UNIVERSIDAD JAUME I

DEPARTMENT OF FINANCE AND ACCOUNTING

DOCTORAL PROGRAM IN ECONOMICS AND BUSINESS

THE EMPLOYERS' RESPONSIBILITY TOWARDS EMPLOYEES IN GROUP HEALTH INSURANCE PLANS IN ISRAEL: ANALYSIS OF THE PERCEPTION OF THE INSURANCE COMPANIES, THE EMPLOYERS AND THE EMPLOYEES

DOCTORAL DISSERTATION

Submitted by:

Shlomi Luttinger

Supervisors:

Dr. Juan Angel Lafuente Luengo

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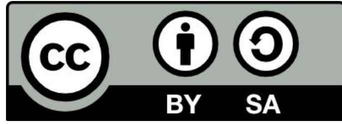

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In memory of my parents Natan and Claudia Luttinger, may they rest in peace.

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LIST OF ABBREVIATIONS

A.H.S	Additional Health Services
C.B.S	Central Bureau of Statistics
C.R	Concentration ratio
E.P.E.R	Employees’ Perceptions of Employer’s Responsibility
H.M.O	Health Maintenance Organization
H.R	Human Resource
N.I.S	New Israeli Shekel
O.E.C.D	Organization for Economic Cooperation and development
V.P	Vice President

Resumen

Antecedentes: La estructura del sistema sanitario de Israel y el presupuesto deficiente del sistema de salud público ha dañado la disponibilidad y la calidad de los servicios sanitarios y ha creado una creciente demanda de seguros de salud privados: pólizas contratadas de manera privada por los individuos, y planes de seguros para grupos normalmente adquiridos por los empleadores para un grupo de empleados y sus familiares.

Las ventajas inherentes de un plan de seguros para grupo se han convertido en una herramienta importante del bienestar del empleado en Israel, que los empresarios utilizan para atraer y retener a los empleados.

Como tomadores que firman un seguro sanitario colectivo, los empresarios tienen una responsabilidad frente a los empleados en vista de la confianza que estos depositan en ellos. Desde el punto de vista del regulador, la responsabilidad del empresario se expresa en las regulaciones del seguro sanitario colectivo y los tomadores deben actuar con “fe y diligencia” en el mejor interés de los asegurados. Esta obligación es más bien general y está abierta a interpretaciones legales, lo que crea incertidumbre para los empresarios y les genera riesgo jurídico.

En este contexto, los principales objetivos de este estudio son:

a. Proporcionar un significado operativo de la responsabilidad de los empresarios frente a sus empleados derivada de las disposiciones de un seguro médico colectivo.
b. Crear una guía para los empresarios sobre cómo deberían actuar para cumplir sus responsabilidades de gestión, éticas y legales frente a sus empleados en lo relativo a las disposiciones de un seguro médico colectivo.

La principal pregunta de investigación derivada de estos objetivos es: **¿Qué responsabilidad tienen los empresarios hacia sus empleados en relación con el seguro médico colectivo y cómo deberían actuar para cumplir sus obligaciones directivas y legales hacia sus empleados?**

Para responder a esta pregunta de investigación, se examinan las percepciones de cada uno de los participantes en los contratos de un seguro médico colectivo: la compañía de seguros, el tomador del seguro -el empresario u otra corporación autorizada a firmar un acuerdo de seguro colectivo para sus miembros (por ejemplo, una asociación de consumidores)- y los empleados -que son los asegurados-.

Metodología

Para responder a la pregunta de investigación, el estudio se ha llevado a cabo en tres fases.

En primer lugar, se realizó un estudio cualitativo exploratorio mediante entrevistas en profundidad semiestructuradas a cinco ejecutivos (VP) de los departamentos de seguros médicos colectivos de cinco compañías de seguros, que controlan el 93% del mercado de seguros médicos colectivos de Israel (Commissioner's Report, 2018). El objetivo de esta fase es revelar cómo perciben los ejecutivos la responsabilidad del empresario frente a los empleados y cómo describen sus acciones en el acuerdo de seguro colectivo. Los resultados cualitativos de esta fase permiten formular las preguntas en las posteriores entrevistas con los empresarios.

En una segunda fase se realizaron entrevistas semiestructuradas en profundidad a diez directores de recursos humanos de empresas líderes de Israel que han contratado un seguro médico para sus empleados. Se trata de dos empresas de alta tecnología, dos empresas industriales, dos empresas de servicios privados (financieros, marketing), dos organizaciones de servicios públicos y dos asociaciones de consumidores. El objetivo de las entrevistas es explorar cómo perciben los empresarios su responsabilidad hacia sus empleados y qué medidas adoptan en relación con el acuerdo de seguro.

Después de analizar los datos por categorías y crear temas que describan las acciones de los empresarios a lo largo del acuerdo de seguro, se llevó a cabo la tercera fase del estudio entre los empleados. En esta tercera fase se aplicaron métodos cuantitativos y cualitativos para examinar las percepciones de los empleados asegurados.

El objetivo específico de la investigación cuantitativa entre los empleados es examinar la asociación entre las acciones de los empresarios, tal y como se describen en los temas expuestos en la investigación cualitativa entre los empresarios, y la percepción de los empleados de la responsabilidad de quien los contrata frente a ellos, así como examinar las variables que podrían afectar a la percepción de los empleados de esta responsabilidad: el impacto de los factores demográficos y otros relacionados con el lugar de trabajo.

Además, el estudio examina la diferencia entre las actitudes de los empleados respecto a la importancia de cada una de las acciones del empresario y las acciones del empresario en la práctica.

Participantes

En esta parte del estudio participan 500 empleados en diferentes puestos de trabajo que están asegurados mediante seguros médicos colectivos.

Procedimiento

La investigación cuantitativa se lleva a cabo mediante una encuesta *on-line* a través de una agencia de recopilación digital israelí (P-Value Data Analytics) que cuenta con un panel web demográficamente diverso de sujetos que se presentan voluntarios para realizar encuestas seleccionadas. Como parte del proceso de inscripción, estos individuos deben completar un cuestionario demográfico inicial basado en la web, que incluye preguntas sobre el género, la edad, la educación y otras variables. La muestra de este estudio incluye a empleados de diversos sectores y empresas. La participación es voluntaria y se pide a los participantes que completen una encuesta sobre las acciones de su empresa en relación con la contratación del seguro médico colectivo.

Cuestionario

Los participantes rellenan un cuestionario dividido en cuatro partes: (a) datos demográficos y antecedentes (8 preguntas); (b) historial de actividad con la compañía de seguros (8 preguntas); (c) acciones de la empresa/organización en relación con el seguro médico colectivo (10 preguntas); y (d) percepción del empleado de las acciones de la empresa/organización en relación con el seguro médico colectivo (17 preguntas). En este

apartado se pide a los participantes que valoren cada aspecto en una escala de Likert entre 1 (nada importante) y 5 (muy importante).

Variables de investigación

Para examinar las variables independientes hay preguntas sobre los datos demográficos y los antecedentes, la experiencia y la actividad con una compañía de seguros en relación con el acuerdo de seguro, y las acciones y la participación del empresario en la contratación del seguro colectivo. Para examinar la variable dependiente, se plantean preguntas sobre la percepción que tienen los empleados de las acciones del empresario en lo relativo al seguro médico colectivo.

Hipótesis de investigación

1. Existe una asociación positiva entre la inclusión de los empleados en la formulación de un plan de seguros y la percepción de los empleados sobre la responsabilidad del empresario hacia ellos. Cuanto más implican los empresarios a sus empleados en la formulación del plan de seguros, mayor es la percepción que tienen los empleados de la responsabilidad del empresario hacia ellos.
2. Existe una asociación positiva entre la contratación de un experto o consultor externo por parte del empresario y la percepción que tienen los empleados de la responsabilidad del empresario hacia ellos. Los empleados consideran que la responsabilidad del empresario hacia ellos es mayor cuando este contrata a un experto externo.
3. Existe una asociación positiva entre la realización de una licitación o un procedimiento competitivo para la elección de la aseguradora y la percepción que tienen los trabajadores de la responsabilidad del empresario hacia ellos. Si se licita o se inicia un procedimiento competitivo, la percepción de los trabajadores sobre la responsabilidad del empresario hacia ellos será mayor.
4. Existe una asociación positiva entre el intercambio de información y la puesta al día de los empleados sobre sus derechos en el marco del seguro colectivo, y la percepción de los empleados sobre la responsabilidad del empresario hacia ellos. Cuanta más información compartan los empresarios con los empleados sobre el seguro colectivo,

mayor será la percepción de los empleados sobre la responsabilidad del empresario hacia ellos.

5. Existe una asociación positiva entre el nivel de implicación del empresario en la gestión del seguro y la percepción que tienen los empleados de la responsabilidad del empresario hacia ellos. Cuanto más se implique el empresario en la gestión del seguro, mayor será la percepción de los trabajadores sobre la responsabilidad del empresario hacia ellos.

Análisis de datos

En primer lugar, se elaboran estadísticas descriptivas mediante frecuencias, medias y desviaciones estándar. Las correlaciones entre las variables se calculan mediante las pruebas de Pearson. Además, las diferencias entre las preguntas de clasificación de los mismos participantes se calculan mediante un análisis de varianza de medidas repetidas (ANOVA). Del mismo modo, las diferencias entre grupos (por ejemplo, diferentes industrias) se calculan mediante pruebas ANOVA. Además, se estiman modelos de regresión multivariante para evaluar la asociación de los distintos factores demográficos y las características del seguro con la percepción de la responsabilidad del empresario por parte del empleado.

Resultados

Los principales resultados pueden resumirse como sigue:

a. La primera hipótesis de investigación no se confirma. No se encuentra una correlación significativa entre la participación de los empleados en la formulación de un plan de seguros y la percepción de los empleados sobre la responsabilidad del empresario. En otras palabras, los empleados no consideran que su participación en la elaboración del plan de seguros sea un factor que afecte a la responsabilidad del empresario hacia ellos.
b. La segunda hipótesis de investigación se confirma. Se encuentra una diferencia significativa en la percepción de los empleados sobre la responsabilidad del empresario entre los empleados cuyos empresarios contratan a un consultor y aquellos cuyos empleadores no lo hacen. La percepción de los empleados sobre la responsabilidad del empresario es mayor cuando este utiliza los servicios de un consultor profesional externo.
c. La tercera hipótesis de investigación no se confirma. No hay diferencias significativas en la percepción de los empleados sobre la responsabilidad del empresario entre los empleados

cuyos empresarios llevan a cabo un procedimiento de licitación/competitivo en comparación con aquellos cuyos empresarios no lo hacen. Al mismo tiempo, los empleados creen que se pueden obtener mejores condiciones de seguro y un precio más bajo cuando los empleadores llevan a cabo un procedimiento de licitación/competitivo, en comparación con los empresarios que no lo hacen. Esta conclusión es coherente con la posición de los empleados de que las consideraciones antes de contratar un seguro médico son principalmente el precio y las condiciones del mismo.

d. La cuarta hipótesis de investigación se confirma parcialmente. Se encuentra una diferencia significativa entre los empleados cuyos empleadores comparten información sobre el seguro médico colectivo y sobre los derechos de seguro complementario de las HMO (Israel tiene cuatro Organizaciones de Mantenimiento de la Salud sin ánimo de lucro, que prestan servicios sanitarios a toda la población) y los empleados cuyos jefes sí lo hacen. Además, este tema tiene una importancia relativamente alta para los empleados asegurados. Los datos muestran que se considera que los empresarios que informan a los empleados sobre sus derechos en el marco del seguro médico colectivo y sobre los derechos complementarios ofrecidos por las Organizaciones de Mantenimiento de la Salud muestran una mayor responsabilidad en comparación con los empresarios que no lo hacen.

En cuanto a la puesta al día de los empleados sobre los cambios en las condiciones de la póliza de seguro, no se encuentran diferencias en la percepción de la responsabilidad del empresario entre aquellos cuyos empleadores les informan sobre los cambios en la póliza de seguro y aquellos cuyos empleadores no lo hacen.

e. La quinta hipótesis de la investigación no se confirma. Para esta hipótesis, se comprueban dos correlaciones: la participación del empresario en el rechazo de reclamaciones y la participación del empresario o de un experto en su nombre cuando surge un problema. En lo que respecta al rechazo de las reclamaciones, no se encuentran diferencias significativas en la percepción de los empleados sobre la responsabilidad del empresario entre los empleados cuyos empleadores informan a sus empleados sobre las denegaciones de las reclamaciones y los que no lo hacen. Por lo tanto, no se encuentran diferencias significativas en la percepción de los empleados sobre la responsabilidad del empresario en lo que respecta a la implicación cuando surge un problema con la compañía de seguros.

Se estima un modelo lineal multivariante para evaluar el nivel de percepción de los empleados de la responsabilidad del empresario hacia ellos en función de las acciones del

empresario, las variables demográficas, los factores relacionados con el lugar de trabajo y las consideraciones sobre el seguro.

Los resultados muestran que la contratación de un experto externo, el intercambio de información y la puesta al día de los empleados sobre sus derechos en el marco del seguro colectivo están positivamente asociados con el nivel de percepción de los empleados sobre la responsabilidad del empresario hacia ellos. Además, los resultados muestran que ninguna de las características sociodemográficas predice el nivel de percepción de la responsabilidad del empresario por parte de los trabajadores. Al mismo tiempo, los trabajadores del sector de la alta tecnología tienen una mayor percepción de la responsabilidad del empresario hacia ellos, en comparación con los demás trabajadores del resto de sectores.

Los empleados asegurados a través de un empleador perciben la responsabilidad del empleador como mayor que los empleados asegurados a través de asociaciones de consumidores, sin embargo, en el modelo multivariante, no se encuentra esta correlación. Del mismo modo, los empleados de las empresas en las que no hay Comité de Empresa perciben la responsabilidad del empresario hacia ellos como mayor que los empleados de las empresas en las que hay Comité de Empresa; sin embargo, en el modelo multivariante, no se encuentra esta correlación.

Por último, se identifican diferencias significativas entre las actitudes de los empleados y las acciones de los empresarios en relación con algunos aspectos del seguro médico colectivo. En concreto, los resultados muestran que los empleados atribuyen una gran importancia a que el empresario les informe de sus derechos en materia de seguros, mientras que, según los conocimientos de los empleados, los empresarios solo son moderadamente activos a la hora de informarles de sus derechos.

Investigación cualitativa entre los empleados

Tras el análisis de los resultados cuantitativos, se realiza un breve estudios cualitativo utilizando entrevistas semiestructuradas en profundidad entre 10 participantes tras completar el cuestionario, para revelar sus percepciones sobre determinados aspectos surgidos del estudio cuantitativo y, en particular, cómo perciben la responsabilidad de los empresarios frente a ellos, hasta qué punto conocen sus derechos en el marco del seguro médico colectivo y cómo comparte con ellos información sobre sus derechos relacionados con el seguro médico colectivo por parte del empresario.

Conclusiones

El estudio revela que los "participantes", las empresas aseguradoras, los tomadores (empresarios o clubs de consumidores) y los empleados asegurados, interpretan el término "fe y diligencia" como la obligación de obtener las mejores condiciones del seguro en lo relativo al precio, para crear un seguro que cumpla las expectativas de las partes aseguradas. El empresario debe actuar de buena fe y en el mejor interés del asegurado, debe informar a los empleados sobre sus derechos en derivados del seguro y debe garantizar que puedan ejercer los derechos del acuerdo colectivo.

El análisis de la responsabilidad del empresario por cada acción a través del acuerdo del seguro colectivo revela que los empleados, las aseguradoras y la mayoría de empresarios percibe que la responsabilidad de los empresarios es media-alta. En particular, se extraen las siguientes conclusiones:

1. Se considera que la participación de los empleados en la formulación de un plan asegurador tiene una importancia baja. La inclusión de los empleados no es adecuada para todas las organizaciones. Se recomienda que el empresario analice las necesidades y las expectativas de los empleados ante un plan asegurador mediante encuestas, grupos focales o incluso la participación activa de sus representantes en el proceso. De manera alternativa, el análisis de los informes de reclamaciones y la recogida de información recibida en las solicitudes o quejas de los empleados son herramientas efectivas para examinar las necesidades de los empleados.
2. Existe una obligación de contratar un consultor o profesional de seguros sanitarios. Esto cubre la obligación del empresario frente a los trabajadores en lo relative a la precaución. Las aseguradoras consideran al consultor profesional como un "mediador experto" porque los empresarios no están familiarizados suficientemente con la terminología y las normas de los seguros.
3. Es muy importante realizar un concurso o procedimiento competitive para establecer las normas sobre cuándo hacerlo. Un procedimiento de licitación/competitivo amplía la transparencia y la confianza del empleado en la conducta del empresario A la hora de renovar el seguro, es importante analizar la viabilidad económica del seguro médico y cualquier cambio en el sector asegurador, y ajustar el seguro a las necesidades económicas y de aseguramiento del asegurado de manera acorde.
4. El empresario está legalmente obligado a informar a los empleados sobre sus derechos en un seguro médico colectivo al inicio del seguro y cada vez que se renueva, y

especialmente sobre sus derechos en la finalización del empleo o cuando termine el plazo del seguro. El empresario debe garantizar que la aseguradora y/o el agente de seguros cumplen esta obligación vinculante, según las normas del seguro médico colectivo. El empresario también debe garantizar que la información en los anuncios es clara y se ajusta a las características de los empleados, porque los empresarios son los que mejor conocen a sus empleados.

5. El empresario está legalmente obligado a informar a los empleados de todos los medios de los que dispongan relacionados con cambios en las cláusulas del seguro que pudieran afectar a su elegibilidad para recibir servicios médicos, y relativos a los cambios y actualizaciones en las condiciones del seguro médico colectivo. El empresario debe inspeccionar y aprobar el texto de los anuncios remitidos por la aseguradora.
6. El empresario está legalmente obligado a informar a los empleados de sus derechos en virtud del seguro complementario de su Organización para el Mantenimiento de la Salud (HMO por sus siglas en inglés). El empresario no está obligado a informar a los empleados sobre sus derechos como parte de la “bolsa de servicios médicos” estatal; sin embargo, el empresario debería informar a los empleados sobre las diferentes formas de recabar información sobre este tema.
7. Existen diferencias de conocimiento y poder entre las aseguradoras y los empleados. El empresario está obligado legalmente a garantizar que la aseguradora cumple sus obligaciones frente a los empleados, incluid la intervención cuando se rechaza una reclamación o cuando hay falta de acuerdo. El empresario está obligado legalmente a informar a los empleados sobre su derecho a utilizar los servicios del empresario. Deben redactarse normas claras y dares a conocer a los empleados. Los empresarios deberían utilizar una entidad profesional para este objetivo.
8. El empresario tiene la obligación de realizar el seguimiento de la aseguradora, garantizar la recepción de información e informar periódicamente (semestralmente o anualmente) sobre el seguro médico colectivo y debatir sobre los resultados de los informes y las implicaciones derivadas de estos. Además, el asegurado debe actualizar los resultados de los informes. Esto mejorará la transparencia y la confianza del empleado en el pago del seguro y ayudará al empleado a recibir apoyo en el caso de cambios en el seguro médico o de un aumento en los costes del seguro.

Abstract

Background: The structure of Israel's healthcare system and deficient budgeting of the public health system has harmed the availability and quality of healthcare services and created an increasing demand for private health insurance: policies purchased privately by individuals, and collective group insurance plans usually made by employers for a group of employees and their family members.

The advantages inherent in a group insurance plan have made it an important tool of employee welfare in Israel, one that employers use for the purposes of employee recruitment and retention.

As policyholders signing a group health insurance, employers have a responsibility towards employees in light of the latter's trust and reliance on them. From a regulator's point of view, employer responsibility is expressed in group health insurance regulations according to which a policyholder must act with "faith and diligence" in the best interests of those insured. This obligation is general rather than defined, and as such, is given to court interpretations, which creates uncertainty for employers and places them at legal risk. Therefore, the main objectives of current study are:

a. To provide an operative meaning of employers' responsibility toward their employees regarding the group health insurance arrangement.
b. To create a guide for employers as to how they should act in order to fulfil their managerial, ethical, and legal responsibilities towards their employees with regard to the group health insurance arrangement.

The main research question deriving from these objectives is: **What responsibility do employers have towards their employees regarding the group health insurance arrangement, and how should employers act in order to fulfil their managerial and legal obligations toward their employees?**

To answer this research question, the perceptions of each of the participants in group health insurance arrangements are examined: the insurance company, the policyholder - the employer or another corporation authorized to sign a group insurance agreement for its members (e.g., a consumer club) - and the employees – those who are insured.

Methodology

To answer this research question, the study is conducted in three stages.

First, an exploratory qualitative study using semi-structured in-depth interviews is conducted among five executives (VPs) in the group health insurance departments of five insurance companies controlling 93% of Israel's group health insurance market (Commissioner's Report, 2018). The aim of this stage is to reveal how the executives perceive employer responsibility towards employees and how they describe their actions throughout the group insurance arrangement. The qualitative findings of this stage enable the formulation of the questions in the subsequent interviews with the employers.

In a second qualitative stage, semi-structured in-depth interviews are conducted with 10 HR managers of leading companies in Israel that have signed a health insurance agreement for their employees. These include two hi-tech companies, two industrial companies, two private services companies (financial, marketing), two public services organizations, and two consumer clubs. The aim of the interviews is to explore how the employers perceive their responsibility towards their employees and what actions they take with regard to the insurance arrangement.

After analysing the data by categories and creating themes that describe the employers' actions throughout the insurance arrangement, the third stage of the study is conducted among the employees. In this third stage, mixed quantitative and qualitative methods are applied to examine the perceptions of the insured employees.

The specific objective of the quantitative research among employees is to examine the association between employers' actions as they are described by the themes exposed in the

qualitative research among employers, and the employees' perception of their employer's responsibility towards them, and to examine variables that might affect employees' perceptions of this responsibility: the impact of demographic and workplace-related factors.

In addition, the study examines the gap between employees' attitudes regarding the importance of each of the employer's actions and the employer's actions in practice.

Participants

Participating in this part of the study are 500 employees in various occupations who are all insured by group insurance agreements.

Procedure

The quantitative research is conducted using an online survey through an Israeli digital collection agency (P-Value Data Analytics) which maintains a demographically diverse web panel of subjects who opt in to taking selected surveys. As a part of the sign-up process, these individuals are required to complete an initial web-based, self-reported demographic questionnaire which includes questions regarding gender, age, education, and other variables. The sample in this study includes employees in a variety of industries and companies. Participation is voluntary and participants are asked to complete a survey about their employer's actions with regard to the group health insurance arrangement.

Questionnaire

Participants complete a questionnaire divided into four sections: (a) demographics and background (8 questions); (b) history of activity with the insurance company (8 questions); (c) the employer's / organization's actions in regard to group health insurance (10 questions); and (d) the employee's perceptions of the employer's / organization's actions in regard to group health insurance (17 questions). In this section participants are asked to rate each aspect on a Likert scale between 1 (not important) and 5 (most important).

Research variables

To examine independent variables there are questions about demographics and background, experience and activity with an insurance company regarding the insurance

arrangement, and the employer's actions and involvement regarding the group insurance arrangement. To examine the dependent variable there are questions about the employees' perceptions of the employer's actions concerning the group insurance arrangement.

Research hypotheses

1. There is a positive association between the inclusion of employees in the formulation of an insurance plan, and the employees' perception of the employer's responsibility towards them. The more employers involve their employees in formulating the insurance plan, the greater employees perceive the employer's responsibility towards them.
2. There is a positive association between the hiring of an external expert or consultant by the employer and the employees' perception of the employer's responsibility towards them. The employees see the employer's responsibility towards them as greater when the employer hires an external expert.
3. There is a positive association between conducting a tender or a competitive procedure for the choice of insurer, and the employees' perception of the employer's responsibility towards them. The more employers conduct a tender or competitive procedure, the greater employees perceive the employer's responsibility toward them.
4. There is a positive association between the sharing of information and updating employees regarding their rights as part of the group insurance plan, and the employees' perception of the employer's responsibility towards them. The more employers share information with employees and update them regarding the group insurance plan, the greater employees perceive the employer's responsibility toward them.
5. There is a positive association between the level of the employer's involvement in managing the insurance arrangement, and the employees' perception of the employers' responsibility towards them. The more employers are involved in managing the insurance arrangement, the greater employees perceive the employer's responsibility toward them.

Data analysis

First, descriptive statistics are produced using frequencies, means and standard deviations. Correlations between variables are computed using Pearson tests. In addition,

differences between ranking questions among the same participants are computed using Repeated Measures Analysis of Variance (ANOVA). Similarly, differences between groups (for example, different industries) are computed using ANOVA tests. In addition, multivariate regression models are conducted to assess associations with employer responsibility.

Results

The main results can be summarized as follows:

a. The first research hypothesis is not supported. No significant correlation is found between employee involvement in the formulation of an insurance plan and the employees' perceptions of the employer's responsibility. In other words, employees do not consider their participation in the construction of the insurance plan as a factor affecting the employer's responsibility for them.

b. The second research hypothesis is supported. A significant difference in employees' perceptions of employer responsibility is found between employees whose employers hire a consultant and those whose employers who do not. Employees' perceptions of the employer's responsibility is greater when the employer uses the services of an external professional consultant, compared to the responsibility ascribed to employers who do not use such services.

c. The third research hypothesis is not supported. No significant difference is found between employees' perceptions of the employer's responsibility among employees whose employers conduct a tender/competitive procedure compared to those whose employers do not. At the same time, employees are found to believe that better insurance terms and a lower price can be obtained when employers conduct a tender/competitive procedure, compared to employers who do not. This finding is consistent with the employees' position that the considerations before joining an insurance plan are mainly the price and terms of the insurance.

d. The fourth research hypothesis is partially supported. A significant difference is found between employees whose employers share information about group health insurance and about HMO supplementary insurance rights (Israel has four non-profit Health Maintenance Organizations, providing health services to the entire population) and employees whose employers who do. Moreover, the issue is of relatively high importance for the insured employees. The data show that employers who inform employees about their rights under the group health insurance and about the

supplementary rights offered by the HMOs are perceived as showing a greater responsibility compared to employers who do not.

As for updating employees on changes in the insurance policy terms, no difference is found in the employees' perception of the employer's responsibility between those whose employers inform them about changes in the insurance policy and those whose employers do not.

e. The fifth research hypothesis is not supported. To check this hypothesis, two correlations are tested: employer involvement in rejecting claims, and the involvement of the employer or an expert on the employer's behalf when a problem arises. Regarding claim rejection, no significant difference is found for employees' perceptions of the employer's responsibility between employees whose employers who inform their employees about rejections and employees whose employers do not. Hence, no significant difference in the employees' perception of the employer's responsibility is found regarding involvement when a problem arises with the insurance company.

A multivariate linear model is applied to assess the level of the employees' perceptions of the employer's responsibility towards them according to employer's actions, demographic variables, workplace-related factors and insurance considerations.

The multivariate model results show that hiring an external expert, sharing information and updating employees about their rights as part of the group insurance positively predicts the level of the employees' perceptions of the employer's responsibility towards them. Furthermore, the results show that none of the socio-demographic characteristics predict the level of the employees' perceptions of the employer's responsibility. At the same time, employees in the high-tech industry demonstrate a higher perception of the employer's responsibility towards them, compared to other industry employees.

Employees insured through an employer perceive the employer's responsibility as greater than employees insured through consumer clubs, however, in the multivariate model, this correlation is not found. Similarly, employees in companies where there is no Workers' Committee perceive the employer's responsibility to them as greater than employees in companies where there is a Workers' Committee, however, in the multivariate model, this correlation is not found.

Finally, significant gaps are identified between employees' attitudes and employers' actions relating to some aspects of group health insurance. Specifically, findings show that

employees attribute high importance to the employer's informing them of their insurance rights, while, according to employees' knowledge, the employers are only moderately active in informing them of their rights.

Qualitative research among employees

Following analysis of the quantitative research results, a short qualitative study using semi-structured in-depth interviews is conducted among 10 interviewees after completing the questionnaire, to reveal their perceptions regarding certain issues emerging from the quantitative study, and in particular, how they perceive their employer's responsibility towards them, how aware they are of their rights within the group health insurance plan, and how the employer shares information about their rights regarding the group health insurance plan with them.

Conclusions

The study reveals that the "participants" – the insurance companies, the policyholders (employers or consumer clubs), and the insured employees – interpret the term "faith and diligence" as the obligation to obtain the best insurance terms relative to the price, to create insurance that meets the insured parties' expectations. The employer must act in good faith and in the best interests of the insured, must inform employees about their insurance rights and must ensure that employees receive their rights under the group agreement.

Analysis of an employer's responsibility for each action throughout the group insurance arrangement reveals that employees, insurance companies and the majority of employers perceive the responsibility of employers to be medium-high. In particular, following conclusions arise from the overall findings:

1. Inclusion of employees in the formulation of an insurance plan is found to be of low importance. Inclusion of employees does not suit every organization. It is recommended that an employer examines the needs and expectations of employees from the insurance plan through surveys, focus groups, or even active inclusion of their representatives in the process. Alternatively, analysis of claims reports and gathering of information received from employees' applications or complaints are effective tools for examining employee needs.

2. There is an obligation to hire a consultant or a health insurance professional. This fulfils an employer's obligation to employees regarding caution. Insurance companies regard a professional consultant as a "knowledgeable mediator" because employers are not sufficiently familiar with insurance terminology and rules.
3. It is highly important to conduct a tender or competitive procedure and to set regulations and rules as to when to do it. A tender/competitive procedure amplifies transparency and employee trust in conduct of an employer. When renewing the insurance, it is important to examine economic viability of the insurance plan and any changes in the insurance sector, and to adjust the insurance to economic and insurance needs of the insured accordingly.
4. An employer is legally obliged to inform employees regarding their rights in a group insurance plan upon initiation of the insurance and every time it is renewed, and particularly regarding their rights upon termination of employment or when an insurance term ends. An employer must make sure that the insurance company and/or insurance agent fulfils this binding obligation, according to group health insurance regulations. An employer must also make sure that the phrasing of announcements is clear and adjusted to characteristics of employees, because employers know their employees best.
5. An employer is legally obliged to inform employees of any means at their disposal regarding changes of insurance ordinances that may affect their eligibility to receive medical services, and regarding changes and updates to terms of the health insurance plan. An employer should inspect and approve the wording of announcements sent by the insurance company.
6. An employer is legally obliged to inform employees of their rights under the supplementary insurance of their HMO. An employer has no obligation to update employees regarding their rights as part of the state 'healthcare basket'; however, an employer should inform employees regarding possible ways of receiving information on this issue.
7. There are gaps of knowledge and power between insurance companies and employees. An employer is legally obliged to make sure the insurance company fulfils its obligations towards the employees – including intervening when a claim is rejected or when disagreements arise. An employer is legally obliged to inform employees regarding their right to use the employer's services. Clear regulations are to be worded and brought to knowledge of employees. Employers should use a professional entity for this purpose.

8. An employer has an obligation to monitor the conduct of the insurance company, to ensure receipt of information and periodic (semi-annual and annual) reporting regarding the group insurance plan and to hold discussions regarding findings of the reports and implications thereof. Moreover, the insured should be updated on findings of the reports. This will enhance transparency and employee trust in insurance settlements and help an employer receive employee support in case of changes to the insurance plan or an increase in insurance costs.

Chapter 1. Introduction

The structure of Israel's health system and the lack of budgeting of the public health system (Ministry of Health & Gertner Institute, 2019), are the main reasons that led group health insurance to become a significant element in the array of conditions of employment and the welfare of employees in Israel, and a tool used by employers for recruitment and retention of employees.

The complexity of the field of insurance, the different types of health insurance that exist (Gaydos & Fried, 2002), the lack of knowledge and information among the insured (Social Survey, 2017), employee reliance on information from the employer (Procaccia & Clement, 2014), and the involvement of the policyholder throughout the insurance arrangement term (Elias, 2001) – all establish the employer's responsibility regarding actions vis-à-vis employees.

