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A COMPARISON OF THE ROLE OF THE EMPLOYER IN THE FRENCH AND U.S. HEALTH CARE SYSTEMS

*Kathryn L. Moore**

I. INTRODUCTION

The United States is unique among developed nations in its heavy reliance on employment-based health insurance.¹ The United States, however, is not the only nation in which employers play an important role in the financing of health care. Indeed, long before employment-based health insurance became common in the United States, countries with social insurance systems, such as France, Germany, Hungary, and the Czech Republic, provided for the delivery of mandatory social insurance benefits, including health insurance, through the workplace.²

This article explores the role of the employer in the health care system in one such country: France. The French health care system merits study because in 2000 the World Health Organization ranked the system the best in the world based on its reputation for universal coverage, responsiveness to patient needs, and positive health outcomes, including longevity, infant mortality, and population health status.³

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1. PIERRE-LOUIS BRAS & DIDIER TABUTEAU, *LES ASSURANCES MALADIE* 19-20 (2010) (describing the American system as unique); Jacob S. Hacker, *Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Policies of Health Reform*, 34 *BRIT. J. POL. SCI.* 693, 697 (2004) (noting that the United States is the only advanced industrial state to rely principally on voluntary employment-based health insurance).

2. SHERRY A. GLIED, *The Employer-Based Health Insurance System: Mistake or Cornerstone*, in *POLICY CHALLENGES IN MODERN HEALTH CARE* 37, 39 (David Mechanic et al. eds., 2005).

3. World Health Organization [WHO], *The World Health Report 2000 – Health Systems: Improving Performance*, at 153 (2000). *But see* Victor G. Rodwin, *The Health Care System under French National Health Insurance: Lessons for health reform in the United States*, in *UNIVERSAL HEALTH INSURANCE IN FRANCE HOW SUSTAINABLE? ESSAYS ON THE FRENCH HEALTH CARE SYSTEM* 59, 59 (2006) (noting that the methodology used in assessment has been criticized but that

This article begins by providing an overview of the French health care system. It then discusses the role of the employer in the French health care system. Finally, it compares the role of the employer in the French system with the role of the employer in the U.S. health care system.

II. OVERVIEW OF THE FRENCH HEALTH CARE SYSTEM

The French health care system is a unique blend of public and private health insurance based on a compromise between two competing ideologies: egalitarianism and liberalism.⁴ Under the egalitarian ethos, all citizens are considered to be equal and thus entitled to equal access to health care.⁵ Liberalism, on the other hand, refers to the market-based economy⁶ and protects choice and competition in the provision of health care.⁷ French politicians claim that the French health care system is the ideal synthesis of “solidarity and liberalism,” lying between Britain’s “nationalized” system which rations health care too much and the American “competitive” system which leaves too many individuals uninsured.⁸

The French health care system consists of two tiers:⁹ (1) mandatory

French health care system is still impressive).

4. DAVID G. GREEN & BENEDICT IRVINE, HEALTH CARE IN FRANCE AND GERMANY: LESSONS FOR THE UK 29 (Civitas 2001); see also Monika Steffen, *The French Health Care System: Liberal Universalism*, 35 J. HEALTH POL. POL’Y & L. 353, 356 (2010) (noting that “the French system combines and develops simultaneously what elsewhere would appear as contradictory, universalism and choice”).

5. GREEN & IRVINE, *supra* note 4, at 29; see also Paul Clay Sorum, *France Tries to Save its Ailing Health Insurance System*, 26 J. OF PUB. HEALTH POL’Y 231, 241 (2005) (stating that “like most other developed countries, France remains committed, in the name of social solidarity, to the access of all its citizens (if not necessarily, in the Raffinin government, to all its residents) to the same basic health care”).

6. Victor G. Rodwin, *The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States*, 93 AM. J. PUB. HEALTH 31 (2003) (noting that liberalism is “a term understood in much of Europe to mean market-based economic systems”).

7. GREEN & IRVINE, *supra* note 4, at 29.

8. Rodwin, *supra* note 6, at 31. In 2010, the American health care system was fundamentally reformed with the enactment of the Patient Protection and Affordable Care Act (Affordable Care Act). Pub. L. 111-148, 124 Stat. 119 (2010), as amended by Pub. L. 111-152, 124 Stat. 1029 (2010). Among other things, the Affordable Care Act was intended to address the problem of uninsurance in this country. Nancy-Ann DeParle, *The Affordable Health Care Act Helps America’s Uninsured*, THE WHITE HOUSE BLOG (Sep. 16, 2010, 2:33PM), <http://www.whitehouse.gov/blog/2010/09/16/affordable-care-act-helps-america-s-uninsured>. Whether it will do so remains to be seen.

9. See YUKATA IMAI ET AL., *The Changing Health System in France*, in UNIVERSAL HEALTH INSURANCE IN FRANCE: HOW SUSTAINABLE? ESSAYS ON THE FRENCH HEALTH CARE SYSTEM 79, 81 (2006).

public health insurance, sometimes referred to as “statutory” health insurance,¹⁰ and (2) voluntary,¹¹ mostly private, health insurance, sometimes referred to as “complementary” health insurance.¹² Coverage under the first tier is universal.¹³ About 90 percent of the French population has second tier voluntary private health coverage.¹⁴

A. First Tier – Mandatory Public Health Insurance

The first tier mandatory public health insurance is provided through the country’s extensive social security system.¹⁵ Established in 1945,¹⁶ the French social security system originally only covered workers and their families.¹⁷ In 1961, coverage was extended to farmers, and in

10. See, e.g., ISABELLE DURAND-ZALESKI, *The French Health Care System, 2012*, in INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS (The Commonwealth Fund, 2012); Karine Chevreur et al., *France: Health System Review*, at 17 (Health Sys. in Transition, Vol. 12 No. 6, 2010).

11. Effective January 1, 2016, employment-based complementary health insurance will become mandatory. See France Enacts the Labor Law Reform Act, LEGAL MONITOR WORLDWIDE (JORDAN), 2013 WLNR 16536778 (July 8, 2013) [hereinafter Labor Law Reform Act].

12. Some authorities distinguish between “complementary” and “supplementary” insurance, though not necessarily in an entirely uniform manner. Compare Chevreur et al., *supra* note 10, at 69-70 (treating “complementary” insurance as insurance that “covers the discrepancy between [statutory health insurance] coverage and health care expenses” and treating “supplementary” insurance as insurance as covering services not covered by statutory health insurance) with World Health Organization Europe [WHO], *What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?* (July 2004) (stating that both “complementary” and “supplementary” private health insurance provide coverage for services excluded or not fully covered by statutory health insurance but that the main purpose of “supplementary” insurance is to “increase the choices of provider. . . and level of inpatient hotel amenities”); see also Sarah Thomson & Elias Mossialos, *Private health insurance and access to health care in the European Union*, EURO OBSERVER: NEWSLETTER OF THE EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES, Spring 2004, at 2 (stating that complementary insurance covers “services excluded or not fully covered by the state,” while supplementary insurance “provides cover for faster access and increased consumer choice.”).

13. See IMAI ET AL., *supra* note 9, at 81.

14. See Chevreur et al., *supra* note 10, at 65.

15. See Thomas C. Buchmueller & Agnes Couffinhaul, *Private Health Insurance in France*, 8 (OECD Health, Working Paper No., 12, 2004). The French Social Security system provides compulsory protection of (1) health (disease, maternity, incapacity, and death), (2) work-related illness and injuries, (3) family allowances, and (4) retirement (pension and widowhood). Chevreur et al., *supra* note 10, at 20.

16. Chevreur et al., *supra* note 10, at 19. France’s first statutory health insurance system was established in 1930. This system was replaced by the Social Security system in 1945. SIMONE SANDIER ET AL., *Historical Background, Organizational Structure, and Management*, in UNIVERSAL HEALTH INSURANCE IN FRANCE: HOW SUSTAINABLE? ESSAYS ON THE FRENCH HEALTH CARE SYSTEM 129, 136 (2006).

17. Chevreur et al., *supra* note 10, at 20.

1966, coverage was further extended to the self-employed.¹⁸ Because coverage under the Social Security system was linked to employment status, gaps in coverage existed for certain low-income and unemployed individuals.¹⁹ In 2000, *Couverture Maladie Universale* (CMU) extended basic health insurance to all legal residents of France, regardless of employment status or prior contributions to the Social Security system.²⁰ The entire French population is now covered by the first tier mandatory public health insurance.²¹

1. Structure of System

Mandatory health insurance under the social security system is divided into three main regimes or schemes.²² The first regime or scheme is the general regime (*régime général*).²³ It covers employees in commerce and industry and their families as well as individuals who receive CMU.²⁴ The general regime is by far the most significant in terms of coverage; it covers more than 85% of the French population.²⁵ The second regime is the agricultural regime (*mutualité sociale*

18. See *id.* at 20. Coverage was extended to students in 1948 and career soldiers in 1949. *Id.* at 54.

19. Statutes were enacted in 1974 to extend coverage to individuals who were not otherwise covered by the social security system. In order to receive coverage, individuals were required to contribute to the system, or request the department to contribute on their behalf if they had insufficient means. As a practical matter, however, access to public insurance remained problematic for some groups. *Id.* at 20.

20. See Martine M. Bellanger et al., *The "Health Benefit Basket" in France*, 6 EUR. J. HEALTH ECON. S24, S24 (Supp. 1 2005). CMU "changed the old system of individual insurance, with contributions that could be financed by the general councils according to income scales that varied from one department to another, to a system based on the logic of the right to social protection through insurance. Since this reform, those whose income is below a certain level (2.3% of the population in 2006) are entitled to free public coverage." Chevreul et al., *supra* note 10, at 21.

