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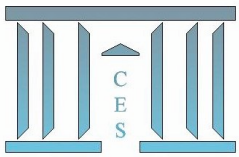

Regulating Private Health Insurance in France : New Challenges for Employer-Based Complementary Health Insurance

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2009.56

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http://ces.univ-paris1.fr/cesdp/CES-docs.htm
ISSN : 1955-611X

Regulating Private Health Insurance in France: New Challenges for Employer-Based Complementary Health Insurance

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ABSTRACT

In France, people obtain basic health insurance coverage through a public health insurance system. Although public coverage is comprehensive, substantial co-payments and deductibles are more and more required and individuals become increasingly dependant on private complementary health insurance, to be better reimbursed. In the context of strengthened constraints to control public health spending, the market for complementary cover is indeed likely to develop. This expansion has several implications for the regulation of private health insurance. Starting in the early 2000s, public policies have emphasized tools that directly motivate employers to provide group-insurance schemes. These include subsidies to employers for offering compulsory, supplementary coverage, and mandating social partners to negotiate the implementation of health coverage in every company, whatever its size or activity. Such changes tend, to some extent, to "re-couple" health insurance with companies. This paper explores the implications of this experience for France.

RÉSUMÉ

En France, l'assurance maladie de base relève du système public de l'assurance sociale. En dépit d'une couverture qui reste étendue, l'élargissement des co-paiements et des franchises rend nécessaire l'accès à une assurance santé complémentaire. Dans un contexte qui voit les contraintes pesant sur les dépenses publiques se durcir, le marché pour l'assurance complémentaire est de fait appelé à se développer. Cette tendance n'est pas sans conséquence sur la régulation de l'assurance maladie privée. Au début des années 2000, les autorités publiques se sont dotées d'instruments destinés à inciter les employeurs à mettre en place des dispositifs d'assurance de groupe rendus obligatoires pour les salariés en même temps qu'elles encourageaient les partenaires sociaux à négocier collectivement l'implémentation de couvertures complémentaires dans l'ensemble des entreprises, quels que soient leur taille ou secteur d'activité. Le papier explore ce qui est en jeu dans cette nouvelle forme de couplage entre l'assurance santé et l'entreprise.

MOTS CLÉS : Assurance-santé privée, protection sociale complémentaire d'entreprise

KEYWORDS: Private health care insurance, complementary employer-provided health insurance

JEL Classification: I 18 – G 22 – G 28 – J 33

[1] *This study is based on a research sponsored by the French Ministry of Health (MiRe). Earlier versions of this article were discussed at the 2008 Conference of Association d'Economie Sociale and at 2009 workshop in Paris1University (Seminar TemPs). In its present form it was presented at the SASE's 21st annual meeting (France, July 2009). We are grateful to Nicholas Sowels for its precious help in writing this paper in English.*

INTRODUCTION

This paper deals with complementary health insurance provided to people working in companies in France. Recent trends do show that complementary "private" insurance, especially through company schemes, is increasingly taking over from the compulsory "public" health insurance, which is a part of France's *Sécurité sociale* established in 1945. By giving firms and insurers new responsibilities, this process constitutes one of the key changes that would shape the future of the French health care financing system towards what, at first glance, could appeared to be a market-oriented system. Nevertheless, the state is not without capacity to develop and implement rules and governance mechanisms to ensure that private providers act in the public interest. Therefore marketization hypothesis has to be challenged by the analysis of the ways in which privatization appears and how market forces are affecting social health insurance. If several recent studies have explored the public-private mix and privatization in health care in health insurance (Maarse, 2006; Thomson *and al*., 2003; Tuohy *and al*., 2004), these issues have not been investigated much in France.[2] The purpose of this paper is to fill this gap with the aim to draw on several ways of analyzing the employer-based health benefits scheme, starting with a few questions, rather simple, but rich enough to capture the complexity of a dynamic process involving many factors that touch on the insurance coverage and the consumption of care, as well as the labor market changes and the dynamics of wages and its negotiation within companies.

First, why is the public regulator encouraging private insurance? In France, the health spending has grown extremely rapidly over the last 30 years, with only a few, unsustainable periods, of slower growth. Resources, on the other hand, have experienced the opposite trend. As in all Bismarkian systems facing structural high level of unemployment and great sensitiveness to the labor cost, France's public health system has experienced difficulty in securing its financing. If health spending in France as a share of GDP has not fallen significantly, compared to cutbacks elsewhere, important changes have taken place within this apparent stability (Palier, 2005b). The growing recourse to private health insurance, as a way for diminishing the pressure on public expenditure is one of these changes.

Second, what are the regulator's preferences? Starting in the early 2000s, public policies have emphasized tools that directly motivate employers to provide coverage or for employees to take it up. This is a major change because, even if employer-sponsored health

[2] Note the notable exception of the IRDES (Institute for Research and Information in Health Economics) surveys dedicated to private complementary health insurance, see below.

benefits emerged historically in the 19th century, within paternalist companies (Castel, 1996), it moved into a relatively limited basket of health services for complementary insurance in 1945, when the public (social) health insurance system was set up. Thereafter this complementary private health insurance evolved separately and autonomously from public one and was either provided within firms or for civil servants, or directly purchased by individuals. Recently while social rights within the public health system are being eroded, private insurance has been under more public policy intervention. These include granting subsidies to employers to offer compulsory, complementary coverage, and mandating social partners to negotiate the implementation of health coverage in each company, whatever its size or activity. In doing so, regulators seem to lean more on the Bismarckian social insurance rationale for organizing complementary company-based health insurance, rather than on a "pure" private insurance model, without, however, imposing a "employer mandate" model, at least until today. Indeed, unlike social insurance, complementary private health insurance remains voluntary for firms, but a large set of incentives tend to push them to participate and, no less important, to shape employer-based health benefits in a way consistent with basic principles of equity in access and solidarity in financing. If such a position may appear to be, at a macro-level, less costly politically in a time of justifiable concern about the privatization of risk protection, it remains to be seen whether a company-based health insurance could achieve social goals of access and efficiency.

This question leads to the third issue, why do companies offer complementary health insurance? To answer, we need to look at what really happens on the ground and to study how company practices fit in with the dynamic incentives put forward by the public authorities. It can be shown that while complementary health coverage is indeed strongly regulated, much still needs to be decided at the microeconomic level. The behavior of the actors involved takes place within a wide range of decision-making parameters, which conditions employees' rights, the level of coverage and the share of the burden the employers and employees carry. These issues are not without consequences for the heterogeneity of situations experienced by employees within firm-based social protection. Given these circumstances, a series of questions stress the paradoxical nature of a policy whereby public decision-makers are bestowing a social security mission on today's private sector. At the most general level, it must be asked whether such measures can really be viable within the company sector, given the pressure on wage costs stemming from global competition. It is surely paradoxical to expect a high level of complementary, company health insurance at the

same time as the risks bearing down on companies and employment are clearly not without consequences for employees and their status with respect to social insurance coverage. More significantly, can private coverage really spread within the small- and medium-sized company sector? Is a new social compromise being nurtured at the microeconomic level within companies which will act as a substitute to the weakened, macro-social post-war compromise?

