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Group Complementary Health Insurance: Means of Implementation that Vary According to the Firm

The Results of the 2017 Employer-provided Complementary Health Insurance Survey

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Since 1 January 2016, every private-sector employer are mandated to provide complementary health insurance for their employees. According to the results of the 2017 Employer-provided Complementary Health Insurance Survey (*Protection Sociale Complémentaire d'Entreprise*, PSCE), almost all employees now work in a firm that provides a complementary health insurance scheme.

The ways in which employer-provided complementary health insurance is generalised are strictly regulated by the law. The employers must cover at least half of the cost of the premium and provide coverage that is greater than or equal to the "basic" scheme, while respecting the constraints of 'responsible' insurance policies that also impose certain coverage ceilings.

This study shows the diversity of the ways in which employer-provided complementary health insurance is implemented, while respecting the legal regulations. The levels of coverage and the employer's contribution depend in particular on the activity sector, the size of the firm, and its qualification structure.

The higher the average wage and the greater the number of executives working in the firm, the more generous the coverage and the higher the proportion of the employer's contribution. The major firms generally provide the most beneficial conditions, as well as a greater number of possibilities of complementing the basic contract with optional coverage or supplementary contributions.

Lastly, firms that already provided a complementary health insurance scheme before it became compulsory to offer better coverage and make a higher contribution to the payment of the premium than firms which had to comply with the mandate to provide insurance. Generally, the latter restrict their financial contribution to the minimum stipulated by the law.

In France, the Social Security system covered 78% of the healthcare expenses in 2019 (National health accounts, DREES, 2020), but the degree of its coverage is extremely variable depending on the type of treatment, excluding high co-payments for certain treatments, when they are provided by medical professionals who charge additional fees, or when the hospital stays are not exonerated from the patient's contribution. These co-payments are mostly reimbursed by the complementary health insurance schemes, which cover 96% of the population (in 2017), and pay for 13% of the healthcare expenses (Fouquet, 2020).

In addition to funding by the French Social Security system, French residents must also pay complementary health insurance premiums to private insurance firms to avoid facing high out-of-pocket payments that would restrict their access to certain treatments. This complementary payment of healthcare expenses enables France to be —on the macroeconomic level—, the country with the lowest out-of-pocket payments in the Organisation for Economic Cooperation and Development (OECD). However, this situation, which is generally favourable, is accompanied by disparities, in particular with regard to healthcare access for persons who have no complementary health insurance. Access to complementary health insurance is possible, either through individual policies, or *via* group policies, generally provided by firms. Individual policies for civil servants, retired persons, and the unemployed are more expensive than group policies and generally provide less coverage (DREES, 2019). Lastly, individual policy premiums are age dependent, which makes them particularly expensive for retired people, and are entirely paid by households, with the exception of beneficiaries of the Complementary Health Solidarity (*Complémentaire Santé Solidaire*, CSS), which is based on an individual's resources[1]. Group policies benefit from better risk pooling, which depends on the firm's age pyramid, and

SOURCE

The analysis is based on the 2017 Employer-provided Complementary Health Insurance Survey (*Protection Sociale Complémentaire d'Entreprise*, PSCE). As with previous editions, the 2017 survey (PSCE) set out specifically to gather information about employer-provided complementary health insurance coverage and the acquisition of these policies by employees, based on the observation of their professional, social, and medical characteristics. The survey functioned on two levels: a component that gathered data from establishments concerning the characteristics of the complementary health insurance available to the employees, particularly the levels of coverage and cost of premiums. And a component aimed at a sample of employees working in establishments that responded to the survey made it possible to collect information about the opinions of individuals about the coverage provided by their firm, the opinion of the employees about this coverage, and the social and medical characteristics that account for their choices and opinions. The Establishments and Employees sections were matched with the Annual Declarations of Social Data (*Déclarations Annuelles des Données Sociales*, DADS) from 2015, 2016, and 2017. This study only involved the Establishments section matched with DADS 2015. In this section, the (DADS) data provides information —with regard to the establishment and the firm of which it is a part— about the structure in terms of the professional characteristics of the population of employees working in the establishment on 31 December 2015.

