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The Compatibility of Private Health Insurance Schemes with EU Law: Applying the Health Insurance Exception beyond Substitutive Private Health Insurance

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Abstract
The lack of clarity as to the scope of the health insurance exception enshrined in Article 206 of the Solvency II Directive has created uncertainties surrounding the implications for government intervention in the private health insurance market. A contentious interpretation of the health insurance exception, offered by former EU Commissioner Bolkestein, and the approach subsequently taken by the Commission and the Court of Justice of the European Union in assessing the compatibility of Member State intervention in private health insurance have led to a divergence in the application of EU law, which further increases uncertainties around the legality of Member State intervention. This article proposes an alternative interpretation of the health insurance exception that draws on a contemporary understanding of private health insurance as a socio-economic institution aimed at achieving a highly competitive social market economy. This alternative interpretation extends the applicability of the health insurance exception from substitutive private health insurance to complementary private health insurance that covers statutory user charges and thus improves the compliance of national health insurance systems in several Member States with EU law and enhances the coherence of EU law.

Keywords: private health insurance, health insurance exception, Third Non-life Insurance Directive, Solvency II Directive, service of general economic interest

I. INTRODUCTION

Various cultural, historical, socioeconomic, and political factors have led to a considerable degree of diversity in the way healthcare systems in the European Union (EU) are organised and financed. All EU Member States, with the exception of Cyprus, use public financing as a principal healthcare financing mechanism.[1] They use one of two basic models: taxation (the Beveridge model) or social insurance (the Bismarck model).

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[1] Organization for Economic Co-operation and Development (OECD), *OECD Health at a Glance 2016, Europe 2016* (OECD Publishing, 2016), p 123.

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Private healthcare financing, on the other hand, is much more diverse (eg private health insurance, health saving accounts, and out-of-pocket payments). Great diversity also characterises private health insurance.[2] The various types of private health insurance, the different scope of benefits that they provide, and, most importantly, their varied roles in a given social security system reveal the broadness of the term. Yet despite great diversity, private health insurance can be classified, based on its fundamental characteristics, into three main types: substitutive, supplementary, and complementary private health insurance. Substitutive private health insurance provides the same or similar health cover (benefits) as the statutory health insurance for members of the population who are either excluded from or allowed to opt out of the statutory health insurance.[3] Supplementary private health insurance provides cover in addition to the cover provided by the statutory health insurance (eg faster access and enhanced consumer choice). Complementary private health insurance is further differentiated into two subcategories: complementary health insurance that covers services that are excluded from the statutory health insurance, and complementary health insurance that covers user charges (co-payments) imposed under statutory health insurance.[4]

Private health insurance plays a significant role in healthcare financing in several EU Member States. World Health Organization ('WHO') statistics show that in 2014, private health insurance exceeded 5 percent of total health expenditures in Slovenia (14.1 percent), Ireland (14.0 percent), France (13.3 percent), Germany (8.9 percent), Croatia (6.9 percent), the Netherlands (5.9 percent), and Portugal (5.1%).[5] Sagan and Thomson have noted that alongside the usual financial or prudential regulation, eight EU Member States[6] have adopted special material regulation aimed at ensuring access to healthcare.[7] It should come as no surprise that the five

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[2] For the purpose of this article, we follow the definition of private health insurance used by Mossialos and Thomson: 'Private health insurance is health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. It can be offered by public or quasi-public bodies and by for-profit (commercial and non-profit) private organizations'. See E Mossialos and S Thomson, *Voluntary Health Insurance in the European Union*, European Observatory on Health Systems and Policies (WHO, 2004), p 15.

[3] For more see A Sagan and S Thomson, *Voluntary Health Insurance in Europe: Role and Regulation* (WHO, 2016), p 30.

[4] For more on the nature of and differences between the basic categories of private health insurance, see S Thomson and E Mossialos (a), 'Voluntary Health Insurance in the European Union: A Critical Assessment' (2002) 32(1) *International Journal of Health Services* 19; S Thomson and E Mossialos (b), *Private Health Insurance in the European Union*, Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities (London School of Economics and Political Science, 2009); S Thomson and E Mossialos (c), 'Private Health Insurance and the Internal Market' in E Mossialos, G Permanand, R Baeten, and T K Hervey (eds), *Health Systems Governance in Europe: The Role of EU Law and Policy* (Cambridge University Press, 2010).

[5] WHO, 'Global Health Expenditure Database (GHED)', available at http://www.who.int/health-accounts/ghed/en.

[6] Belgium, Croatia, Estonia, France, Germany, Ireland, Italy, and Slovenia. Sagan and Thomson, note 3 above, p 25.

[7] The regulation of private health insurance is based on two approaches: minimal financial or prudential regulation (protecting consumers from insurer insolvency) and material or contract regulation

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Member States with the largest private health insurance markets (Slovenia, Ireland, France, Germany, and Croatia) can be found among the heavily regulated countries. An upswing in regulation intensity over the last two decades can be observed in these countries, which indicates the tendency of some Member States to intervene in private health insurance when private health insurance plays a significant role in healthcare financing.[8] Besides preventing 'market failures',[9] protection of social welfare or welfare-state institutions by means of ensuring access to healthcare through access to private health insurance (more affordable insurance and financial protection for people with private health insurance) is the main objective for their intervention.[10] Despite Article 168(7) of the Treaty on the Functioning of the European Union ('TFEU'), which specifies that the organisation of health services and medical care is a Member State competence, Member States are not free to regulate the health insurance market in accordance with their political, economic, or social interest. The comprehensive European regulatory framework established by internal insurance market legislation—insurance directives and the Solvency II Directive—and EU competition law imposes constraints on national regulatory competences in the field of healthcare financing.[11] Despite a recent trend towards the full harmonisation of the internal insurance market legislation and attempts by European Institutions and scholars to determine the applicability and scope of competition law in the field of healthcare, some uncertainties regarding national regulatory competences remain.[12]

(F'note continued)

(ensuring access to healthcare through access to health insurance). Financial regulation focuses on *ex post* scrutiny of an insurer's financial returns on business, while material regulation involves *ex ante* scrutiny of an insurer's policy conditions and premium rates on the grounds that this eliminates the potential for insolvency. See S Thomson and E Mossialos (c), note 4 above, p 426; S Thomson and E Mossialos (d), 'Regulating Private Health Insurance in the European Union: The Implications of Single Market Legislation and Competition Policy' (2007) 29(1) *Journal of European Integration* 92.

[8] See also Sagan and Thomson, note 3 above, p 23.

[9] K J Arrow, 'Uncertainty and the Welfare Economics of Medical Care' (1963) 53 *The American Economic Review* 941.

[10] Sagan and Thomson, note 3 above, p 23. See also P Calcoen and W PMM van de Ven, 'Voluntary Additional Health Insurance in the European Union: Free Market or Regulation?' (2017) 24 *European Journal of Health Law* 15.

[11] From a theoretical point of view, this matter could be conceptualised as an interaction between the EU's free-market(s) and social solidarity or, according to Hervey and McHale, 'competition-driven efficiencies and solidarity-based equality'. T K Hervey and J V McHale, *European Union Health Law, Themes and Implications* (Cambridge University Press, 2015), pp 227 ff; T Prosser, 'EU Competition Law and Public Services' in E Mossialos, G Permanand, R Baeten, and T K Hervey (eds), *Health Systems Governance in Europe: The Role of EU Law and Policy* (Cambridge University Press, 2010), pp 315 ff.

