

**Sarah Thomson and Elias Mossialos**

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European Union: the implications of single  
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**Abstract**

This paper examines the implications of the single market in insurance for regulation of private health insurance in the European Union. It considers areas of uncertainty in interpreting the third non-life insurance directive, particularly with regard to when and how governments may regulate private health insurance, and questions the Directive's capacity to promote consumer and social protection in health insurance markets. The Directive reflects the regulatory norms of the late 1980s and early 1990s, when boundaries between 'social security' and 'normal economic activity' were still relatively well defined in most member states. Today these boundaries are increasingly blurred, and as governments look to private health insurance to ease pressure on public budgets, uncertainty about the scope of the Directive and concerns about its restrictions on material regulation are likely to grow.

**Key words**

European Union, government regulation, voluntary health insurance

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## 1. Introduction

The European Union (EU) has traditionally considered health and health systems to be subject to the subsidiarity principle, a view confirmed by successive European treaties. In practice, however, there are a number of health-related areas in which EU policies directly or indirectly provide a framework for national legislation or override national competence all together. Obvious cases involve public health activities such as epidemiological surveillance, control of communicable diseases and rules about labelling of tobacco products. In other areas the influence of EU law, although significant and growing, has been less visible; for example, the free movement of people in search of treatment abroad and the freedom to provide health services, including insurance, across national borders (Mossialos and McKee 2002).

In 1992 the European Commission (hereafter referred to as ‘the Commission’) established a regulatory framework intended to enhance competition and consumer choice in markets for all types of non-life insurance including, for the first time, markets for health insurance. To facilitate the free movement of health and other non-life insurance services throughout the single European market, the introduction of the third non-life insurance directive removed barriers to entry and outlawed various forms of government intervention. For example, governments can no longer impose price and product controls in private health insurance markets, except where these form a ‘partial or complete alternative’ to statutory health insurance (European Communities 1992).

This paper examines the implications of the single market in insurance for regulation of private health insurance in the European Union. In doing so it considers areas of uncertainty in interpreting the third non-life insurance directive (referred to here as ‘the Directive’), particularly with regard to when and how governments may regulate private health insurance. As in other spheres of EU legislation, interpretation largely rests on the jurisprudence of the European Court of Justice (ECJ), so clarity may come at a high cost and after considerable delay. The paper also questions the Directive’s capacity to promote consumer and social protection in health insurance markets. In many ways the Directive reflects the regulatory 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 (White 1999). Today these boundaries are increasingly blurred, and as governments in old and new member states look to private health insurance to ease pressure on public budgets, uncertainty about the scope of the Directive and concerns about its restrictions on regulation are likely to grow.

Our study is based, where possible, on discussion of ECJ rulings and cases in which the Commission has considered national regulation of private health insurance to have infringed the Directive or contravened other forms of EU legislation. Where actual examples are lacking, our analysis is, inevitably, more speculative. In the following section we summarise the main changes brought about by the Directive and its initial impact on regulation of private health insurance in the European Union. A subsequent section examines the issue of uncertainty as to when and how governments can intervene in private health insurance markets (that is, where health insurance is voluntary and paid for privately by individuals and/or their employers). The paper concludes with a discussion of key points.

## **2. The introduction of the third non-life insurance directive and regulation of private health insurance in the European Union**

Markets for health insurance suffer from inefficiencies triggered by the nature of health risks, asymmetrical information between insurers, consumers and regulators and the absence of perfect competition (Barr 1998). As a result, voluntary (private) insurance rarely achieves an adequate quantity or quality of population coverage, a failure starkly illustrated in the United States, where one in three adults under the age of 65 has no health insurance, sporadic cover or cover that exposes them to high out of pocket health care costs (Schoen *et al* 2005).

For efficiency and equity reasons governments intervene in markets for health insurance in several ways. Many choose to organise statutory (public) health insurance, typically combining compulsory risk pooling on a national or regional

scale with rules concerning levels of pre-payment through taxation or earmarked ‘contributions’, the range of services to be covered and the provision of benefits in kind (Rice 2001). Some allow health insurance to operate on a private basis subject to regulation intended to protect consumers and improve access. Less direct intervention may involve subsidising the price of private cover or favouring particular insurers – for example, by giving tax breaks to non-profit entities.