The article is organized as follows. The section 1 develops the institutional and quantitative explorations that exhibit some initial evidence on the growing role of private health insurance in the scope of French risk protection. In the section 2, analysis of the very nature of the recent employer-based health insurance policy is provided, which highlights its "two-face" design: policies are encouraging private benefits within the confines of social insurance but potentially allow considerable discretion on the part of private actors. We then can attempt in section 3 to understand the factors shaping companies social preferences, using some empirical studies that have portrayed employers as health benefits providers. The final section concludes with a synthesis of our analysis and a discussion of the future of private health insurance in France.

1. THE BREAKDOWN OF PUBLIC AND PRIVATE FINANCE FOR HEALTH CARE

Following J. Schreyögg and al. (2005), the coverage of a given population for health care can be characterized in three dimensions: breadth, depth and height. While "breadth" can be designed as the extent of covered population and "depth" as the range of goods and services covered, "height" specifies the extent to which costs of the defined goods and services are covered by pre-paid financial resources as opposed to cost-sharing requirements. This conceptual framework is useful to interpret the global trends in health care expenditures for France.

Trends in health expenditures

Since 1945, French governments have shaped the original Bismarckian Social Health Insurance (SHI) scheme towards the provision of universal and mandatory insurance for health care (Palier, 2005a). Initially designed for protecting workers and their families only, the SHI progressively extended to all categories of people. At the same time, the compulsory health insurance covered a broader range of benefits (i.e. reimbursing numerous health services and medical devices). Due to the combined effects of "breadth" and "depth", social health insurance

contribution to health spending has been steadily growing over the period 1950-1980. Running at only about 50% between 1950 and 1960, the average level of mandatory health insurance rose by 30 percentage points by the early 1980s, to reach 80%. From 1980 until today, its share in total expenditures has fallen, stabilizing on average at around 77% after 1995. The consequence is that, during this period, a growing proportion of the overall health spending shifted over to private health insurance and out-of-pocket payments whose cumulative share increased from 17% in 1980 to 20% in 1995. Since 1995, as it is shown in table 1, the increase of the non-publicly spending is only attributable to private health insurance because the share of the out-of-pocket decreased. In 2007, French households pay only 8.5% of total health expenditures versus 9.5% ten years before, while the private health insurers share increased from 12.2 to 13.6% of total health expenditures. During this period it should be noticed that the process of generalization continued while the health benefits basket remains comprehensive. The decreasing percentage observed from 1980 to 1995 and after is thus due to the transformations of the third dimension evocated, i.e. the "height" of the population coverage, whose features are strongly challenged by the cost-containment policies.

Table 1: Main sources of finance (percentage of total expenditure on health care)

Financing organisations	**1960**	**1970**	**1980**	**1990**	**1995**	**2000**	**2005**	**2006**	**2007**
Public Health Insurance	54,9	72,8	80,0	77,4	77,1	77,1	77,1	76,8	76,6
State	9,5	5,7	3,1	1,1	1,1	1,2	1,3	1,4	1,4
Private Health Insurance	nd	nd	nd	nd	12,2	12,8	13,3	13,4	13,6
■ ***Mutual funds (non for profit)***	*5,4*	*4,7*	*5,3*	*6,4*	*7,3*	*7,7*	*7,7*	*7,8*	*7,9*
■ ***Co-managed Institutions (non for profit)***	*30,2*	*16,9*	*11,7*	*15,0*	*3,3*	*2,7*	*3,1*	*3,2*	*3,2*
■ **For profit *Insurance companies***					*1,6*	*2,4*	*2,5*	*2,4*	*2,5*
Out-of-pocket					9,6	9,0	8,4	8,4	8,5

Sources: National Health Accounts (Ministry of Health)
Notes: Before 1995, National Health accounts did not clearly separate out-of pocket expenses and complementary insurance.

Cost sharing in the French health system

Social health insurance in France covers a wide range of medical goods and services, yet patients shoulder a share of costs, which may be more or less significant. Cost-sharing can usually take three forms: co-payment (the user pays a fixed fee or flat rate per item or service), co-insurance, known as the *ticket modérateur* (the user pays a fixed proportion of the total price, with the insurer paying the remaining proportion) and deductible (the user bears a fixed quantity of the prices, with any excess borne by the insurer) (Thomson *and al*. 2003). Unlike co-insurance and co-payments, the latter has never played a significant role in the French Social

Health Insurance system until now. Reference tariff (so-called *tarif de responsabilité*) is an indirect form of cost-sharing too. It refers to any rule used by the insurer that sets the basis for reimbursement: payment rates set by the SHI's authorities may be less than what patients pay, the difference being paid out-of-pocket.

The argument in favor cost sharing is twofold. On one hand, it can be argued that it constitutes a good incentive to improve the efficiency of the health care system. The arguments stem from the issue of moral hazard that refers to misuses of health services when the individuals do not bear the full cost of their decisions. On another hand, cost sharing is seen as a political lever to sustain or to expand the provision of health care under resources constraints. In fact, both arguments are linked, because the efficiency gains at the micro-level serve the macro-level (Thomson *and al., op. cit*). More specifically, cost-sharing functions may vary along time depending on the specific interactions between private insurance and publicly funded system.

Cost sharing has a long tradition within the French health care system. In the form of a 20% co-insurance for ambulatory care, it was put in place into the SHI original legislation from 1945. Note that the principle of a partial insurance coverage was introduced former in 1930 with the preparation of Social Insurance Acts. Unlike their predecessors, the 1945 legislators introduced the re-insurance of the co-insurance. Therefore, in contrast to private arrangements where Private Health Insurance may play a supplementary or substitutive role, PHI in France by the start of *Sécurité Sociale* era is clearly a complementary one (OECD, 2004). However, during the fifties and sixties, few people accessed complementary coverage. Therefore, to avoid that bad health people pay unsustainable health care costs, a co-payment exemption was introduced for patients suffering from a serious or a chronic disease (so-called "*Affections longues et coûteuses*"). For those patients the public health insurance paid 100% of the health cost when related to the registered disease. From this date, the share of health costs burden between publicly funded systems, patients and private health insurance became a major tool for the public authorities regulating the health care expenses. In that matter, there is usually a trade-off between fairness and economic constraints. If the user charges started slightly from a low level, various forms of cost sharing got more sophisticated over the years.

