveals three legal spaces within the regulatory environment (Del Sol 2016; Mossialos et al. 2010) (see Fig. 5.2).

Positive law has created an “off-market” space for activities that are not provided by “undertakings” within the meaning of EU competition law. *Activities that are exclusively social in nature* – a category that has emerged in the Court’s jurisprudence – fall within this space. As such, the latter therefore falls outside the scope of application of TFEU articles 101-113, i.e. it is not subject to EU competition law; from this it follows that a State may grant a single institution or body a monopoly on managing this space. The legal space in question may be understood as having come into existence by default, by opposition with the “on-market” space.

Activities provided by undertakings (i.e. activities that are not exclusively social in nature, as it were) fall within an “on-market” space. This space therefore falls within the scope of application of TFEU articles 101-113, and is thus subject to EU competition law and its principle of free and fair competition. It may be understood as being the legal space within which activities should theoretically take place, since the European Union promotes the market economy and aims to construct a huge internal market. This quite clearly includes the insurance sector, as the CJEU stated in 1987¹⁴.

Within this on-market space, there is also a legal enclave: TFEU articles 106 and 107 specify both exceptions and restrictions to competition rules. For instance, subject to certain conditions, TFEU article 106§2 allows restrictions to market rules to be implemented for “*undertakings entrusted with the operation of services of general economic interest*” (hereinafter, SGEIs). Such mechanisms provide a way to adjust competition rules for social purposes via what may be referred to as social instruments of competition law (Driguez 2006).

Defining the scope of the “on-market” space. The “on-market” legal space is the space that applies in principle. This space is defined by the scope of application of EU competition law, the implementation of which applies only to undertakings. However, primary legislation does not precisely define the concept of “undertaking”. As a result, it has been up to the Court of Justice to define what the EU means by “undertaking” during the course of a number of disputes, a significant proportion of which pertain to the field of social protection.

According to the foundational *Höfner & Elser* ruling in 1991¹⁵, “*in the context of competition law [...], the concept of an undertaking encompasses every entity engaged in an economic activity...*”. From this it follows that the existence of economic activity can be used to determine whether the activity in question falls within the scope of EU competition law (the “on-market”

¹⁴ ECJ case 45/85, *Verband der Sachversicherer vs Commission*, 27 January 1987, ECR 1987, p. 405

¹⁵ ECJ case C-41/90, *Höfner and Elser*, 23 April 1991, ECR 1991, p. I-1979

space). The European Union definition of “undertaking” supplied by the Court of Justice considers the characteristics of the activity engaged in rather than those of the entity, body, or structure engaging in it. From the *Höfner* ruling onwards, the Court of Justice has remained agnostic as to the legal nature and form of entities engaging in an activity when it comes to determining whether or not an “undertaking” within the meaning of EU law exists. The organic criterion, i.e. looking at the nature of the body in question, cannot therefore be used to determine economic activity in this respect. From this it follows that a non-profit body may be deemed to constitute an “undertaking”. The same may also apply to a mutual benefits societies or a statutory body.

The Court’s jurisprudence is based on a functional approach, in which economic activity is the kernel of the definition of an “undertaking”¹⁶. Typically, the Court rules that the concept of an undertaking covers any entity engaged in an economic activity that consists in offering goods or services on a given market¹⁷. In using the term “market”, the Court is making reference to situations involving competition. However, defining the existence of economic activity does not necessarily mean that an actual situation involving competition has been determined; a potential situation may suffice. An activity will be defined as economic if it is exercised, or is liable to be exercised, by a private actor for profit. In other words, the reasoning is deductive. For instance, in its *FFSA*¹⁸ ruling, the Court states that “*the mere fact that the CCMSA is a non-profit-making body does not deprive the activity which it carries on of its economic character*” to the extent it competes with life assurance companies. This has led the Court of Justice to clarify that “*the fact that the offer of goods or services is made without profit motive does not prevent the entity which carries out those operations on the market from being considered an undertaking, since that offer exists in competition with that of other operators which do seek to make a profit*”¹⁹.

In theory, it should be checked whether the activity in question is or could be comparable to the activity of a private-sector, for-profit undertaking, or any activity liable to be exercised by such an entity. Generally speaking, the court adopts a comparative approach, in particular by seeking to verify whether the activity in question is actually managed (or may have been managed recently) by private-sector, for-profit entities in other Member States.

Criterion for defining the “off-market” space. Activities that are solely social in nature do not fall within the scope of competition law: since they do not entail any economic activity, they cannot be defined as an “undertaking” and therefore find themselves in the “off-market” space. This makes it all the more important to examine what constitutes an “exclusively social activity”: if no such activity can be identified, the default conclusion is that the activity is economic in nature. This question is particularly acute in the field of social protection, and indeed this makes up a substantial part of the Court’s jurisprudence. The founding rulings are the *Poucet and Pistre* rulings (see above) on independent workers who refused to pay contributions to social security funds, taking the view that for their mandatory basic social insurance, they should be entitled to approach a private insurance company, rather than suffer from the dominant position occupied by social security. The Court excludes from competition

¹⁶ Following this approach, a single structure may be defined as an undertaking for one type of activity in which it engages, and not for another.

¹⁷ ECJ case C-118/85, *Commission vs Italy*, 16 June 1987, *ECR* 1987, p. 2599; ECJ case C-475/99, *Ambulance Glöckner* 25 October 2001, *ECR* 2001, p. I-8089

¹⁸ ECJ case C-244/94, *FFSA* 16 November 1995, *ECR* 1995, p. I-4863

¹⁹ ECJ case C-49/07, *MOTOE*, 1st July. 2008, *ECR* 2008, p. I-4013; ECJ case C-222/04, *Cassa di Risparmio di Firenze*, 10 January 2006, *ECR* 2006, p. I-289

law “the organizations involved in the management of the public social security system that fulfil an exclusively social function”.

While the social aim of the social protection scheme being challenged is a prior condition for this definition, it is not a sufficient condition, because the activity must be “exclusively social”. The fact is that the defining criteria have not always emerged very clearly from the Court’s jurisprudence. However, the *Kattner* ruling handed down in 2009²⁰ now offers a greater degree of certainty²¹. Indeed, in this ruling, the CJEU specifies that, when a social insurance scheme has a social aim, “it remains to be examined, in particular, whether that scheme can be regarded as applying the principle of solidarity and to what extent it is subject to supervision by the State, given that these are factors that are likely to preclude a given activity from being regarded as economic²²”.

Criteria and conditions for regulating the “on-market” space with respect to SGEIs.

Within the field of economic activities subject to competition law, competition rules may be adjusted to allow services in the general interest to be deployed. In other words, the TFEU allows the “off-market” space to be regulated, subject to certain conditions. To do this, the “social instruments” of competition law specified in TFEU articles 106 and 107 may be used (Driguez 2006).

