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Chapter 6. Collective bargaining on health coverage in a conflict of logics

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To consider health risk in the field of social protection is to place it in the order of social law, its principles, rules and functions. This is reflected in particular in the role entrusted to the social partners in the context of collective bargaining, which is unquestionably part of the order of social law. However, this order has been significantly disrupted: on the one hand, it is experiencing major disruptions and, on the other, it is now being impacted by the order of economic law, which itself has its own principles, rules and functions.

In the field of social protection law, the national interprofessional collective agreement of 11 January 2013 (ANI) and its legislative “transposition” by the law of 14 June 2013 now oblige private sector companies to provide complementary health cover for their employees. The result is a (partial) paradigm shift, as complementary health insurance becomes compulsory for a large part of the population, whereas it has historically been characterized by its voluntary nature; in so doing, the relationship between compulsory (Social Security) and complementary health insurance tends to be modified. But the disruption of social law also stems from the cumulative effect of the law of 14 June 2013 and the evolution of collective bargaining law, more precisely the decentralization of negotiated standards which gives preference to agreements concluded at company level.

Regardless of the route taken in social law, the company must now take out a group insurance contract to meet its new obligation to finance complementary health cover. Thus, in return for the payment of a contribution (or premium), the insurance logic leads to employees being entitled to contributory benefits for health care required by their health condition. These insurance guarantees represent the core of complementary social protection for employees; they also constitute a market for insurers.

In the wake of the 2013 law, the modification of the conditions for awarding this market has given a substantial place to the economic logic involving telescoping between competition law and social law. This phenomenon of telescoping results precisely from the function that the law now assigns, since 2013, to collective bargaining and to social partners. More than ever, it is becoming a tool for regulating competition in the health insurance market, leaving aside to some extent its primary function, which was that attributed to it by the social order, of improving social rights.

This disruption of the order of social law reveals a contrasting landscape. On the one hand, the logic of decentralization of collective bargaining undermines the interests of employees (1). On the other hand, the logic of competition can lead to a deterioration in mutualisation between companies in the same branch, thus harming the interests of some of them (2).

1. Employees' interests undermined by the decentralization of social law standards

The general process of decentralization of collective bargaining, which has been underway for several years, is nonetheless of particular significance when it is applied to the field of collective social protection guarantees (1.1). Moreover, decentralization bears the seeds of discriminatory effects for employees, whose protection may depend to a greater extent on the characteristics of the company that employs them (1.2).

1.1. The movement towards decentralization of the production of social law standards

According to article L. 911-1 of the Social Security Code, the collective guarantees by employees in addition to those resulting from the organization of Social Security may result from three types of commitment: a collective agreement, a company referendum or a unilateral decision by the head of the company.

Dating from 1994, this text remains imbued with the spirit that has long animated the relationship between the law and collective bargaining placed under the aegis of the principle of favour and social public order (Souriac & Borenfreund, 2003; Péliissier, 2002). Thus, on reading it, it is clear that occupational norms in the field of social protection are supposed to have an improving relationship with state norms. In this way, the healthcare insurance is part of a logic of complementarity with Social Security. However, this relationship has been constantly undermined, so that it is not clear whether it is still a principle. Derogations from the law and suppletive laws have gained ground, as the legislator seeks to favour negotiated standards.

The main internal upheaval in the order of social law is that which affects its sources. The hierarchy of norms in social law has undergone numerous upheavals, encouraging a logic of decentralization and contractualisation. This phenomenon does not only concern labour law. It also concerns social protection law. This process of decentralization is also part of the emergence of what is known as collective bargaining administered and steered by the public authorities. An analysis of the legal powers to negotiate and the rules for the articulation of contractual standards provides a better understanding of this.

1.1.1. Encouraging collective bargaining

Although the power to negotiate has existed for a long time, the impetus given by the law of 14 June 2013 should be emphasized. The latter first referred to collective bargaining at branch level (by sector of activity) the task of defining the terms of complementary health cover. Within the framework of this empowerment, the branch negotiators can recommend that companies contact an insurer. But they can also provide for “the establishment of collective guarantees with a high degree of solidarity and including benefits that are not directly contributory”. As one author writes, the law “has defined the attributions... [of the branch] giving it access to missions

of general interest” (Barthélémy, 2017). The 2013 law also imposed an obligation on companies to negotiate. If, on 1st January 2014, they were not covered by a branch agreement, they were required to provide complementary health insurance so that, by 1st January 2016, all employees would be covered by complementary health insurance. In the absence of a collective agreement, the employer had to take a unilateral decision.

