Is our health system in danger? Reforming the reimbursement of care (3/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis: the third issue, presented here, concerns the reimbursement of health care, in particular long-term care, and the rise in physician surcharges.

The reimbursement of care by the French Social Security system currently varies with the severity of the illness: long-term care, which corresponds to more serious conditions, is fully reimbursed, whereas the reimbursement of routine care is tending to diminish due to a variety of non-reimbursed fixed fees and their tendency to rise. In addition to this structural upwards trend there is a rise in non-reimbursed doctor surcharges, which is reducing the share of expenditure financed by Social Security. As a result, the share of routine care covered by health insurance is limited to 56.2%, while the rate of reimbursement for patients with long-term illnesses ("ALD" illnesses in French) is 84.8% for primary care [1]. This situation has a number of negative consequences: it can lead people to forego certain routine care, with negative implications for the prevention of more serious conditions; and it increases the cost of supplementary "mutual" insurance that paradoxically is taxed to help compulsory insurance on the grounds of the high public coverage for long-term illness. Finally, it puts the focus on

the definition of the scope of long-term illness, which is complicated since in order to draw up the list of conditions giving entitlement to full reimbursement it is necessary to consider both the measurement of the "degree" of severity and the cost of treatment. The issue of multiple conditions and their simultaneous coverage by health insurance under both routine care and long-term illness is a bureaucratic nightmare that generates uncertainty and expenditure on relatively ineffective management and controls.

This is why some suggest replacing the ALD system by setting up a health shield that would provide for full reimbursement of all spending above a fixed annual threshold. Beyond a certain threshold of average out-of-pocket expenses (*e.g.* corresponding to the current "co-payment" level) after reimbursement by compulsory health insurance, which was about 500 euros per year in 2008[2]), Social Security would assume full coverage. A system like this would provide automatic coverage of the bulk of expenses associated with serious diseases without going through the ALD classification.

One could consider modulating the threshold of out-of-pocket expenses based on income (Briet and Fragonard, 2007) or the reimbursement rate, or both. This possibility is typically invoked to limit the rise in reimbursed expenses. This raises the usual problem of the support of better-off strata for social insurance when it would be in their interest to support the pooling of health risks through private insurance with fees proportional to the risk rather than based on income.

The establishment of a health shield system also raises the issue of the role of supplementary insurance. Historically mutual insurance funds "completed" public coverage by providing complete or nearly complete coverage of anything in the basket of care not reimbursed by basic health insurance (dental prostheses, eyeglass frames, sophisticated optical care, private hospital rooms, etc.). Today these funds function increasingly as "supplementary" insurance that

complements public insurance for the reimbursement of health expenses on the whole (coverage of the patient co-payment, partial refund of doctor surcharges). The transition to a health shield system would limit their scope of reimbursement to expenses below the fixed threshold. It is often assumed that if mutual insurance were to abandon its current role of blind co-payment of care expenditures, it could play an active role in promoting prevention, for example, by offering differential premiums based on the behaviour of the insured [3]. But where would their interests lie if the shield came to limit their coverage beyond the threshold not covered by public insurance? Even in the case of maintaining a substantial "co-payment" beyond the threshold because of doctor surcharges, for example, they would undoubtedly remain relatively passive, and there would not be much change from the situation today, which isolates them from the bulk of coverage for serious and expensive diseases.

A system in which public insurance alone provides support for a clearly defined basket of care is surely better: this would require that the health shield increases with income, with the poorest households receiving full coverage from the first euro. If affluent households decide to self-insure for expenses below the threshold (which is likely if the latter is less than 1000 euros per year), the mutual insurance funds might withdraw almost entirely from coverage of reimbursements of routine care expenses. On the other hand, they could concentrate on the coverage of expenditures outside the field of public health insurance, which in practice would mean dental prostheses and corrective optics. They could intervene more actively than now in these fields to structure health care delivery and supplies. Their role as principal payer in these fields would justify delegating them the responsibility of dealing with the professions involved. However, this solution implies that a system of public coverage would be needed to give the poorest strata access to care not covered by the public insurance system (in a form close to France's

current CMU universal coverage system, which should however be extended and made more progressive). There is thus no simple solution to the question of the relationship between public insurance and supplementary private insurance.

The merger of the two systems should also be considered, which in practice means the absorption of the private by the public. This would have the advantage of simplifying the system as a whole, but would leave partially unresolved the question of defining the basket of care covered. It is quite likely that supplementary insurance would relocate to the margins of the system to support incidental expenses not covered by the public system because they are deemed nonessential. The reimbursement of health costs should certainly remain mixed, but it is urgent to reconsider the boundaries between private and public, otherwise the trend towards declining public coverage will gain strength at the expense of streamlining the system and of equity in the coverage of health expenditures.

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[1] In 2008. This is a level of coverage that excludes optical. Taking optical into account, the rate of coverage by health insurance falls to 51.3% (Haut Conseil pour l'Avenir de l'Assurance Maladie [High Council for the Future of Health Insurance], December 2011).

[2] HCAAM, 2011 (*ibid*).

[3] It is not easy to take into account the behaviour of the insured. Beyond the use of preventive examinations, which can be measured relatively easily, other preventive behaviours are difficult to verify. Another risk inherent in private insurance is that insurers "skim" the population: to attract "good" clients, coverage is provided of expenditures that are typical of lower-risk populations (for example, the use of "alternative" medicines), while using detailed medical

questionnaires to reject expenditures for greater risks.