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Chapter 10. New insurance products with a behavioural dimension in the company

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All insurers now offer companies preventive health products with a behavioural component. These products are growing rapidly and aim to encourage employees to monitor their health more regularly and to adopt behaviours that are considered healthier. For example, with the Vitality program of the Generali insurance company, walking 10,000 steps a day, stopping smoking or eating organic fruit and vegetables enables the 90,000 employees of companies in France who have subscribed to this program to obtain gift vouchers from partner companies. We are thus witnessing a transformation of the health insurance software which articulates a preventive logic to the objective of risk management, oriented towards taking into account and transforming individual behaviour, in short, to govern the behaviour of employees in terms of health. This new risk governance that is now taking shape brings together three types of actor: insurers – who intend to position themselves on the booming prevention market as partners in health –, the company, which is no longer seen as an area of occupational risks that the law is intended to regulate, but as an institution placed at the service of the health and well-being of its employees –, and the State – which, thanks to the transformation of the sources of social law, is delegating some of its missions to these private actors (Dirringer, 2019).

Where do these insurance evaluation systems come from, opening up the integration of the behavioural factor in health insurance? How are these recent programs implemented with the clients of insurers who, in France, are first and foremost companies through which the aim is to reach employees? What are the differences between France and the United States where these products are much older and more widespread due to a legal framework that is more favourable to this behavioural logic?

After characterising these behavioural products proposed by insurers (1), we will identify some of the issues at stake in this new risk management as it is being deployed on both sides of the Atlantic (2).

1. New products for new insurance software?

This section aims to characterise the behavioural products offered by insurers. It first presents the origins of the logic of segmentation of populations according to risk by insurers (1.1) before showing how this is linked to the claimed objective of working towards risk prevention (1.2).

1.1. Behavioural tariffs: the main objective of insurers?

Insurers can make profits by segmenting the insured population in such a way as to vary rates or insurance products according to the characteristics of the insured or their practices, i.e., by looking at the statistical individual behind the biographical individual. Classical in property insurance, this logic of behavioural segmentation has recently appeared in personal insurance, particularly in connection with an objective of differentiation in the health insurance market.

The segmentation of populations according to the behaviour of the insured is increasingly present in property insurance. In car insurance, for example, this is the “pay *when* you drive” principle, which indexes the insurance rate to the frequency of use, or even the “pay *as* you drive” principle, which, through the use of a monitoring device in the car, punishes bad “driving” by means of higher rates or rewards “good” behaviour.

While the segmentation of populations is not new to property insurance, it is now associated with new processes in personal insurance. In 1995, the sociologist D. Torny proposed an analysis of what was then less an emerging situation than a “socio-fictional” one. His article aimed to simulate the application of motor liability insurance to health insurance. He emphasises the problems raised by this transfer, notably around the fact that an individual’s health characteristics are relatively permanent when compared to driving practices, which then explains why the controversy raised by behavioural insurance is more intense in health than in property. But the central contribution of his reflection is to shed light on the possibilities of transforming health behaviours and their limits, particularly in terms of lifting medical confidentiality. He thus points to the rise of new issues related to responsibility and the imposition of a duty of health which is now reaching an unprecedented level.

We must therefore endeavour to describe this duty of care through its moral component, following the example of D. Bouk, who shows that life insurance was imposed in the United States based on the idea that the moral duty of a good father is to insure his family (2015). The new risk design techniques made possible by what L. McFall calls the digitalisation of insurance (2015) are not limited to rate-setting policy, as they offer insurers tools to influence the behaviour of individuals, particularly those most at risk. These techniques must therefore be understood in relation to the injunctions made to the players to monitor themselves in the context of preventive policies which have recently involved insurers in an original way.

To understand the current emergence of health insurance programs incorporating a behavioural factor, we can see in them, rather than a race for segmentation similar to that observed in property insurance, a strategy for differentiating the offer in a market where price competition is no longer effective. This logic of differentiation through the product rather than the price is

achieved through the marketing of innovative services and products, such as these new programs, often free of charge, aimed at building loyalty among future customers.