An analysis of the legal powers allows us to see a hierarchy between the different legal standards. Firstly, the law was not content to simply make the conclusion of these agreements possible; it imposed negotiation and provided for the intervention of the decision-making power of the head of the undertaking in the absence of a collective agreement. In so doing, it showed a clear preference for the negotiated norm rather than the unilateral norm. Secondly, through the obligations to negotiate periodically, it can be seen that complementary health cover is one of the subjects of compulsory negotiation in the company, even though it is absent from the periodic meetings organized at branch level. Without this being explicitly stated, the legislator is thus demonstrating its preference for company-level negotiations and agreements.

1.1.2. Preference for the company agreement

With regard to the articulation of conventional standards, the general trend is that preference is given to the agreement concluded at company (or group) level rather than the branch agreement. Since the law of 4 May 2004 and, above all, the ordinance of 22 September 2017, collective agreements concluded at the level of professional branches no longer have the same normative scope as company agreements. According to a logic of suppletivity, the company agreement takes precedence over the branch agreement, which is only applicable in the absence of a company agreement. There are several exceptions to this principle, particularly in the area of health cover. Collective guarantees with a high degree of solidarity, and therefore including benefits that are not directly contributory, are among the areas where the branch agreement still takes precedence over the company agreement. Without going into the details of the difficulties of application, it should however be pointed out that this precedence is only relative, since the company agreement will nevertheless apply as long as it institutes guarantees at least equivalent to those provided for by the branch agreement.

Directly authorized by the legislator and freed from the stranglehold of branch agreements, the company (or group) is now the preferred regulatory level, including in the field of complementary social protection. Such an upheaval in standards is not without consequences for the principles of solidarity and universality which structure the French social system. For a long time, these principles justified the fact that guarantees were governed by broad regulatory level such as the State through the law or the sector of activity through branch agreements. These principles are now conceived and mobilized differently. The principle of solidarity has been opened up to more restricted spaces, such as the company and the group. As for the principle of universality, it now responds less to a need for equality and social progress, which were guaranteed by the law and branch agreements. It is satisfied with a simple equivalence

resulting from company agreements that allow inequalities between employees to be perpetuated, in particular depending on whether they work in large or small companies.

1.2. The risk of a discriminatory effect between employees

For quite some time now, group health insurance regulations have protected the interests of insured employees by prohibiting insurers from discriminating against individuals on the basis of their health condition, both in terms of coverage and in terms of pricing (the Évin Act of 31 December 1989). The individual is protected by the collective logic that permeates the law; the collective serves as a firewall against possible individual discrimination.

For the rest, as the Libault report (2015, p. 34) points out, “the calling into question of the designation clauses [which allowed the professional branch to entrust an insurer with a management monopoly]... [shifts] the conditions for determining cover and the insurer to the level of the company, to the detriment of the branch. It could result in a sharp deterioration in the ‘model’ of solidarity that was being built up... between employees”. Consequently, despite the obligation to provide complementary health cover, the employment context is more than ever a determining factor in the conditions under which the employees will benefit from this cover. In other words, this employment framework has a discriminatory effect, either negative or positive depending on the case.

The stakes are high if we bear in mind that the collective also makes it possible to construct a “social property”, “the acquisition of social protection [having been] essentially based on the inscription of individuals in protective collectives” (Castel, 2003, p. 37). If the firm is indeed a protective collective, it is a collective indelibly linked to the power of the employer and to the patrimonial and paternalistic conceptions that strongly inspire the theories of the firm in labour law. This is also the reason why a fringe of French trade unionism remains hostile to company collective bargaining and remains attached to branch bargaining, as it is easier to “imagine a wage-earning system without subordination” (Linhart, 2017): the social benefits that are created are independent of the subordination agreed by the employee vis-à-vis his employer. They are not the price of their submission, nor do they depend on the generosity, size or financial means of the company.