With respect to principle and also, more particularly, when it comes to disputes, the legitimacy of such adjustments to the rules of competition (EU law) depend on being able to identify a general-interest mission, entrusted to an undertaking. Doing so is difficult in the absence of certainty as to the precise definition of SGEIs. Indeed, SGEIs are not defined in primary law or derivative law. However, the European Commission has specified that SGEIs are economic activities carrying out general-interest missions that, in the absence of any State intervention, would not be carried out at all, or would be carried out by the market in different conditions in terms of quality, safety, accessibility, equality of treatment, and universal access. It is therefore not surprising to discover that despite the existence of extensive jurisprudence, the law in this respect is not fully predictable, since identifying an SGEI is based on examining a body of evidence which may be difficult to weigh. SGEI-related EU litigation in the field of social protection highlights the fact that the argument rests mainly on the solidarity factors imposed on the operators that manage the schemes in place. Indeed, in most cases, it is argued that if the scheme is characterised by a degree of solidarity imposing significant obligations on the managing operator, the service it provides cannot be delivered at the same price as other operators to whom these constraints do not apply. It is therefore necessary to demonstrate that shouldering the general-interest mission may constitute a form of competitive disadvantage, leading to the service provided being less competitive, because its cost is higher in order to take into account solidarity-based considerations. One illustration of this is the *AG2R* ruling, on a

²⁰ ECJ case C-350/07, *Kattner Stahlbau GmbH*, 5 March 2009, *ECR* 2009, p. I-1513

²¹ The European Commission’s interpretative communications are also useful when it comes to identifying exclusively social activities. In this respect, §20 of the 2016 Communication on the concept of State aid (2016/C 262/01) specifies the following: “Solidarity-based social security schemes that do not involve an economic activity typically have the following characteristics: (a) affiliation with the scheme is compulsory; (b) the scheme pursues an exclusively social purpose; (c) the scheme is non-profit; (d) the benefits are independent of the contributions made; (e) the benefits paid are not necessarily proportionate to the earnings of the person insured; and (f) the scheme is supervised by the State”.

²² “The fact that the body provides insurance services directly does not, of itself, affect the purely social nature of that function, in so far as it does not affect either the solidarity inherent in that scheme or State supervision of it”. See also ECJ case C-218/00, *Cisal*, 22 January 2002 concerning Italian legislation covering “workplace accidents and professional diseases”, *ECR* 2002, p. I-691

case pertaining to a collective agreement concluded for the artisanal bakery branch that established a mandatory “health costs” scheme.²³ To identify the existence of an SGEI, the Court referred to a number of indicators: funding via fixed-rate contributions such that the rate was not proportional to the risk shouldered and thus that age, state of health, and the particular risks inherent in any specific job were not taken into consideration²⁴; the nature of the benefits and the extent of the cover not being proportionate to the amount of contributions paid; the existence of “free” entitlements that did not directly entail contributions (e.g. temporary maintenance of cover after the termination of a contract or the death of the employee). Secondly, it has to be demonstrated that the regulatory measure does not do more than what is strictly necessary to fulfil the mission (control of proportionality); failing this, an operator may be deemed to enjoy an unlawful competitive advantage with respect to other operators present on the market. In other words, any restriction on competition, in particular if it takes the form of financial compensation, must be very carefully calibrated.

The idea is that market intervention should satisfy the general-interest mission, in other words “counter” competition with regulations designed to achieve aims deemed to be indispensable, such as equal access to certain specific benefits. Primary law does not specify the nature of such arrangements²⁵, but does define a framework for any that take the form of state aid (TFEU art. 107-109). It allows restrictions to market rules favouring undertakings responsible for managing SGEIs to be implemented. Broadly speaking, these arrangements may come in one of two forms. One option is to regulate the entire market; any such regulation is thus binding on some or all of the undertakings engaged in competition on the market in question. Regulation imposes obligations on all or part of the offerors such that ultimately, general-interest considerations are satisfied (e.g. the obligation to offer certain services to any citizen approaching an operator).²⁶ Regulation may also require undertakings to provide their products in a manner that would be incompatible with purely market requirements, for instance to correct unequal access to certain goods and services. The alternative approach concerns selective advantages favouring undertakings responsible for an SGEI. Here, adjusting competition rules may take the form of special management rights; these may go so far as to grant exclusive management rights, creating a monopoly to the benefit of the undertaking responsible for the SGEI. Adjustment may also take the form of financial compensation or aid, the benefit of which is reserved solely for undertakings responsible for a general-interest mission.

²³ ECJ case C-437/90, *AG2R*, 3 March 2011, *ECR* 2011, p. I-973

²⁴ In other words, tariffs are not determined on the basis of each employee’s loss exposure.

²⁵ There is also a wide range of possibilities when it comes to management modes, i.e. how, practically speaking, general-interest missions are taken up. Public authorities have a high degree of freedom in this respect: they may perform general-interest tasks “*by their own means, without being required to enlist third-party entities*” (ECJ case C-480/06, *Commission vs Germany*, 9 June 2009, pt 45, *ECR* 2009, p. I-4747). Alternatively, they may also opt to outsource the management of general-interest economic activities, or entrust general-interest missions to private operators.

²⁶ TPI case T-289/03, *BUPA*, 12 February 2008 (Irish case), *ECR* 2008, p. II-81

Fig. 4.3. – The three legal spaces resulting from the EU competition law

EU competition law		Out of the scope of EU competition law
Free competition	Competition adjustment (monopolistic situation, selective benefits...)	<i>Activity fulfilling an exclusively social function</i>
Undertaking (entity engaged in an economic activity)	Undertaking engaged in an economic activity) <u>and</u> entrusted with the operation of services of general economic interest	
Health insurance not solidarity-based	Health insurance with social function and impregnated with considerations of solidarity that justifies regulating market forces	Statutory social security schemes structurally solidarity-based and under state control

Source: authors

1.2.2. Assessing horizontal integration: the many shades of health insurance marketization

The impossibility of using EU competition law to measure horizontal integration. Legally speaking, significant differences arise depending on which of the three identified spaces a health insurance activity is assigned to. Consequently, if a State organises health insurance in such a way that a management monopoly is established, or entrusts selective benefits to a particular body, or imposes specific obligations on certain operators, the issue of compatibility with EU competition law arises – or more accurately, it could be said that the issue of compatibility is likely to arise.

In other words, using EU law to gauge horizontal integration is tricky in conceptual terms, for two main reasons. Firstly, States do not necessarily situate their legislation within the field of EU competition law; the recourse to EU criteriology may only be implicit. For instance, when French law establishes a contractual clause recommending that a body providing insurance to companies in a particular professional sector should provide a high degree of solidarity, it uses the criterion of solidarity at the heart of CJEU jurisprudence with regard to SGEIs, but does not expressly acknowledge the paternity of this concept. At the same time, there are other examples in which EU law has manifestly – and indeed sometimes explicitly – been used as a resource, either to provide support for a particular arrangement, or to support a reform. In such examples, this “Europeanisation” mingles strictly domestic considerations and EU legislation, the outcome of which is a complex hybridisation of levels. For various reasons, to differing degrees, and on different timescales, Belgium, the Netherlands, and Ireland have all adopted this type of approach. Secondly, there is no systematic control of the compatibility of domestic legislation with EU law. As a result, the issue is not necessarily raised or discussed. The issue of Euro-compatibility often arises as a result of litigation. Very generally speaking, this arises when operators ejected from a market, or believing themselves to be the victims of unfair competition,

bring litigation in the form of a civil case.²⁷ In other instances, litigation may be brought by Member States following a ruling by the European Commission, for instance during the course of the latter's control of state aid.