[12] For more on the applicability and scope of competition law in the field of healthcare, see J Lear, E Mossialos, and K Beatrix, 'EU Competition Law and Health Policy' in Mossialos, Permanand, Baeten, and Hervey, note 11 above; W Sauter, 'The Impact of EU Competition Law on National Healthcare Systems' (2013) 38(4) *European Law Review* 457; O Odudu, *The Boundaries of EC Competition Law: The Scope of Article 81* (Oxford University Press, 2006); O Odudu, 'Economic Activity as a Limit to Community Law' in C Barnard and O Odudu (eds), *The Outer Limits of EU Law* (Hart Publishing, 2009); M Guy, *Competition Policy in Healthcare, Frontiers in*

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These uncertainties, which will be discussed in this article, call into question the compatibility of several national health insurance systems with EU law, which would undermine the fundamental arrangements of social security systems in those Member States. This raises not only a theoretical but also a practical concern, which is reflected in a case concerning the compatibility of the Slovakian compulsory health insurance scheme conducted by private and public insurers that is at the time of writing this article still pending before the Court of Justice of the European Union ('CJEU').[13]

A review of the academic literature and prior research findings reveals uncertainties concerning the implications of Member State intervention in the health insurance market, namely private health insurance. Mossialos and Thomson,[14] Sagan and Thomson,[15] Sauter,[16] and Hervey and McHale[17] have identified uncertainties relating to when Member States can justify special material regulation of private health insurance aimed at ensuring access to healthcare. Mossialos and Thomson have neatly summarised the key uncertainties in two basic questions: *When can a government intervene?* and *How can a government intervene?*[18] The first uncertainty concerns whether a Member State can impose specific legal provisions in relation to all types of private health insurance or just a particular type. The second uncertainty concerns what types of specific legal provisions can be imposed by a Member State. Both of these uncertainties are the result of the lack of clarity of secondary EU law, more precisely Article 206 of the Solvency II Directive (former Article 54 of the Third Non-life Insurance Directive) and unwillingness on the part of the EU institutions to formally clarify this provision.[19] EU institutions have further increased uncertainties with their approach in assessing the compatibility of Member States' interventions in private health insurance with EU law.[20] They use one of two approaches, depending on the legal basis of the case. If the case is based in competition law, they rely on the TFEU rules on services of general economic interest (eg Article 106(2) TFEU). If the basis of the case is free movement law, EU institutions assess compatibility with the relevant provisions of the Solvency II Directive (previously the third Non-life Insurance Directive). In the latter case, EU

(F'note continued)
*Insurance-Based and Taxation-Funded Systems (*Intersentia, 2019); J van de Gronden, 'Financing Health Care in EU Law: Do the European State Aid Rules Write Out an Effective Prescription for Integrating Competition Law with Health Care? ' (2009) 6(1) *The Competition Law Review* 5.

[13] *Dôvera zdravotná poisťovňa, a.s. v Commission*, C-262/18 P.

[14] Thomson and Mossialos (d), note 7 above, pp 94–103; Thomson and Mossialos (b), note 4 above, pp 79–94; Thomson and Mossialos (c), note 4 above, 429–55.

[15] Sagan and Thomson, note 3 above, pp 86–89.

[16] W Sauter, *Health Insurance and EU Law* (TILEC, 2011) Research Paper 021/2011, pp 13–15.

[17] Hervey and McHale, note 11 above.

[18] Thomson and Mossialos (c), note 4 above, 429–55; Thomson and Mossialos (d), note 7 above, 94–103.

[19] Thomson and Mossialos (c), note 4 above, pp 436, 455.

[20] See also ibid, p 458.

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institutions have to assess whether specific government interventions can be justified under Article 206 of the Solvency II Directive. In relation to this question, EU institutions have never offered a formal clarification about when a government can intervene under Article 206 of the Solvency II Directive. Nonetheless, a number of factors, led by a contentious non-binding interpretation of Article 54(1) of the Third Non-life Insurance Directive offered by the then EU Commissioner Bolkestein, form a meaningful line of reasoning that strongly implies that specific government interventions aimed at ensuring access to healthcare through access to complementary and supplementary private health insurance, such as open enrolment (Slovenia, Croatia, Ireland, and Belgium), community-rated premiums (Belgium, Italy, Ireland, Croatia, and Slovenia), compulsory cover (France), lifetime cover (Belgium and Ireland), and others, are not compatible with Article 206 of the Solvency II Directive. This raises a serious concern about the compatibility of complementary and supplementary private health insurance systems in several Member States with EU law.[21]

Furthermore, the approach of EU institutions combined with the contentious interpretation of Article 206 of the Solvency II Directive have created divergence between the application of competition and free movement rules relating to private health insurance. Government interventions in complementary and supplementary private health insurance, such as risk equalisation schemes, open enrolment, community rating, and others, that are not compatible with free movement rules are at the same time compatible with competition rules. Such divergence negatively affects the coherence of EU law and further increases confusion among policy makers, national regulators and insurance operators. The main reason for this is that the legality of Member State interventions depends on the legal basis of the case, which potentially leads to different outcomes in cases concerning the same intervention. This could already be observed in a case involving risk equalisation schemes in Ireland and Slovenia.[22]

European Institutions had an opportunity to eliminate the uncertainties surrounding the health insurance exception enshrined in the Third Non-life Insurance Directive upon adoption of the Solvency II Directive that repealed and replaced the Third Non-life Insurance Directive. By retaining the wording of the health insurance exception in the Solvency II Directive, legislators missed an opportunity to address this issue. As legislators have been unwilling to improve the clarity of the health insurance exception, and as there is an apparent lack of dissatisfaction with this provision at the political level that could dictate a future legislative agenda, this article proposes an alternative interpretation of Article 206 of the Solvency II Directive in a quest to eliminate uncertainties surrounding the health insurance exception. Further, this article proposes an alternative interpretation with the objective to increase the coherence of EU law and compatibility of complementary and supplementary private health insurance schemes with EU law. The alternative interpretation is conceptualised via an understanding of private health insurance as

[21] See also Thomson and Mossialos (d), note 7 above, p 103.

[22] Thomson and Mossialos (c), note 4 above, p 458.

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a socio-economic institution aimed at achieving a highly competitive social market economy. It allows countries where complementary private health insurance covers statutory user charges (ie Slovenia, France, and Croatia) to justify special material regulation under Article 206 of the Solvency II Directive, and to thus improve the compatibility of their national health insurance systems with EU law. Nevertheless, it does not completely eliminate the divergences between the application of competition and free movement rules because it fails to justify the same special material regulation of complementary private health insurance that covers excluded services and supplementary private health insurance.

The structure of this article is as follows. Part II demonstrates key uncertainties concerning the implications of Member State interventions in private health insurance, which call into question the compatibility of complementary and supplementary private health insurance systems in several Member States with EU law. In Part III, the article analyses the compatibility of different types of health insurance schemes and specific Member State interventions aimed at ensuring access to health insurance with EU law, namely with competition rules and free movement rules. The analysis examines the case law of the Union courts, the European Commission's decisions and non-binding opinions, theoretical considerations of previous researchers, and the findings of Part II. The analysis reveals divergences between the application of competition and free movement rules relating to complementary and supplementary private health insurance. Part IV of the article proposes an alternative interpretation of Article 206 of the Solvency II Directive and analyses its implications for private health insurance schemes.

II. UNCERTAINTIES CONCERNING THE IMPLICATIONS OF GOVERNEMNT INTERVENTION IN PRIVATE HEALTH INSURANCE

Before the establishment of a liberalised and integrated insurance market, Member States were free to decide on the appropriate form of regulation of their health insurance markets based on the principle of subsidiarity (Article 5 European Community Treaty).[23] The establishment of an integrated insurance market began in 1973 with the First Non-life Insurance Directive.[24] The aim of the integrated insurance market was to enhance competition and consumer choice, based on the principle of free movement of services. The fact that insurance is considered to be an economic activity gives EU competence in this area.[25] The implication of the First Non-life Insurance Directive on the health insurance market was to exempt insurance that forms part of a statutory social security system (ie compulsory health insurance)

[23] Ibid, p 426.

[24] Council Directive 73/239/EEC [1973] OJ L228/3. For more on establishment of an integrated insurance market, see K Nemeth, *European Insurance Law: A Single Insurance Market?* (EUI, 2001) Working Paper Law, 2001/4.

[25] Thomson and Mossialos (c), note 4 above, p 426.

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from the scope of EU internal insurance market legislation.[26] More than twenty years later, EU institutions adopted the Third Non-life Insurance Directive,[27] which was expected to round out the single insurance market through the concept of minimum harmonisation and mutual recognition.[28] The Third Non-life Insurance Directive expanded the application of internal insurance market legislation to the private health insurance sector for the first time. It brought about two key changes for private health insurance. First, it accorded primacy to the financial approach to regulation: the requirement for governments to abolish existing product and price controls rendering material regulation redundant and, in some cases, illegal (Articles 6(3), 29, and 39). Secondly, it required governments to open markets for private health insurance to competition at the national and EU levels (Article 3). Even though it prevented Member States from introducing material regulation that would go beyond solvency requirements (eg national rules requiring the prior approval or systematic notification of policy conditions, premium rates, proposed increases in premium rates, and so forth), Member States retained various competences to intervene and protect their policy holders in special situations and under certain conditions.[29] These exceptions to the principle of non-intervention were introduced in the form of the general good exception (Article 28),[30] and the health insurance exception (Article 54).[31]

Unlike the First Non-life Insurance Directive that undisputedly exempted statutory health insurance schemes from the scope of European insurance market legislation, the health insurance exception created a number of uncertainties concerning the implications for Member State intervention in the private health insurance market. Thomson and Mossialos have noted the ambiguity of the health insurance exception, which authorises Member States to intervene in private health insurance or to impose specific measures in the interest of the general good where insurance contracts covering health risks may serve as a '*partial or complete alternative to health cover provided by the statutory social security system*' (Article 54(1)). If these conditions are met, Member States may introduce specific legal provisions (special material regulation), such as provisions providing for open enrolment, community rating, lifetime cover, policies standardised in line with the cover provided by the statutory health

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[26] Article 2(1)(d) of the First Non-life Insurance Directive specifically exempts statutory social insurance from the scope of the Non-life Directives.