From the Israeli regulator's point of view, as reflected in group health insurance ordinances, a policyholder must act with "faith and diligence" in favour of those insured. The term "faith and diligence" is an amorphous and general concept, leaving wide scope for interpretation by the courts depending on the circumstances, thus creating uncertainty for the employers as policyholders and placing them at legal risk.

Hence, the main objective of current study is to reveal how employers should act to fulfil their managerial and legal obligations toward their employees.

No previous research has been conducted in Israel on the question of the employer's responsibility on this topic.

This comprehensive study describes the employers' main actions throughout the term of the insurance arrangement from the point of view of all participants in the group insurance arrangement: the insurance companies, the employers' HR departments, and the employees, and examines the relationship between employers' actions and employees' perceptions of the employer's responsibility towards them. It further examines whether and how variables related to employee characteristics, workplace-related characteristics and characteristics related to the terms of the insurance plan affect the employees' perception of the employer's responsibility towards them.

The practical contribution of current study is that it provides an interpretation of the policyholder's legal responsibility from the perspective of the participants in the insurance arrangement and creates a guide and a standard for how employers should act in practice to fulfil their legal obligation and meet the expectations of insured employees regarding a group health insurance arrangement.

Adoption of the study's conclusions by employers may, on the one hand, prevent legal actions against them, and on the other, increase employees' confidence in such arrangements, which will have a positive impact on employee satisfaction with the workplace, and especially with the insurance plan.

Chapter 2. Empirical settings and literature review

2.1 Israel's healthcare system

Israel's healthcare system is based on three systems: the Ministry of Health, Health Maintenance Organizations (HMOs) and private sector institutions and organizations (Ben-Noon et al., 2010). Accordingly, the Israeli healthcare system can be divided into three main layers, as illustrated in Figure 1.

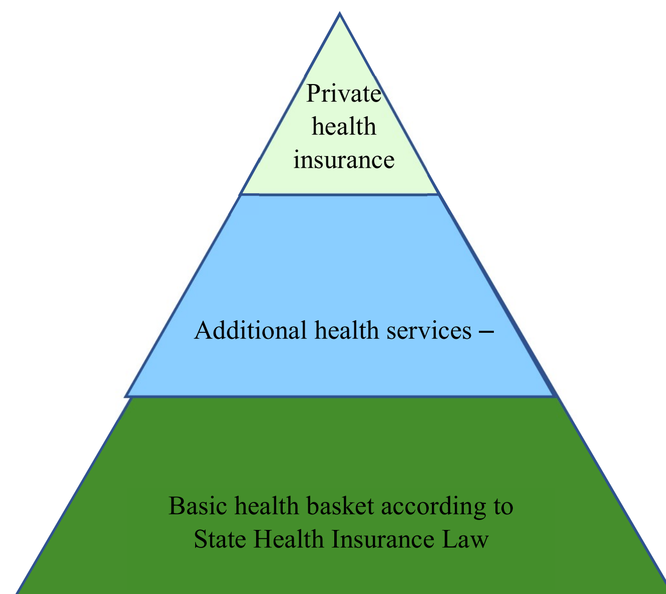

Figure 1: The three layers of Israel's healthcare system: basic health basket, additional health services, private health insurance

2.1.1 First layer – State health insurance

State insurance is enacted via the State Health Insurance Law, 1994. Clause 3(d) of this law determines that health services will be given in Israel according to medical judgement, of reasonable quality, within reasonable time, and in reasonable distance from the place of

residence of the insured individual. Health services will be given through the Health Maintenance Organizations (HMOs), non-profit organizations providing health services described in clause 6 of the Law, and all within funding sources of Israel's four HMOs (Klalit, Maccabi, Meuhedet and Leumit) (Boldor, 2013).

Condition of Israel's healthcare system

Israel's public healthcare system has budget deficits which affect its functioning. The percentage of current national expenditure on health (without investments) out of gross domestic product in Israel is at 7.4% and is lower than the current average expenditure on health in OECD counties, which is 8.8%. The percentage of public funding out of national expenditure on health in Israel is 64% and is lower than average in the OECD, which is 74% (Central Bureau of Statistics [CBS], 2019).

Lack of budgeting affects the availability of healthcare services in Israel. For example, the average waiting time for a specific orthopedist a citizen can choose out of a list provided by the HMO, is 17.3 days (waiting time for a non-specified orthopedist is 8.4 days); waiting time for a specific gynecologist is 18.6 days (for any gynecologist – 4.9 days); for a specific dermatologist 12.7 days (for any dermatologist – 9.5 days) (Ministry of Health & Gertner Institute, 2019). The conclusion is that within HMOs, the availability of specialized medical doctors in general is low, and freedom of choice in choosing a specific doctor, in particular, is very limited.

In order to illustrate the state of Israel's healthcare system, we will examine a few parameters compared to OECD countries: in Israel, there are five hospital nurses for every 1,000 people, as opposed to 9.3 nurses on average in OECD countries. The number of hospital beds in Israel is three for every 1,000 people, as opposed to 4.7 on average in OECD countries. The number of MRI devices is 4.9 for every million residents as opposed to 15.8 on average in OECD countries (OECD Health Statistics, 2018 Bruchim & Keiny, 2018). Moreover, the data testify to a gap favouring citizens living in center of the country, as opposed to those living in the periphery.

The reality of the state of the healthcare system and the absence of suitable budgets as described above, medicine and technology development (Shemer, 2003), population increase and prolonged life expectancy all increase the dependence on and need for private insurance policies and will cause an increase in insurance costs and in employer's health-related expenses.

2.1.2 Second layer – health insurance through HMOs (Additional Health Services)

According to an amendment to the 1988 State Health Insurance Law, HMOs can offer supplementary insurance. Clause 10 of the Law gives HMOs permission to offer Additional Health Services (AHS) for additional payment by members of that HMO. The Law determines that AHS will operate only within resources at its disposal, meaning the AHS program will be actuarially balanced, and in order to achieve balance, the extent of services and cost thereof can be changed from time to time. Joining the AHS is independent of the health or financial situation of its member, and at the most, qualification periods will be determined (clause c(1) to the Law). In 2018, AHS programs in the four HMOs numbered 5.58 million members in the basic layer, and 3.73 million members in the "top" (additional) layer who constitute 75.7% of the total members in the HMOs (Ministry of Health report, 2018).

AHS are offered by HMOs to the entire public. Joining these services is optional, while every individual can purchase according to their choice. The AHS is not an insurance program, even though it is defined in daily jargon as "supplementary insurance". Any individual, regardless of their medical condition, is entitled to be accepted to it as part of their healthcare services (Meuhedet Adif regulations, 2020). An individual asking to join an AHS program of one of the HMOs, must be a member in that HMO, and must pay the HMO for the AHS, in addition to the national health tax. Supplementary insurance programs of AHS include more than 50 different coverages, which can be purchased as one package.

Amongst services offered by AHS programs to the insured are: option to choose a surgeon, participation in acquiring medications and accessories, funding medical treatments abroad, alternative medicine, obtaining a specialist's opinion, dentistry, dietary consultation and more. Monthly cost is determined by the HMOs according to age groups. AHS services might change occasionally, regarding members who have already joined the program as well, subject to approval by the Ministry of Health and advance notice to those insured.

Currently, all the HMOs offer the public two layers of coverage as part of the AHS, and the consideration whether to join, and to which of the layers, is left entirely up to decision of the HMO members. The existence of various layers has an advantage in that it enables those insured to be satisfied with coverages included in the basic layer to join this layer only and bear a premium reflecting only the services included in that layer. However, it has a disadvantage as

well: an HMO might concentrate improvements of the program in the top layer and thereby diminish the worth of the basic layer (Somech, 2007).

It is important to note that the AHS are purchased subject to a qualification during which the individual is not entitled to participation by the insurer (Maccabi Sheli regulations, 2020; Meuhedet Adif regulations, 2020).

As opposed to AHS programs, the terms of private health insurances offered by commercial insurance companies will be determined in a personal contract between the individual and an insurance company. Commercial insurance companies have the right to refuse to insure an individual, for instance, due to a pre-existing medical condition (Stoltzfus, 2009).

2.1.3 Third layer – commercial health services

Health insurance is designed to prevent loss caused to an insured person due to expenses following an illness, hospitalization, etc., as well as lost workdays, etc.

The structure and budgetary deficiencies of Israel's healthcare system are some of the causes of growth in the scope of both personal and group private health insurance premiums. Some consider the expedited growth in private insurance as an expression of free will and rational preference of risk-averting consumers who take personal responsibility for their health. Other ascribe this development to the ongoing erosion of availability and quality of public health offerings, damage that has led to decreasing trust in public healthcare, and the search for alternative private insurance coverage (Ben-Noon et al., 2010).

The main reason for acquiring a private health insurance policy is to ensure a more comprehensive coverage than that supplied by the AHS. For example, the option to choose whether to undergo a medical procedure in Israel or abroad, assistance in financing transplants, participation in medications that are not included in the health basket, and more (Stoltzfus, 2009).

Health insurance is designed to cover the costs of future medical expenses (mainly for very dire medical situations) through an insurance company. An insured individual pays monthly premiums so that, when ill, they will not have to bear a significant financial expense. Commercial health insurance policies in Israel are second and third layers of coverage and are offered in addition to the coverages provided by the State Health Insurance Law and by the AHS (supplementary insurance) of the HMOs. This commercial health insurance enables

citizens who so wish to insure themselves beyond the coverages they already have, due to fear of an excessive and unexpected financial expense in the future (Horev & Keidar, 2012).

The Israel Consumers Council website published a survey of consumer complaints against those bodies dealing with "actualization of medical rights" (Israel Consumers Council, 2012), regarding consumer awareness of their medical rights. The survey revealed the following data: 75% of the public have additional medical insurance policies beyond the basic services. Moreover, it revealed that due to lack of clarity, the public have difficulty in choosing medical services wisely. 30% of the people sought to acquire the AHS based on a recommendation, because "everybody has one" or they simply "don't know". Another 10% do not want to take risks. Over the years, legislation has been promoted to find a way to relieve people from burdensome health insurance payments. A social survey in 2017 revealed that 34.6% of the population over the age of 20 have private insurance, not as part of the supplementary insurance of an HMO, and 32.2% have both private insurance and a supplementary insurance through an HMO.

Most of the insured, mainly in commercial insurance and those who have double insurance, testify that they insure themselves in order to fund surgeries, choose a doctor (which usually means the shortening of queues), and funding medications not in the state 'basket'. The impact of all these upon health is immediate. The relatively large extent of private funding and the increase in privately funded commercial insurance have led to increased gaps between people with high income and low income, between those residing in the center of a country and those in the periphery, and to market failures expressed in increased prices of medicine in relation to other prices (Tshernichovsky, 2019).

Commercial health insurance policies can be divided into individual health insurance and group health insurance.

2.1.4 Types of insurance – private individual insurance and group insurance

Individual health insurance

Private insurance is offered by an insurance company either through an insurance agent or directly to a client. The terms of insurance are determined by the insurer and its price and content is approved by the Commissioner in-charge of capital market and insurance. Private

health insurance is valid as long as the insured individual pays the premium and the insurer has no right to cancel it. According to an amendment that came in force in January 2016, an insurer is entitled to change the terms of insurance once every two years, subject to the approval of the Commissioner (Insurance Circular, 2015). Taking out a private insurance policy usually involves an exam to ascertain the medical condition of an insured individual, and the cost is determined according to their age and state of health. For "malignant diseases" type policies or in long-term nursing care insurance, the price is also dependent upon gender.

The Insurance Commissioner sets guidelines for marketing different insurance coverages in private health insurance programs. These are intended to help individuals make an informed decision regarding their need for each coverage offered as part of a private policy and compare the costs of various types of coverages. An additional reason is that in the opinion of the Commissioner, insured individuals do not always understand that they are purchasing different insurance programs marketed to them in a single package. The Insurance Commissioner's guidelines determined that an insurer will specify in the insurance proposal form what the basic programs and additional programs that can be purchased are, clearly distinguishing between basic and additional programs. Moreover, the insurer must specify to an insured individual the cancellation options of each of the programs they are purchasing (Insurance Circular, 2015).

Group health insurance

Group health insurance is designed for a group of insured individuals in one policy through a policy holder – a single legal entity linked to a certain group of people – that is authorized to sign a group insurance agreement, for example an employer for their employees. Section 2.3 below will address group health insurance in detail.

2.1.5 Insurance types: complementary insurance, substitutive insurance, supplementary insurance

In the Western world, coverage types are divided into several main groups. Since there are occasional differences in definitions of insurance types in the field of health (Fried & Gaydos, 2002), we shall adopt a definition accepted in the European Union. In most cases, a health insurance program can include three main types of coverages.

Complementary (additional) insurance

Complementary insurance generally offers services that are not covered under the statutory scheme such as prescription drugs. Example jurisdictions include Canada and Denmark. Some systems also allow for complementary private insurance to cover costs that are typically left outside the public system (e.g., insurance to cover the cost of user fees). Example jurisdictions include France. The market share for complementary insurance is generally high, given the nature of the insurance. For example, in France, more than 90% of individuals have complementary insurance of some form (Tshernichovsky, 1996).

Substitutive (alternative) insurance

Substitutive insurance covers services included in the health basket or the AHS, however, it also offers alternatives such as choosing a private surgeon, hospitalization in a private hospital, consultation with professionals not included in the health basket and more. In a substitutive insurance, recompenses are paid in full, independent of the coverage given by State insurance or the AHS. This program provides medical insurance for a resident that is not covered by public insurance. Example jurisdictions include Germany. The market share for substitutive insurance is generally smaller than complementary insurance (in Germany the market share for private insurance is approximately 10%).

Supplementary insurance (improving/extending insurance)

Supplementary insurance generally provides access to services that are already available within the publicly financed health insurance scheme but in a more convenient format (presumably affording faster access, greater choice, or other amenities). Example jurisdictions include the UK, Australia, and Sweden. Supplemental private insurance markets tend to have small market shares. For example, the UK market covers approximately 10% of the population (Thomson & Mossialos, 2009).

It is worth mentioning that there are differences between countries in the composition of organizations providing private health insurance policies. In Israel, the definitions of coverage types are slightly different (for example, regarding the definition of alternative

coverage), and in general, coverages in Israel are more heterogeneous and diverse compared with other countries.

2.2 Demographic impact on expenditure on commercial insurance

Expenditure on commercial insurance is influenced by income level to a greater extent than supplementary (AHS) HMO insurance (Tchernichovsky et al., 2016). About 53% of people with high income have a private insurance policy, as do 40% of the population aged 45-64. This is in contrast with 33% of individuals aged 20-44 and 30% among the population aged 65 and above (Social Survey, 2017).

Supplementary insurance and commercial insurance are positively correlated with income, however, the degree of change in the distribution of commercial insurance which accompanies the change in income level is approximately three times higher than change for supplementary insurance. Furthermore, education level of the head of the household has a positive effect on purchasing commercial insurance, while its effect on purchasing supplementary insurance is insubstantial.

The findings correlate with the fact that supplementary insurance has, as stated, public characteristics, and therefore is more accessible. Furthermore, the hypothesis that supplementary insurance encourages and enables moral risk cannot be ruled out. Individuals who require treatment can retroactively purchase a supplementary insurance when they know they need it. This argument is supported in the findings, as expenditure on supplementary insurances increases as do the medical needs of a household. In contrast, no statistical correlation is found between medical needs and expenditure on commercial insurance.

The positive effect that education has on expenditure on commercial insurance may also be related to the fact that employers in orderly workplaces mostly characterized by more educated employees support these insurance policies.

An examination of the distribution of insurance policies s according to population group (following neutralization of all other variables) revealed that the tendency to purchase insurance among Israel's Arab population is less than that of the Jewish population, specifically in purchasing commercial insurance. This behaviour may be explained by the limited possibilities of realizing health insurance in the Arab communities, and possibly as well, by lack of awareness about medical insurance amongst this population. Within the Jewish population, it was found that the ultra-orthodox purchase, on average, fewer commercial insurance policies

than others. The explanation for this relies on the charity and mutual help within the ultra-orthodox community that constitute a kind of self-health insurance.

In general, residence in the periphery has a statistically insignificant negative correlation with purchase of commercial insurance, and a statistically significant negative correlation for the purchase of supplementary insurance. This finding may reinforce the hypothesis that the tendency to purchase insurance is low when the ability to utilize it is low (Tchernichovsky et al., 2016).

2.3 Group (collective) health insurance in Israel

Group health insurance is provided for a group of people with common characteristics that justify arranging a general agreement for that group, and awarding discounts for that reason (Avneon, 1984).

An individual in a group insurance policy is not a direct party to the contract; the parties are only an insurer and a policyholder. The underwriting in the group insurance is not personal, but rather relates to a group's nature (Gilon & Weinrev, 1995). A group insurance contract is, first and foremost, an insurance contract to which both general law and special law apply. General Law is composed mainly of Insurance Contract Law and of General Contract Law (Renner, 1991). Special law applying to group insurance is a specific law, stemming mainly from a special regulation by the secondary legislator through ordinances and/or circulars of the Commissioner of Insurance.

Group health policies is one of insurance branches that has specific regulation (Group Health Insurance Ordinances). A typical group health insurance contract is composed of four parties: insurer, policy holder, insured individual and beneficiary, although it does not have to be based upon four separate parties. As stated, an insurer and a policyholder are the direct parties to the contract and an insured individual is the object of insurance, i.e., the person whose health is insured within a group policy. For example, in a health insurance agreement arranged for a certain group of employees, the employer is the policyholder and an employee is the insured. An employee is the beneficiary of the contract and is entitled to receive the insurance recompenses upon occurrence of an insurance event (Elias, 2016).

Joining group insurances is usually voluntary. At the same time, when an employer pays the full cost of insurance (including the grossed-up tax for the benefit), for an employee, all employees can be added obligatorily (Group Health Insurance Ordinances update, 2015).

Figure 2 shows the three players in a group insurance structure: the insured, the insurance company and the policy holder.

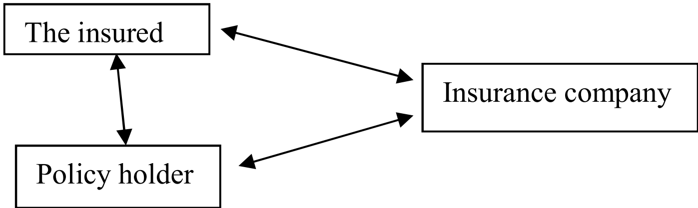

Figure 2: The three factors in group insurance and their interactions

2.3.1 Scope of group health insurance market in Israel

Developments in medicine and technology, demographic changes in Israel and lack of budgeting of the public health system have brought about an increase in consumption of private health insurance. The extent of group health insurance premiums in Israel, including agreements of group insurance of long-term nursing care managed by the HMOs, had in 2018 reached a total of NIS 4.631 billion (about €1.1 billion). According to ordinances of the Commissioner of Insurance, since 2017 it has been forbidden to arrange a long-term nursing care insurance, with the exception of those organized by the HMOs or in insurance settlements that received a special approval from the Commissioner (IDF Pensioners and IDF Disabled Veterans Organization).

The premiums for group insurance with exception of long-term nursing care insurance reach NIS 2.345 billion (about €0.55billion), constituting 34% of the total premiums in health insurance). In 2018 there was an increase of 10.3% in expenditure on private group and personal insurances compared to 2017, and growth of 190% compared to 2008 (Capital Market Commissioner's report, 2018).

2.3.2 Group insurance characteristics

Underlying group insurance is the assumption that large groups of people who join together have the advantage of size, constituting a leverage for better commercial terms vis-à-vis the insurance companies. It is mainly expressed in the scope of benefits and improved insurance terms, and lower cost of insurance (Elias, 2016), and also in terms of facilitating acceptance – often exempting individuals from the need for medical underwriting. Group insurance is widespread amongst employers, employee organizations or groups with a common

denominator constituting a consumer force with much weight, such as the Teachers' Associations, the Israel Defense Forces, the Disabled Veterans Organization and large companies.

However, there are also some shortcomings: not everyone is given an opportunity to join the collective, the period of collective insurance is limited, the sum of recompense and extent of insurance coverage fit the broadest common denominator, so that the needs of each insured individual may not be addressed, and insurance is often limited and does not supply a comprehensive response to needs of the insured.

Group insurance is founded upon mutual guarantee and cross-subsidizing among members. The terms of joining the policy are usually mitigating terms compared to those for taking out private insurance. A policy holder can improve and expand the terms of insurance in terms of what is offered in private insurance and the cost of group insurance is usually fixed for an entire group of employees or is determined according to age groups within that group.

Since group insurance lasts for five years at most (Group Health Insurance Ordinances, 2015), the insurer's risk is lower than individual private insurance in which the obligation, as stated, is for life (as long as the premium is paid). Administrative costs of group insurance are also cheaper for a number of reasons: (a) according to the 2018 Capital Market Commissioner's report, in group health insurance, the agent's commission is 7%, compared to an average commission of 25% in private insurance; (b) there are lower collection expenses, since the payment is usually deducted directly from the employee's pay slip; (c) marketing expenses are cheaper as the target audience is defined, focused, and can be reached via cheap digital means; (d) an employer representing a large number of employees has great bargaining power to obtain a discount at the expense of the insurer. Support for this lies in the rate of recompense (the claims). This rate of recompense for illnesses and hospitalization in group insurance settlements is 90%, as opposed to 45% in individual private insurance (Capital Market Commissioner's report, 2018).

Unlike joining a group insurance, purchasing of private-commercial insurance usually involves submitting a health declaration and undergoing a medical examination. Naturally, over time, the health of a typical insured individual tends to decline, a fact might prevent them from purchasing a different personal insurance, as a potential insurer can reject them due to their health condition, or agree to accept them for a higher premium, while limiting the insurance coverage by excluding prior health issues.

The group policy offered to collectives is approved in advance by the Capital Market, Insurance and Savings Commissioner in the Ministry of Treasury (the “Commissioner”). Any expansion of the insurance requested by the policy holder requires approval from the Commissioner. Additionally, every settlement for a group of over 10,000 individuals also requires special approval from the Commissioner (Commissioner’s Circular, 2015).

A group insurance policy, which is a contract defining the rights and obligations of the insured and the insurer, is attached to the agreement – a contract defining the set of rights and obligations of a policy holder and an insurer, and these two documents together constitute an “insurance agreement”.

2.3.3 Group insurance contract

A “relationship contract”

A group insurance contract is a “relationship contract”, meaning one that regulates long-term relations. In the verdict of Milgrom Hinda (deceased) vs. Merkaz Mishan (1998), Supreme Court President, Aharon Barak, defined the characteristics of a relation contract as one that tries to create a balance between the need for certainty and expectations and the need for flexibility and ability to adjust to changing conditions.

A relation contract is a complete system of relations between parties. Parties to such a contract are perceived as partners that joined together to their mutual benefit rather than as opponents. Therefore, they bear increased obligations of good faith, partnership and solidarity (Porat, 1993).

A “framework contract”

A group insurance agreement is in fact a “framework contract” containing the policies signed between an employee and an insurer (Elias, 2016). In a verdict of Migdal vs. the Organization for Realizing the Treaty for Social Security (2006), the Supreme Court ruled that the combined implementation of the instruction of Clauses 1 and 41 of the Insurance Contract Law reveals that a framework contract agrees with the legal definition of an insurance contract.

A group insurance agreement signed between a policyholder and an insurer is a dual agreement. On one hand, it is an agreement regulating the relationship between a policyholder and an insurer, and on the other, it includes terms of policy coverage, which is an agreement between an insurer and the insured individual. The customary practice is that the terms of a

policy that is a contract between an insured individual and an insurance company are attached as an addendum to the contract, and agreement terms apply to it. As stated, a policyholder (in this case – the employer), is a direct party to an agreement, and is not eligible to enforce the agreement upon an employee, and their joining a policy is usually conditioned upon their consent. A group insurance agreement is in fact an agreement awarding a third party – an employee, a benefit in the form of the privilege of joining the group insurance scheme.

When an insured individual bears the cost of insurance, even if it is just payment of tax for the cost of insurance received from an employer, their consent to join the insurance is required (Group Health Insurance Ordinances, amendment 2017). The reason for this is that in this case the subject is a benefit involving debit, meaning an agreement for debiting a third party, and as such, the third party must actively respond and specifically agree to the contract. When an employer bears the full cost of insurance including tax, the assumption is that an employee – the third party – is interested in receiving the benefit. Therefore, according to Contract Law, there is no requirement for consent to receive this privilege. Enaction of will is required only for rejecting the privilege (Freedman & Cohen, 1991). The verdict of Ayalon vs. Engineers Chamber (2000) determined that, in fact, a group insurance agreement can be considered as an agreement granting an option to an employee to engage in a contract (policy) with an insurer.

2.3.4 Parties to group insurance agreement – distinction between types of insured

The main purpose of Insurance Contract Law is consumer protection of the insured public from the superior strength of the insurers. Legal literature maintains that a distinction between types of insured is required, and consumer settlements of the law should be reduced. Accordingly, there is no reason to prefer a large and strong insured entity such as a bank or a large industrial factory. In this approach, the uniform application of the law to all the insured, strong and weak alike, can be softened through the principle of good faith and its strict application to those insured with financial strength (Shalev, 1990). However, this approach was not adopted in any ruling, inasmuch as the advantage of the insurer over the insured might be expressed in gaps of professional expertise rather than financial ones, and any advantage is enough for a court to rule in a dispute from a consumer viewpoint (Shwartz, 2007).

2.3.5 The policy holder and those insured in group health insurance

The main figure in group health insurance is the policyholder. The term "policyholder" is completely absent from Insurance Contract Law. Clause 1 of the Insurance Contract Law defines parties to a contract, and it states the following: *'an insurance contract is a contract between an insurer and an insured party obligating the insurer in return for insurance fees, to pay, upon occurrence of an insurance event, insurance recompenses to the beneficiary'*.

The policyholder was defined in Clause 1 of the Group Health Insurance Ordinances, as *'the one engaged with an insurer in a health insurance contract for a group of insured individuals. A policy holder is the entity representing the insured group vis-à-vis an insurer, being the one making the insurance contract with an insurer, and in whose name the group policy is registered'*.

Thus, it appears that the one making the group policy is not "insured" but rather a policyholder, as determined in the verdict of Ordan vs. Sahar (2002): *'that who makes the group contract is only formally insured, and the "real" insured paying the premium and entitled to insurance recompenses are the insured'*.

Who is eligible to serve as a policyholder?

According to Clause 2 of the Group Health Insurance Ordinances, those who can serve as policyholders are:

(1) An employer – for their current and retired employees and their family members, even if the current or retired employees are not insured, as well as vis-à-vis family members of current or retired employees who passed away and the insurer continues to insure them.

(2) A corporation – for its members and family members, provided only that making the group health insurance for its members is not the main reason for their incorporation.

(3) A service supplier – for recipients of its service and family members of its insured service recipients, provided only that the service is not in field of insurance, and making a group health insurance is not the main service, and is subject to approval by the Commissioner.

(4) HMOs – for their members, subject to approval by the Commissioner; on the matter of this paragraph, "member" – includes a member whose registration in an HMO was

cancelled according to State Health Insurance Law, but no registration to another HMO was made.

An employer is eligible to be a policyholder and sign an insurance agreement for their current or retired employees, or for family members of current or retired employees, even when they themselves are not insured, and for family members of current or retired employees who passed away as well. As we have seen, Group Health Insurance Ordinances distinguish between the rights of an employer's employee and the rights of a member in another corporation which is not an employer. The Ordinances favour employees, and in fact, enable the insuring of family members even if employees themselves are not insured, for example, in circumstances when an employee is unable to be insured due to their medical condition. The Commissioner seeks to protect the welfare of an employee's family members, even if they do not have a direct linkage to an employer.

According to the Ordinances, a policyholder can be a corporation, as long as the insurance is not the main purpose for its incorporation; in other words, a legal entity such as a trade union or a non-profit association can sign a group insurance agreement for its members and their family members. Additionally, a service provider can be a policyholder and sign an insurance agreement regarding its service recipients and their family members, providing the service is not in the insurance businesses and the essence of the service is not making group health insurance, and an approval is received from the Commissioner to become a policyholder. According to this clause, the Commissioner can approve a legal entity whose linkage to its members is weak, to make a group insurance; for example, an HMO received the Commissioner's approval to make a group long-term nursing insurance, and credit card companies received approval to arrange travel insurance for their credit card holders.

It is important to note that a Workers' Committee is not a legal entity eligible to sign a group insurance agreement. This is reinforced by the court in verdict of Leumi Bank Centre Workers' Committee vs. Shoshana Levi (2003), in an issue when a Workers' Committee was negligent in not anchoring the right of an insured employee when the insurance was transferred from one company to another. The court determined that a Workers' Committee is not a legal entity to be sued, however, the insured is entitled to sue the committee's members individually.

A policyholder's responsibility according to the Group Insurance Ordinances

An employer's responsibility as a policy holder in a group health insurance, relies on obligations determined in clause 3 of the Group Health Insurance Ordinances. As stated in the clause: *'one shall not engage in a group health insurance, unless one acts, as a policy holder, in faith and diligence in favour of the insured alone, having no benefit by being a policyholder [...]'.*

Furthermore, according to the Ordinances, an insurer will not engage with a policyholder unless the latter give the insurer sufficient information regarding the group of individuals to be insured, so that the insurer can maintain their obligations according to law and according to the group health insurance policy.

The role of the policyholder is critical in each stage of an insurance deal: conducting the negotiation, drawing up the contract and ongoing management of the policy, including transfer of insurance fees to the insurer (Elias, 2016).

According to the Ordinances, on one hand, general rather than detailed obligations and instructions apply to a policyholder regarding how they must act as such, and on the other hand, there is no reference in the Ordinances or the Law to any financial or other sanction the Commissioner has, should a policy holder violate their duties. The only recourse is that an insurance company is subject to the Commissioner, who can forbid it to engage with a policyholder unless the policyholder declares in the agreement that their duty will be fulfilled, which, as stated, is general and given to interpretation.

Violations of a policyholder's obligation according to ordinances and other laws, as will be described below, are similar to violating a legislated obligation that can be used in a Torts claim by an employee or a Workers' Committee towards an employer, or in case of an employer's contract violation towards an insurer.

As stated, the Commissioner can enforce the obligation of a policyholder through insurance companies that are subject to his or her authority.

2.4 Employer's ethics and responsibility

Organizational ethics is the perception of proper behaviour as part of an organization, among other things, the proper behaviour of its employees and owners. Organizational ethics is a system of principles aiming to guide the routine activity of its members, as well as in situations of conflict and in emergency (Bukszpan & Kasher, 2005).

"Responsibility" is a multi-faceted expression. It is an ethical value - the proper attitude towards one's words, actions and the trust one is given. It is also one's involvement in either causing a situation or not preventing it when one should have. Responsibility also describes the complex of obligations imposed upon an individual by virtue of their position or authority, or by virtue of an obligation they have undertaken (Levinas, 1995).

The responsibility of an employer towards an employee covers several fields, and it is sufficient to mention emissary responsibility determined in Clause 13 of the Torts Ordinance - responsibility for the safety and wellbeing of an employee, and for creating a safe work environment (verdict of Oved Izhak vs. Lotem Marketing, 2015) and for preventing sexual harassment (Sexual Harassment Law, 2017).

A corporation's role is not limited to maximizing its profits, but rather, its duty is to act to promote of the well-being of its internal society, i.e., among its employees (Geva, 2011).

2.4.1 Responsibility for privacy protection

Employers' involvement in each of the stages of group insurance settlements enables access to medical information about insured employees, and therefore, employers have an obligation to protect their employees' privacy and safeguard their medical information.

Israeli Law recognizes the protection of the right to privacy, which became a basic right as part of its fundamental laws: Human Dignity and Liberty (1992) and as well the Privacy Protection Law (1981).

In most cases, the essence of violation of privacy, amongst other things, is exposing information regarding someone's personal data, including their state of health.

Clause 2 of the Privacy Protection Law defines a series of actions which constitute "violation of privacy", including violating an obligation to confidentiality regarding an individual's private affairs, and use of information regarding such private affairs or passing it on to another, for a purpose other than that for which it was given.