In total, 6,122 establishments responded to the survey and were matched with the data (DADS). The 5,572 establishments that offered complementary health insurance had a total of 6,534 policies.

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The differentiation of the coverage and, with regard to the policies, the availability of optional plans or supplementary health insurance contracts, is explained by a Probit model. With regard to the level of coverage, we constructed a global indicator *via* a Principal Component Analysis (PCA) of the six types of coverage collected in the survey (fees of specialist doctors, hospital fees, a private room in Medicine, Surgery, and Obstetrics (MSO), glasses, dental prostheses, and hearing aids) and by retaining the first axis, which on its own explains 60% of the total variance. This approach amounts to a weighted sum of the six levels of coverage considered[A]. For the analysis of the determinants of the level of coverage taken out, rather than the global indicator being directly regressed, the estimations were carried out per coverage using a Tobit model to take into account thresholds and reimbursement ceilings with log-linear specification[B]. The effects were then re-aggregated. With regard to the employer's contribution, we applied a left-censored Tobit model (50% threshold) and a right-censored Tobit model (100% threshold), also with log-linear specification.

The explanatory variables introduced were:

- The average wage in logarithm, the variability of the wages between employee categories (executives, technical professions, employees, and workers), and the variability within these categories, both measured by the mean logarithmic deviation[C].
- The size of the firm of which the establishment is a part, the establishment's activity sector, its geographical location (Île-de-France, Alsace-Moselle, or a mainland province, excluding Alsace-Moselle, and overseas *départements* (Dom)).
- Variables describing the structure in terms of employees: the proportion of each socio-professional category (executives, technical professions, employees, and workers), the proportions of each type of employment contract (permanent contracts (*Contrats à Durée Indéterminée*, or CDI), fixed-term contracts (*Contrat à Durée Determinée*, or CDD), other non-permanent contracts, and public servants), the proportions of each employment status (full time, part time, other), and the proportions of different age groups (under the age of 30, 30–39, 40–49, 50 and over).

The calculations of the average wage and its variability, as well as the proportions associated with the characteristics of the employees (socio-professional categories, employment policies, employment conditions, and age groups), were made in relation to groups of employees to which each demand variable was applied, that is to say the establishment, for the differentiation variable of the coverage, and with regard to employee categories covered by each contract for the variables of the levels of coverage, employer contribution, and availability of supplementary contributions or optional plans.

Two of the four coverage variables explained also had the status of explanatory variables at certain stages of the analysis: the fact that the coverage is differentiated when the levels of coverage and the availability of optional plans or additional contributions are explained; and the level of coverage and the availability of options or additional contributions is explained.

[A] The coordinates of the coverage variables on this axis, which are all positive, were renormalised by the sum of the coordinates so as to obtain weights between 0 and 1. The indicator was obtained by applying a weighted sum for the weights of the levels of coverage normalised per their standard-deviation.

[B] For a private room in the hospital, there is no compulsory minimum. Nevertheless, almost no policy reimburses less than 15 euros per day of hospitalisation, which may be related to the fact that the complementary insurance firms do not offer lower reimbursements. We have therefore attributed null levels of coverage due to the fact that the reimbursement offered was lower than 15 euros, and hence we used this value as the lower threshold.

[C] The variability indicators of the inter-category and intra-category wages are provided by:

$$\Sigma_j p_j . \ln\left(\frac{w'_j}{w'}\right) \text{ and } \Sigma_{i,j} . \ln\left(\frac{w_{ij}}{w'_j}\right)$$

Where w_{ij} is the wage of the individual i in the category j, w'_j is the average wage of the category j, and w' the average wage in the establishment or in the policy.

the premiums are for the most part paid by the employers, who benefit from social and fiscal exonerations.