The majority of EU member states provide universal or near universal public coverage for health as part of a wider system of ‘social protection’. Private insurance offering ‘supplementary’ cover (see Table 1) accounts for less than 5% of total expenditure on health (Organisation for Economic Co-operation and Development 2003). In some member states, however, private insurance also contributes to social protection, providing cover that substitutes for or complements statutory insurance. Without this ‘substitutive’ and ‘complementary’ private cover, which may be purchased by large proportions of the population and usually accounts for 10-20% of total health expenditure, people would not be sufficiently protected from financial risks associated with ill health.

Historically, the extent to which EU governments regulated private health insurance was determined by the role of private cover in the health system, aspects of market structure (such as the number and type of insurers in operation) and political ideology. Two broad approaches prevailed: minimal financial or prudential regulation of supplementary markets, focusing on solvency levels, and heavier material regulation of substitutive markets, emphasising control of prices and products. While both approaches aimed to protect consumers from insurer insolvency<sup>1</sup>, material regulation also endeavoured to ensure access to health care. Under the subsidiarity principle governments were free to decide on the appropriate form of regulation required in a given context.

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<sup>1</sup> Financial or prudential regulation focuses on ex post scrutiny of an insurer’s financial returns on business. Material or contract regulation involves ex ante scrutiny of an insurer’s policy conditions and premium rates on the grounds that this eliminates the potential for insolvency.

**Table 1 The role of private health insurance in EU health systems**

Role	Coverage and examples
Substitutive	For people excluded from some or all aspects of statutory cover (eg higher-income households in the Netherlands prior to 2006) or allowed to choose between statutory and private cover (eg higher-income households in Germany)
Complementary	Services excluded (eg dental care, alternative treatment) or only partially covered by the state (eg statutory user charges)
Supplementary	Increased choice of provider and faster access to services

Source: Mossialos and Thomson 2004

In the last thirty years the Commission has successfully removed this freedom by introducing a series of directives aimed at creating a single market in insurance (European Communities 1973; European Communities 1988; European Communities 1992). The first and second generation of insurance directives were limited to the cover of ‘large risks’ of a commercial nature considered small enough, in relation to the size or status of their policy holders, not to require special protection (for example, aviation or marine insurance and re-insurance) (Merkin and Rodger 1997; Mabbett 2000). ‘Mass risks’ involving individuals and small businesses were excluded on the grounds that they required special protection because their policy holders would not normally have the ability to judge all the complexities of the obligation they undertook in an insurance contract (Nemeth 2001). The third generation of insurance directives extended the application of single market legislation to all types of risks, including mass risks such as health insurance.

The third non-life insurance directive gives insurers full freedom to provide services throughout the European Union, with or without a branch presence, through the introduction of a single system for the authorisation and financial supervision of an insurance undertaking by the member state in which the undertaking has its head office (‘home country control’); the mutual recognition of systems of authorisation and financial supervision; and the harmonisation of minimum solvency standards (European Communities 1992). ECJ case law confirms that insurance activities fall under the scope of the Directive when they are carried out by insurance undertakings

at their own risk, following insurance techniques, and on the basis of contractual relationships governed by private law (European Court of Justice 1991; European Court of Justice 2000; Hatzopoulos 2002).

To protect the freedoms outlined above and prevent barriers to competition, the Directive brought about three key changes for private health insurance. First, by requiring governments to abolish existing product and price controls, the Directive accords primacy to the financial approach to regulation, rendering the material model redundant and, in some cases, illegal. Second, it requires governments to liberalise markets for private health insurance, opening them to competition at national and EU levels. Third, it prevents governments from discriminating among insurers on the basis of legal status.

Material control in the form of national rules requiring the prior approval or systematic notification of policy conditions, premium rates, proposed increases in premium rates and printed documents insurers use in their dealings with policy holders are no longer permitted (articles 29 and 39). Such rules played an important regulatory function in several countries, notably France, Germany and Italy. However, most member states amended existing laws or passed new laws to comply with the Directive. Legislative changes generally involved the introduction of tighter solvency controls, although some also resulted in the loosening or outright abolition of price and product controls. France proved to be the exception in this respect, contravening the Directive by continuing to insist that insurers notify the supervisory authority when they launched a new product. The ECJ ruled against the French government in May 2000 (European Commission 2000; European Court of Justice 2000).

