Private Health Insurance in France : Marketization Embraced?

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1 Introduction

Over the last twenty years, many studies have reported the growing use of market-based instruments for the delivery of health services in Europe. Though still largely funded by the public purse, the general narrative that emerges is that European healthcare systems face a creeping tendency towards the integration of competition, price mechanisms, exit options, agencification or more specific tools (see for examples Paton, 1998, Neby, 2015). Scholars have devoted a great deal of attention to distinguishing this process of *marketization* from *privatization* (Hansen and Lindholst, 2016). Put simply, the former does not necessarily equate to, nor does it entail, the later. While marketization can occur without significant shifts in terms of the overall share of public spending, privatization designates an increased level of provision led by private providers — conversely, these providers may resemble former public actors more closely than market operators. Stated differently, there can be marketization without privatization, and vice versa. However, research also suggests that marketization in health policy has often been paralleled by privatization, even though contrasting paths have been followed from one country to another (Maarse, 2006).

If marketization is not therefore the synonym of privatization, the two nevertheless tend to develop together. On the basis of this statement, much effort has been deployed by political scientists to explain the connection between marketization and privatization. Most research shows that a key feature of this relationship is that market-based reforms, seen as easier to legitimate than pure privatizations, eventually lead to privatization as an actual outcome. Krachler and Greer (2014) argue that marketization is more likely to induce privatization when firms expect to make a profit from reforms which increase the importance of market arrangements. In another respect, Jensen (2011) established that politicians seeking to avoid the high cost of "dismantling the Welfare State" (Pierson,

1994) tend to promote their agenda through marketization via compensation − a process "where public spending is expanded but where public support of private market solutions is given special priority". According to these views, marketization creates the basic institutional conditions for subsequent privatizations. Thus, it is often presented as a particular case of the "hidden politics of retrenchment" (Hacker, 2004), an argument that has received much support in other policy areas over the last fifteen years (see Pierson 2004; Thelen, 2003).

The present article would like to further the debate on the connection between privatization and marketization in healthcare by analyzing a "deviant" case, one where marketization has developed within the private portion of the Welfare state. More precisely, it examines the situation of private health insurance in France which has experienced a process that has resulted in increasing competition, financialization, and changes in actors' governance and strategies. The marketization of the private health sector in France is far from being negligible from the perspective of health policy as a whole. French private health insurance (which is voluntary) accounts for 13% of health expenditures. It has a high level of coverage (96% of the population in 2010) and plays a significant role in the reimbursement of co-payments by the public purse for treatments and services in the statutory healthcare system. Moreover, historically, it has been dominated by democratic, non-profit organizations (*mutuelles de santé*, for mutual benefit societies). Their development has been encouraged by the state ever since the foundation of Social Security by a range of tax credits and incentives. Indeed, until the 1980s they enjoyed a de facto monopoly. Over the last thirty years, however, the market share of for-profit insurance companies has significantly increased. At the same time, most mutual benefit societies have changed their positioning and have adopted some of the same strategies as these companies, namely by engaging in mergers or takeovers and by

adopting a risk management approach, points to which we will return.

What are the factors that have driven this shift? Throughout the paper, we build and test a hypothesis assuming that the marketization of private insurance is a result of policy feedbacks. In other terms, the conditions for for-profit companies' development and mutual benefit societies' financialization would be the outcomes of past policy choices (Pierson, 1996). A core argument here is that this process is the result of a range of independent causal mechanisms, all of which stem from a series of reforms adopted between 1992 and 2014, both in France and at the scale of the European Union (EU). If our analysis clearly establishes the trend toward marketization of French private health insurance, its main findings are however somewhat unexpected. At no point, has marketization been the purpose, nor the hidden goal, of legislators and policy-makers. In some cases, marketization has even been an unintended result of attempts to de-privatize, or at least to reinforce the regulation of private health insurance.

The rest of the paper is organized as follows: in the first section, we briefly outline the main features of French private insurance and identify which policies may have induced its evolutions over the recent period. The next sections explore the relationships between these policies and the marketization of mutual benefit societies, together with their effects on convergence between different players in the field. Throughout, in order to infer a causal effect of the above-mentioned reforms, we mobilize an analytical framework largely inspired by the Process Tracing literature as applied to policy studies (Kay and Baker, 2015)[1].

[1]The data presented in this article comes from three sources. We first reviewed documents and reports published by private health insurers (mutual benefit societies, for-profit companies and provident institutions) and by their main regulators, namely the Autorité de contrôle prudentiel et de résolution (ACPR, French pensions and insurances regulator). Then, we extracted data from reports published by the Fonds CMU (CMU Fund, in charge of providing health coverage to people excluded from the

2 Marketization in French health insurance: a review of recent reforms

2.1 Health insurance between statization and privatization

Since the foundation of Social Security in France, a share of health coverage has been left to private insurance, subscribed by individuals or corporations on a voluntary basis. Nowadays, different types of private operators are involved in this part of healthcare which is not covered by entities which administer the statutory regime (*régime obligatoire*). Until the 1980s, mutual benefit societies were the only actors developing an activity in this socio-ecoomic segment. A mutual benefit society (or mutual association) is a non-profit firm led by an executive board elected by its members: each person affiliated to a mutual may vote or be elected to head the organization. Created before the Social Security (see Beito, 2000 for a historical perspective), mutual benefit societies were maintained after its foundation by the 1947 *Loi Morice*, which guaranteed them a role in co-payments for treatments and services within the statutory healthcare system. A second group of private insurers was later formed by commercial insurance companies (hereinafter "insurance companies"). These actors emerged more recently and mainly since the 1990s; by contrast with mutual benefit societies, they take the form of for-profit joint stock firms. The third category of private insurers is made up of provident institutions (hereinafter "IPs"), created in 1945 and regulated by the Social Security Code. They mostly operate

compulsory regime in relation with private insurers) and the state's Directorate for Research, Studies and Statistics (Drees). We then conducted two semi-structured interviews campaigns between September 2017 and May 2018. The first mostly involved private and public actors and their involvement in European Union policymaking ($n = 21$). A second series of interviews has been conducted with another group of actors directly involved in this process at the French level ($n = 16$).

in the area of occupational benefits. Involving employer and employee representatives, IPs offer regimes that may encompass healthcare but mostly deal with work disability and invalidity. Like mutual benefit societies, IPs are non-profit organizations. The main features of each type of insurer are summarized in Table 1.

Table 1: Types of organization in French Private Health Insurance Market
*Based on Thomson and Mossialos (2009)

Type	Governance	Economic model	Commercial targets*
Mutual associations	Democratic	Non-profit	Older people, employees, civil servants, mid-level executives
Insurance companies	Shareholding	For-profit	Farmers and self-employed professionals
Provident Institutions	Paritarian	Non-profit	Unskilled workers, senior executives

In spite of their differences, a unified term has increasingly been utilized in French administrative reports or legislative texts to designate all entities who provide "supplementary health insurance" (*assurance maladie complémentaire*). The use of a single term is explained by the growing presence of IPs and insurance companies on the market.

But it is also a by-product of recent institutional changes. In 1999, these three actors were involved in the implementation of the CMU (*Couverture maladie universelle*), a scheme introduced by the *Parti Socialiste* Government of the day. Until then, access to Social Security was only granted to its contributors, namely employers and employees and their families; this left aside many social groups, such as precarious workers or migrants. In this context, CMU (literally "universal health coverage") is a device allowing people previously excluded from Social Security to receive its benefits; at the same time, CMU-C (CMU-*complémentaire*, or supplementary) was also created in collaboration with private insurers, to manage the supplementary share of universal health coverage. CMU and CMU-C involved the different private health insurers at the same level and in a collaborative fashion. In the same vein, a 2004 law created a single representative group for all categories of private insurers — *Union des organismes complémentaires d'assurance maladie* — the National Union of Complementary Health Insurance Organizations (UNOCAM). This law also granted UNOCAM board the right to participate in the determination of reimbursed benefits and 'the basket' of care in the statutory health system — and this because the share of health costs that is not covered by public insurance is mechanically paid by private insurers.