Amongst other things, the Privacy Protection Law addresses databases and direct mailing. Clause 8 of this law obligates database owners to register any database with the database registrar and to appoint an executive responsible for each database. Clause 9 determines that the purposes the database was established for and the purposes for which the information is intended must be specified. Moreover, the law forbids use of information in a

database for purposes other than that for which the database was established or for which the information was intended (Privacy Protection Law, 1981).

2.4.2 Employer's responsibility according to Corporate Law

Corporate Law, Clause 11(a) (1999) states that *'the purpose of a corporation is to operate according to business considerations for maximizing its profits, and within these considerations, amongst other things, the interests of its creditors, its employees and public interest can be taken into account [...]'*; the tension between a corporation's aim to maximize profits and the caring for the interests of its employees has been discussed in multiple verdicts and papers.

The verdict of Miriam Freedman vs. Yuniyuv (2002) determined that the special status of an employee in their engagement with a corporation creates a special and increased level of corporate responsibility, including its controlling interest owners towards an employee, the origin of which is an obligation of good faith the company has as part of contractual relations with the employee.

Corporate Law, Clause 11 should be given a high preliminary status, however, as determined by the clause itself, as part of overall business considerations of a business corporation intended to maximize its profits, it is actually required to address broader social considerations that occasionally might even surpass those of maximizing profits (Bukszpan, 2012).

An integrative view and considering other groups, such as employees, suppliers, creditors and the general public, and cooperation and affinity among all those involved in the corporation's "community", will indirectly contribute to the interest of a corporation to maximize its profits (La Porta et al., 1997). However, Ben-Israel (2002) indicates that imposing an obligation of loyalty upon an employer towards an employee might erode the managerial privilege of an employer. In other words, including employees and considering their position might harm the managerial directive given to an employer.

2.5 Organizational ethics

Organizational ethics is responsibility for an organization's behaviour beyond the limitations of the law, and it encompasses activities expected of an organization, or activities an organization is prevented from executing, despite these not being illegal.

This responsibility includes acting according to standards, norms and societal expectations. At times, an organization's activities executed in light of social norms become, over time, additions to state laws, and in fact become a part of the legal responsibility of an organization. For example, the Sexual Harassment Law in the work environment (passed in Israel in 2017) began as a norm, and is currently anchored in law in developed countries.

The ethical code in an organization determines the obligation of proper behaviour as part of every activity, as well as the obligation of caution regarding the appearance of improper behaviour (Bukszpan, 2012).

Organizational ethics is significant due to increased awareness of employee rights and fair treatment (Izraeli & Shilo, 2000). Ethical management of human resources is a combination of an organization's orientation vis-à-vis employee interests while allowing them to have a voice and be involved (Greenwood & Freeman, 2011).

2.6 Employer's actions in group insurance settlements

Group health insurance is an important layer in the array of employee welfare terms. Rhoades and Eisenberger (2002) found that the perception of employees in an organization that supports and cares for their personal and professional welfare increases satisfaction at work. Similar findings were reached in a study by Johnson (2012), who conducted a study amongst policemen.

2.6.1 Inclusion of employees in decision-making

Use of the term "inclusion of employees" appears in various contexts, and it has no uniform and acceptable meaning, although there are a number of typical goals for inclusion of employees.

Blumberg (1968) believes that the inclusion of employees helps to increase their identification with their workplace and their obligation towards it, a means of improving social climate and reducing dissatisfaction, alienation, and stress at work.

Strauss and Rosenstein (1970) believe that the ideas embodied in inclusion of employees in management and work represent a mixture of different and diverse morals, purposes and expectations. They give several reasons for the inclusion of employees:

1) Ideological – bridging between centralized management systems and social ideals of inclusion and equality.
2) Instrumental– resolving conflicts between management and employees, raising work productivity, increasing employee satisfaction, improving work relations and motivating (mainly educated) candidates to join the organization.

Rozner (1971) maintains that inclusion in decision-making means inclusion in a process of mutual influence between various entities which amounts to making mutual decisions which obligate all participants. He considers inclusion of employees in management as the most important challenge of the current labour world and foresees that application of various forms of inclusion will lead to more cooperative management styles and communication.

Ben-Israel (1976) emphasizes that involvement of employees in formulating their terms of engagement will significantly improve their status, as negotiating terms of employment allows employees to live with dignity. She summed up the complexity of inclusion goals in three clusters:

1) Ethical – neutralizing antagonism of an employee towards work, assigning work a human character and pouring new content into work.
2) Social and political– aimed at integrating employees into their workplace, thereby bringing about industrial democracy in its basic form: mutual managing of representatives of employees in the institutions of an industrial plant.
3) Financial – increasing work productivity as a result of the inclusion.

The hypothesis underpinning programs for the inclusion of employees is that this might advance the goals of both the employee and the organization (Shirom, 1983).

Palgi (1984) presents two main goals for inclusion:

1) Political – equalizing power in an organization and in society, preventing alienation of individuals from the organization and from society. From this attitude stems a need for long-term change in the social and organizational order.

2) Motivational – increasing motivation to work, invest in the organization, take initiative and belong to the organization. This does not mean a radical organizational change, but rather emphasizes a change of attitude towards the employees.

A very significant revolution is taking place, bringing about a gradual change in management culture and style; managing through power is being replaced by the ability to lead. Traditional management based on hierarchy is disappearing and is being replaced by management founded upon trust and values. Employees are smart and loyal, independent and initiating and managers are more democratic and decentralized. Communication, mutuality and exchanges of information are of the utmost importance (Shenhar, 1990).

Erez (1990) makes a similar distinction between an approach that considers the inclusion of employees as a way of life, supporting self-realization, autonomy, realizing achievements and developing self-identity.

Raday (1994) maintained that an employer's prerogative should be limited, and negotiation with employees regarding financial decisions should be encouraged. In his opinion, inclusion of employees in management and imposing an obligation to consult, will be a financial incentive to an employer to negotiate with their employees in order to minimize damages and increase profits.

In most cases, a positive correlation is found between leadership founded upon consideration and placing an employee at the centre, and satisfaction with the workplace. We live in a century in which the assurance of an employee's social dignity, relating to both financial and human dignity, has been recognized as a social human right at work, and thus it obligates employers to grant their employees a voice in decision-making at work (O'Leary-Kelly & Griffin, 1995).

A positive correlation was also found between involvement in decision-making and workplace satisfaction (Bennett, 1997).

Ben-Israel (2002) further maintained that in principle, there is no legal reason why all subjects related to operating a plant should not be open for negotiation between an employee and an employer. However, reality shows that negotiation between the parties is conducted only for part of the managerial, organizational and financial issues requiring a decision. He goes on to claim that the boundary between issues for which the decision is up to the employer, and those that are open to employer-employee negotiation is changing.

Natanzon (2015) indicates that the inclusion of employees in strategic decision-making is in the mutual interest of managers and employees, as they become partners in shaping the structure of a company and its personnel proves itself as a tool for the organization's optimization.

2.6.2 Obligation to consult

The importance of consulting lies in the fact that consultation enables one to receive updated information from professionals, given from a different perspective than that of the decision-maker, and thus improves the decision-making process. According to the Israeli State Comptroller's Report on the subject of regularizing group long-term nursing care insurance (2017), on the one hand, policy holders in insurance settlements are responsible for the people they have insured, but on the other, they may have information gaps in specific professional fields.

Legally, the obligation to consult professionals in certain conditions applies to public or administrative authorities.

In Israel, group insurance policies cover over 4,000,000 individuals (Commissioner's report, 2018) with significant premiums and are the result of an agreement between a policyholder and an insurance company (regarding which was stated: *'... in many fields of their activity insurance companies fill a clear public role. And therefore, they occasionally should be subject to obligations from public law'* [verdict of Chevra Kadisha Burial Society "Kehilat Yerushalaim" vs. Kastenbaum, 1992]). These data invite an examination of the employer's obligation to consult professionals regarding group insurance settlements.

In the verdict of Yosef Fuxman vs. Transportation Commissioner (1966), the Supreme Court determined that the obligation imposed by the legislator upon an administrative authority to consult with a certain body before acting is an important restriction to its legal authority. That same verdict stated that the recipient of the consultation should provide the consultant with enough information and enough time to provide the consultation. The obligation set in the law obligates a "real consultation". In a verdict of the Association of Engineers and Architects in Israel et al. vs. Minister of Labour (1980), the Supreme Court stated that the recipient of the consultation must listen to it with a "receptive mind". In the matter of Azriel et al. vs. Licensing Department Director (1978), the Supreme Court further stated that the consultation is a bilateral process – the consultant factor and the recipient, who should take heed openheartedly and

willingly of the advice presented. We may say that the qualified authority that is obliged to consult, must relate to the advice prior to making a decision, as an important, matter-of-fact consideration should be related to (Zamir, 1986).

2.6.3 Competitive procedure for choosing an insurer and optimal engagement terms

Tender rules characterize those bids admissible in a tender and include every decision defining the winning bid and how it is to be chosen. Many an advantage appears in the literature for allocating assets through tenders, not just for maximizing commercial terms (price), but also for regularization of processes, increasing trust and public benefit, including transparency and fairness, disclosure of information and Pareto efficiency. Occasionally, in a tender, one benefit of an item in a tender (for example, low price of a demanded service or product) will detract from the benefit of other items in the tender (for example quality of product, availability thereof) (Jechiel & Moldovani, 2003).

The Commissioner's report from 2018 revealed that the CR3 index is at 82%, meaning that three insurance companies control the field of group health insurance in Israel. The “refund-settlement” reform in field of surgery insurance (Economic Plan Law, 2016), according to which the insurance programs for surgeries and surgery replacement treatments in Israel will be identical, and all service providers will have an agreement with the insured, invites us, upon choosing an insuring company, to examine other parameters besides price, such as the list and quality of service providers who have an agreement with the insurer, and indexes of service, claims and operation.

Tender Obligation Law

The purpose of the Tender Obligation Law (1992) is to ensure the existence of fair competition in purchasing by public entities, including companies of public ownership (Amoray, 1995), and it constitutes a normative frame for state tenders and its corporations (Shalev, 1996). Tender Obligation Law addresses an encounter between law and economy. Both are interwoven and are usually influenced by the perspective of a legislator or a law interpreter, from both a financial and a legal aspect. The legal aspect stems from the principle that government is nothing but a trustee of the public, and when the government decides to sell or buy, or to make an agreement with anyone from the public, it must give equal opportunity to everyone. This is its duty as public trustee. The financial aspect places competition as a

mechanism for improving financial activity, and the law passed in 1992 is founded upon these principles (Meridor, 1995). A tender is a financial legal tool for attaining the best results for the Authority, while maintaining the basic principles of public administration activity. A tender is an institutionalized framework for negotiating towards contract signing by way of competition between various bids (Shalev, 1996).

Indeed, the use of tenders has grown in the business-financial world as a means of guaranteeing optimal business results for a tender owner, however, over the years, tenders have become a common process, at times vital in public law, and thus tender laws have evolved. And indeed, public tenders – as an organic part of public law – fundamentally assume the obligation of a public authority to act as a public trustee. From this assumption stem public tender laws with their principles, rules and details. A tender has two purposes: financial and public. Financially, a tender is designed to obtain as many suitable bids as possible in order to choose the best and most convenient one. Publicly, a tender is intended to ensure integrity, equality and fairness by opening it up to as many bidders as possible, on the basis of fair competition in equal conditions. Thus, tender laws express both the aspiration to act with prudence and efficiency regarding public funds by attaining maximal advantages for the tender request owner, as well as the realization of the principle of equality by giving equal opportunity to all bidders (Shalev, 1996).

Unlike other pre-contractual proceedings, a tender is characterized by its competitive nature. Judge Berenson defined it in the verdict of Beit Ariza Rehovot vs. Minister of Agriculture (1961) as a *'fair competition in conditions of equality'*. Judge Barak in the verdict of Invest Impact vs. Ministry of Health Director General (1983) indicated that what characterizes a tender is the existence of "organized competition", i.e., the creation of an organized framework, sort of a market, in which bids are asked for and accepted, after being examined against one another in free competition between them.

And indeed, the equality principle, which is the most important principle for tenders, derives from its essence and competitive nature (High Court of Justice petition of Kopatz vs. Minister of Interior, 1977). A competition with no equality cannot be fair. According to the equality principle, all tender participants are entitled to have equal status. As stated by Judge Landoy in the verdict of Sherman vs. Minister of Labour (1968), equality of terms of competition amongst bidders and in relation to a tender request owner to the bidders is "the living soul of a tender".

The Tender Obligation Law (1992), with its added multiple secondary legislations, creates a spectrum of balance points between opposing and competing interests. For example: how to improve the engagement system of a country's authorities and reduce public cost through a tender on one hand, while on the other, equipping the country with sharp efficient tools, by means of which to achieve desired deals from public and financial aspects, also not by way of a tender (Gliksberg, 1995).

Laws also obligate those public entities that have tender obligations to occasionally adjust the terms of a tender to market conditions, and according to the opinion of professionals. In an insurance tender, it is very difficult to create a literal and closed specification, as each insurance company has different and unique policy terms, even in terms of phrasing. Hence, there is practical difficulty in adhering to the strict literal rules. An insurance tender, where a public entity is requested to insure all its activities and entities under its responsibility, is not a standard tender, but rather a complex one, conducted as a "sort of tender" that by nature is a more flexible proceeding, enabling the public authority to adjust it to the unique character of engagement, according to the set criteria (verdict of Givon Insurance Agency Ltd. vs. Rishon-Letzion City Hall, 1994).

Private tender

Initially, tenders grew in the financial-business world as a means of ensuring optimal business results for owners of a private tender. However, as stated, over the years, the tender has become a common, and occasionally vital, proceeding in public law, through which tender laws have developed. In recent decades, an innovative trend has appeared in Israeli law, which in terms of the development of tender laws can be described as a "closure", returning from public law to private law (Shalev, 1998).

On the issue of Beit Yules vs. Raviv (1982), the status of the principle of freedom of contracts was discussed. The question raised was whether the duty to act equally towards participants in a public tender applies to private law as well. And from this question a second question is derived: does a law of private tenders exist in Israel? Professor Shalev maintains that the response to these questions stems from a legal viewpoint regarding the status and extent of the application of the principle of contract freedom in modern Israeli law (Shalev, 1998).

In the verdict of Beit Yules vs. Raviv (1982), the Supreme Court determined that tender proceedings are pre-contractual and therefore, the acceptable general legal norms apply to them

(Torts Laws, Contract Law) as does the obligation of good faith determined in Clause 12 of the Contract Law. Additionally, it determined that there is no automatic obligation to act with equality between bidders in any matter, but rather, each factual system should be examined individually to decide whether an obligation to act with equality between all bidders applies to the tender owner. Judge Barak maintained that the parties partaking in a tender should act without discrimination, while giving equal attention and creating a framework of competition in conditions of equality.

Thus, this trend introduced by president of Supreme Court Judge Barak, applies public tender laws to private tenders, however with changes and adaptations, and it is possible to say that it creates a special law for private tenders in Israeli law.

Shalev (1998) states there is no obligation to act with equality in a private tender, and therefore, there are no actual private tender laws in Israeli law. And conversely: a worldview according to which there is broad leeway to interfere with the freedom of contracts in the name of other principles such good faith, leads towards extending the obligation of equality to private tenders, and acknowledging a law of private tenders in Israel.

Keren (2001) presents the legal status customary in Israel regarding the obligation of equality in private-contractual relations. On the matter of Beit Yules vs. Raviv (1982), it was indeed ruled that the obligation of equality is not to be imposed in the context of a private tender. Nonetheless, Keren maintains that the position of Judge Barak in the verdict of Chevra Kadisha Burial Society "Kehilat Yerushalaim" vs. Kastenbaum (1992) implied that the obligation of equality might reach contract laws through the comprehensive obligation of contract parties, even if they are private, to respect the basic rights of others.

In the verdict of S. R. Avodot Tzaneret vs. Hafetz Haim (2001), Judge Azulay determined that *'the claims put forward regarding the violation of tender principles concerning the principle of equality amongst tender participants and the need to insist on maintaining preliminary terms of a tender – apply with different emphases both to private tenders and to public tenders'*.

Obligation of competitive proceedings on the matter of choosing a provident fund

It is worth examining instructions on the matter of areas of insurance that deal in protecting the safety and future of the insured. Thus, a 2016 circular of instructions on the matter of choosing a provident fund instructs an employer to conduct a competitive proceeding to choose a provident fund for maximal period of 5 years (Commissioner's Circular, 2016). The

circular additionally set terms for choosing a provident fund with criteria and weights according to which a provident fund should be selected, including indexes of service, return and rate of management fee set in clause 7b of the circular.

2.6.4 Information and obligation of disclosure to the insured

Obligation of information disclosure according to agency law

The responsibility of a policyholder towards the insured was anchored in court based on Agency Law (1965) (Barak, 1996). In the verdict of Amzaleg vs. Sahar (2004), the court stated that the policyholder served as an agent of the insured, and as such, should have acted according to the instructions of Clause 8(1) of the Agency Law: *'should an individual undertake to be an agent [...] will reveal to the sender any information and will give them any document regarding the subject of agency and give them a report of their activities'*. The duties of an employer according to Agency Law will be discussed at length further on, in a section on the legal responsibility of a policyholder.

Obligation of information disclosure to an insured individual according to Insurance Contract Law

The Legislator assigned great importance to the obligation of information and disclosure an insurer must present to the insured (Insurance Contract Law, 1981). Clause 2 obligates an insurer, after signing a contract, to deliver to the insured a document specifying the rights and obligations of the parties.

Information gaps

Information upon joining an insurance plan or in case of change in insurance terms

The State Comptroller's report on the subject of regularizing group long-term nursing care insurance (2017) determined there was a substantial gap between the method by which part of the insured public understood the essence of group long-term nursing care insurance, and the characteristics of such policies marketed to the public.

Studies and surveys have revealed a lack of information regarding all matters of the rights of insured individuals regarding receiving medical services and fully realizing their rights

according to terms of supplementary insurance and private (personal or group) insurance. To bridge these information gaps, the Commissioner for Insurance set rules instructing an insurance company or an insurance agent acting on its behalf to clarify and adjust the insurance to the needs of the insured (Clause 3, Insurance Engagement Circular, 2016). Clause 5 instructs an insurer to ask questions and provide the insured with information suitable to their characteristics, age and language. An insurer must act in fairness and deliver credible information including a description of the essence of the insurance coverage, its cost and insurance period. Instructions of this clause do not apply to joining a group health insurance should a policy holder bear the full insurance cost including tax value due to the insurance benefit. Clause 7 of that circular determines that where insurance coverage is added, a document should be delivered specifying the insurance terms, its cost, period and any other relevant information.

The Commissioner of Insurance determined that at the beginning of the insurance period, an insurer must give every insured individual a full disclosure form – an abstract specifying the insurance coverages and terms, the policy, and insurance fact sheet containing details of the insured and unique terms regarding the specific insured individual (such as medical exclusion) (Clause 6(a), Group Health Insurance Ordinances amendment, 2017).

Upon change in policy terms or insurance cost, the insurer is obliged to send an insured individual information specifying the change 60 days in advance. If there is a significant rise in the premium payments, over NIS 15 or 50%, whichever is lower, explicit consent from an insured individual is required (Clause 7(a), Group Health Insurance Ordinances amendment, 2017).

The Commissioner of Insurance provided the citizens with two tools which enable receipt of full information in order to make an informed decision. The first is a website called “The insurance mountain”, enabling receipt of information regarding all the policies the insured individual has, and the other is a price-comparing simulator regarding the principal insurance coverages – transplants and treatments abroad, medications not included in the health basket and surgeries.

Information in case of termination of employment

Terminating the insurance policy for a particular employee due to dismissal, leaving a workplace or the decision of an insurance company not to continue the engagement at the end

of the period determined in an insurance agreement, has double meaning: losing preferable terms which exist in a collective policy and losing the privilege of paying a low premium.

When a group insurance policy ends and is not renewed for all or some of the insured individuals, either with the same or a different insurer, the insurance company is obligated to inform the insured individual within 30 days regarding their right to purchase a private insurance program offered to the general population at that time. It is the right of an insured individual to transfer to private insurance with full insurance continuity, meaning, they need not fill out any new health declaration, and there will be no qualification periods, with the exception of insurance coverages not included in the group insurance. Additionally, an insured individual will be eligible for a discount upon purchasing private insurance according to their age, should this be determined in the group agreement (Clause 7(a2), Group Health Insurance Ordinances, 2015).

Where leaving a workplace is due to employment termination or retirement, the insurance company is obligated to inform an insured individual, within the times specified in the Ordinances, regarding termination of their eligibility according to the group insurance, and regarding rights to continuity as part of a private policy (Clause 7(a3), Group Health Insurance Ordinances, 2015). It should be noted that an employer and an insurance company can agree that in case of termination of employment, the insured will be enabled to continue the group insurance until end of agreement period (5 years at the most). The rationale is, amongst other things, to provide a response to the insured for an intermediate period until they join a group insurance in another workplace or to save on insurance costs for a limited period of time (Clause 8(c), Group Health Insurance Ordinances, 2015).

When a group insurance is renewed with another insurer, the new insurer has an obligation to inform the insured regarding the renewal. Termination of an insurance agreement and its renewal with a different insurance company is a common situation, and in such cases, the Ordinances do not obligate an insurance company to inform the insured regarding the expected termination of insurance, and as stated, the obligation only applies to the new insurance company. Without reducing the obligation of the new insurance company to inform the insured regarding renewal of insurance, according to the researcher, in these cases it is the policyholder who is obliged to inform the insured regarding the expected termination of insurance and their transfer to a new insurance company.

Information regarding medical rights

A survey on customer awareness of their medical rights published by the Israel Consumer Council (2012) revealed the following data:

a. 75% of the public have additional health insurances beyond the basic service basket.

b. The survey reveals a high rate of ambiguity in the public to conduct an informed examination of medical services. 30% of the respondents purchase the AHS following recommendations, as "everyone has them" or they just "don't know", and another 10% do not want to take risks.

Over the years, multiple bills have been submitted in order to find a way to facilitate payments of health insurance for the insured, which has become a burden on the insured public. A social survey (2017) found that 48.8% of people aged 20-44 and 47.55% of those aged 45-64 have no information regarding their rights within the healthcare system.

Impact of behavioural economy on delivering information and reporting, and way of choosing insurance plans

Behavioural economy is a branch of research combining aspects of psychology, economy, and decision-making. Research in behavioural economy strives to identify variables such as thinking, emotion and environmental clues, and empirically examine how they affect behaviour. Through careful use of behavioural research insights, one can shape an environment that does not limit freedom of choice or provide material incentives, but rather helps individuals realize their goals, and encourages a healthier, more economical and safer lifestyle.

"Nudge" is a key term in behavioural economy theory, meaning a sort of "clue" in information or the physical environment that encourages a certain behaviour – without the use of material incentives and without limiting freedom of choice. The principles of Nudge Theory include use of light and clear messages, use of authoritative figures, etc. (Thaler & Sunstein, 2008). Different actions are distinguished by their complexity level, and most people have difficulty executing particularly complex actions requiring proficiency, and in such cases, an effective Nudge can improve decision-making, simplify the decision and bring about a better-informed choice. For example, choosing a health insurance program can be extremely complex, and simplifying existing options is expected to improve freedom of choice.

Thaler and Sunstein (2008) demonstrated how, by this method, policy makers can affect the public's decision-making through the design of choices by a "choice architect". According to this approach, through behavioural tools it is possible to influence people's decisions in favour of a choice that is probably preferable for them, without forcing this choice upon them. Occasionally, it is possible to discern between different possibilities according to clear distinct parameters, and at times, alternatives are confusing and do not facilitate an informed choice. The role of a choice architect is to simplify information so that it has meaning and is comparable.

In most cases, as part of a group health insurance agreement, employees are offered a single policy including a bundle of insurance coverages. Naturally, the insured have the right to compare the insurance proposed by an employer with other private policies offered in the market, however, an employer's proposal is a default for an employee. Studies have found that when a default exists, most examined subjects chose to adhere to that option (Samuelson & Zeckhauser, 1988). Additionally, it was found that choosing a default greatly affects multiple fields, including the choosing of an insurance policy (Johnson et. al., 1993). Therefore, there is an increased obligation of an employer to inform the insured regarding their rights in the proposed insurance, and regarding its benefits compared to alternatives offered on the market.

Automatic registration to increase employee participation in health insurance plans

Evidence from additional policy fields suggests that a behavioural approach to the subject of health insurance participation may produce productive perceptions (Bertrand et al., 2006). For example, studies of employee participation in 401K plans in the USA have found that registration in such plans increases significantly when employees are registered automatically (Madrian & Shea, 2001). These findings led to legislative and governing changes to encourage the adoption of automatic registration to increase retirement savings. Although researchers are progressively bringing behavioural perceptions to accept the specific questions related to health insurance and healthcare policy (Frank, 2007), a wide-ranging picture is not yet clear.

Long and complicated applications cause decrease in participation

There is some confirmation of the influence of transaction expenses on the use of health insurance. For instance, extended applications and complex eligibility guidelines seem to lessen

enrolment in Medicaid in the USA (CMS, 2011), while support during enrolment may increase participation (Aizer, 2003).

Choice Overload and Complexity is a descriptive finding from psychology, choice overload means that as the number of options in a choice set expands, people can become overwhelmed and thus choose nothing. Tests in which participants are given more choices show that they are less likely to make a purchase (Iyengar & Lepper, 2000). There is some evidence of this in retirement plans when the more choices that employers propose, the less likely it is that employees will take part (Huberman, Iyengar & Jiang, 2004). The conclusion about retirement plan selections is quite like employer-sponsored health insurance choices. There is also some reliable, direct evidence from Medicare Advantage, where enrolment rates first increase with the number of options, however ultimately, they drop as the choices increase (McWilliams et al., 2011). In Medicare Part D, surveyed pensioners preferred fewer options (Rice et al., 2010), although trial evidence has not found a link between the number of choices in Part D and the chance of enrolment (Bundorf & Szrek, 2010). The specific case of Choice Overload relates to a broader finding in psychology that individuals are discouraged by challenging choices and in such situations often avoid choosing entirely (Tversky & Shafir, 1992). Choosing a health insurance plan is complex due to the obvious difficulties that individuals have in choosing plans optimally, as in Medicare Part D (Abaluck & Gruber, 2011). One result of this complexity is that it may reduce participation as individuals delay choosing: “It’s too hard to choose – I’ll deal with this tomorrow”.

There is also evidence that even for the uninsured who do not meet the requirements for public programs, private coverage is regularly available and affordable. The main way for individuals to register for private insurance in the United States is through their employers, although the acceptance of these procedures is far from complete. More than 80% of those offered insurance by an employer accept it (Fronstin, 2007). Those who decline mostly say that other coverage is offered to them, although about one quarter declare that they are not able to afford the coverage (Fronstin, 2007).

Following studies in behavioural economy, certain changes were made in the Israeli insurance market. For example, the Commissioner of Insurance revealed that some insured individuals purchased personal accident insurance without understanding its content. Moreover, many individuals over-insured themselves by purchasing several insurance policies beyond their needs. Consequently, insurance companies and insurance agents were instructed that following a phone-sale conversation, a text message must be sent, and the deal is only made

valid after the individual confirms by return message that they are interested in the insurance (Personal Accidents Insurance Circular, 2019). The same is true for any increase in administrative fees in pension savings, an insurance company must send the individual a text message informing of the increase 30 days prior to the administrative fees update, so they may examine and consider other alternatives. Additionally, a periodical report sent to the insured public will indicate the rate of administrative fees they pay compared to average administrative fees paid in the same saving model (Administrative Fees Circular, 2017), so that here, too, an individual can compare and consider alternatives.

2.7 Obligations of the insurer and policy holder from the perspective of Group Insurance Ordinances

2.7.1 Insurers' obligations

As delineated in previous sections, the Group Health Insurance Ordinances (2015) and subsequent Commissioner's circulars delineate the obligations of an insurer towards the insured, from the offer to join a group insurance until the termination of insurance period, including delivery of documents, informing the insured regarding their insurance rights, changes, costs, continuity, etc.

The obligations specified in the Commissioner's circulars and instructions include the following: a set of rules for clarifying and settling insurance claims, including forms, details and information required for dismissal of a claim, as well as deadlines obligating an insurer to respond to the insured (Clarifying and Settling Claims Circular, 2016); the method of delivering information and reports to the insured, and the use of digital means and tools to compare insurance plans (Instructions for Health Insurance Plans and Policies Circular 2018); the Phrasing Instructions for Insurance Plans Circular (2016) instructs insurance companies, amongst other things, to remove exceptions and restrictions, to phrase coverages clearly and explicitly; the Revealing and Reporting to the Insured Circular (2018), specifies the method of informing the insured of any increase in insurance cost, delivering the annual report, specifying information to appear on insurance details page, the obligation to append a "proper disclosure" and guiding document prior to joining the insurance by comparative tools regarding insurance cost and service indexes published by the Commissioner. Needless to say, regulations regarding "uniform surgical insurance" facilitated price comparisons between insurance companies, and greater certainty amongst the insured (Supervision of Financial Services Ordinances, 2015).

2.7.2 Policyholders' obligations

The obligations of a policyholder are determined in Clause 3 of the Group Insurance Ordinances (amendment 2017). These obligations are informed by the Trust Law (1979), as detailed below.

Good faith and diligence in favour of the insured

Clause 3, as stated, determines that a policy holder must act in "good faith and diligence". In order for policyholders to be able to fulfil their duties towards a group of insured individuals, it must be guaranteed that they have at their disposal all the information concerning the group insurance. Thus, for example, a policyholder requires information regarding claims attempts of a group of insured in order to make a decision whether to continue and engage in a group insurance contract, with which insurer, and on which terms (Delivering Information to a Policy Holder in Group Insurance Circular, 2009).

This obligation is based on Clause 10(b) of the Trust Law (1979) which determines that amongst other obligations and authorities of a trustee: *'in filling his duties a trustee must act in good faith and diligence, as a reasonable individual would have in the same circumstances'*.

In the verdict of John Doe vs. District Committee of The Bar Association Tel-Aviv-Jaffa (1973), the Supreme Court interpreted the term "trust" or "faith" as – credibility, honesty, and dedication, and the term "dedication" as diligence. According to Academy of the Hebrew Language, *'diligence is persistence, industriousness and doing something without intermission'*.

We can see that in different verdicts, the courts attempt to interpret the term "due diligence" in an effort to estimate the action of an individual in particular circumstances. For example: proper and reasonable diligence (verdict of Basamia Abed vs. B.Y. Agriculture and Sons, 2016), expected diligence (verdict of Jalao Bimero vs. Internal Affairs Department, 2014). On the matter of the behaviour of the plaintiff to locate the offending driver in a car accident whose details were unknown, Judge Rivlin related to the examination of due diligence while focusing on an interpretation of "probability" and outlined a path to implement judicial opinion for courts discussing a matter of retrieving details of an offending driver – known as the "Koren ruling" (verdict of Karnit vs. Koren, 2009).

Clause 12 of the Trust Law entitled "responsibility" determines: (a) *'a trustee is responsible for damage caused to trust assets or beneficiaries due to violation of the trust…'* and (b) *'the court is entitled to dismiss a trustee from entire or partial responsibility, if he acted in good faith and intended to fulfil his duty'*. Kerem (2004) maintains that a trustee cannot be dismissed from obligation to act in good faith and diligence as a reasonable individual, as required by Clause 10(b) of the Trust Law. Additionally, an exemption given to a trustee in trust terms, from responsibility for damage caused to trust assets due to breach of obligation as a trustee (Clause 12(b)) will have no validity. The reason for that is that the legislator considers maintaining its cogent instructions a public interest, originated in greater good, and obstruction thereof is not to be permitted.

The fundamental obligation assigned to a trustee, as presented in Kerem's book, is the obligation of trust. Above all, an obligation of avoiding a conflict of interests appears as a limitation. Obligation to act in good faith and diligence and without conflict of interests is expressed in the regularization of consulting and marketing of provident funds and pension plans. Clause 15 of the Supervision of Financial Services Law (2005), entitled "obligation of trust' determines that *'a license owner will act in favour of his clients in good faith and diligence, will not prefer his or another's interests over the best interests of his clients…'*. It appears that in all matters of pension consulting, the Commissioner considers the terms of good faith and diligence as part of the obligation of trust assigned to a pension consultant.

