Health insurance development in France
Evolution, trends and future challenges
1 Health insurance system in France and financing
   1.1 A 3 level scheme
   1.2 Health care expenditure: France ranks 3rd among OECD countries, distribution by type of services,
   1.3 Financing healthcare expenditure: distribution by sponsors, LTI financing
   1.4 Private health insurance market in France: a still growing market, still a fragmented market despite merging trends, various health insurers

2 Evolution in Healthcare expenditure and financing
   2.1 Constant growth
   2.2 Public financing remains the major financing agent of Medical care and Goods* expenditure
   2.3 … but relative withdrawal of public financing from outpatient care
   ♦ Increase share of households and private health insurers in the outpatient care bill paying
   ♦ Hospital care costs are still mainly sponsored by public financing despite a significant increase of the costs supported by private health insurers
   ♦ Dental care expenditure are largely supported by health insurers

3. Major health care cost drivers
   ♦ Increased demand of healthcare
     ➢ Demand boosted by a protective health insurance schema
     ➢ Consumption boosted by the prepayment mechanism
   ♦ Outpatient care organisation
   ♦ New medical technologies
   ♦ Long Term Illnesses and chronic diseases

4. Health Insurance: challenges and stakes
   ♦ Macro economic issues and stakes for private health insurers
   ♦ Future public budget pressures, cut in public financing
   ♦ The big map for health insurers
   ♦ Increased transfers from the state universal health coverage to private insurers: some scenarios of transfers
   ♦ Increased transfers from the state universal health coverage to private insurers and switch from Solvency I to Solvency II
   ♦ Impact of LTI transfer
   ♦ Among other issues at stake on the private health insurance market
**MGEN Group**: private mutual* health insurance company

- Created in 1946, **3.4 million people covered in France. First mutual* insurer in France**
- Administering State health insurance scheme (state social security) in Education, Universities, Research, Culture, Communication, Sports
- Providing complementary health insurance and provident insurance (death protection, short and long term disability, long term care, income protection, pensions)
- Owning and managing a network of 33 healthcare centers (3,300 treatment beds): medical centers, convalescent care centers, residential homes for dependent elderly people, mental health centers
- Providing expatriate teachers and their families international health insurance (over 55,000 people covered in 170 countries and overseas territories)

* A mutual Insurance company = non profit health insurance company which has no shareholders but instead is owned by its policyholders

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**Istya group**: insurance group formed by MGEN Group and 5 other mutual health insurers

- With 6.3 million people covered, leader on the health insurance market in France.
1. Health Insurance system in France and financing
1.1 French health insurance system: a 3 level scheme

- **State universal social health coverage** *(National Social security = Sécurité Sociale)*
  - Mandatory contributions based on the fair principle that “one pays according to one’s incomes and receives care according to one’s needs” (income-related contributions, rather than risk related)

- **Voluntary health insurance** *(complementary)*
  - Payable by households
  - Includes voluntary health insurance premiums and out-of-pocket costs (co-payments, deductibles)

- **Out-of-pocket expenditure**
  - Payable by households
  - Includes social contributions (payroll taxes: employers’ and employees’ contributions + unemployed and retirees) and dedicated taxes

*Contributions to the State universal social health coverage (National Social security = Sécurité Sociale) are mandatory, based on the fair principle that “one pays according to one’s incomes and receives care according to one’s needs” (income-related contributions, rather than risk related)*
French social health insurance system: a 3 level scheme

- Private voluntary health insurance in France
  - Private Health insurers are also central to the system
  - as supplemental insurers
  - covering a part of the expenses not reimbursed by the « State social security »

- Social health insurance or coverage named « Social security », is a mandatory scheme controlled by French government
  - created in 1946
  - built on fundamental principles: equity for healthcare access and solidarity
  - The benefits to recipients are determined by government
  - The Social health insurance is financed by compulsory contributions (by employers, employees, retirees, unemployed …)
    - Individuals’ contribution is calculated according to their revenues and the health benefits granted according to their needs
    - There is no direct link between the amount of contribution paid by an individual and the risk to which this individual is exposed
    - Article 1 of the law of 13 August 2004 concerning Health Insurance: "The Nation shall affirm its commitment to the universal and compulsory character of health insurance, grounded in solidarity. Regardless of a person's age and state of health, every social health insurance policyholder shall benefit from protection against the risk and consequences of health, funded on the basis of his or her resources."
1.2 Healthcare expenditure: France ranks 3rd among OECD countries

Health spending accounted for 11.8% of GDP in France in 2009, around 2.3 percentage points higher than the OECD average of 9.5%.