The ways in which employer-provided complementary health insurance is being generalised: firms have room for manoeuvre in a framework established by the law

Since 1 January 2016, every firm in the private sector must provide complementary health insurance for its employees and contribute to its funding. The latter are obliged to take out the healthcare coverage provided by their firm, unless their situation enables them to benefit from a health coverage exemption[2]. Prior to this date, only half of the establishments, representing 75% of the employees, provided access to employer-provided complementary health insurance. The employees of small firms and the most precarious employees had access less often to an employer-provided complementary health scheme, and were most often covered by individual policies. In 2017, after the reform, 84% of the establishments, representing 96% of the employees, provided access to an employer-provided complementary health insurance scheme according to the 2017 Employer-provided Complementary Health Insurance Survey (*Protection Sociale Complémentaire d'Entreprise*, PSCE) [Lapinte, Perronnin, 2018]. Confirming the results of simulations carried out before the generalisation in relation to the potential effects of this reform on the diffusion of complementary healthcare policies (Pierre, Jusot, 2017), a study conducted after the reform (Fouquet, 2020) attests that it has had an impact on vulnerable employees, particularly apprentices, young people, temps, employees with short-term policies, and persons unemployed for under a year, thanks to the extension of the portability of policies. However, the generalisation of employer-provided complementary health insurance has only had a slight impact on the general coverage of the population by a complementary health insurance scheme, because the beneficiaries of the reform were mostly covered by an individual contract prior to the reform. As expected (Pierre, Jusot, 2017), the main effect of the reform has therefore been the transfer of individual policies towards group policies.

The implementation of the generalisation of employer-provided complementary health insurance may also result in extensive heterogeneity amongst firms. The law sets out a certain number of rules that must be respected: the employer's contribution should represent at least 50% of the premium and the coverage must be higher or equal to that of a "basic" policy, but it must also respect the criteria of "responsible" policies, which also imposes reimbursement ceilings for optical care or extra billings (see Inset above). Beyond the framework imposed by the law on every firm, more drastic obligations may exist at the level of the different branches of activity with regard to the minimum levels of coverage, the conditions of extending the Employer-provided health insurance to relatives, the cost of the premium for the basic policy, and the extent of the employer's contribution. In order to promote the risk-pooling amongst firms at branch level, certain branches recommend that policies should be taken out with specific insurance firms. The firms, however, are able to take out health insurance with the insurance firm of their choosing[3].

The regulation of firm policies gives the employer a certain freedom to implement the employer-provided complementary health insurance, which may lead to differentiated access by employees to complementary health insurance according to the characteristics of their employment,

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The regulation of complementary health coverage

Several provisions aimed at regulating the levels of reimbursement of firm and individual policies have been introduced into the Law. The most general provision stipulates that the responsible policies must reimburse the patient's contribution for almost all out-of-hospital and hospital healthcare, the cost of hospital stays with no limit, and for glasses, they must provide reimbursements ranging from at least 50 to 200 euros. They must also cap reimbursements for ambulatory and hospital healthcare provided by doctors who have not adhered to the Controlled Pricing Practices Option (*Option pratique tarifaire maîtrisée*, OPTAM), with a maximum coverage for additional fees of 100% of the conventional rate, and glasses, with maximum reimbursements ranging from 470 euros for glasses with simple lenses to 850 euros for glasses with very complex lenses. As far as the firm policies go, the ceilings considered are those in responsible policies. Nevertheless, the minimums that need to be respected, which define the provision of a minimum "basic'"policy, are slightly higher for glasses (coverage ranging from 100 to 200 euros) and dental treatments (coverage of additional fees up to 25% of the conventional rate in addition to the patient's contribution).

Those who take out individual insurance policies are not obliged to take out a 'responsible' policy. Nevertheless, they are encouraged to do so, because if they do not the additional solidarity tax (*Taxe de Solidarité Additionnelle*, TSA) applied to their contract is increased. However, the minimum corresponding to the threshold established by the National Inter-Professional Agreement (*Accord National Interprofessionnel*, ANI) and responsible insurance policy ceilings are applied in the case of group policies.

