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# Voluntary health insurance markets in France.

## Economic rationales and legal mechanisms<sup>1</sup>

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### Abstract

In France, there are two types of health insurance: compulsory public health insurance and voluntary private health insurance which is organized as a market. This paper deals with private health insurance. We define the market place (position and scope) according to two criteria. On the one hand, the standardization or differentiation strategies of the insurance companies, which structure competition through quality and innovation. Secondly, the type of pooling (or mutualisation) at work in insurance contracts, distinguishing between commercial pooling and solidarity-based pooling. We draw up a typology of four “ideal-type” market configurations: residual market, educated market, polarized market and autonomous market.

Voluntary health insurance (VHI) organisations are the traditional providers of ‘health expense’ coverage in France. VHI is private health insurance that is called “complementary insurance” in France. Public insurance is called “Social Security” or compulsory healthcare insurance.

VHI continue to grow in influence. Their total revenues have risen by 117 per cent in 15 years (from €17 billion in 2001 to €37 billion in 2017). Their area of activity consists in covering the out-of-pocket costs of social insurance beneficiaries (after reimbursement under the statutory health insurance scheme). This is a particularly wide area when it comes to routine health care – which the compulsory scheme (SHI)<sup>2</sup> has gradually pulled out of – and to hospital treatment for which the out-of-pocket costs may prove ‘catastrophic’ for patients.

On the strength of this economic need for coverage, over the course of time the VHI organisations have secured institutional rights, actual risk-management ‘powers’, and are now involved in regulating health provision as a whole, and more especially through their formation into a national body (*Union nationale des organismes complémentaires d'assurance maladie, UNOCAM*). New legal powers have been conferred on UNOCAM to negotiate and sign-off on agreements, and more specifically for healthcare charges for which the compulsory scheme refunds only a minor proportion. Expenses for opticians, dentists and hearing-aid specialists now come under a specific statutory price setting scheme.

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<sup>2</sup> We use the abbreviations SHI and VHI for statutory and voluntary health insurance respectively.

Legal mechanisms and economic rationales are very often intertwined. The economic weight gained by the VHI organisations induces the establishment of legal mechanisms enabling them to take part in the ‘management’ of ‘health expense’ coverage in such a way that they are not ‘paying out blindly’. The legal mechanisms shape the VHI market. In other words, they contribute to its construction by fashioning it and procuring the legal tools and techniques required to safeguard the provision of VHI as an economic activity.

This paper examines how the VHI market is jointly constructed by legal mechanisms and economic rationales in a context of competition among three operators: mutual societies, commercial insurance companies and provident institutions. The ‘place’ of the market is to be understood here in the two senses of its position and its scope (Favereau, 2010).

## **1. Voluntary health insurance markets**

The VHI market shares features common to other markets for goods and services and specific features that make it an original subject of investigation.

The first of those specific features is that it is not hegemonic in its field of healthcare coverage. VHI organisations have to come to terms with the Social Security system. The world of health cover is a ‘world with a market’ and not a market world. A second specific feature is that the space covered by the VHI market depends on SHI which, in some sense, governs the market or has the authority to do so. It is the spaces left vacant by SHI that determine the scope of the VHI market. But VHI does not just fill in the gaps left by SHI and “complementary” insurance is not just a top-up to SHI. VHI does not want some of the spaces and insurers prefer the hale and hearty to the very ill, the very elderly or the very poor. Now, while the VHI market place is subject to the prerogatives of SHI, it is also bound by the commercial strategies of the VHI organisations.

And the VHI market is not necessarily a commercial market. It may be based on values that are not market values. It may even thrive by taking up a language that is not market language. VHI organisations may cover risks for which costs outweigh benefits. Some operators (mutual societies) may call for competition to be restricted and the market space cut back. All plead for no unification of prices which, in a true market place, is the outcome of competition. The current development of the VHI market rests on solidarity-based principles (preferential provisions for the poorest, solidarity-based contracts, etc.) and/or on industrial (connected health, etc.) and domestic or proximity principles (healthcare networks, etc.). Such values provide market leverage but are not market values (Batifoulier 2014, André et al., 2016).