21. Chevreul et al., *supra* note 10, at 17, 54.

22. Steffen, *supra* note 4, at 357.

23. See Bellanger et al., *supra* note 20, at S24.

24. See *id.*

25. Not surprisingly, estimates of coverage vary. For example, according to one authority, employees in commerce and industry and their families constitute about 84% of the French population while CMU was estimated to cover about 2.4% of the population in 2003. See *id.*, at S24. According to another source, CMU extended coverage to 0.4% of the French population. DURAND-ZALESKI, *supra* note 10, at 39. According to yet a third source, the general scheme "covers 56 million employees in commerce and industry and their families (87% of the population) and CMU beneficiaries (1.4 million people, 2.3% of the population in 2006)." Chevreul et al., *supra* note 10, at 28. See also Pierre Loiseau, *When the Clouds Hung Oppressively Low in the Heavens: Unhealth Cost-Cutting in France and in the U.S.*, 70 LA. L. REV. 945, 946 (2010) (stating that the general regime covers 80% of the French population).

agricole).²⁶ It covers farmers and agricultural workers and their families, which constitute about 7% of the French population.²⁷ The third regime is the regime for the non-agricultural self-employed (CANAM).²⁸ It covers the 5% or so of the population that is self-employed, such as self-employed professionals like lawyers and craftsmen.²⁹ The remainder of the French population is covered by ten or so other work-related schemes.³⁰

Each of the three major regimes consists of a national health insurance fund and local structures that correspond to the geographic distribution of their members.³¹ For example, the general regime has more than 100 local funds and 16 regional funds.³²

2. Management

Each fund is a “self-governing unit, with a management board composed of an equal number of representatives of employer and trade unions,”³³ as well as representatives of the mutual insurance associations and individuals appointed by the Minister of Health.³⁴

26. See Bellanger et al., *supra* note 20, at S24.

27. See *id.* Cf. Chevreul et al., *supra* note 10, at 28 (stating that the agricultural regime covers “3.6 million people or around 6% of the population”).

28. Bellanger et al., *supra* note 20, at S24.

29. See *id.*; see also Chevreul et al., *supra* note 10, at 28 (stating that the self-employed regime covers 3.4 million people or about 5% of the population).

30. Bellanger et al., *supra* note 20, at S24; see also Chevreul et al., *supra* note 10, at 28-29 (noting that some of the smaller schemes are linked to the general regime while others have their organization and function independently; for historical reasons, individuals from the Alsace and Moselle regions have their own specific scheme with better coverage in return for higher contributions).

31. See Chevreul et al., *supra* note 10, at 29.

32. Again, specific estimates vary. For example, according to one authority, the general regime has 16 regional funds and 105 local funds. Chevreul et al., *supra* note 10, at 29. According to another authority, the general regime has 16 regional funds and 133 local funds. GREEN & IRVINE, *supra* note 4, at 30. The regional funds’ responsibilities are limited to work-related accidents and illnesses. Chevreul et al., *supra* note 10, at 29.

33. GREEN & IRVINE, *supra* note 4, at 30. Agricultural workers, independent professions, civil servants, medical doctors, and students are covered by seventeen other funds. *Id.* Prior to 1967, representatives of employees constituted a majority of the elected boards of director of the insurance funds. In 1967, “elections to the board of directors were discontinued and replaced by a system of appointment by trade unions, with parity between employers and employees.” SANDIER ET AL., *supra* note 16, at 139.

34. SANDIER ET AL., *supra* note 16, at 155. For a more detailed discussion of the management of the health care funds, see *infra* Part II.

3. Coverage

The mandatory health insurance covers medical goods and services such as hospital care, outpatient care, diagnostic services, pharmaceuticals, and health-care related transportation.³⁵ In order to be eligible for coverage, the services or treatment must have been provided or prescribed by a doctor, dentist or midwife, and distributed by a health care professional or institution registered by the mandatory health insurance program.³⁶

Coverage varies depending on whether it is provided on an outpatient or inpatient basis. Covered outpatient services are specifically identified in official lists displayed on the mandatory health insurance program's web site.³⁷ The lists are defined at the national level and apply throughout the country.³⁸ Reimbursement for hospital care is provided on a diagnosis-related group (DRG) basis rather than on a procedure by procedure basis.³⁹ Unless specified otherwise, hospital clinicians can decide what care to provide and what drugs to prescribe (so long as the drugs have market authorization).⁴⁰

Initially, mandatory health insurance was intended to provide curative care for illnesses and accidents, rather than preventive care.⁴¹ Over the years, however, coverage has extended to include more and more preventive care. For example, coverage is now provided for compulsory and recommended immunizations as well as mammograms.⁴²

Historically, the French health care system has been generous in terms of coverage,⁴³ partly because the tendency had been to add items

35. Chevreul et al., *supra* note 10, at 55.

36. *See id.*; *see also* Bellanger, et al., *supra* note 20, at S26 (“The reimbursement of goods and services depends on their inclusion in positive lists, according to Articles L.162-1-7, L.162-17, and L. 165-1 of the [Social Security Code].”).

37. Chevreul et al., *supra* note 10, at 55-56. There are three official lists: (1) a list of covered procedures, (2) a list of reimbursable drugs, and (3) a list of reimbursable medical devices and health materials. *Id.* The Ministry of Health is responsible for identifying the covered drugs and medical devices while the National Union of Health Insurance Funds is responsible for the list of covered procedures. *Id.* at 57. The official website is found at www.amelia.fr. *See* ISABELLE DURAND-ZALESKI & KARINE CHEVREUL, *The French Health Care System, 2011*, in INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS, at 45 (The Commonwealth Fund, 2011).

38. Chevreul et al., *supra* note 10, at 57.

39. *See id.*, at 17; Bellanger, et al., *supra* note 20, at S26.

40. Chevreul et al., *supra* note 10, at 56.

41. *See id.*

42. *Id.*

43. *See* Steffen, *supra* note 4, at 363 (“From patients’ point of view, the French health system is indeed generous. It offers universal access and high quality and affords each individual the

to the covered lists but never to delete them.⁴⁴ In recent years, however, some services, and especially drugs with no proven efficacy, have been eliminated from the coverage list.⁴⁵ In addition, there are a few categories of care where public health insurance benefits are quite limited, such as for eyeglasses, dental care, and non-dental prostheses.⁴⁶

Generally, individuals are expected to pay for the full cost of ambulatory care at the time services are provided and wait for reimbursement from their health insurance fund.⁴⁷ Hospital care, in contrast, is generally paid for directly by the health funds.⁴⁸

4. Co-payments

Although the mandatory insurance system is generally generous in terms of the services and drugs it covers, it typically does not cover 100% of the costs.⁴⁹ Although reimbursement rates varied with the particular scheme in the past, the reimbursement rates are now uniform across the schemes.⁵⁰ The level of reimbursement depends on the category of care or service.⁵¹ For example, the mandatory health

choice to consult general practitioners and specialists as well as to receive outpatient care at a public hospital or private clinic in often comparable financial conditions.”).

44. See Chevreul et al, *supra* note 10, at 59; see also Steffen, *supra* note 4, at 363 (“[T]he rational interests of the actors involved – doctors, patients, unions, health industries, local politicians, and political parties – all converged to develop rather than to limit medical services and free access. Only those responsible for public finances pursued and continue to pursue a restrictive policy.”).

45. See Chevreul et al, *supra* note 10 at 59; see also Steffen, *supra* note 4, at 369 (discussing efforts to limit coverage under mandatory health insurance).

46. See Buchmeuller & Couffinhal, *supra* note 15, at 10-11.

47. See Chevreul et al, *supra* note 10, at 54. There are, however, exceptions to the requirement that the patient make the initial direct payment. For example, *CMU* beneficiaries are not required to make initial payments nor are individuals involved in occupational accidents and patients admitted to the hospital. In addition, third party payments may be used in laboratories, pharmacies, hospital consultations and outpatient clinics and by some doctors for expensive examinations and treatments. *Id.*

48. See *id.* at 55.

49. See *id.* at 59. Full reimbursement is available in three instances: (1) individuals suffering from one of 30 specified long-term illnesses may be entitled to 100% reimbursement for treatment related to those diseases; (2) certain hospital and fertility treatments are fully reimbursed; and (3) full reimbursement is available for work accidents, pregnant women after the fifth month of pregnancy, and disabled children and pensioners. *Id.* at 61; see also *id.* at 62 tbl 3.9 (listing 30 illnesses eligible for 100% reimbursement); cf. Steffen, *supra* note 4, at 365 (stating that the “authorizing list has grown to thirty-one pathologies”). For a comparison of cost sharing under the French, German, and Swiss health care systems, see KAISER FAMILY FOUNDATION, COST SHARING FOR HEALTH CARE: FRANCE, GERMANY, AND SWITZERLAND (2009).

50. See Chevreul et al., *supra* note 10, at 59.

51. See *id.* at 59.

insurance system generally reimburses 80% of the cost of inpatient care,⁵² 70% of the cost of doctor and dentist visits,⁵³ 60% of the cost of services provided by laboratories, and 65% of the cost of most drugs.⁵⁴

Co-payments (*'ticket modérateurs'*),⁵⁵ that is, the requirement that insureds pay for a portion of the cost of care, were instituted to moderate demand.⁵⁶ Over the years, the patients' share of costs has steadily increased.⁵⁷ The ability of co-payments to rein in costs, however, has been limited because of the prevalence of the second tier voluntary complementary insurance, which generally covers most of the costs not covered by the mandatory insurance system.⁵⁸

In 2005, the government introduced additional flat co-payments.⁵⁹

52. The reimbursement rate increases to 100% after the 31st day of a hospital stay, for certain surgeries, and maternity care. In addition, patients have to pay a flat-rate catering fee of €18 per day for hospital accommodations. *See id.* at 60.

53. Generally, costs for treatment procedures and tests that exceed €91 are fully covered. *Id.* Since 2006, however, most patients have had to pay a flat rate of €18 for such treatment and procedures. *See id.* at 63.

54. *See id.* at 60 tbl 3.8. Non-substitutable or expensive drugs are reimbursed at the rate of 100% while drugs judged to have a low medical benefit are reimbursed at the rate of 15%. *See id.* at 60.

55. *See* Lisa Gentile, *The Battle for Health in France: The Role of Ideas and Discourse in Constructing the Political Economy of Policy Reform (1990-2010)*, at 162 n. 212. (Sept. 2010) (unpublished Ph.D. dissertation, New York University) (explaining the origin of the term *ticket modérateur* and its evolution in France).