Major reforms of user charges since the mid-1970s

Since the mid-1970s, when public budgets became under pressure the co-insurance rates increased by small increments. Reimbursements have been withdrawn on several

occasions, either by not reimbursing new types of goods and services or by increasing the co-insurance rate. Furthermore, doctors were allowed to charge more than reimbursed fees to their patients who had to pay extra-billing. During the 1980s co-insurance is thereby more and more often combined with co-payment, while reference tariffs become a growing part of cost-sharing for GP and ambulatory specialist care, as well as for dental care and non-physician care. It resulted in a significant increase of patient charges, only partially covered by complementary insurance and thus sustaining an increasing demand for more "private" health insurance coverage.[3]

In spite of these cost-containment measures, the gap between resources (never guaranteed sustainably) and expenditure (never controlled effectively) widened inexorably throughout the 1980s, leading to the so-called a wider deficit. A cost contained plan, called the "Juppé "reform, was put forward in 1995 during a particularly difficult economic context, which coincided with implementation of the Maastricht Treaty. In contrast to previous money-saving programs that were predominantly demand-side oriented, the Juppé Plan is connected in a systemic way around main orientations, one of which is the achievement of "universalism" (Barbier and Theret, 2002). The idea was to create a universal health insurance regime, encompassing all existing regimes, while substituting residence requirements to the work-based conditions for benefit entitlement. Due to strong opposition, these elements of the reform, as others, have lasted. But it led to the CMU-universal medical coverage Act (*Couverture Maladie Universelle*) later passed by Parliament in July 1999. The general design is notwithstanding quite different. First, instead of challenging the fragmentation of the existing system, it entails the creation of a universal additional subsidiary regime, for the very few people (0.6%) who were still not covered by the public health insurance scheme. More, it provided a publicly-funded complementary coverage for low-income individuals (Grignon *et al*. 2008). Several years of spending control and increasing out-of-pocket payments, were not actually without consequences to health care access for poor persons. In the end of the 1990s, charitable organizations were stressing the extent to which certain fringes of the population were no longer getting health care, and the role poor

[3] The following are some examples of the extension of cost-sharing in various health care areas (Buchmueller and Couffinhal, 2004). When until 1977, all *medicines* were covered up to 70%, the Veil reform introduced the distinction between drugs considered to be "not substitutable and particularly extensive", fully reimbursed, and dugs "mainly used for the treatment of disorders not usually of a serious nature", reimbursed at the rate of 40%; the co-insurance rate remained at 30% for the other drugs. Thereafter reimbursement rates were lowered from a wide-range of products while others were struck from the list. Cost-sharing for *hospital care* was introduced in 1983 in the form of a per-diem co-payment of € 3 for in-patient stay; since then, nominal amounts have been steadily increased to € 8.4 in 1993, €10.7 in 1996. *Dental care* and *optical care* were the areas where SHI patients pay the largest share of out-of-pocket expenditures due to the mechanism of reference tariff: for these products, prices used to be higher than the official tariff; the patient has to pay an extra-billing, more expensive over time.

health played in the causes of social exclusion. By doing so, they brought the issue of the real rights to health care onto the political agenda, leading to the CMU-C, universal complementary medical coverage (*Couverture Maladie Universelle Complémentaire*). Enrollment to this complementary insurance program is income related (the monthly income should be lower than € 621). Approximately 4.5 million individuals are eligible in 2008 to this program. It covers all the out-of-pocket payments for a predefined standard basket of health goods and services. Resources stem predominantly from a special tax on private health insurance providers (tax rate is of 5.9% on complementary insurance contract sales), the traditional links between "professional" and national solidarity that characterize a Bismarck type of heath insurance are thus strengthened (Barbier and Theret, *op. cit*.).

Economic growth again slowed markedly in 2002-2003. At the same time, social spending accelerated, while revenues fell. Under these straightened economic circumstances, a major pension reform was implemented in 2003, which changed profoundly the whole tax framework of complementary health insurance provided by companies (see below). This was followed by a further reform of health insurance in 2004, which led to an important institutional reform of governance where public mandatory and complementary insurance organizations should pilot health insurance together. More, demand-side control was placed at the center of the reform process, opening up means of regulation that broke with the Juppé Plan. The Act began by going back to using co-insurance rates as a policy lever (Palier and Hassenteufel, 2007). But one of its cornerstones was the development of a new organization of access to care via the creation of a gate keeping from GP to specialists outpatient services. On the basis of this legislation, parties involved in health insurance (doctors' unions, insurance organizations) accorded attending physicians a key role in coordinating patients' medical care. Under the guise of improving the quality of care and promoting the role of general practitioners, this measure aims at rationalizing the progress of patients' treatment within the health care system, thus avoiding "nomadic", costly, behavior by insured consumers which is facilitated by open access. Under the 2004's reform, reimbursement levels vary. They are higher when patients accept to conform to the gate-keeping scheme. Nevertheless, spending was not still under control. This is the reason why, the last cost-containment measures extended previous policies, seeking once again to reduce the share of compulsory health insurance, thanks to the introduction of deductible, a form of cost sharing mechanism that have never played a significant role in the Social Health Insurance system until now. As a result, the cost-sharing arrangements show up a

very complicated map, where the "scrubland" of reimbursement rules is combined with the "scrubland" of reference tariffs.

Protecting people from user charges

The final picture that emerges from this overview highlights two main features. First, as observed in other European countries (Maarse, 2006), there are clear indications that cost sharing has increased since mid 1980s, following an incremental rather a radical pattern. Second, as shown in table 1 (see above), there is no massive evidence for a crowding-out effect of an increase in private health spending on public spending (Tuohy *and al.*, 2004). This observation suggests that the impact of the latter on the public-private mix has been offset by a concomitant growth of public health care spending. An explanation is that there are many exemptions from user charges granted for patients of specific population sub-groups. For example children and teenagers up to the age of 16 years are eligible for exemption from deductibles, this is the same for women more than 5 months pregnant and newborns in their first 30 days. Some exemptions from user charges are also granted to individuals receiving state benefits (war-invalids and disabled) and similar rules are applied to victims of workplace accidents or occupational disease. Some 2% of the population is exempted from co-insurance for these reasons. But above all, the main exemptions are related to individuals defined as having poor health, notably chronic or life-threatening diseases (*Affections de longue durée'*, see above). Aging and chronic diseases increasing mean that a rising number of patients would benefit from payment exonerations. In 2006, roughly 9 millions of individuals were benefiting from these exemptions (13% of the whole population); it represents more than 60% of the total public health care spending.[4]

Given all these exemptions mechanisms, the actual medical inflation continue to pull the overall public health care spending even if absolute private spending indeed increase considerably. Hence, if the French health care spending features a process of privatization, the latter is "creeping" rather than significant. Notwithstanding, with a picture less global, there are indications that some health services are more prone to privatization than the others. This is the case in ambulatory and in auxiliary healthcare goods and services, where the growth of private spending is concentrated.

As a result, the start of the new millennium has seen individuals become increasingly dependent on complementary coverage, to insure the expanding share of risks which compulsory health insurance is covering to an ever-smaller extent. According to the French health and social

[4] The effectiveness and equity of mechanisms for paying for long and expensive care are today being questioned and the creation of a health care ceiling (a stop-loss mechanism) is currently being debated.

protection survey conducted by IRDES, the proportion of population without complementary coverage has fallen since 1996, largely due to the implementation of CMU-C. The percentage of uninsured dropped from 16 percent in 1996 to 7 percent in 2006. Complementary health insurance is most often contracted on an individual basis (for 60% of French people). A little more than one-third of privately insured persons obtained it through an employer, even because they work in a company which offers coverage or because they are dependants of workers enrolled in a health plan. Coverage access arrangements exhibit significant variations associated with family income; persons most likely to have employer-provided health insurance are those who have better revenues (see table 2).

