Unclassified **DELSA/ELSA/WD/HEA(2004)3**

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

11-Mar-2004

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

DELSA/ELSA/WD/HEA(2004)3
Unclassified

OECD HEALTH WORKING PAPERS NO. 12

PRIVATE HEALTH INSURANCE IN FRANCE

Thomas C. Buchmueller*
Agnes Couffinhal**

JEL Classification: I11, I18, I19

**Graduate School of Management, University of California, Irvine*

***CREDES*

The paper is based on info collected prior to December 2003 and therefore does not take into account current and future reform proposals.

JT00159760

English - Or. English

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ACKNOWLEDGEMENTS

The authors are very grateful to Francesca Colombo and Nicole Tapay for their numerous comments and encouragements during the preparation of this document. Emily Raiche provided excellent research assistance. Many thanks also to the people who helped us understand the legal and technical aspects of the health insurance market's regulation and organisation. All remaining errors are ours.

SUMMARY

1. While France has a universal public health insurance system, the coverage it provides is incomplete and the vast majority the French population has private complementary health insurance. Among OECD countries, the share of health care financed by private insurance is third highest behind the US and the Netherlands, two countries where private coverage is the primary source of payment for a large percentage of the population.

2. France's high rate of private insurance coverage is partly explained by historical factors and partly by the preferential tax treatment of employer-sponsored coverage. Because of the high rate of employer-provision – roughly half of all contracts are obtained through the workplace – coverage tends to vary with activity and industry classification. Historically, coverage was also positively related with income. In 2000, the French government introduced a new program, the *Couverture Maladie Universelle* (CMU), which extended eligibility for publicly funded complementary coverage to low income individuals. Since then, the percentage of the population with complementary coverage has increased from 86% to roughly 92%.

3. Unlike in other countries, private insurance in France is not used to jump public sector queues or to obtain access to elite providers. Rather, it provides reimbursement for co-payments required by the public system and coverage for medical goods and services that are poorly covered by the public system, most notably dental and optical care. Considerable research indicates that by reducing (and in some cases eliminating) out-of-pocket costs, private insurance significantly increases medical care utilisation.

4. Private complementary health insurance is provided by three types of organisations. *Mutuelles* represent roughly 60% of the total market. Non-profit provident institutions and private insurance companies (including both for-profit and non-profit carriers) split the remaining 40%. The three types of organisations operate under distinct regulations as well as different philosophies. *Mutuelles* emphasise the concept of solidarity, which means premiums and contract provisions tend not to vary with subscriber risk. Private insurance companies make greater use of risk-rating, though less so than is typical in the US. In recent years their regulatory treatment has converged, as dictated by European Union regulations. This convergence is likely to increase competition among the different types of carriers and perhaps alter the nature of private health insurance.

5. Another change that may be on the horizon is in the relationship between private complementary insurance and the statutory public system. The public system is facing chronic deficits and recent cost-containment policies have not proved very successful. The government has signalled an interest in reforms that would redefine the role of public and private insurance, shifting some responsibilities from the former to the latter.

RESUMÉ

6. Si la France a un système d'assurance maladie publique universel, la couverture qu'il propose n'est pas complète et la majorité de la population française a une assurance complémentaire privée. La France est le troisième pays de l'OCDE en ce qui concerne la part des dépenses de santé financée par l'assurance privée, après les Etats-Unis et les Pays-Bas, deux pays où l'assurance privée représente la seule source de couverture pour une grande partie de la population.

7. L'importance de l'assurance privée en France s'explique pour partie par des facteurs historiques mais aussi par le traitement fiscal préférentiel dont bénéficient les assurances de groupe. Etant donnée qu'environ la moitié des contrats sont obtenus par le biais de l'emploi, la couverture est très liée à la participation au marché du travail et au secteur d'activité. Historiquement, le taux couverture de la population augmentait avec le revenu. En 2000, le gouvernement a mis en place un nouveau programme public, la Couverture Maladie Universelle, qui propose aux personnes les plus défavorisées une complémentaire maladie gratuite. Depuis cette date, la proportion de personnes couvertes par une complémentaire maladie est passée de 86 à 92% de la population.

8. Contrairement à ce qui se passe dans d'autres pays, l'assurance privée en France ne permet pas de couper des files d'attentes dans le secteur public ou d'avoir accès à des prestataires proposant des services plus élitistes. En fait, l'assurance privée rembourse les co-paiements du système public et couvre des biens et services mal pris en charge par ce dernier, comme les prothèses dentaires et les lunettes. Une recherche abondante montre que l'assurance, en réduisant, voire en gommant les co-paiements, augmente significativement la consommation médicale.

9. L'assurance privée est proposée par trois types d'organismes. Les mutuelles représentent environ 60% du marché, le reste étant partagé à peu près également entre les assurances privées et les institutions de prévoyance. Les trois types d'organismes sont soumis à des réglementations et opèrent selon des philosophies différentes. Les mutuelles mettent l'accent sur le concept de solidarité ce qui se traduit par le fait que les primes et les clauses des contrats ne varient que peu en fonction des risques. Les assurances privées ajustent plus leur offre aux risques même si ces pratiques sont beaucoup moins courantes que dans un pays comme les Etats-Unis. Au cours des dernières années, le traitement réglementaire des différentes institutions a tendu à converger, notamment sous la pression des réglementations européennes. Cette convergence aura probablement pour conséquence une intensification de la concurrence et pourrait changer la nature de l'assurance privée.

10. Un autre changement se profile qui pourrait concerner l'articulation entre assurance publique et privée. Les efforts pour réduire le déficit chronique du système public ont jusqu'à présent échoué, et le gouvernement a affiché une volonté de réformer l'assurance maladie, ce qui pourrait se traduire par une redéfinition des rôles respectifs de l'assurance privée et publique.

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Introduction

11. While France has a universal public health insurance system, the coverage it provides is incomplete and the vast majority the French population has private complementary health insurance. This private coverage accounts for 12% of total health spending. Among OECD countries, the share of health care financed by private insurance is higher only in the US, where private insurance is the predominant source of coverage, and the Netherlands, where private insurance represents the primary payer for 36% of the population (Mossialos, Thomson *et al.*, 2002). Given the extent of private coverage and its importance as a source of financing care, an understanding of private health insurance is essential for understanding France's health system and the policy challenges it faces. France's experience with private insurance is also relevant to other countries, where the role of private health insurance is central to numerous policy issues.

12. Several factors point to a changing and likely growing role for private, complementary health insurance in France. Legislation enacted in 2000 established the *Couverture Maladie Universelle* (CMU), which extended eligibility for publicly funded complementary coverage to low income individuals, raising the percentage of the population with complementary coverage from 86% to roughly 92% (Paris, Polton and Sandier, 2003). This coverage expansion addressed equity concerns relating to the fact that lower income patients, who were less likely to have private complementary insurance or who held contracts with limited benefits, tended to face higher out-of-pocket costs than higher income individuals, who had more complete private coverage.