[27] Directive 92/49/EEC and Amending Directive 73/239/EEC and Directive 88/357/EEC (Third Non-Life Insurance Directive) [1992] OJ L228/1.

[28] Nemeth, note 24 above, p 32; P Sharma and P Cadoni, 'Solvency II: A New Regulatory Frontier' in C Kempler, M Flamée, C Yang, and P Windels (eds), *Global Perspectives on Insurance Today, A Look at National Interest Versus Globalization* (Palgrave Macmillan, 2010), p 54; W Welf, 'Multilateral Insurance Liberalization, 1948–2008' in R Pearson (ed), *The Development of International Insurance* (Routledge, 2015), p 96.

[29] Thomson and Mossialos (c), note 4 above, pp 426–28; Thomson and Mossialos (d), note 7 above, p 93; Sauter, note 16 above, p 12.

[30] For more on the general good exception, see Thomson and Mossialos (c), note 4 above, pp 429–55; Thomson and Mossialos (d), note 7 above, p 93; Sauter, note 16 above, p 13.

[31] The general good exception was also enshrined in the health insurance exception (Article 54(1) of the Third Non-life Insurance Directive). For more, see Sauter, note 16 above, p 13.

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insurance scheme at a premium rate at or below a prescribed maximum, participation in risk equalisation schemes, and the operation of private health insurance on a technical basis, similar to that of life insurance (Article 54(2) and Recitals 22–24 to the Directive). Measures taken to protect the general good must be shown to be non-discriminatory, necessary, and proportionate to this aim and may not unduly restrict the right of establishment or the freedom to provide services.[32] Thomson and Mossialos have highlighted two main concerns in relation to the health insurance exception: *What is meant by complete or partial alternative to statutory health insurance?* and *What types of interventions are necessary and proportional?*[33] These concerns create the following legal uncertainties in relation to the implications for Member State intervention in the private health insurance market: *When can a government intervene?* and *How can a government intervene?*[34]

The most recent step towards a fully functioning single European insurance market was taken in 2009 with the adoption of the Solvency II Framework Directive,[35] which had as its objective the 'full harmonisation'[36] of European insurance supervision.[37] The Solvency II Directive, which repealed and replaced the Third Non-life Insurance Directive, did not profoundly alter the existing health insurance regulation concerning when and how Member States may regulate their private health insurance markets. With the exception of Recital 85 to the Solvency II Directive, which will be discussed in the following sections, the health insurance exception enshrined in Article 206 of the Solvency II Directive is a carbon copy of the provision in Article 54 of the Third Non-life Insurance Directive. By maintaining the same wording, legislators missed an opportunity to address uncertainties surrounding the health insurance exception in the Solvency II Directive.[38]

A. *When Can a Government Intervene?*

The first uncertainty concerns whether a government can impose specific legal provisions aimed at ensuring access to healthcare (special material regulation) in relation to all types of private health insurance (substitutive, supplementary, complementary covering user charges, or complementary covering services that are excluded from the statutory health insurance) or only for specific types of private health insurance.

[32] Thomson and Mossialos (c), note 4 above, p 428; Thomson and Mossialos (d), note 7 above, p 93; Sauter, note 16 above, p 12.

[33] Thomson and Mossialos (c), note 4 above, p 430; Thomson and Mossialos (d), note 7 above, p 94.

[34] Thomson and Mossialos (c), note 4 above, pp 429–55; Thomson and Mossialos (d), note 7 above, 94–103.

[35] Directive 2009/138/C (Solvency II) [2009] OJ L335.

[36] There are some exceptions to the full harmonization objective, which are further explained in M Dreher, 'Harmonization of Insurance Supervisory Law' in M Dreher (ed), *Treatises on Solvency II* (Springer Berlin, Heidelberg, 2015, first published as 'Die Vollharmonisierung der Versicherungsaufsicht durch Solvency II' (2011) *VersR*), pp 3–25.

[37] Ibid, p 23.

[38] See also Thomson and Mossialos (c), note 4 above, p 457.

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What is the exact meaning of 'complete or partial alternative to statutory health insurance'? Even though the EU institutions have never offered a formal answer to this question, a number of factors strongly imply the answer. These include the *travaux préparatoires*,[39] lobbying conducted during the negotiations prior to the drafting of the Third Non-life Insurance Directive,[40] and the position of the Commission, which has informally and indirectly addressed this issue on several occasions. The strongest factor and most unequivocal example of the Commission's position has been the informal opinion of the Commissioner for the Internal Market, Frits Bolkestein, in a letter to the Dutch Minister of Health, Welfare and Sport.[41] Bolkestein strongly suggested that whether a private health insurance scheme is to be understood as a partial or complete alternative to health cover provided by the statutory social security system depends on the specific benefits provided by the particular private health insurance scheme. Only private health insurance which provides the same benefits (health cover) that are (is) provided by statutory health insurance can be considered a partial or complete alternative to the health cover provided by the statutory social security system. Private health insurance that provides benefits that go beyond the basic social security benefits laid down by legislation cannot be considered an alternative to the health cover provided by the statutory social security system.[42] Consequently, government intervention is justified only in the case of substitutive private health insurance, because it provides the same or similar benefits (health cover) that are provided by statutory health insurance. The alternative nature of the health cover provided by substitutive private health insurance is best reflected in the fact that in some Member States certain groups of the population can opt out of the statutory health insurance and enrol in substitutive private health insurance.[43] Hence, they are *de facto*

[39] The objective of the drafters of the Directive was to assimilate private health insurance that serves as a substitute to the social health insurance system into statutory insurance. This assimilation was justified by the fact that in practice, all residents are covered by health insurance (universal health coverage) through either the social health insurance or private health insurance. For more on the importance of travaux préparatoires for the interpretation of EU law, see K Lenaerts and J A Gutiérrez-Fons, *To Say What the Law of the EU Is: Methods of Interpretation and the European Court of Justice* (EUI, 2013) Working Paper AEL, 2013/9.

[40] The regulatory measures outlined in Article 54(2) of the Third Non-life Insurance Directive and Recitals to the Directive are identical to the regulatory measures already in place in countries with fully developed substitutive private health insurance markets (Germany, the Netherlands, and Ireland). For more, see Thomson and Mossialos (d), note 7 above, p 95. See also Thomson and Mossialos (c), note 4 above, p 430; Sauter, note 16 above, p 14.

[41] The Dutch Minister of Health, Welfare and Sport sent a request to the Commissioner for the Internal Market for clarification of Article 54 of the Third Non-life Insurance Directive with regard to the compatibility of the Dutch compulsory health insurance reform with EU law. For more on his request and Bolkestein's reply, see also Thomson and Mossialos (c), note 4 above, pp 431 ff; Thomson and Mossialos (d), note 7 above, pp 95 ff; Sauter, note 16 above, pp 14 ff.

[42] F Bolkestein, Letter from the European Commission to the Dutch Minister of Health, Welfare and Sport, 25 November 2003, Ministry of Health, Welfare and Sport (The Hague, 2003).

[43] In Germany, households with earnings over a certain threshold, certain self-employed occupational groups, and civil servants can opt out of the statutory health insurance. See Sagan and Thomson, note 3 above, pp 42–43.

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exempted from being required to participate in the statutory health insurance. In other Member States, certain groups of the population are not entitled to participate in the statutory health insurance, but may obtain "basic" health cover through substitutive private health insurance.[44] Both of these situations clearly demonstrate the alternative nature of the health cover provided by substitutive private health insurance and its important role in achieving universal health coverage. By the same token, complementary and supplementary private health insurance cannot be considered alternatives to statutory health insurance, as they provide benefits in addition to those provided by statutory health insurance.[45]

The Commission maintained Bolkestein's position in two subsequent instances. First, in a legally non-binding response to questions put forward by Members of the European Parliament in 2005 and 2006, Commissioner McGreevy followed Bolkestein's position concerning the Dutch compulsory health insurance scheme, but unlike Commissioner Bolkestein before him, in his interpretation of Article 54 of the Third Non-life Insurance Directive, McGreevy did not venture beyond an assessment of the Dutch health insurance scheme. It is therefore impossible to discern what his position on complementary and supplementary private health insurance in general actually was.[46]

The second instance was an infringement procedure launched by the Commission in 2006 against the Slovenian complementary private health insurance scheme. Between 2006 and 2010, the Commission had sent Slovenia a reasoned opinion and several informal and formal notices in which the Commission accused Slovenia of not fulfilling its obligations under Article 8(3) of the First Non-life Insurance Directive, and Articles 29 and 39 of the Third Non-life Insurance Directive, and also of violating Articles 49 and 56 of the EC Treaty.[47]

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[44] In Cyprus, the Czech Republic, and Slovenia, certain categories of foreigners are not entitled to participate in the statutory health insurance scheme. See Sagan and Thomson, note 3 above, pp 42–43.