Table 2: Complementary heath insurance access according to the standard living (percentage)

Standard of living	group	Individuel	CMUC	No cover	Total
Decile 1	9	33	38	19	100
Decile 2	19	50	17	14	100
Decile 3	23	60	6	11	100
Decile 4	29	60	3	8	100
Decile 5	36	57	2	5	100
Decile 6	38	56	1	5	100
Decile 7	41	54	1	5	100
Decile 8	41	53	1	5	100
Decile 9	42	54	1	4	100
Decile 10	43	53	0	4	100
Total	32	53	7	8	100

Sources: IRDES/ESPS survey with re-treatments by DREES (Ministry of Health)

Half of the uninsured cite costs as the reason for not purchasing complementary insurance. Indeed, for many years, the purchasers face strong rises in premiums and contributions. The lower is the individuals' or households' income, the higher is their contribution: it has been estimated that households with the lowest incomes pay out of 10% of their earnings on complementary health insurance that is three times more than the households with the highest incomes (Kambia-Chopin *et al.* 2008).

Nevertheless, the two protective measures which have been adopted continue to play a role. On the one hand, low-income households benefit from free complementary coverage (see above). On the other hand, individuals defined as having poor health are exonerated from paying high co-insurance rates. But this does not provide access to complementary coverage for households with low income who may remain without complementary health insurance and therefore face significant out-of-pockets expenses for their medical treatments. This raises the growing concern over the question of not only how to lower the number of uninsured persons but also how to diminish the burden of complementary insurance premiums for low income

categories. Two steps in that direction were made in 2000; both proposed extending the tax incentive for health insurance to encourage insurance purchase. A first step was the creation of a health insurance voucher providing partial rebate on the purchase of a complementary coverage for individuals living in households with income just over (15 to 20%) the CMU-C eligibility threshold. The second one advocated an alternative approach: subsidizing employers to implement and employees subscribe to employer-provided health insurance plans. While support for individuals is relatively traditional, which does not mean that it is fully effective (Grignon and Kambia-Chopin, 2009), selective incentives for companies may address specific issues.

2. ACCESS TO COMPLEMENTARY INSURANCE IN COMPANIES: A PARADOXICAL SUBJECT OF PUBLIC POLICY

Implementing a collective complementary health insurance in a firm is a voluntary choice resulting from a unilateral decision of the employer, a referendum or a collective agreement between the employer and the employees. The schemes that stems from each of these decision-making processes can make the coverage optional or compulsory for the employees. Individuals eligible to receive benefits may be either a group of salaries (eventually their dependants) or the general population of the firm (eventually the dependants). The employer financing contribution to the insurance premium may be high (90%) or low (0%) and can vary between employees categories (for example between executives and non-executives). Finally, the complementary insurance coverage may be parsimonious or more and less generous. As a result, several types of employer-provided health insurance schemes are observed, each with a different impact on breadth, depth and height of the medical coverage, as well as on employee's financial effort to take-up the employer-sponsored health insurance. Notwithstanding, until recently each type of collective coverage could benefit from tax advantages that didn't discriminate against different contract types. Reshaping those tax incentives was precisely one of the aims of the 2003 and 2004 French reforms of pensions and social health insurance that together have worked in favor of compulsory forms of complementary health insurance for employees as a result of collective bargaining negotiations. The resulting reform scenario will be examined in details.

A shift in tax incentives

Historically, company-related health insurance benefited from tax and social security contributions advantages. The same was true for complementary pensions and for death,

invalidity and incapacity insurance which constitutes, with health insurance, the company based "welfare plan". This system was overhauled by the Fillon Act of 21 August 2003. Its aim was mainly to reform pensions, but the Act also included a set of measures to encourage companies to develop all types of complementary insurance contracts that could complement the health social insurance benefits.

In fiscal terms, the contributions paid by employees into a complementary health scheme are tax deductible, up to a certain limit. Moreover employers' contributions into schemes are not deemed to be equivalent to extra wages, and so are not subject to income tax. Indeed, employers' financial participation is considered as a part of their business costs and so may be deducted from corporation tax, under the same conditions as employee compensation. Employer contributions favoring employees are also excluded from the overall wage bill of each employee and so are not subject to normal social security contributions (payroll taxes), within certain limits. The limit to deductibility is fixed on the basis of a composite formula, which in part links the size of exonerations to each employee's wage. The same holds for the limit on employers' social security exonerations. Beyond these limits, contributions are reclassified as extra wages, and hence included in taxable income and are subject to normal social security contributions.

So what changed? In the previous system, contributions to pension schemes, death-incapacity and invalidity insurance and health insurance were not distinguished. A generous supplementary pension scheme could thus absorb all non-taxable contributions at the expense of health or death, incapacity and invalidity insurance (and vice versa).[5] Because they set apart supplementary pension on one hand and health, death, incapacity and invalidity insurance on the other hand, the new measures allow companies greater room for maneuver in structuring the supply of complementary coverage.

But what of the incentive effects created by the new rules? Firstly, the changes in the limits of exemptions or deductibility have pushed the wage "available" for tax relief towards the top of the pay hierarchy. The new rules thus favor high income earners more, for whom companies have greater scope in raising health coverage, compared to the previous system. It must also be noted that tax incentives operate fully for higher incomes, which have higher marginal rates and so have a preference for higher insurance coverage.

These technical changes are not without consequences for the economy as a whole. They also ultimately affect trade-offs made by companies between risks, levels of coverage, financial

[5] These contributions are "available" from a social and tax point of view: they correspond to the fraction of the wage which can be paid into a complementary scheme, while benefiting from social and tax advantages.

burden levels and their distribution between employees and their employers. But above all that it should be noted that new conditions have been introduced that constitute a radical break as they have created rights to tax advantages only within the framework of collective, compulsory contracts. In other words, complementary insurance must be mandatory for it to be exempt from social security contributions, whereas in the previous regime, the exemption was independent of the insurance contract type, which could have been collective, individual, part of a compulsory scheme or optional. Henceforth, all coverage must be collective (i.e. it must benefit to all of a company's personnel or one or several categories of employees defined objectively, in a general and impersonal manner) and all the employees are obliged to take it up. Other conditions of eligibility have also been introduced. Thus, employees must pay significant contributions fixed at a uniform rate for all employees belonging to the same, "objective" category (for instance executive, non-executive, technicians, blue collars, etc).

A further new measure introduced later, relative to the 2004 reform concerning social health insurance, is that tax and contribution benefits are available only for "responsible" contracts. As stated above, incentives for patients to remain within a gatekeeping system were reinforced by the reduction of reimbursements for health care consumed outside this path. So-called "responsible" contracts are committed to not reimbursing extra out-of-pocket payments when patients visit directly an outpatient specialist. It is only under "responsible" contracts that companies and patients can benefit from all the tax and social contribution advantages of complementary health insurance. Subsequently, such "responsibility" was extended to contracts which provide higher reimbursement in areas of preventative medicine.

Why making complementary insurance compulsory matters to policy maker?