Prohibition of receiving benefits and conflict of interests

As stated, underlying Clause 3 of the Group Health Insurance Ordinances is a policyholder's obligation not to have any conflict of interests, particularly ones with financial considerations. Reinforcement of this position is expressed in Clause 14 (amendment, 2017), which forbids payment of fees to an insurance agent connected to a policyholder.

The policy holder represents the insured, and therefore, obligations derived from agency and trust law apply to them. In his book, New Corporate Laws, Prof. Procaccia (1989) presents the "representative problem", meaning that an individual appointed as an agent or a trustee might occasionally prefer their personal interests over the interests of those they represent. This inherent problem has no perfect solution. Although Prof. Procaccia was writing about a general representative problem, in her opinion, the representative problem exists in regard to policyholders of group insurance as well.

An important rule that has a strong and inseparable bond with the principle of trust, is that which forbids position holders who have an obligation of trust to put themselves in a situation where there is even a concern of conflict of interests between their personal interests and the interests of an individual or the public in whose favour they must act. Clause 13(a) of the Trust Law determines: *'a trustee shall not purchase for himself or for his relative an asset from assets of a trust or any privilege in it, shall not gain for himself or for his relative any other benefit from the trust assets or from its actions, and shall not do anything that contradicts the trust, best interest or the interests of himself or his relative'*. One of the basic obligations of a trustee is the obligation *'not to put himself in a situation of a possible clash between his obligation as a trustee and personal favour [...]'* (verdict of Levitin vs. Attorney General to the Israeli Government, 1954).

The approach of Israeli law in all matters of conflict of interests is expressed in a paper by Prof. Aharon Barak: *'... the rule is that anyone performing an action or filling a role for another, must not be in a situation in which a conflict of interest might arise between the interest of the one he acts for and some other interest.'* Prof. Barak emphasizes that the rule prohibits an individual from having any conflict of interests and clarifies this while emphasizing the prohibition itself, regardless of an essential relation to its practical implications (Barak, 1980). The prohibition not only relates to the judgement itself while performing the action or the role, but also to being in a situation in which there might be a conflict of interests. To enable a beneficiary to cancel a deal or to claim a return of profit, multiple cases are sufficient in which there is potential or risk of conflict of interests, and there is no need to prove an actual conflict of interests (Freedman, 1981).

Delivering information to an insurer regarding a group of insured individuals

A group insurance contract is one in which a maximal extent of disclosure is required. A policyholder has a double obligation: an obligation of disclosure and of good faith towards an insurance company as a party to the group agreement. As the one representing a group of insured individuals, and negotiating on their behalf, an increased obligation of disclosure is expected of a policyholder that will enable an insurer to assess the risk and guarantee a stable insurance program over time (Delivering Information to a Policy Holder in Group Insurance Circular, 2009).

Unlike private health insurance, in which an insurer relies on statistics for the entire population it insures, on data existing with sub-insurers, prices offered by competitors, etc., the

cost of the premium in group insurance settlements is mainly based on the characteristics of a specific group of individuals for whom the group insurance agreement is made. A policyholder has this information and is expected to present the information to any potential insurer.

According to Jensen & Richter (2001), the main points of information an insurer requires are as follows:

Way of joining an insurance – obligatory joining of insured individuals to an insurance plan lowers the insurer's risk regarding a group of insured individuals eligible to join voluntarily. The higher the percentage of those joining from the entire group, the lower the risk to an insurer (anti-selection).

Participation of an employer in insurance cost – the more an employer participates in the insurance cost, the larger the percentage of those joining, and the more it guarantees cross-subsidizing among the insured.

Demographic and financial data such as employees' place of residence, gender and age – the actuary age (average insurance cost according to each insured individual) of a group affects the general insurance price. The older the age of a group, the higher an insurer's risk. However, this also depends upon the scope of the insurance coverage. For example, the younger a group's age, the broader use is made of insurance coverages characterizing the young, such as fertility treatments. Conversely, older individuals will broadly use coverage for medicines and surgeries. The gender of insured individuals affects insurance risk regarding illnesses that appear at certain ages in men and women. Employees' place of residence also affects insurance price. A population living in the periphery has less access to public medical services, which might affect utilizing to the fullest the services in a private framework (Shmueli, 2016).

Characteristics of the arrangement – the occupation of insured individuals in an organization affects medical expenses. For example, a factory dealing in hazardous materials is more exposed to claims than another. A study published in Science Daily in 2011 revealed a correlation between working shifts and risk factors for heart diseases in women (Givon, 2011). Occupations characterized by high turnover also affect insurance costs due to the lesser exposure of an insurance company to claims.

Group size – the larger the group, the smaller the standard deviation of big claims, and the lower the insurer's risk, and this affects how high the premium is.

Experience of past claims – one of the important parameters for determining a premium is the experience of past uses of all insurance coverages in relation to the number of

insured in same group. The insurer examines the trend of increase or decrease in claims regarding each coverage over time and predicts future use of healthcare services as well.

Expected changes in organizational structure – structural change in an organization might affect insurance costs. For example, dismissals of employees affect the size of a group, however, on the other hand, retirement of elderly employees might improve insurance profitability.

An insurer has an obligation to send an annual report to a policy holder, specifying the scope of premiums, claims experience and settlement profitability. In other words, the information regarding claims experience is available to a policy holder and enables its presentation to an insurance company as part of a negotiation with an insurer or as part of a tender procedure for choosing an insurer.

Collection funds and administration

The Group Health Insurance Ordinances (2015) enable a policyholder to manage funds collection, to collect insurance fees from the insured and transfer them to an insurer. Usually, the subject of collective collections are regularized in the group insurance agreement. On this matter, Torts Ordinance (Clause 15) determines that whoever is making a contract with another so that something will be done for them (in the matter at hand, collections administration, sending information or updates to the insured), will not bear responsibility for any injustice developing from that act unless they approved or authorized the act which caused the damage or harm. Hence, in this case, the responsibility falls upon the insurer. Even if it appears that for these actions an insurer represents the employer, Clause 14 of the Ordinances applies, which determines that the one employing an emissary who is not one's employee to perform actions for one, will bear responsibility for all actions of the emissary and for how they are performed.

In summation, Group Health Insurance Ordinances assign the insurer most of the obligations towards the insured. Moreover, an insurer will not be able to engage with a policyholder in a group insurance settlement unless the latter declares they will fulfil their obligations. Reinforcement of this position comes through Clause 14 of the Trust Law (1979): *'an action done in violation of an obligation of trust, and the third party (in our case the insurer) knew or had to know about the violation […] the court is entitled to cancel it and responsibility and obligations will apply to the third party as of a trustee […]'*.

Therefore, it appears that Commissioner's position, as reflected in Group Insurance Ordinances and circulars, is that the lead participants in the relationship triangle are an insurer who is supervised by and subject to the Commissioner's authority, and the insured. Conversely, the policyholder's obligations rely on a perception that a policyholder is a trustee of sorts, and their obligations are general, not specified and mainly on a declarative level. Therefore, the question arises of whether a policyholder has obligations by virtue of other laws.

2.7.3 Group Health Insurance Ordinances – a legislated obligation

Clause 63(a) of the Torts Ordinance, titled "violation of legislated obligation" determines that *'an individual violating an obligation is one who does not fulfil an obligation assigned to him by any statute'*. The 1981 Interpretation Law determines that a statute is *'law, regulations, orders and any instruction of a legislative nature'*. There is no need for a statute to mention a possibility of civil suit for its violation. It is sufficient that a statute assigns an obligation responding to the requirement of Clause 63 in order for a victim to have the prerogative of a civil lawsuit for its violation. In order to convict an individual due to violation of a legislative obligation, the obligation must be explicit (verdict of Sahar Insurance Company vs. Israeli Discount Bank Ltd., 1995).

Is the obligation determined in Clauses 2 and 3 of the Group Health Insurance Ordinances, according to which a policyholder must act in good faith and diligence in favour of the insured, explicit enough? Clause 63(a) further states that a statute, according to proper interpretation, is designed to ensure the best interests or defense of another. Clause 63(b) states: *'on the matter of this clause, a statute is considered as if made in the interest or defense of another [...] or of people of a type or definition that individual is part of'*. In other words, a group of specific people. And indeed, the term "in the interests of the insured" included in a group insurance settlement, is aimed at "a group of insured people" for whom a policyholder has engaged with an insurer in a group health insurance plan (Commissioner of Financial Service Ordinances, amendment, 2017).

Clause 63(a) of the Torts Ordinance discusses a situation in which violation of a statute has brought damage to that individual of the type or nature intended by the Legislator. The damage that the statute was designed to prevent, is a matter of interpretation. On the matter of group health insurance ordinances, the statute is intended to protect from the violation of rights to medical treatment and the financial rights of the insured.

To prove violation of a legislated obligation, a circumstantial and factual relationship is to be demonstrated between legislated violation and the damage caused. A factual causative relationship implies that a prosecutor should demonstrate that if a legislated obligation had not been violated, the damage would not have been caused (Torts Ordinance, Clause 35). To examine the legal relationship there are three tests (verdict of Moshe Peer vs. Silovat Construction Company Ltd., 2010):

Risk test – the court examines whether the caused damage, and the causation process are of the type of risk that the Legislator wished to prevent.

Common sense test – Did the wrongful behaviour actually contribute to the harmful outcome?

Expectancy test – Should the offender have expected that, as a result of his actions, harm would be caused? One must prove that the action or the omission not only is negligent in nature, but rather that the specific harm caused could have been expected by the offender. The offender should have expected the type and extent of harm, a process of causation and the identity of those harmed (verdict of Shlomo Vaknin vs. Beit Shemesh Local Authority, 1980).

In Group Health Insurance Ordinances, no civil remedy is determined for violation, but rather only enforcement of obligation is indicated. This does not revoke a victim's right to compensation due to incurred damages (verdict of Yona Laslau vs. Emil Jamal, 1990).

Both wrongs of negligence and violation of legislated obligation assign torts responsibility regarding damage brought about as a result of violation of an obligation, however, they differ from one another. Violation of a legislated obligation requires the obligation to be set in a statute, as opposed to negligence deriving from the expectancy test. The behaviour level determined as negligent is that of a reasonable individual, however, violation of a legislated obligation demands the damage to be of the type intended by the Legislator, i.e., violation of a legislated obligation is not necessarily negligence. However, following the instructions of a legislated obligation does not necessarily mean the absence of negligence. Conversely, the existence of legislated obligation and a violation thereof may project on and affect the mere existence of the obligation of the caution of negligence, or regarding the question of whether there has been any negligence.

It is worth noting that the notion that violating a legislated obligation would cause the plaintiff damage of a type or nature intended by the Legislator, has to be proven. Clause 2 of the Torts Ordinance defines what damage is. This definition includes any tangible loss, in

addition to intangible damages, including sorrow, shame and hurt feelings. Furthermore, the plaintiff has the right to claim a violation of legislated obligation only in cases where damage was actually caused to the plaintiff; one cannot claim compensation merely for the fact that an obligation has been violated (Adama Law) (verdict of Adama International Company in Israel vs. Levi, 1955).

2.8 Policyholders' responsibility from a legal aspect

2.8.1 Obligation of disclosure in an insurance contract

The obligation of disclosure defines the relationship between the actors partaking in a group insurance agreement:

a. In an insurance agreement between a policyholder (an employer) and an insurance company.

b. In a relationship between a policyholder (an employer) and an insured person (an employee).

c. In the engagement of an insured person with an insurance company, in a group policy.

As demonstrated above, the Supreme Court ruled that the combined application of instructions in Clauses 1 and 41 of the Insurance Contract Law, show that the insurance agreement is a "master contract" responding to the legal definition of the term "insurance contract" (verdict of Migdal Insurance Company vs. The Organization for Realizing the Treaty for Social Security, 2006). The policyholder's obligation of disclosure towards an insurer is expressed in Clause 3 of Group Health Insurance Ordinances. The policyholder's obligation as the one engaging in an agreement with an insurer, stems additionally from Clause 12 of the Contract Law, according to which *'in a negotiation for making a contract, an individual must act in an acceptable manner and in good faith'*. In the verdict of Moshe Rocker vs. Moshe Salomon (1997), Judge Barak defined the term of good faith as follows: *'the principle of good faith determines maintaining self-interest should be fair and with consideration of justified expectations and proper reliance of the other party: Man is neither wolf nor angel to Man; Man is Man to Man'*.

It should be emphasized that it is not sufficient to tell no lies in order to meet the obligation of disclosure and good faith in a negotiation. A party to a negotiation is actively obligated to disclose details pertaining to the arrangement (Shalev, 1999). Violation of the

obligation to disclose might be misleading according to Contract Law, Clause 15, general part (1973), where it is determined that *'misleading – including nondisclosure of facts that according to law custom or circumstances – the other party was obligated to disclose'*. Where one party has an advantage over another regarding the existence of information or the possibility of obtaining it, the obligation to disclose information to the other party applies (verdict of Sasi vs. Kikaon, 1981).

The obligation of good faith in the negotiation phase might have far-reaching implications, when there is violation of disclosure of essential facts, such as wrongs of fraud and negligence (verdict of Sasi vs. Ministry of Construction, 2008). The Elbit affair best summarizes the importance of the obligation to disclose in relation to negligent false pretence: *'upon examination of the possibility of a reason for cause of negligence in presentation during a negotiation – one should examine whether the presentation of facts was proven; whether the presentation was reliable, and made with proper caution and diligence; whether they should expect the other party to negotiation to rely upon its words and act according to them, and, if so, whether any physical damage be caused to their body or property or other financial damage; whether another, in practice, relied upon the negligent presentation and as a result damage was caused to them'* (verdict of American Microsystems Inc. vs. Elbit Computers Ltd., 1981).

Group Health Insurance Ordinances do not deal in specific obligations pertaining to relations between a policyholder and the insured. We can see that when an employee joins the insurance, they make an unsigned contract (Contract Law, Clause 23, 1973), that appoints an employer-policyholder to serve as their emissary on the matter of the group insurance settlement. This appointment is founded on the employee's reliance on an employer, and thus, there is an increased tendency to protect this interest through obligation of disclosure (verdict of Philips Pascal vs. Moshe Mizrahi, 1992). Furthermore, a long-term relationship contract is "signed" between a policy holder and the insured. During this period, those entitled to do so (employees and family members) join the insurance, usually changes in insurance fees and coverage are made, and the insurance period might be renewed with the same or another insurer. At times, the insurance agreement terminates in circumstances where there is obligation of continuity, with full insurance continuation, as part of a private (personal) policy. The more the information may affect the reliance interest of an employee, and the more it affects their expectations from the arrangement, the greater the tendency to protect those interests and expectations, amongst other things, through the obligation to disclose.

As we have seen, the court determined that an insurance agreement, a master contract, is like an insurance contract. Hence, it is possible to impose the obligation of disclosure in an insurance contract upon the policyholder, as the one signing an insurance agreement with the insurer, and also on an employee – insurance candidate, engaging in an insurance policy with an insurer.

Insurance Contract Law applies to insurance contracts made starting from January 1st, 1982 (Dorot, 1987). Anyone wishing to describe the uniqueness of an insurance contract as opposed to other contracts, always defines it as an "Uberrimae Fidei" contract (Goldstein, 1976). This definition has parallels in English literature in terms and expressions such as: "perfect good faith", "the most abundant good faith" or "utmost good faith". This Latin maxim is translated to "maximal honesty", "maximal relation of honesty and good faith", "increased disclosure obligation" and more. This means a contract in which the maximal extent of disclosure is required. Lack of disclosure on the part of the insured gives an insurer cause for cancelation (Shalev, 1990).

2.8.2 Contract in favour of a third party

Clause 34 of the Contract Law determines that *'an obligation an individual has taken upon himself in a contract in favour of one who is not party to a contract (hereinafter – the beneficiary) gives the beneficiary a right to demand fulfilment of the obligation, should the contract evidently include an intent to give him such right'*. A group insurance contract is a private case of a contract in favour of a third party, enabling two parties to create, through a contract between them, a right in favour of a third party, which is an independent and original right (Kamar, 1993).

A group insurance contract is similar in many respects to a contract in favour of a third party according to its meaning in chapter D of the General Contract Law. A contract in favour of a third party is one in which one party obligates towards another in favour of a third party. Apparently, such a contract is like any other contract. It embodies an agreement between the parties, and includes an obligation of one party, where another party's privilege is parallel to it. Contractual obligation of A towards B to recompense C is not essentially different from obligating A towards B to recompense B, or to do anything else (Elias, 2016). According to this, a contract in favour of a third party implies the intention of the parties to award a third party (in our case, an employee), a favour. Logic says that the third party wants this right,

therefore consent is not required. Meaning, enacting its will is only for purpose of rejecting the privilege rather than for creating or improving it (Shalev, 1990).

In any case, a contract in favour of a third party should be distinguished from a contract whose content is an obligation in favour of a third party. An obligation in favour of a third party must be examined within General Contract Law (Shalev, 1976).

In an absolute majority of cases, a right to join involves participation in insurance costs, even if only paying a tax for the benefit. Hence, joining involves obligation, and tacit acceptance is not enough, and the third party (an employee and their family members wishing to join the insurance) must actively respond and explicitly agree to the contract (Freedman & Cohen, 2000).

2.8.3 Emissary laws and power of representation

Emissary Law, Clause 8 (1965) – "emissary faithfulness and obligations", determines the following: *'should an individual undertake to become an emissary, he must act towards the sender in good faith and according to his instructions; and if no other intent is implied by the essence of the mission or terms thereof, these obligations will apply to him:*

(1) To inform the sender of any message and deliver to the sender any document relating to the matter of the emissary and to be held accountable for his actions.

(2) Not to be an emissary of different senders on matter of a single mission without the consent of the senders.

(3) Not to act as emissary for himself.

(4) Not to receive from anyone a favour or promise of a favour on the matter of the mission without the consent of the sender.

(5) *not to abuse knowledge or documents acquired due to the mission with harm to the sender and to usually avoid anything conflictual between the favour of the sender and one's own favour or that of another'*.

The emissary mission is quite a complex institution. Its foundation lies in giving an individual the power to represent another individual in legal actions. Allegedly, the mission is based on a reciprocal relationship between the emissary and the sender and puts in place a system of rights and obligations binding these parties to each other. An emissary is an extended

arm of the sender therefore the sender is eligible and obligated by force of the emissary action. The actions of an emissary obligate and acquit the sender, *'as if done by the sender himself'* (Barak, 1996). The extent of judgement given to an emissary, changes from one issue to another (Zweigert & Kotz, 1987).

In daily practice, emissary relations are usually contractual. Rather than a contractual model, Emissary Law has adopted one based upon legal relations in which a third party, for whom the legal action is done, plays a substantial role. In fact, the position of a third party in an emissary arrangement is expressed not only in an arrangement regarding outcomes of the activation of representation power, but rather, in the creation of the emissary mission as well (verdict of Capital Gains Tax on Real Estates Administration vs. Kupatch, 1980). Hence stems the saying that the emissary mission is a triangular relationship.

Clause 1(a) of the Emissary Law determines that an emissary mission is *'power of attorney assigned to an emissary to perform in the name or in place of a sender, a legal action towards a third party'*. In this definition, the Legislator recognizes the triangle that underlies emissary relationships: sender, emissary, third party and an object of these relations, which is the performance of a legal action (Ben-Uliel, 2000).

Not always can it be said that the action of an emissary towards a third party expresses the will of a sender, as occasionally, this assumption does not concur with reality. An emissary may exercise their own will, which might differ from the sender's will, and occasionally, might even contradict it (Barak, 1996).

Transferred Contract theory is an approach to emissary theory developed by Stoljer (1961) in which a signed contract is the contract of an emissary with a third party. This contract is transferred from an emissary to a sender, and it obligates a sender parallel to an emissary leaving the scene. This approach is not completely in line with the practice in group insurance settlements, as in this case, an emissary does not leave the scene, and the contract will obligate a sender only should they join the insurance.

Representation Power theory, described by Judge Aharon Barak, according to which an emissary mission is created by expressing a sender's will towards a third party, and delegating a sender's power to an emissary (Barak, 1996), closely describes the practice customary in group insurance settlements. In this case, an emissary is assigned the power to change a sender's legal status through legal action towards a third party. According to Barak, executing the power realizes the reasonable expectations of a sender and a third party. The power of an emissary

originates in a sender, who can authorize (even retrospectively) an emissary and shape the emissary's legal status through their actions, providing only that these fall within the authorization given to them (or given retrospectively). The authorization (or retrospective authorization) and emissary mission are parts of a uniform legal action (Barak, 1996). An additional theory explaining the emissary institution is Representation Power theory (Procaccia, 1986), according to which, underlying an emissary's legal action lies the will of an emissary rather than of a sender. The will of the emissary is what consolidates the legal action towards a third party. The relevance of this legal action acts upon the sender, as the sender's will is expressed.

An emissary is assigned the power of representation through a sender,s authorization. This constitutes the privilege to perform or change a legal action towards a third party with no necessity for the sender,s cooperation. That is as long as the sender has not activated the power of dismissal. This is in fact a "continuous emissary mission". This right is mostly anchored in the internal relationship between a sender and an emissary mostly constituted by a contracting contract, services contract, mandate contract, or any other contract between a sender and an emissary. A sender grants an emissary power, and the emissary must enact this power for the sender and take care of a sender's interests. The power of representation draws its strength from a sender's authorization. However, situations can arise that are determined according to the reliance interest of a third party, in which representation power with no authorization will be recognized. These cases are exceptional, as the power of representation is derived from a sender's authorization (Barak, 1996).

Granting authorization to an emissary is a unilateral legal action by a sender (Emissary Law, Clause 3), whereby power of representation is awarded to an emissary. Clause 3(a) determines that an emissary mission can be assigned via written or oral authorization. Prof. Barak states that, in principle, it is possible to award the power of representation through an action of a sender towards a third party and reception thereof – this is an "external authorization" (Barak, 1996). Clause 6(a) of the Law, according to which a sender may authorize the action retrospectively, may be used and it is as if an authorization was given in the first place. This can describe customary relations between an insured employee and an employer-policyholder.

Prof. Barak states that as part of responsibility of an emissary according to Torts Ordinance, one may include wrongs of negligence and that between a sender and an emissary there exists an obligation of "conceptual" caution, which is one of the conditions for

implementation of Clauses 35 and 36 of Torts Ordinance dealing in negligence. This is in addition to trustee obligation, according to Emissary Law, Clause 8 (Barak, 1996).

2.8.4 Obligation of good faith

In addition to the general obligation applied to contract parties to act in good faith, not to mislead or exert improper pressure, trust relations place a positive demand upon a trustee to guarantee the beneficiary's freedom of will. For the matter at hand, the trustee is an employer-policyholder, and the beneficiary is the insured employee. This is reflected in the fact that the trustee (an employer) has a full disclosure obligation towards the beneficiary (an employee), and occasionally, the trustee is required to guarantee that the beneficiary receives separate and independent counselling (Freedman & Cohen, 1991).

In his book, "Emissary Law", Aharon Barak (1996) maintains that the existence of the obligation of trust does not replace the (lighter) obligation of good faith. Indeed, an emissary owes a sender both obligations of trust and good faith. Violation of either of these might be relevant in the matter of remedies, and they might enrich the sender's remedies.

2.8.5 Obligation of trust

Trust has remained an ambiguous obligation that encompasses more than meets the eye (Orgad, 2012). The word "trust" is a literal translation of terms used in several legal methods for describing a similar complex of legal relationships.

In Israeli legislation that preceded Trust Law, the word "trust" exists in two different instructions: one in the meaning of devotion, honesty, as in the Bar Association Law, Clause 54, and the second is in a close, occasionally similar meaning to that of this term according to a definition in Trust Law, Clause 1, and in Emissary Law, Clause 10(a) (Kerem, 2004).

Loyalty has various expressions. For example, professional loyalty based on a contract or special trust relations, such as loyalty of a lawyer towards a client or a doctor's loyalty to a patient, or personal loyalty of senior figures in a corporation towards the shareholders.

Trust Law (1979) came into force in early February 1980. Through trust, separation is achieved between benefit from a property and management thereof. An individual entrusted with managing properties of a trust is a "trustee", and the profit from a property is for the "beneficiary". Israel passed the Trust Law that filled the voids in which trust had no clear

application and provided the general law for the issue of trust. Thus far, every time a question has arisen regarding trust mentioned in different laws, English law had to be addressed as the foremost supplementary source (Weisman, 1980).

The basic principle is that when one party receives real information, they are expected to make their own decisions for themselves according to their interests. Only on rare occasions do parties to a contract promise to take care of the interests of the other. If they promise to do so, the court might redefine these promises as obligations of trust.

Regulating activities of trustees by law signifies the importance a country attributes to these services. If there is high risk of dishonesty by trustees, people will not put their trust in them and avoid using their services, or will ask for guarantees, or will pay less for the services. The law reduces these risks and the possible reaction of people who must trust others. Inequality between trust parties can be expressed at the level of specialization as well and not necessarily just in the power of negotiation. An individual may be rich and powerful; however, they may have no time to check up on the manager, or they do not have the expertise to monitor their doctor and guarantee their capability and honesty. Regulators are capable of checking trustees better than a small investor or a single patient. The costs involved in legal enforcement are distributed amongst the entire population of taxpayers or amongst all professionals (Frenkel, 2006).

In the verdict of Gal-Goren vs. Aviva Miraz (2004), the court determined that an important rule inseparably linked to the principle of trust, is that forbidding a senior figure who has an obligation of trust to position themself in a situation in which there is even a semblance of conflict of interests between one's personal interests and interests of an individual or a public in whose favour one must act. Obligation of trust also inherently embodies an obligation of dedication towards the relying party (Kerem, 2004).

2.8.6 Trust and fiduciary obligation

Obligation of trust is one of the institutions developed by law to deal with the issue of power in society, especially towards vulnerable parties subject to it (Licht, 2013). Assigning an obligation of trust to an individual turns that person into a fiduciary. A fiduciary must carry out their mission in good faith as a mental element. Behaviour rules are applied for maintaining the obligation of trust: the first – a complete prohibition against remaining in any conflict of interests, and the second – an obligation of full disclosure of any essential information (Licht,

2013). In literature and in ruling, fiduciary relations are defined in the context of trust, emissary missions or partnerships.

Power relations in a legal context involve a willful control one individual has over the legal status of another individual (Hohfeld, 1913). For example, a sender is subject to the power of an emissary to influence unilaterally the interests of a sender. But bestowing such power may arouse fear of opportunistic behaviour on the part of the power holder, who might prefer self-interest and use of the information gap in their possession to their own advantage. In order to minimize the danger of the use of force, a prohibition of deriving benefit from their power should be levelled at the power holder. As the mere existence of power depends upon information differences, arrangements of full disclosure are required (Licht, 2013). *'The principle of trust has broad application. It applies anywhere one is given power and control. The list of situations in which relations of trust exist is not closed…'* (verdict of Kossoy vs. Y. L. Feuchtwanger Bank Ltd.) Licht concludes from the Kossoy ruling that when one has power through which one can influence, according to one's judgement, the interests of another, supervision is required. Barak's approach in the Kossoy ruling is that power and vulnerability necessitate an obligation of trust, in the framework of which one must act in best interests of the beneficiary without any fear of conflict of interests. When an individual manages the interests of another, they must not harm or damage them and must act out of trust and loyalty (Barak, 1980). Licht (2013) indicates that there is a broad range of levels of power and vulnerability, and thus in continuous "relation contracts" the party putting faith in another party can consider them a fiduciary and thus assign them an obligation of trust.

Israeli legislation considers the insured to need protection by law. As a general practice, courts in Israel tend to assign increased obligations of trust and good faith mainly to insurers. This tendency, informed by the instructions of Clauses 12 and 39 of General Contract Law, is explained by the special characteristics of insurance, including the insurers' responsibility to take into account public interest in the public's trust in insurers (Elias, 2016).

Insurance companies play a social role and therefore must apply general obligations of trust towards the public. A picture emerges of a kind a two-sided "deal": in terms of rights, insurance companies benefit from a license to offer the broad public insurance policies and savings and pension plans. In terms of obligations, these companies are subject to a system of special obligations, prohibiting them from using their great power to harm their client public. The system of obligations determines a normative frame for proper management of insurance activity. Insured individuals are guided by insurance companies in all matters of the engagement

in the agreement. They depend on an insurance company and its agents, who have superior information and negotiating power (verdict of Hazan vs. Shimshon Insurance Company Ltd., 1998). Power gaps between the parties prior to making an insurance contract, and particularly after the occurrence of an insurance incident, contract uniformity, its complexity, etc., are subjects that obligate a high level of good faith on the part of the insurer (Elias, 2016).

2.8.7 Obligation of caution

A general obligation of caution was acknowledged in the UK for the first time in a renowned verdict on the matter of Donoghue vs. Stevenson (1932) and gained statutory status in Israel in Clauses 35-36 of the Torts Ordinance. The obligation, as defined in these clauses, is to avoid performing an action that *'a reasonable and wise individual would not do in the same circumstances'* (Clause 35). This obligation exists *'towards each individual and towards the owner of any property, as long as a reasonable individual should have foreseen in the same circumstances that in the normal course of things they might be damaged by an act or an omission specified in that clause'* (Clause 36) (Cohen, 1985).

In order to determine responsibility for negligence, three questions should be answered: does that individual have any obligation of caution towards the injured party? Has the defendant violated the obligation of caution? And was it the violation of that obligation that caused the damage?

The primary question, whether there is an obligation of caution, is examined by the judge both in principle - whether, in relation to a specific risk, there is any obligation of conceptual caution, (for example, whether an employer has an obligation of caution towards an employee regarding any risk pertaining to their job), and regarding a specific injured party in a specific event, whether the employer has a specific obligation of caution (verdict of Shlomo Vaknin vs. The Local Authority Beit Shemesh, 1980). A test determining fulfilment of conceptual obligation is the expectancy test, i.e., whether a "reasonable person" should have anticipated the occurrence of damage, and that not every damage can be expected. The expectancy test is an objective test of expectations of a "reasonable person" and probability of risk created by the damaging individual.

There is also another test determining the proper or required level of caution, comprised of two parameters: severity of risk and probability of risk testifying to its realization. The more severe the risk in its essence, and the higher is its probability of realization– the greater the risk,

and accordingly the required level of caution will be determined as different from the mere existence of obligation in the case under discussion.

A "reasonable person" is a fictitious figure, a creation of the court, embodying within itself the qualities a court wishes to find in an individual, as best expressed by judge Zusman: *'for decades courts have practiced determining expectancy of damage according to behaviour required by a "reasonable person", that embodiment of a naive, honest and decent individual, that might not exist in actuality, however that serves as a useful scale to measure responsibility in torts'* (verdict of Mizrahi vs. Mekorot ,1971).

The specific obligation of caution examines whether in the circumstances of a particular case there exists an obligation of caution between the specific offending party to a specific injured party, due to the specific damage that has occurred. Its existence is determined according to circumstances of an event under discussion. This obligation, as opposed to a conceptual obligation, is based on subjective considerations of a specific wrongdoer, rather than of a reasonable person. The advantage of a specific obligation is the possibility, on one hand of guiding the behaviour of individuals through norms and legal considerations, and on the other, to take into account qualities, circumstances and specific demands of a specific individual in an event under discussion.

The purpose of the norm forbidding negligence is first and foremost to raise awareness of dangers and ways of preventing its realization, since without such awareness, no preventive behaviour (avoiding activity or cautious activity) is possible. The obligation to avoid a dangerous act or to obtain more information before acting, evolves from the combination of what the doer actually knows and what they are capable of knowing and should know, considering the said purpose of the norm (Kremnitzer, 1994).

2.8.8 Reliance doctrine

Reliance is an inseparable part of human and social behaviour; people's actions performed in response to other people's actions or factual situations they encounter. This response itself relies on various operational assumptions – that the current state of affairs, is as it was predicted to be, that a certain situation will exist in the future as well, etc. (Barak-Erez, 1995).