Scholars of French healthcare agree that this process has resulted both in a more explicit recognition of the role of private health insurance in the overall system, and a homogenization of for-profit (insurance companies) and non-profit actors (mainly mutual associations), at least from the perspective of their relationship to the statutory regime administration. However, such specialists diverge when it comes to analyzing the causes of these trends. For some (André et al., 2016), they have been generated by a tacit, yet powerful logic of privatization of French healthcare, defined here as a transfer of resources and ownership from public to private insurance. Indeed, and since the 1980s, one can note

a stagnation of the share of health spending paid for by Social Security. This shift coincides with the first mentions in reports and legal texts of the field of "supplementary health insurance", a field that "should be organized and regulated". The creation of CMU-C and UNOCAM is seen as institutionalizing this “scrambling” trend, and this by reinforcing the integration between private and public insurance − and offering the basis for further disengagement from the public sphere. Without necessarily rejecting this interpretation, other specialists insist that private health insurance homogenization and recognition has been paralleled by a process of "statization" or "technocratization" of Social Security governance (Hassenteufel and Palier, 2009). From this perspective, successive reforms have reinforced the role of the State at the expense of unions and employer representatives. A small group of senior civil servants was identified as instrumental in this shift (Genieys, 2010), shaping the development of two interdependent spheres (statutory insurance led by Social Security representatives and supplementary insurance under the umbrella of UNOCAM), both overseen by a new "regulatory healthcare state".

Though useful in order to understand the overall governance of French healthcare, these interpretations each have their blind spots. This is mainly because they both tend to consider private health insurance essentially from the viewpoint of the statutory regime. Put differently, advocates of the "privatization" thesis see the rise of private insurance as the fruit of prior disengagements (explicit or not) from the Social Security system − the growth of private sector being seen only as a function of the retrenchment of the public one. On the other hand, supporters of the "statization" theory assume that reforms affecting the regulation of public and private health insurance have participated in a single trend linked to a greater presence of the regulatory State. As a consequence, both conceptions miss a part of the story: what has happened within the field of private health insurance, and the transformation of the relationships between its different actors.

A closer look at the reforms who mainly or only affected this segment shows, however, that several policies ultimately induced deep institutional changes in this area, and that such shifts were imperceptible through the lenses generated by the conflict between the privatization and statization explanations.

2.2 The marketization thesis

Over the last twenty-five years, mutual benefit societies, insurance companies and IPs have been affected by a series of reforms, adopted at both French and European levels. All of these concerned the three categories of operators; but their individualized effects and, more importantly, their interactions remain largely unknown. In 1992, private insurers have first became governed by European Union "Insurance" directives, irrespectively of their status. These texts initially aimed at creating a European space for insurance goods and services; they also were intended to structure financial operations on the market. Mutuals and IPs were not their main target. However, as private entities, both were constrained to comply with the new legislation's requirements. One of their most obvious consequences has been to align these operators on the legislative and regulatory frameworks of for-profit companies, especially in terms of governance − all of which could have potentially jeopardized their democratic (mutual associations) and paritarian (IPs) structures.

Moreover, this framework was markedly reinforced in 2009 via the "Solvency 2" directives. After the financial crisis, the purpose of European legislators was to deepen a more prudential regulation of insurance market. Formally, Solvency 2 directives forced insurers to meet a standard of technical provisions and capital requirements. For insurance companies, it notably reduced the possibility for a firm engaging in risky behaviors or investment strategies. The consequence was exactly the opposite for mutual associations

and IPs: as non-profit entities, they traditionally had reinvested their surpluses into benefits or services to their members. Under Solvency 2, they have been incited (in order to respect the capital and technical provision requirements) to set aside financial provisions or to market their savings. At the national level, French regulatory agencies and legislators as of 2009 began to encourage the development of managed care, initially to reduce the cost of medical technologies for which the share of private health insurance has historically been high (notably for dental and optical care). In 2014, a law (*Loi Le Roux*) granted the right to mutual benefit societies to practice differentiated reimbursement rates; a common strategy of insurance companies, but that was until then strictly forbidden for mutual benefit societies. This policy has fostered the development of risk management within mutual associations, and potentially, their control over the behaviors of their members. Finally, and without any obvious link to the previous reforms, a national industrial agreement was signed by employer and employee representatives, and became part of the law in 2013 (*Accord national interprofessionnel*, within the Employment Security Act). In order to attain a better coverage of workers, it introduced an obligation for employers to provide their workers with a private health insurance scheme. By creating new outlets, this last reform potentially paved the way for increased competition between insurance companies, mutual benefit societies and IPs − the latter appearing to benefit from this reform, due to their positioning as regards corporation-level based contracts. But it also provided actors with new opportunities for strategic alliances, and perhaps reinforced the trend toward more homogenization within the sector.

At first glance, each of these reforms has seemed to involve different actors and addressed specific issues. Without any further examination, it would even be fair to say that their only clear common point is to have affected norms, rules and conventions institutionalizing private health insurance in France. None of these, however, seem to

clearly fit into the privatization/statization dichotomy. The Insurance and Solvency 2 directives certainly contributed to the formation of an "institutional order" (Jullien and Smith, 2014) for the insurance industry at the scale of the European Union, and perhaps trivialized the business model of non-profit entities. But they also created an unprecedented regulatory framework, based on strict prudential and governance rules. The reforms adopted in the French context (development of managed care for mutual benefit societies and Employment Security Act) were initially justified in terms of "better access to care". But it is true that they also created, at least in legal terms, the condition for increasing competition and business combinations. In this sense, all reforms can be said to have led to the marketization of private health insurance in France. This in turn suggests that this process may have occurred through the intervention of either public or private actors; if regulation has increased, market-like instruments or opportunities have expanded. However, the share of private health insurance has remained stable around 13.3% of global health spending. Official figures tend to confirm this assumption. In its most recent (2017) report, the Directorate for Research, Studies and Statistics (Drees, Ministries of Health, Labour and Public Action) collated data from different regulatory sources. It revealed a significant rise of the market share of for-profit companies, rising from 19% in 2001 to 30% in 2016. During the same period, that of mutual benefit societies has decreased to hit a low of 52% in 2016. Some indications also suggest a financialization of non-profit actors. Amongst other indicators, the concentration rate for these entities increased dramatically: there were 1528 mutual benefit societies in 2001, and only 365 by 2016; 57 IPs in 2001 and only 25 in 2016. This figure is mainly explained by the rise of strategic alliances, mergers and acquisitions within this category of health insurance, all this leading to the formation of large and private "social protection" groups. But can we identify a causal effect of one or several of the reforms mentioned above as regards

this change? Did they interact, or even generate cumulative effects? If so, what does this case tell us about the connection between privatization and marketization in healthcare?

More generally still, answering these questions amounts to identifying "which mechanistic explanation accounts for this outcome" (Beach and Pedersen, 2013; George and Bennett, 2005; Hall, 2006), by supplementing basic figures by within-case analysis, and by taking into account the "temporal sequence[s] of events" (Collier, 2011). Taking marketization as our dependent variable, we need to identify the proper effect of the three basic reforms under study (European directives, managed care and Employment security act) as well as their potential cross-combinations. Control mechanisms also need developing. Consequently we have integrated within our analysis some shifts that cannot be directly attributed to the policies in question, in particular autonomous market dynamics or actors' strategies separated from the logics of reforms. Accordingly, in the next two sections we will unpack the process of marketization to look for causal chains between the observed events (Palier and Trampusch, 2016). For each sequence identified, we will also examine the temporalities and feedback effects of prior reforms adopted at different points in time.