The phenomenon of interaction between the EU and national levels. In this field, the term “Europeanisation” is often used: EU legislation is said to produce a top-down vertical effect that “shapes” the national level. However, the field of health insurance may well serve to demonstrate the limits of this traditional assumption, since EU law does not appear to be making public or private-sector health systems more uniform or harmonised. Despite this, the impact of EU law is sometimes perceived in such a way as to give the impression that application of EU economic law is intended to achieve conformity of national systems with a European model destined to grant a large slice of the pie to private insurance and the free market. This assumption is mistaken. Indeed, when it comes to health insurance, EU law is likely to produce an impact only where there is a health insurance market; this cannot happen unless a market has actually been identified. If one works on the assumption that a market is not a “spontaneous” creation but a legal/political construction, the fact is that EU-level interference depends not only on social and historical characteristics, but also on the political decisions governing the construction of national systems in the realm of health insurance. That said, the contingent nature of the concept of economic activity should be borne in mind. *“Apparently, its contents can be determined only on a case-by-case basis [by taking into account] the facts of each matter, and then deducing the existence of economic activity, without having previously defined the scope of this concept”* (Bernard 2009, p. 357). This contingency is thus a source of uncertainty, as can be seen from the dispute concerning mandatory health insurance in Slovakia (see box below).

**A topical example of the contingent nature of the concept of economic activity:
the dispute over mandatory health insurance in Slovakia²⁸**

In the country of Slovakia, all health insurance bodies are limited companies, the sole purpose of which is to provide mandatory public health insurance. Slovakian residents can choose between three bodies: two private insurance companies and one public insurance company. These bodies are legally required to affiliate any resident that so requests; from this it follows that they cannot refuse to insure an individual on the grounds of their age, state of health, or risk of illness. Moreover, the scheme is based on a system of mandatory contributions, the amounts of which are established by law, in proportion to beneficiaries' income, and thus independently of the benefits used or “individual” risk. Moreover, all beneficiaries are entitled to the same minimum level of benefits, and there is a system to balance risks out between the different bodies. Lastly, these bodies are subject to special legislation. In particular, they cannot carry out any activity other than those specified by law (i.e. mandatory public health insurance) and are controlled by a regulatory agency.

In the light of all these elements, the European Commission had concluded that the activity of providing mandatory health insurance was non-economic in nature, taking the view that the above characteristics were evidence of the predominance of social, solidarity-based, and regulatory aspects in this scheme. In other words, in the view of the Commission, there was an

²⁷ For an example, see chapter 6 (Belgium case). For another example, see the challenge to aid granted by the French State to certain mutual benefit institutions for civil servants following a ruling by the European Commission on July 27, 2005.

²⁸ General Court case T-216/15, *Dóvera zdravotná poisťovňa vs Commission*, 5 February 2018. It should be noted that this ruling has been appealed before the CJEU (262/18 P); the appeal is still pending.

exclusively social activity due to the existing solidarity and state control being foundational elements. However, the Court did not come to the same conclusion as the Commission, due to a particular characteristic of the system put in place: the legally recognised possibility for health insurance companies to make, use, and distribute profits. For the Court, “[this] *possibility... is of a nature liable to compromise the non-economic character of their activity*” (pt 63) since it “*is, in any event, and independently of the performance of their public health insurance mission and the state control operated, evidence of the fact that they are pursuing a for-profit goal; on this basis, the activities in which they engage on the market qualify as economic*” (pt 64). The Court also emphasised the existence of a degree of competition regarding the quality and extent of the offer: with the profits they make, the bodies may freely supplement mandatory, statutory benefits with related, free benefits (e.g. better cover for some types of treatment or assistance services): “*these bodies’ freedom of manoeuvre to engage in competition allows insured parties to benefit from better social protection for equivalent levels of contribution, since the supplementary benefits are offered free of charge*” (in other words without the payment of any additional contributions) (pt 66). Competition therefore exists regarding the insurance’s value for money; according to the Court, far from being residual, this competition is “intense”, particularly due to the volatility of the market, with beneficiaries being able to change their affiliation every year and incited to do so by their personal assessment of the quality of service.

Even where a health insurance market exists, the impact of EU law is not uniform from one Member State to the next. As the Commission explains, Member States’ public authorities enjoy extensive room for manoeuvre in defining what they deem to constitute an SGEI, provided they observe EU law and that there are no manifest errors of appreciation.²⁹ In view of this, interference at national level is largely dependent on certain systemic configurations. Indeed, EU competition law criteriology is such that it allows different types of appropriation, the effects of which are liable to vary widely in terms of health insurance organisation and regulation. To paraphrase one author (Bernard 2009, p. 374), Member States may set “*any degree of market conditions*” they like, with a view to situating the market in one of the two legal spaces made available in competition law: that of a market that is not specially regulated, or that of a regulated market, allowing general-interest considerations to come into play³⁰. So, for instance, in a field in which competition is predominant, existing legislative instruments may be brought to bear such that significant general-interest considerations, such as health protection or the correction of inequalities and the access to certain services, and off-market values such as solidarity, can be deployed on a particular market. This “*explains the fluctuating nature of competition and thus of the market, depending on historical periods, geographical spheres, and above all, the goals pursued by the political and legal powers that be*” (Bernard, 2009, p. 374).

In substantive terms, the solidarity components governing the overall workings of the social protection activity must be identified. This identification is very often expressed in terms of degree, with the court seeking to identify and assess the extent to which the configuration rules for the scheme affect the workings of traditional insurance. In this case, the question becomes: is it possible to identify solidarity components to a degree that would legally and justifiably allow exclusive or special rights on this insurance market? The degree of differentiation from “conventional” private insurance present on the market, in which there is a direct proportionate link between the contribution and the benefit, is what makes it possible to assess

²⁹ Guide to the application of the European Union rules on state aid, public procurement and the internal market to services of general economic interest, and in particular to social services of general interest – Commission SWD(2013) 53 final/2

³⁰ This binary alternative may apply not only to an entire market, but also to particular market segments.

implementation of the principle of solidarity and thus provide grounds for adjusting rules derived from EU competition law. Identifying the degree of solidarity in an insurance scheme involves studying the rules used to configure the proportionality that is normally determined in insurance, between the contribution and the risk on the one hand, and between the contribution and the benefit on the other hand. Despite extensive jurisprudence relating to the application of the concept of SGEIs in the field of social protection, the law is not entirely clear, since this identification uses the approach of a body of evidence, which can be complex to weigh.

2. National arrangements and various forms of health coverage marketization

Under the Treaty on the Functioning of the European Union, article 168§7, the definition of health policy and the organization and delivery of health services and medical care are prerogatives of the Member States. The so-called principle of subsidiarity applies in this area. Traditionally, the organization of health services and medical care at national level has been directly connected with social security schemes which provide people with (more or less) universal access to healthcare. As pointed out above, the area of social security is in principle exempted from the application of European competition law. Thus, there should be a clear and well-marked frontier between healthcare provided through social security on the one hand, and healthcare and services provided by the market on the other hand. When healthcare is provided by the market through voluntary and private health insurance, the European Insurance directives are supposed to apply. However, as noted by Thomson and Mossialos (2010), “the European 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 in most Member States. Today, these boundaries are increasingly blurred”. Indeed, some countries have chosen to introduce market forces and competition into the statutory health insurance scheme, while others use and, in a certain way, “instrumentalize” the complementary health insurance market in order to make it an actor of the national health policy. These situations may challenge the EU legal framework.