13. However, the increased medical spending induced by this coverage expansion comes at a time when the public system is facing chronic deficits. This fiscal situation has contributed to increased discussion and debate on the relative roles of public and private health insurance. The current government has signalled a willingness to reform the system and an increase in the scope of benefits provided by voluntary health insurers is likely to be among the options under consideration. Arguments for such an approach were provided in a government-sponsored report (Chadelat, 2003) that was released in April 2003 to considerable controversy. The commercial insurance industry has expressed support for the idea of shifting the responsibility for certain treatments from the public to the private sector. Their main competitors, non-profit *mutuelles*, however, are less supportive of reducing the role of the public system.

14. The regulatory treatment of private health insurance in France is also evolving. Commercial insurers and *mutuelles* are regulated and operate differently. The differential regulatory treatment was in conflict with EU directives calling for more uniform regulations for firms providing insurance services. Changes in policy to conform to the EU directive, enforced since January 2003, may alter the historical dominance of the *mutuelles*. Because the *mutuelles* operate in a way that emphasises solidarity rather than profit, such a change may alter the very nature of health insurance in France.

15. This paper examines the role that private health insurance plays in France with an emphasis on the key features of the market and the empirical evidence on its performance. In the next section, we briefly sketch the history of private health insurance in France and its current relationship to the statutory public insurance system. The historical importance of *mutuelles* in France is likely one reason why such a large fraction of the population holds complementary coverage. Section III considers other explanations and describes how coverage varies within the population. Key policy questions concern how private insurance affect access to medical care and public and private health spending; section IV summarises the relevant research on these questions. Sections V and VI review the structure, regulation and performance of the market. Concluding remarks are presented in the final section.

I. The development of public and private health insurance in France

16. In France, public health insurance is part of the Social Security system, which was established in 1945 (Glaser, 1991).[1] The new program built upon coverage provided by the *Assurances Sociales*, a statutory means-tested program that was established in 1930. The *Assurances Sociales* was based on the Bismarkian model, requiring participation for salaried workers with incomes below a certain level.

17. The history of France's *mutuelles* predates the Social Security system, dating to the mid-19th century.[2] In 1900 there were roughly 13 000 *mutuelles* covering over 2 million people and by the start of World War II, two-thirds of the population had coverage for illness (Sandier, Polton and Paris, 2002). The *mutuelles* participated in the management of the *Assurances Sociales*. However, despite their political and economic importance, they were not given the role of managing the new statutory insurance system, as was done in other countries.[3] The formal relationship between the *mutuelles* and Social Security was established with laws passed in 1947. The historical importance of the *mutuelles* provided a springboard for the development of private health insurance in France. That history and the fact that the *mutuelles* have continued to play an important role, not only as market participants but in influencing the public policy environment, are important factors that explain the high rate of private insurance coverage in France today.

18. The Social Security system has evolved over time. Workers and their families were the first to be covered, and coverage was extended to other demographic groups over the next several decades. Farmers and self-employed workers were brought into the system in the 1960s, and in 1975 legislation established coverage for individuals falling outside the existing coverage categories. By the 1990s, coverage was nearly, though not entirely, universal. The CMU Act, passed in 1999 and enacted January 2000, extended statutory coverage to the roughly 1% of legal residents who still remained outside the Social security system.

19. Today the Social Security system provides universal health coverage that allows substantial freedom to both patients and providers. Patients are free to choose any physician they wish including the right to self-refer to specialists. Providers are paid on a fee-for-service basis and enjoy considerable autonomy with respect to all areas of their practice.[4] There is no gate-keeping, and the supply of medical facilities and technology is sufficient that waiting lists or other limits on access that exist in other systems are not an issue in France.

20. Private health insurance serves a complementary function in the French system, reimbursing patients for cost-sharing required by the public system and for medical goods and services for which public reimbursement levels fall below market-determined prices. Unlike in some other countries, private insurance is not purchased to avoid public sector queues or to access a different type or quality of care than what is available to patients with only public coverage.

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1. Similar to the case of the British National Health Service, a comprehensive social security system was a war aim of the French resistance in World War II. Glaser (1991), p. 59.

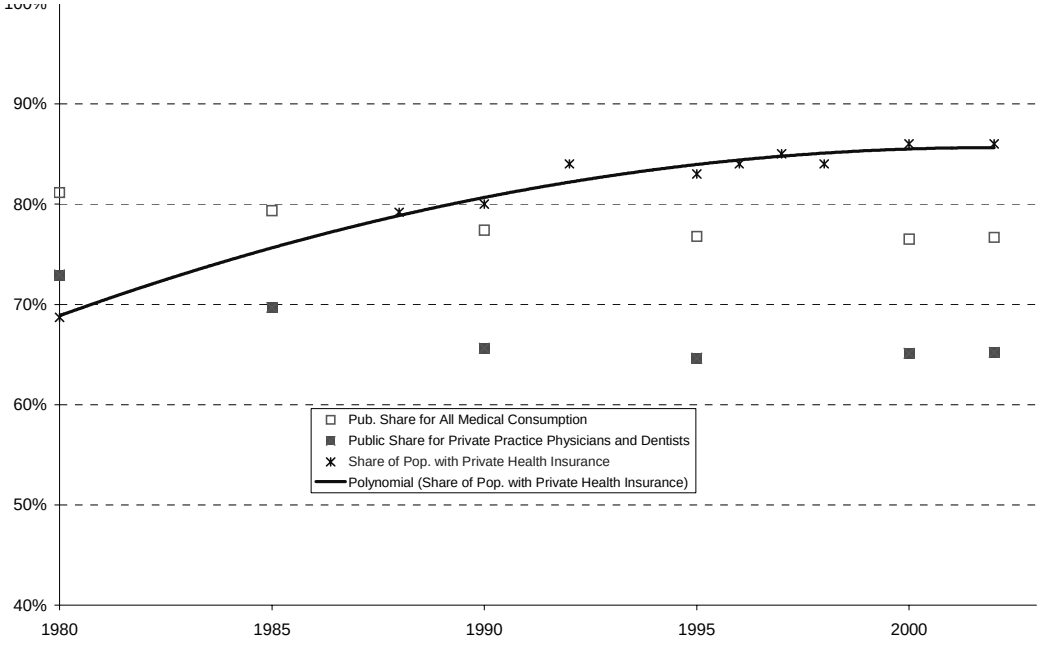
2. For a complete chronology of the mutualiste movement see www.musee.mutualite.com.

3. Glaser (1991), p. 59.

4. Indeed, France has been described as "a model of 'unmanaged,' solo-based, fee-for-service private practice." See Rodwin (1997).