56. *See* SANDIER ET AL., *supra* note 16, at 146; *see also* Buchmueller & Couffinal, *supra* note 15, at 10 (“As the name suggests, the purpose of the *ticket modérateur* is to reduce the moral hazard associated with insurance coverage.”); *cf.* Steffen, *supra* note 4, at 360 (stating that the reason the first tier mandatory health insurance funds only provided partial reimbursement was because private and decentralized mutual benefit societies were widespread at the time the statutory system was introduced and the mutual benefit societies were the only institutions with the technical expertise to run a health insurance scheme); VICTOR G. RODWIN & SIMONE SANDIER, *Health Care Under French National Health Insurance: A Public-Private Mix, Low Prices and High Volume, in UNIVERSAL HEALTH INSURANCE IN FRANCE HOW SUSTAINABLE? ESSAYS ON THE FRENCH HEALTH CARE SYSTEM* 169, 170 (2006) (“The attachment to *la médecine libérale* and to cost sharing rests on the principle of liberalism – the notion that there should be freedom of choice for physicians and patients and some direct responsibility for payment by patients.”).

57. *See* SANDIER ET AL., *supra* note 16, at 146 (“Over the years, the patient’s share of treatment costs has steadily increased by means of progressive increments, the introduction of a daily charge in hospitals and authorizations for Sector 2 doctors and for certain services, such as dentures and artificial limbs”); *see also* Jason J. Kilborn, *Comparative Cause and Effect: Consumer Insolvency and the Eroding Social Safety Net*, 14 COLUM. J. EUR. L. 563, 587 (2008) (“[I]n 1993, the reimbursement level for medical services and drugs that were not fully reimbursable fell 5% (from 75% to 70% for medical services, 70% to 65% for major prescription drugs, and 40% to 35% for drugs for non-serious conditions”).

58. *See* SANDIER ET AL., *supra* note 16, at 146; Buchmueller & Couffinal, *supra* note 15, at 10-11; Gentile, *supra* note 55, at 162-63.

59. *See* Chevreul et al., *supra* note 10, at 63 (describing additional flat co-payments and stating that they were introduced to raise additional revenue).

Under these additional co-payments, individuals must pay €1 for every doctor visit and test up to €4 per day and €50 per year, and €2 for each medical transport by ambulance or medical taxi, and €0.50 for each drug, up to a second ceiling of €50.⁶⁰ These additional co-payments may be more effective in moderating demand than the *ticket modérateurs* because voluntary health insurance is prohibited from picking up these additional co-payments.⁶¹

In addition, a gatekeeping element was introduced to moderate demand.⁶² Historically, no individual or entity served as a gatekeeper in the French health care system.⁶³ Rather, individuals had the freedom to choose their doctors and other medical care providers.⁶⁴ Under the new gatekeeping element, visits to a registered gatekeeping general practitioner (GP) and/or specialist recommended by a gatekeeping GP are reimbursed at the rate of 70% while visits outside of the gatekeeping system may only be reimbursed at the rate of 50%.⁶⁵ Voluntary health insurance is prohibited from reimbursing the rate differential.⁶⁶

5. Financing

Traditionally, mandatory health insurance was financed almost exclusively by “social contributions” (*cotisations sociales*) imposed on both employers and employees.⁶⁷ The social contributions, like the payroll taxes used to fund the U.S. Social Security system,⁶⁸ are based

60. *See id.*

61. *See supra* Part 2.A.5.

62. *See* Chevreul et al., *supra* note 10, at 71.

63. *See* Jean-Pierre Poullier & Simone Sandier, *Reconsidering the Role of Competition in Health Care Markets*, 25 J. HEALTH POL. POL'Y & L. 899, 899 (2000); *see also* RODWIN & SANDIER, *supra* note 56, at 176. Recently, however, the system introduced a gatekeeping element under which visits to a gatekeeping general practitioner (GP) are reimbursed at the rate of 70% while visits to other GPs may only be reimbursed at the rate of 50%, and voluntary health insurance is prohibited from reimbursing the rate differential. DURAND-ZALESKI & CHEVREUL, *supra* note 37, at 47; *see also* Bellanger, et al., *supra* note 20, at S27 (discussing new gatekeeping rules); Steffen, *supra* note 4, at 368-69.

64. Poullier & Sandier, *supra* note 63, at 899; RODWIN & SANDIER, *supra* note 56, at 176. Indeed, French doctors have insisted on the system retaining the principles of independent medical practice, specifically, free choice of doctor, freedom to prescribe, professional confidentiality, and direct payment of fees by patients. SANDIER ET AL., *supra* note 16, at 142.

65. DURAND-ZALESKI & CHEVREUL, *supra* note 37, at 47; Bellanger, et al., *supra* note 20, at S27; Steffen, *supra* note 4, at 368-69.

66. *See supra* Part 2.A.5.

67. Chevreul et al., *supra* note 10, at 20; Steffen, *supra* note 4, at 357; BRUNO PALIER, *GOUVERNER LA SÉCURITÉ SOCIALE* 81 (2005).

68. 26 U.S.C. §§ 3101(a), 3111(a) (2012).

on a percentage of compensation.⁶⁹ As the cost of health care increased, so too did the social contribution rate.⁷⁰ By 1992, the social contribution rate had reached a combined rate of 19.6% of gross wages, with employers contributing 12.8% and employees contributing 6.8%.⁷¹

Mandatory health insurance continues to be funded in large part by employer wage-based social contributions.⁷² In 2013, the employer contribution rate is 13.1%,⁷³ and employer contributions account for about 47% of the mandatory health insurance system's revenues.⁷⁴ For the most part, the employee wage-based social contribution, which has fallen from 6.8% in 1992 to 0.75% of gross earnings in 2013,⁷⁵ has been replaced by an earmarked tax, the general social contribution (*contribution sociale généralisée* or CSG).⁷⁶ The CSG is based on total income, with the rate depending on the source of income.⁷⁷ It is

69. When the system was originally enacted, there was a cap on the wages against which health insurance contributions would be levied. PALIER, *supra* note 67, at 81. The cap was gradually eliminated between 1967 and 1984. Rémi Pellet, L'évolution du financement de l'assurance maladie: Bilan et perspectives [Financing French Health Insurance: Evolution and Perspectives] 76 *Revue d'Économie Financière* 87, 92 (2004); Chevreur et al., *supra* note 10, at 66. *But cf.* Kathryn L. Moore, *Social Security Reform: Fundamental Restructuring or Incremental Change?*, 11 LEWIS & CLARK L. REV. 341, 355 (2007) [hereinafter *Social Security Reform*] (discussing maximum taxable wage base under U.S. Social Security system).

70. See Steffen, *supra* note 4, at 363-66.

71. Chevreur et al., *supra* note 10, at 66; PAUL V. DUTTON, DIFFERENTIAL DIAGNOSES: A COMPARATIVE HISTORY OF HEALTH CARE PROBLEMS AND SOLUTIONS IN THE UNITED STATES AND FRANCE 201 (2007). *But cf.* RODWIN & SANDIER, *supra* note 56, at 177 & n. 25 (stating that since 1992, employers pay 12.8% of the wage bill and employees pay 6.9% of their full salary, bringing the total payroll tax for health insurance to 19.7% of all wages.”).

72. “Although there seems to be a consensus on the need for a reform to employers’ contributions, the experts remain cautious because of the economic and technical problems of alternatives, whether in the form of a ‘social value-added tax’ (VAT) or generalized fiscalization.” Steffen, *supra* note 4, at 366.

73. *Taux en vigueur pour les salaires versés à partir du 1er janvier 2013*, (stating that effective January 1, 2013, the employer social contribution is levied at the rate of 13.1%), available at http://www.lexisnexis.fr/services_gratuits/indices_taux/charges_sociales_salaires.html. Lower rates and even exemptions may be available for unskilled or low cost jobs and for handicapped employees. See also Steffen, *supra* note 4, at 357; Gérard Cornilleau and Thierry Debrand, *Crise et déficit de l'assurance maladie: Faut-il changer de paradigme?*, *La Revue de L'OFCE* 315, 325 (Janvier 2011).

74. See Steffen, *supra* note 4, at 357.

75. *Taux en vigueur pour les salaires versés à partir du 1er janvier 2013*, (stating that effective January 1, 2013, the employee social contribution is levied at the rate of 0.75%), available at http://www.lexisnexis.fr/services_gratuits/indices_taux/charges_sociales_salaires.html.

76. *Id.* at 66. The CSG was introduced in 1991, and the rate and base have progressively expanded. Steffen, *supra* note 4, at 366. The CSG was intended to (1) be employment-friendly, reducing the burden of employment-based taxes; (2) reinforce social equity by expanding the tax base, and (3) raise revenue to reduce the social security deficit. Gentile, *supra* note 55, at 152.

77. See Chevreur et al., *supra* note 10, at 66.

generally 7.5% on earned income,⁷⁸ 8.2% on capital,⁷⁹ 9.5% on gambling winnings, 6.6% on pensions, and 6.2% on benefits.⁸⁰ Employees' income-related contributions constitute about 37% of the systems' revenues.⁸¹ The remaining 16% of the systems' revenues come from a variety of other sources such as taxes on tobacco, alcohol, and pharmaceutical companies.⁸²

B. *Second Tier—Voluntary Health Insurance*

Mandatory basic health insurance covers about three-quarters of health expenditures in France.⁸³ Remaining costs are covered by voluntary health insurance and individual patients.⁸⁴

First instituted in the mid-19th Century, voluntary health insurance predates the first tier mandatory health insurance system.⁸⁵ By the start of World War II, *mutuelles* provided voluntary health insurance coverage to about two-thirds of the French population.⁸⁶ Today, about 88% of the French population has voluntary private health insurance, and another 7% of the population has voluntary health insurance through the public *Couverture Maladie Universelle Complémentaire* (CMU-C) program.⁸⁷ Effective January 1, 2016, complementary employment-

78. 5.1% goes toward mandatory health insurance. *Id.* at 66-67. The CSG rate on earned income is reduced to 3.8% of earned income for low-income individuals who are exempt from income tax, which is about half of French households. *Id.* at 67.

79. 5.95% goes toward mandatory health insurance. *Id.*

80. *Id.*

81. Steffen, *supra* note 4, at 357.

82. *Id.* For a breakdown of the other taxes and their relative contribution to revenues, see Chevreur et al., *supra* note 37, at 67-68 & tbl. 3.12; see also DURAND-ZALESKI & CHEVREUL, *supra* note 10, at 47 (identifying sources of revenue and their relative contributions).