[1] The free Complementary Health Insurance (*Couverture maladie universelle complémentaire*, CMU-C) and Health Insurance Voucher Plan (*Aide au paiement d'une complémentaire santé*, ACS) merged in November 2019 and became the Complementary Health Solidarity (*Complémentaire santé solidaire*, CSS). Below a revenue of 753 euros per month for a single person, the CSS is free; between 753 and 1,015 euros, the individual pays a small contribution that depends on the person's age.

[2] In particular, when they are covered compulsorily by their spouse's group coverage, when they are covered by a civil service mutual insurance policy or their spouse's "Madelin" policy, or if they are a beneficiary of the Complementary Health Solidarity (resulting from the merging of the free Complementary Universal Health Insurance (CMU-C) and Health Insurance Voucher Plan (ACS)) and, in the short term, if they have an individual policy at the time of the implementation of the group policy.

[3] Following a decision made by the *Conseil Constitutionnel* on 13 June 2013 that prohibited the designation clauses but authorised recommendation clauses, to promote competition, based on the Opinion of 29 March 2013 of the French Competition Authority (*Autorité de la Concurrence*).

their firm, or their activity sector. Hence, the law enables firms to make distinctions in the coverage provided according to "objective" categories of employees, as this distinction is generally based on the executive and non-executive statuses. The level of coverage provided by the firm insurance's minimum plan may exceed the levels of reimbursement imposed by the law, and this basic policy may, depending on the firm in question, be complemented voluntarily by more comprehensive plans or supplementary policies. Lastly, the employer's contribution to the payment of the premium may exceed the legal minimum.

Theoretically, a broader source of heterogeneity for group than individual complementary health insurance

Unlike individual policies, for which individuals select their level of coverage according to a relatively limited number of characteristics (healthcare needs, health preferences, risk aversion, revenues, etc.), the decisions to take out group insurance may be the result of a much larger range of characteristics that need to be taken into account. Theoretically, firms resolve the issue by taking into account the entire cost of the employee, and finance this type of coverage because the employer may, in the long term, compensate for its financial contribution by a lower wage (Gruber, Krueger, 1991[4]). The employer's contribution to the funding of complementary health insurance is not subject to social security contributions and is deductible from the taxable profit with regard to firm tax. The implementation of an employer-provided complementary health insurance may be used as a device for attracting and retaining (at lower cost) categories of employees that are in demand on the labour market.

[4] Most of the theoretical and empirical studies on the economic mechanisms linked to the companies' demand for health insurance were described in the American context. Although certain aspects are very different from the French context (the fact that coverage starts with the first dollar in the United States), many other aspects are similar, in particular the existence of an employer contribution, the fact that this contribution is not subjected to social security contributions, and the existence of options.

As with individual policies, the level of coverage taken out may, in theory, depend on the distribution of the characteristics linked to the employees' insurance demand. However, the demand for coverage within the firmmay vary considerably from one employee to another (Bundorf, 2002) and is not necessarily known by the parties involved in the negotiation of the policy. The result is that the level of coverage taken out may be inadequate for some of the employees and too high for other employees. To counter this problem, the employer may, on the one hand, differentiate coverage according to employee categories (for example, executives, and non-executives) and, on the other, provide additional forms of coverage, which are optional and entirely paid for by the employees.

Lastly, the specific characteristics of the firm and its activity sector may also influence the insurance application. Certain activities (computer work, carrying heavy loads, etc.) may increase the level of risk for certain expenditure items and justify a higher coverage demand. The union representation within the firm and the organisation of consultative bodies, in which issues relating to employer-provided complementary health insurance are discussed, may give employees a greater ability to defend their interests and obtain more advantageous conditions (with regard to the coverage and employer contributions).

Differences in coverage between executives and non-executives are more common in industry, in firms with more than 50 employees, and when there is significant wage dispersion

In 2017, only 11% of the establishments, representing 21% of the employees, provided distinct coverage to various objective categories of employees. However, if the analysis is restricted to establishments employing at least two categories of employee, and which are then able in practice to distinguish their offer, this proportion applies to 17% of the establishments. In almost every case, the policies are distinguished according to executive and non-executive categories.