[45] See also Hervey and McHale, note 11 above, pp 241–42; Thomson and Mossialos (d), note 7 above, p 96; Thomson and Mossialos (c), note 4 above, pp 432–33; Sauter, note 16 above, p 14.

[46] C McCreevey, Answer given by Mr. McCreevey on behalf of the Commission, European Parliament, Doc. No. E-3829/05EN, 12 December 2005; C McCreevy, Answer given by Mr. McCreevey on behalf of the Commission, European Parliament, Doc. No. E-3828/05EN, 5 January 2006; C McCreevy, Answer given by Mr. McCreevey on behalf of the Commission, European Parliament, Doc. No. E-3830/05EN, 24 January 2006. See also Thomson and Mossialos (c), note 4 above, p 432.

[47] In 2005, Slovenia adopted an amendment to the Health Care and Health Insurance Act, which imposed several obligations on health insurers providing complementary private health insurance. The Commission had taken the legislative amendment under scrutiny and notified Slovenia that mandatory prior approval of the Ministry of Health for general insurance conditions, the requirement for insurers to notify the Insurance Supervision Agency of general insurance conditions, and the actuary's prior approval of the premium increase were not compatible with the provisions of Article 8(3) of the First Non-life Insurance Directive and Articles 29 and 39 of the Third Non-life Insurance Directive. In addition, the Commission held that the requirement for foreign health insurers to appoint a representative in Slovenia would discourage them from providing services in Slovenia which constitutes an obstacle to the freedom to provide services under Article 49 EC Treaty. The Commission also complained of a violation of the free movement of capital under Article 56 EC Treaty, due to the obligation to return

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The Slovenian Government responded by arguing, *inter alia*, that the Slovenian complementary private health insurance scheme served as a partial alternative to the statutory health insurance system and that the government intervention was in line with the health insurance exception.[48] The Commission rebutted Slovenia's claims, arguing that the Slovenian complementary private health insurance scheme did not serve as a partial alternative to the health cover provided by the statutory health insurance scheme, since it only complemented the social protection offered by the statutory health insurance scheme.[49]

All of these factors strongly support the interpretation offered by Commissioner Bolkestein. While these arguments are all circumstantial and of questionable legal bindingness, as a whole, they form a meaningful line of reasoning by which government intervention (special material regulation) is permissible only in the case of substitutive private health insurance. Application of this interpretation of the health insurance exception to the Article 206 of the Solvency II Directive, which is a carbon copy of the provision in Article 54 of the Third Non-life Insurance Directive, leads to the same conclusion. It is therefore reasonable to assume that Members State intervention in private health insurance can be justified pursuant to the health insurance exception enshrined in Article 206 of the Solvency II Directive only in the case of substitutive private health insurance.

B. How Can a Government Intervene?

An overview of Member State private health insurance schemes reveals numerous specific legal provisions aimed at ensuring access to healthcare through access to private health insurance. To name a few: open enrolment (Slovenia, Croatia, Ireland, and Belgium), community-rated premiums (Belgium, Italy, Ireland, Croatia, and Slovenia), compulsory cover (France), lifetime cover (Belgium and Ireland), and risk equalisation schemes (Ireland and Slovenia). If Member States are permitted under certain conditions to impose specific legal provisions in the field of private health insurance, what types of specific legal provisions are permitted? The former Article 54(2) of the Third Non-life Insurance Directive and Recital 24 to the Directive listed specific legal provisions that governments could introduce where private health insurance cover served as a partial or complete alternative to statutory health insurance cover. In addition to requiring that private health insurance systems be operated on a technical basis similar to that of life insurance, Recital 24 listed

(F'note continued)
one half of the profit from complementary private health insurance activity back to the management of this activity. For more, see M Osenar, 'Opomini Evropske komisije v zvezi z dopolnilnim zdravstvenim zavarovanjem' in *Dopolnilno zdravstveno zavarovanje in zdravstvena reforma* (Slovensko zavarovalno združenje, 2011) and Hervey and McHale, note 11 above, p 242.

[48] The Commission's additional formal notice to Slovenia C(2009) 4852, sent on 25 June 2009, para 3.

[49] Ibid; Press release of the 83rd regular session of the Government of the Republic of Slovenia. Ljubljana, 20 May 2010.

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additional specific legal provisions on open enrolment, community rating, lifetime cover, and standard policies in line with the cover provided by the statutory social security scheme and participation in loss compensation schemes. Due to the interpretative value of the recital and complete lack of any kind of institutional clarification, it was not clear if the list of specific legal provisions provided in Article 54(2) and Recital 24 was exhaustive or open-ended. Would any unlisted government intervention contravene the Directive or was the list completely open-ended and constrained only by the proportionality test?[50]

As noted above, the Solvency II Directive did not make substantial changes to the health insurance exception. It did, however, contribute at least partially to resolving the uncertainty surrounding what types of specific legal provisions are acceptable under the health insurance exception. Recital 85 to the Solvency II Directive, which closely matches Recital 24 to the Third Non-life Insurance Directive, does not contain the above-mentioned list of specific legal provisions outlined in Recital 24. Although Thomson and Mossialos argue that it is not clear whether this omission has any particular significance,[51] the wording of Recital 85 strongly implies that due to the lack of restraints or defined exceptions, the list of specific legal provisions is completely open-ended and constrained only by the proportionality test.

III. COMPATIBILITY OF HEALTH INSURANCE SCHEMES AND SPECIFIC LEGAL PROVISIONS AIMED AT ENSURING ACCESS TO HEALTHCARE WITH EU LAW

Member States are inclined to intervene in the field of private health insurance mainly to prevent market failures and protect social welfare by means of ensuring access to healthcare through access to private health insurance. The specific legal provisions are often at the margins of the conditions imposed by liberalising legislation and judiciary deregulation, rendering their legality questionable. An ambiguous health insurance exception and unwillingness by the EU institutions to formally clarify it further increases uncertainties around the legality of government interventions, especially in relation to complementary and supplementary health insurance. These uncertainties often turn into disputes which take the form of infringement proceedings or even legal proceedings before the CJEU.

Yet such infringement proceedings and disputes before the CJEU have largely failed to resolve the uncertainties surrounding the health insurance exception. On the contrary, they have increased confusion. Instead of formally clarifying the health insurance exception and defining which specific legal provisions are in accordance with the exception, the Commission and the CJEU have assessed the compliance of government intervention in private health insurance with the rules on services

[50] Thomson and Mossialos (c), note 4 above, p 437; Thomson and Mossialos (d), note 7 above, p 97; Sauter, note 16 above, pp 13–16.

[51] Thomson and Mossialos (c), note 4 above, p 457.

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of general economic interest ('SGEI'), more precisely Article 106(2) TFEU. Article 106(2) is traditionally seen as a derogation, which allows for activities that are economic in nature and as such subject to the Treaty rules, under certain conditions to be exempted from the scope of the Treaty rules.[52] Despite the fact that Article 106 TFEU is located within the Treaty rules on competition, the SGEI exception is designed not only to justify government intervention that restricts competition rules, but also internal market rules to the extent that such restrictions are necessary and proportional to the desired legitimate public interest.[53] Such an approach by the Institutions has created additional uncertainty as to which set of rules is to be applied when assessing the compliance of specific legal provisions relating to private health insurance: Article 106(2) TFEU, Article 206 of the Solvency II Directive, or both?[54] The approaches of the Commission and the CJEU in cases involving Dutch[55] and Slovakian[56] compulsory health insurance schemes, Irish supplementary private health insurance,[57] and Slovenian complementary private health

[52] For more on Article 106(2) TFEU, see, eg, J Burke, *A Critical Account of Article 106(2) TFEU, Government Failure in Public Service Provision* (Hart Publishing, 2018); K Lenaerts. 'Defining the Concept of "Services of General Interest" in Light of the "Checks and Balances" Set Out in the EU Treaties' (2013) 19(4) *Jurisprudencija/Jurisprudence* 1247; V Hatzopoulos, *The Concept of 'Economic Activity' in the EU Treaty: From Ideological Dead-ends to Workable Judicial Concepts* (College of Europe, 2011) Research Paper in Law 06, pp 30 ff; C Wehlander, *Services of General Economic Interest as a Constitutional Concept of EU Law* (T.M.C. Asser Press, 2016).