These specific features of the VHI market make it difficult to identify a well-delimited place (space and scope). There is a range of market places and we can attempt to draw up a panorama of them using the orientation table below.



of customers. Conversely, differentiation rests on heterogeneous insurance products meant for diverse target audiences. Strategies designed to identify and enhance differences play primarily on the register of quality (both of the insurance products and the people covered) which is a leading argument for singling out customers (Batifoulier et al., 2011).

Each quadrant thus defines an ‘ideal type’ of identification of the VHI market place that can be made out in the legal mechanisms. The market for health expense cover has been the subject of legal mechanisms that have undergone wholesale transformations over the course of time, and those transformations can be grasped using the same quadrants. The VHI market can be characterised, then, by types or families of legal mechanisms that can be identified in each quadrant, primarily by characterising the type of provision that can be observed.

## **2. Forms of market and rationales of provision**

### **2.1. Market fundamentalism: a residual market**

The north-west quadrant is for ‘insurance fundamentalism’ in which health insurance is just one more source of profit like any other. Pooling is based on the profitability of providing coverage, which is spread across the entire customer base. This canonical model of the insurance contract in which insurance is the ‘daughter of capital’ as F. Ewald (1986) put it, turns upon the computation of probabilities in order to liken uncertainty about the future to an idea of calculable risk. Chance events are standardised so as to be more manageable. Pooling relates to the individual chance event. Insurance sets to dividing populations into statistically homogeneous classes of risk. By breaking down risks using probability computations, uniform subpopulations are defined that are as controllable as can be. Under these circumstances, it is indeed therefore a matter of providing standardised products, even if they may differ marginally. Accordingly, the insurance operation works to the same standard: parameters are set by age (which is a paramount criterion), place of residence, income and date the contract was first subscribed.

This view of insurance applies to any form of product and/or behaviour to be insured and ignores the primacy of health for individuals. It runs counter to the objectives of vertical equity (from each according to their means) and horizontal equity (to each according to their needs). On the contrary, payments out are related to the capacity to pay in.

Because it disregards the social function of health insurance, this form of market can only be residual in the European political context where healthcare coverage is associated with fostering social pact and must contribute to collective security. It may be reserved to those with sufficient income to do without SHI (in Germany for the highest incomes) or it may be confined to healthcare that is not included in the basket of provision or that comes under unregulated provision. In Beveridgian models where waiting lists form as in the UK, Sweden, Spain or Italy, ‘duplicative’ private insurance has developed for those who can afford it (Benoit et al., 2021). While this type of insurance is residual and restricted to the best-off, it is also segregative in that it allows not just faster access and a greater freedom of choice but also better quality care.

In all of these arrangements, the residual charge is invariably the outcome of individual deliberation by individuals who are free to choose. This conception of the market relates to an unfettered organisation of provision. It is recognised and organised by law so as to give maximum freedom to insurance provision and its operators. This perspective is the one opted for in European directives that enshrined the introduction of ‘free and fair competition’ in insurance operations. Accordingly, it was decided in the early 1980s in France to refuse a monopoly for mutual societies, which progressively led to the spread of competition.

The first reports and legislation governing complementary social protection also fit into that context: organising a market allowing operators to trade freely within a supposedly egalitarian setting. Legal rules should thus be the same for all three operators with the legislation (*la loi Evin*) enacted as of 1989 outlining the structure of unrestricted provision operations, which may be individual or collective, optional or mandatory. The arrangements for organising and financing these complementary protections fall primarily within the scope of individual freedom of contract or the freedom of contract to be conferred on unions and management, who are specifically authorised to arrange their own social protection scheme within a firm or trade. Freedom of contract and free competition are the cardinal principles of this legal configuration of the market that is organised, save a few exceptions, around the classical rules applicable to insurance contracts.

## **2.2. Solidarity conveyed by VHI: the educated market**

In the north-east quadrant, VHI seeks to take account of the social function of healthcare coverage without giving up on its capitalist foundations. The aim then is to imitate the objectives of SHI with the resources of VHI and, in a nutshell, to introduce ‘social security’ into private insurance. The objective of pooling conveyed by SHI here becomes a market argument and an argument for differentiation among operators. We find again here the historical justification for pooling that sought to pursue the objective of solidarity outside of SHI. This is also nowadays its main market argument setting it apart from the competition. But mutual societies do not have any exclusivity because the objective of lending consistency to solidarity outside of SHI is of interest to all forms of insurers, whether mutual societies or commercial companies.