3 The European dimensions of marketization of French private health insurance

3.1 The impact of the Insurance directives

EU Treaties are categorical as to the limited competencies of the Union when it comes to Welfare, especially in the area of health policy (Steffen, 2005). For this reason, the influence of the EU, largely documented, has regularly taken circuitous routes. In this

respect, health policies or services have typically been affected by legislation relative to the architecture of the Single market, such as fiscal governance (Greer et al., 2016). The situation has nevertheless been different for the particular case of private Welfare providers and, consequently, private health insurance. Considered as enterprises in the European sense of the word, all insurance schemes which are not explicitly part of the statutory system are entities for which European rules and regulation may legitimately apply, especially in terms of competition policy. It is thus easily understandable that the first sequence of reform that pushed toward the marketization of private health insurance in France opened with the adoption of European directives. Its effects have been perceptible in the long run and lead to a new regulatory framework at the end of the 2000s. These changes in turn deeply affected the governance and the organization of each private health insurance operator, especially mutual benefit societies.

When the Insurance directives were passed at the European scale in 1992[2] their main objective was to facilitate competition between insurance companies in the Single market. Once an insurer had obtained an administrative agreement to carry out its activity within a member-State, it could sell its products and services on the whole internal market. If Social Security and public Welfare insurance schemes were explicitly excluded from these directives, they nevertheless included entire segments of the private sector operating within this field. The absorption of mutual benefit societies and IPs within these texts opened a first sequence of institutional change, that can be linked to the marketization thesis. Indeed, most of their activities have henceforth been partially indexed to the judicial and regulatory evolutions that taken place at the scale of the EU.

The Insurance directives were framed in terms of "liberal market building" (Crespy and Menz, 2015): they involved all suppliers within an industry and their main purpose

[2]Directive 92/49/CEE and Directive 92/96/CEE.

was to increase and facilitate competition between them. At the national level, this implied guaranteeing that competition was fair and, by extension, that the devices that could be more favorable to a particular category of operators were to be removed. Scheduled for 1994, the implementation of the Insurance directives constituted a major issue for French mutual benefit societies, and this more than for insurance companies and IPs. For the former, they extended a competitive environment in which they already operated. For their part, IPs, managed between labor organizations and employee representatives aligned their position on that defended by the European Trade Union Confederation: these actors considered that the Insurance directives could constitute an opportunity to expand at the European level their conception of private insurance, based on social dialogue and in close relationships with labor organizations. Moreover, IPs were firmly positioned as regards collective contracts, at the scale of large corporations or professional branches; consequently, they did not see this change as a threat to their activities. The positioning of mutual benefit societies is, however, more ambiguous. A latent divide rapidly emerged between two opposing positions, a development that can be explained by the dominant member profiles of each entity and by their relative proximity to French labor organizations. Mutual associations that were specialized in the supplementary health coverage of civil servants and were closest to the General Confederation of Labor (CGT) expressed their strong opposition to the market logic behind European directives. They feared a trivialization of their democratic, non-profit model within one big European market. By contrast, Mutual associations closer to the Democratic Confederation of Labor (CFDT) and operating on an inter-professional basis (i.e., not dedicated to a specific category of worker) saw the directives as an opportunity for building a European mutualist movement, as well as creating synergies with other

non-profit organizations across the continent[3]. Ultimately, a compromise was found within the National Federation of French Mutuality (FNMF), an organization supported by some civil servant mutual associations who were in favor of the line defended by inter-professional mutual associations. FNMF representatives publicly took position in favor of the integration of French mutual benefit societies within the framework of the Insurance directives, but in exchange for the recognition of a specific status which would dissociate mutual benefit societies from other insurance companies − namely on the basis of their longstanding vocation in healthcare and their democratic, non-profit business model. On the basis of the values shared amongst mutual benefit societies, the goal of the FNMF was thus to reject the principle of equal treatments between insurer operators as established by the draft directives, a corollary of consumers' "freedom of choice" as promoted by the European Commission. However, agents from the Commission quickly rejected this demand: according to their view, the Insurance directives, as with other EU business legislations, never recognize the 'organic criterion', and only consider the nature of a firm's activities. Stated differently, mutual benefit societies and IPs could keep their democratic organization and their non-profit business model, since it was not the purpose of EU law to modify these traits. But they could not claim a specific status on this basis since they did not undertake the same kind of operations as for-profit insurance companies. Consequently, the French mutual benefit societies were forced to accept the European directives without gaining any compensation in return.

[3]The CGT and the CFDT are the two main French labor organizations (unions). The CGT's ideological positioning is inspired by Anarcho-unionism and communism. It traditionally developed a statist and class-struggle conception of industrial relations. The CFDT has always been closer to Christian-democracy, social-democracy and Fabianism. Several members of the CFDT have been instrumental in the building of European Community, including the European Commission's former president Jacques Delors. See Ancelovici (2013) for a detailed comparison.

At the national level, the legal Europeanization of mutual associations has had direct effects upon institutionalized relationships within the sector of private health insurance, especially for those in charge of the supplementary coverage of civil servants. While competition for whole corporation-level contracts slightly increased between insurance companies and IPs, these mutual associations seemed relatively protected on this market segment. In addition to financial support, the State provided them with personnel and benefits in kind. But this situation changed when a mutual excluded from these aids successfully brought legal action in the *Conseil d'Etat* (French highest administrative court) and prompted the European Commission to denounce, on the very basis of the Insurance directives, the principle of State aids to civil servant mutual associations. The *Conseil d'Etat* and the Commission agreed with the view of the mutual who brought this case and pressed the French government to abrogate these "unfair subsidies", considered to be illegal selective advantages within a competitive market.

These decisions quickly induced changes. Each call for tenders now had to be organized before any selection of a supplementary health insurance by the State for its employees; more importantly, insurance companies, IPs and mutual benefit societies now had the possibility to compete on the same level. The promotion of this new instrument was thus a direct consequence of European directives; if they did not modify the governance or the core principles of mutual benefit societies, they certainly increased competition between the different players in the field, since they contributed to equalizing their opportunities to develop in different segments, including the protected ones such as the supplementary health coverage of civil servants.

However, this indicator in favor of the marketization thesis has not been paralleled with a symmetrical trend toward privatization. Following their legal injunction, agents from European Commission recommended French authorities offset this opening up to

competition by maintaining some public aids or fiscal allowances within the sector. To them, the problem was not that several contracts were favored on the basis of a range of principles, but that these contracts being offered by only one category of market actors, led mechanically to selective advantages. In its opinion, the European Commission suggested generalizing these aids to any kind of private health insurer on the basis of its acceptance of a range of principles initially promoted by mutual benefit societies. In this respect, the standard for private health insurance contracts was reformed in 2006. When the subscription of a supplementary health contract was not conditioned or based on the health status of a person, and if the insurer in question did not charge additional fees if this person's health status deteriorated, the contract became eligible to a range of tax allowances. If competition between insurers has increased, these typical mutual association principles have thus been generalized through State regulation. In this context, it is thus not "marketization with compensation" that has led to subsequent opportunities for privatization. What we see instead in this first move is a marketization of the private sector organized around other logics, but then compensated for by a more stringent regulatory framework.

3.2 "Solvency 2": an increasing homogenization of insurers?