21. Figure 1 charts trends in the percent of health expenditures reimbursed by the statutory public system and the share of the French population holding private health insurance.[5] Overall, the public sector's share of health spending declined slightly between 1980, when it was just above 81%, and the mid-nineties, when it stabilised below 77%. It increased again slightly in 2000 due to the CMU (which is included in the public share of expenditure). However, these aggregate figures are somewhat misleading since they are strongly influenced by spending on hospital care (roughly 45% of total spending in France) for which the public sector's share has remained over 90% over the past two decades. The data for outpatient care reveal a greater decline in the role of the public sector. For instance, the public share of spending for services provided by physicians and dentists declined by more than 8% between 1980 and 1995. Between 1980 and 2000, the percentage of the population with private health insurance increased from 69% to 86%. As a consequence, the share of total health spending paid by insurers increased from 10.6% in 1992 to 12.7% in 2002, while the share directly by households declined, from 12.4% to 10.6%.

Figure 1 Trends in the division of health spending and private health insurance coverage in France, 1980 to 2002



Source: Comptes Nationaux de la santé (Eco-Santé France 2003, 2ème ed.). For private health insurance, no consistent time series is available, extrapolations based on the INSEE and the CREDES Health Surveys were used and a trend is displayed based on them.

5. The share of population covered by public complementary insurance schemes such as the CMU and its predecessor, the AMG (see footnote 10) are not included in the share of the population covered.

22. These trends suggest that the demand for private health insurance has increased, at least in part, in response to deterioration in the extent of public coverage for certain types of care. A more detailed breakdown of the data for the year 2002, presented in Table 1, provides further evidence for this hypothesis and gives a more complete sense of how the public and private systems interact.

23. As noted, public coverage for inpatient care is quite complete. The main sources of potential out-of-pocket cost for patients are a per diem co-payment of EUR 10.67 plus additional charges for a private room[6]. Nearly all complementary insurance contracts cover the per diem co-payment, though there is considerable variation in the coverage for private rooms.

24. Public coverage is less complete for medicines and physician services, though public spending still accounts for 65% and 72% of total spending on these categories, respectively. In the case of physician services, patients are responsible for the payment of the *ticket modérateur*, a co-payment that equals 30% of the conventional tariff, the fee that is the basis for reimbursement by the public system. As the name suggests, the purpose of the *ticket modérateur* is to reduce the moral hazard associated with insurance coverage. In 2003, the *ticket modérateur* was EUR6 for a GP office visit (.30 x EUR20), and EUR6.9 for a simple office visit with a specialist (.30 x EUR23).[7] Patients are also responsible for physician fees that exceed the conventional tariff, *i.e.*, balance-billing. Roughly one quarter of French physicians have the right to charge more than the conventional tariff;[8] about 11% of GP visits and 33% of specialist visits lead to balance billing (Fenina, 2001).

25. For prescription drugs, the *ticket modérateur* ranges from 0% for drugs considered to be 'not substitutable and particularly expensive' to 65% for 'convenience drugs'. It should be noted that these *tickets modérateurs* are covered by most insurance contracts. Thus most people are fully reimbursed for the cost of prescription drugs; non-prescription drugs, which are not reimbursed, account for the bulk of direct household expenditure on drugs.

26. The last two columns of Table 1 illustrate the areas where the statutory public coverage is most limited and therefore voluntary health insurance coverage plays the most important role. The category "other medical goods" includes such things as eyeglasses and non-dental prostheses.[9] While the statutory public insurance scheme provides reimbursement for spending on these goods, the reimbursement rates are extremely low relative to contemporary prices. For example, the public system rarely reimburses adults more than EUR15 for eyeglasses, despite the fact that the actual average price is roughly EUR300. In the vast majority of cases, the public system provides no reimbursement for the cost of contact lenses. Consequently,

6. For a detailed analysis of out of pocket payments in France, see Couffinhal and Paris (2003).

7. Patients suffering from certain serious and chronic illnesses (diabetes, AIDS, cancer, and psychiatric illness are several examples) are exempted from paying the *ticket modérateur* as well as the hospital co-payment. A similar rule applies if the patient suffers from a serious and disabling illness not included on the list, but requiring a medical treatment longer than 6 months or particularly expensive, or for the disabling combination of several pathologies.

8. Physicians who accept the conventional tariff as payment in full are said to be in Sector 1, while those who maintain the right to balance bill are in Sector 2. When the two sectors were established in 1980 all physicians could choose between the two. Subsequently, entry into Sector 2 has been limited to physicians with particular qualifications. Physicians who choose to be in Sector 1 pay reduced social contributions compared with those in Sector 2.

9. Dental prostheses are included in dental care.

public funds account for only 45% of the spending in this category. The public share is even lower for care provided by dentists. For this category, the share funded by private insurance is actually slightly higher than the share paid by the public sector.

27. It is interesting to note that while the share of expenditures paid by private insurance is similar for physician services and other medical goods, there is a large difference in the share of spending borne directly by patients. This is because public and private insurance interact quite differently for these two categories. Even the most basic private contracts cover the cost of the *ticket modérateur*, which is the main source of potential out-of-pocket spending on physician spending. Contracts vary in the extent of coverage for balance-billing. While research suggests that complementary insurance leads to higher utilisation of physician services (see below), the cost of this moral hazard is borne largely by the public system. Moreover, since the *ticket modérateur* is based on conventional tariffs which change infrequently, insurers do not face much risk related to medical inflation. Fees of physicians practicing in Sector 2 may vary more over time, but even here the exposure of complementary insurers is limited, as most contracts specify coverage for balance-billing as a percentage of the conventional tariff.

Table 1. The financing of medical expenditures, 2002

	(1) Total	(2) Inpatient Care	(3) Pharma-ceuticals	(4) Physician Services	(5) Other Med. Goods	(6) Dental Services
% of Total Expenditures	100%	43%	21%	12%	6%	6%
By Source of Payment						
Public	76.4%	92.0%	65.3%	71.8%	44.8%	34.8%
Complementary Insurance	12.4%	4.2%	17.6%	20.2%	25.4%	35.2%
Private households	11.1%	3.7%	17.1%	8.0%	29.8%	30.0%
Total	100%	100%	100%	100%	100%	100%

Source: Comptes Nationaux de la santé and Eco-Santé (2003).

28. In contrast, public reimbursement rates for eyeglasses and dental prostheses are so low that there is effectively no public coverage for these goods. Thus, in these cases private insurers are essentially the primary payers and face greater financial exposure. As a result, private insurers manage their exposure by placing explicit limits – *i.e.*, a fixed euro amount per year – on the level of reimbursement for these categories of care. Even with these limits, between 1991 and 1999, reimbursements by *mutuelles* for optical and dental care increased at an average annual rate of 13% and 8%, respectively, compared to an average growth rate of 5% for prescription drugs and 6% for physicians' fees (Roussel, 2002).