Reliance interest passes as a common thread through Israeli law and as the basis for substantial parts of private law. This was the judgement in the past, when the principle of

prevention, which is based on reliance principle, was customary. It is the same today, when the realization of reliance interest can be considered part of the principle of good faith. Thus, a violation of the obligation of good faith in negotiation will usually entitle the injured party with "reliance compensations" (verdict of Kal Construction Ltd. vs. A.R.M. Raanana for Construction and Hiring Ltd., 2002). The compensation awarded in a torts claim due to negligent false pretence, protects the reliance interest of a contract party (verdict of Zaleski vs. Local Committee for Planning and Construction, 1997).

The term "reliance interest" describes the interest of the anticipation of the existence of a contract (Freedman, 1997), and reliance compensations are determined according to the benefit one would have produced from upholding the contract (verdict of Hotel Tzukim Ltd. vs. Netanya City Hall, 1992). The purpose of compensations is to put an injured party in same situation they would have been if a contract had been realized. This is the great principle of restoring a situation to normal. This compensation is awarded due to damage to interest of anticipation of profit that was denied (verdict of Bank Mizrahi HaMeuhad Ltd. vs. Liluf, 2001).

From the reliance interest derives the obligation to operate with decency, honesty, reasonability and proportionality (High Court of Justice appeal of Yelena Genis vs. Ministry of Construction, 2001). From these we can learn of the obligation to consider an individual's reliance interest. (Barak-Erez, 1995).

2.9 Additional influences on the policy holder's responsibility in group insurance settlements

2.9.1 Interpretation of insurance contract

An insurance contract is unique in the fact that being different from other products where the acquirer can examine their characteristics, an insurance product is intangible, and an insured individual usually lacks the skills to examine the quality of that intangible merchandise. What adds to the product intangibility is also the procedure that the insurance deal is engaged in, as there is an immanent gap between the insurance product as perceived in the awareness of an insured individual at the time of signing the contract, and the same product later reflected in specified terms of the insurance contract embodied in the policy. This gap was created at the time of signing the contract, since an insured individual does not have the specified terms of insurance contract before them, and even if they did, it is doubtful that they could assimilate them, due to professional and cognitive limitations. Those limitations might create the failure

of structured market in terms of a lack of expectancy in delivering information on the part of an insurer, due to the incompetence of insured individuals to process and assimilate, alongside additional market failures (Schwartz & Shelinger, 2003).

In the verdict of Nave Gan Constructions and Investments Ltd. vs. The Phoenix Insurance Company Ltd. (2002), the Supreme Court determined that an insurance contract bears unique characteristics that distinguish it from other contracts: it is an intangible product, there are financial and professional power gaps between the insurer and the insured, and an insured individual has only a limited ability to understand and influence a contract. Additionally, the method of drawing up a contract is different, as the offer and the acceptance are controlled by the insurer. All these make courts to do as much as they can to bridge the gaps through unique interpretation rules in addition to general interpretation rules: *'according to parties' estimation of opinions, as is evident in a contract, and should it not be evident in it – then in the circumstances'* (Contract Law 1973, Clause 25).

In the field of insurance, courts employ unconventional tools compared to similar tools used in general contract law to supply private insurance coverage, due to insufficient insurance coverage on the state level. In ruling, interpretation is employed to broaden the responsibility of an insurer, by transitioning from a text-dependent interpretive tool known as "interpretation against the drafter" to adopting an extra-textual interpretive tool of a "probable expectations of the insured" test, enabling a court to make a flexible judgement, and promote policy it considers as proper in interpretive conflicts surrounding an insurance agreement. However, the application of the stated rule is still text-dependent, and within the "contractual game", as the rule of interpretation against the drafter has still left an opening for insurers to phrase texts conclusively to avoid vagueness, and escape being subject to this rule (Schwartz & Shelinger, 2005), on matter of Shalev vs. Sela Insurance Company (1989).

The basic assumption is, that every legal text requires interpretation, especially according to the Apropim rule (State of Israel vs. Apropim Housing and Initiation, 1991), where the majority opinion of the judges maintained that contract clauses should be interpreted according to the purpose of engagement, rather than sticking to a literal interpretation of the text. The majority opinion annulled the distinction between internal and external interpretation. Legal text should be interpreted according to its purpose, and therefore, in a text written one-sidedly by a supplier for a consumer public, should be interpreted in a way that brings about a fair outcome between the parties. (Deutsch, 1994),

Currently, new theories are proposing to invert the pyramid of interpretation and completion of contracts. Accordingly, contracts will be interpreted first and foremost according to the principle of good faith, hence the importance of the interpretation against the drafter rule will only increase, and there will be no reason not to give it its proper weight in the interpretation of contracts of adhesion.

American insurance laws shaped the "reasonable expectancy doctrine", according to which a policy should be interpreted according to reasonable expectations of the insured. In its "strong" version, this doctrine enables one to determine the content of an insurance policy according to reasonable expectations of insured individuals, even if the wording of a policy does not coincide with those expectations (Zamir, 2004).

Grosskopf (2011) maintains that interpretation of a contract is made according to the estimation of opinion of both parties. In other words, in an attempt to reach their common intention, rather than according to the intention or will of one party, even if that party had actually worded the agreement.

2.9.2 Expectation doctrine of the insured

In insurance conflicts, there is a scale known as the 'test of reasonable expectations of the insured'. This test was initially developed by Keeton (1970). In his paper, Keeton analysed the ruling discussing insurance conflicts and demonstrated that, in practice, court rulings, are interpretive in nature, while assigning crucial weight to reasonable expectations of the insured. Accordingly, as described in above paper, courts rule in favour of an insured individual, even where the wording of the text specifically determines otherwise, in order to fulfil the reasonable expectations of the insured. The innovation of the test, according to Keeton, regarding the 'interpretation against the drafter' rule, was that while a preliminary condition for applying this rule is the element of vagueness in the text, in the reasonable expectations test, even unambiguous wording that determined otherwise did not prevent application of the test in order to reach an outcome reflecting the reasonable expectation of the insured. The 'reasonable expectation test' became a point of reference both for those supporting and opposing it (Schwartz & Shelinger, 2003).

In the verdict of Cooperative Society Beit Knesset Ramat-Hen vs. Sahar Insurance Company (1994), the reasonable expectation test was adopted as one of the tests that can be used in ruling in insurance conflicts.

This doctrine in its full version enables a court to withdraw from the wording of the contract itself and determine those reasonable expectations of the insured will be protected even against opposing stipulation in a contract, as long as it was not proven that the insured party had been explicitly informed of the stipulation in question. It can specifically be used in its reduced version when there is a need to interpret an ambiguous clause in a policy (Keeton, 1970). There are three main reasons underpinning the doctrine of reasonable expectation of the insured:

- Financial – application of the doctrine might encourage an insurer to give the insured more information, and thus to bring about a more efficient allocation of resources. This way the doctrine bridges over the gap created between inaccessible terms of a policy and the expectation of the insured to receive fair and reasonable coverage. As a policy is sent to the insured only after signing of a contract, a substantial part of the policy terms is brought to their knowledge only retroactively, and even then the terms are not always understood by the insured in light of the fact that a contract is phrased in cumbersome professional language, which is not understood by a "ordinary" people (and includes plenty of "fine print").
- Ethical – application of the doctrine is in line with the fairness principle, which deals in assigning responsibility to an insurer who created expectations in an insured individual that are not anchored in the instructions of the policy.
- Distributive – the doctrine enables the distribution of damages caused to a single insured individual amongst all insured public, a reason that is in line with the main purpose of the insurance mechanism.

Nonetheless, despite the above, the main criticism of the doctrine maintains that it leads to uncertainty, increases insurance cost, and causes delays in claims settlements. These claims add to the argument that implementing the doctrine causes insurers to reduce insurance coverage, and toughen policy terms (Elias, 2016). Expectation doctrine, as stated, will be applied in any case of text vagueness, even when there are no interpretation possibilities of equal reasonability (Schwartz & Shelinger, 2003). This means that the doctrine might be on the side of the insured, even in cases when the more reasonable interpretive possibility supports an insurer's interest. However, Elias (2016) maintains that there are opposite situations as well, in which, despite textual vagueness, there is no expectation of the insured to receive coverage and then, according to Elias, the expectation doctrine has no application.

2.9.3 Standard contract

The issue of a standard contract has preoccupied both courts and the legislators in many a country (Kretzmer, 1971). In the current industrial society, contracts of adhesion are highly important, and they are an inevitability. In a society founded on mass consumption, multiple-branched trade and broad demand, it is only natural that the legal means through which those demands will be fulfilled is a standard contract. As presently in marketing, mass marketing means are employed instead of negotiation between a single merchant and a single client, and the same goes for contracts, which have shifted from a negotiation-based document to a standard contract, in which suppliers dictate their terms to multiple clients. These clients do not, in fact, have any other choice but to purchase the commodity according to terms dictated by the supplier (Grossman, 1972).

Deutsch (1980) maintains that alongside the benefits of a standard contract, such as saving time, effort and financial resources, one should not ignore the fact that contracts are prepared in advance, in uniform formats, written in cumbersome legal language that a lay person finds very difficult to fully comprehend. Mostly, engagement circumstances do not enable negotiation or any change of standard clauses. A supplier dictating the terms to a consumer or service provider, might insert into a contract harsh and unfair terms towards clients (Kretzmer, 1971), therefore the choice clients face is to accept the terms or not make the purchase at all, as chances are that other suppliers will dictate similar terms to clients (Deutsch, 1980). Thus, a supplier can simply say "take it or leave it". This is particularly emphasized in monopolies or in cases where suppliers of that service or product make their clients sign contracts including harsh and unfair terms. The purpose of legislation in standard contracts was to find a solution to this problem and protect a client from unfair exploitation by a supplier (Kretzmer, 1971). Hadar (1992) maintains that a standard contract is to be viewed as a special type of contract, and that as much meaning as possible should be given to the real intent of the parties.

Standad Contract Law (1982) applies to an insurance contract in Clause 1, which defines what a standard contract is: *'a form of contract in which all or some of the terms, were predetermined by one party, to serve as terms in many contracts between them and other people unspecified in their number or identity'*.

Insurance contracts are presently phrased by professional entities, and engagement terms are controlled and predetermined by those large entities – the insurance companies. Therefore, it we may say that an insurance contract is a standard contract, and thus, the contract is subject to Standard Contract Law and to limitations determined within it regarding contract terms, for example, due to deprivation or unfair advantage. That is all on the matter of private standard contract, regarding which there is no disagreement that it responds to definition of the clause in the Law. And what about a group insurance contract - is this type of contract a standard contract?

Unlike the definition of standard contract, a group insurance agreement is a contract for a particular defined group of insured individuals, even though group insurance settlements might include millions of insured individuals (for example group long-term nursing care insurance for HMO members) and the composition of the group might change over time. In a group insurance, as opposed to private insurance, a stage of specific negotiation between a policyholder and an insurance company is held and yields the formulation of insurance terms. Consequently, according to Elias' approach, such an agreement is not a standard contract, and therefore blindly implementing an interpretation against the drafter rule in relation to this policy is not called for (Elias, 2016). On the other hand, an insurance policy offered to employees is the fruit of an agreement between a policyholder and an insurance company, and the choice they face is to accept the insurance terms or not to join the group insurance at all. Hence, concerning employees, this is a standard contract being imposed upon them.

2.10 Literature review summary

Studies show a lack of knowledge and information among Israelis regarding their rights to receive medical services, as well as a lack of knowledge among those insured, regarding rights under insurance plans, especially because of the complexity of the field of insurance, and the different types of health insurance that exist. All of these establish the responsibility policyholders have towards their employees or members.

The state regulator determines that in accordance with the Group Insurance Ordinances, policyholders must act with "faith and diligence" in best interests of the insured, though this obligation remains general and poorly defined.

The literature review describes the policyholder's legal responsibility, based on the perception that the policyholder is an emissary and a trustee of a group of employees who signs the insurance agreement in favour of a third party - the insured employees. This creates a

fiduciary relationship between employer and employees. This fiduciary relationship is based, on one hand, on the employer's duty of loyalty towards the employees, and on the other, on the employee's reliance on and trust in their employer to represent their interests and take care of their welfare and safety. According to these perceptions, an employer has an obligation to have no conflict of interests, and an obligation to report to and inform the employees about any activities regarding the group health insurance.

The literature review suggests expanding the research to examine how the partners in the group insurance arrangement – the policyholder, the insurance companies and especially the employees – perceive the responsibility of the policyholder towards the employees, and providing operative content for the regulator's perception and the legal perception on this issue.

Chapter 3. Empirical analysis of the perception of the insurance companies, employers and employees regarding employer responsibility towards employees

3.1 Objectives and research question

3.1.1 Primary research objectives

The primary objectives of current study are:

a. To provide an operative meaning of an employer's responsibility towards their employees regarding the group health insurance arrangement.
b. To create a guide for employers as to how they should act in order to fulfil their managerial, ethical, and legal responsibilities towards their employees with regard to the group health insurance arrangement.

3.1.2 Research question

Thus, the research question is: What responsibility do employers have towards their employees regarding the group health insurance arrangement, and how should employers act in order to fulfil their managerial and legal obligations towards their employees?

3.2 Research design

To answer this research question, the perceptions of each of the participants in group health insurance arrangements are examined: the insurance company, the policyholder - the employer or another corporation authorized to sign a group insurance agreement for its members (e.g., a consumer club) - and the employees – those who are insured.

In the first stage, as detailed in Section 3.3 below, qualitative exploratory research using a semi-structured interview is conducted among five VPs of group health insurance departments from five different leading insurance companies in Israel.

In the second stage, as detailed in Section 3.4 below, qualitative research using a semi-structured interview is conducted among eight Human Resource managers from different leading employers in Israel who have signed a health insurance agreement for their employees, and two managers of insurance departments of different consumer clubs belonging to employee organizations authorised to sign a group health insurance contract for their employees.

In the third stage, as detailed in Section 3.5 below, a survey study distributed via an Israeli digital collection agency is conducted among 500 employees in various occupations who are insured in group health insurance agreements.

As detailed in section 3.5.2, to complete the research among employees, semi-structured telephone interviews are conducted by phone with 10 employees after completion of the questionnaire in order to clarify their perceptions regarding certain issues arising in the quantitative study, as well as their views on issues not examined in the quantitative research, and specifically: how the employees interpret the term “faith and diligence.”

Finally, the results for insurance companies, employers and employees were integrated to establish the perception of an employer’s responsibility towards employees in group health insurance arrangements, and to draw final conclusions as to how employers should act in order to fulfil their obligation towards their employees.

The structure of the research is presented in the Figure 3 below.

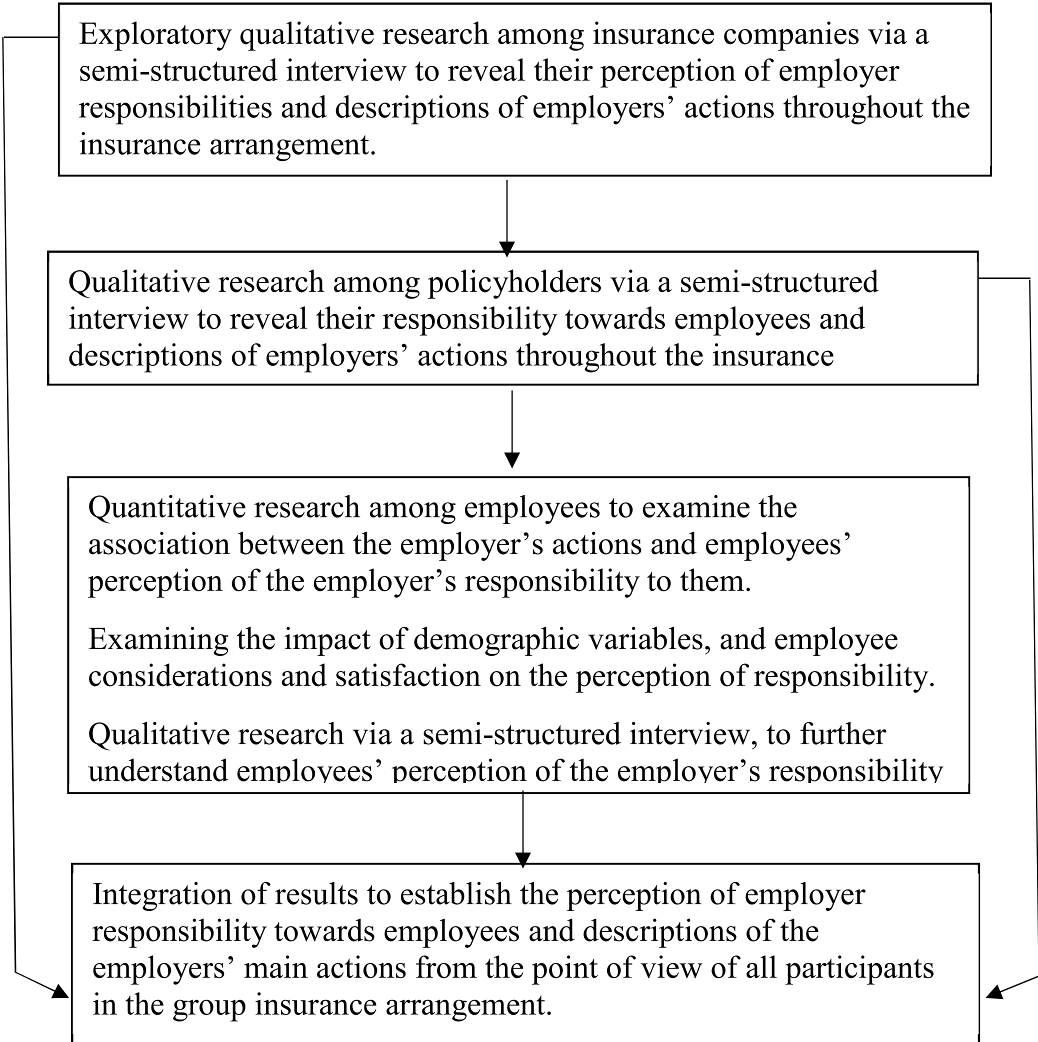

Figure 3: Research model

3.3 Perceptions of the insurance companies

3.3.1 Methodology

The insurance company is a major factor in the group insurance arrangement and interacts with both the policyholders and the insured. Research on insurance companies reveals what actions the policyholders actually take, and their perceptions of how insurance companies should act to fulfil their responsibilities towards the policyholders. The qualitative findings of the research among the insurance companies enable the formulation of the questions for the subsequent interviews with the employers.

Qualitative exploratory research is conducted among five leading insurance companies in Israel. The qualitative research involves an in-depth semi-structured interview (Cohen & Crabtree, 2006), because this has been found to be most appropriate for a study which reveals organizational strategies (Peck & Theodore, 2000).

The specific objectives for the research on the insurance companies are to gain an understanding of how they interpret the term "faith and diligence" and show how they perceive an employer's responsibility towards employees. An additional objective seeks to reveal how the insurance companies believe policyholders should act in order to fulfil their legal responsibilities towards their employees.

Following a request to group health insurance departments from the five different insurance companies controlling 93% of Israel's group health insurance market (Commissioner's Report, 2018), five VPs participate in an interview, conducted by the researcher at the offices of each insurance company, on the understanding that the insurance company name will not be mentioned in the study.

The participants are asked the same five key questions. This enables the formulation of the questions for the subsequent interviews with employers. For example, two interview questions are: 'Can you describe the policyholders' actions from the beginning of formulating the insurance arrangement to the end of the insurance period?' and 'From your point of view, is the policyholder responsible to employees regarding the insurance plan? What is the extent of this responsibility?' The interview questions are attached in Appendix 1.

3.3.2 Results: Analysis of the interviews

The term "faith and diligence"

Insurance companies mention the concepts of "good faith" and "decency": *'employers need to act in good faith for the insured'*. They argue there is a conflict between the desire to preserve the employers' interests and the cost of insurance. On the one hand, they want to achieve the best coverage, and on the other hand they want to cut costs:

- *'For example, they want to alleviate the criteria for joining the insurance agreement, but this incurs additional costs'*
- *'Employers need to safeguard the interests of all kinds of workers and not to prefer just a certain population'*

Some insurance companies perceive "faith and diligence" as the effort to obtain the optimal terms of insurance: *'employers need to act responsibly'*. One insurance company states that sometimes the employer tries to woo the employees and in doing so passes on information and messages that may harm the employees:

> *The most important thing is that they must be careful and not promise the employees that the insurance covers all cases. This creates expectations and later results in dissatisfaction. The truth must be told. We have come across several such cases resulting from employers trying to gain favour with their employees.*

In conclusion, generally speaking, insurance companies perceived the term "faith and diligence" as the duty to act in the employees' interests rather than prefer the organization's interests.

Employers should cooperate with employees in the insurance plan

Attitudes of the insurance companies on this issue are varied. Three insurance companies ascribe low importance to cooperation with the employees for several reasons:

- *'employees do not understand this matter'*
- '*everyone has different needs and therefore no one can be satisfied'*
- *'the employer usually pays and is responsible for the insurance'*.

They further argue that the employer can learn about insurance issues from the reports and complaints they receive.

However, two other insurance companies argue that there are advantages in working with employees because in this way, the insurance plan can be adapted to the employees' needs, for example, *'young people have different needs from those of older adults'*.

In conclusion, most companies ascribe low importance to employee inclusion mainly due to employees' lack of understanding of the subject.

Using a professional expert

All insurance companies in this study support the notion of employing a consultant or professional to help the employer manage the insurance plan:

- *'The employer does not understand these issues, and hence he/she should not accept responsibility for an incomprehensible issue'*
- *'Some claim that hiring a consultant actually helps the insurance companies'*
- *'It helps us communicate with the policyholder on professional issues'*
- *'The consultant really acts as a knowledge mediator between the insurance companies and the employers'*

In conclusion, the insurers argue that the consultant helps them communicate with employers professionally and in their opinion, it is very important to hire a consultant.

Choosing an insurer

The insurance companies ascribe moderate importance to conducting a tender or competitive procedure. On the one hand, they argue for transparency and encourage competition, and on the other, this can harm their interests. They argue that tenders lower prices and hurt their profitability.

- *'It is important to consider the quality of the company and not just the price'*
- *'It is important to set standards of size and quality for the chosen insurer'*

Another argument is that every employer has different requirements and that responding to any kind of tender requires time and resources, for example, *'of course, if employees are*

insured in my company, I don't want a tender, but if they are insured with the competitors, I really want one'.

Again, this is a position that best serves the interests of the insurance company. Another argument is that conducting a tender also requires a time and money investment from the employer and is not always worthwhile: *'it is not necessarily important to conduct a tender, but it is important to check the quality of the insurer, the terms and the cost'.*

In conclusion, the insurance companies ascribe medium importance to conducting a tender or other competitive procedure. The larger insurers express less support for them, since this generates greater competition and may push employers to switch to smaller competitors.

Involvement in advertising and information sent to policyholders

All insurance companies in this study mention the importance of the employers' involvement in advertising and advising policyholders. Companies report that there are employers who want to pre-authorize any information sent to policyholders:

- *'They authorize the documents sent to employees in advance'*
- *'They know the employees better'*
- *'They mediate information between us and the employees'*
- *'We have a legal duty to send information to the insured, but employers' involvement is welcome and justified'*

Two insurance companies claim that the advisory responsibility is based on the employees' right to join the insurance:

> *They have the duty to explain to new employees the right to join the insurance together with family members within a window of opportunity (a certain period during which a new employee can join without a health declaration), as well as their entitlement to continue the insurance.*

All companies report that it is not the responsibility of the employer to inform about rights in the health basket or HMO supplementary insurance and private medical services:

- *'It is not their responsibility since they do not understand the subject'*
- *'This is the role of the agent, not the policyholder'*

One company states that employers have a legal responsibility to authorize the information in advance.

In conclusion, the insurance companies ascribe considerable importance to the involvement of the policyholder in informing employees of their rights under the group health insurance plan.

Monitoring

Insurance companies argue that most employers are satisfied with an annual report that insurance companies are obliged to submit under the regulations. They argue that most employers pay close attention to reports before renewing insurance or when a premium adjustment is required. The companies claim that employers ask for reports mainly to audit their costs and '*to make sure the premium has not been increased*'.

Insurance companies suggest that high-tech employers conduct monitoring more often:

- *'Maybe because it is their professional field, they ask for more data reports'*
- *'Maybe they are more concerned about the employees'*
- *'They consult more often with experts to analyse the reports'*

In conclusion, all insurance companies ascribe great importance to monitoring during the insurance period.

Involvement in claims

All insurance companies attribute great importance to employers' involvement when there are disagreements but note that '*not everyone does it*'. The insurance companies' representatives argue that *'it is in not our best interests, but it is for the benefit of policyholders'*.

One insurance company notes that '*the more the employers update the employees, the more employees file claims against the insurance companies*'. On the other hand, when employers do not constantly inform the employees, the employees might file claims since they feel their rights are being violated: *'It is not as good for us because then the employee files a legal claim or a complaint'*.

The companies claim that employers involved in the claim process have the procedure of a face-to-face appeal committee of which representatives of the employers and insurance company are members:

- *'We don't like it, but it solves problems'*
- *'It increases our costs'*

They argue that it is sometimes more of an issue for the employer whose claim should be approved and to what extent. They also claim that it creates discrimination among policyholders among those who are aware of their rights, those who apply and fight for their rights, and those who do not do so.

In conclusion, the insurance companies believe it is very important for employers to be involved in disagreements in the event of a claim, even though it is against their interests.

Employer's responsibility for employees

All the insurance company representatives state that the employer has a great deal of responsibility towards the employees, with the exception of one company that states that an employer's responsibility is only moderate. The companies argue that the responsibility exists because employees do not have enough knowledge about the insurance sector and thus *'they trust the employer'*.

All employers argue that there is no difference in the level of responsibility, whether the employer participates in the insurance cost or not. To the same extent, they argue that there is no difference in the degree of responsibility whether or not the employer has a Workers' Committee. However, they argue that in their experience, Workers' Committees are highly involved in formulating the plan: *'There are strong Workers' Committees that set the conditions, and sometimes the representatives of the Workers' Committees have a direct channel to us'.* They further argue that there is no difference in the degree of responsibility whether the policyholder is a direct employer or a consumer club.

In conclusion, from the insurance companies' point of view, whoever has a collective insurance policy arrangement has a great deal of responsibility for their employees. The insurance companies regard the employer's duty to act with "faith and diligence" as the duty to act in good faith and decency, to prefer the interests of the employees over those of the organization and to make sure the insurance meets the employees' expectations.

The insurers state that the responsibility does not depend on the employer's participation in insurance cost or the type of policyholder (employer or consumer club), on the type of occupation, whether Workers' Committees are involved, or the extent of the insurance coverage.

According to the insurance companies, the employers' responsibility arises because insurance is complex, and employees do not have enough knowledge and information about it. The insurance companies attribute a great deal of importance to operational issues such as collection administration, and they note an absolute obligation regarding the right of new employees to join the insurance and the right to continue the insurance individually when they leave their place of employment or retire.

3.4 The perceptions of employers and consumer clubs

3.4.1 Methodology

A policyholder is the entity representing the insured group vis-à-vis an insurer, as the one drawing up the insurance contract with an insurer, and in whose name the group policy is registered. (Ordan vs. Sahar, 2002). The role of the policyholder is critical in each stage of an insurance deal: conducting the negotiation, drawing up the contract and ongoing management of the policy, including transfer of insurance fees to the insurer (Elias, 2016).

The specific objective of the study among the policyholders is to expand the understanding of how they perceive their responsibility towards their employees, in particular to examine what actions they take regarding the insurance arrangement, and elicit their view of how they should act in order to fulfil their legal responsibilities towards their employees.

A qualitative study involving an in-depth semi-structured interview (Cohen & Crabtree, 2006) is conducted among ten policyholder representatives: eight Human Resource managers of leading companies in Israel that have signed a health insurance agreement for their employees. These include two hi-tech companies, two industrial companies, two private services companies (financial, marketing), two public services organizations, and two consumer clubs belonging to employee organizations authorized to sign a group insurance arrangement for employees.

Following a request via email and phone calls to 40 HR managers and executives in the benefits and compensation departments of companies that signed group health insurance agreements for their employees, eight companies agree to participate in the interview. In

addition, two out of seven consumer clubs agree to be interviewed. The interviews are conducted following a signed undertaking not to publish the names of the companies and not to contact their employees directly as part of the study. The smallest company has about 400 employees and the largest about 9,000. Each of the consumer clubs has approximately 70,000 insured members (employees) and their families. The researcher conducts the interviews at the company's offices. At the request of three interviewees, the interview is conducted in the presence of the company's legal counsel.

The participants are asked the same 13 key questions. The questions are formulated on the basis of the findings of the exploratory research among insurance companies. For example, two such questions are: 'What was the process for choosing the insurance company?' and 'Can you describe whether and how you inform employees about their rights?' The interview script is attached in Appendix 2.

3.4.2 Results: Analysis of the Interviews

The term "faith and diligence"

Generally speaking, despite being aware of their duty to act in "faith and diligence", employers cannot define exactly the meaning of this concept. The interviews indicate that the employers' conception of this term is divided into three main issues: (a) not to accept any favours from anyone; (b) to make sure the insurance procured is the most extensive relative to the cost of the insurance; and (c) to make sure the insured receive what they deserve from the insurance company and make the appropriate changes in light of developments and regulations in the field of insurance.

All the employers report that they must act on behalf of the insured, and that they cannot accept favours such as commission or participation in expenses in order to operate the insurance: *'The insurance belongs to the workers; the employees pay tax on the benefit we give them. We should not accept money.'*

The employers argue that "faith" means *'to achieve a policy we believe is the best possible for the employees and the best professionally'*. The term "diligence" is interpreted by some employers as a duty to formulate the most extensive policy with respect to cost. Others interpret it as updating the policy during the agreement term and following developments in the medical field:

- *'to keep a finger on the pulse; changes are ongoing'*
- *'we must update the insurance coverages according to the market'*
- *'diligence means remaining alert to changes in the law and to introduce coverages and new technologies'*

Some employers understand the term "diligence" as having to monitoring the insurance company's fulfilment of its obligation according to the agreement: *'they should pay the employees their due and charge an appropriate premium'*.

Employers' participation in insurance costs

First, most employers interviewed for the current research mention that they provide full insurance for their employees only. Indeed, seven out of the ten employers provide insurance for employees only, while for one of these, families can join the insurance for an additional fee. Only two employers pay the insurance for the whole family, and hence provide full family insurance. It is important to note that a single employer provides partial insurance for the employee, only in cases of catastrophes – insurance for transplants and surgeries abroad and insurance covering medicines.

Another important finding is that four employers and the two consumer clubs provide supplementary insurance, meaning that they provide insurance *in addition* to supplementary HMO insurance and the basic health rights. The rest provide substitutive insurance.

It is important to note that consumer clubs belonging to workers' unions (such as the teachers' union or civil servants' union) do not participate in costs. The basic idea underlying this approach is to find a balance between the level of personal employee participation, and the employers' perception of responsibility. The main outcome of such a balance is that consumer clubs belonging to workers' unions have a higher level of responsibility compared to other organizations. However, in companies that fund the full insurance cost (e.g., the high-tech industry), the interviewees argue that employees expect very little from the employer, while where the insurance is voluntary, the employees participate in insurance costs.

Cooperation with employees in building the insurance agreement

This study's results show that employers do not consider it their responsibility to form the details of the insurance agreement in collaboration with their employees. Out of ten

organizations participating in current study, seven employers construct the insurance agreement together with their Workers' Committee (two in low-tech, public services, private services, and one in high-tech). In these organizations, representatives of the Workers' Committee participate as follows: two Workers' Committees are active in all meetings as full partners – these Workers' Committees are strong and highly engaged in working processes in their organizations; five Workers' Committees are only updated or allowed to participate in the final stage of decision-making, but are significantly less involved in the process of shaping these agreements with the employers.