2.1. Marketization within the statutory health insurance scheme

In a number of countries, public health insurance is administrated by a wide variety of operators such as public or quasi-public bodies, non-profit organizations and commercial companies, so that people – i.e., “consumers” - have a choice. Theoretically, consumer choice in the health insurance market is assumed to discipline insurers to make them increase their efficiency and be responsive to consumers’ preferences. In Europe, this kind of arrangement can be observed in particular in Belgium, the Czech Republic, Germany, the Netherlands and Switzerland.³¹

What these national systems have in common is that private insurers are legally entrusted with public interest missions. This means that the scope, the content and the conditions of the health coverage they offer to the population is strictly regulated, so one may wonder whether there is room for market and competition rules. Actually, marketization is more or less obvious, depending on specific national arrangements.

³¹ In the present chapter, only EU member States will be reviewed.

2.1.1. Private insurers entrusted with public interest missions

Private actors within social security. In countries with a Bismarckian welfare tradition, private actors have been entrusted with administering statutory health insurance. Traditionally, the social partners - i.e., employees' and employers' representatives – as well as mutual benefits societies and other non-profit organizations, have been at the centre of the system, which is a “non-State” one (Pennings *et alii*, 2013). According to the Bismarckian model, health insurance funds are ruled by the self-governance principle (Busse *et alii* 2017). In most cases, though those actors are private entities, the national legislation or their own articles of association do not allow them to make a profit. There are no shareholders to reward. The Belgian, German and Czech systems are of this kind. Nevertheless, two European countries are known to have opened statutory health insurance to for-profit companies: The Netherlands and Slovakia.

In Belgium, as early as the 19th century sickness funds were held by mutual benefits societies or trade unions. The system became compulsory in 1944 with the creation of Social Security, but the health insurance funds remained in the hands of the mutual societies and the unions. Currently, seven health insurers are entitled to operate: the five main Belgian mutual benefits societies,³² a national public body called CAAMI, and the railway mutual fund SNCB-Holding. Belgian mutual benefits societies also offer complementary coverage to their members.

In Germany, since the beginning of social insurance (1883), the legislation has deliberately opted for a plurality of health insurance funds and has required people to be affiliated to one of them (Kaufmann 2004). Germany has a wide variety of funds: local funds, mutual benefits societies, company funds, corporative funds and sectoral funds (agriculture, mines, railway, seafarers), but they are all autonomous bodies governed by public law.³³ These funds (113 in 2017) are usually held organized within associations. Population coverage by the statutory health insurance scheme is almost universal, but some categories of people³⁴ can opt out and purchase private health insurance that plays a substitutive role. Private plans are offered by commercial companies and also by non-profit companies under market conditions, though the German substitutive PHI has to comply with certain legal requirements (see below).

The Czech and Slovakian paths have been rather tortuous due to historical circumstances. The two countries were one – Czechoslovakia – from 1918 to 1992. In the early 20th century, sickness funds covering workers and their families were made mandatory (1919), and were then unified and centralized (1924). Following the Second World War, Czechoslovakia fell under the economic and political influence of the Soviet Union, resulting in health legislation on national insurance in 1948. This system was totally funded by employers' contributions. Then, in 1951, a “Semashko-type” healthcare system was introduced: centralized, managed by general government and financed through general taxation. A Bismarckian system was nevertheless reintroduced after 1989. Czechoslovakia was dissolved in December 1992. The Czech Republic and Slovakia were formed in 1993.

³² *Alliance nationale des mutualités chrétiennes, Union nationale des mutualités neutres, Union nationale des mutualités socialistes, Union nationale des mutualités libérales, Union nationale des mutualités libres.*

³³ This does not preclude the determination of whether these sickness funds are or are not undertakings in the sense of EU competition law (ECJ case C-59/12, *BKK vs Zentrale zur Bekämpfung unlauteren Wettbewerbs*, 3 October 2013).

³⁴ Civil servants, self-employed individuals and high-income employees (the annual earnings threshold was €59,400 in 2019).

The Czech health insurance system is currently managed by seven health insurance companies. These insurers are quasi-public, self-governing bodies. The biggest one, the General Health Insurance Company, covers around 60% of the population and its payments are guaranteed by the State. Its activities are governed by a special law called the Act on the General Health Insurance Company. The activities of the other health insurance companies are governed by the Act on Employee Insurance Companies. None of these health insurance companies are allowed to make a profit.

In Slovakia, the 1994 Act on Health Insurance introduced multiple health insurance funds. This scattered system was considered as inefficient and an extensive reform took place in 2004. The reform was based on managed competition, with the introduction of services related to healthcare and the possibility of user fees, the liberalization of networks (eligibility for permits and licences), selective contracting, independent oversight by HCSA, and the transformation of all health insurance funds into joint stock companies (Smatana et alii 2016). It should be noted that this was not a “straight ahead” reform and that successive legislatures seemed hesitant: in 2007, the possibility of profit-making in health insurance was banned, but was reintroduced by parliament in 2011 in order to comply with a ruling of the Constitutional Court of the Slovak Republic, under which the provision of health insurance could take place in the sphere of competition and insurers could make profits. Then, in 2012, the Slovakian government planned to reform the system and create a single public institution. This plan was stopped in 2014.

In the Netherlands, the statutory health insurance scheme is rooted in the Bismarckian tradition of social insurance. Early predecessors of the country’s health insurance funds were mutual benefits societies, which appeared in the 19th century. These voluntary arrangements were replaced by mandatory state health schemes (Sickness Act 1913). Then, in 1941, the Germans occupying the country put in place a compulsory insurance system with sickness funds for employees earning less than a certain income level. Under this system, social health insurance covered only two-thirds of the population, those with lower incomes. For the other one-third a private health insurance scheme applied. Thus, until 2006, it was a hybrid system based on social insurance with a dominant role for not-for-profit sickness funds, combined with a long-standing role for private insurance covering the better off. The major healthcare reform of 2006 not only brought with it the long-desired unified insurance scheme, it also drastically changed the role of actors in the healthcare system. Multiple private health insurers are now supposed to compete in a regulated environment (Kroneman et alii 2016). The 2006 reform is now emblematic of the so-called “Dutch model”. Currently, there are 25 health insurers (in 9 groups) and even though the legislation considers them as commercial companies, mutual benefits societies and non-profit organizations remain present and active on the market.

Health insurance under public interest regulations. In the above-mentioned countries, the statutory health insurance scheme is plural, with the participation of multiple private actors administrating health insurance funds, some of them commercial companies acting in a quasi-market. This theoretically includes user choice and provider competition to a certain extent (Legrand 2011). Nevertheless, because health insurance is mandatory, as a legal consequence of solidarity,³⁵ health insurance business has to comply with public interest regulations. In other words, within statutory health insurance schemes, private actors are entrusted with public service missions: they must guarantee a universal coverage governed by the principle of solidarity.

³⁵ The principle of solidarity is at the core of social security programs and systems. Technically, it means that contributions or premiums paid to social insurance schemes are not related to individuals’ risk profile. Healthy persons subsidize people in poor health, young people subsidize older ones, etc.

Universality means that everybody has access to healthcare coverage, either for free or under financially affordable conditions. Access for all is the flipside of the mandatory nature of statutory health insurance. We should keep in mind that in Bismarckian “corporatist” systems, healthcare coverage is traditionally achieved through sickness fund membership based on occupational situation or position. In this respect, insurance enrolment is not fully open. Nevertheless, these systems have evolved so that everybody, regardless his/her position, is currently entitled to register and have access to healthcare coverage. Universality also implies that health insurances cover a uniform and standardized basic benefits package – the “health benefit basket” - which is generally determined by legislation or regulation,³⁶ through procedures that differ from one country to another. So there can be no competition between private insurers as regards the range or level of benefits included in the mandatory scheme (though private health insurers try to attract customers with “extras” and supplementary benefits proposed in their voluntary health benefit package, which supposes extra premiums).