29. As noted in the introduction, the most important development in recent years was the implementation of the CMU in 2000. The complementary coverage offered by the CMU includes reimbursement for co-payments required by the public system (*ticket modérateur*, per diem hospital co-payments). The law prohibits physicians from charging CMU patients more than the conventional tariff of the public system. This is an improvement relative to the *Aide Médicale Générale* (AMG), the program that the CMU replaced, which did not prohibit balanced billing.[10] From the patient's perspective this prohibition provides protection comparable to a private contract that fully reimburses patients for balance-billing.[11] For eyeglasses and dental prostheses, the prices that can be charged by providers to CMU beneficiaries are capped and the difference between the price and official tariff is fully reimbursed to the patients. In a sense, the providers bear part of the financial burden of the CMU, with the final result that for CMU beneficiaries, care is completely free.

II. The distribution of private health insurance coverage

30. Table 2 shows how coverage varied with labour market status, occupation and family income for 1998, just prior to the passage of the CMU. In addition to showing the percentage of the population without any private insurance, the table provides information on the quality of coverage held. Specifically, we report the percentage of individuals holding contracts providing minimal coverage, which is defined to be coverage for officially-required co-payments but very limited coverage for eyeglasses or dental care, and the percent with excellent coverage, which is defined based on the level of reimbursements provided for vision and dental care.[12]

31. The data show a strong positive relationship between income and other proxies for socioeconomic status and the level of coverage. People in the lower income categories account for a disproportionate share of those with no complementary coverage, while nearly half of all individuals with the most generous coverage are from the highest income category. Cutting the data by occupational categories or employment status tells similar stories: the higher individuals are on the social scale, the more likely they are to be covered and, when covered to have better insurance.

10. The coverage provided by the AMG varied across *départements*. In all areas its extent was fairly limited, mainly exempting people from having to pay the *ticket modérateur* and offering no additional coverage for balance-billing by providers or for optical or dental care.

11. This assumes that the physician agrees to see a CMU patient. Unlike the case of Medicaid in the US, physicians in France are not allowed to explicitly refuse to see publicly insured patients.

12. Since vision and dental care are the two areas where there is the greatest need for complementary insurance, the 1998 ESPS asked respondents to give detailed information on how much their contract would reimburse them for eyeglasses and for dental protheses. From this information, researchers at CREDES constructed a typology for the quality of insurance coverage. Coverage for balance-billing tends to be correlated with coverage for optical and dental care. For more details, see Bocognano, Couffinhal, Dumesnil and Grignon (2000).

Table 2. The level of complementary insurance coverage of insurance policy holders and heads of non-insured households, 1998

	No Coverage	Minimal Coverage	Excellent Coverage	Any Coverage
By Income per Consumption Unit				
Less than EUR 610	41.7	20.5	11.6	16.5
EUR 610 to 915	12.8	28.1	17.9	26.9
EUR 915 to 1 220	4.8	19.3	15.6	19.1
More than EUR 1 220	7.2	21.4	46.8	27.3
Unknown	33.6	10.7	8.1	10.3
By Occupational Profession				
Farmer	4.8	2.7	2.3	2.7
Artisans Retailer	8.4	7.2	2.9	5.0
Executive, Intellectual Profession	8.2	8.1	38.2	16.2
Technical Profession	9.7	25.0	25.4	25.7
Employee	22.5	24.9	13.3	24.1
Skilled Workers	24.1	17.4	13.9	16.6
Unskilled Workers	18.3	9.1	2.3	6.8
Other Workers	4.1	5.6	1.7	3.0
By Employment Status				
Public employee	9.0	18.9	9.3	18.8
Agricultural salaried worker	2.2	1.4	0.6	1.7
Other salaried workers	69.6	63.4	83.2	67.5
Non salaried workers	15.6	11.1	5.2	9.1
Unknown	3.8	5.4	1.7	3.0

Source: Bocognano *et al.* (2000).

32. The fact that coverage varies according to labour market variables is partly explained by the fact that roughly half of all private insurance contracts in France are provided through the workplace. While this rate is lower than in the US, the reasons for employer provision of health insurance are similar. In addition to economies of scale in administration, there are tax advantages to receiving health insurance through the workplace.[13] One difference with the US is that risk pooling is a less important argument for employer provision because of the complementary nature of the coverage. While the pure premium for a given benefit design tends to be lower for employer-sponsored contracts for which employee participation is obligatory as compared to individually-purchased contracts, the difference is not especially large (Pleynet-Jesus, 2003).

13. When enrolment by employees is obligatory (which is true for roughly half of all employer-sponsored contracts) health insurance is considered a tax-deductible business expense for employers and a tax-free benefit to employees. Additional payroll contributions rebates apply for the employers' contribution to health insurance regardless of the mandatory characteristic. Tax deductions also exist for the self-employed.

And, as will be discussed below, non-price barriers to obtaining coverage faced by high risk consumers in the US are not an issue in France's non-group market.

33. CMU complementary coverage is available to individuals with monthly incomes below EUR562. Initially, roughly 5 million persons (8% of the population) were eligible. This includes 3.8 million who had previously been covered by less generous means-tested programs, and were automatically enrolled in the CMU. As of December 2002, 4.5 million persons (about 7% of the population) had complementary coverage through the CMU (Boisguérin, 2003). A survey conducted in 2000 (Boisguérin, 2002) showed that CMU beneficiaries were younger, more frequently female and members of single parent households than the general population. Compared with the target population, beneficiaries are also more often unemployed or out of the labour force. Over one-third of the population in overseas departments is covered by the CMU, compared to a coverage rate of 7% for the rest of France.

34. In 2002, policies were enacted to help CMU beneficiaries whose income increases above the income eligibility threshold to maintain complementary coverage. If the income of someone covered by the CMU increases to less than 110% of the eligibility threshold, she is eligible for a lump-sum subsidy toward a private supplemental contract (EUR 115 for a single person). Whether or not this option is taken, former CMU beneficiaries receive a one year exemption from the standard requirement of having to pay for care at the time it is received and then submit for reimbursement from Social Security.

35. After the enactment of the CMU, roughly 6% of the French population remains without complementary insurance. It appears that the bulk of these are people who have incomes that exceed the CMU eligibility limit but are still unable to afford private coverage.[14]

III. Effects on utilisation and expenditures

36. Private health insurance reduces the out-of-pocket cost of health care, creating essentially first euro coverage for physician services and prescription drugs. More comprehensive contracts also significantly reduce the cost of goods such as eyeglasses, contact lenses and dental work. A number of studies indicate that complementary health insurance has a significant impact on health care utilisation in France.

37. A recent study found that, controlling for socioeconomic and demographic characteristics and detailed measures of health status, adults with private insurance were 86% more likely to visit a physician within a one month period than those without complementary coverage.[15] This difference is comparable to differences between insured and uninsured adults in the US, where the insured/uninsured differential in out-of-pocket costs is much greater. The magnitude of this difference might suggest that the French results are driven by adverse selection, rather than moral hazard. However, several other results argue against that interpretation. In particular, an analysis using multiple measures of health status finds no evidence that persons with complementary health insurance are less healthy than those without coverage.