[53] In the field of healthcare, Article 106(2) could be invoked in relation to free movement, public procurement, and competition rules (private conduct and state aid). V Hatzopoulos, note 52 above, pp 30 ff. For readings on the application of Article 106(2) TFEU, see also Wehlander, note 52 above, pp 130–45; D Gallo, *Social Security and Health Services in EU Law: Towards Convergence or Divergence in Competition, State Aids and Free Movement?* (EUI, 2011) Working Paper RSCAS 2011/19; K JM Mortelmans, 'Towards a Convergence of the Application of the Rules on Free Movement and Competition?' (2001) 38 *CMLRev* 613; Lenaerts, note 52 above. On the other hand, Bekkedal argues that Article 106(2) TFEU may not operate as a derogation from the Treaty provisions on free movement. See T Bekkedal. 'Article 106 TFEU Is Dead. Long Live Article 106 TFEU!' in E Szyszczak, J Davies, M Andenæs, and T Bekkedal (eds), *Developments in Services of General Interest* (Springer, 2011), pp 61–102.

[54] For the simultaneous application of free movement and competition rules to a single factual situation, see the Opinion of Advocate General Lenz in *Union Royale Belge des Sociétés de Football Association Asbl v Jean-Marc Bosman, Royal Club Liégeois SA v Jean-Marc Bosman and Others and Union des Associations Européennes de Football (UEFA) v Jean-Marc Bosman*, C–415/93, EU:C:1995:463, para 253; and O Odudu. 'The Meaning of Undertaking within 81 EC' (2005) 7 *Cambridge Yearbook of European Studies* 235 (and references listed therein).

[55] Commission Decision N541/2004 of 3 May 2005 – Netherlands Retention of financial reserves by sickness funds and risk equalization schemes C(2005) 1329 final, OJ C/324. The Dutch compulsory health insurance scheme could also be considered substitutive private health insurance according to Commissioner Bolkestein's interpretation.

[56] Commission Decision 2015/248 of 15 October 2014 on the measures SA.23008 (2013/C) (ex 2013/NN) implemented by the Slovak Republic for Spoločná zdravotná poisťovňa, a. s. (SZP) and Všeobecná zdravotná poisťovňa, a. s. (VZP) C(2014) 7277, OJ L41; *Dôvera v Commission*, T-216/15, EU:T:2018:64.

[57] Commission Decision N46/2003 of 13.5.2003 C(2003) 1322 final, OJ C186; *BUPA and Others v Commission,* T 289/03, EU:T:2008:29.

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insurance,[58] have not given us a clear answer. Are Member States and EU institutions free to apply the specific set of rules that is most consistent with their political or economic interests, or is such 'cherry picking' unacceptable?

There are two different answers to this question. As noted by Thomson and Mossialos, in the *BUPA* case (supplementary private health insurance) the General Court allowed a wide margin of appreciation concerning the application of the concept of a SGEI. If a Member State has relative freedom to define private health insurance as a SGEI and specific legal provisions are justified under the SGEI exception (Article 106(2) TFEU), then there is little need for further assessment of the compliance of those measures with the free movement rules (ie Article 206 of the Solvency II Directive).[59] The Commission took the opposite view in a more recent case involving Belgian complementary private health insurance. The Commission held that the applicability of a particular set of rules is not at the discretion of a government or EU institution, nor predetermined by a wide margin of appreciation concerning the application of the concept of a SGEI. The Commission explicitly stated that the application of free movement rules (ie the Third Non-life Insurance Directive) cannot be avoided by referring to the SGEI exception.[60] The same view could be seen in a case concerning the Third Non-life Insurance Directive, where the CJEU held that in a field that is subject to harmonisation, in the context of which the EU legislature has taken account of the general interests, Article 106(2) TFEU cannot be applied in a manner that would contradict the rules of that harmonisation.[61] The approach of the Commission and the CJEU regarding Slovenian complementary private health insurance indirectly supports this latter view.[62] This understanding of the application of the specific set of rules strongly imply that the applicability is not at the discretion of a government or EU institution, but depends on the legal basis of the case. If government intervention is challenged on the ground of violating internal market rules, the applicability of free movement rules (ie the Solvency II Directive) is beyond dispute. In such cases Member States or EU institutions cannot override the application of the free movement rules with the SGEI exception (Article 106(2) TFEU), but must justify specific legal provisions under Article 206 of the Solvency II Directive.

If the applicability of a particular set of rules depends on the legal basis of the case, does this affect the compliance of specific legal provisions with EU law? In other words, could the compliance of specific legal provisions with EU law depend on the legal basis of the case? Moreover, if government intervention in the private health insurance market is simultaneously challenged on the ground of violating internal

[58] Commission's additional formal notice to Slovenia C(2009) 4852, sent on 25 June 2009; *Commission v Republic of Slovenia*, C-185/11, EU:C:2012:43.

[59] See Thomson and Mossialos (c), note 4 above, p 457.

[60] *Commission v Kingdom of Belgium*, C-41/10, EU:C:2010:653, para 24.

[61] *Commission v Kingdom of Belgium*, C-206/98, EU:C:2000:256, para 45. See also CH Bovis, *EU Public Procurement Law* (Edward Elgar Publishing Limited, 2012), pp 16–17; JL Buendía, 'Finding the Right Balance: State Aid and Services of General Economic Interest' in *Liber Amicorum* Francisco Santaolalla, EC State Aid Law (Kluwer Law International, 2008), p 205.

[62] *Commission v Republic of Slovenia*, EU:C:2012:43.

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market rules and competition rules, would simultaneous application of free movement and competition rules give different results in relation to both set of rules? Could a government intervention be compatible with competition rules and at the same time violate internal market rules? This potential divergence between the application of competition and free movement rules threatens to further increase the uncertainties surrounding government interventions in the health insurance market.[63] Hereafter, the article analyses the potential divergence between the application of competition and free movement rules when assessing the compatibility with EU law of special material regulation relating to four basic types of health insurance schemes: compulsory, complementary, supplementary, and substitutive health insurance. For this purpose, this section is divided into two sub-sections. Each sub-section covers the set of rules against which government intervention is assessed: compliance of the health insurance schemes (special material regulation) with (1) competition rules and (2) free movement rules.

A. *Compatibility of Health Insurance Schemes with Competition Rules*

Based on the Commission's approach and the CJEU's case law, three different categories can be distinguished upon assessing the compatibility of government intervention in health insurance schemes with EU competition rules. In the first category, a health insurance scheme is excluded from the application of competition rules, meaning that government intervention in the health insurance market is not restricted by competition rules. In the second category, a health insurance scheme falls within the scope of competition rules, however government intervention that restricts those rules might be justified under exceptional conditions. If such conditions are not met, government intervention in the health insurance market cannot be justified. Such instances fall into the third category.

A crucial element in deciding whether a health insurance scheme is excluded from the application of competition rules is the concept of 'undertaking engaged in an economic activity'. If an undertaking responsible for managing and financing a health insurance scheme is engaged in an economic activity, it falls within the scope of competition rules.[64] On the other hand, if the activity of a particular health insurance scheme is regarded as a non-economic activity, the entity responsible for managing and financing this health insurance scheme is not considered as an undertaking, and is therefore outside the scope of competition rules.[65] The distinction between the economic and non-economic nature of a health insurance activity depends on a case-by-case analysis of the competition and solidarity-based elements that are

[63] For more on divergence between different areas of EU law, see Gallo, note 53 above; Mortelmans, note 53 above.

[64] Commission Decision N541/2004, OJ C/324 ; *Dôvera v Commission*, EU:T:2018:64; *BUPA and Others v Commission*, EU:T:2008:29; *AG2R Prévoyance v Beaudout Père et Fils SARL*, C-437/09, EU:C:2011:112.

[65] Commission Decision 2015/248, OJ L41; *AOK Bundesverband and Others*, C-264/01, C-306/01, C-354/01, and C-355/01, EU:C:2004:150.