An underlying implication of envisaging European integration as a consequence of the Insurance directives (fast and without much difficulties for IPs and insurance companies, slower and more conflictual for mutual associations) leads *de facto* to a mere indexation of their activities to change in EU legislation. From this perspective, the supranational side of private health insurance marketization naturally accentuated during the second half of the 2000s when new directives were adopted. The latter are seen as simply adding to the principle of equal treatment amongst operators an issue of security.

In 2009, "Solvency 2" directive was indeed adopted at the scale of the EU[4]. Legitimized on the basis of security principles − namely that of financial operations of insurance activities − it provided new quantitative measures of equity capitals for enterprises subject to Insurance directives[5]. Solvency 2 was explicitly presented as a response by EU authorities to the financial crisis. It developed a risk-based approach to regulation, in accordance with the idea that "the riskier an insurer's business, the more precautions it is required to take"[6]. Formally, these texts set a threshold of Minimum Capital Requirement (MCR), below which an entity is considered unsustainable and should face a withdrawal of its insurance authorization. In the same vein, a Solvency Capital Requirement (SCR) was also defined. It designated the amount of capital required to meet quantifiable risks on an existing portfolio. More simply, it is the level of capital that an entity should possess to "absorb an exceptional shock", such as the necessity to fulfill all of its engagements.

The consequences of Solvency 2 vary according to the situation of the different operators. For insurance companies, this rule explicitly depreciated financial strategies based on the acquisition of higher-yielding bonds, but that may result in heavy losses. Nevertheless, it appears that this change did not significantly change the structure of insurance companies, since most of them were able to comply with these requirements. Indeed, these actors had already "marketized" their non-health activities and were thus familiar with this kind of prudential regulation. The impact of Solvency 2, however, is clearly deeper for mutual benefit societies and IPs. These two categories of actors previously disregarded the private accumulation of profits; their gains served directly to

[4]Directive 2009/138/CE

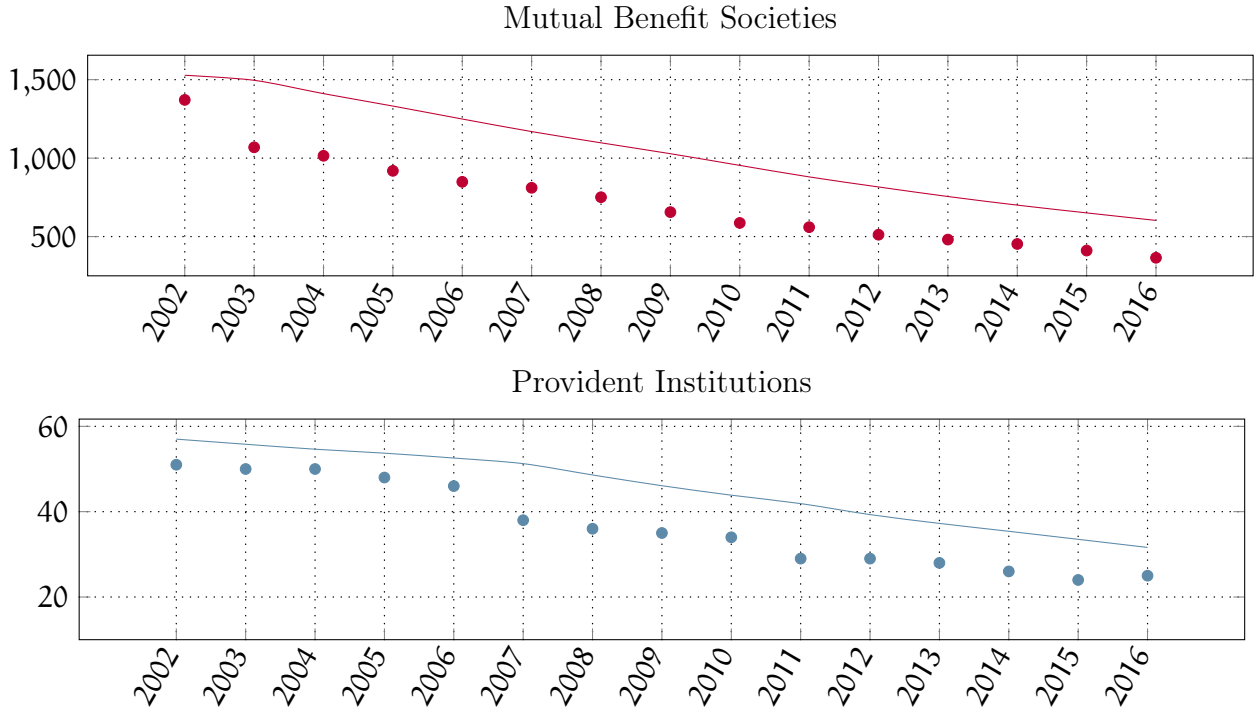
[5]The Solvency 2 directive is itself a translation of Bâle 2 agreements, a prudential regulatory device ostensibly providing for a better assessment of banking risks, on the basis of new requirements in terms of equity capitals and financial strength.

[6]Financial Times, January 3 2016.

improve the benefits provided to their members or to increase their insurance coverage. To comply with Solvency 2 requirements, however, they now needed to make provisions and to find ways to increase the value of their funds − this in order to possess enough capital to satisfy both the MCR and SCR ratios. In addition, most of them are small and medium-sized firms, whose funds might be considered as far below these ratios. This situation was to have a direct impact on the configuration of the sector. Between the preliminary sessions prior to the adoption of Solvency 2 and its official date of enforcement (January 2016), Mutual benefit societies and IPs engaged in a vast movement of concentration in order to reach a critical size to comply with the criteria laid down in the directive (Figure 1).

Figure 1: Evolution of the number of Mutuals and provident Institutions

Brown's Linear Exponential Smoothing, Source : ACPR, Drees, CMU Fund



If the overall number of insurance companies thus remained stable, a significant decrease in the number of IPs and mutual benefit societies occurred. However, qualitative data reveals that in the case of IPs this trend cannot be attributed solely to the enforcement of Solvency 2 . In order to realize economies of scale, employer and employee representatives decided to engage in several mergers years before and irrespectively of the European legislative context. Solvency 2 only contributed to accelerating a trend that was already happening. However, the trajectory followed by mutual benefit societies was more disrupted. More dispersed and fragmented, they were much more exposed by the new prudential requirements. This situation encouraged an increase in the number of strategic alliances, or mergers and acquisitions between entities and the formation of big mutualist firms such as Vyv care, the result of the merger of Harmonie and MGEN (France's biggest civil servant mutual association) − Harmonie and MGEN being themselves the result of previous mergers. But this situation was also the product of the longer-term effect of Insurance directives. A clear combination between these policies can indeed be seen. Facing an increasingly competitive environment, due to the growing presence of insurance companies and to the loss of their selective advantages, mutual benefit societies have considered themselves forced to adapt and to respond to the decrease in their market share (Bras and Tabuteau, 2012). But Solvency 2 also induced changes at the organizational level. Since the regulatory framework now became risk-based and reinforced, non-profit entities, previously formed of elected members (mutual associations) and labor organization representatives (IPs) needed to hire new skill profiles. Their democratic and paritarian governance is now partially shaped by specialists of the quantitative measure of risks, notably actuaries and data-scientists. By creating new regulatory requirements, the frame institutionalized by Solvency 2 thus contributed to weakening the capacities of elected members and worker representatives to shape dialogue with the regulator or with

other national authorities in charge of the activity of these entities.