In terms of health spending as a share of GDP, France ranks third after the United States (17.4%) and the Netherlands (12.0%).

France also ranks above the OECD average in terms of health spending per capita, at 3,978 USD (adjusted for purchasing power parity) in 2009, compared with an OECD average of 3,223 USD. However, health spending per capita in France remains less than half that in the United States (7,960 USD per capita).

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base.

PPPs are the rates of currency conversion that equalise the cost of a given “basket” of goods and services in different countries.
1.2 Healthcare expenditure in France: distribution by type of services

Current healthcare expenditure (CHCE) 2010: 234 billion €

Medical care and goods: 174,9 billion €

- Preventive Care, Research, Medical staff Education ... 33,63 billions € (13%)
- Elderly and disabled people nursing home care ... 17,2 billions € (7%)
- Daily sickness benefits 12,45 billions € (5%)
- Medical care and goods: 174,9 billion € (75%)
- Outpatient healthcare 25%
- Medical goods 26%
- Hospital care 47%
- Sick people transportation 2%

Total 100% = Consumption of and Medical Care and Goods (CMCG = CSBM)

*Medical goods*: outpatient care (physicians, nurses ..., prescription drugs, optical equipment, prostheses ...)

Source: Social Security Account 2010
77% of medical care and goods spending are sponsored by the national solidarity: various collected taxes and social contributions...

13.5% financed by private insurance business: insurance premiums are paid by households and by companies for employers’ sponsored health plans

- 59% of private healthcare costs are financed by healthcare insurers

Out-of-pocket spending account for 9% but the health insurance premiums paid by the consumers are to be added to the households’ burden

Sources: Insee, Social Security Account 2010
1.3 Financing healthcare expenditure: distribution by sponsors

- Some services are mainly financed by households (health insurance premiums and out-of-pocket spending): dental care, optical equipment and prosthetic devices.
- Others (mainly hospital care and transportation ...) are sponsored by public funds.

2010 Sponsors by type of care (medical care and goods) (%)

<table>
<thead>
<tr>
<th>Service</th>
<th>Households' Out-of-Pocket</th>
<th>Private Health Insurers</th>
<th>Public Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental care</td>
<td>25.5%</td>
<td>38.5%</td>
<td>36.0%</td>
</tr>
<tr>
<td>Other medical goods (optical equipment, prosthetic devices ...)</td>
<td>21.4%</td>
<td>35.8%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Physicians</td>
<td>10.8%</td>
<td>19.2%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>16.3%</td>
<td>16.3%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Biology</td>
<td>3.0%</td>
<td>25.5%</td>
<td>71.5%</td>
</tr>
<tr>
<td>Physiotherapists, nurses ...</td>
<td>8.5%</td>
<td>12.0%</td>
<td>79.5%</td>
</tr>
<tr>
<td>Hospital care</td>
<td>3.2%</td>
<td>4.9%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Sick people transportation</td>
<td>2.7%</td>
<td>4.5%</td>
<td>92.8%</td>
</tr>
</tbody>
</table>

Disparities in public coverage according to the type of healthcare services.

Source: Social Security Account 2010

Jean-Louis Davet – MEXICO City November 2011
1.3 Financing healthcare expenditure: LTI (Long Term Illnesses and chronic diseases) distribution by sponsors

- Patients suffering from Long Term Illnesses and Chronic diseases benefit from a total or extremely high exemption of co-payments.
- Reimbursement by the State universal health coverage = 100% of the « Official tariff » of the State universal Health Coverage (National Social security) for all health services related to the declared Long Term Illness.
- 2010: 9 million people (15.5% of the population) covered by the State universal health insurance who concentrate 63% of the total health care spending.