When asked about their perception of the employees' level of involvement in this process, several different answers emerge. Employers' perceptions of why employees should not get involved in this process can be attributed to the following main reasons:

1. A group insurance agreement is not one of the main interests of employees:

- *'Mainly because of politics, they do not understand, and it does not interest them'*
- *'Insurance is not at the core of the employees' occupation; they do not understand it; it's a decision of Human Resources'*
- *'These workers' committees have various opinions, and therefore it is very difficult to make decisions'*

2. Employers are wary of sharing details with employees:

- *'We'd rather avoid developing expectations among employees. If we do not meet these expectations, it will cause disagreements and dissatisfaction'*
- *'We do not want to disclose the costs and budgets of insurance'*
- *'There are things that only the employer decides'*

As seen in the statements above, employers who view the engagement of employees in the process of shaping group insurance agreement negatively argue that they prefer to have exclusive control over the agreement and are afraid that any involvement of employees might harm the employers' obligations (e.g., increasing insurance costs).

However, employers with a positive attitude towards getting employees more involved, state the following reasons for doing so:

- *'It's preparation for accepting the changes that should be made to the policy'*
- *'It increases satisfaction'*
- *'It reduces objections later on'*

As seen in the statements above, employers who view the engagement of employees in the process of shaping the group insurance agreement positively argue that cooperation with employees creates better trust and satisfaction between employers and employees. In this way, the insurance agreement is used to create a better work environment.

Choosing the insurance company

The answers of all employers in current study reveal that in order to choose the insurance provider, initially a competitive procedure is conducted among insurance companies with the exception of one employer, who put out a tender according to the law. The other companies (9 out of 10) conducted a competitive procedure that is similar in many ways to a tender, but – most importantly – is not as legally binding as a tender.

Specifically, over the years only five employers have conducted such procedures for the following reasons: three employers did so because the insurance companies did not want to continue to insure the employees due to losses or because the insurance company stopped marketing the collective insurance. One employer conducts a competitive procedure every three years, and another employer is obligated to act in accordance with the Tenders Law. The other companies have extended the agreements with their existing insurers.

In all cases interviewed for this research, the cost of the insurance is the primary consideration, the weight of which is 80%-100% among the considerations for selecting the insurer, as appears in the statement: *'we determine the terms of service in the policy and choose according to price'.* As stated by one employer in this study, it appears that the employers determine the terms and conditions of insurance, and only then choose the appropriate insurance provider by price.

Informing employees about changing insurance terms

Interviewees state that in general, they tend not to inform employees about changes in insurance terms. Specifically, when new employees begin their positions in the company, high-tech companies give lectures at the beginning of the insurance period, when the agreements are renewed, or when a new agreement is started with another insurance company. In addition, in high-tech companies, personal meetings are held with the insurance agents in the field of health and pensions or there are conferences dedicated to this issue. This kind of conference is also held when a major change occurs in the pension or insurance terms for all employees. All high-tech companies refer to the insurance agency website where the information is very detailed,

including the terms of the policy. In addition, two of the organizations participating in the study publish such details (in addition to the insurance company); one organization provides general information including the terms of the policy and refers people to the insurance agency, where the information is further elaborated.

One company (not high-tech) publishes full information, including policy terms. The rest refer readers to the agents or to the insurance company's website.

One Government Ministry states when an employee starts working, he meets with a professional representative of the Workers' Committee to explain the insurance. Moreover, that Government Ministry Workers' Committee occasionally has lectures for all employees in order to explain the policy.

It should be noted that all consumers clubs and companies interviewed for this research provide a booklet containing all the rights included in the insurance agreement. All companies have general information on their website and refer to the websites of the agency or the insurance company.

The interviewees made the following statements:

- *'This is a lot of text, no one reads it, and anyone who is interested comes to get information'*
- *'People who need insurance know how to find it'*

These quotations indicate that some of the employers avoid assuming responsibility for communicating the complexity of the insurance agreement to their employees. To conclude this theme, it seems that the general approach of employers regarding involving employees in the process of shaping insurance agreements is to give them a general idea of the agreement. However, most employers tend to avoid significantly engaging employees in this process. Hence, they believe their responsibility for this issue is merely to inform employees about the agreement, but without allowing them to influence it.

Satisfaction surveys among employees

Results deriving from the interviews show that employee satisfaction surveys are conducted by only one employer in this study. The following statements show the other employers' attitudes regarding satisfaction surveys:

- *'The employer has no responsibility for satisfaction surveys. We need to provide an insurance agreement but not to comply with employees' attitudes'*
- *'This is an unnecessary step. It is obvious that those who have a claim rejected will not be satisfied'*
- *'It can raise employees' expectations from the insurance, increase dissatisfaction and create conflicts'*

It seems that such surveys put the HR departments under pressure, since they are afraid the agreement is testing their performance and decisions regarding the agreement. Moreover, it seems that employers sense threat from any procedure that might upset the balanced relationship between them and their employees regarding the insurance agreement. When asked how they learn about employees' needs and positions, they state that they mostly learn from employees' complaints when the insurance agreement is activated for any reason.

To conclude, results show that satisfaction surveys are perceived as another step of actively involving employees in the insurance agreement –a step that employers would rather avoid.

Monitoring the health insurance plan

The results of this study show that one company monitors the plan every six months, when the insurer presents it with data. In addition, two companies hold a meeting every year. In this manner, the employer can follow any changes in insurance terms and rates and be updated on any major issues that might change the group insurance agreement.

- *'We want to know about morbidity'*
- *'We want to prepare for a premium increase'*

According to these statements, it seems employers want to remain vigilant by monitoring the insurer at certain intervals. In doing so, they express their responsibility for being updated on any major change that might affect insurance.

The other companies state that they monitor the agreement less frequently:

- *'from time to time'*
- *'mainly when there is a request to raise the premium'*
- *'when we receive complaints or see that there is a problem'*

All the companies say that they receive an annual report from the insurance company and read it with the consultant.

To conclude, there are two main approaches to monitoring an insurance agreement. The first focuses on periodical monitoring (once a year or once every six months), an approach that can be defined as "vigilant care". The second approach can be defined as "troubleshooting", in which employers get actively involved only in cases where a health-related event has occurred.

Prior lawsuits

The study results show that no lawsuits have been filed against employers. However, lawsuits have been filed against two consumer clubs. The topics of the lawsuits are: (1) collection of the insurance premium without the explicit approval of the insured; (2) erroneous advertising and the employer's reliance on false information; (3) rejected claims because of flawed wording of the insurance terms.

All the interviewees report complaints to the employer about their activities:

- *'Complaints come mainly from managers'*
- *'Complaints when their claims are rejected'*
- *'Most the complaints are about service or collection'*
- *'Very little, especially administrative problems, and the employees' wish to choose the insurance terms more freely'*

It is interesting to note that complaints regarding insurance issues come mostly from managers; apparently, they feel safer about complaining than a subordinate does. This pattern probably creates inequality of rights used by subordinates compared to their supervisors.

The importance of a health insurance plan within the terms of the employment

On the importance of an insurance health plan as part of the general terms of employment, all employers without exception state that insurance is an important element in the terms of employment. They mention that health insurance plans for employees are one of the most significant factors for employee satisfaction and job engagement. Following are several quotes on this subject:

- *'It is a very significant matter since this way the employees are more satisfied'*

- *‘Candidates for insurance are looking for price comparisons and checking what happens after the end of the deal’*
- *‘We are checking all the time’*
- *‘Without health insurance it will be harder to recruit employees, but what interests them is the salary’*

It seems that despite the difficulty for employers to actively involve employees in shaping the insurance agreement, they all agree that it is important to get a good deal for employees as part of their terms of employment. Moreover, the decisions of international high-tech companies are made by the global management department and examine the costs in other countries in which their company’s branches or subsidiaries operate.

Most respondents understand the importance of private insurance in view of the state of public health in Israel. Hence, employers view insurance as a tool in the competitive realm of employee recruitment and loyalty.

The responsibility as perceived by the employers

Finally, employers are asked about their responsibility in providing their employees with a group health insurance agreement. Their comments can be divided into the following two positions:

1. Employers as mediators between employees and the insurance company

Several employers state that their primary responsibility for health insurance is only as a mediating factor between the employees and the insurance company. Hence, they hold no other, broader responsibility:

- *‘transfer payments’*
- *‘that there will be appropriate coverage for the market’*
- *‘I have a guarantee that they will receive services’*
- *‘ensure that service is provided’*
- *‘promote the employer’s interest vis-à-vis the workers’*
- *‘we provide members with assistance dealing with the insurance company, which serves as a bridge between the member and the insurance company and stand with the employee as much as possible’*

Other, lengthier comments are the following:

The main responsibility is to choose a reliable and stable insurance organization known for its reputation in working with quality service providers, as well as a responsibility to choose the coverages in the policy that will be consistent with the organizational concept. There is no responsibility for the quality of service provided by the medical staff.

I definitely think that a policyholder in a collective medical insurance arrangement has a responsibility for the insured, to conduct fair and exhaustive negotiations, to formulate an arrangement that benefits his members and to faithfully represent them throughout the span of the policy with the insurer, regardless of the policyholder's being a sponsor and/or participant in the cost of the insurance.

Efforts should be made to reduce the premium rates in relation to the market in order to create an attractive offer for employees, but I think that financing by the employer stems more from benchmark considerations than from the employer's responsibility.

2. Broad responsibility for employees' rights

A different perspective held by other employers is that the employer is not just a mediator but also holds broader responsibility to ensure employees receive all they need from the insurance company, and that their rights are not violated.

- *'employee satisfaction'*
- *'that there shall be no favours or connections with any insurer whatsoever'*
- *'it's important to have a professional and perform benchmarking'*
- *'visibility – I want to show that I'm a friend who cares'*
- *'as an ethical employer I have to take care of the workers'*

Lengthier comments include:

There is a collective health insurance arrangement, the premium for the employees is financed by the employer, the employee is the subject of the tax benefit, and the full cost of the employee's family members as much as he wishes to enrol them. And there is an internal position in the company whose role is to deal with matters pertaining thereto.

I certainly think that a policyholder has responsibility for the employees in a group policy of any kind, and certainly in medical insurance. The responsibility is first and foremost ethical, where the policyholder must do their best to create a policy that

maximizes their rights with the insurance company. At the managerial level, the policyholder must assist the members of the group to exercise their rights, when necessary, with the insurance company in accordance with the agreement signed with the insurance company, primarily on those subjects that are "in the grey zone". In addition, at the legal level, the policyholder must be free of any conflict of interests and economic and financial matters so that the collective insurance will not grant any benefit to the policyholder.

To conclude, employers interviewed for this part can be divided to two main groups regarding their perceived responsibility for employees. The first group of employers view their responsibility merely as mediators between their employees and the insurance company. Hence, they negotiate with the insurance company, conduct periodic monitoring and consult with specialists in order to achieve the best agreement for the employees. However, their primary concern usually focuses on the insurance costs they must pay. Since employers belonging to this group do not see any other responsibility for their employees, they do very little to encourage greater employee involvement in shaping the agreement or informing employees about any changes.

The second group includes employers that have a broader sense of ethical responsibility. They view their mission as ensuring employee satisfaction and that personal health rights are provided safely within the agreement. Hence, it is important for them to hear from employees about their needs, demands and price sensitivity regarding the agreements. They are also very sensitive about any conflict between their obligations and the law. In addition, they update the employees on insurance terms, conducting periodical audits on service and assisting employees in submitting appeals.

The differences between these two employer groups are reflected also in their interpretations of "faith and diligence". The first group perceive this term as the duty to achieve the broadest insurance possible relative to the price and budget they allot to this purpose, while the second group perceive it also as the duty to update the insurance policy in accordance with regulatory and other changes.

3.5 The perception of the employees

3.5.1 Survey study

Survey design

The survey study among the employees is intended to complete the overall perception of the employer's responsibility towards employees regarding the group insurance arrangement, from the point of view of all participants. The main objectives of the survey study are to examine the association between the employer's actions and the employees' perception of the employer's responsibility toward them, and to examine variables that might affect employees' perception of the employer's responsibility toward them.

The questionnaire created specifically for this study consists of the following parts:

1. **Part one: Demographic details –** gender, age, marital status, number of children, industry, occupation.

2. P**art two**: **Experience with the insurance company**– participants are asked about their personal history of claims against the insurance company. For example: 'Have you or your family filed a claim with your insurance company related to health insurance in the past three years'. In addition, they are asked to rate the importance of several considerations when joining a group health insurance plan, using a Likert-type scale between 1 (not important) to 5 (most important).

3. **Part three: Employers' actions regarding group health insurance** – participants are asked about their knowledge of their employer's actions regarding group health insurance. For example: 'How much does your employer inform the employees about their insurance rights?'

4. **Part four: Employees' attitudes toward the employer's actions regarding group health insurance** – participants are asked about their perceptions of the importance of their employer's actions. For example: 'How much do you trust your employer to choose the best insurance company?'

The full questionnaire is attached in Appendix 4.

3.5.1.1 Research hypotheses

The study hypotheses are formulated according to the findings from the interviews with the insurance companies and the policyholders, regarding the main actions policyholders perform to fulfil their responsibilities towards the employees. Thus, the research hypotheses are:

1. There is a positive association between the inclusion of employees in the formulation of an insurance plan, and the employees' perception of the employer's responsibility. The more employers involve the employees in formulating the insurance plan, the greater the employees' perception of the employer's responsibility toward them.
2. There is a positive association between the hiring of an external expert or consultant by the employer and the employees' perception of the employer's responsibility towards them. This perception is greater when the employer hires an external expert.
3. There is a positive association between conducting a tender/competitive procedure for the choice of insurer, and how the employees perceive the employer's responsibility towards them. The more employers conduct a tender/competitive procedure, the greater the employees' perception of the employer's responsibility towards them.
4. There is a positive association between sharing of information and updating employees regarding their rights as part of the group insurance plan, and the employees' perception of the employer's responsibility. The more employers share information with employees and update them regarding the group insurance plan, the greater the employees' perception of the employer's responsibility toward them.
5. There is a positive association between the level of involvement of employers in handling a group insurance settlement, and the employees' perception of the employer's responsibility. The more employers are involved in handling a group insurance settlement, the greater the employees' perception of the employer's responsibility toward them.

3.5.1.2 Sample

Data Collection

Data derives from an online survey distributed to 500 employees in various occupations who are insured in group health insurance agreements. The Israeli digital collection agency distributing the survey maintains a demographically diverse web panel of subjects who opt in

to taking selected surveys. As a part of the sign-up process, individuals are required to complete an initial web-based, self-reported demographic questionnaire containing questions about gender, age, education, and other variables. The sample for this study includes employees in a variety of industries and companies. Participants in this voluntary survey are asked to answer questions about their employer's actions throughout the health insurance arrangement. The sample is chosen randomly based on these characteristics. No identifying details are taken from the participants in order to maintain confidentiality.

Participants

To calculate the sample size, G-power software is used with the following assumptions: type 1 error of 5%, desired power of 80% and an expected moderate effect size for the correlation between employees' considerations regarding collective insurance and employer's responsibility (Pearson correlation of 0.10). This calculation yields a sample size of 510 participants.

Table 1 presents the demographic information for the sample. Regarding gender, 63% of the participants are male and 37% are female. Participants' ages range from 28 to 73 (Mean (M) =42.02; Standard Deviation (SD)=10.18). Most employees in the sample (64.5%) are married, 15.1% are single, 18.3% are divorced and 2% are widowed. 75% of the total sample have between 1 and 8 children (M=2.41, SD=1.13). About 50% of the total sample has academic degrees, 28.6% have post-secondary education and 21.2% have finished high school. Employees in the sample work in several industries: 27.3% in low-tech industries, 22.8% in high-tech industries, 25.3% in private services, 24/8% in public services.

Table 1 :Demographic information for the research sample

Variable	Coding	Number of respondents (N)	Percent (%)	Range	Mean (M)	Standard Deviation (S.D)
Gender						
Males	1	305	63.0			
Females	2	179	37.0			
Age				28-73	42.02	10.18
Marital status						
Single	1	75	15.1			
Married	2	320	64.5			
Divorced	3	91	18.3			
Widowed	4	10	2.0			
Number of children				1-8	2.41	1.13
Education						
High-school	1	75	21.2			
Post-secondary	2	101	28.6			
Academic	3	177	50.1			
Industry						
Low-tech	1	109	27.3			
High-tech	2	91	22.8			
Private services	3	101	25.3			
Public services	4	99	24.8			

3.5.1.3 Descriptive analysis of the survey answers and research variables

There is no prior research on employer responsibility regarding group health insurance arrangements. Therefore, the choice of the variables is based on the literature review addressing related topics, and on the preliminary qualitative research conducted among the insurance companies and policyholders.

Questions in parts 1-3 of the questionnaire help define the independent variables:

1. **Demographic variables** - The literature review shows an impact of demographic and socioeconomic variables on the rate of insurance purchasers (Gartner Institute, 2019).
2. **Employer actions** - According to Israel's Group Health Insurance Regulations (2015), the policyholder's obligation is to act with faith and diligence on behalf of those insured. The insurance arrangement is a "ratio contract", i.e., a long-term contract describing the relationship between each of the participants in the insurance arrangement. The

employer's actions are defined in accordance with the themes that emerged in the qualitative research among employers.

3. **Considerations of those insured** - This variable describes the considerations of those insured when joining the insurance plan and the degree of employee reliance on the employer (Proccia & Clement, 2014) to see whether and how these considerations have an impact on the employees' perceptions of the employer's responsibility.
4. **Employee satisfaction** – This variable is complex and multidimensional. However, studies have found an association between employee satisfaction and organizational factors (Glisson & Durick, 1988). This variable aims to examine how satisfaction with insurance conditions and the workplace affects employees' perceptions of the employer's responsibility.
5. **Workplace-related** factors examine whether employment and employment conditions have an impact on the employees' perception of the employer's responsibility.

The questions in part 4 of the questionnaire examine the dependent variable: employees' perception of the employer's actions throughout the group insurance arrangement.

Table 2 presents the questionnaire's variables, definitions and measurement methods. The main goal of this table is to show how each variable has been measured, both for the purpose of descriptive statistics and the determination of statistical tests to examine each research question. Because the questionnaire is specifically designed for this study, it is important to show exactly how each question and variable are measured.

Table 2: Variable definition table

<u>Part 1 – Demographic and background data</u>

Variable	Definition	Measurement
Type of policyholder	The participant is/is not insured through a consumer club	Question: Are you insured by a consumer club that belongs to a workers' union? Dichotomous variable - 1 if the participant is insured, 0 if not.
Gender	Gender of the participant	Dichotomous variable - 1 if the participant is a male, 2 if female.
Age	Age of the participant	Age of the participant (years)
Children	Number of children	Number of children of the participant
Marital status		
Single	Single status of the participant	Dichotomous variable - 1 if the participant is single, 0 otherwise.
Married	Married status of the participant	Dichotomous variable - 1 if the participant is married, 0 otherwise.
Divorced	Divorced status of the participant	Dichotomous variable - 1 if the participant is divorced, 0 otherwise.
Widowed	Widowed status of the participant	Dichotomous variable - 1 if the participant is widowed, 0 otherwise.
Education	Level of education of the participant	Participant's level of education, - 1 if it is high school, 2 if it is post-secondary, 3 for a bachelor's degree or above.
<u>Employment domain</u>		
Industry	Industry employment of participant	Dichotomous variable - 1 if the employment domain is industry, 0 otherwise.
Hightech	High-tech employment of participant	Dichotomous variable - 1 if the employment domain is high-tech, 0 otherwise.
Privserv (private service)	Private-services employment of participant	Dichotomous variable - 1 if the employment domain is private services, 0 otherwise.
Publicser (public service)	Public-services employment of participant	Dichotomous variable - 1 if the employment domain is public services, 0 otherwise.
Yearsemploy (years of employment)	Years of employment in the workplace	Number of years in the workplace.
Workcom (Workers committee)	Existence of a workers' committee in the workplace	Dichotomous variable - 1 if there is a workers' committee in the participant's workplace, 0 otherwise.

Part 2 – History of activity with an insurance company

Variable	Definition	Measurement
Manyclaims *(many claims)*	Participant or family member filed a health insurance claim with the insurance company in the past three years	Dichotomous variable - 1 if the number of claims filed by the participant or family member with the insurance company in the three years prior to answering the questionnaire is higher than 3, 0 otherwise.
Claim_lawyer	Lawyer helped participant file the claim	Dummy variable - 1 if a lawyer represented the participant in his claims, 0 otherwise
Claim_insagent *(claim insurance agent)*	Insurance agent helped participant file the claim	Dummy variable - 1 if an insurance agent represented the participant in his claims, 0 otherwise
Claim_companyrep *(claim company rep)*	Company helped participant file the claim	Dummy variable - 1 if a company representative represented the participant in his claims, 0 otherwise
Claim_inshelp *(claim insurance help)*	Insurance company help desk helped participant file the claim	Dummy variable - 1 if an insurance company help desk represented the participant in his claims, 0 otherwise
Insagent *(insurance agent)*	Participant insured by agent	Dummy variable - 1 if as part of the group health policy the participant is insured through an insurance agent, 0 otherwise
Inscompany *(insurance company)*	Participant insured by insurance company	Dummy variable equalling 1 if, as part of the group health policy, the participant is insured by an insurance company, 0 otherwise
Inscompwny_direct *(insurance company direct contact)*	Participant should contact insurance company in case of a problem	Dummy variable - 1 if, as part of the group health policy, the participant should contact the insurance company, 0 otherwise
Insagent_direct *(insurance agent direct contact)*	Participant should contact insurance agent in case of a problem.	Dummy variable - 1 if. as part of the group health policy. the participant should contact the insurance agent, 0 otherwise
Emp_cons_direct *(employer's consultant direct contact)*	Participant should contact employer's insurance consultant in case of a problem.	Dummy variable - 1 if, as part of the group health policy, the participant should contact the employer's insurance consultant, 0 otherwise
Emp_direct *(employer direct contact)*	Participant should contact employer in case of a problem	Dummy variable - 1 if, as part of the group health policy, the participant should contact the employer, 0 otherwise
Privinsur *(private insurance)*	Participant pays a private health insurance.	Dummy variable - 1 if the participant pays for a private health insurance, 0 if not

Variable	Definition	Measurement
Name_imp (name importance)	Importance the participant attributes to the name of the insurance company	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the importance the participant attributes to the name of the insurance company when joining a group health insurance plan
Price_imp (price importance)	Importance the participant attributes to the price	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the importance the participant attributes to the price when joining a group health insurance plan
Par_emp (participation importance)	Importance the participant attributes to employer participation in insurance costs	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the importance the participant attributes to employer participation in insurance costs
Terms (terms importance)	Importance the participant attributes to the terms of insurance	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the importance the participant attributes to the terms of insurance
Emp_prop (employer's proposal importance)	Importance the participant attributes to the reliance on the employer's proposal	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the importance the participant attributes to the reliance on the employer's proposal
Consultprof (consulted a professional)	Participant consulted a professional on behalf of the employer	Dummy variable - 1 if the participant consulted a professional on behalf of the employer before he signed up for the group health insurance plan, 0 if he did not
Consultagt (consulted an agent)	Participant consulted an insurance agent	Dummy variable - 1 if the participant consulted an insurance agent before he signed up for the group health insurance plan, 0 if he did not
Rely_emp (relying on employer)	Participant relied on the employer	Dummy variable - 1 if the participant just relied on the employer before signing up for the group health insurance plan, 0 if he did not
Consufrind (consulted a friend)	Participant consulted a friend	Dummy variable - 1 if the participant consulted a friend before signing up for the group health insurance plan, 0 if he did not
Read	Participant read information brought to their attention by the employer	Dummy variable - 1 if the participant read information brought to their attention by the employer before signing up for the group health insurance plan, 0 if he did not

Variable	Definition	Measurement
Know_rights	Participant knows his rights in the group health insurance policy	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the extent to which the participant knows his rights in the group health insurance policy

Part 3 – Employer activity regarding group health insurance

Variable	Definition	Measurement
Inform_rights	The degree to which the employer informs the participant about his insurance rights.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the degree to which the employer informs the participant about his group insurance rights
Inform_supp (inform supplementary insurance)	The degree to which the employer informs the participant about his rights as part of the HMO supplementary insurance	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the degree to which the employer informs the participant of their rights as part of the HMO supplementary insurance
Inform_pub (inform state health basket)	The degree to which the employer informs the participant about his rights as part of the state health basket.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the degree to which the employer informs the participant of their rights as part of the state health basket.
Inform_form	The degree to which the employer informs the participant about the formulation of the group health insurance policy with the employees	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the degree to which the employer informs the participant about the formulation of the group health insurance policy with the employees.
Ext_exp (external expert)	The degree to which the employer uses an external expert for health insurance	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the degree to which the employer uses and external expert for health insurance
Tender_know	Participant knows whether or not the employer put out a competitive procedure to select an insurance company	Dummy variable - 1 if the participant claims to know whether or not the employer put out a competitive procedure to select an insurance company, 0 if he claims not
Should_tender	Participant thinks the employer should or should not put out a competitive procedure to select an insurance company	Dummy variable - 1 if the participant thinks the employer should put out a competitive procedure to select an insurance company, 0 if he claims not

Variable	Definition	Measurement
Update	Participant thinks the employer updates the employees on regulations and changes in the field of health insurance	Dummy variable equalling 1 if the participant claims the employer updates employees on regulations and changes in health insurance, 0 if he claims not
Appeal	Participant claims to have the option to appeal or involve the employer in case an insurance claim is rejected	Dummy variable equalling 1 if the participant claims having the option to appeal or involve the employer in case an insurance claim is rejected, 0 if he claims not
Family	The employer provides insurance for the participant's family members	Ordinal variable ranging from 1 to 5 depending on the degree to which the employer provides insurance for the participant's family members. 1 denotes not at all, and 5 fully for family members.

Part 4 – The employee's attitude towards the employer's/consumer club's actions regarding group health insurance

Variable	Definition	Measurement
Imp_involve (importance involving employees)	Level of importance the participant attributes to the employer involving employees in formulating the group health insurance policy	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance a participant attributes to the employer involving employees in formulating the group health insurance policy.
Imp_experts (importance using experts)	Level of importance the participant attributes to the employer using external experts in formulating the group health insurance policy.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance the participant attributes to the employer using external experts in formulating the group health insurance policy.
Imp_tender (importance tender)	Level of importance the participant attributes to the employer regularly issuing a tender to choose the insurance company	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance the participant attributes to the employer regularly issuing a tender to choose the insurance company.
Trust_bestcompany (trust best company)	The level of trust that the employer chooses the best insurance company	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring if the participant trusts the employer to choose the best insurance company.

Variable	Definition	Measurement
Trust_bestpolicy (trust best policy)	The level of trust that the employer chooses the best policy terms considering his interests.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring if the participant trusts that the employer chooses the best policy terms taking his interests into consideration.
Trust_bestprice (trust best price)	The level of trust that the employer chooses the best price.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring if the participant trusts that the employer chooses the best price.
Price_imp (price importance)	The level of the impact of the insurance price on purchase.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the impact of the insurance price on purchase.
Imp_info_changes (importance informing about changes)	The level of importance the participant attributes to the employer informing employees about changes in the law and regulations related to insurance and medical services.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance the participant attributes to the employer informing the employees about changes in the law and regulations related to insurance and medical services.
Imp_info_rights1 (importance informing about rights state health insurance)	The level of importance the participant attributes to the employer informing the employees about their rights as part of the state health insurance.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance the participant attributes to the employer informing the employees about their rights as part of the state health insurance.
Imp_info_rights2 (importance informing about rights supplementary insurance)	The level of importance the participant attributes to the employer informing employees about their rights in the HMO supplementary insurance.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance a participant attributes to the employer informing the employees about their rights in the HMO supplementary insurance.
Prov_ins (importance provision insurance)	The level of importance the participant attributes to the provision of an insurance arrangement by the employer as part of the terms of employment.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of importance the participant attributes to the provision of an insurance arrangement by the employer as part of the terms of employment.
Satisf_conduct (satisfaction with group insurance)	The level of satisfaction claimed by the participant with the group health insurance arrangement	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of satisfaction claimed by the participant with the group health insurance arrangement.

Variable	Definition	Measurement
Satisf_work (satisfaction with work)	The level of satisfaction claimed by the participant with the place of work.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of satisfaction claimed by the participant with the place of work.
Satisf_ins_coverage (satisfaction with coverage)	The level of satisfaction claimed by the participant with the level of insurance coverage	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of satisfaction claimed by the participant with the level of insurance coverage.
Satisf_ins_price (satisfaction with insurance price)	The level of satisfaction claimed by the participant with the level of insurance price	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of satisfaction claimed by the participant with the level of insurance price.
Eper (employer responsibility)	The perceived level of responsibility of the employer towards their employees.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the perceived level of responsibility of the employer towards their employees.
Trust_ins_age (trust in insurance agent)	The level of trust in the insurance agent to represent the participant's interest with the insurance company when necessary.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of trust in the insurance agent to represent the participant's interest with the insurance company when necessary.
Trust_cons (trust in consultant)	The level of trust in the insurance consultant to represent the participant's interest with the insurance company when necessary.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of trust in the insurance consultant to represent the participant's interest with the insurance company when necessary.
Trust_comm (trust in Commissioner)	The level of trust that the Commissioner of the Capital Market and Insurance acts and safeguards the interests of the insured.	Ordinal variable ranging from 1 (not at all) to 5 (very large extent) measuring the level of trust that the Commissioner of the Capital Market and Insurance acts and safeguards the interests of the insured.

Descriptive statistics for individual responses

Table 3 presents frequencies, means and standard deviations for all questions. This table consists of the most basic information regarding the sample and the questionnaire. We can learn from this table about the distribution of the demographic characteristics, as well as about the

distribution of responses to each topic. Generally, the variance of the responses for each topic indicates the reliability of the questionnaire, since different participants report different answers. At the same time, it seems that, in general, a very high percentage of respondents answered all the items on the questionnaire.

The distribution of the number of responses can indicate a problem with understanding the question or the respondents' knowledge regarding a particular question. For example, regarding the question of whether the employer uses an external consultant (M=2.49, SD=1.13), only 41% of all respondents answered. A possible explanation for this is that employees may not be aware of the employer's activities regarding health group insurance.

The distribution of the respondents' answers can also indicate about their perceptions about the group insurance arrangement, about the employer's conduct regarding the group insurance arrangement, the employer's responsibility toward them, and their satisfaction with several aspects regarding the group insurance arrangement. Thus, 74.2%of the respondents perceive the employer or organization through which they are insured as having a high level of responsibility toward them (M=3.92, SD=1.05), but only 24.5% report a high level of satisfaction with the employer's conduct regarding the group insurance arrangement (M=2.52, SD=1.27).