Three arguments can be made. The first concerns the presence of externalities, which are usually put forward in economic theory. Individuals undervalue certain goods, whose consumption provides positive externalities. This justifies public intervention, in this case as a subsidy for the purchase of private insurance, because the costs incurred by individuals who are insured and who receive treatment generate important social benefits. Compulsion is therefore compensated by tax advantages (Summers, 1989). However, for a country with a generalized public health insurance this motive may be much less compelling than the second argument that relates to adverse selection. Complementary health insurance may be subject to self-selection by employees on the basis of their idiosyncrasies. To the degree that young and/or healthy workers don't take-up (or leave) the employer-sponsored coverage, workers enrolling (or remaining) in the group system will be comparatively older and unhealthy, which will raise the premiums. As

premiums increase, the youngest and healthiest employees would likely opt-out of the company health insurance plan, which will continue to drive up the costs for employer coverage until only higher-risk individuals remained in the group, making the health insurance coverage unsustainable. Were the so-called "death-spiral" appears, employers could eventually drop coverage. As a result in order to ensure that low-risk employees take-up or remain in the insured group, the company may choose a compulsory scheme, which is, in theory more efficient when markets are subject to adverse selection.

However it could be argued that individuals covered through an employer are less likely to be self-selected than those who purchase health insurance by their own (i.e. contract individually). The reasons are twofold. First, due to the fact that the premium is partly subsidized by the employer, the insured is less price-sensitive (Ettner, 1997). Second, there are not many high risk profiles in a firm (employees have all working capabilities) and there is probably no great heterogeneity in employees' of the same firm risk profile, so it could be supposed that subscription would be exogenous to health status. Finally, the incentive for mandatory employer-sponsored complementary health insurance is more likely to lie in the substantial economies of scale permitted by large pooling mechanisms (Gruber and Lettau, 2004). Company-related health insurance schemes therefore can provide better guarantees at lower costs than individual contracts purchased on the market.

In addition to the advantages conferred by preferential tax treatment employer-sponsored health insurance is also attractive because the compulsory contract favors the implementation of a sort of "long-time coverage", on the condition that costs are acceptable to employees. The cornerstone of such "guaranteed" protection is the Act of December 31, 1989, the so-called Evin Act which "reinforces the guarantees provided to insured persons against certain risks". According to the latter, the protection acquired by subscribing a contract with compulsory membership is above all a form of protection against risk selection. The Act thus stipulates that when employees are insured collectively and compulsorily, the organization (i.e. the insurer) "which provides the guarantees will finance the consequences of illnesses contracted prior to the subscription to the membership contract or convention, subject to the usual penalties for persons making false statements". Legal requirements are comparatively more selective for optional collective or individual contracts and the insurer may exclude financial coverage of the consequences of certain illnesses.

The same Act sets out conditions under which collective coverage can be maintained individually in certain situations. The first relates to the termination of work contracts. Under

the Act, an employee who benefits from a compulsory company insurance contract for groups covering health care may also receive coverage in case of incapacity, invalidity, unemployment, and even early-retirement or retirement. Insurance freedom to set tariffs for this "after work" contract, which has been changed in an individual one, is limited: premiums cannot be up to the rates imposed on working employees by more than 50%. The second situation in which guarantees are maintained (whatever the risk covered may be) concerns the termination or non-renewal of a collective contract with compulsory membership. The contract must stipulate price modalities and conditions under which the insurer can maintain coverage on an individual basis, without any trial period or medical questionnaire. In this case, however, the insurer is free to set premiums.

For contracts with compulsory membership, the right to the continuing of guarantees is completed by the right to the continuing of coverage and services. The Act states that: "when insured persons or members are guaranteed collectively against risks, breaches of physical integrity, maternity, death or risks of incapacity and invalidity, the termination or non-renewal of a contract or convention will not affect the right to immediate or differed insurance payments acquired or established during the period of the contract's validity". Insurance payments of all types will continue at a level at least equal to that of the last payment due or paid out prior to termination or non-renewal. As a result, the insurer's commitment must cover at all times, for all outstanding contracts and conventions, by providing equivalent assets to those which have been supplied during the previous period.

To sum up, it is undeniable that the Evin Act protects insured persons, especially employees who are collectively and compulsorily insured through their company. Consequently, any incentives favoring this contractual arrangement contribute to the extension of protection against the excesses of market forces in insurance (adverse selection, termination and/or revision of contractual guarantees).

Taken together, these arguments favor compulsory schemes and legitimate public incentives. But the equation *compulsory coverage = tax relief* does not exclude adverse effects. On one hand, government tax receipts diminish. One the other hand, exonerations from social security contributions sap the resources available for the public health insurance. While these are hard to quantify,[6] the loss of public revenues is not negligible. Furthermore, the collective costs

[6] The tax exclusion is estimated to cost more than €3 billion in foregone state tax revenues in 2006. The losses of revenues in Social Security budget related to company-welfare plans are estimated to be around €2 billion (Senat, 2008).

of these measures must also include the indirect effects of moral hazard, which may be more widespread with higher complementary insurance. Despite persistent debates the argument that a higher level of health insurance leads to increased consumption of healthcare goods and services is generally accepted, as well as the argument that the tax treatment of company health benefits, which may induce "over-insurance", causes inefficiency (Pauly, 2006). In 2004, the authorities therefore dealt with this "anomaly" by making deductibility and exonerations conditional to the respect of contract standards, by introducing the notion of "responsible contracts". The encouragement of collective and compulsory contracts in companies must contribute to orienting supply and demand towards good practices, which also support efforts to stabilize the finances of compulsory public schemes. From the policy-makers' point of view, making cost reduction for insurance in companies conditional to the respect of standards meant to encourage "tit-for-tat" behaviors, given scarce resources. At the same time, in political terms, favoring compulsory, complementary insurance, which provides benefits to insured employees, could make the weakening of the legal and universal public schemes probably less "costly".

Encouraging a wide-spread complementary coverage in companies through collective bargaining

Tax and contribution incentives are not the only means used by the public authorities to encourage complementary insurance in companies. Complementary social insurance is also traditionally a dimension of collective bargaining within the company. To make the latter more effective, employers not covered are now obliged to include the issue of health insurance within annual wage negotiations. But even if both parties are obliged to dialogue, they do not have to reach agreement. Given this, the public authorities invited the social partners to enter into negotiations, within an inter-industry framework, in order to make complementary health insurance mandatory in all small and medium-sized companies. Several economic arguments favor collective agreements, with compulsory membership, negotiated at branch level. First, such agreements allow risks to be mutualized among a very large number of employees, which small companies cannot do. Second, they allow more favorable guarantees to be offered at more affordable costs. Third, they harmonize constraints companies face and hence prevent social competition from developing between companies operating in the same branch. However, representatives of small and medium-sized companies found these arguments hard to accept, given companies' low "capacity to pay". They reacted very cautiously to these political initiatives, which in fact have tended to be dissipated within a much wider social policy agenda.