**Annual health spending per capita**

**LTI patients (%)**

<table>
<thead>
<tr>
<th></th>
<th>Outpatient care</th>
<th>Hospital care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTI</td>
<td>6%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>LTI patients (%)</td>
<td>85%</td>
<td>98%</td>
<td>92%</td>
</tr>
</tbody>
</table>

**“Regular” patients without LTI (%)**

<table>
<thead>
<tr>
<th></th>
<th>Outpatient care</th>
<th>Hospital care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTI</td>
<td>13%</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>32%</td>
<td>5%</td>
<td>23%</td>
</tr>
<tr>
<td>LTI patients (%)</td>
<td>55%</td>
<td>92%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Disparities in public coverage according to the health status

- LTI = High coverage by public funds and low Households’ financing

Source: Social Security Account 2010
1.3 Financing healthcare expenditure: **LTI (Long Term Illnesses and chronic diseases) distribution** by sponsors

**Disparities in public coverage according to the health status**

<table>
<thead>
<tr>
<th>LTI patients in (€)</th>
<th>Non LTI patients in (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient care</strong></td>
<td><strong>Outpatient care</strong></td>
</tr>
<tr>
<td>199</td>
<td>106</td>
</tr>
<tr>
<td>336</td>
<td>266</td>
</tr>
<tr>
<td>3110</td>
<td>446</td>
</tr>
<tr>
<td>3110</td>
<td>814</td>
</tr>
<tr>
<td><strong>Hospital care</strong></td>
<td><strong>Hospital care</strong></td>
</tr>
<tr>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>53</td>
<td>20</td>
</tr>
<tr>
<td>3776</td>
<td>368</td>
</tr>
<tr>
<td>3776</td>
<td>3776</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>228</td>
<td>285</td>
</tr>
<tr>
<td>390</td>
<td>368</td>
</tr>
<tr>
<td>6886</td>
<td>814</td>
</tr>
</tbody>
</table>

**Annual health spending per capita**

<table>
<thead>
<tr>
<th>Outpatient care</th>
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<td>6886</td>
<td>117</td>
<td>814</td>
</tr>
</tbody>
</table>

Despite high level of public coverage, LTI patient’s OOP spending are twice higher than regular patients’OOP

Development opportunity for the private health care insurers

*Source: Social Security Account 2010*
1.4 Private health insurance market in France: a still growing and attractive market

2010 = 31.4 billion €

Insurance market evolution
(gross written premiums)

Sources: annual reports 2007 to 2010 FFSA/GEMA (car insurance and house insurance) and annual report 2010 Fonds CMU (health insurance)
1.4 Private health insurance market in France: a still growing market divided in employers’ sponsored healthplans and individual ones

2010 = 31.4 billion €

Health insurance market 2009: market share of employers’ sponsored healthplans and individual plans

Individual healthplans
Employers’ sponsored healthplans

Source: Fonds CMU report 2010

Sources: Fonds CMU, FFSA, CTIP, FNMF
1.4 Private health insurance market in France: still a fragmented market despite merging trends

The number of health insurance companies operating in France has decreased over the last 5 years as a result of the wave of mergers and acquisitions to comply with the new European solvency requirements in terms of capital requirements and risk management.

2010: 713 health insurance companies
2005 / 2010: -34%

2010: 587
Mutual insurers
2005 / 2010: -36%
2005: 919

2010: 34
Provident institutions
2005 / 2010: -29%
2005: 48

2010: 92
Joint stock health insurance companies
2005 / 2010: -14%
2005: 107

**Mutual insurance companies** = non-profit health insurance organizations which have no shareholders but instead are owned by their policyholders.

**Provident institutions** = non-profit organizations jointly ruled by employees unions and employers, involved in pension funds before entering the health insurance market.

Source: Fonds CMU
1.4 Private health insurance market in France: a fragmented market

Top ten of the largest health insurers in France gross written premiums (€ billion)

Source: Extract of Top 30 of Health insurers Argus de l'assurance 06/24/2011

(1) Group of 6 Mutual insurance companies built in may 2011: (MGEN, MNH, MNT, MGET, MAEE, MCDéf)
(2) including Sphéria Val-de-France et Santévie
(3) Merger of two Provident Institutions Aprionis and Vauban Humanis to be joined by Novalis Taibout in 2012

Source: Extract of Top 30 of Health insurers Argus de l'assurance 06/24/2011
1.4 Private health insurance market in France: various health insurers’ market share and contribution to global premiums

- **Mutual insurers**
  - Health insurance market share: 56%
  - Contribution of Health insurance in the global turnover: 89%