Another typical aspect of health insurance in Bismarckian systems is copayment (or user charges). This means that public universal health insurance does not necessarily cover the whole cost of healthcare and services. This is generally well accepted – and leaves room for complementary private health insurance – but can pose problems in countries in which the population was used to cost-free healthcare. This was the case of Slovakia. The 2004 reform introduced user charges into statutory health insurance and the Constitutional Court had to decide if this was in line with the Slovakian constitution. The Court stated that user fees for health services were in conformity with the constitutional guarantee of cost-free healthcare (Constitutional Court of the Slovak Republic, 2005).

Solidarity requires pooling of heterogeneous risks. This implies that private insurers providing statutory health coverage cannot use risk selection: they are not allowed to risk-rate their premiums depending on health, age, sex, etc. This kind of requirement generally fits with the ethos of mutual benefits societies and non-profit organizations. Moreover, national legislations usually oblige sickness funds to accept all eligible applicants irrespective of their health status. In countries such as the Netherlands or Slovakia, although health insurance is now governed by commercial law (under the EU Insurance directives), private insurers providing statutory health coverage have a duty to accept each person’s application and cannot impose risk selection. In countries in which the legislation strives to combine competition with solidarity, a risk equalization system (RES) is usually in place, which compensates insurers for predictable variations in medical spending. Indeed, the riskier portion of the population – older people – is covered by a specific sickness fund, for historical and sociological reasons, so that this fund’s “competitors” have an advantage as they cover those who make fewer medical claims (the healthy). Risk equalization or compensation is achieved through a national subsidy fund that collects contributions and subsidies each health insurer according to the risk profile of the population it covers. So, in theory, risk adjustment is supposed to make both good and bad risks equally attractive to insurers through adjusted financial compensation. Risk equalization schemes are to be found in the Czech Republic, Germany, The Netherlands and Slovakia, among others.³⁷

In addition, it should be noted that in countries in which certain categories of the population can opt for voluntary health insurance that substitutes the public scheme, some legal provisions

³⁶ The content of the basic benefit package is not uniform in Europe, though it is fairly comparable. In many countries, optical care is totally excluded and dental care is partially covered.

³⁷ These are the EU countries in which managed competition has been introduced into the statutory health insurance scheme. There are also RES in voluntary health insurance markets such as in Ireland.

may be applicable, under article 54(2) and recitals of the 1992/49 Directive: 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. In Germany, voluntary health insurance has to comply with certain requirements: lifelong insurance guarantee, similarity to statutory insurance, level premium (premium rates must not increase because of increasing age, though health status is taken into account at the time of application).

2.1.2. Room for both market and competition?

Some EU member States have decided to introduce managed competition into their statutory health insurance scheme through market-based reforms. In this model, health insurance agencies compete with each other and selectively contract providers on behalf of their insured, under narrowly defined rules set by government. This is particularly manifest in the Netherlands and Slovakia, while to a certain extent, managed competition has also been introduced in the Czech Republic and Germany. As noted regarding the 2006 Dutch reform, health insurers are expected to negotiate with providers and purchase efficient, good-quality care; patients are expected to critically assess and select the health insurer and provider of their choice (Van Ginneken et al. 2011). A comparative overview shows some legal characteristics which reflect this trend, though it is ultimately unclear whether it leads to real competition from an economic perspective. Two main characteristics or criteria will be examined here: user choice, i.e., the possibility to choose and the freedom to switch health insurance; and insurers’ ability to differentiate themselves in the market and to offer better coverage.

User choice among a plurality of health insurers. Freedom of choice of the health insurer is not truly a principle of the so-called Bismarckian model. Some countries such as France opted (in 1945) in favor of a single health insurance fund, so people have no choice: they must register with the local health insurance fund that provides them with basic health coverage. Note that before 1945 and under the French 1930 Social Insurances Act, people had a choice among a variety of organizations and bodies entrusted with statutory health coverage. At that time, mutual benefits societies played a prominent role. The immediate postwar political and social context explains why the French opted for a single fund mainly managed by workers’ trade unions representatives,³⁸ while mutual benefits societies and provident funds were given the possibility to offer complementary (voluntary) health coverage (Martin 2013).

In Belgium, unlike in France, an important place was given to mutual benefits societies within the statutory health insurance scheme set up in 1944-1945. Everyone is legally bound to be affiliated to a health insurance fund for basic coverage and has a choice in this respect. User choice might be guided by the health insurer’s offer in the sense that mutual societies traditionally propose complementary coverage (user charges, hospital fees, etc.) to their members. Nevertheless, since 2012 complementary coverage has become compulsory, which means that a person affiliated to a certain mutual company for basic health coverage must pay an extra premium for the complementary plan “offered” by this company. This creates a very strong bond between the user and the insurer. From a pure customer and market point of view, this might seem a little unorthodox, but it fits with the ethos of mutual societies based on membership (members sit on management boards).

³⁸ Employers’ representation was progressively introduced into the health insurance boards during the 1960s.

In Germany, though insured persons used to be automatically affiliated on the basis of their profession, they currently can choose their health insurance fund (since the 1993 Healthcare Structure Act).³⁹ This implies that they can switch from one fund to another. It seems that despite this legal possibility, most people with poor health or chronic diseases do not change, or only do so rarely. This has consequences on competition. Conversely, some categories of people – the healthiest – appeared to be very mobile, so in 2002 the lawmaker restricted the freedom to switch from one insurer to another, imposing an 18-month probation period before a switch is allowed (Kaufmann 2004).

Recent national legislations have tended to regulate the freedom to switch health insurer. In the Czech Republic, each insured person can change his or her health insurance company twice a year. In Slovakia, the 2004 health reform gave health insurance companies tools to compete for clients. The insured may change their health insurance company once a year. The deadline to switch health insurance companies is 30 September, becoming effective from 1st January the following year. The switch can only be refused if the insured person has applied to more than one health insurance company at the same time. Other administrative barriers that could have hindered this switching of health insurance companies (e.g. a written notice) were removed. The mobility of the insured has varied significantly over time and is influenced by marketing activities and by the extent to which the insured exercise their freedom of choice. In the Netherlands, the insured can change health insurer at the end of each year (before 1st January). In fact, mobility is determined by the structure of the health system: in countries in which health insurers cover the public scheme and also offer supplementary plans, people tend to be more “captive” because of the risk selection applied to the supplementary health insurance they have purchased.

Insurers’ ability to differentiate themselves. Key elements in differentiation are: price freedom; selective contracting; “special offers”; and extra benefits.

Price freedom, i.e. the possibility for each health insurer to set the price of contributions or premiums is not fully recognized in the countries under review here. In some countries such as Belgium, the Czech Republic or Slovakia, all health insurers in the statutory health insurance scheme apply a uniform contribution rate determined by the State. In Germany, before 2007, each sickness fund had the freedom to set the contribution rate, so local funds were able to differentiate themselves from the others. Generally, the funds that cover “good risks” (healthy persons) are able to propose low contribution rates and thus attract customers. In 2007, Germany reformed its system and since then, a single and unique contribution rate is established by governmental decision (sickness funds are nevertheless allowed to demand a flat-rate complement from their members). In the Netherlands, private health insurers in the statutory scheme are free to set the contribution rate, but as mentioned above, because they are not allowed to engage in risk selection, they must charge all their policyholders the same premium (community rating system).⁴⁰ Residents have market choice, though very few variations are to be observed in prices between the different health insurers, because the legislation requires them to offer a standardized basic benefits package and thus prevents risk selection.