ONTEXT

This study, based on the 2017 Employer-provided Complementary Health Insurance Survey (*enquête Protection sociale complémentaire d'entreprise*, PSCE), carried out by the Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health) and the Institute for Research and Information in Health Economics (*Institut de recherche et documentation en économie de la santé*, IRDES), aims to investigate certain descriptive results in the report devoted to this survey (Perronnin, 2019). The focus on the provision of employer-provided complementary health insurance will be complemented by a study of the choices employees make when taking out complementary health insurance provided by their firm.

Everything being equal, the proportion of establishments that differentiate their complementary health insurance offer between categories of employees increases with the size of the firm of which the establishment is a part (first column on the table): compared with establishments that are part of a firm with 1 to 4 employees, the proportion is 5 points higher amongst firms of 5 to 9 employees, 13 points higher amongst establishments of 10 to 49 employees, and 15 to 19 points higher in establishments that are part of a larger firm. It is in the industrial sector that the differentiation between executives and non-executives is most common. Establishments in the "Public administration, teaching, health, and social" sectors, "Other service activities", and "Communication, finance, insurance, and real estate" sectors are those that differentiate least often.

The probability that the coverage is differentiated between employee categories increases with the level of the average wage within the establishment and the distribution of these employees amongst the professional categories (see Table). An increase of 10% of the average wage is accompanied by an increase in the probability of differentiating the coverage by 0.7 points. An increase of 0.1 of the dispersion index of the wages increases the probability of differentiation by 2.5 points.

The higher the average wage, the better the coverage and the higher the employer's contribution

There is great heterogeneity in the levels of coverage provided by the employer-provided complementary health insurance policies, particularly for coverage which is not capped by responsible policies: for example, an inter-decile ratio of 4 for dental prostheses and 5.4 for hearing aids.

However, the employer contributions (60% on average), are close to the minimum threshold of 50%: for 61% of the policies, the percentage is exactly this minimum, for 15% of the policies it is higher than 50% but lower or equal to 60%, and for almost one quarter of the policies it is greater than 60%.

A global indicator of the level of coverage was established using a Principal Component Analysis (PCA) [see Insets: "Source" and "Method", p.2], based on the levels of six types of coverage collected in the 2017 Employer-provided Complementary Health Insurance Survey (*Protection sociale complémentaire d'entreprise*, PSCE): (reimbursements of the fees of specialist doctors and hospital doctors who have not adhered to the Controlled Pricing Practices Option (*Option pratique tarifaire maîtrisée*, OPTAM), the reimbursement of one night spent in the private room of a hospital in Medicine, Surgery, and Obstetrics (MSO), reimbursements for glasses, dental prostheses, and hearing aids). The employer's contribution is the subject of a separate analysis.

All things being equal, the size of the firm of which the establishment is a part has an impact on the level of coverage and the employer contribution. Although establishments that are part of firms with less than five employees tend to propose lower coverage levels than the others, the differences are small and only slightly significant or insignificant, except for establishments that are part of firms with 500 employees and over. The largest firms provide coverage levels that are higher than those provided by all of the other firms.

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Effect of the main explanatory variables on the four variables of the complementary health coverage analysed