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characteristic of the specific health insurance scheme. The case law of the CJEU distinguishes between schemes based on the principle of solidarity (non-economic nature of the activity) and economic schemes (economic nature of the activity). The CJEU uses a range of criteria to determine whether a health insurance scheme is solidarity-based or economic.[66] Certain schemes combine elements of both categories, which makes it even more challenging to determine their nature. A perfect example is compulsory health insurance. In principle, it is considered as a non-economic service of general interest and, as such, is excluded from the application of competition rules.[67] However, in 2005, the Commission took a different position in a Dutch compulsory health insurance case. It declared that a Dutch compulsory health insurance scheme conducted by private insurers at their own risk and based on a contractual relationship governed by private law was an economic activity.[68] The Commission took a different stand in 2014 in the case of a Slovakian compulsory health insurance scheme conducted by private and public insurers. It declared that the Slovakian compulsory health insurance scheme was a non-economic activity despite certain features that could indicate its economic nature (eg the presence of public and private insurance operators, some competitive elements, and so forth).[69] The General Court annulled this decision in the beginning of 2018, claiming that the activity of providing compulsory health insurance in Slovakia was, due to the profit pursued by health insurance companies and the existence of intense competition as to quality and the services offered, considered economic in nature.[70] This leads to the conclusion that compulsory health insurance is in principle a non-economic activity as long as it has an exclusively social purpose and is based on the principle of solidarity. If a Member State decides to incorporate elements of competition in this activity, as in the Dutch and Slovakian compulsory health insurance cases, the boundary between economic and non-economic activity remains unclear. This was confirmed by recent developments in the Slovakian case, where Advocate General Pikamäe in his opinion opposed the decision of the General Court and considered Slovakian compulsory health insurance to be a non-economic activity.[71]

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[66] For more on the concept of undertakings engaged in an economic activity and criteria determining the nature of health insurance schemes, see Commission Decision 2015/248, OJ L41, paras 79–82; Hervey and McHale, note 11 above, pp 227–47; Odudu, note 54 above; Hatzopoulos, note 52 above; Lear, Mossialos, and Beatrix, note 12 above.

[67] Commission Decision 2015/248, OJ L41; *Poucet and Pistre v Assurances Générales de France and Others*, C-159/91 and C-160/9, EU:C:1993:63; *AOK Bundesverband and Others*, EU:C:2004:150.

[68] Commission Decision N541/2004, OJ C/324.

[69] Commission Decision 2015/248, OJ L41, para 89.

[70] *Dôvera v Commission*, EU:T:2018:64, para 68. It is worth mentioning that at the time of writing this article, case C-262/18 P is still pending before the CJEU.

[71] The opinion of Advocate General Pikamäe with regard to the economic nature of insurance is that the General Court erred in law in that it overestimated the impact of the degree of competition permitted under the Slovak compulsory health insurance scheme and thus wrongly concluded that Slovak compulsory health insurance scheme is considered economic in nature. Opinion of Advocate General Pikamäe, EU:C:2019:1144, para. 130.

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If an activity is considered as economic, as in the case of supplementary private health insurance,[72] complementary private health insurance[73] and compulsory health insurance conducted by private insurers in the Netherlands and currently still in Slovakia,[74] specific legal provisions that restricts competition rules might be justified under the legal concept of service of general economic interest (SGEI) enshrined in Article 106(2) TFEU.[75] The Commission and the CJEU have applied the SGEI exception to justify government intervention in the field of health insurance on three occasions.

The first case involved an Irish supplementary private health insurance scheme (the *BUPA* case). The General Court followed the Commission's decision[76] by defining the Irish supplementary private health insurance as an SGEI. The Court decided that restrictions on competition imposed by the Irish government in the form of a risk equalisation scheme did not constitute state aid within the meaning of Article 107(1) TFEU, and that even if these restrictions were to be considered state aid, this aid would be compatible with the SGEI exception.[77] In addition, the Court decided that government intervention in the form of open enrolment, community rating, lifetime cover, and minimum benefits are SGEI obligations and, as such, compatible with the competition rules.[78]

The Commission assessed the conformity of a risk equalisation scheme with competition rules for a second time in a case involving Dutch compulsory health insurance.[79] It reached the same conclusion but took a different approach. Unlike in the *BUPA* case, the risk equalisation scheme was found to constitute state aid within the meaning of Article 107(1) TFEU.[80] But even though the risk equalisation scheme constituted state aid, the Commission ruled that this aid was compatible with the SGEI exception, meaning that the Dutch equalisation scheme did not violate competition rules. The Commission confirmed this conclusion also in its subsequent decision.[81]

In the third case, the CJEU assessed whether the monopoly rights of the insurance company AG2R within the French supplementary private health insurance scheme (a compulsory affiliation) could be justified under the SGEI exception. While leaving it ultimately to the national court to examine whether AG2R was engaged in an

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[72] *BUPA and Others v Commission*, EU:T:2008:29; *AG2R*, EU:C:2011:112.

[73] The CJEU considered Belgian mutuals offering complementary health insurance to be entities engaged in an economic activity. See *Commission v Kingdom of Belgium*, EU:C:2010:653, para 23.

[74] Commission Decision N541/2004, OJ C/324; *Dôvera v Commission*, EU:T:2018:64.

[75] Wehlander argues that SGEI is not merely a legal concept of EU law but emerges as a broad constitutional concept of EU law. See Wehlander, note 52 above.

[76] Commission Decision N46/2003, OJ C186.

[77] Ibid, para 61; *BUPA and Others v Commission*, EU:T:2008:29, para 333.

[78] *BUPA and Others v Commission*, EU:T:2008:29, para 103.

[79] Commission Decision N541/2004, OJ C/324.

[80] The reason for a different approach is a stricter interpretation of the fourth Altmark condition.

[81] Commission Decision N 214/2010 of 9 July 2010 – Netherlands Risk equalization system in the Dutch Health Insurance C/333. C (2010)/4893, OJ 333/2010.

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economic activity, the Court concluded that AG2R could be considered an undertaking engaged in an economic activity.[82] Furthermore, the CJEU concluded that granting monopoly rights to an insurance company responsible for managing a supplementary private health insurance scheme could be justified under the SGEI exception.[83]

Regardless of the fact that the Commission and the CJEU have never applied the SGEI exception to a complementary or substitutive private health insurance scheme, certain parallels and conclusions can be drawn based on the above cases. Nikolić has extended the Commission's and the Court's application of the SGEI concept to the complementary private health insurance in Slovenia. He concluded, in line with Mossialos and Thompson's predictions,[84] that Slovenia had an even stronger case when applying the SGEI exception to its complementary private health insurance scheme than Ireland did in the *BUPA* case. According to his findings, government intervention in Slovenian complementary private health insurance along the lines of the Irish intervention analysed in the *BUPA* case could also be justified under the SGEI exception with an even greater degree of conviction.[85] Based on the analysed cases and the nature of substitutive private health insurance, despite the absence of CJEU case law, one could reasonably assume that the SGEI concept could also be applied to substitutive private health insurance with even greater legitimacy than to supplementary or complementary private health insurance.

B. *Compatibility of Health Insurance Schemes with Free Movement Rules*

The same three categories outlined in the previous section can also be distinguished upon assessing the compatibility of government intervention in health insurance schemes with free movement rules. When considering whether a health insurance scheme is excluded from the application of free movement rules, the view of the CJEU is consistent with its view regarding the exemption from the application of competition rules. In *García v Mutuelle de Prévoyance Sociale d'Aquitaine*, the CJEU interpreted Article 2(1)(d) of the First Non-life Insurance Directive and Article 2(2) of the Third Non-life Insurance Directive in line with the criteria for defining a health insurance activity as a non-economic activity (non-economic service of general interest).[86] It concluded that statutory social security schemes, such as compulsory health insurance, are excluded from the scope of the Non-life Insurance Directives (ie free movement rules).[87] The same interpretation could be

[82] *AG2R*, EU:C:2011:112, para 65; see also L Gyselen, 'Public Service and EU Competition Law' (2011) 2(6) *Journal of European Competition Law and Practice* 573.

[83] *AG2R*, EU:C:2011:112, paras 79–81; see also Gyselen, note 82 above, p 574.

[84] Thomson and Mossialos (c), note 4 above, 447.

[85] B Nikolić, 'Slovenian Complementary Health Insurance as a Service of General Economic Interest' (2015) 13(1) *International Public Administration Review* 49.

[86] See note 63 above.

[87] *José García and Others v Mutuelle de Prévoyance Sociale d'Aquitaine and Others*, C-238/94, EU:C:1996:132, para 16. For more, see J W van de Gronden, 'Free Movement of Services and the

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extended to Article 3 of the Solvency II Directive, which is an exact copy of the above-listed provisions of the Non-life Insurance Directives.

Even in the case of Dutch compulsory health insurance, which the Commission considered an economic activity and thus subject to competition rules, there has been consistency in the application of free movement rules. This is reflected through the informal and legally non-binding opinions by Commissioners Bolkestein and McGreevy who took the position that the Dutch compulsory health insurance scheme constituted a complete alternative to the statutory social security regime and, as such, fell within the scope of the Solvency II Directive.[88] Consequently, it was not exempted from the scope of free movement rules.