Although the Directive prevents governments from introducing regulatory measures that go beyond solvency requirements, member states do retain limited residual powers to protect policy holders. For example, if the home supervisory authority fails to prevent an insurer from infringing the host country's domestic law, the host supervisory authority may take action, but only as a last resort (Merkin and Rodger 1997). More importantly, the host supervisory authority may impose specific measures, in the form of restrictions on insurance contracts, in the interest of the 'general good', if contracts covering health risks 'serve as a partial or complete

alternative to health cover provided by the statutory social security system' (article 54.1). Where this is the case, the government can require private insurers to 'comply with the specific legal provisions adopted by that member state to protect the general good in that class of insurance' (article 54.1) (European Communities 1992).

Article 54.2 and recitals to the Directive lists the types of legal provisions that may be introduced if private cover provides a partial or complete alternative to statutory cover: open enrolment, community rating, lifetime cover, policies standardised 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 equalisation schemes (referred to as 'loss compensation schemes') and the operation of private health insurance on a technical basis similar to life insurance. Measures taken to protect the general good must be shown to be necessary and proportional to this aim; not unduly restrict the right of establishment or the freedom to provide services; and apply in an identical manner to all insurers operating within a member state.

Governments in Germany and the Netherlands have used article 54.1 to justify intervention in their substitutive markets, where risk selection by private insurers prevents some older people and people with chronic illnesses from buying an adequate and affordable level of private cover (Wasem 1995; Rupprecht *et al* 2000). Regulatory measures in both countries (prior to 2006 in the Netherlands) include the provision of lifetime cover, the introduction of policies with mandatory pooling, standardised minimum benefits, guaranteed prices and the establishment of direct or indirect cross subsidies from those with private to those with statutory coverage. German private insurers are subject to further regulation concerning the way in which they fund substitutive cover (on a similar basis to life insurance) and the provision of information to potential and existing policy holders. The Irish market is also tightly regulated; insurers must offer open enrolment with community rating and the Minister of Health has the power to trigger a risk equalisation scheme if this is deemed necessary by an independent regulatory body.

In contrast, regulation of most markets for complementary and supplementary cover tends to focus on ex post scrutiny of financial returns on business to ensure that insurers remain solvent. Insurers are permitted to reject applications for cover,

exclude cover of or charge higher premiums for individuals with pre-existing conditions, rate premiums according to risk, provide non-standardised benefit packages and offer annual contracts, while benefits are usually provided in cash rather than in kind.

### **3. Implications for government intervention in health insurance markets**

At first sight the Directive appears to give governments significant scope for regulating private health insurance under the general good principle, which broadly refers to any legislation aimed at protecting consumers. On closer examination, however, interpretation of the principle is shown to be problematic in two areas: first, the issue of what is meant by complete or partial alternative to statutory health insurance; and second, what types of intervention are necessary and proportional.

These problems arise because there is no agreed definition of the general good; interpretation relies on ECJ case law. Following complaints about the absence of a definition, the Commission tried to clarify when and how the general good might be invoked in the insurance sector, but its interpretive communication failed to provide new information (European Commission 2000). Calls for further clarification persist on the grounds that the lack of a definition creates legal uncertainty, while the process of testing questionable use of the general good through the courts is prohibitively lengthy and expensive (Mossialos and Thomson 2004). We discuss interpretation of the general good in relation to when and how governments can intervene in markets for private health insurance.

#### **When can governments intervene?**

Uncertainty about when the general good can be invoked to justify material regulation arises from the need to distinguish between private health insurance that serves as a partial or complete alternative to statutory health insurance, as set out in article 54.1, and private cover that does not fall into such a category. Circumstantial factors suggest that the distinction hinges on whether or not private health insurance plays a substitutive role. For example, article 54 was inserted during negotiations prior to the

drafting of the Directive at the instigation of the German, Dutch and Irish governments (Association Internationale de la Mutualité 1999). As a result of lobbying from member states with substitutive markets, the regulatory measures outlined in article 54.2 are an exact match of those already in place in Germany, the Netherlands (prior to 2006) and Ireland, and so far the stringent regulatory frameworks applied to private insurers in these three countries have not been challenged by the Commission.