Table 3: Descriptive statistics for individual responses

Part 1 – Demographic and background data

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Are you insured by workplace or a consumer club that belongs to a workers' union?	Yes	1			500	100.0
	No	0			0	0
Sex	Males	1			305	63.0
	Females	2			179	37.0
Age			42.02	10.18		
Marital status	Single	1			75	15.1
	Married	2			320	64.5
	Divorced	3			91	18.3
	Widowed	4			10	2.0
Number of children			2.41	1.13		
Education	High-school	1			75	21.2
	Post-secondary	2			101	28.6
	Academic	3			177	50.1
Employment domain	Industry	1			109	27.3
	High-tech	2			91	22.8
	Private services	3			101	25.3
	Public services	4			99	24.8
Years of employment in the workplace			6.18	5.81		
Is there is a Workers' Committee in your workplace?	Yes	1			171	36.3
	No	0			300	63.7

Part 2 – History of activity with an insurance company

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Have you or your family filed a claim with your insurance company related to health insurance in the past three years?	3 claims or more	1			34	92.7
	Less than 3 claims	0			430	
What kind of professional assisted you to file the claim?	A lawyer on my behalf	1			42	8.4
	An insurance agent representing me	2			23	4.6
	A representative from the company I work for	3			21	4.2
	Insurance company help desk	4			22	4.4
As part of the group health policy, you are insured	through an insurance agent	1			164	32.9
	directly with the insurance company	2			69	13.8
	I don't know	3			226	45.3
To the best of your knowledge, when a question or problem arises in your health insurance, whom should you contact?	The insurance company directly	1			148	29.7
	The insurance agent	2			113	22.6

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
	The employer's insurance consultant	3			25	5.0
	The employer directly	4			32	6.4
	I don't know	5			91	18.2
Within the organization, do you also pay for private health insurance in addition to the group health insurance	Yes	1			247	49.5
	No	0			235	47.1
The degree of importance of each of the following considerations when joining group health insurance:						
Name of the insurance company		1-5	3.04	1.37	459	91.8
Price		1-5	3.85	1.13	493	98.6
Employer participation in the cost of the insurance		1-5	3.80	1.32	468	93.6
Terms of insurance		1-5	3.98	1.25	450	90
Reliance on the employer's proposal		1-5	3.84	1.24	419	83.8

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Before you were signed into the insurance program, did you…						
Consult a professional on behalf of the employer?	Yes No	1 0			327 153	65.5 30.7
Consult an insurance agent?	Yes No	1 0			350 137	70.1 27.5
Just rely on the employer	Yes No	1 0			175 321	35.1 64.3
Consult a friend/family member	Yes No	1 0			337 154	67.5 30.9
Read information brought to your attention by the employer	Yes No	1 0			301 188	60.3 37.7
To what extent do you know your rights in the group health insurance policy in which you are insured?		1-5	3.48	1.32	455	91

<u>Part 3 – Activity of the employer regarding group health insurance</u>

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
To what extent did your employer…						
Inform the employees of their insurance rights		1-5	3.45	1.17	459	91.8

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Inform you of your rights in the HMO supplementary insurance		1-5	2.71	1.26	461	92.2
Inform you of your rights in the state health basket		1-5	3.32	1.25	463	92.6
Share the formulation of the health plan with the employees		1-5	3.20	1.14	493	98.6
Use an external expert for health insurance		1-5	2.49	1.13	205	41
Has the employer put out a competitive procedure (e.g., tender) to select an insurance company to insure the employees?	Yes	1			150	31.3
	No	0			329	68.7
Should the employer conduct a competitive procedure (e.g., tender) to choose an insurance company to insure the employees?	Yes	1			172	36.8
	No	0			296	63.2
Does the employer consistently update the employees on regulations and changes in the field of health insurance?	Yes	1			151	32.8
	No	0			309	67.2

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Do you have the option to appeal or involve the employer in case an insurance claim is rejected?	Yes	1			172	36.1
	No	0			304	63.9
Does your employer provide health insurance for your family members?	Not at all	1			40	8.0
	Partially for the employee but not for family	2			48	9.6
	Fully for the employee but not for family	3			216	43.3
	Partially for family members	4			130	26.1
	Fully for family members	5			29	5.8

Part 4 – The employee's attitude towards the employer's/consumer club's actions regarding group health insurance

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Is it important for the employer to involve the employees in formulating the health plan?		1-5	3.92	1.0	493	98.6
Is it important that the employer use external experts in formulating the health plan?		1-5	3.02	1.36	497	99.4

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Is it important for the employer to regularly issue a tender to choose the insurance company?		1-5	3.43	1.16	493	98.6
Do you trust the employer to choose the best insurance company?		1-5	3.25	1.13	497	99.4
Do you trust the employer to choose the best policy term that take your interests into consideration?		1-5	3.33	1.08	499	99.8
Do you trust the employer to obtain the lowest price in relation to the insurance coverage?		1-5	3.57	1.13	496	99.2
How much does the price of the insurance policy impact your purchase of the health insurance policy?		1-5	3.72	1.16	492	98.4
Is it important that the employer inform employees of changes in the law and regulations related to insurance and medical services?		1-5	3.84	1.08	499	99.8
Is it important that employer inform you of your rights in the state health insurance?		1-5	3.98	1.03	492	98.4

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Is it important that your employer inform you your rights in the HMO supplementary insurance?		1-5	3.80	1.15	497	99.4
Are you satisfied with your employer's conduct regarding the group health insurance arrangement?		1-5	2.52	1.27	493	98.6
Are you satisfied with the group health insurance arrangement?		1-5	3.25	1.17	492	98.4
Are you satisfied with your place of work?		1-5	3.15	1.31	499	99.8
Are you satisfied with the level of insurance coverage?		1-5	3.38	1.14	499	99.8
Are you satisfied with the insurance price?		1-5	3.21	1.03	491	98.2
Do you think the employer or organization through which you are insured has any responsibility toward you?		1-5	3.92	1.05	464	92.8
Do you trust the insurance agent to represent your interests with the insurance company when necessary?		1-5	3.13	1.19	462	92.4

Question	Values	Coding	Mean	Standard Deviation (S.D)	Number of respondents (N)	Percent (%)
Do you trust the insurance consultant employed by the organization to represent your interests with the insurance company when needed?		1-5	3.13	1.19	464	92.8
Do you trust the Commissioner of the Capital Market and Insurance to act and safeguard the interests of the insured		1-5	3.24	1.21	467	93.4

Empirical Evidence

First, descriptive statistics are produced using frequencies, means and standard deviations. Correlations between variables are computed using Pearson tests. In addition, differences between ranking questions among the same participants are computed using Repeated Measures Analysis of Variance (ANOVA). Finally, differences between groups (for example, industry) are computed using Analysis of Variance (ANOVA). In addition, multivariate regression models are used to assess associations with employer responsibility.

3.5.1.4 Univariate analysis of the determinants of the employees' perception of the employer's responsibility

Differences between employer's main actions and employees' perception of the employer's responsibility

In this section we examine differences in employees' perception of the employer's responsibility according to the employer's main actions.

The comparison between groups for the mean of employees' perception of the employer's responsibility are conducted using independent t-tests for two groups or ANOVA for three or more groups. The comparison between groups in the question: "Employees'

involvement when a question or problem arises" is conducted using Chi-square. All the assumptions of the statistical procedures are validated. Specifically, as shown in table 4, the variances of the groups were equal in the t-tests are measured by a Leven test as a preliminary analysis.

In addition, frequency in the expected cells are tested for statistical validation.

Table 4: Differences between the employees' perceptions of the employer's responsibility according to the employer's actions

Employer's actions	**Groups**	**Mean (M)**	**Standard Deviation (S.D)**	**t**	**Leven Test**	**X^2**	**p-value**
Employees' involvement	Yes No	3.92 3.81	0.99 1.11	0.80	Equal variances p=.67		p=.43
Hiring an external expert	Yes No	4.04 3.53	1.06 1.29	2.21*	Equal variances p=.39		P=.02
Conducting a competitive procedure	Yes No	3.98 3.87	0.89 1.02	0.82	Equal variances p=.89		p= .40
Sharing of information and updating employees about their rights as part of the group insurance	Yes No	4.10 3.75	0.90 1.02	1.92*	Equal variances p=.55		P=.04
Informing employees about the HMO supplementary insurance	Yes No	3.94 3.14	0.90 0.94	1.92*	Equal variances p=.68		P=.03
Updating employees on changes in the insurance policies terms	Yes No	3.99 3.91	0.96 1.08	1.51	Equal variances p=.72		p= .538
Claim rejection	Yes No	3.91 3.80	0.84 1.12	1.02	Equal variances p=.81		p=.722
Employees' involvement when a question or problem arises						4.32	P=.34

Note: * indicates that statistically significant at p-value < 0.05.

Discussion of the empirical findings

Involving the employees in the formulation of the insurance plan

An independent sample t-test assesses the difference between employers who share the formulation of the group insurance policy with their employees and those who do not, in terms of employee perception of the employer's responsibility for them.

Our data suggest that there is no significant difference in the perceived level of responsibility between employers who involve employees in the group policy formulation (M=3.92, SD=0.99) and those who do not (M=3.81, SD=1.11), (t=0.807, p=.43). In other words, employees do not consider their involvement in the construction of the insurance plan as a factor affecting the employer's responsibility for them.

A possible explanation why this hypothesis is not supported is based on another finding of the study: employees trust employers to obtain the best terms, and employees may think they cannot contribute to the process of formulating the insurance plan because of the subject's complexity and their lack of relevant knowledge.

The same perception is found among employers who reject the notion of employee involvement in the formulation of the insurance plan, arguing that the insurance issue is complex, employees do not understand it, as it is not within their area of expertise.

Another explanation why this hypothesis is not supported is that in a significant proportion of organizations there are Workers' Committees, and these are usually involved in the formulation of the insurance arrangement. Employers report that Workers' Committees are actively involved in the process of formulating the health insurance plan and in making insurance decisions, or at least are updated about the insurance plan.

Although no significant correlation has been found between employees' involvement in the formulation of an insurance plan and their perception of the employer's responsibility, it has been found that employees perceive the importance of their participation in the process as middling to high.

While the primary purpose of a group insurance arrangement is to protect employees against high medical expenses, insurance also protects employers, as greater availability of diagnosis, treatment and rehabilitation services can reduce sick days, increase job satisfaction and security, and contribute to increased productivity. These considerations are consistent with

the notion that including employees in decision-making may simultaneously promote employee and organizational goals (Shirom, 1983), increase employee identification with and commitment to their workplace, and serve as a means of improving the social climate and reducing job dissatisfaction, alienation and stress (Blumberg, 1968). Employee inclusion and engagement is an important factor in ethical human resource management (Greenwood & Freeman, 2011).

Insurance companies that ascribe low importance to the issue of involving the employees argue that insurance coverage, as part of group insurance arrangements, addresses the largest common denominator, and does not always address the individual needs of each person insured. Thus, a group of young employees may request insurance coverage that differs from that needed by an older group of employees. The needs of unmarried insured persons will also be different from those who have families. For example, young employees will want coverage for pregnancy and childcare, while older employees will want more access to medicines, check-ups and specialist consultations.

The study finds that employers ascribe low importance to employee inclusion, although their position is not uniform. Employers who reject employee involvement in the formulation of a group insurance plan argue that health insurance is a matter to be decided by the employer, and they even refuse to disclose to the employees the costs and budgets available to them for health insurance. They also argue that involving employees in the formulation of the health insurance plan may foster expectations they are not able to meet, and that employees' demands may force the employer to increase the insurance budget.

Employers who support employee involvement in the formulation of the health insurance plan argue that this inclusion will prevent conflicts and disputes in case changes to insurance terms are required in the future. They argue that inclusion increases employee satisfaction and trust, creating a more pleasant work environment. An indirect way to involve employees is by conducting satisfaction surveys, from which one can learn about problems with the insurance plan, and about the changing needs of those insured.

It is important to mention that employers report that when insurance is fully funded by the employer, employee involvement is lower, and when the employees themselves pay for the insurance policy, they are more involved.

Hiring an external expert

An independent sample t-test assesses the difference in the employees' perception of their employer's responsibility for them when the employer hires (or does not hire) an expert/counsellor.

Our data suggest a significant difference between employees whose employers hire a consultant and employees whose employers who do not. The analysis shows that employers who hire an external consultant (M=4.04, SD=1.06) are perceived as having greater responsibility for their employees, compared to employers who do not (M=3.53, SD=1.29), ($t = 2.21$, $p<.05$).

Insurance consultants serve as the professional arm of the employer-policyholder, assisting the policyholder at all stages of the group insurance agreement, including formulating the group insurance terms, choosing the insurer, managing the group insurance arrangement, and achieving the professional and financial goals it has set. The insurance agents, who are representatives of the insurance companies, usually work directly with the insured employees, handling claims and insurance operations, including signing up new people, removing those leaving the group plan, and handling the collection of insurance premiums. It may be that when an insurance agent operates in an organization, employees are less aware of the role of the consultant, and confusion ensues between the respective roles of the consultant and the insurance agent. Current study shows a statistically significant difference (albeit it a small one) in employees' greater reliance on consultants than on agents, and, their lesser reliance on the Insurance Commissioner to safeguard their interests. Because insurance is not within the scope of the employer's expertise, because group health insurance concerns a large group of insured people and a large amount of money, and because medical insurance is concerned with the safety and welfare of the employee, the policyholder has greater legal obligations to the insured by virtue of being their trustee and representative (Trust Law, 1979) and the need arises to hire a professional consultant in this field. It is conceivable that employees also understand this, and so the more the policyholder tends to employ a consultant, the greater the employees perceive the employer's responsibility.

The insurance companies consider it very important that employers hire a consultant. They maintain that employers should not take responsibility for an issue they do not fully understand, mainly because they simply lack the knowledge. The insurers argue that the importance of employing a professional consultant lies in the fact that this provides up-to-date

professional information, which has a different perspective than that of the decision-makers in the organization, and it improves the decision-making process. They also argue that the consultant helps them communicate with employers professionally, and the former is in fact a "knowledge broker".

Most employers report that they use insurance consultancy services regularly. They argue that the role of the consultant includes: bridging existing knowledge and information gaps among decision makers regarding insurance in the organization; providing information on the state of the market; assisting procurement and HR departments in negotiating with insurance companies; informing and communicating with employees about insurance terms and changes to them during the relevant period; and help the policyholder analyse data and information obtained from the insurance company. Only one employer reports using consulting services only before conducting a tender or renewing the insurance.

Conducting a tender/competitive procedure

An independent sample t-test assesses the associations between the employees' perception of their employer's responsibility, according to whether the employer puts out a tender or not.

Our data suggest there is no significant difference in the perception of the employers' responsibility between employees whose employers conduct a tender or a competitive procedure (M=3.98, SD=0.89) and employees whose employers do not (M=3.87, SD=1.02), ($t = 0.829$, $p= .40$).

The study also examines employees' perception of the link between conducting a tender/competitive procedure and choosing the better insurance company, obtaining better insurance terms, and obtaining a lower price.

Results show that issuing a tender does not affect the choice of the best insurance company, but it does have a positive effect on obtaining better insurance terms and prices. These facts are consistent with the employees' position that the considerations in choosing an insurance plan are mainly the price and terms of the insurance.

A possible explanation of why there is no correlation between the perception of responsibility and conducting a tender/competitive procedure lies in the fact that 47.2% of respondents do not even know whether or not the employer conducts one. There may be a lack of information and lack of interest on the part of the employees regarding the conduct of the

employer, and the employers should be aware of the possibility of holding a tender/competitive procedure, which may increase the employees' confidence in the employer's conduct and in the proposed health plan. Another possible explanation is that employees generally rely totally on employers, and do not express interest in the process. Supporting this is the fact that at the time of joining the insurance plan, they rely to a great extent on the employer's offer.

There are many advantages to allocating assets through tenders or other competitive procedures, not only for maximizing commercial terms (price), but also for the purpose of regulating processes, increasing public trust and the public good, including transparency and fairness, disclosure of information and efficiency. Actually, this kind of procedure has two objectives: economic and public. From an economic point of view, it is designed to obtain as many suitable bids as possible in order to select the best and most suitable one. From a public point of view, it is intended to ensure ethical conduct, equality and fairness, by opening it up to as many bidders as possible, on the basis of fair competition under conditions of equality (Shalev, 1995).

The insurance companies report that they ascribe medium importance to conducting a tender. Some companies report that a tender is important to encourage competition. They note that it is important to also consider the quality of service for the insured rather than just the cost. Such attitudes of the insurance companies are expected, since they want to ensure profitability. The bigger insurers express less support for tenders, since they generate greater competition and may push employers to switch to smaller competitors. Nevertheless, all the insurers concede that if no competitive process is held, the employer has to check the data, examine the level of service offered by the existing insurer, check market prices, and update the insurance policy to match regulatory changes, survey employee needs, improve current insurance coverages or add new and up-to-date ones.

Among the employers participating in this study, all respondents initially conduct a tender or a competitive process to select an insurer. One employer issues a tender under the Tenders Law, and the rest conduct a competitive procedure similar to a tender but not subject to the terms of the law. Regarding the question whether the employers issue a tender even after recently renewing their insurance, of the eight employers and two consumer clubs participating in this study, three report having to conduct a competitive process because insurance companies did not want to continue the arrangement due to losses, or the withdrawal of one of the companies from the group insurance business; one employer is subject to the Tender Law; and one employer enacts a procurement policy which mandates a regular competitive procedure

every three years. The other interviewees report that they renew the insurance without a competitive procedure. The employers report that they formulate the policy and set the terms of service for the insured, and that cost is the main consideration for choosing an insurer, with the relative weight given to the price parameter ranging from 80% to 100%.

Informing employees about their rights

Three independent sample t-tests assess the differences in perception of the employer's responsibility between the following groups: informing employees about their rights under the group insurance plan (yes/no), informing employees about the HMO supplementary rights (yes/no), and informing employees about changes in the law and regulations related to insurance policy terms (yes/no).

Our data suggest that employers who inform their employees about their insurance rights (M=4.10, SD=0.90) are perceived as having greater responsibility for their employees, compared to employers who do not (M=3.75, SD=1.02), ($t = 1.924$, $p < .05$).

With respect to informing employees about the HMO supplementary insurance, our data suggest that employers who inform their employees about HMO rights (M=3.94, SD=0.90) are perceived as having greater responsibility for their employees, compared to employers who do not (M=3.14, SD=0.94), ($t = 1.912$, $p < .05$).

As for updating employees on changes in the law and regulations related to insurance policy terms, our data suggest there is no significant difference in how employees perceive the employer's responsibility is found between employees whose employers update their employees (M=3.99, SD=0.96) and those who do not (M=3.91, SD=1.08), ($t=1.616$, $p= .538$).

A survey published by the Israel Consumers Council, (2012) regarding consumers' awareness of their medical rights, found that the public was deeply uninformed as to the proper selection of medical services. A social survey found that 48.8% of people aged 20-44 and 47.55% of people aged 45-64 lack information about their rights in the health system (Social Survey, 2017). The lack of access to information in these areas may lead employees to believe that it is the employer's responsibility to inform them about these issues as well.

This lack of knowledge can be explained as stemming from four main causes:

- People are only interested in this topic when they need treatment.
- The topic is too complex.

- Information is unclear and inaccessible.
- Psychologically, people prefer to avoid thinking about services related to illness or medical problems.

The insurance companies attribute a great deal of importance to the involvement of the policyholder in informing employees of their rights under the group health insurance. They also claim that it is the employers who relay the information from them to the employees, and that there are employers who demand the insurers get their approval for their advertising wording, believing that they know their employees better, and want to ensure that the message and information are transmitted optimally and clearly. The insurance companies also report that updating on changes in the regulations and in the group insurance framework is of great importance.

Nevertheless, one insurance company claims that the policyholder's responsibility to inform and update is too limited. In that company's opinion, it is incumbent upon the policyholder to inform a new employee of their right to join the insurance plan, and upon leaving work – of their right to continue the insurance privately.

In contrast, the insurance companies ascribe low importance to updating employees about their rights in the State Health Basket and in the HMO supplemental insurance. They claim that it is not the employer's job, the subject is not within their field of expertise, and they have insufficient knowledge of it.

Similarly, while most employers report that updating on changes in the insurance policy terms framework is of great importance, they consider updating employees about their rights in the State Health Basket and in the HMO supplemental insurance to be of low importance. Their argument is that providing information in these areas may increase their responsibility for employees, and they are not interested in doing so.

The employers themselves, who disagree about their responsibility for the employees, also disagree about the responsibility to pass on information. Employers who believe that their responsibilities are limited see themselves merely as intermediaries between the insurance companies and the employees. These report that their responsibility amounts to informing employees of the existence of the insurance, and their right to join it. In contrast, employers who feel more responsible report that they make sure to send employees information and explanations via e-mail and advertising on the organization's website. They also make sure to

arrange lectures to employees at the beginning of the insurance period or when it is renewed for an additional period, or when changes to the insurance terms apply.

Involvement in managing the insurance arrangement

An independent sample t-test assesses the difference in perception of the employer's responsibility and the employer's involvement in a rejected claim (yes/no).

They study data suggest no significant difference in how employees perceive the employer's responsibility is found between employees whose employers are involved in rejected claims (M=3.91, SD=0.84) and those who are not (M=3.80, SD=1.12), (t=1.02, p=.722).

To assess the relationship between employees' involvement when a question or problem arises and the perceived responsibility of the employer, a Chi-square test is conducted.

The study data suggest no significant difference in how employees perceive the employer's responsibility regarding involvement when a problem arises with the insurance company.

A possible explanation for this lies in the fact the employees are not familiar with the employer's administrative actions vis-à-vis the insurance company. It is important to note that a significant proportion of employees (22.2%) do not even know whom to contact in the event of a claim. Finally, about half (49%) of the sample do not know who manages the insurance arrangement. This means that these employees are not aware of the possibility of involving the employer or a professional acting on his behalf.

According to the insurance companies, involvement in managing the group insurance arrangement can be described as follows:

- Employer involvement in rejected insurance claims, and in case of disputes between the insured and the insurance company, and when a problem arises regarding the insurance arrangement.
- Employer involvement in insurance administration: regular reporting of the state of those insured and collection administration.
- Monitoring the reports of the insurance company and its conduct.
- Employer involvement in the termination of the insurance agreement.

The insurance companies claim that the benefit of group insurance over private insurance is, among other things, the possibility of approving exceptional claims, assisting the insured in disputes, and approving payments that go beyond the letter of the law. They attribute a great deal of importance to employers monitoring the group health insurance plan and being involved in disagreements in the event of a claim.

There are disagreements among employers on this issue. Employers' involvement when a claim is rejected or when a dispute arises between the employee and the insurance company is found to be of medium importance, although they state that they have an obligation to act and ensure that employees' rights are fully exercised within the group insurance. Three employers report that they approve a "beyond-the-letter-of-the-law fund" payment, and they approve payments primarily for expensive medical costs, or for medical treatments for difficult or life-threatening medical conditions. Most employers argue that running such a fund is not their responsibility, and that the insurance company must pay only under the terms of the policy. This attitude reflects employers' reluctance to be involved, and an attempt to reduce insurance costs.

Monitoring and control are also part of the relationship between the employer and the insurance company. In this regard, some employers report that they hold periodic meetings with insurance company representatives, and others report that they meet with insurance companies from time to time, when there is a demand to raise the premium, when employees' complaints about the insurance company accumulate, or when the agreement needs to be renewed. Periodic monitoring of the insurance company's reports enables the employer to keep abreast of developments and expected changes in coverage. Employers want to know about trends in morbidity and insurance utilization and want to be prepared in the event of an expected increase in premium.

Employers seem to monitor insurance companies primarily to protect their interests from an increase of premiums in the future. It can be said that regularly monitoring the activities of the insurance companies is a deterrent that will cause the insurance companies to act fairly towards the insured parties.

The employers see themselves as responsible for the collection of premiums, mainly for the sake of convenience and cost savings. Reporting to the insurance company about the status of the insured, reporting about new recruits, or employees quitting or retiring, is an inherent responsibility of the employer.

Understanding differences in perceptions

Demographic characteristics

Table 5 presents differences between groups in how employees perceive the employer's responsibility according to demographic variables.

Table 5: Differences between groups in how employees perceive the employer's responsibility according to demographic variables

Factor	Groups	Mean (M)	Standard Deviation (S.D)	t	F	p-value
Gender				0.23		.82
	Male	3.90	1.07			
	Female	3.93	1.02			
Age					1.08	.35
	Up to 30	3.55	1.18			
	31-40	3.96	1.06			
	41-50	3.88	0.99			
	51+	3.94	1.10			
Marital status					1.71	.15
	Single	4.09	0.93			
	Married	3.84	1.09			
	Divorced	4.04	1.03			
	Widowed	3.90	1.20			
Education					1.89	.21
	High-school	3.99	1.02			
	Post-secondary	3.81	0.98			
	Academic	4.10	1.12			

Note: * indicates that statistically significant at p-value < 0.05.

A one-way ANOVA assesses the differences in employees' perceptions of their employer's responsibility for them across demographic variables.

Our data suggest no associations between gender, age, marital status or education and how employees perceive the employer's responsibility.

A possible explanation for these results is that young people who are insured lack experience and knowledge about insurance plans and are expected to trust the employer and perceive the employer's responsibility as greater. On the other hand, older participants in a group health plan are usually married and have children, so the issue of insurance is important to them to protect the family and they will perceive the responsibility of the employer as greater. The result regarding education is surprising, because it shows that employees in high-tech companies, who usually have an academic education perceive the employer's responsibility as greater. In addition, generally those with academic education have a higher salary and are more aware of health and insurance services and are more aware of their rights in this area (Chernovsky et al., 2016).

Workplace factors

Table 6 presents differences between groups in how employees perceive the employer's responsibility according to workplace-related factors.

Table 6: Differences between groups in how employees perceive the employer's responsibility according to workplace-related factors

Factor	Groups	Mean (M)	Standard Deviation (S.D)	t	F	p-value
Type of employer				1.86*		.04
	Direct employer	4.17	0.95			
	Consumer club	3.66	0.87			
Industry					4.21*	.02
	Low-tech	4.05	0.92			
	High-tech	4.15	1.23			
	Private services	3.12	1.09			
	Public services	3.20	1.01			
Existence of a Workers' Committee	No	4.03	0.91	1.92*		.04
	Yes	3.51	1.07			

Note: * indicates that statistically significant at p-value < 0.05.

Difference between policyholder types: direct employer and consumer clubs.

An independent sample t-test assesses the differences of employees' perception of the employer's responsibility, when the policyholder is the direct employer or a consumer club.

Our data suggest a significant difference in how the employees perceive the employer's responsibility. It is higher among employees insured directly by their employer (M=4.17, SD=0.95) compared to employees insured by a consumer club (M=3.66, SD=0.87), (t=1.861, $p < .05$).

A possible explanation for this is that employees see the employer as responsible for welfare conditions, while the consumer clubs primarily provide economic benefits in the form of shopping discounts.

Among insurance companies, there is no difference in the perception of responsibility based on the identity of the policyholder – employer or consumer clubs belonging to a workers' union. In contrast, consumer clubs (teachers, civil servants) perceive their own responsibility to be higher than direct employers, possibly because membership in consumer clubs is voluntary, and consumer clubs seek to strengthen the relationship with their members and ensure their trust. Another fact that stands out is that consumer clubs operate a special department or appoint a designated supervisor for insurance matters, while employers usually have a person who oversees insurance and other issues as part of the salaries and benefits department.

Difference between industrial and service sectors

A one-way ANOVA assesses the differences in employees' perceptions of their employer's responsibility for them across different employment sectors. Our data suggest a significant difference between industries and services sectors (F=4.214, $p < .05$). The employees' perception of the employer's responsibility is higher among employees working in high-tech (M=4.15, SD=1.23) and low-tech (M=4.05, SD=0.92) industries, compared to those who work in private (M=3.12, SD=1.09) and public (M=3.20, SD=1.01) service sectors.

A possible explanation for this lies in the characteristics of work in these sectors and the inherent risks they contain.

The competition in high-tech, the need to meet challenges and goals, and the rapid technological changes in this field result, on the one hand, in job insecurity and, on the other,

in many hours of work (Golden, 2006). All of these affect the level of stress and pressure at work and can cause physical and mental illness (Dembe et al., 2005).

In contrast, industrial workers are exposed to environmental risks related to their workplaces (noise, contact with materials, use of machines, etc.), and are at greater risk of accidents at work. Their work is characterized by more physical effort, which has adverse effects on health conditions (Meijman & Mulder, 1998).

Most workers in industrial companies have lower incomes, and sometimes work long hours, or sometimes work in more than one job. Long working days, including overtime, have been associated with mental and physical health risks (Burke & Cooper, 2008) Exhausted workers make more mistakes, and are found to be more involved in road and work accidents (Caruso, 2006).

Another possible explanation for the fact that high-tech employees perceive the employer's responsibility as greater is that the high-tech industry is characterized by highly paid and highly educated employees who can afford to purchase private health insurance and are more aware of their right to receive medical services (Social Survey, 2017). The finding that workers in industrial companies also perceive the employer's level of responsibility as high is surprising, since these companies have a Workers' Committee, and another finding shows that when there is a Workers' Committee, the employees perceive the employer's responsibility as lower.

It is important to mention that the qualitative study shows that among employers and insurance companies, there is no difference in their perceptions of the employer's responsibility across the various fields of employment.

Difference between workplaces with a Workers' Committee and those without

An independent sample t-test assesses the differences of employees' perception of the employer's responsibility, according to whether or not there is a Workers' Committee at the workplace.

Our data suggest a significant difference in the employees' perception of the employer's responsibility with and without a Workers' Committee. It is higher when there is no Workers' Committee ($M=4.03$, $SD=0.91$) compared to when there is one ($M=3.52$, $SD=1.07$), ($t=1.926$, $p< .05$).

A possible explanation for this is the fact that Workers' Committees are representatives of the employees and are usually involved in formulating the group health insurance plan and sometimes assist employees when problems arise regarding insurance issues, and as a result, employees perceive the employer's responsibility as lower. On the other hand, when there is no Workers' Committee, employees rely more on the employer and perceive the employer's responsibility as greater.

It is important to note that the insurance companies argue that the fact there is a Workers' Committee has no impact on the responsibility of the employer, but in many cases, when there is a Workers' Committee, they are involved in the management of the plan and have a direct connection to the supervisor at the insurance company. Employers report that when there is a Workers' Committee, it is involved in making decisions about group health insurance.

Insurance considerations

Table 7 presents differences between the employees' perception of the employer's responsibility according to considerations before joining to the insurance plan.

Table 7: Correlations between employees' perceptions of the employer's responsibility and insurance considerations

Insurance considerations	r	P-value
Price of insurance	.08	.09
The employer participates in the cost of insurance	.01	.78
Insurance terms	.06	.17
Company name	.04	.35

Pearson correlations assess the correlations between employees' perception of the employer's responsibility and insurance considerations before joining the insurance plan.

As shown in Table 7, the study data suggest no significant correlations between employees' perceptions of the employer's responsibility and insurance considerations before joining the insurance plan.

The results obtained are quite surprising. It was expected that when the price of insurance is more expensive, or when the employer does not fund the insurance, the perception of responsibility will be greater. In fact, we can see that the price considerations are almost significant ($p=0.09$). The price of insurance and the insurance terms are important factors for conducting a competitive procedure among the insurance companies, but there is no correlation between the competitive procedure itself and the employees' perception of the employer's responsibility. A possible explanation for these results is, on the one hand, a lack of knowledge and information regarding the issue of insurance, and on the other hand, there is a reliance on the employer as a strong economic factor.

3.5.1.5 Multivariate analysis of the determinants of the employees' perception of the employer's responsibility

As previously reported, the univariate model shows a significant difference between the averages of the variables describing the employer's actions: hiring an external expert, sharing information and updating the employees about their rights of the group insurance, sharing information about supplementary insurance, and the average of the employees' perception of the employer's responsibility. It also shows a significant difference between the averages of the variables describing the workplace and the employees' perception of the employer's responsibility. As described in table 8, these variables have been defined as important ones. The multivariate linear regression is used to assess whether the important variables predict the employees' perception of the employer's responsibility when examining all the variables together. The demographic variables are entered into the multivariate linear model in order to statistically control their variance.

Table 8: Description of the important variables in the univariate analysis

Variables	Importance
Employer's actions	
Employees' involvement	No
Hiring an external expert	Yes
Conducting a competitive procedure	No
Sharing of information and updating employees about their rights as part of the group insurance	Yes
Informing employees about the HMO supplementary insurance	Yes
Updating employees on changes in the insurance policies terms	No
Claim rejection	No
Employees' involvement when a question or problem arises	No
Demographic variables	
Gender	No
Age	No
Marital status	No
Education	No
Workplace variables	
Type of employer	Yes
Industry	Yes
Existence of a Workers' Committee	Yes
Insurance considerations	
Price of insurance	No
Employer's participation in the cost of insurance	No
Insurance terms	No
Company name	No

Thus, the multivariate linear model is used to assess how the employer's actions, demographic variables, workplace-related factors and insurance considerations can predict the level of employees' perception of the employer's responsibility. The multivariate linear regression is conducted according to the following equation (3.1):

$$Eper_i = B0 + B1 * Female_i + B2 * Age_i + B3 * Married_i + B4 * Academic_i + B5 * Inform_Form_i + B6 * Ext_Exp_i + B7 * Tender_Know_i + B8 * Inform_rights_i + B9 * Inform_Supp_I + B10 * Imp_Info_Changes_i + B11 * Claim_Inshelp_i + B12 * Direct_i + B13 * Hightech_i + B14 * Workcom_i + B15 * Price_Imp_i + B16 * Par_Emp_i + B17 * Terms_i + B18 * Name_Imp_i \quad (3.1)$$

Results show that in the multivariate model, none of the socio-demographic characteristics predict how employees perceive the employer's responsibility. According to the previously reported, non-statistically significant differences, on average, socio demographic aspects also have no power to explain how employees perceive the employer's responsibility.