The sequence of change which opened with the Insurance directives has thus introduced a range of market-like instruments and principles within a sector partially governed by other logics, notably those of mutual benefit societies and IPs. Accordingly, it can be considered as a first level of the marketization of private health insurance in France, a trend that has contributed to homogenizing different categories of actors. However, this development has not been paralleled by a movement of privatization. Efforts have been made at the national scale to protect and extend principles and values shared by non-profit actors; moreover, not all of these changes can be attributed to European legislation given that the trend in concentration that affected IPs was partially driven by other strategies.

4 When a European legislative framework collides with a national political agenda

4.1 The new frontiers of risk management

The marketizations opened up by European legislation has been paralleled and reinforced by a series of reforms and policies at the French level. However, there is no clear relationship between the two scales, since the principles defended at the national one contrast with the rationale behind supranational interventions. While European legislation has pushed in favor of a more integrated framework for the different operators of private health insurance on the basis of the values of security and liberty, changes at the French level have been mostly legitimized in terms of better access to care. The outcome of this process, however, is little different from that of EU directives, since it introduces

institutionalized rules which have fostered a deeper marketization of the field.

During the second half of the 2000s, most actors of private health insurance have sought to develop, initially without much explicit strategizing, new instruments for risk management − a term that within the insurance industry designates claims management, a prevention of their aggravation and the reduction of repair costs. To be more efficient in this area, the different categories of health insurers have tried to develop managed care organizations of variable sizes and forms. Their basic common trait is to rely upon agreements passed between private health insurers on the one hand, and healthcare professionals or facilities on the other. These providers are committed to respecting fixed prices or rates, which allow health insurers to control their expenditures − knowing that insured persons are incited to go in priority toward these professionals and facilities by the modulation of rates and levels of reimbursement. Since they generate the possibility for insurers to collect data on insured persons, managed care organizations facilitate claims management and have allowed them to structure their supply (i.e. range of products). During the same period, management platforms have also developed. Playing a role of brokers between insurers and healthcare professionals or facilities, these entities are now in charge of the former of co-payment and negotiating commercial advantages with professionals; for the latter, they channel patients and handle information systems. These quasi-industrial platforms have in turn contributed to the emergence of large managed care organizations after 2010.

Albeit significant, these initial developments were made without any formal regulatory framework, health insurers generally determining their own criteria in terms of quality and health services evaluation. At this stage, however, one could hardly speak about an ongoing marketization process, since insurance companies were the main actors building these entities; an approach that they had already developed in other segments (i.e., non-

health) of their activities. However, risk management through managed care organizations spread after 2009, notably following an opinion by the French Competition Authority, a government-based competition regulator. It expressed support for these entities, praising their "pro-competition impact", their transparency and their positive effect on prices[7]. This opinion gave key support to an intensified development of managed care organizations and, by extension, industrial platforms. Thereafter the constitution of large networks or professionals and facilities came to be seen as an opportunity for other categories of health insurers, especially non-profit actors. If it did not originate this strategy, this competition authority's opinion nevertheless legitimized a posteriori the development of managed care without appealing for greater regulation. Using the argument of free competition, subsequently insurers through managed care organizations increasingly based their relationships with healthcare professionals on financial and managerial criteria. The feedback effects of European directives were observable during this short period of time: in a context of intensified competition with insurance companies, IPs in particular developed their own managed care organizations to increase the profitability of their collective, business-level contracts.

This change has been particularly important for mutual benefit societies, whose historical values have always been in strong opposition to the logic conveyed by the managed care model. From the end of the XIX$^{\text{th}}$ century until the end of the 1990s, the mutualist movement developed its own network of health and social facilities. Since its origins, this project had been conceived as a political alternative to the development of individualistic medicine, based on the autonomy of physicians (in a mutualist health facility, they are employees); the contemporary model of French medicine developing for its part largely in reaction to the collective approach fostered by mutual benefit

[7]Avis n° 09-A-46 2009 September 9.

societies (Hassenteufel, 1997). These facilities were subsidized by mutual benefit societies on the basis of patient needs, using their surpluses to increase the benefits offered to their members. They have never been subject to budgetary constraints. The mutualist conception of managed care spread on the basis of these principles throughout the XXth century, aiming at enhancing access to care. In 2001, the coming into force of the European Insurance directives modified this approach. Indeed, these texts required insurance firms to specialize: in order to prevent a random use of their funds, they pushed all enterprises subject to European legislation to focus on insurance activities. For mutual benefit societies this implied separating themselves from their own facilities that could be considered as charities under European law, and thus incompatible with an insurance activity. In order to retain these entities that were constitutive of their very model, most French mutual benefit societies accordingly decided to separate their activities into two autonomous firms, one dealing with insurance operations, the other with health and social facilities — an umbrella structure being generally created to articulate both, and to ensure financial solidarity between the two. Within this framework, the insurance side was to be fully submitted to the Insurance directives while the other was not. Most of these transformations occurred after 2001, the date of the enforcement of the European directives. Within the FNMF, a debate took place over the following years on the future of mutualist health and social facilities. A diagnosis quickly emerged: in the context of an organizational convergence between the different actors of private health insurance, they presented themselves as a major component of mutualist identity, and as a vehicle for its non-profit, solidarity-based conception of health and access to care. However, if this position is firmly defended by the Federation, this formula is seen less and less as a viable solution by individual mutual benefit societies. This situation is a direct consequence of the growing engagement of insurance companies and IPs as managed care organizations.

The size of these networks is significantly larger than mutualist ones; moreover, these actors have engaged into hard bargaining with healthcare professionals to obtain the lowest possible prices, an approach that mutual associations have traditionally refused to adopt in their own facilities.

Mostly during the second half of the 2000s, several big mutualist groups began to develop an activity based on managed care organizations; this change mainly taking the form of an integration of former mutualist facilities and structures into larger managed care organizations. In most cases, their administration was delegated to a platform gathering together IPs, insurance companies and mutual benefit societies. This shift is also a consequence of the trend towards concentration initiated by Solvency 2. Big mutualist groups that initially developed to meet the new regulatory requirements, gained as a result greater market power in their relations with healthcare professionals, making it appropriate for them to impose their own prices and rates upon these actors. The position defended by the FNMF on managed care organizations had shifted in accordance with these changes by the end 2000s: the issue is no longer to find solutions to protect the model of mutualist health and social facilities, but to determine how and to what extent managed care organizations could be compatible with mutualist values. The diagnosis had thus been subtly reformulated. Since they participate in the reduction of health expenses and access to care, managed care organizations are presented as fully compatible with mutualist principles as initially promoted through mutualist health and social facilities. Using the opinion expressed by the Competition Authority to legitimize this change, these actors have argued that their efficiency is also of great interest to their members.