Recent policy developments in the Netherlands shed further light on this crucial distinction. Since the late 1990s successive governments have put forward proposals to replace the existing dual system of statutory cover for lower earners and voluntary private cover for higher earners with a single, universal system of health insurance. Uncertainty about how to interpret article 54 persuaded a previous government to propose a public rather than private system (Maarse 2002), but the current government introduced a private system in 2006. Under the new system health insurance is operated by private insurers and governed by private law. Regulatory measures include open enrolment, lifetime cover, community-rated premiums set by insurers, a package of minimum benefits in kind or cash defined by the government and a risk equalisation scheme (Hamilton 2003; Ministry of Health Welfare and Sport 2005).

Before the private system came into force, concerns about relying on article 54 to justify such extensive regulation prompted the Dutch Minister of Health to request clarification from the (then) Commissioner for the Internal Market Frits Bolkestein (Hoogervorst 2003). In his response, Bolkestein notes that the private system cannot be excluded from the scope of the Directive as the insurers involved are carrying out ‘an insurance activity’. However, the regulatory measures can be justified under article 54 because the system, though private, constitutes a complete alternative to statutory health insurance and the regulations (with some caveats; see below) ‘appear necessary to ensure legitimate objectives pursued by the Dutch government’ (Bolkestein 2003: 2). The Commission has recently confirmed this position in response to written questions put forward by Members of the European Parliament (McCreevy 2005; McCreevy 2006).

Bolkestein goes on to point out that it would not be proportionate to apply the proposed regulatory measures ‘to any complementary insurance cover offered by private insurers which goes beyond the basic social security package of cover laid down by the legislation’ (Bolkestein 2003: 3). His letter strongly suggests that ‘partial or complete alternative’ can be understood in terms of the benefits provided by a particular insurance scheme. Substitutive private health insurance constitutes an alternative to statutory cover because it replaces statutory benefits for those who are excluded from some aspects of the statutory system (higher earners in the Netherlands and Ireland) or those who are allowed to choose statutory or private cover (higher earners in Germany). Whether the substitutive cover is a partial or complete alternative depends, presumably, on whether the benefits it provides are ‘partial’ (cover of mainly outpatient care in Ireland) or ‘complete’ (cover of outpatient and inpatient care in Germany and the Netherlands). Conversely, complementary and supplementary cover cannot be construed as alternatives to statutory cover because they offer benefits in addition to those offered by the statutory system. Therefore private health insurance is only eligible for material regulation if it covers benefits offered by statutory health insurance.

But ‘partial alternative’ could be interpreted in other ways. For example, the logic behind allowing governments to intervene in substitutive markets is implicitly based on the assumption that purely financial regulation of private insurers’ solvency levels will suffice for the purposes of consumer protection but will not be enough to ensure access to health care when private cover fulfils a social protection function. If this is the case, what are the implications for regulation of non-substitutive private health insurance that also fulfils this function?

Where the statutory benefits package (the basic social security package of cover mentioned by Bolkestein) is relatively narrow or subject to extensive co-payments, it could be argued that individuals do not have full protection from financial risks associated with ill health unless they purchase complementary private health insurance covering excluded (and effective) services and / or statutory user charges. In such cases complementary cover provides a degree of social protection, thereby justifying material regulation to prevent private insurers from selecting risks, but rules to ensure affordable access to private cover might contravene the Directive.

Markets for complementary cover are likely to develop and expand in future, particularly in the context of constraints on public funding. Policy makers increasingly put forward the idea of offering a defined and more restricted package of statutory benefits (perhaps based on proven cost-effectiveness), usually on the understanding that the statutory package can be complemented by voluntary take-up of private insurance covering less effective and non-cost-effective services. In practice, however, efforts to set priorities and measure cost-effectiveness tend to be limited by technical, financial and political considerations, making it easier for governments to exclude whole areas of service, such as primary care, outpatient drugs or dental care, than single interventions of low cost-effectiveness (Ham and Robert 2003). This means that complementary insurance often covers a range of necessary and cost-effective services.

Governments in some countries have resorted to introducing or raising user charges to supplement public resources, again under the assumption that complementary cover will bridge the funding gap. In France the proportion of the population covered by private health insurance reimbursing statutory user charges grew from 33% in 1960 to 86% in 2000 and accounts for about 13% of total expenditure on health (Sandier *et al* 2004). Complementary cover of statutory user charges introduced in Slovenia in 1993 now covers around 70% of the population and accounts for over 11% of total health expenditure (Albrecht *et al* 2002). Recognising that this type of private cover contributes significantly to social protection, the French government has paid for complementary cover for people with low incomes since 2000, raising the proportion of the population covered to over 90%, while the Slovenian government enacted legislation in 2005 to require private insurers to offer open enrolment and community-rated policies accompanied by a risk equalisation scheme (see below).