Examination of the contribution of employer's actions show that hiring an external expert (*Ext_Exp*) positively predicts the employees' perceptions of the employer's responsibility (*Eper*) (β=0.371, $p < .05$). This result is consistent with the univariate model, which shows a significant difference, on average, of the perception of the employer's responsibility between employees whose employers hire a consultant and those whose employers do not.

Sharing of information and updating employees about their rights as part of the group insurance (*Inform_Rights*) positively predicts the employees' perceptions of the employer's responsibility (β=0.192, $p < .05$). This result is consistent with the univariate model. Moreover, the univariate model shows a significant difference on average of the perception of the employer's responsibility between employees whose employers inform them about their insurance right and those whose employers do not.

However, with respect to informing employees about the HMO supplementary insurance, the univariate model shows a significant difference between employees whose employers inform them about HMO rights, and those whose employers do not, and yet, according to the multivariate model, informing employees about the HMO supplementary insurance does not predict the employees' perceptions of the employer's responsibility.

The multivariate model shows that employment in the high-tech industry (*Hightech*) positively predicts the employees' perceptions of the employer's responsibility (β=0.901, $p < .05$). The industry variable is entered into the regression as a dummy variable, comparing high-tech vs. other sectors. This comparison is conducted due to the importance of the high-tech sector above all other sectors. The univariate model shows a significant difference, on average,

of the perception of the employer's responsibility towards the employees among employees working in high-tech and low-tech industries, compared to those who work in private and public service sectors.

Results show that in the multivariate model, none of the insurance considerations predicted how employees perceive the employer's responsibility. Moreover, the previously reported Pearson correlation also shows no significant correlations between employees' perceptions of the employer's responsibility and insurance considerations before joining the insurance plan.

Finally, the univariate model shows significant differences, on average, of the perception of the employer's responsibility towards the employees between direct employers and consumer clubs. The multivariate model shows that the existence of a direct employer *(Direct)* does not predict how employees perceive the employer's responsibility.

Table 9: Linear regression coefficients predicting the level of employees' perception of the employer's responsibility by demographic variables, employer's actions, workplace-related factors and insurance considerations

	Name of variable	**Name of variable (short)**	**B**	**standard error of coefficients B (S.E. B)**	**Beta**
Demographics	Gender (Females)	*Gender*	0.031	0.279	0.043
	Age	*Age*	0.212	0.341	0.031
	Marital status (Married)	*Married*	0.225	0.412	0.032
	Education (Academic)	*Education*	0.321	0.891	0.012
Employer's actions	Employees' involvement	*Inform_form*	0.210	0.911	0.023
	Hiring an external expert	*Ext_exp*	2.071	0.531	0.371*
	Conducting a competitive procedure	*Tender_know*	0.077	0.116	0.090
	Sharing information and updating employees of their	*Inform_rights*	0.164	0.029	0.192*

	Name of variable	Name of variable (short)	B	standard error of coefficients B (S.E. B)	Beta
	rights as part of the group insurance				
	Informing employees about the HMO supplementary insurance	*Inform_supp*	0.062	0.143	0.061
	Updating employees on changes in law and regulations related to insurance policy terms	*Imp_info_changes*	0.121	0.191	0.021
	Involvement in claim rejection	*Claim_inshelp*	-0.059	0.111	-0.066
Workplace - related factors	Direct employer	*Direct*	0.351	0.214	0.026
	Industry (high-tech)	*Hightech*	1.931	0.321	0.901*
	Existence of a workers' committee at the workplace	*Workcom*	0.211	0.102	0.012
Insurance considerations	Price of insurance	*Price_imp*	0.398	0.908	0.022
	Employer takes part in insurance cost	*Par_emp*	0.402	0.623	0.012
	Insurance terms	*Terms*	0.693	0.892	0.053
	Company name	*Name_imp*	0.281	0.543	0.011

Note: * indicates that statistically significant at p-value < 0.05.

3.5.1.6 The gaps between employees' attitudes and the employer's actions

To examine whether the employer's actions in practice meet employees' expectations, the gap between the employees' attitude towards the employer's actions and the employer's actions in practice regarding the group health insurance are examined. This gap is defined as the difference between the mean level of participants' knowledge about the employer's actions

in practice, as received from their answers in the third part of the questionnaire, and the mean level of participants' attitudes about the importance of the same actions as received from their answers in the fourth part of the questionnaire. Hence, paired sample t-tests are conducted for every main aspect of the group health insurance.

Table 10: Gaps between employees' attitudes and the employer's actions

Aspect	Employees' attitude		Employer's actions in practice		t
	Mean (M)	Standard Deviation (S.D.)	Mean (M)	Standard Deviation (S.D)	
Informing about rights	4.65	1.23	3.45	1.17	2.41**
Formulating the health plan	3.78	1.18	3.20	1.14	1.81*
Using external experts	3.22	1.34	2.49	1.14	2.76*
Conducting periodical tenders	4.71	1.05	4.23	1.29	1.26
Updating employees on changes in the law and regulations related to insurance policies terms	4.62	1.29	4.57	1.31	0.89

Note: * indicates that correlations are statistically significant at p-value < 0.05.
**indicates statistically significant at p-value < 0.01

As shown in Table 10, significant gaps are identified between employees' attitudes and actual employers' actions relating to most aspects of group health insurance. Specifically, the data show that employees attribute high importance to employers informing them of their rights in the insurance (4.65), while the employers are only moderately active in informing employees of their rights (3.45). Moreover, while employees believe the employer should involve them in formulating the health plan (3.78), employers do so to a lesser extent (3.20). Moreover, while employees believe employers should use external experts to provide the best health plan (3.22),

employers do not regard this as highly important. Finally, results show that employees have a more positive attitude towards the conducting of periodical tenders and towards being informed of changes to the law compared to their employers. However, none of these differences are significant.

3.5.1.7 Summary of the results of the survey study

The multivariate model results show that hiring an external expert and sharing information and updating employees about their rights as part of the group insurance positively predicts the level of the employees' perceptions of the employer's responsibility towards them. In addition, the results show that none of the socio-demographic characteristics predict the level of the employees' perceptions of the employer's responsibility. At the same time, employees in the high-tech industry demonstrate a higher perception of the employer's responsibility towards them, in comparison to employees of other industries.

Employees insured through an employer perceive the employer's responsibility greater than employees insured through consumer clubs. However, in the multivariate model, this correlation is not found. Similarly, employees in companies where there is no Workers' Committee perceive the employer's responsibility to them as greater than employees in companies where there is a Workers' Committee, while in the multivariate model, this correlation is not found.

Finally, significant gaps are identified between employees' attitudes and employers' actions relating to some aspects of group health insurance. Specifically, the data shows that employees attribute high importance to the employer's informing them of their rights in the insurance, while, according to employees' knowledge, the employers are only moderately active in informing them of their rights.

3.5.2 Interviews with employees

To complete the research among employees, semi-structured interviews are conducted by phone (Bechhofer & Paterson, 2000) with 10 questionnaire respondents in order to elicit their perceptions on certain issues arising in the quantitative study, and on issues not present in the quantitative research, and specifically: How do employees interpret the term "faith and diligence", in what ways does the employer inform employees about their rights regarding the

group health insurance policy, and to what extent are employees aware of their rights in the group health insurance policy?

A request was sent via the web panel to conduct a short interview with questionnaire respondents. Of the 10 randomly selected interviewees, 7 are men and 3 are women. Two are between the ages of 30 and 40, 3 are between the ages of 40 and 50, 4 are between the ages of 50 and 60, and one is over 60.

Participants are asked three main questions to elicit how they interpret the term "faith and diligence", their level of knowledge about their rights in health group insurance, and what actions they think their employer takes to inform them about their health insurance rights. The interview questions are attached in Appendix 3. For example, one of the questions is "Does and how the employer inform you of your rights regarding the group health insurance plan, and how is this done"?

The term "faith and diligence"

Responses to the question of what the term "faith and diligence" means to the interviewees in relation to the employer's actions within the group health insurance show that the concept of faith and diligence is related to the expectation that the employer will obtain the best insurance terms and the lowest price: '*He has to make sure I have the best insurance*'. '*He has to find us the best conditions*. '*Price, price is the most important*'. '*They are constantly raising the price for us. We are a big group – he should take care of us*. Responses also show that employees believe that the task of the employer, in general, is '*to protect employees' interests against insurance companies*'; they exhibit distrust of insurance companies and think that it is the employer's job to safeguard policyholders against insurance companies. '*He should take care of me – I don't trust the insurance companies*. '*He should safeguard our interests. People don't understand much about it and it costs a lot of money*'. '*They* [the insurance companies] *do not pay claims. He needs to take care of us*'. '*When you need them, they find all sorts of reasons "in the fine print" why they shouldn't pay claims.*' '*They need to make sure we get paid what we deserve*.' When asked how or what actions the employer must take to protect employees' interests, they do not know the answer. '*If the insurance company does not deliver on its promises, the employer should replace it.*' It can be understood from this that there is an expectation that the employer should use the group's purchasing power and size to ensure that the insurance company meets its obligations.

Knowledge about the rights in group health insurance

Responses as to whether the interviewees know their rights in the group insurance, and what coverage it gives them show that, in general, respondents' knowledge of their insurance rights is low. Six respondents report that their level of knowledge about group health insurance rights is very low. One claims to be familiar with the terms because he had filed a claim and studied the matter. Three other employees claim they knew the terms in general.

Example responses include: '*I don't get it, it's complicated*'. '*I'm not interested, and I hope I won't need to be*'. '*I don't understand any of this, and if I need anything, I'll ask the agent*'. '*Not interested – the details are on the company's* [employer's] *website*'. '*I happened to file a claim, so I read a little and I understand a few things*'. A government ministry official said, '*we have a strong union. I trust them'.*

Regarding the coverage the policy offers, some do not know how to respond to the point, saying '*we have everything*'. In contrast, four respondents know only generally: '*medicines, operations, specialist doctors*'.

There are no differences in the level of knowledge between the respondents' age, occupation, level of education and place of residence.

Employer's actions to inform employees of their rights in the group health insurance.

As to the question of whether or not their employer takes actions to inform them of their rights in group health insurance, a small number of them (3) do not know at all. '*I don't know, maybe*'. Most respondents claim having received emails about the renewal of the insurance. However, some report not reading the messages. '*I didn't read it – it's complicated*'. '*I don't know anything about it, my wife deals with this*'. Most respondents report getting information from the company's website (of the employer). Four report that lectures are given at the beginning of the insurance period, but only two have attended such lectures. Most respondents report receiving information when there are updates to the insurance: '*Now they sent us something; they announced a rise in the insurance cost*'. Most respondents report receiving information from insurance companies but not reading it.

No differences in answers are found for the age of the respondents. Employees in high-tech companies are familiar with updates sent from the employer; service and industry sectors employees are less aware of information sent from the employer.

To conclude, interviews show that the respondents are unaware of their rights in group health insurance. However, it is important for them to know whom to contact when a problem arises. It is important for them that the employer to whom they refer should represent their interests. There is great employee distrust of the insurance companies. There is also a lack of knowledge about the actions of the employer vis-à-vis the insurance company.

3.6 Conclusions

Main objectives and research design

According to the Israeli regulator's point of view as reflected in group health insurance ordinances, an employer must act with "faith and diligence" in favour of the insured. This term is an amorphous and general concept, leaving wide scope for its interpretation by the courts depending on the circumstances, leaving the employer with uncertainty and legal risk.

Therefore, the main objectives of the current study are:

1. To provide an operative meaning of the employer's responsibility towards employees regarding the group health insurance arrangement.
2. To create a guide for employers as to how they should act to fulfil their managerial, ethical, and legal responsibilities towards their employees regarding the group health insurance arrangement.

Thus, the research question is: What responsibility do employers have towards their employees regarding the group health insurance arrangement, and how should they act to fulfil their managerial and legal obligations towards their employees?

To answer this research question, the perceptions of each of the participants in group health insurance arrangements are examined as follows:

Insurance companies: Qualitative exploratory research using a semi-structured interview is conducted among five leading insurance companies in Israel.

Policyholders: Qualitative research using a semi-structured interview is conducted among eight employers and two consumer clubs belonging to employee organizations authorised to sign a group health insurance contract for their employees.

Employees – the insured: An online survey questionnaire created specifically for this study is distributed to 500 employees in various occupations who are part of a group health

insurance agreement to examine the association between the employer's actions and the employees' perceived responsibility of the employer towards them, and to examine variables that might affect employees' perception of the employer's responsibility towards them.

In addition, qualitative research is conducted among 10 respondents to the employees' questionnaire in order to elaborate on their perceptions regarding certain issues arising in the survey study.

Finally, the study examines the gap between the attitude of the employees regarding the employer's actions and their knowledge of the employer's actions in practice regarding the group health insurance arrangement

A summary of the empirical findings and their contribution to the literature

Involving employees in formulating the plan

No significant difference is found in level of responsibility between employers who involve employees in the group policy formulation and those who do not. Among employees, the issue was mostly found to be of medium to high importance. In opinion of employers and the insurance companies, the issue is of low importance.

Conclusion: it is advisable to cooperate with employees with tools that enable assessment of their needs, such as surveys, focus groups, or even through their active participation in the process of constructing the group health insurance policy.

An employer, as a representative and emissary of the insured group, has a duty to formulate a policy that meets the reasonable expectations of the insured employees (Keeton, 1970), and to make sure that the policy is formulated clearly and unambiguously (Schwartz & Schlesinger, 2003). Not only is employee inclusion in formulating the insurance terms an effective tool serving this purpose, but there is also a positive correlation between employee involvement in decision making and their job satisfaction (Bennett, 1997).

Hiring a consultant or relevant professional

A significant difference is found between employees whose employers hire a consultant and employees whose employers who do not. The analysis shows that employers who hire an

external consultant are perceived as having greater responsibility for their employees, compared to employers who do not.

Among employees, the issue was mostly found to be of medium to high importance. Also, the multivariate model shows that hiring an external expert positively predicts the employees' perceptions of the employer's responsibility.

The issue is found to be highly important among employers and insurance companies, as well. Legally, employing a consultant fulfils the employer's duty of conceptual caution.

Conclusion: there is a legal duty to consult with a professional, especially before formulating the policy terms, as well as receiving ongoing professional support, up-to-date information, and assistance when problems arise in the insurance plan or with the insurance company.

Conducting a tender/competitive procedure

No significant difference is found in employees' perception of the employer's responsibility between employees whose employers conduct a tender or a competitive procedure and employees whose employers do not. This is found to be of great importance for obtaining the best price and terms, and of low importance for choosing a better insurance company. In the employers' view, conducting a tender/competitive procedure is of great importance, even though it is not frequently performed. In the opinion of the insurance companies, the issue is of medium importance. Legally, during a competitive process, employers must act honestly and equitably (Shalev, 1995).

Conclusion: a tender or competitive procedure contributes to employees' confidence in the insurance arrangement offered by the employer. It is the employer's responsibility to conduct a formal tender or competitive procedure and to set the rules and procedures that determine when this should be done. Because of the lack of competition in the group health insurance market (Commissioner's Report, 2018), service and quality of the insurance company must be considered. Because of the uniqueness of the insurance tender, as part of a tender, an employer must formulate a detailed insurance policy (Givon Insurance Agency ruling, 2013).

Informing employees of their rights

A significant difference is found between employees' perception of the employer's responsibility for them and the employer's providing them with information about their entitlement to group insurance, and the issue is found to be of relatively high importance among employees. Also, the multivariate model shows that sharing of information and updating employees about their rights as part of the group insurance positively predicts the employees' perceptions of the employer's responsibility.

Even among employers and insurance companies this issue is perceived as highly important. The insurance agreement is for benefit of a third party, the employees (Elias, 2016), therefore, from a legal point of view, an employer has a duty to inform the employees of their eligibility to join the insurance, and, because of the employer's fiduciary duty and the employees' trust, to inform them of their rights in regard to the group insurance (Licht 2013).

Group health insurance regulations do not obligate the insurance company to announce the termination of insurance and its transfer to a new insurance company. Therefore, the employer has a greater duty to inform and update the insured regarding their entitlement when the group insurance agreement ends. The employer also has a duty to inform and update the insured when they leave the workplace, although according to group health insurance regulations, this obligation applies to the insurance company. In addition, it is the employer's duty to anchor within the insurance agreement the conditions that will apply to employees after leaving the insured group, or when the insurance ends, and especially regarding implications for cost of the insurance (the premium).

Informing employees about the HMO supplementary insurance

A significant difference is found between employees' perception of the employer's responsibility for them and receiving information about rights in the HMO supplementary insurance. Informing employees on this issue is found to be of relatively high importance to employees, but of low importance to employers and insurance companies. According to the multivariate model, informing employees about the HMO supplementary insurance does not predict employees' perceptions of the employer's responsibility.

Conclusion: it is not mandatory for an employer to inform employees about their rights in the HMO supplementary insurance, however, at least, it is advisable to inform them about ways to obtain information on this subject.

Informing employees about changes in regulations and in the group insurance

No significant difference is found between the perception of employer responsibility and informing employees about changes and updates in regulations pertaining to the group health insurance, but the issue is found to be of high importance to employees, employers and insurance companies. Legally, an employer has a duty to update employees by virtue of being a representative and trustee of the group of insured employees (Friedman & Cohen, 1991).

Conclusion: employers are required to inform employees about their group insurance rights at the beginning of the insurance period, whenever the insurance is renewed, and especially at the end of the insurance period: when leaving work or retiring, or when the insurance agreement ends. To do this, employers must use all the tools at their disposal – e-mail, posting on the company website, conferences and lectures. The employers must make sure that the insurer and/or an agent on their behalf fulfils the duty of disclosure imposed on them under the group health insurance regulations.

Insurance administration and operation involvement in case of the rejection of a claim or disputes, and involvement when a problem arises regarding the insurance arrangement

No significant difference is found in how employees perceive the employer's responsibility between employees whose employers are involved in rejected claims and those who are not, nor is any significant difference found in how employees perceive the employer's responsibility regarding involvement when a problem arises with the insurance company.

Findings show that employees do not have enough information about the right to involve the employer when an insurance claim is rejected and when a problem arises with the insurance company. Employees usually do not know who is responsible for the group insurance arrangement. The insurance companies report that when a claim is rejected or when a dispute arises between an employee and the insurance company, employer involvement constitutes an advantage for group insurance over private insurance. Employers state that they have a duty to act and take care to fully exercise the employees' rights under the group insurance.

Conclusion: it is imperative for an employer to ensure that the insurance company meets its obligations to the employees, and to intervene whenever a claim is rejected or when disputes arise between an employee and the insurance company. The employer must inform the employees of their right to use the employer's services for this purpose. The employer should arrange an arbitration procedure in the event of a dispute between the employee and the

insurance company, and when the employer has a prerogative to approve claim payments beyond the letter of the law, clear procedures should be formulated and brought to the attention of the employees. The employer should hire a professional entity for this purpose.

Monitoring reports of the insurance company and its conduct

Inspection of the insurance companies depends on the relationship between an employer and the insurance company. On one hand, the employer has an interest in monitoring their insurance costs, examining trends and preparing accordingly, and it is therefore important to keep track of claims reports and insurance uses. On the other hand, as a representative and emissary of the insured group, the employer must ensure that the insurance company fulfils its obligation to the insured.

Conclusion: it is mandatory for an employer to monitor the insurance company's conduct, to obtain information and periodic (semi-annual or annual) reporting on the group insurance, including information about any claims. Employers are required to hold periodic appointments with the insurance companies. They should inform their insured employees about this. Updating employees about the control and monitoring process will increase trust in the employer and in the group insurance arrangement.

Demographic characteristics

No significant difference is found between gender, age, marital status or education and how employees perceive the employer's responsibility. Neither insurance companies nor employers report that the employer's activities depend on employees' demographic characteristics.

Conclusion: demographic characteristics have no impact on employer activities regarding group health insurance.

Workplace factors

A significant difference is found between policyholder types (direct employer and consumer clubs), between industrial sectors and service sectors, and between workplaces with a Workers' Committee and those without. The multivariate model shows that only being

employed in the high-tech industry positively predicts the employees' perceptions of the employer's responsibility. Neither insurance companies nor employers report that the employer's activities depend on workplace factors.

Conclusion: policyholders who are consumer clubs or employers in the field of private or public services should improve their actions regarding group health insurance in order to improve the level of the employees' perception of responsibility towards them. Moreover, policyholders should cooperate with the Workers' Committees where they exist.

Faith and diligence

Through in-depth interviews the research has attempted to understand how the term "faith and diligence" is interpreted. The study reveals that the participants interpret the term as follows:

- It is mandatory to obtain the best insurance terms relative to the price.
- It is mandatory to create insurance that meets the insured parties' expectations.
- The employer must act in good faith and in the best interests of the insured.
- The employer must ensure that employees receive their rights under the group agreement.
- The employer must inform employees about their insurance rights.

Current study provides an interpretation of the policyholder's legal responsibility according to which the policyholder must act with "faith and diligence" in favour of the insured, from the perspective of all participants in the group insurance arrangement. In fact, the study creates a guide and a standard for how employers should act in practice to fulfil their legal obligation and meet the expectations of insured employees regarding a group health insurance arrangement. Adoption of the study's conclusions may increase employees' confidence in them, which will have a positive impact on employees' workplace satisfaction and, in particular, a positive impact on their satisfaction with the group insurance plan, and may prevent legal actions against the policyholders.

Study limitations and recommendations for future research

Alongside the study's findings and conclusions, it is important to mention its limitations. The following is a description of possible limitations regarding the study procedure, its size and the participants' motivation.

Lack of officially published data - Since Israeli authorities have not released official data regarding the number of people insured in a group health insurance plan and there is no demographic data on these people, there may be a bias in the results of the study.

Limitation in method of distribution of the employee questionnaires - the study examines employee perceptions through a questionnaire distributed online. The disadvantage of this method is that the older population may have less access to this medium. **Length of questionnaire** – a long questionnaire can be tiring, which might affect the quality of the answers. **Bias in the motivation level of study participants** – the respondents were randomly selected from a large mailing list and volunteered to participate in the study. Those who volunteered to answer the questionnaire may have had a good or poor service experience with the insurance company, and this may also have an impact on their perceptions of employers. **Limitation of wording and clarity of the research questions** – the in-depth interviews with 10 randomly selected respondents to assess the level of respondents' understanding of the questions in the questionnaire show that due to the respondents' lack of knowledge, there is evidence of confusion and a lack of clarity regarding certain terms, for example, the difference between agent and consultant. **Limitation in the correspondence between employee data and employer data** - the study examines the attitudes of employers and their employees. However, fearing criticism or enhanced expectations on the part of the employees, all the employers refuse to involve their own employees in the study. Thus, the companies and organizations participating in the study do not employ the same employees who participated in the quantitative research.

Current study and its findings reveal several directions for possible future research deriving from the limitations of current study. Firstly, the perception of responsibility with respect to employers could be expanded and examined in other countries where the health-care system structure is similar to that in Israel (state health care and optional private insurance), and to employers in countries where the health-care system differs from that in Israel.

Second, it could create an empirical formula that describes the employer's responsibility towards employees, by summarising the employer's actions and variables that may impact the

employer's responsibility on the basis of the results of current study. The "responsibility formula" (or "faith and diligence" formula) might act as a quality and risk management tool for the policyholder, which may be useful for analysing an employer's behaviour, and for examining whether the employer's conduct meets the expectations of employees insured in a group insurance arrangement.

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APPENDICES

Appendix 1. Questions for semi-structured interview among insurance company executives in the group health insurance department

A. What, in your point of view, is the meaning of "faith and diligence"?
B. Can you describe the policyholders' actions from the beginning of formulating the insurance arrangement to the end of the insurance term?
C. From your point of view, what actions of the employers most affect their responsibility to the employee?
D. From your point of view, is the policyholder responsible for employees regarding the insurance plan? What is the extent of this responsibility?
E. Do you think there is a difference between the levels of responsibility the employers have towards their employees and the responsibility the consumer clubs (such as teachers, military personnel, etc.) have towards their members?

Appendix 2. Questions for the semi-structured interview among employers' HR managers

A. When employers sign a group health insurance agreement with an insurance company, they must sign a statement to the effect that they will act in "faith and diligence" for the insured party only. What is the meaning of "faith and diligence" in your view?
B. Overview of the insurance arrangement:
   How long does the insurance arrangement last?
   Is the insurance supplementary or substitutive?
   What is the number of insured employees?
   What is the employer's financing policy?
C. How was the insurance arrangement formulated?
   Who was involved in the process?
D. Did you use an insurance expert to formulate and manage the insurance plan?
E. What was the procedure for choosing the insurance company?
F. What were the considerations in selecting the insurer?
G. What weight was given to each consideration?

H. Can you describe whether and how you inform employees of their rights?
I. Have satisfaction surveys been conducted among the employees regarding the insurance policy, and if so, what were the results?
J. Is the health plan being monitored and controlled? (e.g., regarding the insurer's conduct, handling of claims, reports, etc.)
K. Have complaints or claims been filed against the employer by the employees regarding the health plan? If so, which ones? (claims, administration, insurance costs)
L. How does the company perceive the importance of the health plan in terms of the employees' employment conditions?
M. How does the company perceive its responsibility for the employees regarding the group health plan?

Appendix 3. Questions for the semi-structured interview among employees

A. How do you interpret the term "faith and diligence" in relation to the employer's duty towards you within the group health insurance?
B. How well do you know your rights within the group health insurance?
C. Does the employer inform you about your rights regarding the group insurance plan, and in what ways has he done so?

Appendix 4. The Quantitative Questionnaire

Following is the questionnaire for employees insured in a group health insurance policy as part of their employment terms.

The purpose of the study is to examine the expectations of employees regarding the conduct of an employer or an employees' organization in the context of the group health insurance in which they are insured.

The data of the questionnaire and its results are confidential. Therefore, you will not be asked to provide any identifying information. Data are collected only for a study in business administration, which examines the legal and administrative responsibility of the employer in collective health insurance arrangements.

Participation in the study is important; therefore, I would appreciate your cooperation.

Any response is eligible. Please answer or mark the answer to each question that is most suitable for you.

The questions are phrased in masculine form for the purpose of convenience but are intended for both women and men.

Sincerely,

Shlomi Luttinger

Part 1 – Demographic and background data

1. **Age (years)** ________

2. **Gender**:

1. Male
2. Female

3. **Marital Status**:

1. Single
2. Married
3. Divorced
4. Widowed

Number of children: _______________

4. **Education:**

1. High school education
2. Post-secondary education
3. Bachelor's degree
4. Master's degree and above

5. **Employment domain**:

1. Industry
2. High-tech
3. Private Services (such as insurance, banking)
4. Public services (such as government ministry, local authority)

Employer's name: ______________

6. **Years of employment in the workplace**: ______________

7. **Are you insured by a consumer club that belongs to a workers' union** (teachers, IDF, attorneys, CPAs, etc.)

1. Yes
2. No

Workers' union name: _______________

8. **Is there a Workers' Committee in your workplace**?

1. Yes
2. No

<u>Part 2 – History of activity with an insurance company</u>

1. **Have you or your family filed a claim with your insurance company related to health insurance in the past 3 years?**

1. No claim
2. One claim
3. Two claims
4. Three claims
5. More than three claims

2. **What kind of professional usually assisted you to file the claim?**

1. A lawyer on my behalf
2. An insurance agent representing me
3. A representative from the company in which I work

4. The insurance company's help desk.

3. **As part of the group health policy, you are insured:**

1. through an insurance agent

2. directly with the insurance company

3. I do not know

4. **To the best of your knowledge, when a question or problem arises in your health insurance, whom should you contact?**

1. The insurance company directly

2. The insurance agent

3. The employer's insurance consultant

4. The employer directly

5. I do not know

5. **In addition to group health insurance within the organization, do you also pay for private health insurance?** Yes / No

6. **Please rate the degree of importance of each of the following considerations when joining group health insurance: 1 (not important) to 5 (very high importance):**

1) Name of the insurance company

1- not important; 2-low importance; 3-moderate importance; 4 - much importance; 5: very high importance

2) Price

1- not important; 2-low importance; 3-moderate importance; 4 - much importance; 5: very high importance

3) Participation of the employer in the cost of the insurance

1- not important; 2-low importance; 3-moderate importance; 4 - much importance; 5: very high importance

4) Terms of insurance

1- not important; 2-low importance; 3-moderate importance; 4 - much importance; 5: very high importance

5) Reliance on the employer's proposal

1- not important; 2-low importance; 3-moderate importance; 4 - much importance; 5: very high importance

7. **Before you signed up for the insurance program did you… (answer Yes or No):**

1) consult a professional on behalf of the employer? Yes / No

2) consult an insurance agent? Yes / No

3) not consult but just rely on the employer? Yes / No

4) consult a friend/family member? Yes / No

5) read information that was brought to your attention by the employer? Yes / No

8. **To what extent do you know your rights in the group insurance plan in which you are insured?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

Part 3 – Activity of the Employer Regarding Group Health Insurance

A. **Please read the following questions and according to the best of your knowledge respond to what extent did your employer…**

1. **inform the employees of their insurance rights?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

2. **inform you of your rights as part of the supplementary insurance?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

3. **inform you of your rights as part of the public health basket?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

4. **share the formulation of the health plan with the employees?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

5. **use an external specialist expert regarding the health insurance arrangement?**

1 – not at all; 2 –to some extent; 3 – to a moderate extent; 4 –to a large extent; 5 –to a very large extent

B. **The following questions examine your knowledge of the employer's insurance activity (answer Yes / No / Not sure):**

To the best of your knowledge…

1) Has the employer put out a competitive procedure (e.g., a tender) to select an insurance company to insure the employees? Yes / No / Not sure
2) Should the employer conduct a competitive procedure (e.g., a tender) to choose an insurance company to insure the employees? Yes / No / Not sure
3) Does the employer consistently update the employees on regulations and changes in the field of health insurance? Yes / No / Not sure
4) Do you have the option to appeal or involve the employer in case an insurance claim is rejected? Yes / No / Not sure

C. **Does your employer provide health insurance for your family members?**

1) Not at all.

2) Partially for the employee but not for family

3) Fully for the employee but not for family

4) Partially for family members

5) Fully for family members

Part 4 – The position of the employee regarding the employer's/organization's actions in regard to group health insurance

To what degree…

1) is it important for the employer to involve the employees in formulating the health plan?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

2) Is it important that the employer use external experts in formulating the health plan?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

3) Is it important for the employer to conduct a tender regularly in order to choose the insurance company?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

4) Do you trust the employer to choose the best insurance company?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

5) Do you trust the employer to choose the best policy terms considering your interests?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

6) Do you trust the employer to obtain the lowest price in relation to the insurance coverage?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

7) To what extent did the price of insurance have an impact on the considerations of whether to purchase the insurance plan

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

8) Is it important that the employer inform the employees of changes in the law and regulations related to insurance and medical services?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

9) Is it important that employer inform you of your rights in the state health insurance?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

10) Is it important that your employer inform you of your rights in your HMO's supplementary insurance

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

11) Is the provision of an insurance arrangement by the employer important for the terms of employment?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

12) Are you satisfied with the employer's conduct regarding the group health insurance arrangement?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

13) Are you satisfied with the group health insurance arrangement?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

14) Are you satisfied with your place of work?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

15) Are you satisfied with the level of insurance coverage?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

16) Are you satisfied with the insurance price?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree

12) Do you think the employer or organization through which you are insured has any responsibility towards you?

1 – not at all; 2 –to a small degree; 3 –to a moderate degree; 4 –to a large degree; 5 –to a very large degree