A media example was recently provided by the new scheme implemented by the insurer Generali in France from 1st January 2017. This program, entitled Vitality, is intended to build loyalty among the employees of member companies by allowing them to benefit from advantages in the form of discount vouchers from the insurance company's partners (Décathlon, Fnac and Sephora, Club Med, Look Voyages or Weight Watchers), as soon as certain objectives are met (for example, taking 10 000 steps a day or reducing tobacco consumption). This formula, criticised by some as opening the way to health behaviour insurance and going against the principle of solidarity,¹ illustrates the transformation of the insurance logic. In the words of François Ewald, who identifies five factors of change for the "insurance society" (2009), Vitality seems to trigger the transition from insurance as a "second protection" to compensate for a loss to a principle of access to the goods necessary for a normal social life.

A 2018 interview with one of the people in charge of external communication at Generali suggests that this transformation of the insurer's role is assumed, insofar as it is less a question of maximising short-term profit by playing on insurance rates than of diversifying the insurer's missions with a view to strategically differentiating the offer. It is therefore understandable that the program is free of charge, although it requires the client to register, and that it is scrupulously monitored. Vitality thus pursues a long-term loyalty objective and is part of a general movement by which the insurer intends to become a player in prevention and well-being.

1.2. Are health insurers conquering the prevention market?

Generali is not the only insurer to offer a program aimed at taking into account and transforming the health behaviours of policyholders. In France, AXA has launched the "Pulsez votre santé" product in partnership with the connected bracelet company Withings. Since 2010, Malakoff Médéric (now Malakoff Humanis) has been developing a range of services, including an e-coaching program called Vigisanté, which is also based on voluntary participation and the confidentiality of the data collected. It enables companies to establish a diagnosis and activate appropriate services (absenteeism dashboard, prevention and screening programs, health e-coaching, support for returning to work, etc.). With the Lyfe platform, CNP Assurances is implementing the same strategy for companies and policyholders, encouraging them to play an active role in dealing with health issues.

1. For the national secretary of the Confédération française démocratique du travail (CFDT), Jocelyne Cabanal, "this initiative, which is unprecedented in France, puts the finger in a dangerous trap from the point of view of solidarity and the pooling of risks between the sick and the healthy", [<http://www.argusdelassurance.com/acteurs/compagnies-bancassureurs/generali--les-inquietudes-persistent-apres-la-presentation-du-programme.110679>], accessed on November 13, 2023). In a press release issued on 9 September 2016, the CISS, a collective of patient associations, criticised this initiative based on the "reward system".

This massive arrival of behavioural programs is evidence of a transformation of health insurance. While this could weaken the principle of mutualisation of risk, it also signals the desire of insurers to develop through the prevention market in order to capture a new clientele and hope in the long term for a reduction in benefits paid. Indeed, all these offers are primarily intended for companies and their employees. The preventive approach is therefore expressed in the recent terms of “quality of life at work” (QWL), or even “corporate well-being”.

In order to fully understand the issues it raises, this new insurance software must be placed in a broader framework in which various professionals are involved. The corporate world is a potentially useful field for reporting on these insurance transformations, insofar as the insurance products identified so far are primarily geared towards companies and, through them, reach employees on the basis of voluntary subscription to an option attached to the company’s collective cover. For the moment, the French Vitality formula only targets companies. For Yanick Philippon (in charge of the group insurance segment for corporate clients at Generali), “companies have an objective of retaining their staff and reducing absenteeism with fit people”,² the objective to which this insurance formula claims to contribute.

The legal obligation to engage in negotiations on “quality of life at work” (QWL) at company level is therefore a windfall for insurers offering health and well-being programs to companies. As of September 2017, the Vitality program is available in nearly a thousand companies and potentially reaches 90,000 employees at that time. The link with QWL issues is highlighted by the way in which Generali offers its service to companies, putting the medical dimension on the back burner in favour of an emphasis on well-being issues.

2. Behind these new products, a new government of risks?

These products raise multiple issues at the crossroads of three dimensions. Firstly, the behavioural approach to health that they entail tends to make working conditions invisible as an occupational risk factor (2.1). Moreover, this approach generated by these new products, which are developed through digital means (connected objects and e-health platforms, see box), raises questions about their scope in terms of monitoring workspaces (2.2). Finally, existing law opens up contrasting prospects for behavioural insurance (2.3).