Another factor or element of differentiation in the market is health insurers’ capability to control the costs of healthcare and services. This can be achieved by selective contracting, i.e. contractual arrangements between health insurers (sickness funds) and healthcare providers.

³⁹ The 1993 Act has been in force since 1997.

⁴⁰ “Community rating” means that the insurance company must charge the same rate for a given level of service, regardless of age, sex or health status.

Under certain legal conditions, health insurers can negotiate the prices, volume and quality of medical and pharmaceutical care provided. This is “strategic purchasing”. These arrangements often take the form of integrated care, which means that a group of providers is contracted by an insurer to provide services across sectoral boundaries. They are “selective”, as they usually limit beneficiary freedom of choice to those providers within the selected network. Among EU member States, selective contracting has been implemented in Germany, the Netherlands and Slovakia, though as pointed out by Thomson et al. (2013), “Dutch insurers have access to many more efficiency-enhancing tools than do their counterparts in other countries”. In Germany, before 2000, there were restrictions to selective contracting and, like in Belgium, sickness funds were only allowed to have collective agreements with healthcare providers (Busse et al. 2017). This restriction was removed in 2000 and in the mid-2000s, sickness funds were permitted to negotiate discounts with pharmaceutical drug manufacturers. In 2007, they also began to offer a choice of tariffs, which was a feature previously reserved for private health insurance companies. The funds can adapt to the individual needs of their members by offering different benefits packages and prices (Busse et al. 2017). Though it remains rather low, the share of statutory health insurance expenditures in selective contracts increased significantly between 2002 and 2015.⁴¹ In the Netherlands, health insurances propose basically two kinds of plans to enrollees: in-cash benefits plans (the insurance reimburses healthcare expenses and the enrollee is totally free to choose the physician, the hospital and all kinds of health professionals); and in-kind benefits plans with selectively contracted providers (the providers are directly paid by the health insurance). It should be noted that premiums are often lower if enrollees choose in-kind benefits plans. Theoretically, Dutch health insurers can negotiate the prices and quality of health services. Actually, the negotiation margins are quite narrow, as for a wide range of healthcare services, tariffs are established by the Dutch Healthcare Authority (DHA). As far as hospital care is concerned, tariffs are partially regulated by the DHA, and about 70% of hospital care is provided through selected networks. However, Dutch health insurers seem to be rather reluctant to implement selective contracting as they believe their enrollees will not accept it (Bes et al. 2013). In Slovakia, purchaser-provider relations are based on selective contracting regulated by the Ministry of Health. Since 2012, this regulation has been strengthened as the Ministry of Health has set a list of selected state providers, which is in fact a compulsory network that has to be contracted by all health insurance companies. All in all, selective contracting does not appear to be a strong element of differentiation in European countries.

A common way to differentiate and attract health insurance customers is to offer extra benefits. As already mentioned, private health insurers in the statutory health insurance scheme often propose supplementary or complementary plans. This market is well developed in countries such as Belgium and the Netherlands. Economically speaking, it can be analyzed as a driver of competition. In legal terms, however, a distinction is made between a health insurer’s activity as a provider of statutory (public) coverage, which in principle is beyond the scope of EU competition law, and voluntary health plans which, in principle, are an economic activity under EU competition law.⁴² Nevertheless, it can happen that health insurances are allowed by national legislation to complement the statutory basic benefits package for free, which means that enrollees do not purchase a complementary plan: extra benefits are part of the statutory coverage offered by certain private health insurers. This obviously provides an opportunity for differentiation and competition as regards quality and service offerings. The Slovakian legislation exemplifies this situation. Indeed, despite the strong regulations governing the scope of covered services within the statutory scheme, health insurance companies can attract new customers by offering additional services such as medicine discounts; reimbursing co-payments

⁴¹ From 0.02% in 2002 to 1.5% in 2015 (Busse et alii 2017).

⁴² With a possible exemption based on the exception for services of general economic interest (*BUPA* case).

for some medicines, vitamins or non-healthcare services; shorter surgery waiting times; broader preventive examinations; or a variety of electronic support services. These circumstances, plus the fact that Slovakian health insurance companies are for-profit organizations, led the Court of 1st instance of the European Union to consider that there was competition between the various Slovakian health insurance companies as noted above. The Court notably states that “even if there is no competition within the Slovak compulsory health insurance system in respect of either the compulsory statutory benefits or formally on the amount of contributions, there is nevertheless intense and complex competition due to the market volatility resulting from insured persons’ power freely to choose their health insurance provider and to switch insurance company once a year, and the fact that health insurance bodies are competing in terms of the quality of service, which is assessed individually by the insured persons”. In this regard, according to the Court, health insurance in Slovakia is economic in nature and competition law has to apply.⁴³

From this comparative overview, a first conclusion can be drawn: the different features analyzed – the presence of private insurers, user choice, market-oriented reforms and policies - do not lead to a systematic application of EU competition law. Players actually implement social security schemes widely controlled by the State. EU competition law appears to apply exceptionally and due to peculiar circumstances (*cf.* the Slovakian case).

2.2. Complementary health insurances and mixed market-social security patterns

As pointed out by Thomson and Mossialos (2010), “Governments in several member States recognize that complementary cover of statutory user charges can contribute significantly to social protection”. So they tend to regulate and manage this market - the complementary cover of user charges - as a tool for social protection or welfare policy. This is particularly manifest in Belgium, Ireland, France and Slovenia.⁴⁴ Note that this approach is quite ambiguous given that on the one hand, national regulations aim at correcting market effects which tend to create or increase inequalities (by risk selection), and on the other hand those regulations serve public policies that seek to deal with the flaws of statutory public health insurance. In a context of government budget constraints, cost sharing between public and private health insurance might be the way to go for some countries.⁴⁵ Moreover, this creates a blurry situation as regards the EU legal framework.

The present section aims to outline some features of national regulations that possibly pose or have posed problems from the EU law perspective.

2.2.1. The presence of non-profit insurers and mutual benefits societies (and the recognition of a special status)

In the field of health insurance, non-profit organizations and mutual benefits societies play an important role in the EU countries under review here, as statutory health coverage

⁴³ General Court case T-216/15, *Dóvera zdravotná poisťovňa, a.s. vs Commission*, 5 February 2018.

⁴⁴ We shall focus here on countries in which voluntary health insurance plays an explicitly *complementary* role, covering user charges for publicly financed health benefits.

⁴⁵ Overall, private health insurance does not make a significant contribution to total health spending in the European Union. It accounts for less than 5% of total health expenditure in two-thirds of the Member States, although it plays a considerably larger role in Slovenia (13.1%), France (12.8%), and Germany (9.3%). Source: European Commission, *Private health insurance in the European Union: Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities*, 24.06.2009, p. 6.

providers and/or as complementary health insurers. Mutual societies are prominent in the Belgian and French complementary health insurance markets, for historical reasons. In Slovenia, when voluntary health insurance was introduced (in 1993), two entities offered complementary plans covering user charges: Vzajemna, a mutual society specializing in health, and Adriatic Slovenica, a commercial joint-stock company offering a range of insurance products. The mutual society – Vzajemna – was linked with the statutory health coverage. In Ireland, the market for voluntary health insurance was instituted by the Voluntary Health Insurance Act 1957 which created a semi-public (non-profit) body, the Voluntary Insurance Board, now known as VHI Healthcare, which remained monopolistic for a long time.