That said the mobilization of social partners on the question of a negotiated scenario highlights the authorities' resolution in bringing collective health insurance within the ambit of the two key institutions shaping French industrial relations, namely collective bargaining agreements and bi-partite cooperation. Collective accords and conventions are not just favored by political decision-makers. More implicitly, they underline *de facto* the role of the bi-partite model when encouraging compulsory health coverage. Why? Three groups of actors share the market for complementary health insurance, along demarcation lines set by regulations which historically allocated specific activities to insurance companies, *mutuelles* and bi-partite provident institutions. In accordance with EU Directives, entry barriers between these groups' activities have come down, so that all actors may now operate in all areas of insurance. As institutional partitions disappear, the three groups of actors are increasingly in competition in the various market segments, though in reality a certain number of comparative advantages remain. Up until 1989, provident institutions had the monopoly of implementing collective agreements for complementary health insurance, giving them a privileged position in collective, provident insurance, especially when it was compulsory. *Mutuelles*, which historically organized their activity in the health sector, concentrated more on individual coverage, within companies, on a voluntary basis. Insurance companies faced a specific tax regime concerning health, up until 2001, and so for very long held a portfolio centered mainly on major risks and pensions. To be sure, *mutuelles* and insurance companies are redeploying their resources in the collective health insurance market. But the bi-partite provident institutions still hold a number of advantages in this area.

By favoring the compulsory model, and hence the bi-partite model, the public authorities are renewing the practice of centralized coordination, which allowed France's social security regime to develop historically. The sharing out of responsibilities between the state and the social partners makes it possible to construct negotiated frameworks within which certain principles of solidarity and equity can be put forward and maintained. From this point of view, the transfer of social security functions to companies can draw on the existing organization of industrial relations. It must however be asked whether the reference to the bi-partite model is purely rhetorical or actually guarantees employees' acquired rights. There is no clear answer to this question, especially as the collective negotiating process itself is undergoing profound transformation (Traxler, 2003). In any case, the final outcome remains open, given the third characteristic of compulsory social security provided by companies, namely its life-time nature.

More generally, and taking into account all the features presented and discussed here, one can stress the way in which the varied instruments of public policy are linked together to frame and regulate complementary social security within companies. That said, the changes which began in 2000 are characterized less by a diversity in the instruments of public action, than by the fact that the authorities have mobilized them simultaneously through the use of targeted incentives. In doing so, the authorities have shown a preference for a model of compulsory, complementary insurance, largely mutualized, responsible and standardized, and negotiated with social partners. In the final analysis, this model is close to the "employee insurance" model on which France's *Sécurité sociale* is based. However, while the *Sécurité sociale* was constructed on the basis of compulsory insurance *outside* companies, the new institutions in complementary health insurance involve the rationalization of a system of protection *within* companies. As a result, the expected impact of incentives (i.e. to limit the effects of a weakening of acquired social rights in the public insurance system) depends mainly on the willingness and the capacity of actors to take part in a process they are not obliged to, and to align themselves on the authorities' "preferred" model. The economic, social and political factors which interact in this issue are complex. What trade-offs do companies make between concerns over compensation and those relating to social insurance that are linked to complementary, collective protection? This issue is examined below, more from a prospective point of view rather than as an assessment, and it will be asked how company practices fit in with the dynamic incentives put forward by the public authorities.

3. COMPANY RESPONSES TO MANDATED BENEFITS

At least two questions arise. First, to what extent will it be possible to encourage companies which do not have complementary health schemes to adopt them, and how? Second, how far will it be possible to lead companies that do have an optional scheme to make it compulsory and how will they deal with the ensuing constraints? These two issues will be discussed here and then two other questions will be raised rapidly. One relates to the negotiation process and the governance of complementary insurance, the other concerns the life-time character of company coverage.

The decision to establish complementary insurance within companies

What factors shape the implementation of complementary coverage in companies? Traditionally, economists consider in-company health insurance to be a form of compensation.

From this point of view, the driving force behind insurance may be found on the demand side (Buchmueller, 2000). If a collective scheme is established by joint agreement between the employer and the employees, it is because the latter are willing to accept a lower wage in exchange for the advantages of having collective coverage against future, random risks. If employees value company insurance, it is because they believe it to hold a number of advantages they appreciate, in terms of lower insurance premiums and tax deductions, if the price elasticity of such health insurance is greater than unity. Employees value these advantages all the more, the higher their marginal tax rate. Economic analysis assumes implicitly that the employer decides the degree to which total labor costs can be borne, with there being a trade-off between direct and indirect wages. In the final analysis, in-kind benefits should be offset by lower wages, an idea taken up in the modern theory of compensating differentials (Rosen, 1986). This theoretical framework is often used by American economists to analyze health benefits economically (Pauly, 1997; Miller, 2005). No unequivocal empirical proof exists, however, for this theoretical argument. Instead, generous social benefits are often to be found in companies where wages are high.

The fact that trade-offs do not always function clearly supports the hypothesis that companies offering social benefits like complementary health care may be using them as a lever of human resource management. A general approach to overall compensation implicitly draws on the idea that complementary insurance in fact stems from clearly-understood employer interests. Consultants very often sell the argument that overall compensation improves company performance to human resource managers. Based on a compensation package (direct, substitute or deferred pay) and an evaluation of the social and tax yields of each of its components, companies may conduct a human resource management and compensation policy compatible with their strategic objectives, internal efficiency and competitive performance. Complementary social security may therefore also be a source of competitive advantage. As with efficiency wages, it may be part of a strategic choice made by employers to attract and retain the best employees and to encourage efficient work (Weiss, 1980; Stiglitz, 1974). From this point of view, market incentives exist to establish health benefits, in a context in which managing productivity is at least as important as minimizing costs. As a result, it is not sure that the dynamics of inter-branch agreements establishing compulsory complementary health coverage fit in with companies' individual strategies for generating competitive advantages, in this case via "social" competition in tight labor markets. Obliging all companies to provide insurance for their employees deprives pioneer companies of their relative advantage and obliges them to raise

their coverage levels. This is probably one of the first reasons which explain the clear reticence of the social partners to follow up calls by the authorities for complementary insurance and why the subject has not been brought back into discussions.

If on the other hand, complementary insurance (financed by both employees and companies) is taken theoretically to be a supply question, then empirical studies still have difficulties in proving the returns on these investments for the company. There is thus no evidence that access to health insurance helps diminish absenteeism or employee turnover. The generally accepted assumption that positive spillover effects exist between social benefits and productivity does not lead to robust conclusions either. Consequently, there is still no answer to the question as to why companies provide social benefits. It is doubtless necessary to draw on arguments that are not directly utilitarian to explain such behavior. Social policy within companies does not result from *ex ante* economic calculations, in as far as such policy is undertaken subject to cost-benefit analysis of complementary insurance. Company history, culture, the views of top management and the demands of parties involved surely offer better explanations. Furthermore, compensation, its level and distribution are partly determined by social norms, while the mechanisms for spreading complementary coverage (in large companies at least) are certainly based more on imitation and reputation (so-called organizational isomorphism according to Di Maggio and Powell, 1983) than the search for a specific way of increasing efficiency. The present re-positioning of policy on social benefits within the framework of raising ”corporate social responsibility” reveals the importance of conformist behavior relative to certain rules and practices, when adopted for reasons of efficiency as much as legitimacy. This seems to be the case at least for large companies. From this perspective, complementary health insurance may be viewed more as an extension of old-fashioned paternalism, though today companies take on responsibilities voluntarily with respect to society, by providing a public good, whereas formerly they were compensating for a deficient state. But conformism does not mean that both companies and employees are constrained to one type of behavior. The implementation of complementary coverage in a company may lead to various models. This is shown when examining the real consequences of incentives to set up compulsory schemes for employees.