14. For example, in the 2000 ESPS, 52% of respondents without complementary coverage said the reason was that it was too expensive. Only 11% said they chose to be without coverage because they were in good health (Auvray, Dumesnil, and Le Fur, 2001).

15. Buchmueller, Couffinhal, Grignon and Perronnin (forthcoming). Earlier research using other data obtains similar results. See Genier (1998); Caussat and Glaude (1993). In contrast, one study examining the effect of a change in cost-sharing for individuals covered by one particular insurer finds little effect on utilisation. Chiappori, Durand, and Geoffard (1998).

38. As noted, patients in France enjoy considerable freedom in choosing their own physicians including the ability to self-refer to specialists. While private insurance does not eliminate formal barriers to see certain physicians, it conceivably could affect a patient's choice of physicians by lowering the cost of physicians in Sector 2, whose fees exceed the conventional tariff. Along these lines, complementary insurance may induce substitution away from GPs, who tend not to balance bill, to specialists, who are relatively more likely to be in Sector 2. One study documented that individuals from higher income occupations were more likely to have complementary insurance and more likely to visit a specialist conditional on some utilisation (Mormiche, 1993). However, recent studies controlling for income and other patient characteristics found no effect of complementary insurance on the choice between seeing a specialist or a GP (Buchmueller *et al.*, forthcoming) and that coverage was not related to the level of fees a patient would pay.[16] These finding may be explained by the fact that in many cases the difference in price between a specialist and GP is not very large – in the absence of balanced billing the difference is only EUR1. Alternatively, the explanation may have to do with limitations of the data and related econometric issues.

39. France has the highest per capita rate of pharmaceutical spending in Europe. A recent study using data from 1998 found a strong relationship between complementary insurance coverage and spending on prescription drugs (Dourgnon and Sermet, 2002). Holding constant the effects of age and sex, individuals with private insurance were 10% more likely than individuals without complementary coverage to have any prescription drug use during a one month period. Among people with any pharmaceutical expenditure, mean spending was actually 10% higher for individuals without complementary coverage. One explanation for this pattern is that private insurance induces expenditures on drugs for less serious conditions.[17]

40. One recent study using data from 2000 compares the utilisation and expenditures of individuals just enrolled in the CMU, people with other complementary coverage and people with only the statutory coverage (Raynaud, 2003). The analysis is based on a data set that combines survey data with Social security claims data.[18] Holding health status and other factors constant, the results indicate that total ambulatory expenditures for CMU beneficiaries and individuals with private insurance were 40% and 26% higher, respectively, than for individuals without complementary coverage. Whereas previous work had found that the uncovered had significantly higher inpatient expenditures than the covered, (Cassaut and Glaude, 1993), this study found no effect of complementary coverage on inpatient utilisation.

16. This analysis encompassed the choice between sector I and II physicians as well as the possibility to visit a physician who would bill a large amount beyond the tariff. See Buchmueller, Couffinhal, Grignon, Perronnin and Szwarcensztein (2002).

17. In France certain drugs can be obtained with or without a prescription, though only the former type of expenditure can be reimbursed. Thus, one reason that French physicians prescribe so much is that by writing a prescription they are helping their patients get a lower price on non-essential drugs like pain relievers, cough syrups, etc.

18. Other research compares the utilisation of CMU beneficiaries to all other individuals using only claims data. (Girard-Le Gallo, 2003a and 2003b). An important limitation of this work is that it is very difficult in the claims data to distinguish non-CMU beneficiaries who truly received no care during the period from individuals who appear in the data set but, in fact, are covered under a different regime of the Social security system. This problem biases any comparisons with CMU beneficiaries (for whom false negatives are not an issue), especially if a key effect of complementary coverage is to increase the probability of consuming any care. An additional problem of interpretation is that the non-CMU group combines individuals with private complementary coverage and those without such coverage.

41. Given the limited reimbursements provided by the statutory public insurance, we would expect that utilisation effects would be especially pronounced for optical and dental care. Holding constant other factors, complementary coverage is found to increase the probability of having any expenditure on optical care (among people needing glasses) by 84%. In the case of dental care, the results indicate that, all else equal, individuals with complementary coverage are between 38% (private coverage) and 50% (CMU) more likely to have at least one visit compared to someone without such coverage. The estimated effect on total spending on dental care is 22% for private coverage and (a statistically insignificant) 5% for the CMU.

42. Another study on dental care looks not at utilisation per se, but at the decision to forego treatment (Gerard and Henry, 2002). New patients at a dentist's office were asked whether they had gone without dental care in the previous 6 months. Holding constant demographic characteristics and the reason for the visit, individuals without complementary health insurance were over three times more likely to report having gone without care than those with coverage.

43. Since the public system reimburses patients for roughly two-thirds of the cost of physician visits and pharmaceutical drugs, it bears most of the cost of the additional utilisation induced by complementary insurance coverage. Indeed, for these categories of care, private coverage essentially neutralises the effect of the *ticket modérateur*, which was introduced with the express purpose of reducing moral hazard. Of course, to the extent that mandatory cost-sharing represents a significant burden for patients of limited means, the objectives of economic efficiency (reducing "excess" utilisation) and equity (eliminating access barriers) are in direct conflict. By expanding complementary coverage via the CMU, the French government chose to enhance equity at the expense of efficiency.

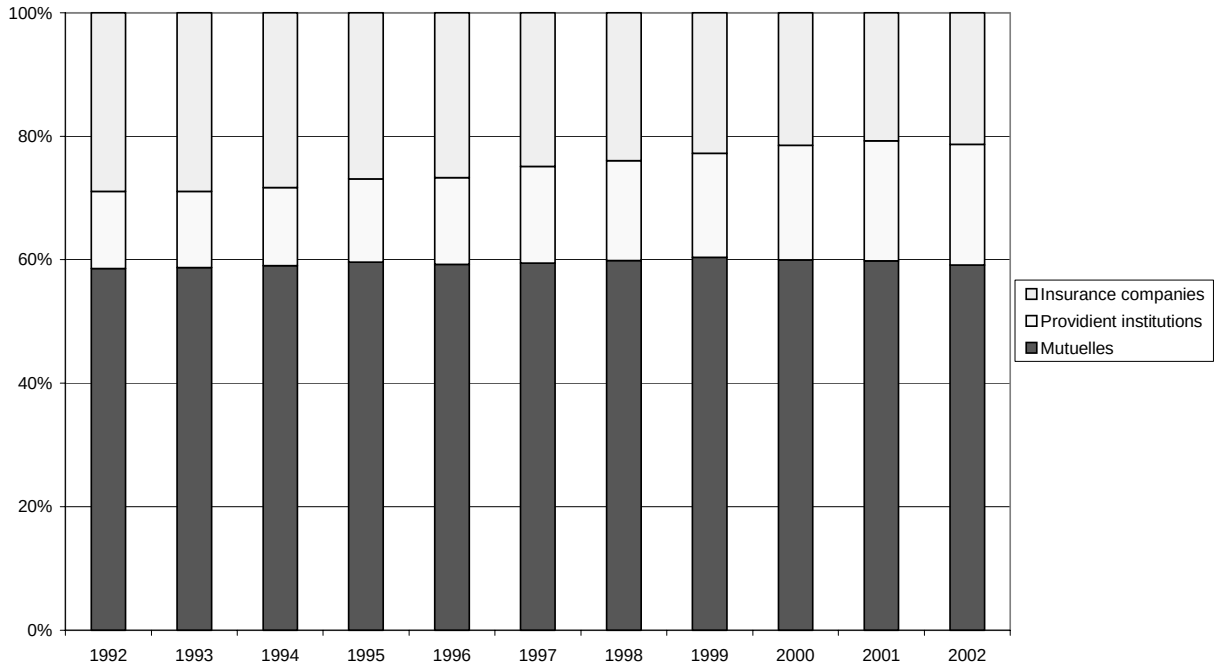
44. With respect to the equity objective, the initial evidence suggests that the CMU was successful. Whereas one study showed that individuals covered by the less generous departmental programs that the CMU replaced had significantly lower utilisation than those with private complementary coverage, (Raynaud, 2002), the results from the study just described indicate that the differences between CMU beneficiaries and individuals with traditional complementary coverage are small and, for many types of utilisation, statistically insignificant.