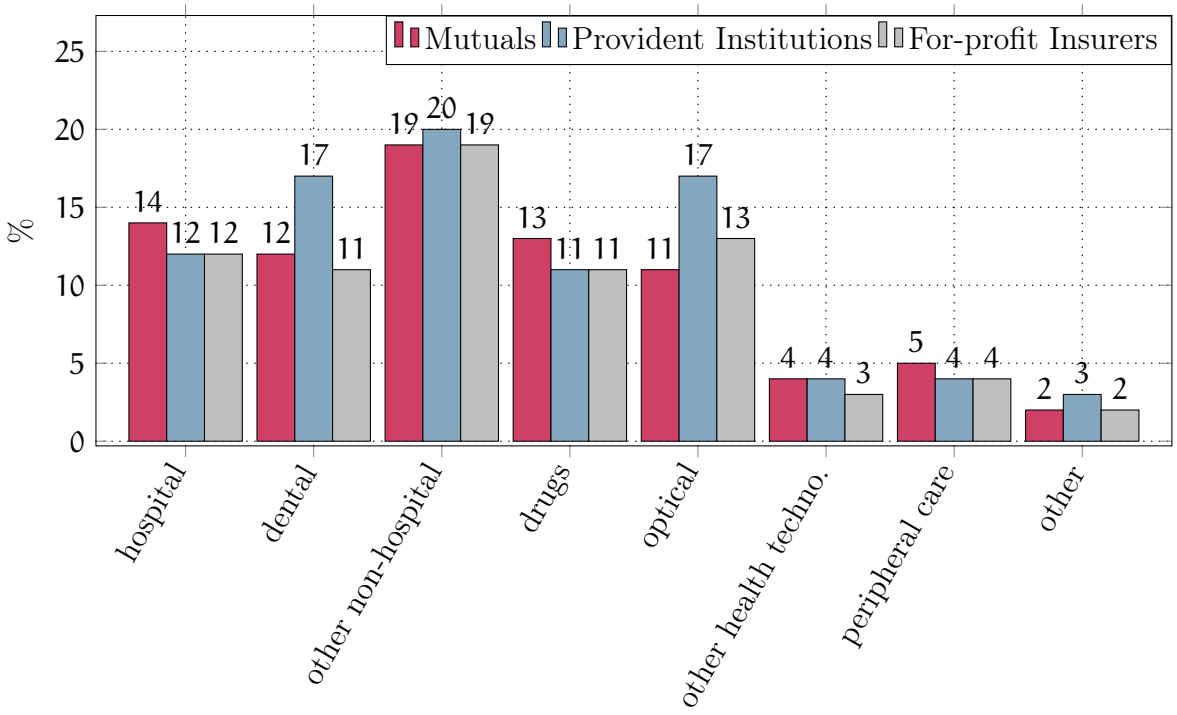
On the basis of this new diagnosis, mutual benefit societies have increasingly involved themselves in managed care organizations. They have also begun to develop a modulation

of levels of reimbursement, with patients benefiting from higher coverage if they decide to consult a professional who is under contract with a managed care organization. However, the spreading of this approach to insurance amongst mutual benefit societies was suddenly halted in 2010 by the Court of Cassation, which considered the adoption of this practice by mutual benefit societies to be illicit − and this because, in the French context, mutual associations still operate within a legal framework that distinguishes them from insurance companies, and prohibits several practices. Publicized by national newspapers, this case reintroduced a difference between mutual benefit societies and other types of private health insurers. Fearing that this decision would be remobilized in future cases, the FNMF's president pressed the government to restore equality of treatment amongst private health insurers − which might be considered as an implicit recognition of their common identity, at least from a legal point of view. The mutualist movement thus became an advocate of free competition. Indeed, this initiative lead to the adoption of a new law (*Loi Le Roux*) in 2014 legalizing the modulation of levels of reimbursement by mutual benefit societies.

From a governmental perspective, its implicit support to managed care organizations through this law has been in no way disinterested. Most funds allocated by private health insurers encompass benefits for which the coverage of Social security has been historically weak, such as dental care, optical care and hearing aids (Figure 2). Rather than extending public coverage, an approach preferred by successive governments has been to put pressure on healthcare professionals to lower their prices in order to limit out-of-pocket expenditures. However, this strategy has proven ineffective. In this context, the development of large managed care organizations is seen by several agents within the Ministry of Health as a way to contain the rise of these costs, and this through an implicit delegation of rate and price negotiations to private health insurers.

Figure 2: Share of Private Health Insurance Benefits

Source: ACPR, Drees, CMU Fund (2017)



In November 2014, a decree relative to private health insurance contracts reinforced this trend. Its goal was to curb the rise of extra-fees charged by several healthcare professionals, such as medical doctors but, more importantly, dentists and opticians. To this end, it forced private health insurers not to reimburse the supplementary share of health benefits exceeding a certain amount of money: in this context, they cannot guarantee to insured persons, even for the most generous contracts, that their expenses will be fully covered in any case, especially if they have consulted a health professional who charges extra-fees. Private health insurers cannot thus reimburse more, and are constrained to pay less. If they want to maintain high levels of coverage, they are incited

to act directly on prices as charged by these professionals – and this mainly through managed care organizations. The tacit and partially unwanted recognition of managed care organizations in the public sphere (through opinions expressed by Competition Authority, Loi Le Roux and the 2014 decree on the regulation of private health insurance contracts) has thus constituted an additional step toward the marketization of private health insurance in France. While this process has increased a risk-management based competition between insurers, it has also reinforced homogenization within the sector, especially through the authorization granted to mutual benefit societies to practice modulation of reimbursement rates. One should also note that these policies have legitimized and reinforced a trend that had already developed amongst private insurers. However, most prior engagements from health insurers towards these entities can be explained by the frame institutionalized by European legislation. Again, the case of mutual benefit societies is particularly revealing from this perspective: the development of managed care organizations has been a causal result of the fact that they now compete on equal footage with IPs and insurance companies; this trend has been reinforced by the Solvency 2 directive, since it has led to the formation of big mutualist groups more able to engage in hard bargaining with healthcare professionals. Without directly supporting managed care organizations, the government has seen this approach to risk management as a way of delegating the containment of health costs to the private sector.

4.2 Generalization of supplementary health insurance: better access to care or marketization?

During the 2010s, another series of policies adopted in France has accentuated the marketization of private health insurance and combined with the previously mentioned ones. Their high point has been the ratification of the Employment Security Act in

2013 by employer and employee representatives, converted into law a few months later. This historical sequence corresponds to the compulsory generalization of supplementary health coverage to all employees working in the private sector as of January 2016. In this context, the major changes were expected for small enterprises, only 33% of whom gave supplementary health coverage to their employees in 2009. In particular, this reform has developed a major aspect of the marketization process of private health insurance since it sees labor organizations and the State as forcing private firms to subscribe an insurance contract to cover their employees – resulting both in an increasing competition between insurers, but also in a new distribution of individual and firm-level based contracts. However, a closer look at the genesis of this reform does not support the idea that the reform was the result of an initial marketization project. Rather, this critical shift appears to be a compromise resulting from the linkage between two independent sequences – the first being related to health policy per se, and the other to the internal structure of the relationships between employer and employee representatives at the national level.

If the Employment Security Act and the accompanying 2013 law can be formally considered as an extension of the market, from the State's perspective they fit with an older concern. As seen for the case of managed care organizations, a common objective shared by successive French governments since the 1980s has been to limit out-of-pocket payments without substantively extending Social Security coverage. Privatization has not, however, been the hidden rationale behind this agenda: over the last thirty years, the global, gross increase in health expenditures has not been paralleled with a significant variation in the respective share supported by public and private insurances, still around 13% for the latter in 2016. Instead, a more explicit agenda has been to repeatedly try to socialize the field of private health insurance, or at least, to orientate its development via a series of policies likely to foster governmental objectives. In this context, several governments of

different political colors have considered that encouraging the generalization of private health insurance was a viable option: here, the goal of public policy has been to make sure that each person affiliated to the Social Security holds a private health insurance for the reimbursement of treatments and services that are not, or are poorly, covered by the public one (see Figure 2 below).