If a health insurance scheme is not subject to Article 3 of the Solvency II Directive (statutory social security schemes), meaning that it falls within the scope of free movement rules, specific legal provisions that restrict those rules can be justified under the health insurance exception enshrined in Article 206 of the Solvency II Directive (second category). Although EU institutions have never formally assessed the compliance of special material regulation with the health insurance exception or offered any official interpretation concerning the ambiguity of the health insurance exception, the analysis in the previous section, supported by the views of other researchers, indicates that special material regulation may be justified only in the case of substitutive private health insurance.

The only deviation from this position can be observed, albeit vaguely, in the Commission's decision in the *BUPA* case (supplementary private health insurance), where the Commission took a confusing approach. The Commission first restricted the assessment of compliance of the risk equalisation scheme with the competition rules by claiming, in two separate points (paragraphs 38 and 61), that the assessment was without prejudice to the analysis of compatibility with other relevant EU rules and in particular with the Third Non-life Insurance Directive.[89] Yet in paragraph 61, the Commission argued that even if the risk equalisation scheme were to be considered state aid, this alone would not amount to a violation of the Third Non-life Insurance Directive. This position is confusing for two reasons. First, it is somewhat of a contradiction to its position to limit its assessment only to competition rules. Secondly, if special material regulation in the form of a risk equalisation scheme does not *per se* amount to a violation of the Third Non-life Insurance Directive, as suggested by the Commission, it means that these provisions have to be justified under the health insurance exception (second category) or entirely exempted from the scope of the Third Non-life Insurance Directive (first category). The voluntary nature of the supplementary private health insurance scheme eliminates the latter

(F'note continued)
Right of Establishment. Does EU Internal Market Law Transform the provision of SSGI?' in U Neergaard, E Szyszczak, J W van de Gronden, and M Krajewskivan (eds), *Social Services of General Interest in the EU* (T.M.C. Asser Press, 2013), pp 137–39.

[88] F Bolkestein, note 42 above. Ministry of Health, Welfare and Sport (The Hague, 2003); McCreevy, note 46 above.

[89] See the third paragraph of Part III of this article.

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option, because it cannot be considered as a statutory social security system. Deductive reasoning leads to the following conclusion: the Commission considered that the risk equalisation scheme could potentially be justified under the health insurance exception, meaning that the Irish supplementary private health insurance could be considered to be a partial or complete alternative to the health cover provided by the statutory social security system (second category). The Directorate-General ('DG') for Competition thus hypothetically extended Bolkestein's interpretation, ie the position of the DG for Internal Market and Service DG GROW, to supplementary private health insurance. However, due to the hypothetical nature and vagueness of the Commission's position in the *BUPA* case and lack of any meaningful argumentation that would more clearly imply that the Irish supplementary private health insurance scheme could be considered to be a partial or complete alternative to the health cover provided by the statutory social security system, this consideration has little practical value.

C. Interim Conclusion

A comparative analysis of the compatibility of the basic types of health insurance schemes and the government interventions to which they have been subjected with free movement and competition rules reveals a divergence between the application of the two sets of rules. Such divergence does not appear for all of the basic types of health insurance, but only in relation to complementary and supplementary private health insurance.

The analysis of compulsory health insurance reveals that it is generally exempted from the scope of competition and free movement rules (first category). Even in the case of the Dutch compulsory health insurance, the outcome was the same irrespective of the legal basis of the case. Government intervention might be justified under the SGEI exception if the case is based in competition law, or under the health insurance exception if the case is based in free movement law (second category). This approach indicates the convergence between the application of competition and free movement rules in the field of compulsory health insurance.

When comparing the compatibility of health insurance schemes that are not excluded from the scope of competition and free movement rules (second category), the result is different. The analysis reveals that if the case is based in competition law, the SGEI exception may be applied to justify government intervention that restricts competition rules in relation to all basic types of private health insurance schemes—supplementary, substitutive, and complementary. If on the other hand the basis of the case is free movement law, government intervention that restricts free movement rules may be justified under the health insurance exception only in the case of substitutive private health insurance. The convergence of EU rules as in the case of compulsory health insurance appears only in relation to substitutive private health insurance. In cases of complementary and supplementary private health insurance, there is a divergence between the application of competition and free movement rules. A specific material regulation (eg risk equalisation scheme) may be compatible with competition rules (under the SGEI exception) but not with free movement rules

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(under the health insurance exception). Therefore, the compatibility of government intervention in complementary and supplementary private health insurance schemes with EU law is largely dependent on the legal basis of the case and application of a particular set of rules. If the case is based in competition law, a government intervention such as risk equalisation schemes or open enrolment or community rating, is compatible with EU law. If the basis of the case is free movement law, the same set of government measures is not compatible with EU law. This leads to a divergence between competition and free movement rules which is not a result of the natural asymmetries between the two, but rather of pathological dissonance.[90] Such divergence negatively affects the coherence of EU law and creates further confusion among policy makers, national regulators, and insurance operators.

IV. AN ALTERNATIVE INTERPRETATION OF THE HEALTH INSURANCE EXCEPTION AND ITS IMPLICATIONS

The analysis of the application of EU rules to health insurance reveals uncertainties with regard to when Member States can justify special material regulation of private health insurance and which specific legal provisions Member States can impose. These uncertainties are a result of the lack of clarity of the health insurance exception. A contentious interpretation of the vague health insurance exception, offered by Commissioner Bolkestein, and the approach subsequently taken by the European Commission and the CJEU in assessing the compliance of government intervention in private health insurance have led to a divergence in the application of EU law, which further increases uncertainties around the legality of government interventions. The aim of this section is to examine whether an alternative interpretation of the health insurance exception, one conceptualised around a contemporary understanding of private health insurance as a socio-economic institution aimed at achieving a highly competitive social market economy (Article 3(3) of the Treaty on European Union), might overcome the uncertainties that have been highlighted in previous sections and increase the coherence of EU law. In other words, can an alternative interpretation of the health insurance exception justify government restrictions on free movement rules in complementary and supplementary private health insurance?

The classification of private health insurance into basic types does not determine the true nature of the insurance cover or the socio-economic role of each individual insurance scheme. It is merely a theoretical classification based on the fundamental features of the different insurance schemes. Even health insurance schemes that fall under the same basic type sometimes differ considerably as to their socio-economic role. Some private health insurance coverage offers benefits that constitute an important, one could even say fundamental, part of the social security system, while others offer benefits that go beyond the basic coverage provided by the social security system. This distinction plays an essential role for understanding and justifying government intervention in private health insurance.

[90] For more on natural asymmetries, see Gallo, note 53 above.

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The Third Non-life Insurance Directive introduced the health insurance exception to assimilate private health insurance into statutory health insurance. According to the proposal for the Third Non-life Insurance Directive, the justification for this assimilation was the need to guarantee access to healthcare (universal health coverage) through access to social health insurance or private health insurance (material regulation).[91] The aim of the health insurance exception is therefore to justify government intervention in private health insurance where insurance provides universal health coverage. EU countries with a Bismarckian healthcare system pursue universal health coverage through access to compulsory health insurance. Compulsory health insurance can be described as a 'basket or package of essential services or benefits' prescribed by law, which are available to the entire population regardless of individuals' ability to pay for them.[92] Bolkestein's interpretation of the health insurance exception is extremely restrictive in its assessment of whether private health insurance provides universal health coverage. A key element in this consideration is the basket of benefits provided by the given private insurance scheme. Only private health insurance which provides the same benefits as are provided by compulsory health insurance can be assimilated into statutory health insurance. Private insurance offering benefits that go beyond the basic compulsory health insurance coverage therefore cannot be subject to government intervention, because it does not provide for universal health coverage. According to this interpretation, complementary and supplementary private health insurance schemes do not provide the same benefits as compulsory health insurance, which means that they do not provide universal health coverage. The article will hereafter demonstrate that justification for government intervention could also be extended to other types of private health insurance based on a contemporary understanding of the nature and role of private health insurance cover. In order to extend the justification for government intervention under the health insurance exception to other health insurance schemes, one would have to demonstrate that the private insurance scheme (supplementary or complementary) provides universal health coverage.

To do so, one has to understand the nature of health cover offered by compulsory health insurance and private health insurances. Compulsory health insurance that aims to guarantee universal health coverage is an essential part of any social security system. The conventional theory of health insurance has highlighted several inherent deficiencies in compulsory health insurance.[93] One such deficiency is moral hazard, which is most often reflected in overutilisation and rising health expenditures.[94]

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[91] For more, see the proposal for the Third Non-life Insurance Directive, especially the explanation to Article 43a of the Third Non-life Insurance Directive.