2.1. The behavioural approach to health, a vector for making working conditions invisible as an occupational risk factor

This behavioural horizon for insurance raises the issue of making invisible the working conditions as an occupational risk factor. Through these new arrangements, such as the use of

2. [<http://www.latribune.fr/entreprises-finance/banques-finance/assurance/generali-retorque-a-touraine-l-assureur-n-a-pas-acces-aux-donnees-medicales-585127.html>], accessed on November 13, 2023.

connected watches for example, are health problems that previously went unnoticed made visible or, conversely, do these products, because they operate through a focus on individual health behaviours, contribute to make the risks associated with collective working conditions invisible?

The second part of the alternative needs to be taken seriously. Anne-Sophie Ginon rightly points out that the purpose of the service offered in a behavioural program is not to insure a risk, as when a policyholder takes out a health insurance contract, but to bring about new individual health behaviours. In return, the employee will obtain points which he or she can then convert into various commercial rewards chosen from a list of predetermined goods and services. It emphasises the “legal weight [given] to individual health risk behaviour(s)” by these programs. For example, the rewards given by the insurer Generali under the Vitality program are “completely disconnected from the world of social protection and work. They are not intended to improve working conditions, nor even to distribute additional insurance benefits” (Ginon, 2017).

This type of program could reduce the role of occupational medicine. Indeed, occupational physicians could be excluded from these schemes because they capture clinical conditions thanks to new standardised health data collection methods (Juston Morival, Ginon & Del Sol, 2019). Thus, in the behavioural health insurance mechanism, the emphasis on changing the behaviour of the insured employee as a key factor that would have a significant impact on his or her health contributes to further obscuring, and thus making invisible other risk factors such as working conditions.

At the intersection of the assessment of insurance risk factors and the production of medical data, a multitude of players are involved, from the design of these new systems to their concrete implementation. We can analyse these two processes of digitisation and ‘behaviouralisation’ of insurance in a dynamic way and report on the way in which they are linked to health data collection and analysis systems. The latter refers to media, applications and platforms offering users personalised health monitoring. The measurement and apprehension of these clinical states then seem to involve other modes of health data collection, one consequence of which could be to displace doctors from these devices. These changes are part of a more profound change that is affecting the whole of medicine, which is moving from an art of healing to a science of measurement and from a therapeutic logic to a preventive logic. As a result, they affect the whole of insurance, as François Ewald notes, for whom “as much as the 20th century was the century of insurance, the 21st will be the century of prevention” (2009).

Discussing the scope or effects of these products invites us to consider the renewal of medical surveillance of workers and its effects on the system of industrial relations. Behind the development of insurance tools in companies, we must then question the effects in terms of sorting out individuals through the conversion of social inequalities in health into social inequalities of another kind, with the ‘badly insured’ possibly being stigmatised as people who do not take charge of their lives (Batifoulier, 2018; on this principle of actuarial justice, see McFall, 2015, pp. 37-38).

Box: Issues arising from the use of digital tools in behavioural insurance

In behavioural insurance, digital tools such as connected objects or e-health platforms are central. The issue arises with regard to health data produced in and by the deployment of connected objects and e-health devices through which these products are developed (legal nature, reliability, etc.). Indeed, insurers have an interest in principle in the collection and processing of data with a view to “profiling” policyholders. However, the possibilities of collection and processing will depend on the exact legal qualification of these data (personal data, health data).