Transforming an optional scheme into a compulsory one

Companies which set up a compulsory health insurance scheme benefiting from socio-tax breaks face a range of constraints. The “collective” nature of the scheme must be clearly established in order not to favor particular employees, and all must join the scheme (excluding

recognized derogations). Furthermore, employers' contributions must be "real and uniform", with optional choices being prohibited. Lastly, contracts must be "responsible", as discussed above.

Though limited, there is still some scope for decision-making. First, the optional model retains several advantages: the flexibility of implementing an optional contract frees employers from the constraint of non-exclusion and can make the optional model appear more respectful of employees' individual/family situations and their preferences. In particular, the optional model limits double insurance phenomena whereby two persons living together are insured twice through the company schemes of each partner. But above all, the compulsory nature of the contract leaves questions to be answered in number areas.

Which employees are to be covered? It must be recalled that compulsory health insurance must cover all staff or an "objective" category: categories legally recognized are "employees", "workers", "technicians" and "managers". Also, all employees (or members of objective categories) belonging to a compulsory scheme must receive the same rights. There may not be any discrimination by age, workplace or sex and certainly not by type of contract. Does this constraint contradict existing practices? Not really. The decision-making rule of "choosing a single, general system" to be applied to all employees is already the most widespread: in 2003, 83% of those organizations providing health insurance made no distinctions among their personnel (Couffinhal *and al*., 2004). This may be analyzed as merely meeting cost criteria: the larger the group of insured persons, the lower the average contract price. It may also be seen as manifesting a preference for equality of treatment among employees. In practice therefore, compulsory contracts are mainly provided in a single, standard form to all professional categories. A widespread notion is that health risks are events over which individuals have absolutely no control. Given this, there is no reason why companies should distinguish between employees,: within small groups, equality of treatment may be viewed as a means for consolidating cohesion, motivation and confidence (Bewley, 1999). That said, tensions may arise on the one hand between a compulsory insurance model which creates a community with coverage or guarantees against risks and on the other hand a simultaneous move to differentiate and distinguish employees according to their competencies and via the individualization of wages. In other words, a company seeking to attract and reward specially an employee or several employees will not be able to use better forms of health protection in its differentiation strategy. Actually, this is still an option, though a company doing so would forfeit tax and social security breaks. The general trend is thus towards non-differentiation, though more detailed

study does reveal that when contracts are differentiated by professional category, the best guarantees are offered to managers (Francesconi, 2006). This trend should be reinforced by the new contribution and tax rules, which favor higher-paid employees more (as already discussed above).

How are contributions to be distributed? As with compulsory, public social insurance, the finance of complementary health insurance depends on contributions relative to wages, with both employers and employees bearing the costs. Contributions may be proportional to wages (capped or calculated according to the gross wage) or they may be flat-rate, perhaps expressed in terms of a percentage of a reference value. Various trade-offs must therefore be made, which implicate both the "economic" and "solidarity" aspects of complementary insurance. For a given level of services/benefits, the contribution rate may be lowered, the wider the collection base is. The higher the contributions' ceiling, the more finance is based on full wages and so the less the scheme is actuarial which requires contributions to vary according to risk. A higher ceiling thus favors redistribution: in classes of similar risks, raising or removing the contribution ceiling leads to vertical solidarity (from higher income earners to lower earners) in financing spending (largely) independently of income. In contrast, the lower the wage contribution ceiling (especially if it has been decided to make contributions flat-rate), the more such contributions are regressive and proportionately larger for lower income earners.

What actually occurs? Generally speaking, complementary company health schemes are not very redistributive. Flat-rate contributions dominate, and when they are proportional, they usually have a ceiling: employee contributions which are fully linked to wages are very rare (Couffinhal *and al.*, 2004). From this point of view, the new rules do not imply any major, direct changes. The main new features concern the introduction of the notion of a "significant contribution" by employers and the impersonal nature of benefits provided. This implies that contributions must be identical, within defined, objective categories. But they do not have to be identical across categories: employers' contributions may be higher for certain categories, for example if a particular professional category is exposed to greater risks because of the work involved. This again, however, is not a break with existing practices, as the financial contribution of employers is the same for all employees, averaging about 60% for the 87% of organizations providing complementary health insurance (*ibid*).

In contrast, the impact may be indirect. From the point of view of a company which has set up a voluntary scheme, the move to a compulsory scheme may significantly increase its overall social security contributions. To be sure, the company needs to take into account the fact

that the voluntary scheme would have incurred higher tax and social contributions. But the extra costs of a compulsory scheme may lead it to reconsider all existing choices favoring solidarity. The issue of solidarity is most crucial to retired persons, due to new accounting rules. The implementation of new accounting standards obliges companies to include in their liabilities all commitments undertaken in terms of pension benefits granted or maintained, subsequent to recruitment. Thus, if a company decides to cover health care for its retired employees, it is tied into a life-time commitment, which must be evaluated and entered into the company accounts. Such social liabilities are all the more important given demographic aging. For many companies which are overhauling their pension schemes to meet new legal requirements, this raises the question of the sustainability of solidarity mechanisms, and often leads to employers withdrawing health coverage from former employees.

Should the "socialized" perimeter be extended or restricted? To what extent can the "responsibility" principle modify trade-offs in companies and lead them to adopt "moderate" behavior? It was shown above that the "responsible" nature of a collective contract has become a condition for contributions to receive tax and social security reductions. There is thus a clearly understood interest for contracts to coverage on "responsibility", with the aim of supporting health spending control. But the manner in which companies commit themselves to responsibility may vary, especially as a function of expectations and pressures expressed within companies, and the degree to which a company may wish to accommodate individual preferences. The creation of optional arrangements financed only by employees may be a solution to these issues, as is borne out by the number of contracts with options provided in complementary coverage, especially with private insurance companies. There is thus a risk that a two-tier system may eventually emerge in the company sector, which would be very far from concerns for solidarity. The first tier would follow from companies' responsibilities for providing compulsory complementary coverage. The second would depend on employees themselves, as they buy individual coverage within a collective framework.

In as much as it organizes a compulsory scheme for its employees and respects the conditions required to obtain tax and contribution breaks, a company remains free in terms of the financing and content of the coverage it organizes. Put another way, it is not sure that the heterogeneity observed among optional company schemes will diminish significantly with the spread of compulsory contracts. While employees belonging to the same company may have more homogenous coverage, great variety in coverage may continue to exist depending on company size, or whether the firm is in manufacturing or services.

The linkages between schemes and governance

The public regulator's interest lies in company insurance being as extensive as possible. The invitation to the social partners to negotiate on health insurance at branch level and within companies is aimed especially at bringing small- and medium-sized companies "into the game". As has already been shown, this expansion has the capacity to take place within the sign-posted domain of industrial relations whose supports (i.e. collective bargaining and the bi-partite management of organizations responsible for social protection) are directly engaged by the authorities. The industrial relations system today is, however, experiencing profound change. While the tradition of centralized negotiation continues, a new system leaving more scope at company level is emerging. It may be assumed that this shift in the locus of negotiation will not be without consequences for complementary insurance coverage and on the contents of agreements.