- **Joint stock health insurance companies**
  - Health insurance market share: 27%
  - Contribution of Health insurance in the global turnover: 14%

- **Provident institutions**
  - Health insurance market share: 17%
  - Contribution of Health insurance in the global turnover: 49%

Source: ACAM, Report of Budget Ministry to Parliament 2009
- Processing and analysis: MGEN

Jean-Louis Davet – MEXICO City November 2011
1.4 Private health insurance market in France: a saturated and replacement market

- **A saturated market**: 94% of French people are covered by complementary private health insurance = 61 million persons
  ⇒ a replacement market

- **Switching behaviour**:
  - 10 to 13% of French people covered switch their private health insurer because of dissatisfaction or to make savings

Source: Arcane Research Institute 2010
1.4 Private health insurance market in France: a saturated and replacement market

A high average rate of private health insurance coverage (94%) obscuring growing inequity and disparities ⇒ 6% of the population not covered by a complementary health insurance: 4 millions persons

Management, skilled and technical occupations with higher revenues subscribe more health plans

Percentage of individuals not covered by complementary health insurance: distribution by occupation

Source: Issues in Health Economics N° 161 January 2011
1.4 Private health insurance market in France: **growing disparities**

Higher rate of health coverage among households with higher revenues

The poorest households are more frequently those not covered by private complementary health insurance.

Inequal and reduced access to health insurance and to health care: a key determinant of social exclusion

- **30%** of people not covered by private complementary health insurance **forego care**, mainly dental and optical care, for which reimbursements of the State universal health coverage are extremely low.
- only **15%** of people covered by private complementary health insurance **forego care**

Source: Issues in Health Economics N° 161 January 2011
High level of public coverage: 77% of health medical care and goods expenditure
High average rate of private health insurance coverage (94%)
Health insurance in France = a very competitive market

But …

Disparities in public coverage according to the health care services
Disparities in public coverage according to the health status
⇒ Growing inequity

Still development opportunity for health insurers

Source: Arcane Reasearch Institute 2010
2. Evolution in Healthcare expenditure and financing
2.1 Healthcare expenditures in France: constant growth

Healthcare expenditure have risen constantly since 1945. Such health spending growth was enabled by the economic boom. In the recent years healthcare expenditure grew faster than national wealth.

Compared growth rates for Consumption of Care and Medical Goods (CCMG = CSBM) and GDP

*« The Thirty Glorious Years » of supergrowth 1945-1974, between the end of the World War II and the first major oil crisis in the 1970s

Sources: Drees, Insee - Processing and Analysis: MGEN
2.2 Public financing remains the major financing agent of Medical care and Goods* expenditure

Health spending, 2010
(Medical care and goods* :175 billions €)

Public financing
(Social security, state…)
77%

Private financing
(Households, private health insurance)
23%

Public financing of medical care and goods* 1950-2010

Share of public financing / total Medical Care and Goods spending (%)

« The Thirty Glorious Years* »

* Medical Care and Goods : outpatient care (physicians, nurses …, prescription drugs, optical equipment, prostheses …) + Hospital care + sick people transportation

Source: Insee, Comptes nationaux de la santé, 2010
2.3 … but relative withdrawal of public financing from outpatient care

- Increase share of households and private health insurers in the outpatient care bill paying
  - Physicians costs
  - Prescription drugs
  - Dental care

- Hospital care costs are still mainly sponsored by public financing despite a significant increase of the costs supported by private health insurers

Source: Insee, Comptes nationaux de la santé, 2010
Increase share of households and private health insurers in the outpatient care bill paying

**Physicians costs**: increased burden for households

- Households’ out-of-pocket spending grew faster than other sources of financing

*Growth in Physicians care spending (index base 100 in 1995): distribution by sources of financing*

- State universal health coverage
- National Social Security, State, CMUC
- Private Complementary Health insurers
- Households
- Growth income

*Source*: DREES (Comptes nationaux de la santé 2010)/ calculs FNMF
➢ Prescription drugs: households’ increased spending due to the successive de-reimbursements

➢ Co-payments on each medicine box and decrease of reimbursement of pharmaceuticals having a low or moderate or insufficient medical service

Growth in prescription drugs spending (index base 100 in 1995) : distribution by sources of financing agent

Source: DREES (Comptes nationaux de la santé 2010) / calculs FNMF

State universal health coverage
National Social Security, State, CMUC

Private Complementary Health insurers

Households

Growth income
Hospital care costs are still mainly sponsored by public financing despite a significant increase of the costs supported by private health insurers:

- increased part of hospital bills not reimbursed by the state universal health coverage (State Social security): physicians' fees, and increase of various co-payments on hospital treatments and medical services.