Legally speaking, mutual and non-profit organizations that sell voluntary/complementary health plans fall under the scope of the EU insurance Directives and competition law. Nevertheless, national legislations have tended to grant them a special legal status which may be incompatible with EU law requirements. This has led to some adjustments. A comparative view reveals different national approaches to the EU Insurance Directives and to their transposition.

In France, for a long time, mutual benefits societies, their federations and unions as well as the French government resisted the applicability of the EU Insurance Directives. In the 1970s and 80s, mutual benefit federations did not consider themselves as “undertakings” or insurance businesses as defined by first- and second-generation insurance Directives. Nevertheless, they finally had to comply with the new legal framework designed by the French legislation through the 1985 Act which reformed the Mutual Societies Code. This reform opened the market and competition to for-profit insurance companies which were allowed to offer complementary health coverage. The reform of the Mutual Societies Code was followed by an important Act, in 1989, regulating the market for complementary health coverage⁴⁶ but also confirming the principle of a competitive market open to commercial companies. However, at that time, the federation of mutual societies still believed they could maintain a certain legal specificity, such as the fact that mutual societies could have several activities combining health coverage and the management of welfare services and institutions. Just before the adoption of the 1992 non-life insurance Directive, a discordance appeared between the different French federations of mutual benefits societies about whether or not they entered into the EU legal framework. The biggest federation opted for an adaptation of the legal status of mutual benefits societies in order to comply with the EU insurance directives. But as soon as the 1992 Directive was adopted, the federations mobilized in order to delay the transposition procedures and obtain recognition of their specificities from the French government and the EU.

This situation lasted a few years, but in 1998, the European Commission appealed to the EU Court of Justice (ECJ). According to the Commission, by not transposing the insurance Directives in respect of mutual societies governed by the Mutual Societies Code, the French Republic had failed to fulfil its obligations under the EC Treaty and under the directives. Two main points were underlined by the European Commission. First, French mutual societies were not subject to the prudential and financial requirements laid down in Directives 92/49 and 92/96 (adequate technical provisions, solvency margin). Second, their insurance activities as such were not legally separate from their ‘philanthropic’ activities, particularly in relation to pharmaceuticals, optical centres, holiday centres and the renting of meeting rooms, in breach of the principle of specialisation of insurance companies laid down in Directives 92/49 and 92/96, which requires that the commercial and philanthropic activities pursued by mutual

⁴⁶ The French legislation limits risk selection within collective complementary health plans set by employers or sectoral collective bargaining.

societies should not be managed by the same legal entity; a distinction would be drawn in national law between mutual insurance activities carried out in the form of services provided for consideration in cash or in kind and falling within the scope of the prudential rules in Directives 92/49 and 92/96 on the one hand, and activities carried out by mutual societies which are unconnected with insurance and which ought to be managed by subsidiaries, on the other. The ECJ agreed with the European Commission and ruled that the French Republic had failed to fulfil its obligations.⁴⁷

In Belgium as in France, mutual societies' activities had remained out of the scope of the EU insurance Directives for years. Oddly enough, this situation was not challenged until 2008 when the European Commission initiated an infringement procedure against the Kingdom of Belgium for incorrect transposition of the EU insurance Directives. The reason for this late reaction from the EU Commission might be that in Belgium, unlike in France, mutual societies administrated the statutory health insurance scheme, so that even if they usually offered complementary plans to their members, this activity tended to be considered as provident services and welfare fund management. In other words, under the Belgian legislation, those "extra benefits" were a kind of extension of the statutory scheme and this justified the exemption from EU internal market law. The problem was that in the "complementary package" offered by the mutual societies to their members, coverage of user charges and hospitalization fees were generally included. According to the European Commission, alerted by ASSURALIA – a Belgian union of insurance companies – these activities were economic in nature and must fall within the scope of the insurance Directives. The European Commission observed that the package of complementary benefits as well as the related premiums were freely determined by each mutual society, that solidarity only applied within the scope of the mutual society (not at national level) and that insurance companies offered the same kind of coverage, so there was competition. The European Court of Justice agreed with the European Commission and stated that the Kingdom of Belgium had failed to fulfil its obligations under the EU insurance Directives.⁴⁸ As a consequence, the Belgian government and parliament had to modify the legislation on complementary health coverage. What is remarkable when comparing the French and the Belgian pathways is that the Belgian reform passed in 2010 managed to keep certain complementary plans out of the scope of insurance law. Under certain legal conditions, complementary coverage of hospital fees by mutual societies could be considered as "operations" in the sense of art. 2.2. b. of the first non-life Directive (73/239).⁴⁹ Thus, in Belgium, complementary health coverage was not totally "marketized" as insurance products and activities offered in a competitive market.

Ireland provides another example of resistance by non-profit organizations towards alignment with the EU legal framework. In Ireland, between 1957 and 1997, the semi-public body VHI Healthcare was the only voluntary health insurer in the Irish market.⁵⁰ Following the introduction of the EU's Third Non-Life Insurance Directive in 1992, the VHI market was opened up to competition in 1994. Private and for-profit health insurers then entered the market but VHI Healthcare remained exempted from the regulations of the Insurance Act. Actually, VHI Healthcare had a high profile in the media and political debate, and substantial influence in the health system. A key issue was the discussion about the status of VHI Healthcare in relation to its competitors (Turner 2016). VHI Healthcare's competitors claimed that its

⁴⁷ ECJ case C-239/98, *Commission vs France*, 16 December 1999, *ECR* 1999, p. I-8935

⁴⁸ ECJ case C-41/10, *Commission vs Kingdom of Belgium*, 28 October 2010, *ECR* 2010, p. I-138

⁴⁹ "Operations of provident and mutual benefit institutions whose benefits vary according to the resources available and in which the contributions of the members are determined on a flat-rate basis."

⁵⁰ Alongside a number of smaller occupational schemes with restricted membership.

exemption from the regulations of the Insurance Acts gave it unfair advantages because it was not required to hold a minimum level of reserves to guarantee solvency and did not need to establish subsidiaries to engage in other business activities. Changing the regulatory status of VHI Healthcare to bring it in line with its competitors was initially proposed in 1999 and again in 2008, but has been fully implemented only recently,⁵¹ after the ECJ found the exemption to be unlawful.⁵²

The Slovenian case shows a much quicker and less conflictual alignment with the EU legal framework. As mentioned, voluntary health insurance was introduced in 1993 and Vzajemna, a mutual society specializing in health, started selling voluntary health insurance as an integral part of the Health Insurance Institute of Slovenia (HIIS), the statutory body responsible for purchasing publicly financed health coverage. To a certain extent, the situation could be compared to the Belgian one.⁵³ But in 1999, the Slovenian legislation was modified in order to comply with EU law: following amendments to the Slovenian Health Care and Health Insurance Act, the HIIS separated its mandatory health insurance from its VHI business. Vzajemna's activity is currently exclusively dedicated to complementary/voluntary health insurance and though it remains a non-profit organization, its legal status is in line with the EU insurance Directives.