83. See Chevreur et al., *supra* note 10, at 43; Bellanger et al., *supra* note 20, at S24.

84. France is ranked third among OECD countries in the share of health care financed by private health insurance. Only the U.S. and the Netherlands have a higher share of health care costs financed by private insurance. Buchmeueller & Couffinhal, *supra* note 15, at 7. In 2007, the national health insurance funds covered 76.6% of personal health expenditures, state and local authorities covered 1.4%, mutual benefit funds 7.9%, insurance companies 3.2%, employer-sponsored health benefit schemes 2.5%, and households 8.4%. Steffen, *supra* note 4, at 365 tbl. 1. Cf. Chevreur, et al., *supra* note 10, at 65 (complementary insurance “covers about 13.4% of total health expenditures (7.7% by mutual insurance associations, 3.3% by private insurance companies; and 2.5% by provident institutions)” and private households pay about 6.8%).

85. See Chevreur et al., *supra* note 10, at 20 (discussing the mutual benefit movement which started in the 19th century and whose membership had grown to nearly 10 million members by 1940).

86. See Buchmeueller and Couffinhal, *supra* note 15, at 8.

87. See Chevreur et al., *supra* note 10, at 71, 73 (stating that by 2006, 88% of the French population had private voluntary health insurance and 7% of the French population had CMU-C so that 95% of the French population had complementary health insurance). Cf. Steffen, *supra* note 4,

based health insurance will become mandatory under the “Law for the security of employment” (“Loi de Sécuritisation del’Emploi”) enacted on June 14, 2013.⁸⁸

1. Types of Voluntary Private Health Insurance

Commentators and policymakers often divide voluntary private health insurance into three different types: (1) substitutive, (2) complementary, and (3) supplementary.⁸⁹ As its name suggests, substitutive health insurance substitutes or replaces first tier mandatory health insurance.⁹⁰ It provides coverage for individuals who are excluded from the first tier mandatory health insurance program.⁹¹ Complementary insurance provides coverage for services excluded or not fully covered by first tier mandatory health insurance.⁹² For example, it may pick up the cost of co-payments or cover services, such as dental services, that are excluded from the first tier. Finally, like complementary insurance, supplementary insurance may cover services that are excluded or not fully covered by first tier mandatory health insurance.⁹³ Its principal purpose, however, is to increase the choice of providers and thus provide insureds with faster access to care.⁹⁴ It may also provide insureds with a higher level of inpatient hotel amenities, such as private rooms.⁹⁵

In France, voluntary private health insurance is “complementary.”⁹⁶ For the most part, it simply covers co-payments for services covered by the first tier public health insurance;⁹⁷ although recently private health

at 358 (stating that about 93% of the French population and 96% of French employees have voluntary complementary insurance).

88. Labor Law Reform Act, *supra* note 11.

89. See, e.g., Sarah Thomson & Elias Mossialos, *Private health insurance and the internal market*, in HEALTH SYSTEMS GOVERNANCE IN EUROPE: THE ROLE OF EUROPEAN UNION LAW AND POLICY 419, 421-23 (Mossialos et al. eds., 2010). Not all commentators use the terms in an identical fashion, however. See *supra* note 12.

90. See, e.g., Thomson & Mossialos, *supra* note 89, at 422-23.

91. See *id.*

92. See *id.* at 422.

93. *What are the equity, efficiency, cost containment and choice implications of private health-care funding in Western Europe?*, *supra* note 12, at 9.

94. See *id.*

95. See *id.*

96. See Buchmueller & Couffinal, *supra* note 15, at 8 (“Private health insurance serves a complementary function in the French system, reimbursing patients for cost-sharing required by the public system and for medical goods and services for which public reimbursement levels fall below market-determined prices.”).

97. DURAND-ZALESKI, *supra* note 10, at 40; see also Steffen, *supra* note 4, at 362

insurance providers have extended coverage to services and amenities that are not covered by the basic health insurance system.⁹⁸ Unlike in other countries, private health insurance in France is not “supplementary;” that is, it “is not used to jump public sector queues or to obtain access to elite providers.”⁹⁹

Voluntary private health insurance may be purchased by individuals or through group contracts.¹⁰⁰ About half of voluntary private health insurance contracts are purchased through the group insurance market by employers providing job-related benefits.¹⁰¹

2. Public Provision of Voluntary Health Insurance

When CMU extended first tier public health insurance to all legal residents of France in 2000, it also introduced CMU-C, free public complementary health insurance for low-income individuals.¹⁰² CMU-C

(according to a 2007 study by the Ministry of Health, two-thirds of mutual benefit societies’ “contracts provide full reimbursement for those medical services partially reimbursed by national health insurance, without offering any services that are not at all covered by the latter”).

98. DURAND-ZALESKI & CHEVREUL, *supra* note 37, at 48; *see also* Chevreul et al., *supra* note 10, at 70 (“With the wide development of a market that is almost saturated, a few VHI providers recently extended complementary coverage. These providers may compete on offering contracts that cover goods and services not covered by SHI, such as omega-3 fatty acids and surgery for short-sight.”).

99. Chevreul et al., *supra* note 10, at 69.

100. *See id.* at 71.

101. *See* IMAI ET AL., *supra* note 9, at 126, n.3; Buchmueller & Couffinhal, *supra* note 15, at 14. *See also* Kilborn, *supra* note 57, at 572 (noting that in about 57% of cases, voluntary health insurance is paid for by employers); Dominique Polton, *Recent reforms affecting private health insurance in France*, EURO OBSERVER: NEWSLETTER OF THE EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES, Spring 2004, at 4 (stating that “[m]ore than 50% of VHI policies are purchased through employers, who often pay a part of the premium as a fringe benefit”); Francesca Columbo & Nicole Tapay, *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems* 18, (OECD Health Working Papers No. 15, 2004) (stating that about 50% of VHI is employment-based). *Cf.* Chevreul et al., *supra* note 10, at 71 (noting that according to a 2006 general population survey, 40% of privately insured individuals are covered by a company group contract and that 85% of group contracts are sponsored by employers who pay, on average, 60% of the premium); Michel Grignon & Bidénam Kambia-Chopin, *Income and the Demand for Complementary Health Insurance in France* 8, (Institut de Recherche et Documentation en Économie de la Santé, Working Paper No. 24, 2009) (stating that according to self-reports, 39% of contracts are purchased through an employer, 2% through a pool for the self-employed, 39% are obtained through the non-group market and 15% are by retirees maintaining coverage they had through their previous occupation); GLIED, *supra* note 2, at 40 (noting that “[i]n France, supplemental job-based coverage accounts for about two-thirds of voluntary private health insurance”).

102. *See* Chevreul et al., *supra* note 10, at 72-73; *see also* Buchmueller & Couffinhal, *supra* note 15, at 7 (“This [CMU-C] coverage expansion addressed equity concerns relating to the fact that lower income patients, who were less likely to have private complementary insurance or who held

is available free of charge to individuals with an annual income below a ceiling, equal to €7521 in January 2010.¹⁰³ CMU-C is financed principally by a tax on voluntary health insurance contract premiums,¹⁰⁴ and covered 7% of the French population in 2008.¹⁰⁵ CMU-C reimburses eligible individuals for *tickets modérateurs*, the co-payments required under the first tier health insurance system,¹⁰⁶ and prohibits doctors from charging CMU patients more than the statutorily agreed rates.¹⁰⁷ Prices that providers can charge CMU-C patients for eyeglasses and dental prostheses are capped, and CMU-C pays the share of covered patients' costs that are not covered by the first tier health care system.¹⁰⁸ CMU-C beneficiaries may choose to receive their complementary coverage through the statutory system or through a private health insurer.¹⁰⁹

In order to assist low-income individuals who do not qualify for CMU-C coverage, a voucher system was created in 2004 to help individuals with incomes below a ceiling equal to 120% of the CMU ceiling to purchase voluntary health insurance.¹¹⁰ The assistance increases with an individual's age ranging from €100 for individuals under age twenty-five to €400 for individuals over sixty in 2010.¹¹¹ In 2008, only 380,000 out of 2.2 million eligible individuals used the voucher system.¹¹²

contracts with limited benefits, tended to face higher out-of-pocket costs than higher income individuals, who had more complete private coverage.”); Michel Grignon et al., *Does Free Complementary Health Insurance Help the Poor to Access Health Care? Evidence from France*, 17 HEALTH ECON. 203, 205 (2008) (noting that the French government introduced CMU-C “to help the non-elderly poor access health care”).

103. See *id.* at 72-73. The income ceiling varies with the household size. It ranges from €7521 for individuals to €3760 per person for a household of six and €3008 for each additional household member. *Id.* at 73, n.8.

104. *Id.* at 73.

105. *Id.* See also Buchmueller & Couffinhal, *supra* note 15, at 15 (“A survey conducted in 2000 showed that CMU beneficiaries were younger, more frequently female and members of single parent households than the general population. Compared with the target population, beneficiaries are also more often unemployed or out of the labour force.”).

106. Buchmueller & Couffinhal, *supra* note 15, at 13.

107. See *id.*

108. *Id.*

109. *Id.* at 23 (noting that by December 2002, 15% of individuals were covered by a private plan).

110. Chevreur et al., *supra* note 10, at 73.

111. *Id.*

112. *Id.*; see also Michel Grignon & Bidénam Kambia-Chopin, *supra* note 101, at 7 (noting that only between 10 and 20% of the target population has taken advantage of the voucher system and investigating the reasons for the low up-take).