A first move in this direction occured at the end of 1990s. As with the CMU, the then socialist government tried to get populations covered who had previously been excluded from private health insurance. This reform focused on the usual target groups of universal health coverage (see Greer and Méndez, 2015), in particular retirees and employees at the bottom end of the wage scale. CMU-C ("supplementary") was implemented in 2000, a device completed in 2004 by Assistance for supplementary health coverage (ACS, for *Aide à la complémentaire santé*). ACS took the form of a financial aid to purchase private insurance, allocated to individuals whose incomes are slightly above the threshold for benefiting from CMU-C. They may then freely choose a supplementary health insurance on this basis. CMU-C and ACS can thus be considered as a market institutionalized by the State. These policies reinforced a partnership between the State and private insurers. The State removed barriers to access for a product from which several social groups were de facto excluded; private health insurers got new customers, in exchange for a financial contribution through an additional "solidarity" tax on insurance contributions. In 2015, public regulation of these devices was reinforced with the aim of better targeting beneficiaries and maximizing their performance from the viewpoint of public health. Public actors in charge of CMU-C and ACS have since established a set of eligible contracts on the basis of a call for tenders. Depending on their interest in public health, but also on a cost-effectiveness balance, a range of contracts were to be selected and proposed to the beneficiaries of ACS. If individual choices were to remain free, public

regulation was considerably reinforced since it reduced the supply to a limited number of "good" products.

The development of CMU-C and ACS might be considered attempts to de-privatize the field of private health insurance. For this segment, public spending increased and regulation was reinforced. However minor in appearance, this process is nevertheless quite distinct from "marketization via compensation" as studied by Jensen (2011), where the share of public spending is expanded but where priority is given to market solutions supported by private actors. Moreover, it is not, as in other countries such as The Netherlands, an increase in the share of private spending heavily regulated by the government (van de Ven and Schut, 2008), nor a transfer of several risks from the public to the private sector, since both devices were designed for specific social groups. Here, a share of health insurance that was already private and market-like has been socialized, in the sense that public expenses and State capacities to shape private contracts have been extended. Nevertheless, it is true, that marketization has developed on the basis of State intervention. Indeed, CMU-C and ACS now cover people previously excluded from the market; rather than grant them directly with health coverage, public intervention has organized their free choice and created a new space for competition between private health insurers. Nevertheless, marketization has corresponded here more to the "default option" (Ansaloni and Smith, 2017) than to the initial governmental intention: it appears more as a way of expanding health coverage in a context of budgetary austerity.

Indeed, years after their implementation, the initial objectives of CMU-C and ACS — better health coverage and ultimately, access to care − have proven difficult to reach due to the design of these devices, which remain voluntary and because these financial aids are not automatically granted to eligible beneficiaries who first need to apply through a complex process. Worse still, data from the Ministry of Health reveals that both policy

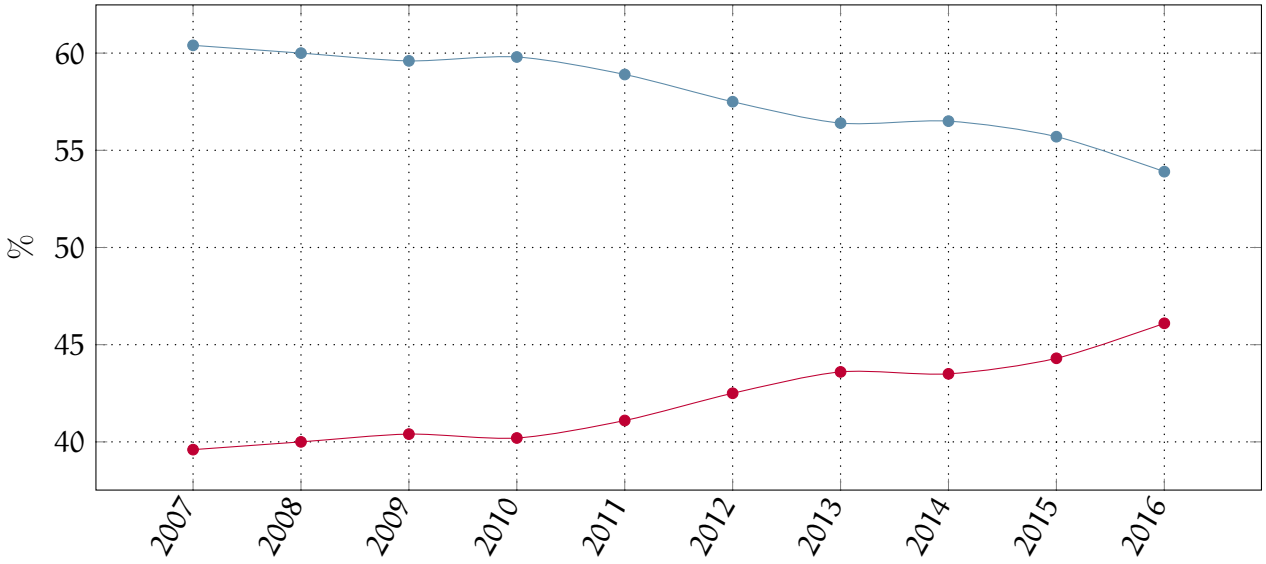
instruments remain largely unknown, especially ACS (Barlet et al., 2016): for the newly elected socialist government in 2012, this market-way quickly came to be considered an imperfect response. In parallel with the better regulation of CMU-C and ACS in 2015, agents from the Ministry of Health therefore began to identify alternative routes to increasing health coverage. A solution that would consist in generalizing supplementary health coverage through a range of fiscal mechanisms was considered. A proposal is elaborated on the basis of this diagnosis: since retirees, precarious workers and young people are the main populations excluded from supplementary health coverage, the government sought to remove fiscal aids for several private health insurance contracts (such as those set at the corporation level) to reallocate these aids to uncovered individuals, and thus to provide them directly with supplementary health coverage. The proposal was presented in detail by President François Hollande during the 40^{th} FNMF Congress: most mutual benefit societies indicated their strong support for this initiative. However, and despite explicit support from the FNMF, this attempt failed for unexpected reasons due to independent shifts within industrial relations. At the same time, employer and employee representatives were negotiating a national inter-professional agreement on "competitiveness and employment security". Initially, supplementary health insurance was a peripheral issue in these negotiations: they mainly focused on amendments to the Labour Code and on employment standards. While the CGT as well as other unions strongly opposed the propositions of employer representatives, the latter asked for more "flexibility", especially in terms of working time. In this context, members of the CFDT accepted part of these demands but imposed a compensation: all employees should have access to a corporate level-based supplementary health insurance, to be funded at least 50% by employers. An agreement was finally reached in 2013 on the basis of this compromise, without however the signature of the CGT. Albeit officially hostile to

this decision that nullified the governmental proposal, the FNMF was unable to take up a position in this debate. Indeed, the Federation could not follow up upon its initial claims because many mutual benefit societies who were already well-established in the field of corporate contracts saw this policy as a lucrative commercial opportunity. Others had even built strategic alliances with IPs favorable to it. Ultimately the transcription of the agreement into law constitued an important milestone in the generalization of supplementary health insurance in France. The government tried to present this change as having two significant advantages: on the one hand, it would reinforce the role of unions and employer representatives who had recently faced an important decrease in their prerogatives in terms of governance of the statutory regime. On the other, it would considerably extend the level of coverage of supplementary health insurance: it would thus provide the same benefits that the initial governmental proposal had aimed for. However, it should be noted that a reduction of health inequalities, which was the main purpose of the first attempts to generalize supplementary health insurance, was shelved during this reform. Since generalization is now to be enacted at the scale of corporations and on the basis of employment, it de facto excludes more marginalized populations, such as retirees or the unemployed. If CMU-C and ACS have nevertheless been maintained, the issues related to access to these devices have not been dealt with. More fundamentally still, this reform has reinforced the trend toward marketization within the sector, by creating new space for competition between private health insurers. Indeed, it created the conditions for a displacement of the focus of private health insurance, traditionally dominated by individual-level contracts. Since 2013, one can thus note a progressive rise of collective, corporation-level based contracts (Figure 3). IPs and insurance companies have been the main beneficiaries of this change. In many respects, the consequences of the Employment Security Act are similar to the development of European legislation and to

the recognition of risk management through managed care organizations. This is because it develops and intensifies competition between private health insurers in a new area, that of corporations. It has also reinforced the homogenization of different actors: until then, few mutual benefit societies developed activities at this scale. To gain market share, they have been incited to build strategic alliances with IPs which are far less well-established on collective contracts – indeed, to a lesser extent, this is also the case for insurance companies. Correlatively, this situation appears likely to favor the further development of risk management through encouraging managed care organizations to offer the most 'cost-effective' contracts.