IV. Market structure and regulation

45. Three types of organisations compete in the market for complementary health insurance. The non-profit *mutuelles* account for nearly 60% of the market[19]. Another category of non-profit organisations, provident institutions, account for between 15% and 20% of all complementary insurance; commercial insurance companies account for slightly more than 20% of the market. Over the past decade, the market share of *mutuelles* has remained fairly constant, while provident institutions have gained market share at the expense of insurance companies (Figure 2). However, since some provident institutions operate in conjunction with commercial insurers part of this shift in market share may be more apparent than real.

19. To be more precise, *mutuelles* finance 60% of the benefits paid by all types of private insurance providers (National Health Accounts).

Figure 2 Distribution of the participation to health financing among the 3 types of institutions that provide insurance



Source: Comptes Nationaux de la santé (Eco-Santé France 2003, 2ème ed.).

46. The three categories of insurers differ in their organisational objectives and in the way that they are regulated. In 2000, there were 1275 *mutuelles* that each covered at least 3500 people.[20] Among this group, 565 account for over 90% of benefits paid by *mutuelles*. Many *mutuelles* are organised along occupational lines – for example, the largest ones cover groups of public sector employees such as teachers or postal workers – while others draw their membership from individuals living in a particular *departement*. *Mutuelles* have historically have had a distinct orientation, which emphasises the concepts of mutual aid and solidarity. This means they make very limited use of risk-rating or risk selection strategies. Traditionally, many *mutuelles* defined premiums as a percentage of income. *Mutuelles* are financed almost entirely by payments and fees paid by subscribers, and complementary health insurance is their main line of business, representing 95% of outlays in 2000.[21] *Mutuelle* enrolment is split roughly evenly between group and individual contracts.

47. Provident institutions historically existed to provide retirement benefits and other forms of social insurance to employees; they are jointly managed by representatives of the employers and employees. Today, 51 offer complementary health insurance (Chadelat, 2003). Health insurance represents the largest

20. Roussell (2003). The Code de la *Mutualité* draws a distinction between *mutuelles* above and below this enrolment threshold. The latter have no autonomous health insurance activity.

21. See Roussel (2003). Other activities include the provision of other types of social insurance such as disability and life insurance. Some *mutuelles* also operate different types of facilities including pharmacies, optical care clinics and retirement homes.

portion of the industry's business, accounting for roughly half of all revenues in 2002 (CTIP, 2003). Provident institutions offer mainly group contracts within the private sector (mandatory group contracts account for half of their activity), with individual organisations focusing on particular industries or professional groups.

48. There are 118 private insurance companies operating in the French market for complementary health insurance (Chadelat, 2003). This comprises for-profit and non-profit firms (mutual insurance companies). In contrast to the *mutuelles* and provident institutions, complementary health coverage is one of many insurance products supplied by these firms. In the life and health insurance industry, complementary health insurance represents less than 5% of total revenue (FFSA, 2003). Group and individual contracts account for comparable numbers of contracts.

49. The different types of organisations are regulated under three different regulatory codes: *mutuelles* by the *Code de la Mutualité*, provident institutions by the Social Security code, and private insurers by the Insurance Code. There are several similarities among these regulatory regimes. There are no required benefits, nor are there any benefits that carriers are prohibited from offering, provided the industry-level specialisation principle is respected.[22] Likewise, there is no requirement that benefits be standardised in any way. Group contracts are prohibited from excluding any medical conditions. Individual contracts can exclude coverage for certain conditions if they are clearly defined and the insurer can show that consumers were made aware of the limitations prior to enrolment. Once someone has been insured for two years, the carrier cannot terminate the contract or reduce the level of coverage. In addition, retirees and other individuals leaving a group can maintain their complementary coverage through the group.

50. The main differences in the regulatory regimes pertain to tax treatment. [23] Historically, mutuelles and provident institutions were exempted from a 7% premium tax on insurance contracts. [24] This tax preference was intended to acknowledge that these organisations contribute to the general interest and belong to the social economy sector. However, this violated EU policy requiring the equal treatment of all insurers, leading the French Federation of Insurers (FFSA) to file a complaint with the European Court of Justice. This, in turn, led to a new regulation, implemented in October 2002, stipulating that contracts that adhere to a solidarity principle are exempted from this tax. The solidarity principle prohibits an insurer from requesting any health information prior to subscription or charging premiums based on subscriber's health status.[25] For reasons we describe below this automatically applies to the mutuelles and, although no public information is

22. There was an exception. Traditionally, *Mutuelles* directly provided health care and offered other services to their beneficiaries (this part of their activity is known as *oeuvres sociales*, social undertakings). While it was not clear whether this really was in contradiction with the specialisation principle that should apply to the insurance business according to European Directives (see Rocard Report, 1999), other types of insurance providers would not have been allowed to offer such services. Since then, the social undertakings of *mutuelles* have been reorganised so as to be provided by "sister-mutelles" in order to improve the transparency of management, see below.

23. For a detailed comparison see Millot and Rudelle Waternaux (2001), p. 118.

24. Regardless of the provider type, employment-based personal protection insurance contracts were also exempted provided that the part of the premium financing health represented less than 20% of the total (which could include occupational disability, term life and health care insurance). This technical requirement was usually met until recent years as the importance of health insurance grew. Insurers could also avoid paying the tax was by organising reinsurance agreements with IP and Mutelles (cf. Liaisons sociales, Supplément au numéro 12694 du 26 juin 1998).