	Probability of differentiated coverage	Level of coverage	Employer Contribution	Probability of optional plans
	In points	*In %*	*In points*	*In points*
Size of the firm of which the establishment is a part *(ref.: 1–4 employees)*				
5–9 employees	5.5*	0.4	-4.6***	9.3***
10–49 employees	13.0***	3.8*	-4.0***	15.1***
50–99 employees	19.1***	1.3	-2.5*	17.0***
250–499 employees	16.3***	6.4*	0.7	24.1***
500 employees and over	19.2***	5.4	0.9	22.6***
500 salariés et plus	14.6***	13.3***	0.7	31.5***
Activity sector *(ref.: Industry)*				
Agriculture, forestry, fishing	-5.7	-4.1	-3.4*	5.7
Construction	-5.0**	-8.3***	2.4*	-10.1***
Commerce, car repair	0.4	-4.5*	-2.2**	2.8
Transportation and storage facilities	-5.4*	-0.7	0.9	7.4*
Accommodation and restaurants	-4.6	3.7	-6.2***	-4.4
Communication, finance, insurance, real estate	-11.9***	-2.3	1.9	-10.1***
Scientific and technical activities, administrative services	-4.2*	-0.6	-2.3**	3.3
Public administration, teaching, health, social services	-13.9***	-21.6***	-5.5***	7.2**
Other service activities	-13.4***	-24.9***	0.8	2.2
Composition according to the socio-professional category *(ref.: proportion of executives)*				
Proportion of…				
Technical professions (+ 10 pts)	0.3	-0.8**	-0.2	0.9**
Administrative employees (+ 10 pts)	0.2	-1.2***	-0.2	1.0***
Commercial employees (+ 10 pts)	-0.2	-1.8***	-0.2	1.0***
Qualified workers (+ 10 pts)	0.5	-1.8***	-0.5***	0.6
Unqualified workers (+ 10 pts)	1.3**	-2.3***	-0.4*	0.0
Composition according to age *(ref.: Under 30)*				
Proportion of …				
30–39 yrs (+ 10 pts)	-0.3	-0.5	-0.1	0.0
40–49 yrs (+ 10 pts)	0.2	-0.3	0.3*	-0.1
50 yrs and older (+ 10 pts)	0.0	-0.2	0.1	-0.3
Composition according to gender *(ref.: Proportion of men)*				
Proportion of women (+ 10 pts)	0.0	-0.1	-0.1	0.6*
Wage variables				
Gross average wage(+ 10%)	0.7***	1.3***	0.4***	-0.6***
Variability of gross wages: between socio-professional categories (+ 0.1)	2.5***	-2.5**	0.1	-0.2
Variability of gross wages: socio-professional intra-category (+ 0.1)	-0.5	0.6	-0.2	-0.6
Uniform offer	-	-2.5	-2.1**	5.7***
Level of coverage (+ 10%)	-	-		-2.8***
Number in the analysis databases	4,080	6,216	5,988	6,134

*: significant at 5%; **: significant at 1%; ***: significant at 0.1%.

Note: Compared with establishments that are part of a firm with 1 to 4 employees, those with 5 to 9 employees have a probability 5.5 points higher of differentiating the policy according to the socio-professional category, a level of coverage 0.4% higher, a level of employer contribution 4.6 percentage points lower, and a probability 9.3 points higher of including optional plans and supplementary contributions.

Remarque: The other variables introduced in the analysis, which are not included in the table, are the establishment's location, and the composition of the establishment in terms of employment contract and employment category.

Source: 2017 PSCE Survey.

Download the data

With regard to the employer's funding of the health insurance, establishments that are part of a firm with 100 employees or over pay a higher financial contribution than establishments that are part of firms with less than 100 employees, with the exception of firms with less than 5 employees, which are no different than the largest firms.

The higher the average wage of the group of employees that has access to the policy, the more generous the coverage, whether in terms of the level of reimbursement or the employer's contribution: an increase of 10% of the average wage is linked to an increase of the basic coverage by 1.3% and the employer contribution by 0.4 points.

All things being equal, and hence, in particular, by taking into account differences in the average wages of employees concerned by each policy, the firm's qualification structure also influences the level of coverage provided by the basic policy and, to a lesser degree, the employer's contribution. With regard to coverage, a form of social gradient emerges, with coverage that is higher when there is a high proportion of executives, with the technical professions and administrative employees in a median position. In contrast, the greater the proportion of unqualified workers, the lower the level of coverage provided by the policy. The employer's contribution seems to be less associated with the qualification structure, but the contribution is lower when the proportion of workers (qualified and unqualified) is greater.