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

or buying private cover, which is why, when the Irish market was liberalised in 1994, private insurers were subject to quite stringent regulation (see below). However, the level of public benefits has gradually increased so that low-income households and all those aged 70 and over have free access to all types of care, while non-elderly higher-income households have access to services that are predominantly publicly-funded but subject to co-payments up to a maximum of €550 peryear (McDaid and Wiley 2006). In 2006 the government further increased the number of people eligible for free primary care (Department of Health and Children 2006). The regulatory framework originally justified under article 54.1 could now be questioned on the grounds of whether or not private health insurance in Ireland still constitutes a partial or complete alternative to statutory health insurance. In other words, it is debatable whether the Irish market for private health insurance continues to play a significant role in providing social protection.

Material regulation that hinges on Bolkestein's distinction between 'basic' and complementary or supplementary cover may also be problematic if the latter is offered by the same insurers responsible for providing statutory health insurance. Insurers could take advantage of the absence of regulation governing access to private cover to exploit consumers through the practice of conditional sale (that is, terminating a voluntary contract if an individual moves to a rival insurer for statutory cover). Although conditional sale poses a barrier to competition and is likely to infringe competition rules, it has been problematic in the Netherlands (Mossialos and Thomson 2004).

### **How can governments intervene?**

The second area of uncertainty concerns the types of intervention that might be considered necessary and proportional. Article 54.2 and recitals to the Directive list the legal provisions governments can introduce where private cover provides a partial or complete alternative to statutory cover. However, it is not clear if the list should be understood as being exhaustive, in which case unlisted interventions would contravene the Directive; and again, there is the problem of interpreting partial or complete alternative. In this section we discuss interventions that have been disputed or may be contentious.

### *Financial transfers*

Risk equalisation schemes are a direct form of intervention typically involving financial transfers from insurers with low risks to insurers with high risks. They are intended to ensure access and fair competition by lowering incentives for insurers to select risks in markets with open enrolment and community-rated premiums (van de Ven and van Vliet 1992; Puig-Junoy 1999), but their existence has been challenged in the Netherlands, Ireland and Slovenia.

Bolkestein's letter raised concerns that the Dutch government's risk equalisation scheme, part-financed from public funds, might contravene EU rules about state aid (Bolkestein 2003: 3), but the Commission has now authorised the transfer of public funds as, in its opinion, the aid does not unduly distort competition (European Commission 2005; McCreevy 2005). Nevertheless, the fact that a regulatory measure specifically mentioned in the Directive as permissible under article 54.1 could be seen to be contentious, even when it has been agreed that the Dutch system is a 'complete alternative', reinforces the potential for confusion. Despite further assurances from the European Commissioner for Competition (Reerink and Rosenberg 2005), Dutch analysts and politicians continue to question the legality of the risk equalisation scheme, noting that the ECJ will have the final say on whether or not the scheme is both necessary and proportionate (den Exter 2005; Meijer and Liotard 2005).

Risk equalisation in Ireland has been the subject of a complaint to the European Commission (even though it does not involve public funds) on the grounds that financial transfers between private insurers would constitute a form of state aid to the largest private insurer in the market. Prior to liberalisation in 1994 private health insurance in Ireland was mainly provided by Vhi Healthcare, a quasi-public body under the jurisdiction of the Department of Health. By 1994 Vhi Healthcare covered about 37% of the population (Department of Health and Children 1999). After liberalisation the Irish government relied on article 54 to maintain the existing regulatory framework which required insurers to offer open enrolment, community-rated premiums, minimum benefits and lifetime cover. The government also passed new legislation allowing it to establish a risk equalisation scheme to be activated by the government at the request of the independent Health Insurance Authority (HIA) if it became evident that private insurers were competing through risk selection rather

than on the basis of administrative efficiency and quality (Department of Health and Children 1999).