3. Benefits

Unlike mandatory health insurance benefits, voluntary health insurance benefits are not uniform.¹¹³ Most voluntary health insurance fully reimburses patients for the cost of covered drugs, other than those considered to be “of low medical benefit,” and for the cost of procedures and tests up to the statutorily agreed rate.¹¹⁴ About 25% of doctors work in “Sector 2” and are permitted to charge fees that exceed the statutorily agreed rates.¹¹⁵ Voluntary contracts differ on the amount that they will reimburse with respect to charges that exceed the statutorily agreed rate, often referred to “balance-billing.”¹¹⁶ In addition, voluntary contracts differ with respect to reimbursement rates for low-benefit drugs, medical devices, private amenities, and services not covered by the first tier health insurance regime.¹¹⁷ Group contracts tend to provide better coverage than do individual contracts,¹¹⁸ and higher paid individuals tend to have better and more complete coverage than do lower paid workers.¹¹⁹

Recently, the French government introduced some degree of uniformity in the voluntary private health insurance market by providing financial incentives to voluntary health insurance providers that enter into “responsible contracts” (*contrats responsables*).¹²⁰ In order to qualify

113. For a discussion of the various types health insurance offered to employees, see Camille Francesconi et al., *Company supplementary health insurance: Compulsory or voluntary schemes, avoiding adverse selection and its effect on employees*, QUESTIONS D'ÉCONOMIE DE LA SANTÉ, Nov. 2006, No. 115.

114. See Chevreul et al., *supra* note 10, at 70. Nearly all private health insurance contracts also pay the per diem co-payment for in patient hospital stays. There is, however, considerable variation in coverage for the cost of private rooms. Buchmueller & Couffinal, *supra* note 15, at 10.

115. See Chevreul et al., *supra* note 10, at 97-98. The proportion of “Sector 2” doctors varies by speciality. Only 8% of general practitioners are Sector 2 doctors while 75% of surgeons work in “Sector 2.” *Id*; see also Buchmueller & Couffinal, *supra* note 15, at 10 (“Roughly one quarter of French physicians have the right to charge more than the conventional tariff; about 11% of GP visits and 33% of specialist visits lead to balance billing.”).

116. See Chevreul et al., *supra* note 10, at 70; Buchmueller & Couffinal, *supra* note 15, at 11.

117. See Chevreul et al., *supra* note 10, at 70; Grignon & Kambia-Chopin, *supra* note 101, at 6.

118. See Chevreul et al., *supra* note 10, at 71.

119. See RODWIN & SANDIER, *supra* note 56, at 193, n.26; Thomson & Mossialos, *supra* note 89, at 3; Buchmueller & Couffinal, *supra* note 15, at 13; see also Kilborn, *supra* note 57, at 572 (“In 2000, coverage rates ranged from 72% of unskilled workers to 85% of office employees to 94% of teachers, administrators, and other intermediate and managerial ‘white collar’ workers In 2000, the rate of those either uninsured or underinsured ranged from just under 40% of those earning \$1500 or more per month to over 70% of those earning less than \$750 per month.”).

120. Chevreul et al., *supra* note 10, at 71. Premiums from responsible contracts are exempt

as a responsible contract, voluntary health insurance must not cover the mandatory health insurance co-payments that were introduced in 2005 (€1 for every doctor visit and test up to €4 per day and €50 per year and €2 for medical transport and €0.50 for each drug, up to a second €50 ceiling) or the additional co-insurance and co-payment fees imposed when patients do not use the new registered gatekeeping physician process.¹²¹ On the other hand, if patients do use the new registered gatekeeping physician process, responsible contracts must cover 100% of physician fees, at least 95% of the costs of important drugs covered at the 65% level by mandatory health insurance, and at least 95% of the cost of laboratory tests covered by mandatory health insurance.¹²² In addition, responsible contracts must cover at least two important types of preventive services from a defined list.¹²³ By 2006, almost all voluntary health insurance contracts were “responsible contracts.”¹²⁴

4. Types of Providers

Three types of organizations offer voluntary health insurance in France: (1) non-profit *mutuelles* which account for almost 60% of the market, (2) non-profit provident institutions which account for 15 to 20% of the market, and (3) commercial for-profit insurance companies which account for about 20% of the market.¹²⁵

i. Mutuelles

Mutuelles, which date to the mid-19th Century, played a key role in insuring the French population prior to the enactment of the French Social Security system.¹²⁶ Although *mutuelles* were not chosen to manage the first tier mandatory health care system, they played – and

from a 7% tax that would otherwise apply. *Id.*, at 70. “Solidarity contracts” (*contrats solidaires*) are also exempt from this 7% tax. Solidarity contracts are contracts that do not require a health questionnaire or base premiums on pre-existing health conditions. *Id.*

121. *Id.* at 71.

122. *Id.*

123. *Id.*

124. *Id.*

125. Buchmueller & Couffinal, *supra* note 15, at 17. Generally, the elderly are more likely to be covered by *mutuelles*, farmer households are more likely to be covered by commercial insurance companies, and executives are more likely to be covered by provident institutions. See Chevreul et al., *supra* note 10, at 76.

126. Buchmueller & Couffinal, *supra* note 15, at 8. “In 1900 there were roughly 13,000 *mutuelles* covering over 2 million people and by the start of World War II, two-thirds of the population had coverage for illness.” *Id.*

continue to play – an important role in the development of voluntary private health insurance in France.¹²⁷

Mutuelles are non-profit organizations that emphasize mutual aid and solidarity.¹²⁸ They generally offer open enrollment, lifetime coverage,¹²⁹ and use community-rated premiums or base premiums on a percentage of income rather than using risk-rating or risk selection strategies.¹³⁰ Complementary health insurance is the principal focus of business for most *mutuelles*, and they are financed almost entirely by subscriber fees and payments.¹³¹

Mutuelles may be organized along occupational lines or geographic lines.¹³² For example, *mutuelles* may cover particular “groups of public sector employees such as teachers,” while others cover individuals who live in a particular geographic area.¹³³ Enrollment is fairly evenly divided between individual and group contracts.¹³⁴

ii. Provident Institutions

Provident institutions were initially created to provide retirement and other social insurance benefits to employees.¹³⁵ About fifty-one such institutions offer complementary health insurance, which accounted

127. *Id.* (“That history and the fact that the *mutuelles* have continued to play an important role, not only as market participants, but in influencing the public policy environment, are important factors that explain the high rate of private insurance coverage in France today.”).

128. *Id.* at 18.

129. Thomson & Mossialos, *supra* note 89, at 454.

130. *Id.*; Buchmueller & Couffinhal, *supra* note 15, at 18; *Cf.* Chevreul et al., *supra* note 10, at 75 (stating that mutual insurance companies “avoid, as much as permitted by competition, differentiation in premiums for a given level of coverage. For this reason, they make limited use of risk rating. Moreover, some mutual companies also adjust their premium according to income.”) The *Code de la Mutualité* limits the factors that can be taken into account in determining premiums to the following: “[I]ncome, the time span since the initial subscription of a contract, the health insurance fund that the subscriber is a member of, the location, the number of beneficiaries, and their age.” Buchmueller & Couffinhal, *supra* note 15, at 20.

131. In 2000, 95% of *mutuelles*’ outlays were for complementary health insurance. “Other activities include the provision of other types of social insurance such as disability and life insurance. Some *mutuelles* also operate different types of facilities including pharmacies, optical care clinics and retirement homes.” Buchmueller & Couffinhal, *supra* note 15, at 18 & n. 21.

132. *Id.* at 18.

133. *Id.*

134. *Id.*

135. *Id.*; *see also* Chevreul et al., *supra* note 10, at 75 (“[Provident institutions] were created at the end of the Second World War to manage the supplementary retiree pensions for senior executives and intellectual professionals They progressively enlarged their activity to the coverage of ‘heavy risk’ and finally offered [voluntary health insurance].”).

for about half of the industry's revenues in 2002.¹³⁶ Provident institutions principally offer group contracts,¹³⁷ and individual organizations tend to focus on particular industries or professional groups.¹³⁸

iii. Commercial Insurance Companies

Unlike *mutuelles* and provident institutions, commercial insurance companies operate for profit, and complementary health insurance is only a small portion of the industry's business.¹³⁹ Unlike *mutuelles*, commercial insurance companies use risk-rating strategies (such as taking health status into account) to rate premiums.¹⁴⁰ Commercial insurance contracts are more or less evenly divided between individual and group contracts.¹⁴¹

iv. Regulation of Providers

Mutuelles are regulated by the mutual insurance code (*code de la mutualité*) while provident institutions are regulated principally by the Social Security code (*code de la sécurité sociale*)¹⁴² and commercial insurance companies are regulated by the commercial insurance code.¹⁴³ Traditionally, the most significant difference in the regulatory regimes related to tax treatment,¹⁴⁴ specifically, *mutuelles* and provident institutions were exempt from the health insurance premium tax.¹⁴⁵ In

136. Buchmueller & Couffinal, *supra* note 15, at 18-19.

137. *Id.* at 19; *see also* Chevreul et al., *supra* note 10, at 75 (“[Provident institutions] specialize in providing group contracts for companies that have a policy of mandatory enrolment in [voluntary health insurance] for their employees.”).

138. Buchmueller & Couffinal, *supra* note 15, at 19 (stating that mandatory contracts account for half of provident institutions' activity).

139. *See id.* at 19. (“In the life and health insurance industry, complementary health insurance represents less than 5% of total revenue.”).

140. Chevreul et al., *supra* note 10, at 75. Unlike the traditional practice of *mutuelles*, commercial insurance carriers, which entered the market in force in the 1980s, “practiced risk-based pricing, varying premiums with age and according to the results of medical questionnaires. Buchmueller & Couffinal, *supra* note 15, at 21.

141. Chevreul et al., *supra* note 10, at 75 (stating that sixty percent of business is in individual contracts and forty percent is in group contracts); Buchmueller & Couffinal, *supra* note 15, at 19 (“Group and individual contracts account for comparable numbers of contracts.”).

142. Individual contracts offered by provident institutions are regulated by the commercial insurance code. Chevreul et al., *supra* note 10, at 75.