25. Article 995 of the Tax Code.

available on the topic, it is said that most contracts provided by insurers were changed to respect this principle.

51. Another important consequence of the transposition of EU regulation to French law was a rewriting of the *Code de la Mutualité*. This was supposed to occur by 1993 but, in fact, did not happen until 2001. The new *Code de la Mutualité* stipulates that "social undertakings" must be managed within separate entities and includes stronger solvency requirements. These reforms led to a consolidation within the sector. Finally, the new code explicitly states the "*mutualiste*" principles that govern their activity. In particular, it specifies that premiums collected can vary only according to the following factors: income, the time span since the initial subscription of a contract, the health insurance fund that the subscriber is a member of, the location, the number of beneficiaries and their age.[26] In contrast, private insurers, if they choose not to respect the solidarity principle, can still require potential subscribers to complete a medical questionnaire and can use such data in setting premiums and contract terms. The actual use of such practices always varied within the sector. Some insurers did require medical questionnaires for their most comprehensive contracts but not for their more basic ones.

V. Market performance

52. Unlike other European countries, like the Netherlands or Switzerland, France has never embraced market competition as a public policy strategy for providing health coverage and controlling costs. However, in some ways the structure of the French health insurance is more conducive to competition than its neighbours. In the Netherlands, supplementary insurance is sold by the same sickness funds that provide the system's statutory coverage. Until recently, these organisations were regional monopolies. While policies enacted in the 1990s allow consumers the freedom to choose among competing supplementary insurers, most continue to purchase such coverage from the same fund that provides their basic coverage. In this way, supplementary insurers have an essentially captive base of consumers, which is a source of market power. Similarly, in Switzerland private insurers provide both basic statutory insurance and supplementart coverage. While it is possible to for consumers to buy the two types of insurance from different carriers, as a practical matter this seldom happens. Again, this limits competition in the supplementary market.

53. In contrast, in France there has always been a clear separation between the funds operating the Social Security system and the complementary insurers, and there is a longer history of choice in the complementary market. Whereas in the Netherlands (Laske and Schut, 2002) and Switzerland (Colombo, 2001) it is relatively uncommon for consumers to switch insurance carriers**,** a recent study found a fairly high rate of switching by French consumers (Grignon and Sitta, 2003).

54. The French market is also much less concentrated than private health insurance markets in other countries. The top 5 carriers (2 *mutuelles*, 2 provident institutions and 1 commercial insurer) account for roughly one quarter of market-wide revenues; the top 10 carriers account for just over one-third.[27] To put this in perspective, in Great Britain and Ireland, the top three players account for 75% and 100% of the market for private insurance (Mossialos and Thomson, 2002).

55. The different rules under which *mutuelles* and commercial insurers operate along with the differential tax treatment resembles the situation that once pertained to Blue Cross/Shield plans and

26. Article L-112-1 of the Code de la Mutualité.

27. These are approximate figures calculated by combining data from several different sources.

commercial carriers in the US. There, competition from commercial insurers for better risks generated adverse selection for the "Blues", forcing most to abandon community rating (Thomasson, 2002). It is interesting, therefore, to consider whether a similar scenario has played out in France. The answer is yes, though to a more limited degree.

56. Commercial insurers entered the French complementary insurance market in force in the 1980s.[28] Prior to that, *mutuelles* had dominated the market and had operated in a manner that strongly emphasised the principle of solidarity that is at the centre of the *mutualiste* movement. *Mutuelles* traditionally charged a single rate to all subscribers (typically denominated as a percentage of income rather than a function of claims), offered a single level of coverage, and used no non-price strategies for limiting their exposure to high risk consumers. In contrast, the private insurance companies that entered the market practiced risk-based pricing, varying premiums with age and according to the results of medical questionnaires. They also offered a wide range of benefit packages with the goal of inducing consumers to self-select on the basis of risk and used other risk-selection strategies, such as excluding certain consumers from certain plans.

57. For *mutuelles* specialising in collective contracts to closed groups (*e.g.*, public employees) the entry of private insurers was not a major threat. Their groups were stable and they could continue to operate according to the principles of solidarity. Commercial insurers posed more of a direct challenge for *mutuelles* that did most of their business in the individual market. If they did not respond, these *mutuelles* faced the possibility of adverse selection, as lower risk consumers gravitated toward the lower prices offered by the commercial insurers. A comparable trend took place in the highly competitive market for group coverage of private firms. As a result, over time, many *mutuelles* operating in the market began adopting practices similar to their commercial competitors.

58. Today, both *mutuelles* and commercial insurers vary non-group prices according to subscriber age. In many cases, individuals who initially enrol at an advanced age are required to pay a surcharge and older consumers (say 65 or older) are prohibited from enrolling in certain contracts. However, *mutuelles* tend to make use of fewer age categories than do commercial carriers. As noted, they are prohibited by the *Code de la Mutualite'* from using other variables used by commercial insurers, such as sex or health status. Both types of carriers make use of waiting periods for certain types of care. For example, most contracts do not cover pregnancy-related care for the first 9 or 10 months of a contract. Also, most *mutuelles* now offer a range of contracts, varying in generosity, though not as many different options as is typical for private insurers.

59. These responses by *mutuelles* appear to have been sufficient to maintain stability in the market. This stability, which contrasts with the often volatile nature of competition among different types of health insurers in the US, may be attributable to certain features of the French system. An important difference between France and the US is what is covered by private insurance in the two countries. Whereas, the distribution of total health expenditures is quite concentrated, this is less the case with the expenses covered by complementary coverage in France. Thus identifying and avoiding high cost individuals is more profitable in the US context than in France. A second and related point is that in France the *ticket modérateur* is waived for roughly 7% of the population who have certain long term, high cost medical conditions, such as diabetes, cancer or AIDS (Sermet, 1995; Couffinhal and Paris, 2001). This further limits the risk to insurers of covering a high risk person. Third, the differences in the regulatory treatment of *mutuelles* and private insurers in France is less pronounced than the differences that once existed between the Blues and commercial insurers in the US.

28. The following discussion draws heavily from Mauroy (1996).

60. Another interesting contrast with the US concerns the relationship between insurers and providers. By international standards, the Social Security system is a passive purchaser of health care. The lists of reimbursable items have always been managed on a day-to-day basis by the State, sometimes based on advice by the health insurance funds and health professionals. The process for including an item on the list and choosing a reimbursement rate is not always rational or transparent, at least to the public. Little attempt is made to manage care and cost control efforts have not been very effective (Imai, Jacobzone and Lenain, 2000).[29] In the last few years, attempts have been made to encourage priority setting based on economic evaluation, yet, for administrative and political reasons, the process has been very slow.

61. Complementary insurance providers have also been passive, tending to base their benefits closely on the public system. Complementary coverage provides additional reimbursement for goods and services covered by Social Security, but generally provides little or no reimbursement for treatments not recognised by the public system. Like the statutory system, complementary insurers have historically done little to steer patients to certain types of providers or to influence prescription drug use. Yet, there is a limited degree of interaction between private insurers and providers.