As the results of the survey on *Company Complementary Social Protection* carried out in 2017 by the Institut de recherche et documentation en économie de la santé (IRDES) underline, “the guarantees offered and the employer’s participation in the payment of the premium are all the higher the larger the company and the higher the level of qualification and the salaries offered” (Perronin & Raynaud, 2020). In a way, we find characteristics that were decisive for companies to voluntarily commit themselves to the implementation of complementary health coverage before it became compulsory. Today, these characteristics are exacerbated by the changing legal framework.

The size factor is particularly interesting. Indeed, the larger the company’s workforce, the greater the chances that the issue of health cover will be included in a social dialogue. Through elected and trade union representation, employees are more able to influence the choices and the parameters: nature and level of cover, level of employer funding, pricing methods (flat rate, proportional to income, family dimension). In some companies, employee involvement is not limited to discussing

the content of the group contract and therefore the level of protection. Some go further by involving employees in the implementation and management of complementary social protection. For example, some collective agreements set up a complementary social protection commission within the framework of the single staff representation body (the social and economic committee). This brings to light another form of inequality between employees which does not only concern the level of protection, but also the participation granted or not in the management of this protection.

Although no study provides information on this, it can also be assumed – on the basis of an analysis of a few collective agreements – that the fact that the company where the employee is employed belongs to a group of companies is a positive discriminating factor. Indeed, some groups negotiate at this level. The choice of this level of negotiation reflects the place of social protection in the group's policy towards its employees. Moreover, negotiating at group level gives employee representatives more influence on the direction of social protection cover, but also to monitor – often within an *ad hoc* committee set up by the collective agreement – its deployment and the development of the scheme's accounts. Finally, in relations with insurers, the group's size may place it in a particularly favourable position both to obtain attractive pricing and to establish this contractual relationship over time. This may result in the constitution of financial reserves which negotiators within the group will be able to use. For example, the results of the Total group's health insurance contract and the level of reserves allowed the negotiators to decide in 2019 to deduct only 95% of the contribution. A deficit could have made it possible to mobilize the reserves built up in order, for example, not to increase the contribution. In view of the new regulatory environment, the group approach may paradoxically be more favourable than the branch approach, both for the companies in the group and for their employees.

2. The interests of companies undermined by the competitive logic of degraded mutualisation

If collective bargaining is made the preferred source of complementary health cover, it also becomes an unexpected source of competition law (2.1). But what consequences can the intervention of this mode of regulation have on companies seeking health cover? More specifically, we are led to wonder about the possible effects of economic domination, in particular for the smallest companies, which are in a situation of definite imbalance with regard to the insurers with whom they take out supplementary health insurance (2.2).

2.1. Collective bargaining as a new source of competition law

Social law has been turned upside down and is being challenged by economic law, which is introducing a new form of regulation, more oriented towards competition law and the functioning of the market. The structuring principles of the economic order have succeeded in imposing themselves, weakening the edifice of complementary social protection and health cover in companies that social law had built.

Thus, in 2013, the Constitutional Council mobilized the principles of contractual freedom and entrepreneurial freedom to censure the designation clauses included in branch collective agreements. By granting a management monopoly to an insurer, these clauses were imposed on companies, which could not choose to contract with the insurer of their choice. In so doing, the constitutional judge ignored the reasons that could justify a possible restriction by the legislator on these two fundamental freedoms under economic law, in particular the issues of mutualisation.

There is also the question of how the principle of free competition, enshrined in article 101 of the Treaty on the Functioning of the European Union (TFEU), relates to the freedom of collective bargaining. In European Union law, because of the social policy objectives involved, collective bargaining and its outcome, the collective agreement, are excluded from the scope of article 101 TFEU. Thus, the collective agreement is not considered a violation of the cartel prohibition. This follows from the Albany judgment of 1999 and the solution has been recalled several times, including in a case concerning complementary health insurance. Thus, in the AG2R judgment of 2011, the Court of Justice of the European Union considers that the public authorities may make a collective agreement providing for compulsory membership of a complementary health cover scheme compulsory for all undertakings in a sector of activity.