Certainly, the data collected by these connected objects fall under the very general category of personal data, as the General Data Protection Regulation (GDPR) has adopted a broad definition of such data. Third parties are free to process this data, provided that they are able to demonstrate at any time that they comply with certain cardinal principles, in the event of checks by the European data protection authorities (accountability logic). The data collected by these connected objects could also fall into the category of health data, a specific category of sensitive data subject to a specific and strict legal regime, which establishes a principle of prohibition on the processing of health data with limited exemptions. The GDPR has adopted a broad definition of health data, in its article 4.15: “Data concerning health [are] personal data relating to the physical or mental health of a natural person, including the provision of healthcare services, which reveal information about that person’s state of health”. As insurance companies cannot set up health databases or charge on the basis of health data, welfare data is not covered by this regulation for the time being. It will therefore be necessary to look at the shifting boundary between these two types of data, in particular by reporting on the discussions about it and the developments it is undergoing. For example, companies manufacturing connected objects producing well-being data, such as Withings and Apple, are starting to manufacture increasingly sophisticated connected objects generating increasingly reliable and secure data, which can almost be assimilated to health data (electrocardiograms detecting cardiac arrhythmia, blood pressure monitors detecting hypertension, etc.). As regards the sensitive nature of the data collected in the context of these programs, insurers are already showing a certain amount of inventiveness. As the law currently stands, the health data produced by these new formulas are not accessible to insurers. In order to comply with the law, Generali has created the subsidiary Generali Vitality GmbH, which is responsible for storing the data collected from employees who subscribe to the program and for ensuring its confidentiality. Similarly, the Lyfe platform, recently proposed by CNP Assurances, is a subsidiary of the group which is governed by commercial law and as such is registered with the Organisation for the Register of Insurance Intermediaries (ORIAS), so that it can neither build nor sell insurance.

Another issue lies in the uses and processing to which this data can or could be put. The question arises as to the conditions under which quantified self-connected objects are placed on the market and those relating to the protection of users’ privacy. Depending on the use that the individual makes of the connected object, the law imposes different quality standards in terms of security and reliability. The imposition of such standards by the law is explained by the possibility that these data could be used for profiling purposes – particularly in the field of health insurance – but also because the data could eventually be taken into account in the patient-doctor relationship (Redon, 2020).

2.2. The scope of these products for workspace monitoring

In France, the employer is required by labour law to respect an obligation of safety and health at work for all his employees. Consequently, he has a strong interest in reducing the health risk of his employees, and therefore in insisting on prevention. This safety obligation is tending to be transformed into an obligation to prevent occupational risks, under the impetus in 2015 of the social chamber of the Court of Cassation. This development is indicative of the importance of prevention in the workplace. As the employer is under an obligation to prevent occupational risks, the links between the use of connected objects and the terms and conditions of coverage or reimbursement in group health insurance raise in the background the question of the responsibility – or even liability – of the insured employee, and in particular that of the insured employee who has not behaved “virtuously” even though he or she has self-quantification tools. However, the GDPR requires the employer to guarantee the security and confidentiality of the personal data collected on employees. And French labour law prohibits discrimination by employers against employees on the basis of their health status.

With regard to the monitoring of workspaces, we can also cite the hypothesis formulated by K. Ball (2010) who notes that the monitoring of individual performance (which supplants that of production units) sometimes corresponds to the expectations of employees, thereby promoting forms of self-monitoring. A competing hypothesis, however, is that these forms of self-control result from a restructuring of power relations following the new division of risks and responsibilities. Thus, in the same way that the state increasingly relies on market mechanisms to direct the behaviour of the population (Dubuisson-Quellier, 2016), companies can, on the basis of these insurance programs, exercise forms of government of individual behaviour through interest.

2.3. Contrasting perspectives on behavioural insurance under existing law

On the one hand, the prospects for the development of behavioural health insurance depend on the legal framework for the insurance business, but also on the rules governing personal and health data. A comparison with other countries shows that the relationship between insurers and health data is regulated differently. With regard to the Vitality program, there are variations in the form of the program, which in Germany, for example, is offered directly to insured persons, whereas in France it is aimed at companies. Behavioural insurance is highly developed in Germany, whereas in France the regulations are more restrictive. In France and the United States, this type of insurance with a behavioural dimension can be developed. However, the interest of insurers is not the same because they cannot draw the same consequences from the behaviours adopted (or not) in their relations with the insured (with regard to a possible effect or not on the evolution of the tariff, on the coverage of care in case of health problems). The American regulations allow the insurer, or even the employer, to make the behaviour adopted by their policyholders produce effects. More fundamentally, the comparison with the United States is justified by the fact that this country has already institutionalised these public health issues with a high degree of judicialization in this area.