143. *Id.*

144. Buchmueller & Couffinal, *supra* note 15, at 19.

145. *Id.*; Thomson & Mossialos, *supra* note 89, at 453.

addition, *mutuelles* were traditionally subjected to less rigorous solvency rules.¹⁴⁶

Both the differential tax treatment and less rigorous solvency rules were found to violate the European Union's Third Non-life Directive regulating private health insurance and requiring equal treatment of all insurers.¹⁴⁷ In response, the French government tightened up the solvency rules applicable to *mutuelles*¹⁴⁸ and replaced the tax exemption for *mutuelles* and provident institutions with a tax exemption for "solidarity" and "responsible" contracts.¹⁴⁹ "Solidarity" contracts are contracts that do not require a health questionnaire or base premiums on pre-existing health conditions.¹⁵⁰ "Responsible" contracts are contracts that, among other things, do not provide reimbursement for the mandatory co-payment fees and gatekeeping differentials introduced in 2005.¹⁵¹ Any provider, including a commercial insurance company that offers a "solidarity" or "responsible" contract is now exempt from the insurance premium tax.¹⁵²

III. ROLE OF THE EMPLOYER IN THE FRENCH HEALTH INSURANCE SYSTEM

The employer plays an important role in the French health insurance system in three ways. First, employer contributions account for a little less than fifty percent of the funding of the first tier mandatory health care system.¹⁵³ Second, employers help administer the first tier health funds.¹⁵⁴ Finally, about half of second tier voluntary private health insurance is purchased in the group market through employers as job-related benefits.¹⁵⁵

146. Thomson & Mossialos, *supra* note 89, at 450.

147. *See id.* at 450, 453.

148. *Id.* at 451; *see* Buchmueller & Couffinal, *supra* note 15, at 20.

149. Thomson & Mossialos, *supra* note 89, at 453-54. In 2007, the European Commission launched a formal investigation into the "solidarity" and "responsible" contract. *Id.* at 454.

150. *See id.* at 454; Buchmueller & Couffinal, *supra* note 15, at 19. This requirement automatically applies to *mutuelles* and it is thought that most contracts now satisfy these requirements. Buchmueller & Couffinal, *supra* note 15, at 19-20.

151. *See supra* Part II.B.3.

152. *See* Thomson & Mossialos, *supra* note 89, at 455.

153. *See* Steffen, *supra* note 4, at 357.

154. *See* Sorum, *supra* note 5, at 232.

155. *See* Kilborn, *supra* note 57, at 572.

A. Funding of Mandatory Health Insurance

At the time the French Social Security system was originally enacted, there were two basic approaches to social protection: the British “Beveridgean” model and the German “Bismarckian” model.¹⁵⁶ Under the Beveridgean model, the main policy objective is the prevention of poverty.¹⁵⁷ Under the Bismarckian system,¹⁵⁸ the main policy objective is income maintenance for employees.¹⁵⁹ In structuring their Social Security system, the French deliberately elected to adopt a Bismarckian system rather than a Beveridgean model.¹⁶⁰

Consistent with the Bismarckian model, the French elected to fund their Social Security system, including health care benefits, exclusively with wage-based social contributions imposed on both employers and employees.¹⁶¹ There were two reasons underlying the decision to fund benefits exclusively with social contributions. First, the French feared that social policy might take a backseat to financial considerations if Social Security were funded by general taxes.¹⁶² Second, and more importantly, the French believed in the social insurance model,¹⁶³ which requires that the individuals benefitting from the plan be the ones paying

156. See Giuliano Bonoli & Bruno Palier, *Reclaiming Welfare: The Politics of French Social Protection Reform*, in SOUTHERN EUROPEAN WELFARE STATES 240, 242 (Martin Rhodes ed., 1997) [hereinafter *Reclaiming Welfare*].

157. *Id.* at 242 (“[I]n France, a Beveridgean system is seen as one in which benefits are directed at the whole population, are typically flat-rate and are financed through taxation.”).

158. The Bismarckian model is sometimes referred to as a “corporatist conservative” regime or “occupational welfare state.” See *id.* at 243.

159. *Id.* at 242. (“[A] Bismarckian welfare state is one which typically grants earnings-related benefits, where entitlement is conditional upon a contribution record and financing is provided by employers’ and employees’ contributions.”).

160. PALIER, *supra* note 67, at 81; SORUM, *supra* note 5, at 232; see GENTILE, *supra* note 55, at 135 & n.167—(discussing universalist aspirations of French social security system but noting that system’s goal was security and income maintenance, not redistribution).

161. See *supra* Part II.A.6.

162. PALIER, *supra* note 67, at 81. A similar concern has been raised in debates regarding the funding of the U.S. Social Security system. See *Social Security Reform*, *supra* note 69, at 359-60 (“[C]ritics of general revenue financing fear . . . that [it] might erode public support for the program by drawing it more explicitly into annual budget debates.”).

163. See *Reclaiming Welfare*, *supra* note 156, at 246 (“The use of funds collected through taxation in order to finance the social insurance system is not seen as legitimate. Conversely, money collected through contributions cannot be used to finance assistance (or *solidarité nationale*) that is, to benefit people who have not contributed to the social insurance system.”); see also Lawrence H. Thompson & Melinda M. Upp, *The Social Insurance Approach and Social Security*, in SOCIAL SECURITY IN THE 21ST CENTURY 3, 6-7 (Eric R. Kingson & James H. Schulz eds., 1997) (identifying “contributory financing” as one of seven characteristics typically included in social insurance).

for it.¹⁶⁴

Over the years, a number of Beveridgean elements have been incorporated into the French mandatory health insurance system.¹⁶⁵ For example, in 2000, *CMU* extended basic health insurance to all legal residents of France, regardless of employment status or prior contributions to Social Security.¹⁶⁶ As the mandatory health care system has incorporated Beveridgean elements, funding has shifted from a purely contributory system to a system partially funded by general taxes.¹⁶⁷ For example, the employee share of wage-based social contribution funding¹⁶⁸ has been largely replaced with a general social contribution that is levied on total income, not just wages.¹⁶⁹

Wage-based social contributions, however, have not been entirely eliminated.¹⁷⁰ Employers remain subject to a 13.1% wage-based social contribution, which accounts for about 47% of the mandatory health insurance system's revenues.¹⁷¹

164. PALIER, *supra* note 67, at 81.

165. *Reclaiming Welfare*, *supra* note 156, at 243 (recognizing the incorporation into the French system of a non-contributory, Beveridgean element into their system to provide for individuals who do not have access to insurance benefits); SORUM, *supra* note 5, at 234 (“Like other developed countries, however, France had evolved its own particular blend of Bismarck and Beveridge, of public and private, and of centralization and decentralization.”). *See generally* Bruno Palier & Giuliano Bonoli, *Entre Bismarck et Beveridge: <<Crises>> de la sécurité sociale et politique(s)*, 45 REVUE FRANÇAISE DE SCIENCE POLITIQUE 668 (1995) (Fr.) [hereinafter *Entre Bismarck et Beveridge*] (providing a detailed discussion of the mix of Bismarckian and Beveridgean elements in the French social security system).

166. *See* SORUM, *supra* note 5, at 234.

167. *Cf.* Giuliano Bonoli and Bruno Palier, *Changing the Politics of Social Programmes: Innovative Change in British and French Welfare Reforms*, 8 J. OF EUR. SOC. POL’Y 317, 327 (1998) [hereinafter *Changing the Politics*] (“What these measures have in common is that they contribute to change the original Bismarckian nature of the French social security system, and move towards a state-run, tax-financed system, at least in the area of health care and family benefits.”).

168. The employee share of wage-based social contributions has fallen from 6.8% of gross earnings in 1994 to .75% of gross earnings in 2013. *See* DUTTON, *supra* note 71, at 201 (stating that employee share of social contributions was 6.8% in 1994; *Charges sociales sur salaires: Taux en vigueur pour les salaires versés à partir du 1er janvier*, LEXISNEXIS, http://www.lexisnexis.fr/services_gratuits/indices_taux/charges_sociales_salaires.html (last visited April 24, 2013) (stating that effective on January 1, 2013, the employee social contribution is levied at the rate of .75%).

169. *See supra* Part 2.A.6. In addition, a small portion of the mandatory health insurance system is funded by taxes on tobacco, alcohol, and pharmaceutical companies.

170. *See supra* Part 2.A.6.

171. *See supra* Part 2.A.6. There has, however, been debate about alternative forms of employer financing. *See* Pellet, *supra* note 69, at 121-27.

B. Administration of Mandatory Health Insurance Funds

In a traditional Bismarckian system, employer and employee representatives coadminister the health insurance funds and are fully responsible for the system's management and financial stability.¹⁷² Thus, when the French mandatory health insurance system was originally created, it, like any traditional Bismarckian system, was to be independent of the state and jointly administered by employer and employee representatives.¹⁷³ The decision to confer management authority to employee and employer representatives (often referred to as the social partners) was motivated in large part by mistrust of the state¹⁷⁴ and justified by the fact that employees and employers fund the system and thus have an interest in it.¹⁷⁵

In fact, however, the government has long played an important policymaking role in the French first tier mandatory health insurance system.¹⁷⁶ For example, the government sets the health insurance premium levels¹⁷⁷ and establishes the statutory rates that health care

172. Steffen, *supra* note 4, at 355.

173. PALIER, *supra* note 67, at 81; *Reclaiming Welfare*, *supra* note 156, at 244; Sorum, *supra* note 5, at 232. When the health insurance system was originally created, there were more employee representatives than employer representatives in the governing boards of the health insurance funds. Now, there are an equal number of employee and employer representatives, and more importantly, there are four representatives appointed by the government as well as one or two representatives of mutual and family associations. *Reclaiming Welfare*, *supra* note 156, at 256.

174. PALIER, *supra* note 67, at 84. (stating that the French mistrusted the state because of its lack of flexibility and adaptability and its bureaucratic structure).

175. *Reclaiming Welfare*, *supra* note 156, at 244.

176. According to Simone Sandier, Valérie Paris, and Dominique Polton, Traditionally . . . the state handled policy concerning public hospital and drugs, while the health insurance funds took charge of independent (private) medical practice (including the services provided by self-employed professionals and private for-profit hospitals) on the basis of negotiated agreements. Decisions concerning the financing of health insurance funds (conditions and levels of social contributions) were clearly within the state's remit.

SANDIER ET AL., *supra* note 16, at 140; *see also* PALIER, *supra* note 67, at 142-48 (describing the three-party (*tripartisme*) governance of the social security system under which governance is shared by employer organizations, trade unions representing employees, and the government); Pellet, *supra* note 69, at 108 (stating that since the social security system was created in 1945, the state has had the responsibility for financial stability of the health care system; the social partners have only had responsibility for the managing the administrative budget of the health care funds).

