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Health Policy

journal homepage: www.elsevier.com/locate/healthpol



The likely effects of employer-mandated complementary health insurance on health coverage in France

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ARTICLE INFO

Article history:

Received 16 March 2016

Received in revised form 7 December 2016

Accepted 9 December 2016

Keywords:

Complementary health insurance

Inequality

National Interprofessional Agreement

Simulation

ABSTRACT

In France, access to health care greatly depends on having a complementary health insurance coverage (CHI). Thus, the generalisation of CHI became a core factor in the national health strategy created by the government in 2013. The first measure has been to compulsorily extend employer-sponsored CHI to all private sector employees on January 1st, 2016 and improve its portability coverage for unemployed former employees for up to 12 months. Based on data from the 2012 Health, Health Care and Insurance survey, this article provides a simulation of the likely effects of this mandate on CHI coverage and related inequalities in the general population by age, health status, socio-economic characteristics and time and risk preferences. We show that the non-coverage rate that was estimated to be 5% in 2012 will drop to 4% following the generalisation of employer-sponsored CHI and to 3.7% after accounting for portability coverage. The most vulnerable populations are expected to remain more often without CHI whereas non coverage will significantly decrease among the less risk averse and the more present oriented. With its focus on private sector employees, the policy is thus likely to do little for populations that would benefit most from additional insurance coverage while expanding coverage for other populations that appear to place little value on CHI.

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1. Introduction

The goal of health insurance is to protect individuals against the risk of unexpected and catastrophic health expenditures. For efficiency and equity arguments, this protection is mainly assured by public health insurance that covers higher than 70% of health expenditures in most of OECD countries, with a notable exception in the US where it only reaches 49% [1]. However, public insurance is always partial since it concerns either a limited basket of care (e.g. in Canada where drugs are out of the public sys-

tem or in Spain and in the UK where services provided by private physicians are uncovered), a limited population (as in the US where public coverage only covers old, vulnerable and poor populations) or since it lets copayments on a quite large basket of care through coinsurance rates and deductibles (as in Belgium, in France or in Switzerland). As a consequence, private health insurances exist in most countries. They can be voluntary or compulsory through individual or employer mandates and their weight in health expenditure finance increases with the financial risk let by public coverage. Thus, private health insurances constitute a mainstay of the health system in the US where they cover 35% of health expenditures mainly as primary health insurance. It is also the case in nearly every country with a universal public health insurance system, especially

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<http://dx.doi.org/10.1016/j.healthpol.2016.12.004>

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where there is no out-of-pocket expenditures ceiling such as in Canada and in France where private health insurances cover 13% and 14% respectively of health expenditures [1].

In France, the health insurance system is characterised by the presence of both public health insurance and complementary health insurance (CHI) in the same ‘basket of care’. Indeed, whereas public health insurance provides compulsory and universal health insurance that accounts for 77% of overall health expenditure, copayments vary according to the type of care, from 10% of regular fees for hospital care to 30% for physicians visits and 85% for some drugs. Moreover, small deductibles exist for most of care and extra fees can be particularly high for specialists, dental and optical care. Therefore out-of-pocket payments continuously increase with health care use and individuals with chronic illnesses can be faced catastrophic out-of-pocket expenditures left by the public scheme (despite the existence of a specific device called “ALD” which offers extra public coverage for care related to a limited number of diseases). Moreover, France is characterised by the largest differences in death rate between educational groups among Western European countries [2]. This situation is partly explained by the large magnitude of inequalities in health care use (especially for specialist and preventive care) and in complementary health coverage in comparison with other European countries [3–6]. The ability of public health insurance to guarantee equitable access to care and to protect the sickest and the poorest against financial burden related to diseases has been questioned and reforms have been suggested such as the introduction of a out-of-pocket payment threshold funded on income proportional taxes [7–11]. However, due to financial constraints, policy makers have chosen to increase access to CHI rather than simply increase the comprehensiveness of the public insurance program.

Two schemes designed to facilitate access to CHI for low-income populations, the “*Universal Complementary Health Insurance*” (called *CMU-C*) and the *Assistance in Financing Complementary Health Insurance* (called *ACS*), were introduced in 2000 and 2005, respectively. Another way to promote CHI has been to support employer-sponsored health insurance by introducing tax and social contribution exemptions as early as 1985. As a result, 95% of the population benefited from CHI in 2012. However, access to CHI remains an issue for policy makers since non-coverage rate is greatly higher among the poorest [4,12–17]. This situation is partly due to the low inclusion threshold for the “*CMU-C*” device (20% below the poverty line), which only concerns 7% of the population, and the very high non take-up rate of the “*ACS*” device which offers quite low voucher amounts and still remains poorly known [18] whereas CHI premiums can reach 10% of income for the poorest households [14,16]. Moreover, the level of CHI coverage varies a lot in the population according to income and the way individuals are insured: employer sponsored-CHI coverage are on average more advantageous than contracts individually subscribed [19]. Thus, the promotion of widespread access to a quality CHI became a core factor in the national health strategy set out by the French government on September 23rd, 2013, alongside the overall aim of reducing social health inequalities [20]. This objective

was first implemented in the National Interprofessional Agreement (“*Accord National Interprofessionnel*” called *ANI*), which mandates that all private sector employers offer partially financed compulsory CHI to all of their employees beginning on January 1st, 2016. This agreement also aimed to improve the portability of coverage for the unemployed for up to 12 months after the end of their last job [21].

The ability of mandating employers to offer health insurance to their employees in order to improve health insurance coverage and its equity can be discussed. Employer mandate allows policymakers to promote health insurance limiting public spending and the deadweight losses induced by taxation [22]. Employers can also negotiate better cost/quality premiums. Regarding equity issue, it can be less equitable than standard public programs as it excludes individuals who are out of the labour market and therefore who may be more frequently uninsured, economically deprived and in poor health. Moreover, since CHI premiums are not progressive, it does not constitute an instrument of redistribution, conversely to social contribution and income taxation. Finally, the impact of such a mandate on social welfare could be discussed since it prevents employees to choose their optimal level of coverage according to their budget constraints and their preferences. Indeed, a number of theoretical and empirical studies have highlighted the role of risk preferences in the decision to be uninsured [23–30] and Marquis and Long [31] showed that implementing a mandate on primary health insurance that would require uninsured families to purchase health insurance may induce very high welfare costs, which reflect a strong preference for remaining uninsured and/or a low willingness to pay for health insurance.

Even if there are employer-provided health insurances in many countries, employer mandate is very rare. The employer mandate for companies over 50 employees in the US has just been implemented as an integral part of the Affordable Care Act and its outcomes have not still been analysed. To our knowledge, only the employer mandate implemented in Hawaii in 1974 for full-time employees has been evaluated [32–35]. Those few studies focused on its impacts on the wage and employment growth, as well as on insurance coverage but without properly analysing its impacts on inequalities in coverage related to socioeconomic status and need for healthcare. Moreover, no studies concern a country where public health insurance is universal and employer mandate would only concern complementary or supplementary health insurance whereas due to pressure on public budgets, it is tempting for governments to set up such mandates to push some health spending from the public sector to the private sector.

This article provides a simulation of the likely effects of the ANI mandate implemented in 2016 on CHI coverage and related inequalities in the general population. It questions its capacity to generalize access to CHI, to improve coverage equity and to enable those who would like to be insured to benefit from a CHI coverage without constraining those who would prefer remaining uninsured. This work is based on data from the 2012 French Health, Health Care and Insurance survey (called “*ESPS*”), which is the latest available survey in France that provides information on insurance coverage, health status, socioeconomic

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