In the United States, these new behavioural insurance products are mainly part of wellness programs offered by private insurers with whom employers purchase coverage for their employees. Federal regulations in the United States are very favourable to the use of these wellness programs, but they pose problems regarding the rights of insured employees. The question of freedom of participation in these prevention programs arises because there are financial penalties for non-participation in the employer's wellness program. As for the pricing of the insurance premium, the regulations authorise wellness programs to modulate the amount of this premium, as a bonus or a penalty, according to the individual's assessed state of health, by analysing his or her behaviour in particular. Employees are therefore penalised by this system if they do not want to join these programs, particularly because they refuse to be profiled. It is true that federal anti-discrimination regulations were adopted from the 1990s onwards to combat one of the dangers created by the operation of these welfare programs, namely discrimination, by prohibiting employers from requesting medical information from employees and drawing unfavourable consequences for them. But these federal regulations allowing employers to collect medical information do not apply in the context of wellness programs³ (Redon, 2019). Thus, these wellness programs have several consequences for the employee: the obligation to adhere to them in order to avoid financial penalties and the obligation to adopt a behaviour considered as virtuous in terms of health in order not to have to pay a higher insurance premium.

Wellness programs that use connected objects pose a threat to privacy in the relationship between insurer, employer and employee, due to the mass of data collected and the lack of regulation regarding the circulation of information. Indeed, the data obtained via the applications can be marketed for various purposes and to different recipients, including employers and insurers. In the United States, companies can buy lists of individuals affected by a particular disease or pathology from data brokers (data brokers who make massive use of the possibilities offered by big data). The question then arises as to how to ensure that the employer does not use this data for purposes unfavourable to employees. Indeed, anonymised data can easily be re-identified thanks to the cross-referencing of data. Big data can be used to discriminate (a practice known as redlining). For example, a health insurer could refuse coverage or increase its prices if the results of wellness programs are not good. In the context of the employment relationship, some employees fear that employers will use productivity data to justify raises, promotions and hiring (Zabawa & Eickhoff-Shemek, 2017). The supervision of profiling and data dispersion is therefore necessary to combat these dangers, which can lead to discrimination against individuals, the most important of whom are insured employees.

3. These are the *Americans with Disabilities Act (ADA)* of 1990, the *Health Insurance Portability and Accountability Act (HIPAA)* of 1996, the *Genetic Information Nondiscrimination Act (GINA)* of 2008 and the *Affordable Care Act (ACA)* of 2010. The ACA prohibits discrimination based on the health status of insured persons. Among other things, it provides for the elimination of medical history exclusions in individual and group insurance and prohibits the adjustment of insurance premiums based on medical history. However, once again, an exception has been made for situations involving membership of a wellness program.

In France, access to group health insurance is mainly regulated by a law of 31 December 1989, known as the “Évin” law, whose provisions are of public order. This law provides for protections against the potential risks of discrimination based on health status. Indeed, insurers are allowed to collect information on the state of health of employees who are beneficiaries of a group contract taken out by their employer. However, a legal protection is granted to the insured person who wishes to subscribe to such a contract, since insurers are prohibited from individually selecting insured persons, especially those in poor health. Consequently, the insurer must either insure all the insured collectively or refuse to insure them. Regarding the pricing of the insurance contract, health insurers offering group contracts may only apply collective pricing: the insurer is not allowed to increase the insurance premium of one of the group’s employees according to a change in his state of health (Del Sol, 2020). French legislation is thus very protective of policyholders, leaving little room for manoeuvre for insurers who would like to select and price group insurance policies more individually to be closer to reality.

These products reveal the tension between a logic of prevention of health problems and a logic of risk prediction. Beyond the empirical object analysed here, the questions examined open up to broader issues. Indeed, we can question the fact that these programs are part of a more profound change in medicine, which would move from “an art of healing to a science of measurement” and from a therapeutic logic to a preventive and predictive logic. Moreover, this subject invites us to analyse the process of privatisation of social protection as well as the convergence of models in this area between the United States and European countries. The massive but recent emergence of new products in the insurance sector therefore opens up fundamental questions relating to the relationship between the individual and society, which can be examined through the changes in the insurance society, which is stretched between a logic of caring for the sick and a logic of taking responsibility for their state of health.

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