177. *See* SANDIER ET AL., *supra* note 16, at 137 (“[T]he French health insurance funds have never really had the management responsibilities accorded to sickness funds in the German health care system. The state rapidly took responsibility for the financial and operational management of health insurance (for example, setting premium levels and the price of goods and services, etc.)”); *see also* Steffen, *supra* note 4, at 360 (“Health insurance thus started without institutional autonomy and no control over the amounts of contributions, rates of reimbursement, and the rates applied by doctors.”).

providers may charge for their services.¹⁷⁸ The government also oversees national negotiations between the principle mandatory health insurance regimes and health care providers in order to ensure that all providers are subject to uniform reimbursement policies.¹⁷⁹ Moreover, since 1996, the total social security budget has been set in advance each year by parliamentary vote, and the Parliament votes for the target rate of growth for ambulatory care expenses and total health care expenditures.¹⁸⁰

The division of power between the government and the health insurance funds has long been problematic,¹⁸¹ and as funding of the system has shifted from pure wage-based social contributions to more general tax-based financing, the social partners' justification for controlling the system has weakened while the state's right to control the system has increased.¹⁸² Thus, perhaps not surprisingly, the social partners have objected to the shift away from wage-based financing and the concomitant dilution of their power to regulate the health care funds.¹⁸³

In sum, employers play a role in managing the first tier health insurance funds.¹⁸⁴ Their powers, however, are circumscribed,¹⁸⁵ and

178. See Chevreur et al., *supra* note 10, at 97.

179. Victor G. Rodwin & Simone Sandier, *Health Care Under French National Health Insurance: A Public-Private Mix, Low Prices and High Volumes*, in UNIVERSAL HEALTH INSURANCE IN FRANCE: HOW SUSTAINABLE? 169, 175 (2006). Different reimbursement rates apply to the Alsace-Moselle region's local scheme as well as certain public sector schemes. Bellanger et al., *supra* note 20, at S24.

180. Lise Rochaix & David Wilsford, *State Autonomy, Policy Paralysis: Paradoxes of Institutions and Culture in the French Health Care System*, 30 J. HEALTH POL. POL'Y & L. 97, 113 (2005). In practice, however, the targets are not mandatory and are regularly surpassed. *Id.* at 114; see also Chevreur et al., *supra* note 10, at 85-87 (discussing the national ceiling for mandatory health insurance expenditures).

181. See SANDIER ET AL., *supra* note 16, at 141 (“[T] division of responsibilities remains unclear, and in recent years relations between state authorities and the health insurance funds have been marked by periods of open conflict, with the trend towards increased state control regularly denounced by the health insurance funds.”).

182. See *Reclaiming Welfare*, *supra* note 156, at 253; *Entre Bismarck et Beveridge*, *supra* note 165, at 327.

183. See, e.g., DUTTON, *supra* note 71, at 202 (“Employers and labor leaders alike understood that if health insurance premiums were ‘fiscalized,’ that is, transferred to a generalized income tax, their claims to control *Sécurité Sociale* governing boards would surely diminish. This was a prospect to which they were determinedly opposed.”); PALIER, *supra* note 67, at 78 (discussing trade union and employer objections).

184. See DUTTON, *supra* note 71, at 218-19 (“French union leaders and employers still exert an influence over *Sécurité Sociale* that is out of all proportion to what should be a democratically accountable institution of universal health coverage.”).

185. See Rochaix & Wilsford, *supra* note 180, at 101. (“[National Health Insurance] funds are considered quasi-public agencies, as opposed to integrated organs of the state In truth, all the

according to some authorities, employers play a minor role in creating policy.¹⁸⁶

C. Provision of Voluntary Health Insurance

About half of voluntary private health insurance contracts are purchased through the group insurance market by employers providing job-related benefits,¹⁸⁷ and more than seventy percent of employees are offered supplementary health insurance by their employer.¹⁸⁸ On average, employers pay about sixty percent of the cost of premiums for voluntary health insurance.¹⁸⁹ Employees can exclude the cost of premiums paid by their employer from their income; although, there is no tax advantage for the employee's share of the premium or for the cost of insurance purchased through the individual market.¹⁹⁰ Effective January 1, 2016, employers will be required to provide complementary health insurance.¹⁹¹

laws governing sickness fund operations reserve ultimate authority to the French state, which increasingly intervenes in the sickness funds' decision making); Ph. R. Mossé, *Towards A Professional Rationalization: Lessons from the French Health Care System*, 53 AM. J. ECO. & SOC. 129, 130 (1994) ("From an institutional point of view, the [National Social Security System] is an independent and non profit organization managed by representatives of the employers and the labor unions. Currently, however the State plays a great part in its regulation.").

186. See Rochaix & Wilsford, *supra* note 180, at 101-02; Indeed, the *Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés* published a strategic plan proposing a number of reforms. IMAI ET AL., *supra* note 9, at 124. Most of the reforms, however, required governmental approval and legislation to implement. *Id.* at 125; Steffen, *supra* note 4, at 372-73 ("The funds' former governing boards have been reduced to advisory organs and enlarged to include members other than the social partners. It is now the director general who leads negotiations with the medical unions on a program of objectives that the government board can only discuss. The central aspect of the Bismarckian institution (i.e., self-government) has thus been eliminated.").

187. See *supra* Part 2.B.1.

188. Francesconi et al., *supra* note 113, at 1.

189. Chevreul et al., *supra* note 10, at 75.

190. See *id.* at 72 ("[F]iscal rebates are offered to employers that buy and offer group contracts to their employees, while employees can [deduct] the cost of premiums from their taxable income."); Grignon & Kambia-Chopin, *supra* note 101, at 8 ("In France contributions paid for directly by employers to a [complementary health insurance] contract are not taxed (even though they could be considered in-kind wages) but there is no tax credit for individuals purchasing [complementary health insurance] on the non-group market or on the employee's share of the contribution in the group market."); Buchmueller & Couffignal, *supra* note 15, at 14, n.13 ("When enrollment by employees is obligatory (which is true for roughly half of all employer-sponsored health contracts) health insurance is considered a tax-deductible expense for employers and a tax-free benefit to employees. Additional payroll contribution rebates apply for the employers' contribution to health insurance regardless of the mandatory characteristic. Tax deductions also exist for the self-employed.").

191. Labor Law Reform Act, *supra* note 11.

IV. ROLE OF THE EMPLOYER IN THE U.S. HEALTH INSURANCE SYSTEM

Like in France, the employer plays an important role in the U.S. health insurance system. First, the employer plays an important role in funding the U.S. mandatory health insurance system, Medicare.¹⁹² In addition, the employer plays a critical role in providing voluntary health insurance.¹⁹³ Unlike in France, however, the employer plays no role in administering Medicare, the mandatory health insurance program.¹⁹⁴

A. Funding of Mandatory Health Insurance

Like France, the United States has a mandatory health insurance program: Medicare, which is part of its Social Security system.¹⁹⁵ Unlike in France, however, the U.S. mandatory health insurance program does not extend coverage to the entire U.S. population. Instead, coverage is limited to the elderly and disabled.¹⁹⁶ While Medicare covers almost the entire 65 and over population,¹⁹⁷ it covers less than 18% of the nonelderly U.S. population.¹⁹⁸

Medicare¹⁹⁹ has two components: mandatory Hospital Insurance (HI), otherwise known as Medicare Part A, and voluntary Supplementary Medical Insurance (SMI), which consists of Medicare Part B and Part D.²⁰⁰ Medicare Part A helps to pay for the cost of hospital, home health, skilled nursing, and hospice care for the elderly and disabled.²⁰¹ Medicare Part B helps to pay for the cost of physician, outpatient hospital, home health and other care for individuals who voluntarily enroll in the program.²⁰² Medicare Part D helps covers the

192. Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 ELDER L.J. 1, 9 (2012).

193. See GLIED, *supra* note 2, at 37.

194. See Kaplan, *supra* note 192, at 9.

195. Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq (2006).

196. THE BDS. OF TRS., FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, 2012 ANNUAL REPORT 6 (2012) [hereinafter 2012 MEDICARE TRUSTEES REPORT] (“In 2011, Medicare covered 48.7 million people: 40.4 million aged 65 and older, and 8.3 million disabled.”).

197. See PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., ISSUE BRIEF NO. 376, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2012 CURRENT POPULATION SURVEY 4 (2012), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2012_No376_Sources1.pdf.

198. *Id.* at 5.

199. See generally Kaplan, *supra* note 192 (providing an overview of Medicare).

200. 2012 MEDICARE TRUSTEES REPORT, *supra* note 196, at 1. Medicare Part C provides a voluntary alternative to Part A and Part B coverage. *Id.*

201. *Id.*

202. *Id.*

cost of drugs for covered individuals.²⁰³

About 85% of the funding of Medicare Part A comes from payroll taxes,²⁰⁴ with employers and employees each paying a payroll tax equal to 1.45% of total wages.²⁰⁵ Thus, about 42% of funding for Medicare's mandatory Part A program comes from employers.²⁰⁶ Beginning in 2013, the employer share will fall a bit as high-income workers will be required to pay an additional 0.9% tax on their earnings above an unindexed threshold of \$200,000 for single taxpayers and \$250,000 for married couples.²⁰⁷

B. *Voluntary Health Insurance*

In the United States, about 60% of the population under the age of 65 is covered by employment-based health insurance.²⁰⁸ On average, employers contribute 82% of the premiums for single coverage and 72% of the premiums for family coverage.²⁰⁹ As in France, employees can exclude the cost of premiums paid by their employer from their income.²¹⁰ In addition, unlike in France, employees can receive favorable tax treatment with respect to their share of health care premiums if their employer offers a cafeteria plan.²¹¹

Historically, the provision of employment-based health insurance was purely voluntary.²¹² With the enactment of the Patient Protection

203. *Id.*

204. *See id.* at tbl.II.B1.

205. 26 U.S.C. § 3111(b)(6) (2006); 26 U.S.C. § 3101(b)(6) (2006). Prior to 1994, Medicare, like Social Security was subject to a wage cap, referred to as the taxable wage base. *Cf. Social Security Reform, supra* note 69, at 369 (discussing maximum taxable wage base under U.S. Social Security system). Effective in 1994, the taxable wage base applicable to Medicare was eliminated so that the Medicare tax now applies to all wages. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13207, 107 Stat. 467 (1993) (codified as amended at 26 U.S.C. § 3121 (2006)).