*Source*: DREES (Comptes nationaux de la santé 2010)/ calculs FNMF
Dental care expenditure are largely supported by health insurers

Growth in Dental care spending (index base 100 in 1995) : distribution by sources of financing

Source : DREES (Comptes nationaux de la santé 2010) / calculs FNMF
3. Major health care cost drivers
No single factor responsible for rising healthcare costs  
⇒ numerous cost drivers.

Healthcare cost drivers:
- Freedom to choose the place where to practice ⇒ great disparities in the geographical distribution of medical professionals
- Freedom of diagnosis, therapy and prescription, freedom to prescribe
- Activity-based pricing boosts physicians’ prescription
- Increased demand of healthcare
- Diffusion of hi-tech and therapeutic innovation

Outpatient care organisation

Increased demand of healthcare

Demand boosted by a very protective health insurance scheme

Consumption boosted by the prepayment mechanism suppressing patients’cost consciousness
(Almost 80% of healthcare are administered by prepayment)

High rate of coverage (94% of the population)
financing 77% of medical care and goods

Long Term Illnesses and chronic diseases

Sources: Institut Montparnasse 2011

Jean-Louis Davet – MEXICO City November 2011
Due to their lasting and evolulotinal nature, chronic and long term diseases and their subsequent costs constitute a real adaption challenge for the French health system that was designed and developed to cover and finance acute and short lasting illnesses, mainly due to a longer life expectancy.

In France, in 2010, 9 million people (15.5% of the population covered by the State universal health insurance) are declared to suffer from a Long Term Illness (LTI) or chronic disease*:

- LTI is an administrative status delivered by the State universal health coverage resulting in a high coverage by the State universal health coverage with total or partial co-payment exemption. All treatments not connected to the Long Term Diseases are reimbursed at a normal rate; so are not fully reimbursed.

Reimbursement by the State universal health coverage = 100% of the «Official tariff» of the State universal Health Coverage (National Social security) for all health services related to the declared Long term Illness.

- 85% of total LTI Outpatient care expenditure are reimbursed (compared to 55% for “regular” patients without LTI)
- 98% of total LTI Hospital care are reimbursed (compared to 92% for “regular” patients without LTI)

A list of illnesses classified as LTI (Long Term illnesses) is reviewed annually by the government. Some of the registered diseases are the followings: disabling stroke, chronic arteriopathies, severe heart failures, other cardiopathies, coronary heart disease, primary severe immunodeficiency requiring long term treatment, infection by HIV virus, diabetes type 1 and 2, severe forms of neurological and muscular conditions (myopathy …), haemophilia, Alzheimer disease and other dementias, Parkinson’s disease, paraplegia, polyarteritis, long term psychiatric conditions, multiple sclerosis, organ transplant, malignant tumors ….
In 2010, 9 million people (15.5% of the population covered by the state universal health insurance) are declared to suffer from a Long Term Illness (LTI) or chronic disease.

The growing population of Long term Illnesses is predicted to amount to 11 million in 2015.

Source: PLFSS 2011 Appendix 1 : Programme de qualité et d’efficience maladie.
The average annual growth rate of the LTI spending, over the period 2002-2009, was 8.5%.

Since the faster growth of the LTI expenditure, their contribution to the global Medical care and goods spending drove up from 44% in 2002 to 59% in 2009.
The majority of the growth of healthcare spending is related to rising spending on long term illnesses and chronic conditions.