[92] See also D Stuckler, A B Feigl, S Basu, and M McKee, 'The Political Economy of Universal Health Coverage' (Montreux, 2010) Background paper for the global symposium on health systems research, first global symposium on health research, p 12.

[93] For more on deficiencies, see C Normand and A Weber, *Social Health Insurance, A Guidebook for Planning*, 2nd ed (WHO, 2009).

[94] Ibid, p 120. Nyman presented an alternative theory which defies the findings of the conventional theory by arguing that moral hazard increases welfare. J A Nyman, *The Theory of the Demand for Health Insurance* (Stanford University Press, 2002).

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In order to rein in rising health expenditures caused by the overutilisation of health services, many countries have introduced statutory user charges (co-payments) or other forms of cost-sharing. In doing so, they have not changed the nature or role of the compulsory health insurance cover, but have merely modified the mechanism of financing the basket of benefits provided by the compulsory health insurance in order to improve the efficiency of the system. Statutory user charges are an integral part of compulsory health insurance because they cover the same set of benefits as compulsory health insurance. If patients do not pay the user charges when they receive certain benefits that are subject to user charges (ie medical services), they are not entitled to the benefits even though such benefits are included in the basket of essential benefits.[95] Some benefits in this basket are entirely covered by compulsory health insurance, meaning that they are not subject to user charges, while the majority of benefits are covered only partially. For a better understanding, we can analyse Slovenian compulsory health insurance. The entire basket of benefits provided by Slovenian compulsory health insurance amounted to 2.1 billion euros in 2012. Of this amount, only 0.8 billion euros were used to cover benefits that were fully covered by compulsory health insurance, whereas 1.3 billion euros were used to cover benefits subject to user charges.[96] Fully covered benefits made up a less than 40 percent of the entire basket. This indicates their limited scope and at the same time makes it impossible to argue that universal health coverage or *de facto* access to healthcare can be guaranteed only through benefits that are entirely covered by compulsory health insurance. Benefits subject to user charges represent a considerable share of the whole basket of benefits and a large volume of the assets dedicated to guaranteeing universal health coverage. User charges are therefore significant, if not indispensable, for the *de facto* provision of access to healthcare.

Paradoxically, user charges are not only an essential part of universal health coverage, but they also create a number of obstacles that prevent access to healthcare. The most important are the share and size of user charges. User charges are set by legislation, and in the case of Slovenia, they cover between 10 and 90 percent of the cost of the individual compulsory health insurance benefit which is subject to a user charge.[97] The size of user charges varies significantly, from a couple of euros to over 20,000 euros (the highest one-time user charge for hospital services in Slovenia in 2013).[98] This maximum is equivalent to twenty times the net monthly salary in Slovenia in 2013, and thus represents a catastrophic medical expense that undoubtedly prevents *de facto* access to healthcare. The financial risk associated with statutory user charges is the general reason behind the creation of complementary private health insurance

[95] There are exceptions ('safety nets') for the financially disadvantaged population. Usually they are not subject to user charges or their user charges are covered by other sources.

[96] P Došenović Bonča, '*Dileme in rešitve financiranja slovenskega zdravstva*' in M Tajnikar (ed), *Prenova gospodarskih vidikov slovenskega zdravstva* (Ljubljana, 2016), p 64.

[97] Statutory user charges are determined by state authorities (legislation, the government, or the managing body of the statutory health insurance).

[98] The services with the highest user charges were needed by more than 8,000 patients in 2013. A Mikeln, '*Pomen zasebnih sredstev za dolgoročno stabilnost zdravstvenega sistema*', lecture at the conference Zdravstvena polemika: Kakšna bo cena vašega zdravja v prihodnje (Ljubljana, 2014).

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that covers statutory user charges, which is essentially a risk pooling mechanism. Its paramount and often only objective is to cover statutory user charges, as is the case in Slovenia. France has expanded complementary private health insurance that covers statutory user charges by allowing insurance operators to offer additional benefits.

As highlighted above, statutory user charges are by their nature an integral and inseparable part of compulsory health insurance. A significant share and volume of assets dedicated to covering benefits subject to user charges further proves their indispensable role in providing universal health coverage. Due to the enormous shares and excessive rates of certain user charges, they may represent an obstacle to access to healthcare and, as such, undermine the objective of compulsory health insurance. To mitigate this risk, complementary private health insurance that covers statutory user charges was created. It provides exactly the same benefits as those covered with user charges, which are an integral part of the compulsory health insurance. As such, it has the same role in the social security system as user charges: to provide universal health coverage. According to this view, complementary private health insurance covering statutory user charges is in line with the justification for the assimilation of private health insurance into statutory health insurance. Following the reasoning behind Bolkestein's interpretation of the health insurance exception, complementary private health insurance covering statutory user charges can be considered a partial alternative to health coverage provided by the statutory social security system, because it represents an alternative to an indispensable part of a compulsory health insurance scheme, ie statutory user charges. The fact that complementary private health insurance operators provide additional benefits on top of statutory user charges and by doing so go beyond the basket of benefits provided by compulsory health insurance does not change the fact that they are considered a *partial* alternative to health coverage provided by the statutory social security system. The introduction of elements of competition to encourage insurance operators to operate in the most effective way and to offer consumers innovative insurance products, which is the motive behind providing additional benefits, does not in any way compromise the alternative nature of the insurance.

Application of the same line of reasoning to complementary private health insurance that covers excluded services and to supplementary private health insurance leads to a different conclusion. The main reasons are the nature of the private health insurance cover and the role of the cover in providing universal health coverage. Although their contribution to providing access to healthcare cannot be disputed, this differs significantly from the contribution of compulsory health insurance. Complementary private health insurance that covers excluded services provides benefits that are entirely excluded from compulsory health insurance, while supplementary private health insurance provides benefits that go beyond compulsory health insurance cover. In both cases, there is a marked disconnection between the benefits provided by compulsory health insurance that aims to provide universal health coverage and the benefits offered by supplementary private health insurance or complementary private health insurance that cover excluded services. The role of both private health insurance schemes in a social security system is not to provide universal health coverage but to provide access to healthcare in addition to universal health

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coverage. This is in contradiction with the aim of the health insurance exception, which is to justify government intervention in private health insurance where insurance provides universal health coverage. The alternative interpretation therefore does not support the claim that government intervention in supplementary private health insurance or complementary private health insurance covering excluded services can be justified under the health insurance exception.

V. CONCLUSIONS

This article demonstrates the uncertainties surrounding the implications for government intervention (eg special material regulation aimed at ensuring access to healthcare) in the health insurance market and the divergence between the application of competition and free movement rules in the field of private health insurance. It offers an alternative interpretation of the health insurance exception enshrined in Article 206 of the Solvency II Directive that draws on a contemporary understanding of private health insurance as a socio-economic institution aimed at achieving a highly competitive social market economy. Use of this alternative interpretation extends the applicability of the health insurance exception from substitutive private health insurance to complementary private health insurance that covers statutory user charges, while still barring its application to complementary private health insurance that covers excluded services and supplementary private health insurance. As a result, the alternative interpretation allows for the convergence of the application of competition and free movement rules relating to complementary private health insurance that covers statutory user charges, which enhances the coherence of EU law. Furthermore, this approach leads to a clearer definition of national regulatory competences and eliminates uncertainties concerning the implications for government intervention in complementary private health insurance schemes that cover statutory user charges. This would strongly benefit countries where complementary private health insurance covers statutory user charges, eg Slovenia, France, and Croatia. Based on this alternative interpretation, these countries could justify special material regulation, aimed at ensuring access to healthcare through the access to the complementary private health insurance, under the health insurance exception and thus improve the compliance of their national health insurance systems with EU law.

On the other hand, the alternative interpretation has failed to justify government intervention aimed at ensuring access to healthcare through access to complementary private health insurance that covers excluded services and supplementary private health insurance. Divergence in the application of EU law is still present in both cases. Even an approach to overcoming the divergence between competition and free movement rules proposed by Gallo and Mortelmans cannot eliminate this inconsistency in the application of EU law. They suggested the application of Article 106(2) TFEU to the free movement provisions as a basis for convergence.[99] While this approach provides a basis for convergence, due to the harmonisation objective

[99] Mortelmans, note 53 above.

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of secondary legislation (Solvency II Directive), it would ultimately fail to overcome the divergence we discuss.[100] In summary, government restrictions on free movement rules (the Solvency II Directive) in the field of complementary private health insurance covering excluded services and supplementary private health insurance cannot be justified under the health insurance exception or under the SGEI exception.

[100] See note 60 above.

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