But there is not generally any spontaneous movement to lend consistency to solidarity in VHI. It requires legal impetus in the shape either of regulatory constraints or of financial incentives to spread the burden or the effort of taking out insurance more equitably among citizens. This is what happens when lawmakers set up specific conditions for covering those people who are most excluded from the market, such as those on low incomes or with serious and costly illnesses. Solidarity-based and responsible contracts, the setting of economic parameters for contracts eligible for tax and social support with schedules and the creation of threshold values designed to attenuate the adverse effects of assurance fundamentalism, are all part of this movement.

The aim is to construct a ‘desirable’ health insurance market in the sense that it would take on the objective of making healthcare coverage a question of solidarity. This market is largely framed and sometimes even regulated with a view to creating an education about solidarity. Moreover, it must be in step with the solidarity objectives conveyed by SHI. The protection afforded to the poorest by complementary universal health coverage (CMU-C) and the health insurance voucher plan (ACS) must not be voided of meaning by the commercial strategies of VHI. In avoiding people waiving healthcare, this ‘educated market’ has ethical roots too: the shared ambition to stave off death as far as possible, to promote autonomy for long-term conditions (ALD) and, for CMU-C or ACS, the pressing need to have access to care in order to engage in social life. The right to complementary social protection gradually changes into a more substantial right, a right with greater, more ‘stringent’ ‘standardising’ content aimed at setting up corrective mechanisms for insurance law.

This involves, to begin with, the creation of public policy rules to bestow a number of rights on subscribers to providential VHI contracts. The rules of insurance law are thereby adjusted to protect the most vulnerable: the prohibition of selection on medical grounds, of unlawful clauses or the obligation to cover prior pathological conditions are all rules devised to ‘moralise’

insurance dealings in the healthcare sector. More recent still are rules and regulations that attempt to correct the gaps and breaks allowed by insurance law, with the creation of mechanisms to maintain insurance coverage for those on unemployment benefit or for smoothing of charges for the retired for the first five years after leaving employment.

But this ambition to implement some social purpose in the provision of private coverage does not concern the most vulnerable patients alone. It is addressed at potentially all patients and is also meant to limit any waiving of healthcare by encouraging people to take out solidarity-based and responsible contracts. These are innovative contractual tools made available to VHI organisations to help them to limit the out-of-pocket costs of their policyholders. The law seeks to organise the insurance market differently by urging organisations to be especially attentive to the prices paid by their policyholders. These legal arrangements have been rolled out particularly in firms since the introduction of the statutory duty of employers to provide group agreements for healthcare cover, which now have economic parameters associated with them. The regulatory authorities have gradually drawn up a new form of schedule defining not just a minimum basket of care but also levels of reimbursement. There are ‘floor prices’ as well as maximum levels of cover that enable the organisations to benefit from fiscal and welfare exemptions (Ginon, 2014, 2017a). The schedules have also gradually evolved: they have become increasingly detailed and specific, now going so far as to set out a list of charges and healthcare to be covered or excluded from coverage. The rules for parameterising the prices paid by the insured are now subject to regulation. This leads then secondarily to a law that is based more on incentives than ‘constraints’ and which seeks to orientate insurance provision to make it more solidarity-based and more responsible. The introduction of ‘responsible contracts’ in 2004 led the lawmaker and the regulator to encourage VHI organisations to reimburse just those expenses that kept to the coordinated care pathway. The rules and regulations were gradually enhanced by an ‘incentive-based public policy’ to define guarantees but also desirable exclusions. The various schedules of responsible contracts are part of the same movement: to guide insurers towards coverage for which the content corresponds to public choices about solidarity. There is a list of public health services that should thus be included and reimbursed and new rules to limit extra-billing. Private pooling has thus been thoroughly re-organised to serve general interest objectives that are compatible with if not common to the interests developed by SHI.