**Contribution of Long Term Illnesses to the growth of Healthcare expenditure over the period 2008-2011**

- Outpatient care: 95%
- Prescription drugs: 100%
- Hospital care: 81%

Source: PLFSS 2011 Appendix 1 du : Programme de qualité et d'efficience maladie.
4. Health Insurance: challenges and stakes

What is at stake in the health insurance industry in France?
Financing healthcare expenditures: Sources of financing 2010
(billions of €, scope: all various Social security schemes: General scheme, agricultural workers’, self-employed, specific schemes (professions, civil servants))

Public financing of the mandatory State universal social health coverage
(National Social security = Sécurité Sociale)

Public financing of health care (77% to 78%) = a major source of fiscal pressure

Healthcare expenditures projections: future public budget pressures

Health care expenditures growth resulting in State universal health coverage DEFICIT

![Graph showing healthcare expenditures growth and state universal health coverage deficit over time.](image-url)
<table>
<thead>
<tr>
<th>Mostly unstable regulatory STRUCTURAL environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Cut in public spending on health, resulting in continuing foreseeable drops in the State universal health coverage: more deductibles, higher co-payments, de-reimbursement</td>
</tr>
<tr>
<td>➢ Regular Increased transfers to private insurers and to households</td>
</tr>
<tr>
<td>♦ Annual and unforeseeable tax increases on health insurers to reduce France budget deficit</td>
</tr>
<tr>
<td>➢ Tax pressure on health insurers multiplied by 5 in 4 years</td>
</tr>
<tr>
<td>♦ French Tax reform imposed by the European Union</td>
</tr>
<tr>
<td>➢ Same taxation for Joint stock health insurance companies and non profit Health insurers (mutual insurers and provident institutions) from 2012 / 2013 on</td>
</tr>
<tr>
<td>♦ New European prudential framework</td>
</tr>
<tr>
<td>➢ From Solvency I to Solvency II (1/1/2014)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2012-2017 macroeconomics and political issues arising out of economic downswings and upswings</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Financial and economic crisis in Europe, GDP growth in France expected to be &lt; 0.6 in 2012, with a risk of recession</td>
</tr>
<tr>
<td>➢ Massive and sudden transfers from the State universal health coverage to private insurers and to households</td>
</tr>
<tr>
<td>➢ Massive insurance premium increase ⇒ social exclusion as a result of a reduced access to needed health services and care (based on affordability)</td>
</tr>
<tr>
<td>♦ Presidential elections in April 2012</td>
</tr>
<tr>
<td>➢ Necessary reforms of the Health system and its financing postponed, with expected drastic measures by the end of 2012</td>
</tr>
<tr>
<td>♦ New questioning of the financial and actuarial regulatory environment as a result of the economic crisis</td>
</tr>
</tbody>
</table>
|   ➢ Continuous modifications in the implementation rules and assets valuation principles of Solvency II (higher calibration parameters, sovereign debt ratings…)}
Mostly unstable regulatory STRUCTURAL environment

- Regular Increased transfers to private insurers and to households
- Taxe pressure on health insurers multiplied by 5 in 4 years
- French Tax reform
- From Solvency I to Solvency II (1/1/2014)

2012-2017 macroeconomics and political issues arising out of economic downswings and upswings

- Massive and sudden transfers from the State universal health coverage to private insurers and to households
- Massive insurance premium increase
- Necessary reforms of the Health system and its financing postponed, with expected drastic measures by the end of 2012
- modifications in the implementation rules and assets valuation principles of Solvency II

High growth opportunities on the private health insurance market

- Increased competition with a risk of hypersegmentation harming risk pooling.
  - Thus resulting in premium increase,
  - with a subsequent risk of reduced access to health insurance and healthcare services
  - and increased impoverishment of the most vulnerable populations, undermining social cohesiveness

More mergers to meet new Solvency II capital and governance requirements and aiming at cost containment:

- large scale savings
- and increased negotiating power with medical professionals within healthcare provider networks

Possibly, deep alteration of the 3 level health insurance scheme
5 scenarios of transfers from the State universal health coverage to private insurers

**TODAY**
- Households Out-of-pocket
  - Voluntary Private health insurance
- State universal social health coverage (National Social security)

**Scenario 1**
- Households OOP
  - Voluntary Private health insurance
- State universal social health coverage

**Scenario 2**
- Households OOP
  - Supplementary
  - MANDATORY
  - COMPLEMENTARY Private health insurance
- State universal social health coverage

**Scenario 3 = double scheme**
- Households OOP
  - Voluntary Private health insurance
- State universal social health coverage

**Scenario 4 = double scheme**
- Households Out-of-pocket
  - Voluntary Private health insurance
  - Majority of the population
  - State universal social health coverage
  - Poorest households
  - State universal social health coverage