BUPA Ireland (a branch of the UK insurer BUPA), the larger of the two private insurers currently operating in the Irish market, lodged a complaint with the Commission in 1998, arguing that the risk equalisation scheme was a form of state aid that distorted competition and discouraged cost containment in the health sector (BUPA Ireland 2003). In response, the Irish government argued that the Directive allowed member states to exercise reasonable discretion with respect to the general good and that the scheme had particular regard for the need for proportionality (Department of Health and Children 2001). Five years later the Commission issued a decision stating that financial transfers made under the scheme would not constitute state aid for two reasons. First, the scheme would legitimately compensate insurers for obligations they faced in carrying out a service of general economic interest; and second, this compensation is limited to what is necessary and proportionate to ensure stability in a community-rated market for private health insurance (European Commission 2003). The decision also noted that the scheme would not distort competition, penalise efficiency or create perverse incentives that might lead to cost inflation, nor was it likely to deter insurers from entering the market as new entrants can exclude themselves from the scheme for a period of up to three years. Even if financial transfers were to be considered a form of state aid, the Commission pointed out that this aid would not, by itself, amount to a violation of the Directive.

The Commission's decision is as noteworthy for what it abstains from commenting on as for what it confirms. It explicitly states that it assessed the risk equalisation scheme's compatibility with state aid rules 'without prejudice to the analysis of its compatibility with other relevant EU rules, and in particular with [the Directive]', emphasising that it was made independently of any consideration as to whether the Irish market could be regarded as a partial or complete alternative to cover provided by the statutory system (European Commission 2003: 8).

BUPA Ireland subsequently challenged the Commission's reluctance to consider whether the scheme infringed the Directive. Asking the ECJ to suspend the decision, it accused the Commission of misapplying the public service compensation test,

wrongly identifying open enrolment, community rating, minimum benefits and lifetime cover as public service obligations when they actually represent rules generally applied to all insurers offering private health insurance (European Court of Justice 2003). It also accused the Commission of failing to consider whether these obligations imposed a financial burden on Vhi Healthcare and whether the risk equalisation scheme would affect the development of trade contrary to the interests of the Community, and of failing to initiate a formal investigation procedure, given the complexity of the arguments and the economic analysis required. The Dutch and Irish governments and Vhi Healthcare have joined the legal proceedings in defence of the Commission and the issue has yet to be resolved. In December 2005 the Irish Minister of Health, acting on advice from the HIA, announced her intention to introduce risk equalisation from January 2006. BUPA Ireland and BUPA Insurance are challenging the legality of the scheme under Irish and European law (The Irish Times 2006).

The Irish proceedings will be of interest in Slovenia, where two out of the three insurance companies operating in the private health insurance market have challenged new legislation establishing a risk equalisation scheme. The largest insurer Vzajemna (a mutual association,) argued that the scheme would favour the two other (commercial) insurers and encourage risk selection, while the larger commercial insurer Adriatic argued that the scheme would distort competition (Adriatic 2005; Vzajemna 2005; Milenkovic 2006). Although the Slovenian High Court ruled in the government's favour in November 2005 (Toplak 2005), further legal challenges at national and EU level are possible, given that private health insurance in Slovenia plays an unarguably complementary role.

Other forms of financial transfer include direct or indirect cross-subsidies. In the Netherlands there has been some discussion about the legality of two cross-subsidies that applied prior to 2006: one from privately- to publicly-insured individuals, designed to compensate the statutory health insurance scheme for covering a disproportionate number of older people (the MOOZ scheme); and another from the privately insured under 65 years of age to cover the costs of standardised benefits and fixed prices for privately-insured individuals over 65 years old or in poor health (the WTZ scheme). In 2000 an independent advisory body suggested that these cross-subsidies contravened the Directive (Raad voor de Volksgezondheid en Zorg 2000),

but other analysts have argued that if the MOOZ contributions were regarded as a form of earmarked tax on private health insurance, they would fall under the fiscal competence of the Dutch government and would therefore be beyond the scope of the Directive (Palm 2002).

### ***Benefits***

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

#### *Minimum or standard benefits*

The Commission expected the single market in insurance to stimulate competition among insurers, precipitating efficiency gains and bringing consumers the benefits of wider choice and lower prices (European Commission 1998). A preamble to the Directive states that it is in policyholders' interest that they should have access to 'the widest possible range of insurance products available in the Community so that [they] can choose that which is best suited to [their] needs' (European Communities 1992).