This complementarity between SHI and VHI is expected to limit the out-of-pocket costs for certain segments of the population and the cost of certain treatments by leaving them within the scope of recoverable charges. Accordingly, in this educated market, VHI organisations are assigned the mission of bringing down out-of-pocket costs; to do this they are provided with the legal tools for managing the basket of reimbursed healthcare (especially for ensuring solvency where excessive pricing is practised).

This sharing of objectives common to both SHI and VHI is particularly clearly expressed in the recent government strategy to implement ‘zero out-of-pocket costs’ for some services and treatments. These ‘zero out-of-pocket costs’ redefine out-of-pocket costs no longer as the co-payment after SHI but as the co-payment after adding together the two forms of coverage, SHI and VHI, with the result that the two are now continuous if not fungible, whereas historically the two forms of insurance had neither the same objectives nor the same legal foundations.

VHI is invited to have social objectives and to comply with the public policy of access to healthcare for all. The ‘social’ objective is thus exported to complementary forms of coverage that are to deal with it in their own ways. This ‘smoothing’ of insurance with the creation of shared objectives leads to healthcare risk being redefined. If this risk was so far tautologically termed ‘social’ (because it was covered by social insurance) it has now become an argument

for the creation of new management prerogatives in favour of VHI. VHI now has social attributes that mean the risk it covers should also be characterised as ‘social’.

This new function of VHI is meant to make the market ‘socially responsible’ and remove from the private insurance reference chart anything that might be opposed to access to healthcare for all and cause people to waive care. As the primary objective of VHI is not to enable access to all types of care, the market is asked to reset its ‘own software’ via a process of social and fiscal incentives inviting the VHI to re-think its offers and consequently the insurance contracts with or without increased insurance premiums.

### **2.3. Separating risks and patients: the polarised market**

Whereas the ideal type world of the market presented in the previous quadrant (*educated* market: north-east) aims at ensuring continuity and even complementarity between SHI and VHI over common coverage of risk, the south-east quadrant organises a discontinuity or even a sharp divide between the two into separate risks. This divide is built on a would-be legitimate boundary: the dividing line between ‘minor risk’, which should be within the ambit of VHI, and ‘major risk’ reserved for SHI. Separate risks lead to separate cover and the VHI market is that of the ‘minor risk’ or of routine healthcare, that is, care for which the unit cost is low but that is more frequent.

This fragmented coverage rests on the calibration of recourse to care by type of risk. On the one side is the ‘minor risk’ that individuals can largely afford by acting as responsible individuals. On the other, the more random ‘major risk’ that implies marked national solidarity. In a context of public spending cuts, the ‘minor risk’ is that which should be de-reimbursed by SHI whereas the ‘major risk’ should not be or not too much so. Although the distinction between ‘minor’ and ‘major’ risk is not readily operational,<sup>5</sup> it has periodically appeared again, especially in the 1979 report by Simon Nora and Jean-Charles Naouri, and was given a new lease of life with the debate over the inefficiency of mixed forms of coverage: having both SHI and VHI for the same types of healthcare is an expensive duplication of administrative costs. And for the economic theory of incentives, the distinction supposedly destroys all incentives for patients to act responsibly (if the patient’s contribution to medical costs – known as *le ticket modérateur* – can be insured against, then it fails to serve its moderating purpose).

This long-standing distinction can be found in the proposals for the creation of safety nets for ‘hard times’. It was already drawn on at the time the Social Security system was developing so as to criticize the general scheme (back in 1945) and try to reduce solidarity to services for the poorest and most seriously ill (Batifoulier et al., 2019). This liberal approach to individual healthcare protection sings the praises of individual providential cover. In a well-ordered society, individuals should count solely on their own resources or their own property to provide for their needs. Autonomy is the precondition for self-realisation and for achieving collective harmony. Society would be threatened if individuals could make others bear the burden of mishaps. But such unrestricted providential care can only be exercised if individuals are in a position to do so. Those who are too poor and/or too ill have no freedom of choice. That is why they must be protected by special-purpose arrangements. On the one side are those who are able to assume their healthcare choices, ‘responsible’ individuals; on the other those who are unable to do so and who must rely on national solidarity.