In as far as the collective, branch agreement, which may impose the insurance provider, does not tie the company, the latter is free to chose. As already stated, the compulsory model gives a sort of "premium" to bi-partite institutions which are favored by unions, though the Act does require contracts to be put out to tender regularly. However, the main issue for companies lies not so much in the choice of the insurance organization, but rather the latitude they have in managing, and more generally in the governance of complementary insurance. Once again, a detailed investigation is required here. But it does seem that the model of "internal governance" in which the company is the key decision-making entity is giving way to a model in which intermediaries have a greater role in advice, and more generally in steering and managing collective schemes. Up until recently, decisions concerning complementary health care were a "routine" matter, as little was at stake. Now, the responsibilities given to companies, which come at a time when insurance premiums are rising strongly, are leading to significant rationalization, whose consequences should not be underestimated. On the one hand, drawing on the traditional distinction put forward by Walton and McKersie (1965), it can be hypothesized that distributive negotiations (with diverging interests and conflict) may become more important relative to previous integrative negotiations (cooperative and consensual). On the other hand, it may reasonably be thought that the rationalization process and the search for coverage and optimal financing will lead to the greater delegation of strategic decisions to intermediaries. The entry of these new actors will surely alter established negotiation rules and the direct relationship between employers and unions is likely to shift to a more technical terrain in which commissions

are responsible for managing social security: the latter will still be bi-partite, but will have more a role of following up arrangements, influenced by insurance market "experts".

Ensuring the effectiveness of lifetime guarantees

The company-related social protection raises one last question. This revolves around the paradoxical nature of public authorities assigning companies, which are largely subject to the uncertainties of a globalized, financial environment, with the task of providing social security and hence insurance against risks. A further paradox stems from trying to provide employees with a high level of protection, though their links to companies are unstable. In other words, it may be asked what the effective security of collective coverage is, given business risks on the one hand and employment risks on the other. More precisely, doubts surround the value of lifetime guarantees of complementary, collective health insurance contracts, which legislators sought to ensure in 1989 by allowing individuals to continue with insurance within tariff guidelines, in the face of current trends favoring business flexibility. The real implementation of this right is little documented, except relating to pensions. In this case, it may be observed that the restriction of ex-employees to individual insurance regimes is not a particularly advantageous solution, leading to high exit rates (Franc *and al.*, 2007). Two factors indeed raise the *de facto* cost of coverage for individuals. First, employers take part less and less (see above) and second, contributions in individual insurance contracts are not tax deductible. Furthermore, though the Act does require contracts to include ways for maintaining coverage, it leaves a degree of latitude for insurance organizations to define the insurance offered contractually. This leads the ambiguities of the "Evin Act" to emerge. Coverage of health costs incurred by pensioners, as well as those of ex-employees meets a commitment criterion over time. But this "lifetime" coverage is associated with guarantees and contributions which are not constant over time, even though they are regulated. Without going into detail here, it may be noted that the recent agreement concerning the modernization of the labor market has introduced the notion of the portability of health coverage for the unemployed. But this in fact only updates a longstanding measure which, in practice, has had much difficulty in proving its capacity to "safeguard" the job mobility of employees. Overall, while the regulation of social insurance appears to be oriented to the need of lifetime security, the protection actually acquired within companies remains strongly limited to labor contracts.

CONCLUSION

Three main lessons can be drawn from the arguments above. First, complementary coverage is today an indispensable pillar of social insurance, despite the comparatively modest financial flows comparatively to compulsory health insurance. Furthermore, complementary coverage is very likely to develop. Given major social and economic trends (demographic aging, slow growth, welfare deficits), the role of the general, public schemes can only decline, even if policies to control spending are partly successful and hence give these compulsory schemes some budgetary room for maneuver. However, in a socio-economic context which is demanding in resources, while pressure on public spending is great, the likelihood of a return to strong, consolidated and generous public insurance is very small.

Despite this, the future for health insurance is unclear. The definition of the new rules of the game involve the public authorities in the process of rearranging diverse interests within an enlarged governance framework with actors who have not played major roles so far. In the past, employer-related health insurance was subject to public regulation occasionally, depending mainly on company management, and sometimes even personnel management. Today, such insurance occurs within a political and institutional framework, which driving it forward, legitimizing and financing it, as well as providing it with enlarged responsibilities. Recent regulatory measures are pushing in the same direction: encouraging collective rather than individual insurance, compulsory rather than optional schemes, dissuading the selection of risks, unifying guarantees within employee categories, favoring negotiation and bi-partite management, as well as integrating contractual mechanisms within a set of responsible rules.

The model preferred by the public authorities is closer to that of public "social security" than a "pure insurance" model. This is the third lesson learnt here. The incentive model is aimed at facilitating the integration of responsible social insurance objectives with respect to employees and the community, within company strategies. Its rapid development would be a "win-win" strategy, and the expected results would be visible both economically and socially. Companies' real interests should lie in implementing, via negotiation, a high degree of protection. Such protection should also be durable, in the face of employment changes and should meet employee needs, at a time when rights within the compulsory, public system are weakening. The analysis presented here, however, qualifies these arguments.

First, at the company level, the advantages of compulsory, complementary insurance do not compensate for all the costs. This is especially so for small- and medium-sized firms. Even large companies, when asked, are not without doubts concerning the sustainability of the efforts they are required to make, and about the effectiveness of the demands by the public authorities. Contributions by firms have limits, and where these are exceeded, the result may be renegotiations on finance with the authorities. The manner in which complementary health care for retirees was recently debated reflects these doubts. The inter-generational solidarity which some company schemes had instituted has been challenged. Solutions put forward today are highly dependent on companies' capacity to pay. Schemes based on solidarity may be able to continue, but these are compromise solutions whose durability is not guaranteed. From this point of view, the futures of the basic and complementary schemes are linked. While the regulation of complementary coverage limits the logic of market forces, it does not eliminate all its effects, especially concerning inequality of access and coverage. The privileges granted under compulsory contracts do certainly guarantee some scope of solidarity for the least fortunate, but such solidarity is fragmented and not collective. Third, company health insurance is far from being generalized. Nor it is homogenous, in as far as the quality of coverage and the sharing-out of contributions between employees and employers depends on negotiations, which take place increasingly at company level. The standardization capacity of branch negotiations is diminishing and the governance of complementary insurance increasingly involves intermediaries who are market "experts". Taken together, these comments do not refute the hypothesis that a new "compromise" is emerging, which is driven mainly at the microeconomic level, and which will take over from the weakened, social, macroeconomic compromise of the Fordist era. They merely stress the fact that the effects generated by the actual role of business involved in efforts to reform health care financing are ambiguous. On the one hand, job-related health insurance is a way of combining labor and social insurance, which is at the core of the process of instituting the *Sécurité sociale*. On the other hand, such protection feeds back into company wage strategies. This "feedback" is very different from the equalitarian and generalized ideal of the architects of France's social health insurance.

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