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

To encourage competition based on price and quality (rather than risk selection), regulators can require insurers to offer a standard package of benefits, use standardised terms when marketing products, inform potential and existing policy holders of all the price and product options open to them and provide consumers with access to centralised sources of comparable information. However, the Directive

specifically outlaws product and price controls except where private health insurance constitutes a partial or complete alternative to statutory cover, and even in these circumstances control is limited to offering benefits standardised in line with statutory benefits; that is, the primary aim is to ensure that the privately insured have access to the same services as the publicly insured rather than to facilitate price competition. For example, governments in Germany and the Netherlands have required private insurers to offer older policy holders benefits that match statutory benefits (Mossialos and Thomson 2004).

In the absence of product regulation, liberalisation of health insurance markets in some member states has been accompanied by rising levels of product differentiation, with evidence suggesting that consumers may be confused by the proliferation of products on offer (Mossialos and Thomson 2004). For example, an official investigation into information problems in the market for supplementary private health insurance in the United Kingdom found that increased product complexity did not benefit consumers; rather, consumers sometimes paid more than they should and often purchased inappropriate policies (Office of Fair Trading 1998). An OECD study noted that as the diversity of schemes in the UK market rose, consumers faced increasing difficulty in comparing premiums and products, a concern echoed by consumer bodies in other member states (Organisation for Economic Co-operation and Development 2001).

Perhaps due to limited price competition and private insurers' limited ability to control costs, prices appear to have gone up rather than down in many member states. Research based on data from several member states shows that, during the 1990s, the compound annual growth rate of private health insurance premiums rose much faster than the average annual growth rate of total spending on health care (Mossialos and Thomson 2004).

### *Benefits in kind*

The provision of benefits in kind enhances social protection by removing financial barriers to accessing health care. Bolkestein's letter suggests that the Dutch government's proposed requirement for insurers offering substitutive private health insurance to provide a basic package of benefits in kind could infringe the free

movement of services by creating barriers for non-Dutch insurers entering the market and might need to be assessed for proportionality and necessity (Bolkestein 2003: 3). This raises concerns not only for the new Dutch system, but for statutory and substitutive private health insurance in other member states.

### *Differential treatment of insurers*

Under the Directive governments can no longer influence market structure (by restricting the provision of private health insurance to a single approved insurer or to statutory health insurance funds) or discriminate against particular types of insurer. For example, recitals to the Directive outlaw regulation preventing non-specialist or composite insurers from providing health insurance. When the German government transposed the Directive it had to abolish its rule excluding non-specialist insurers from entering the private health insurance market, but used its social law to prohibit employers' from contributing to policies offered by composite insurers, leading the Commission to refer Germany to the ECJ (European Court of Justice 2001).

National laws often distinguish between non-profit and for-profit institutions, sometimes resulting in preferential treatment of non-profit institutions, notably mutual associations, which have a long history of involvement in statutory and private health insurance in many member states, traditionally operating in different areas of the market from commercial insurers (Palm 2002). The special status accorded to mutual associations has given rise to difficulties under the Directive. For example, French mutual associations operate under a special 'Code de la Mutualité', which means they are subject to less rigorous rules on financial and prudential accountability than commercial insurers or provident associations (Palm 2002). Following a ruling by the ECJ the French government was forced to adopt a revised code tightening the solvency requirements for mutual associations and bringing national law in line with the Directive (European Court of Justice 1999; European Commission 2000).

Tax incentives in France, Belgium and Luxembourg favour mutual or provident associations over commercial insurers. The French government contravened the Directive by exempting mutual and provident associations from paying insurance premium tax (Mossialos and Thomson 2004). In 1993 the French Federation of Insurance Companies lodged two complaints against the French government for this

discriminatory tax policy. Their complaints were eventually upheld by the Commission in November 2001 and the French government was asked to abolish the tax exemptions in question. The Commission noted that while it recognised the specific role of mutual associations in providing services of general economic interest, it considered that the tax advantages granted to them were disproportionate to the burden they bore in undertaking such services, which only represented a small share of their activities (Palm 2002). However, the Commission allowed the government to continue to make selective corporate tax provisions for non-profit organisations, as this was considered to be a normal part of the fiscal system. In Luxembourg the existence of a ‘gentleman’s agreement’ between mutual associations and commercial insurers has prevented the latter from complaining about preferential tax treatment (Mossialos and Thomson 2004). The agreement rests on the understanding that mutual associations will not encroach on commercial insurers’ dominance of the market for pensions and other types of insurance.