However, in European law, the exercise of the fundamental right to collective bargaining must be reconciled with the requirements arising from the freedoms protected by the TFEU. It is in this balancing act that we must ask ourselves whether the conditions for implementing a social protection system do not disproportionately affect economic freedoms. In other words, “European positive law puts contractual activity under surveillance [...]” (Del Sol, 2015). It requires, in particular, that any management monopoly obtained by an insurer by a collective agreement be granted at the end of a procedure that satisfies conditions of transparency, impartiality and equal treatment between candidates. Such requirements were adopted by French law in 2015 for clauses recommending an insurer. Thus, a decree now requires branch negotiators to carry out a prior competitive bidding process for candidate insurers and also at each review of the recommendation clause. In other words, the collective agreement, far from being excluded from the scope of Article 101 TFEU, must implement it, significantly contradicting the interpretation resulting from the AG2R judgment.

But is it part of the role of the social partners to regulate the health insurance market? This is a form of neo-corporatism that should be questioned from the point of view of the relationship between social democracy and political democracy: can the state so easily leave it to private actors to define what is public economic order? Legally, this seems to be accepted if we refer to the position of the CJEU expressed for example in the AG2R judgment. However, this question is also a political one: does the recognised representativeness of trade unions and employers’ organizations give them a normative power that goes beyond questions relating to labour relations? Should the joint committees set up at branch level not be subject to control?

2.2. The risk of a discriminatory effect between companies seeking health cover

The law of 14 June 2013 makes complementary health cover compulsory for private sector employees. Nevertheless, and no doubt paradoxically, the new legal framework for complementary social protection implemented since 2013 is a source of potential fragility for both the companies subscribing to group contracts and the employees benefiting from the coverage. In a way, this legal environment is less advantageous than the previous one: it subjects companies and, consequently, their employees more to the law of supply and demand because the space for mutualisation has been restricted and the risk profile of employees and the company (age of employees, socio-professional categories, dangerousness of the activity, quality of the work environment, etc.) becomes a determining factor in the conditions for subscribing to an insurance contract.

The Labour Code assigns to branch negotiations the task of regulating competition between the companies within its scope. To this end, negotiating complementary social protection for employees at branch level is undoubtedly part of this regulation, since it is one of the areas in which branch agreements continue to prevail over company agreements. However, this area is not a compulsory subject for branch negotiations, unlike, for example, employee savings schemes. Moreover, the regulation of competition by the branch is very largely conditioned by the mutualisation mechanisms available to negotiators. Indeed, one of the essential issues is the pricing of the insurance contract taken out by the company to meet its commitments in terms of collective social guarantees. There are two possible situations: either the pricing is correlated to the level of risk presented by the company and subjects it to the laws of the market, or it is a collective pricing system based on mutualisation between companies at the level of the branch.

However, the mutualisation mechanisms available to branch negotiators have been disrupted by the 2013 decision of the Constitutional Council. Mutualisation at this level is now hindered, or even dissuaded. On the one hand, it is no longer legally possible to establish solidarity between all the companies in a given branch, since mutualisation can no longer be imposed, unlike the monopoly clauses for an insurer. On the other hand, the benefit of a collective rate system is achieved by inserting a recommendation clause in the branch agreement, which results in a deceptive mutualisation and whose legal regime (conditions, procedure, effects) is hardly an incentive.

2.2.1. Lack of an insurer's recommendation clause: a demutualisation that may leave some companies vulnerable

In this case, there is no collective tariff at branch level and it cannot be used against any insurer. As a result, each company is in a one-to-one negotiation with an insurer. This contractual face-to-face relationship may place the company in a vulnerable situation if its risk profile is unfavourable. Indeed, the pricing envisaged will depend, and sometimes very closely, on the company's claim ratio as estimated by the insurer.