Figure 3: Share of collective and individual contracts

Source: ACPR, Drees, CMU Fund



5 Conclusion: Private health insurance in France between Europeanization and Collectivization

As categories that dominate scholarly discourses on the contemporary dynamics of French Social Security, privatization and statization prove somewhat ineffective when it comes to describing the drivers of private health insurance. Some clues favoring one of these theses or the other can be found in this area. But such data never suggests a clear trend toward a straightforward privatization or statization process. Marketization, we have argued, is certainly a better notion with which to capture the ongoing evolutions of the field. In this paper it has been used to describe the development of market-like principles (free and equal competition, removal of rents and barriers), behaviors (merger and acquisitions, strategic alliances, risk management) and instruments (prudential regulation, managed care organizations) in a sector that had been partially institutionalized on quite another basis. A series of public policies have played a major role in this shift. But surprisingly, none of them explicitly aimed at changing the distribution between non-profit and for-profit actors in the sector of private health insurance in France. In other terms, if increasing marketization has been a common outcome of these reforms or of their cumulative effects, it has never been an explicit nor a hidden goal of legislators and policy-makers.

As for other segments of health policy, the adoption of European legislation related to internal market organization has certainly constituted a critical juncture (Greer, 2008): by creating a legal framework for insurance activities, directives adopted in 1992 put in place the basic conditions for free and equal competition between insurance companies, IPs and mutual benefit societies; seventeen years later, Solvency 2 added to this legal environment a complex and extended regulatory scheme, which induced major strategical

and organizational shifts for non-profit entities. But none of these policies were intended to re-institutionalize private Welfare; more importantly, if they introduced market-like instruments for IPs and mutual associations, they had initially sought to change and to reinforce those kinds of instruments which already shaped the private insurance industry. Marketization has thus developed at the national level following attempts to increase regulation at the supranational level. Reforms adopted at the French scale over the same time period also contributed to reinforcing the marketization of private health insurance, but with a different purpose. From a governmental perspective, the development of managed care organizations has been seen as a way to contain out-of-pocket payments by patients while reducing the fees charged by healthcare professionals. Largely driven by different categories of players within the private sector, this move toward aggressive risk management strategies has been deeply fostered by the effects of European directives on non-profit actors, especially mutual benefit societies. On the other hand, marketization has also developed follwoing governmental attempts to provide a "universal supplementary health coverage" between 1999 and 2013. CMU-C and ACS first created new outlets for private health insurers by trying to encompass parts of the population who could not afford such coverage. If regulatory and budgetary developments have been paralleled with marketization for these devices, we have seen, however, that they cannot be considered as a process of marketization via compensation. Rather they are best described as attempts to socialize the private sector (through deep public interventions on insurance contracts and fiscal incentives) and to make it develop a dedicated offer for the most vulnerable groups. Solutions for universal supplementary health coverage were ultimately proposed by François Hollande's socialist government in 2013. However, it was undermined by the 2013 Employment Security Act: initially focused on labour organization, the generalization of supplementary health insurance at the firm-level was imposed by a labour organization as

a compensation to employer representatives' demands; this led to increased competition and homogenization between the different actors of private health insurance, as well as a rise of collective contracts.

Marketization is thus a clear trend within private health insurance in France, but it has resulted from the cumulative and sometimes contradictory effects of past policy choices. In this context, this process appears to contain two, mutually reinforcing dimensions. The first is Europeanization, as exemplified by the Insurance and Solvency 2 directives: the most salient legal and regulatory features of the sector have now been fully integrated within European rules and norms. This dimension will almost certainly have major political effects in the coming years, notably in relation to future legislation. Most of them are likely to be European transpositions of international agreements on insurance operations, especially in terms of financial regulation or insurance products distribution — such as the recently adopted Covered agreement between the EU and the United States, which shall introduce a common prudential regulatory framework for insurance activities on both sides of the Atlantic. Such a trend might be both slowed down, and in other respects reinforced, by more specifically national evolutions. This other dimension of marketization is best described as a collectivization process, partly autonomous from EU legislative developments. The rise of managed care organizations, especially through huge industrial platforms involving IPs, mutual benefit associations and insurance companies is largely independent from the EU-scale political agenda. The same applies to the consequences of France's Employment Security Act, an agreement that was passed without any linkage to European constraints. If they certainly occured within a context of intensified competition, these two evolutions tended for their part to induce a collectivization of supplementary health coverage: this dimension is observable through the development of collective, corporation-level based contracts, weakening the

principles of free and voluntary subscription of private health insurance contracts that had previously been a major feature of the French system ever since the foundation of the Social Security system. Even this change could incite private health insurers to differentiate between themselves in order to meet this new demand, one might also expect a standardization of their contracts in the long run in relation to the size and form of the different types of firms. Such a development would, again, contradict the traditional principles of private health insurance in France which has historically specialized in individual contracts. But the collectivization dimension of marketization is also visible through the development of managed care organizations, since they constitute the basis for a symmetrical standardization of care and health products.

Finally, what wider conceptual and analytical lessons may be drawn from this case? A first thing to note is that its findings share many features with other research projects on Welfare and, more broadly, with the public policy literature. But this process, referred to as marketization of a private segment of the Welfare State, is also revealing of trends that have not received much attention in the literature. First, and in relation to the European dimension of the case, it shows the considerable role played by EU policies in the area of private Welfare. This influence is now likely to induce deep political changes at the national level, since a significant share of private Welfare institutions in Europe are made up of non-profit actors, such as mutual benefit societies and IPs for the French case. But European law does not take into account the business model of these entities when it focuses upon their activities: in this context, actors are generally asked to choose between a legislation that would assimilate them to for-profit companies (as mutual associations and IPs have done in France) or to be integrated within public Welfare institutions and thusbe excluded from internal market regulations - a solution that has been followed by pension funds in France, or mutual benefit societies in Belgium. In a

context of "permanent austerity" and "Welfare retrenchment", these choices are far from being neutral, both from the perspective of the situation of non-profit actors within the EU, but more broadly from that of Welfare governance in Europe as a whole.

Second, in relation to our findings at the national level, this case is also instructive for conceptual debates on the links between privatization and marketization. Being related to governmental support to managed care organizations or to the generalization of supplementary health coverage, marketization through an increasing control of the private sector has been described here as a "default option" from the viewpoint of the public sphere (Ansaloni and Smith, 2017). In this context, it is neither part of a hidden agenda of politicians, nor an indicator of a deeper privatization strategy. If national policies have fostered the marketization of private health insurance, this is mainly because it has been considered as a weak, but potential solution to solveing a persisting issue (notably rising out-of-pocket payments for patients due to an incapacity to regulate fees charged by healthcare professionals); or as a set of instruments to force private actors to extend their products to targeted social groups (CMU-C and ACS). In the end, both of these insights describe the contradictory nature of the contemporary situation of the relationship between public and private Welfare. On the one hand, national governments increasingly see the latter as a means of solving difficulties. But on the other hand, European legislation has at the same time changed the deep nature of private Welfare by creating the basic conditions for its marketization.

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