206. Financing for voluntary parts B and D, in contrast comes from a combination of enrollee premiums and general tax revenues. 2012 MEDICARE TRUSTEES REPORT, *supra* note 196, at 10 tbl.II.B1.

207. *Id.* at 10.

208. FRONSTIN, *supra* note 197, at 5 fig. 1 (showing that in 2011, 58.4% of the nonelderly population was covered by employment-based health insurance coverage).

209. *See* GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 72 (2012).

210. *See* 26 U.S.C. § 106 (2006).

211. *See* 26 U.S.C. § 125 (2006). *See generally* LAWRENCE A. FROLIK & KATHRYN L. MOORE, LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS 131-33 (3d ed. 2012) (discussing cafeteria plans and their effect on the taxability of employee contributions to fund employer-sponsored health care plans).

212. *See generally* Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 887-92 (2011)

and Affordable Care Act,²¹³ large employers that fail to offer health insurance will be subject to an excise tax beginning in 2014.²¹⁴ In addition, beginning in 2018, an excise tax will be imposed on employment-based health insurance that is too generous.²¹⁵

IV. CONCLUSION

On the surface, the French health care system appears very different from the U.S. system. Specifically, the French health care system has first tier mandatory health insurance that covers the entire population²¹⁶ while the only mandatory health insurance system in the United States, Medicare, generally only covers the 65 and older population.²¹⁷ Moreover, French employers play a role in managing the first tier health insurance system²¹⁸ while U.S. employers play no role in the management of Medicare.²¹⁹

Upon closer examination, however, the French and U.S. health care systems are quite similar in that employers play an important role in both countries' health care systems. First, in both France and the United States, employers' wage-based contributions finance about half the costs of mandatory health insurance.²²⁰ Second, employment-based voluntary health insurance is quite prevalent in both countries.²²¹

Although the two countries are similar in that employers play an important role in their health care systems, that is not necessarily an advantage. Indeed, the employment-based nature of health insurance in

[hereinafter *Future of Employment-Based Health Insurance*] (discussing the history of the development of employment-based health insurance in the United States).

213. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 129 (2010); *see id.* at 903 (discussing the likelihood that the Affordable Care Act will affect employers' willingness to offer health insurance).

214. *See Future of Employment-Based Health Insurance*, *supra* note 212, at 903. On July 2, 2013, the Obama Administration announced that it would delay until 2015 enforcement of the excise tax on large employers who fail to offer health care coverage. Jackie Calmes & Robert Pear, *Crucial Mandate Delayed a Year for Health Law*, N.Y. Times, July 3, 2013 at A1.

215. 26 U.S.C. § 4980I (Supp. 2011).

216. Buchmueller & Couffinal, *supra* note 15, at 8; *see also supra* notes 13-15 and accompanying text.

217. *See supra* notes 195-98 and accompanying text.

218. *See supra* note 33 and accompanying text.

219. *See supra* note 194 and accompanying text.

220. *See supra* notes 71-73 and accompanying text.

221. *See supra* note 101 and accompanying text; *see generally Future of Employment-Based Health Insurance*, *supra* note 212, at 892-902 (discussing the advantages and disadvantages of employment-based health insurance in the United States).

both countries has been subject to significant criticism.²²²

First, critics contend that employment-based financing of health care reduces employers' competitiveness and thus hinders employment and economic growth.²²³ Indeed, the French government shifted from the employee waged-based social contribution to the broader income-based CSG to fund mandatory health insurance in large part because of concerns regarding unemployment and employers' competitiveness.²²⁴

Second, critics of employment-based health insurance contend that employment-based health care contributes to the high cost of health care.²²⁵ In 2010, health care costs in the United States constituted 17.6% of GDP, the highest in the developed world.²²⁶ In France, health care costs constituted 11.6% of GDP,²²⁷ two percentage points higher than the OECD average of 9.5%,²²⁸ and third highest in the world.²²⁹

Critics of the employment-based health care system in the United State object to its high administrative costs relative to a universal single-payer system²³⁰ and contend that its favorable tax treatment creates an incentive to overinsure and thus leads to increased health care costs.²³¹ Effective in 2018, the Affordable Care Act will introduce an excise tax on high-cost employment-based health insurance plans aimed at reducing the incentive to overinsure.²³² Whether the excise tax will be

222. See, e.g., DUTTON, *supra* note 71, at 218 (“[T]he single most imperative reform to U.S. and French health care is to sever the obsolete link between employment and health security.”).

223. See *id.* at 219 (“Only if the link between health care financing and security from the calculations of workers and employers is severed will health care cease to hinder employment and economic growth.”); Gentile, *supra* note 55, at 145-47 (describing and refuting argument).

224. See Bonoli & Palier, *supra* note 156, at 252 (explaining that French government's push to transform mandatory health insurance system from employment-based system to universal, state-managed and tax-financed one was driven in large part by “the desire to reduce contributions and, as a result, the cost of labour”).

225. See, e.g., *Future of Employment-Based Health Insurance*, *supra* note 212, at 893-94.

226. ORG. FOR ECON. CO-OPERATION AND DEV., OECD HEALTH DATA 2012: HOW DOES THE UNITED STATES COMPARE 1 (2012), available at <http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf>.

227. *Id.*

228. See *id.* Health care spending as a share of GDP was much lower in France than in the United States, which was 17.6% in 2010. *Id.* In addition, it was slightly than in the Netherlands (twelve percent) and the same as in Germany. *Id.*

229. The only countries in which health care costs represent a higher percentage of GDP are the United States and the Netherlands. *Id.* Like France, health care spending in Germany constitutes 11.6% of GDP. *Id.* Interestingly, among OECD countries, the four countries in which health care spending represented the highest percentage of GDP are also the four countries in which private health insurance represented the highest percent of health expenditure in 2000. See Columbo & Tapay, *supra* note 101, at 9 fig.1.

230. See *Future of Employment-Based Health Insurance*, *supra* note 212, at 893-94.

231. See *id.*

232. Amy B. Monahan, *Why Tax High-Cost Employer Health Plans?*, 65 TAX L. REV. 749,

effective in reducing costs remains to be seen.²³³

Critics of the French health care system contend that complementary health insurance (which is offered and funded in large part by employers) has made it difficult to contain health care costs.²³⁴ When the French government instituted its mandatory health insurance system, it required that individuals pay a portion of the cost of their care (*ticket modérateurs*).²³⁵ The co-payments were intended to moderate demand.²³⁶ Because complementary health insurance typically covers these co-payments,²³⁷ it eliminates their ability to reduce moral hazard so as to rein in costs.²³⁸

The moral hazard created by complementary insurance may be somewhat tempered by the additional flat co-payments that were introduced in 2005 because the new flat co-payments may not be reimbursed by complementary health insurance.²³⁹ They are unlikely, however, to have a substantial impact on utilization given their relatively modest size - €1 for every doctor visit and test up to €4 per day and €2 for each medical transport by ambulance or medical taxi and €0.50 for each drug up to a second €50 ceiling.

A third criticism leveled against employment-based health care is that it creates inequality in access to care. Lack of health insurance coverage has been a serious problem in the United States. For example, in 2011, 18% of the nonelderly population had no health insurance.²⁴⁰ The Affordable Care was enacted, in part, to address the lack of health care coverage.²⁴¹ It did not, however, eliminate employment-based health care, and how effective it will be in extending health care coverage to the entire U.S. population remains to be seen.

Although the first tier mandatory health insurance system covers the entire French population, prior to the introduction of CMU-C, the poor and unemployed were less likely to have complementary health insurance and thus face out-of-pocket expenses when using health

749 (2012).

233. See generally *id.* (criticizing the new excise tax).

234. See, e.g., Buchmueller & Couffinhal, *supra* note 15, at 15-17.; Gentile, *supra* note 55, at 132; SANDIER ET AL., *supra* note 16, at 146.

235. See Gentile, *supra* note 55, at 132.

236. See *supra* Part 2.A.5.

237. See *supra* Part 2.B.3.

238. See generally Mark V. Pauly, Comment, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 531 (1968) (discussing moral hazard and the use of the deductible and co-payment to reduce moral hazard).

239. See *supra* Part 2.A.5.

240. FRONSTIN, *supra* note 197, at 4.

241. See FROLIK & MOORE, *supra* note 211, at 94-95.

care.²⁴² Studies showed that those who did not have complementary health insurance did not consult doctors and dentists as frequently as those who were covered by complementary health insurance nor were they as likely to spend as much on pharmaceuticals.²⁴³ Critics of the French health care system contended that complementary coverage created inequality of access to health care.²⁴⁴ The French government addressed this concern by extending CMU-C to the non-elderly poor.²⁴⁵

Although the French health care system has been ranked the best in the world, the fact that employers play an important role in the system does not appear to be a strength of the system. Instead, it may be the greatest weakness in the system and exacerbate one of the most pressing issues facing health care systems throughout the developed world, escalating costs.

242. Grignon et al., *supra* note 102, at 205.

243. Thomson & Mossialos, *supra* note 89, at 435; Buchmueller & Couffinhal, *supra* note 15, at 15-16 & n.15 DUTTON, *supra* note 71, at 203 n.65.

244. *Id.* at 203 (“Albeit less pronounced, France’s comparable historical tradition of workplace health coverage underlies inequities of health care access because of the continued importance of supplemental insurance.”); Gentile, *supra* note 55, at 155 (“The disparity in complementary coverage became one of the principle sources of inequality in the French health system.”).

245. According to one study, it appears that CMU-C has increased utilization by newly covered individuals. Grignon et al., *supra* note 102 at 217 (noting that individuals who enrolled in the free plan had a significantly higher probability of using health care services and that this effect is likely driven by those with no supplemental coverage prior to enrollment). Of course, extending complementary coverage increases the likelihood that lower-income individuals will use health care and thus increases costs. By extending complementary coverage, the French government has chosen to enhance equity in coverage at the expense of efficiency. Buchmueller & Couffinhal, *supra* note 15, at 19.