62. The *Mutuelles* have a long tradition of direct service provision through dental clinics, optical centres, pharmacies and even hospitals.[30] There are roughly 1 600 of such facilities, with a total revenue in 2000 of EUR 1.9 bn. (in comparison, benefits paid by *Mutualité* amount to EUR 9 bn.) (Roussel, 2003). These facilities are known to provide services at low prices (in particular for dental care). With the exception of a few leading institutions, their reputation for quality is not strong. In compliance with European legislation these facilities now have to be managed in separate entities.

63. Beginning in the mid-nineties other complementary insurers initiated more proactive interventions in the health sector. One well-publicised project was by the private insurer AXA. In 1997, AXA floated a proposal to manage the entire health insurance of clients and to provide care within a dedicated network in the Ile-de-France region. Participation would have been on a voluntary basis.[31] The proposal generated considerable controversy, raising concerns about the "privatisation of social security." The proposal was ultimately withdrawn. Some observers believe that this provocative step raised suspicions about the intentions of commercial insurers, which ultimately undermined their potential to initiate more active managed care strategies.

64. In spite of this, a few projects were started. Most are modelled like "call centres" and are advertised as services for the consumers rather than instruments of risk management or cost control. Some call centres provide information and advice about health or the organisation of care, but the bulk of their activity is related to dental care and eyewear. They provide information about prices and evaluate the proposed fees on behalf of the patient who then has more information to negotiate with the provider. Some insurers have also set up more formal agreements with providers in these sectors that contain some elements of quality improvement and price moderation, in return for a potential increase of the activity volume.

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29. For detailed discussions of recent policy developments, see Imai, Jacobzone and Lenain (2000) and Sandier, Polton and Paris (2002).

30. Some *mutuelles* also provide "social" services, including services for the elderly and the handicapped and holiday resorts.

31. In order to respond to the concern that beneficiaries might be selected, AXA proposed to include beneficiaries of a means-tested program in its network.

65. Another private insurer, Groupama, recently initiated a unique project with GPs and insured patients in rural areas. In return for a fixed fee, the GPs agreed to participate in quality circles; patients agreed to undertake some preventive actions and to follow their GPs prescriptions. An evaluation of the project suggested that it led to a decrease in health expenditure as well as a high degree of satisfaction among participants (Le Concours medical, 2002).

66. These examples notwithstanding, complementary insurers have been very conservative with respect to moving beyond their traditional role. The call centres and investments in other "managed care" activities are known not to be profitable at the moment, though some consider this as an investment that could pay in the long run.

VI. The evolving relationship between public and private insurance

67. A final point related to market performance has to do with the relationship between the statutory public system and complementary coverage. While most attention focused on the CMU has concerned its impact on the distribution of coverage and access to care, another potentially important impact of the policy is on the relationship between complementary insurers and the statutory system. CMU beneficiaries have the choice of receiving their complementary coverage through the statutory system or enrolling with private carriers, *i.e.*, a *mutuelle*, provident institution or private insurer. The trend is for increased enrolment with private carriers. Whereas only 8% of initial CMU beneficiaries (who were covered by prior public programs) chose to receive their CMU benefits from complementary insurers, by December 2002, 15% of all enrolees were covered by private plans. By allowing public funds to provide what is essentially supplemental insurance, this reform has blurred the distinction between the two markets.

68. Dissatisfaction with the way public health insurance covers care combined with concerns about public program deficits[32] have let to a growing debate over the appropriate role of the public and private sectors in financing health care. The core proposal of the Chadelat report, which was issued in April 2003, is the creation of a “Generalised health insurance” (GHI) program that covers the services all citizens should have access to. This GHI would consist of two separate tiers:

- a mandatory health insurance (not essentially different from the existing one);
- a “basic complementary health insurance” (BCHI), which would not be compulsory but would be made accessible to anyone, with a progressive subsidy for the poorest part of the population. The CMU complementary policy would be maintained as a part of BCHI, along with its constraints on providers (no extra-billing), but only for the poorest insured. The other part of the BCHI would not impose such constraints on providers. In principle, BCHI policies would be provided by private insurers, which would be obligated to cover a defined set of services (co-insurance for goods and services covered by compulsory insurance). Premiums would be set freely but in accordance with “solidarity principles”, *i.e.* no health questionnaire or differentiation of rates according to health status.

69. The GHI positive lists and levels of cost-sharing would be drafted according to the principles of medico-economic economic evaluation and the split between the mandatory health insurance and the BCHI would be negotiated in order to improve their joint and separate capacity to “manage care”. Beyond the basic

32. The public health insurance will reach this year the highest deficit ever (estimated EUR 10 billions for 2003) and the total public deficit is already above the 3% of GDP threshold.

complementary coverage, private insurers would still be free to provide more advantageous contracts (for extra-billing and non-covered care) on an unregulated market.

70. The Chadelat report was heavily criticised by a number of different interest groups, including providers' unions, employer and employees unions, and private insurers. In response to this reaction, the government set up a steering committee that will undertake a broad consultation and will publish a report in June 2004.[33] Whatever the committee proposes, the coming reform of the health insurance will undoubtedly lead to a redefinition of the public and the private sector's respective responsibility in the financing of care in France.

Summary and conclusions

71. The contribution of private health insurance to the financing of care in France is quite important. When the CMU is taken into account, more than 90% of the population is covered by some kind of supplementary insurance. Private insurance accounts for over 12% of total health spending in France. This reliance on private health insurance is explained historically by the role of *mutuelles* which existed prior to the public health insurance but also by the steady erosion of public financing of care over time.

72. By negating the effect of cost sharing required by the Social Security system, private insurance induces more consumption, which drives up public and private spending on health care. Until recently, the impact of public system co-payments was felt mainly by lower income patients who lacked private coverage. The introduction of the CMU reduces this inequity, but the fact remains that the system's architecture dissolves the responsibilities and contributes to growing concerns about the sustainability of the system.

73. The market for private health insurance in France appears both competitive and stable. While non-profit *mutuelles* and commercial insurers operate under slightly different rules, their shares of the market have remained fairly constant over time. Adverse selection against insurers that make limited use of risk-based underwriting does not appear to be a major problem as in the United States. It remains to be seen how recent regulatory changes that eliminated certain advantages enjoyed by *mutuelles* will affect the industry's competitive balance.

74. Despite their important position, health insurance providers have surprisingly little impact on the way the system is run and for a long time did not question their position as secondary payers. The current challenges presented by increases in public sector deficits and private health insurance premiums, as well as the commitment of the government to reform France health insurance system will likely bring about a change in their role and their strategies.

33. *Haut Conseil pour l'Avenir de l'assurance maladie* (the Ministry of Health website will provide information on this Committee's works http://www.sante.gouv.fr/).

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