It is worth examining the role played by the differentiation of the policies in disparities of coverage according to socio-professional categories: to what extent is this differentiation comparatively beneficial for executives and disadvantageous for non-executive employees when there is a single policy? All things being equal, the levels of coverage available for executives are significantly higher when the coverage is differentiated between executives and non-executives than when it is uniform for all the employer categories. Hence, when the policy offering is differentiated between executives and non-executives, it provides better coverage for executives. When there is a single coverage scheme in the establishment, the coverage is more generous in proportion to the number of executives.

Optional coverages are provided more often when the basic formula's coverage is low

In the case of just under half of the policies, the establishment enables the employees to complement the basic plan with more comprehensive optional plans or a supplementary contract. We analysed the decision to provide this kind of complementary coverage according to the characteristics of the establishments previously studied and the level of coverage (see Table).

All things being equal, the probability that optional plans or supplementary health insurance are available is lower when the levels of coverage are high. This possibility is clearly intended to make up for low reimbursements provided by the basic formula. As expected, the size of the firm has an impact; the larger the firm, the greater the possibility of optional plans or supplementary contributions, probably no doubt to take into account the diversity of the demands of the employees with regard to coverage negotiation within large firms.

Firms that provided no coverage before the compulsory scheme provide lower coverage and limit their financial contribution to the minimal threshold

Additional analyses were carried out to identify establishments according to whether they had or did not have a complementary health insurance scheme before it became compulsory. These results are not present in the table.

Establishments that already provided an insurance policy before it became compulsory, all things being equal, differentiate far more often their coverage between executives and non-executives (+ 9.7 points), provide coverage and employer contribution levels that are far higher (+ 24.6% for the level of coverage and + 6.5 points for the employer contribution), and provide supplementary coverage and optional plans less often (- 7.6 percentage points). These additional analyses underline the fact that explanatory factors, such as the size of the firm, the activity sector, the qualification structure, and the wages, which are closely linked with the existence of coverage before and after the reform, only partly explain the differences in coverage between firms that provided coverage before the compulsory coverage and those that did not provide it.

One could speculate that the history of social negotiation and the human resources policy, which were not observed in the survey, are specific to each firm, and may explain some of the differences objectified here. The firms constrained by the mandate, and which did not provide a complementary health insurance scheme for their employees before, restrict their contribution to a minimum of 50% and provide lower coverage, but which is nevertheless generally higher than the minimum threshold.

* * *

Group firm policies give employees access to health insurance policies that are generally more protective than individual policies and benefit from the employer's contribution towards the payment of the premium. The generalisation of employer-provided complementary health insurance (since 1 January 2016) has enabled access to this type of coverage to be extended to precarious employees or those who work in small firms that did not provide coverage before the obligation to do so. However, this study shows that there are persistent inequalities. The coverage provided and the employer's contribution to the payment of the premium are higher when the firm is larger and the qualification levels and wages are higher. Hence, even if the conditions of access to complementary health insurance are relatively homogenous within each firm, the differences between firm categories result *in fine* in the fact that there is still unequal access to complementary health insurance amongst all of the employees. Nevertheless, objective parameters correlated to healthcare needs, such as distribution according to the age and gender of

the employees, does not seem to be linked to the levels of coverage nor the employer's contribution.

With regard to employees, the generalisation of employer-provided complementary health insurance —while establishing employer-provided complementary health insurance as a complement to the wage level— has thus extended the benefit of coverage to the least well-paid employees. However, it is to be noted that the firms obliged to provide coverage tend to offer lower coverage and make less of a financial contribution. For the entire population, this generalisation deepens disparities between, on the one hand, employees who have access to coverage under conditions as advantageous as their professional situations, and on the other hand, persons who are not eligible for employer-provided complementary health insurance, such as employees or associated beneficiaries, who have to take out individual insurance schemes or who have no complementary health insurance. This applies in particular to the retired and civil servants, as well as persons who have no employment, such as the long-term unemployed, and those who are not working for health reasons or due to a handicap. ♦

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