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<sup>5</sup> Risk separation is problematic because there are many definitions of major risk and because the boundary between minor and major risk is not watertight. The distinction combines criteria of seriousness of illness (primary care versus hospital care or chronic illness) and financial criteria (the poorest cannot pay for their care, including primary care). Minor risks may therefore become major if not treated in time.

The marketplace for VHI is therefore well delimited to one class of risks and rests on the segregation of healthcare baskets. This strategy of separating risks weeds out the ‘poor customers’ from the ambit of the VHI and so furthers the development of the market. Polarisation of the VHI market makes for a divide of the out-of-pocket costs. It multiplies out-of-pocket costs for common care while combating catastrophic out-of-pocket costs for the most seriously ill.

The strategy of risk separation is conducted so as to target the fight against inequality on ‘catastrophic’ expenditure for those whose income is too low whatever the resort to care and for those whose resort to care is too costly whatever their income. The levels of effort (proportion of financial contribution from patients depending on their income) are higher for the poorest. They make up a lower proportion of income in the last standard-of-living decile (2%) than in the first decile (7%). And, for hospital care, for which expenses are better reimbursed than for non-hospital care (around 90% on average), it is estimated that nearly 5% of patients are still not covered by private insurance and accordingly are at risk of bearing the entire out-of-pocket costs (Batifoulier et al. 2021).

This conception of the market corresponds to a specific legal organisation meant to favour the legal disconnection of the care baskets. It promotes the development of a VHI that is separate from SHI with the idea that the complementary form will cover what the compulsory insurance does not purport to cover because it does not come under ‘healthcare provision’ within the meaning of social security law. Here the full effect is given to the capacity for innovation included in contractual technique and insurance operators are encouraged to cover what the social security considers need not or cannot be covered: unregulated charges, choice of individual room at hospital, non-conventional forms of medicine, homeopathy, etc. are all services that the authorities consider need not or need no longer be included within the ‘reimbursable’ basket of care. This legal organisation of providential care and the organization of its place within healthcare expenses coverage has found new developments since the introduction of successive policies of non-reimbursement of health services and products for which the medical service rendered has been judged poor to moderate by the National Health Authority (*Haute autorité de santé*). The lawgiver has in this respect given itself the tools to make a medical and economic evaluation of services so as to be better able to assess the basket of reimbursable care. Packages are developed here for coverage, or even options that only VHI takes on to meet needs expressed but also to develop its market share.

The division of risk reinterprets the principles of solidarity between the fit and healthy and the ill. The aim is still to ensure health protection according to need, but by restricting full coverage to those who ‘most need it’ and letting the market move into the ‘minor risk’ areas. The scope of action for VHI is the out-of-pocket costs that are limited for the ‘major risk’ but widened for the ‘minor risk’ unless patients are ready to pay more in insurance premiums for the same coverage.

This strategy of segmenting patients is likely to untie the social compact by establishing differences between individuals and by fomenting suspicion between those who pay dearly for their private insurance and those who are exempted (or spared to a greater extent) by being well reimbursed by SHI.

#### **2.4. Breaking free from SHI: the autonomous market**

In the south-western quadrant, the VHI market seeks to distinguish itself from its compulsory counterpart. It arranges the segmentation of individual and group contracts so as to gain its autonomy from SHI and offer the insured ‘made-to-measure’ rather than ‘one-size-fits-all’

coverage. The aim, then, is to ‘stick’ as closely as can be to customer preferences and to meet new needs, even if it means creating them. The VHI market is directed at smaller communities. Since the communities (or groups of policyholders) are different, the products are differentiated depending on the target group’s real or supposed needs. The product to be sold can be specified by socio-occupational category (e.g. executives or non-executives), occupational sector or branch of activity, etc. Pooling is then limited to covering a small number of people with similar risk profiles and is based on a principle of pooling that can be characterised as ‘commercial’. The price of the product (paid by the patient) is disconnected from the price of the service (reimbursement).

Under this set-up, the VHI market becomes ever more inventive in selling new products, customising insurance products and singling out the offer of coverage (for an individual or a firm).