**Scenario 5 « Health shield »**
- Households out-of-pocket
  - Voluntary Private health insurance
  - State universal social health coverage
  - State + Private Insurers

OOP = « Out-of-pocket

Jean-Louis Davet – MEXICO City November 2011
5 scenarios of transfers

**TODAY**

- **Households Out-of-pocket**
  - Voluntary Private health insurance
  - State universal social health coverage (National Social security)

**Scenario 1**

- **Households out-of-pocket**
  - Voluntary Private health insurance
  - State universal social health coverage

**Scenario 2**

- **Households OOP**
  - Supplementary
  - MANDATORY COMPLEMENTARY
    - Private health insurance
  - State universal social health coverage

---

**Which care services are to be def-reimbursed or less reimbursed?**

- to reduce public spending and State universal Health coverage deficit
- to allow diffusion of new treatments and therapies
- to optimize the ROI : ratio healthcare spending out of quality of care services
- Partial transfer of LTI coverage and spending to private insurers?

---

**Which healthcare services to be included in the Mandatory complementary health insurance?** … What could the «basic coverage basket»?

**Which financing of the Mandatory complementary health insurance?**

- Public subsidy for lower income households?
- Households’financing?
5 scenarios of transfers

Scenario 3 = double scheme according to the type of healthcare services concerned

De-reimbursement of some Health care services

- Households OOP
  - Voluntary Private health insurance
  - State universal social health coverage
- Households OOP
  - Voluntary Private health insurance

Total de-reimbursement of some health care services?
- Optical ?
- Dental ?

Scenario 4 = double scheme according to the population concerned

Poorest households

Households Out-of-pocket
- Voluntary Private health insurance
- State universal social health coverage (National Social security)

Increase in public coverage but only for the poorest households

Majority of the population

Households out-of-pocket
- Voluntary Private health insurance
- State universal social health coverage
5 scenarios of transfers

Scenario 5 « Health shield »

Once the OOP threshold is reached, additional health care expenditures would be totally reimbursed by the State universal health coverage at 100% of « the official tariff », regardless of the diseases or care service.

2 alternatives thresholds have been studied: Income-related threshold or uniform threshold (maximum amount amount for everybody)
= an alternative to the Long Term Illness Scheme, no longer limited to a list of diseases,
= sort of financial cover but independent of the type of illness, whilst based only on a spending criterion

+ • no risk of social exclusion thanks to the shield

- • LTI costs will remain the major healthcare public spending booster (more than 80% contribution to the growth of Healthcare expenditure)
  ⇒ no « miracle impact » on the deficit of the State universal health coverage
• Young and healthy patients might forego to subscribe a voluntary private insurance, knowing to be covered for high risk
  ⇒ drastic decrease in risk pooling and reduced access to preventive and outpatient care
• Change in insurers’ pricing principles (particularly in case of income-related threshold)
• Major changes and developments required in information systems: to administer the benefits and to collect premiums
Whatever the scenario, whatever the assumptions … 2 absolute certainties:

- Increased transfers from the State universal health coverage to private insurers
- Change in regulatory environment: from solvency I to Solvency II
Increased transfers from the state health coverage to private insurers and simultaneous switch from Solvency I to Solvency II:

\[ \text{an explosive cocktail!} \]

---

**French private health insurance under Solvency I**

- Global solvency capital requirement approximatively proportional to the amount of premiums
  
  (approximatively 20% of the premiums)

---

**French private health insurance under Solvency II**

- Solvency capital requirement due to underwriting risks (fluctuations in the timing, frequency and severity of insured events; volatility of expense payments…) calculated as:

  \[ \text{SCR}_{\text{health}} = \rho(\sigma) \times m(V) \]

  \[ \sigma : \text{a measure of the volatility (standard deviation) of the loss ratio} \]

  \[ \nu : \text{a measure of the amount of premiums and reserves} \]

  \[ \rho \text{ and } m : \text{increasing functions} \]

---

**Increased transfers**  
**Much higher volatility of the loss ratio and larger volumes of premiums**  
**Sudden needs of extra capital**
Increased transfers from the state health coverage to private insurers and simultaneous switch from Solvency I to Solvency II

The ultimate scenario: Impact of LTI transfer

- Capital requirement doubled (volatility effect not taken into account)
- Long term risk management required because of transferring LTI costs to private insurers
- Drastic increase in technical provisions pursued on a similar technical basis to that of Life insurance

Private health insurance market 2010: 31.4 billion €

Long term Illness care spending 2010: 100 billion €

Transfer of 30% of these patients’ medical care and goods expenditures (30 bn €)

Private health insurance market doubled
Among other issues at stake
on the private health insurance market ...
Appendix
No single factor responsible for rising healthcare costs

⇒ numerous cost drivers.