Some argue in favour of treating mutual associations differently on the grounds that they provide better access to health services because they offer open enrolment, lifetime cover and community-rated premiums, whereas commercial insurers restrict access by rejecting applications, excluding the cover of pre-existing conditions and risk rating premiums (Rocard 1999; Palm 2002). In a market where mutual associations and commercial insurers operate side by side the latter may be able to undermine the former by attracting low risks with lower premiums, leaving mutual associations to cover high risks. However, while the distinction between non-profit and for-profit insurers is important in so far as an insurer’s profit status determines its motivation and influences its conduct, in practice there is considerable variation in the way in which mutual associations behave; in some member states their conduct may be indistinguishable from the conduct of commercial insurers. As it is not possible to make assumptions about an insurer’s conduct on the basis of its legal status it would be more appropriate to discriminate on the basis of conduct, favouring insurers who offer greater access to health services or, where appropriate, penalising those who restrict access.

#### 4. Discussion and conclusions

The EU regulatory framework established by the Directive places limits on national competence in the area of private health insurance. It relies on financial regulation to protect consumers, prohibiting material regulation such as price and product controls except where private cover constitutes a complete or partial alternative to statutory health insurance and so long as any intervention is necessary, proportionate and non-discriminatory.

There is no agreement as to what is meant by partial or complete alternative and the absence of a definition or guidance from the Commission has led to uncertainty and confusion among policy makers, regulators and insurers. Where the Commission has had opportunity to clarify this aspect of the Directive it has often sidestepped the issue, relying instead on rules about services of general economic interest to authorise (Ireland) or prohibit (France) government intervention. A key exception is Bolkestein's letter, in which he argues that article 54.1 ought not to be used to justify material regulation of complementary private health insurance.

Bolkestein's definition of complementary cover fails to recognise that this type of private health insurance increasingly contributes to social protection for those who purchase it, operating in an unofficial partnership with statutory health insurance where it offers reimbursement of statutory user charges and / or provides access to effective health services excluded from the statutory benefits package. In particular, complementary cover of statutory user charges tends to be purchased by a relatively high proportion of the population, making it regressive in financing health care (because it is not restricted to richer groups) and creating inequalities in access to health care (Wagstaff *et al* 1999).

If, as we have argued, the logic underlying article 54.1 is to permit material regulation where private health insurance fulfils a social protection function, then in either case obliging complementary insurers to offer open enrolment and community rating would be necessary to ensure equitable access to health care, while a risk equalisation scheme might be needed to lower incentives to select risks and to encourage

competition based on price and quality. The Irish experience highlights the complexity of the issues at stake and the difficulty caused by legal uncertainty.

In markets where private health insurance does not contribute to social protection the Directive assumes that financial regulation will be sufficient to protect consumers, but we have argued that solvency rules alone may not be adequate if health insurance products are highly differentiated. Information asymmetry exacerbated by product differentiation appears to be a growing problem in markets across the European Union and the Commission has not yet put in place mechanisms for monitoring anti-competitive behaviour by insurers.

Communications from the Commission have raised doubts about the compatibility of certain regulatory measures with competition rules; for example, the provision of benefits in kind. More attention should be paid to this issue, which could have significant implications for statutory as well as private health insurance.

The Directive reflects the regulatory norms of its time. When it was introduced in 1992 the Commission may have been convinced that it would provide ample scope for governments to protect consumers where necessary and would not jeopardise statutory arrangements. Article 54 would protect markets contributing to social protection, while in markets regarded as supplementary, the benefits of de-regulation (increased choice and competition resulting in lower prices) would outweigh concerns about consumer protection.

These assumptions are more problematic now, partly because there is no evidence to suggest that the expected benefits of competition have, as yet, materialised. Private health insurance premiums in many member states have risen rather than fallen in recent years, often faster than inflation in the health sector as a whole, while insurers' expansion across national borders has been limited to cross-border mergers and acquisitions rather than genuinely new entrants to the market (Mossialos and Thomson 2004). The assumptions are also problematic due to increased blurring of the boundaries between normal economic activity and social security; the latter is no longer the exclusive preserve of statutory institutions or public finance, a development likely to bring new challenges for policy makers.

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Champa Heidbrink  
Managing Editor  
LSE Health  
The London School of Economics and Political Science  
Houghton Street  
London WC2A 2AE

Tel: + 44 (0)20 7955 6840

Fax: + 44 (0)20 7955 6090

Email: [c.heidbrink@lse.ac.uk](mailto:c.heidbrink@lse.ac.uk)

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