2.2.2. VHI market under State control

Some countries regard complementary health insurance as a strategic element – a sort of “pillar” – of social protection and public health policies. Thus, national legislations can be prone to imposing rules that tend to put this activity under control. There are various ways to do so: using legal and fiscal incentives; imposing tight regulation of insurers' activity; regulating the proper market and neutralizing selective effects. Some of these regulations have been found to breach EU rules

Legal incentives to develop VHI as a complement of social security. In France, public policies use a full range of incentives in order to make complementary health coverage universal and congruent with national objectives, especially the containment of health costs: Universal complementary health coverage (a health benefit package for free and with no user charges for low income people);⁵⁴ “responsible and solidary” complementary health plans supported by fiscal incentives;⁵⁵ and employers' legal duty to implement complementary health coverage plans.⁵⁶ Nevertheless, those measures do not appear to challenge EU law.

⁵¹ VHI had to submit an authorization application to the Central Bank, like all health insurers, with a deadline at May 2014. VHI finally complied with the solvency requirements in January 2016.

⁵² ECJ case C-82/10, *Commission vs Ireland*, 29 September 2011, *ECR* 2011, p. I-140.

⁵³ In the sense that there was a blurry zone between mandatory and voluntary health coverage.

⁵⁴ This coverage is offered to all residents whose earnings are under a certain threshold. It is financed through a national fund that collects special taxes from the complementary health insurers (profit and nonprofit organizations) which sell voluntary health insurance in France.

⁵⁵ Private health insurers are induced to offer complementary packages whose content is determined by law, the so-called “responsible and solidary contracts”: these plans must cover all user charges for healthcare provided in the scope of the mandatory scheme (with some restrictions for a certain range of drugs) as well as hospital fees; they must also include minimum services and benefits for optical care. The insurer cannot engage in risk selection. Conversely, these plans must not cover user charges when the patient does not respect the “healthcare pathway” (obligation to consult one's own GP; limitations in the possibility to consult physicians who charge extra fees not covered by the mandatory health insurance, etc.).

⁵⁶ The Employment Act 2013, in accordance with the national collective agreement signed on January 2013 by the French national employers' associations and workers' unions, aims to extend complementary health coverage. It states that the trades unions and employers' associations bound by a sectoral collective agreement have a duty to

In Slovenia, the legislation is quite restrictive. Insurers are required to cover user charges for all publicly financed health services. However, children are exempt from user charges and so do not require complementary VHI. In a way, complementary health coverage appears to be compulsory for adults, as they may pay penalties if they do not purchase complementary VHI as soon as they become liable for user charges. For each complete year (12 months) they do not have VHI, the penalty is equal to 3% of the premium. The maximum penalty is 80% of the premium.

Tight regulation of complementary health insurance activity. Slovenia is the most illustrative example of State control over voluntary health insurance activity. Some authors consider Slovenian complementary health insurance as a SGEI (Nikolic 2015). Indeed, the Slovenian market for complementary VHI covering user charges is subject to relatively tight regulation. Some of these regulations have been found to breach EU rules. The Health Care and Health Insurance Act (2006) introduced a number of controls on VHI business. Under this Act, health insurers from other countries had an obligation to establish a branch office in Slovenia. The legislation also stipulated controls over the use of profits, systematic notification of product changes and prior approval of premium increases. In 2011, the European Commission found these rules to be in breach of EU competition and free movement rules (specifically, the first and third non-life insurance directives). In response, the Ministry of Health planned to bring Slovenian regulation in line with EU rules, but reform efforts were halted due to early elections held in December 2011 and the Commission subsequently referred Slovenia to the European Court of Justice. In 2012, the ECJ found that Slovenia had failed to transpose the non-life insurance directives correctly⁵⁷

Regulations correcting market effects: open enrolment, community rating, etc. In countries in which complementary health insurance is regarded as a driver for better access among the population to healthcare and a key element of the right to healthcare, the legislation tends to impose rules that correct or neutralize possible market effects (the exclusion of certain categories). Various techniques are used, such as open enrolment, community rating, and risk equalization schemes.

Open enrolment means that health insurance companies must accept anyone who wishes to join, regardless of age, sex or health status. Irish and Slovenian legislations stipulate open enrolment. The Irish legislation also stipulates “lifetime cover”, which means that once a person joins a voluntary health insurance and continues to pay his/her premiums, the insurance company cannot refuse to provide him/her with cover. In France, the 1989 Act on complementary health plans for employees limits the possibility for insurers to engage in risk selection (there can be no risk selection in the collective plans) and provides workers with some guarantees as regards the continuity of their complementary health insurance coverage when they quit their job.

Community rating means that the insurance company must charge the same rate for a given level of service, regardless of age, sex or health status. So, all enrollees pay the same amount for the same benefits. This system applies in Ireland and in Slovenia. In France, there is no legal prohibition from differentiating premiums rates, so private insurers can modulate rates according to age. Nevertheless, as mentioned, French legislation – since 2002 – has encouraged

bargain about the implementation of collective complementary health insurance, if such a plan has not yet been implemented in their professional sector. Then, employers at company level have a duty to propose to their employees a complementary health coverage which complies with the collective agreement requirements in this respect (deadline on January 2016). Under the 2013 Act, employers have to financially cover 50% of the premium charges.

⁵⁷ ECJ case C-185/11, *Commission vs Slovenia*, 26 January 2012.

health insurers to offer “responsible and solidary” contracts or plans, with fiscal incentives. In this kind of plan, which is currently the most widespread in the market, there can be no risk selection (no medical questionnaire) and premiums cannot be related to health status.

Risk equalization or compensation schemes for the complementary health insurance market have been set up in Ireland and Slovenia. Risk equalization is needed to support community-rated health insurance. Basically, health insurers receive credits or subsidies from a national fund or authority to compensate for the additional cost of insuring older and less healthy members. As explained and developed in Chapter 8 of this book, the Irish risk equalization scheme was challenged by a private for-profit insurer, BUPA, which strongly contested this system: BUPA claimed the scheme was a State-enforced subsidy to VHI, and was anti-competitive. In 2003, the European Commission said the scheme did not constitute a State aid or subsidy to VHI⁵⁸ and in 2008, the Court of First Instance upheld the Commission’s decision⁵⁹. In Slovenia, Adriatic Slovenica and Vzajemna challenged the risk equalization scheme in the Constitutional Court and eventually at the EU level, claiming that it distorted competition in the VHI market. All disputes were rejected by the Constitutional Court in 2006 and the risk equalization scheme remained in place after the ECJ ruling in 2012 which did not address this issue. One can speculate about the uncertainty of ECJ case law as regards the concept of SGEI applied to national risk equalization schemes. Would the ECJ have made the same ruling on the Slovenian scheme as on the Irish one, according to BUPA case law? One may think that in the Slovenian legal environment, a SGEI appears to be even clearer as regards complementary health insurance than in the Irish case, so the Slovenian risk equalization scheme should not be challenged by EU Law (Thomson and Mossialos, 2010).

⁵⁸ More precisely, the Commission considered that even if the risk equalization scheme could be seen as a State aid, it was nonetheless compatible with the internal market.

⁵⁹ Court of First Instance of the European Communities, case T-289/03, *BUPA e.a. vs Commission*, 12 February 2008, *ECR* 2008, p. II-81

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