"The company must expect its risks to be analyzed by the insurer with which it negotiates the management of its cover: its size, claims experience, demographics, age and the health condition of its employees are all decisive factors for pricing. The smallest companies, which, moreover, have all the characteristics of a 'bad risk', have little negotiating power to counterbalance the pricing variables of the insurers." (Geslot, 2014)

In the absence of a recommendation clause, the situation may therefore be "critical" for some companies that have to negotiate directly with an insurer, particularly for small companies with one or more employees in poor health or with a disability. It is true that, in the case of group insurance contracts with compulsory membership and in application of the 1989 Evin Act, the insurer cannot select among employees or set premiums according to health condition. However, it may weigh up the risks in order to determine the group's loss ratio.

The abolition of the monopoly clauses has not changed this situation. However, it is exacerbated by two factors: on the one hand, the need for each company to meet the obligation to finance at least half of the complementary health cover; on the other hand, the limited attractiveness, for reasons of both financial and technical cost, of recommendation clauses for branch negotiators. Although no official statistics exist, the absence of a recommendation clause seems to be a reality in many branches. For example, of 138 branch agreements on healthcare costs recorded in 2018, the Centre technique des institutions de prévoyance (Technical Centre for Provident Institutions) found that only 48% contained a recommendation clause.

2.2.2. Existence of a recommendation clause: the pitfall of segmenting the market according to risk profiles

By recommending one or more insurers, the branch negotiators mobilize the only mutualisation mechanism available to them for health insurance benefits. However, the mutualisation established may only reflect a minimum level of solidarity between the companies in the sector. This is the result of the reversal of the logic governing the relationship between the companies and the insurer. During the period of validity of the clause (five years maximum), the recommended insurers may not refuse to accept a company falling within the scope of the agreement. They are obliged to apply a single tariff and to offer identical cover for all companies and employees concerned. On the other hand, companies are no longer legally captive, as the 2013 Constitutional Council decision recognised a form of primacy of contractual freedom over all other considerations.

Today, as before with the monopoly clauses, all companies in the sector are guaranteed to find an insurer and to have the collective tariffs to which the recommended insurer has committed itself applied. Their risk profile is therefore irrelevant. In other words, collective pricing expresses solidarity between the companies in the sector. However, unlike the previous situation, this solidarity scheme is relative and does not make it possible to optimize or perpetuate a collective pricing system based on solidarity. Essentially, the internal balance of the sector is exposed to the risk of market segmentation. To put it simply, companies (or groups) with a good risk profile – due in particular to their size – can hope to obtain a more advantageous

rate by negotiating by mutual agreement with an insurer and choose not to join the mutuality of the branch entrusted to the recommended insurer, while at the same time companies with a less good profile will have an interest in joining this mutuality. Inevitably, the collective tariff proposed by the recommended insurer during the call for tenders takes this risk into account and will automatically be higher than with a monopoly clause, because the insurer knows that it cannot count on all the companies in the sector¹. This risk of market segmentation also creates difficulties for the future. On the one hand, the collective tariff planned for the duration of the recommendation may have underestimated the extent of the market segmentation phenomenon in view of the risk profiles; on the other hand, the results of the branch may be affected by the return to mutuality of companies which did not initially opt for the recommendation, but whose risk profile has deteriorated. However, as the regulations currently stand, there are no legal arrangements available to branch negotiators to try to partially counteract this risk of segmentation and thus to promote a more inclusive² collective pricing system.

Ultimately, the pattern that has emerged since 2013 seems to run counter to an ambitious, long-term branch policy that would make it possible to smooth out tariff changes over time for the benefit of all companies in the professional sector concerned. This is due to the preference now given to collective bargaining at company level. It makes it more complicated to make the branch the place for this policy when the stakeholders are encouraged to conduct it at another level. Moreover, collective bargaining at branch level is increasingly concerned with regulating competition in the health insurance market, rather than with fulfilling the objectives that social law has hitherto entrusted: the protection of health, the improvement of employment conditions, the establishment of greater equality and solidarity between employees in the branch.

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1. It can also be estimated that this collective tariff is increased because the recommended insurer will have to incur higher acquisition costs since it must try to convince the companies in the branch to subscribe to it where the monopoly clause required them to do so.

2. The Libault report (2015) suggested that branches should be allowed to set a (framed) penalty for companies that join the recommendation scheme late, "in order to limit entry/exit in line with the changing risk profile" (p. 42).

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