Sources: Institut Montparnasse 2011
Increased demand of healthcare

Demographic pressure:
- Baby Boomers are currently in the age group consuming more healthcare services. They are turning to physicians, hospitals, and other health service providers with increasing regularity.

People’s search for health improving status and quality of life:
- The rise in healthcare expenditure reflects people’s desire to improve their health status and quality of life. Despite the economic crisis, the global increasing purchasing power and improved living standards stimulated the demand for health services and explains why people are willing to spend more of their budget on health.

High rate of private complementary health insurance:
- In France, 94% of the population is covered by a private health insurance. Since individuals covered by health insurance are inclined to more consumption and to ask for the most comprehensive and state-of-the-art treatment.
  - Wide access to medical information and advertising on pharmaceuticals boost the demand.
  - Patients ask their physicians to access drugs that they see heavily marketed and new treatments they’ve heard or read about.
Increased demand of healthcare: demand boosters

- **A 3 level health insurance system:**
  - With a « generous » State universal health coverage *(National Social security)*
  - And a high rate of coverage by private complementary insurers *(94% of the population)*

**Demand boosted by a pre-payment mechanism**

- Prepayment mechanism favours the access to care even for the poorest households but tends to boost the care consumption while suppressing patients' cost consciousness.
- The prepayment mechanism is extremely developed for hospital care, prescription drugs and some other outpatient care services

### Out-of-pocket expenditures

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Private health insurance (complementary)</th>
<th>State universal social health coverage (National Social security)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MGEN (average share of health care reimbursements with prepayment)</td>
<td>79,5%</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP General Practitioner</td>
<td>14,0%</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>11,2%</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>100,1%</td>
<td></td>
</tr>
<tr>
<td>Medical lab tests</td>
<td>97,0%</td>
<td></td>
</tr>
<tr>
<td>&quot;Physiotherapists, nurses, others …</td>
<td>85,6%</td>
<td></td>
</tr>
<tr>
<td>Protheses</td>
<td>94,9%</td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td>27,9%</td>
<td></td>
</tr>
<tr>
<td>Opical care and equipment</td>
<td>49,2%</td>
<td></td>
</tr>
<tr>
<td>Hospital care</td>
<td>99,9%</td>
<td></td>
</tr>
</tbody>
</table>
(*) Studies (French studies of the Montparnasse Institute 2011 and Paris Dauphine University, Brigitte DORMONT) conclude that population aging is in fact a modest cost driver compared to medical advances (new medical technologies)

- If older people have more health problems and use more health care, changes in clinical practices with the development and broadly diffusion of new technologies and drugs (compared to the treatment of the same disease at the very same age some years ago) contribute more to the increase of costs than aging.

- Over the periods from 1992 to 2000 (first study) then from 2000 to 2008 (second study)
  - aging contribute to +3% to the growth of healthcare costs, while changes in clinical practices account for +58%.
  - Increase in prescription drugs spending reached to 57.6%, with only 4.8% due to the aging of the population and 36% to the changes in medical practices.

Health care expenditures driven by diffusion of hi-tech and therapeutic innovation
Physicians and medical professionals are mainly self-employed

Physicians’ and other medical professionals’ freedom to choose the place where they want to practice

- This freedom results in great disparities in the geographical distribution of medical professionals

Physicians’ total freedom of diagnosis, therapy and prescription, whilst prescription drugs and healthcare services are partly or totally reimbursed by the State universal health coverage and the private complementary health insurers.

Information asymmetry prices and quality of healthcare services makes difficult to regulate the price of healthcare services

Activity-based pricing boosts physicians’ prescription

Distribution of physicians in France

Source: DREES 2011

Density: number of physicians per 100,000 inhabitants