Three types of legal arrangements are in operation:

- ‘Non responsible’ contracts, designed to cover everything for certain target audiences and so provide full health expense coverage, including for certain surplus fees, as charged by hospitals or by some doctors. And because the ‘rules and regulations’ of the second stage of social protection (compulsory complementary) hardens, the VHI organisations position themselves on the third stage to implement their differentiation strategies. For large firms especially, group agreements may be used as loss-leader products for insurers to secure a foothold in the business market and enable them to sell supplementary insurance to employees that provides more coverage by enhancing the insurance product with additional quality.
- The earning of rewards and commercial premiums in the form of purchasing points or vouchers or even the paying back of part of the premium at the year end (partner gifts, deposit against insurance excess, behavioural insurance, etc.), which are innovative contractual arrangements and aimed at a specific audience amenable to this type of offer. The various advantages in the form of ‘health coaching’ with connected objects or otherwise are differentiation levers to ‘lure customers’ (Ginon 2017b, Chelle 2018). Complementary social protection law thus includes mechanisms based on the promotion of preventive actions in healthcare and grants those who opt to follow them additional points over those who choose not to sign up. These ‘responsible behaviour’ mechanisms are intended to build a new articulation between the entitlements and conduct of policyholders, further disconnecting these products from their purpose of providing social protection, unless it is considered that one should also watch over the lifestyles and leisure of the insured.
- Lastly, membership of a healthcare network now makes it possible to regulate the prices of some services that are covered by VHI. In this respect, the 2014 ‘Le Roux’ legislation authorises VHI organisations to enter into contracts with healthcare professionals to determine the price conditions for provision of services they cover. This is the unregulated part of the price that may be subject to special arrangements with the VHI organisations. The healthcare networks then feed on the withdrawal of SHI because they aim to contain the out-of-pocket costs after reimbursement by SHI. They thrive on the disjunction of coverage, with VHI trying to take over the ground from which SHI has retreated.

In these set-ups, the out-of-pocket cost (and the size of it) is a powerful lever for developing the market. It is transformed into a commercial argument because it must be ‘self-managed’ by the customer, who decides whether or not to bear the cost. The out-of-pocket cost becomes an element in cost-benefit computation. Customers choose their level of coverage depending on a choice between the satisfaction of need and the cost thereof. The lawgiver has thus constructed a separate legal status for health spending that is little covered by SHI, and especially for opticians, dentists and hearing-aid specialists. This spending now follows different rules that

are aimed at ensuring better coverage by VHI alone. Providential care is thus disconnected or disjoined, attesting that the legislation takes a different view of health expenditure, which is more a question of ‘care’ than of consumer choice for which VHI organisations are the main insurers.

The VHI market develops along different pathways. The initial organisation of ‘health expense’ coverage around three pillars (compulsory, complementary and supplementary) now leaves room for a third, entirely optional, stage that makes no bones about it and is close to the north-west quadrant and assurance fundamentalism. The solidarity constraints imposed by the lawgiver are those of the north-east quadrant (market educated about solidarity). Solidarity has to be reintroduced into VHI so that it prevails for certain types of care, while looking to come to terms with the priorities for coverage that segment the market and organise differentiated healthcare coverage depending on the nature of the health risk (south-east quadrant). Insurers’ response strategies enhancing individual responsibility and behaviour with respect to health act as levers for the development of an autonomous market (south-west quadrant).

Insurers’ differentiation policies combined with competition based on quality lead to a widening gap between VHI and SHI. VHI is less and less complementary to SHI: it is developed through ever more intensive customisation of insurance and the singling-out of the offer of coverage. This sea change leads to a call for the legal reconstruction of the health insurance operation which should now be part of a greater whole, that of insurance and the rights of the insured.<sup>6</sup> It is a question of governing insurance so as to govern the insured.

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<sup>6</sup> Health insurance contracts have so far been left outside the scope of the Hamon legislation of 17 March 2014 (subscribers to such contracts were not allowed to terminate them within less than one year as from the second year of the contract, that is, the possibility of termination at any time, without reasons or charges or penalty charges, once the first year of tacitly renewed contracts had elapsed). However, arrangements have recently changed in favour of a right to terminate complementary health insurance contracts without incurring expenses.

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