Out-of-pocket maximum rules under a compulsory health care insurance: a choice between equality and equity?

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Summary: setup

- Goal of the paper:
  - Analyze policy that replaces the ALD regime by an OOP maximim threshold regime using a microsimulation model
- Underlying hypotheses:
  - Neutrality of the insurance system: OOP(before)=OOP(after)
  - Abolition of ALD and introduction of a maximum threshold
  - CMU and CMU threshold remains
- 3 scenarios in the microsimulation model
  - Uniform threshold
  - Income-related threshold
  - Income-related with increasing marginal effect
  - Subscenario with distinction between ALD and non-ALD

Summary: findings

- Initial observations:
  - More people gain (and less loose) when moving from Uniform Threshold to Income-related thresholds with increasing marginal effect
- Gainers and losers:
  - ALD: losers
  - High incomes least under Uniform Threshold
  - Effects for age, sex and supplemental insurance
  - Very useful for policy makers
- Equity and redistribution
  - Difference in Kakwani indices (progressivity differences)
    - Uniform threshold makes system more regressive, while income-related thresholds reduce the regressivity.
    - Graphs are interesting: e.g. system becomes progressive for the poorest 20% using the latter two simulations!
  - AJL decomposition: confirms these findings
  - SOSD: Uniform Threshold to be preferred by risk-averse agents

Main comments (I)

– Interesting paper, very useful for policy makers!!

1. Authors stress weakness that behavior cannot be analysed with their microsimulation model

  ¡ Nevertheless, for efficiency reasons one might consider the following scenario in the microsimulation (e.g. Keeler et al, 77, Econometrica, effective price):

    ÷ Everyone receives X euros of halth care for free

    ÷ After having paid X euros, one pay OOPs

    ÷ Everyone receives health care for free as soon as the maximum threshold+X is reached

  à Think e.g. of chronically ill (are they rational or myopic?). What are the distributional consequences of such policies aimed at efficiency, i.e. accounting for rationality? Possible even with model without behavior

Main comments (II)

2. How would the effects look like if supplementary cover was introduced in the microsimulation?

   - About 93% has supplemental cover
   - If ex-ALD's get supplemental cover →no more losers?
   - How would figures 1, 3 change? And what is the policy value of these figures without info on supplemental insurance?

3. Why not more focus on catastrophic expenditure?

   - Implicit aim of the underlying policy proposal?
   - There is some info in figures 1-3, but no figures on reductions of population share with catastrophic expenditures

Main comments (III)

4. ## What is the usefulness of the AJL decomposition?

   Are horizontal inequities truely inequitable? Aren't the distributional consequences very different depending on the reasons why individuals with the same gross income have differences in their OOP?

   - Think of *different* OOP due to differences in health vs. differences in preferences?
   - Think of *lack* of OOP due to no health care need vs. postponement of health care consumption.
   - Wouldn't it be safer for an approach that links consumption of health care with payments for health care? Rather than removing this link?

   Why considering H and R separately?

   - R is just a consequence of horizontal inequities. I do not understand the added value of using this in the health context? Why is this relevant for policy makers?

Minor comments (I)

- Income-related maximum thresholds are very similar to system of "maximum à facturer" introduced in Belgium in 2002
  - Evaluation of Belgian system (which is very similar to the French system) has been done by Centre fédéral d'expertise des soins de santé (www.kce.fgov.be) using a microsimulation model
  - US literature on maximum billing might also be relevant
- What incomes considered? Gross? Net? Smth else?
  - Will matter greatly for the Kakwani indices and the redistributive effects!
- What is the reason for considering the ADL vs non-ADL distinction? Political feasibility?
  - Unhealthy are treated similarly to healthy individuals in the maximum threshold scenario

Minor comments (I)

- Charges exceeding the statutory fees have been neglected.
  - Information value of simulations therefore crucially depends on discretion and actual practice of health care suppliers to charge excessive fees. If there is some discretion, evidence from Belgium (which has a very similar health care system) shows that prescribers increase charges when maximum threshold is introduced.
- Why are those qualifying for CMU and those not consuming health care excluded from the analysis?
  - Might artificially change the redistributive effect.
- Why is I1 not zero by assumption?
- Difficult to see difference between graphs with and without ALD

Minor comments (II)

– Kakwani index is the difference between the concentration index of OOP (ranked by gross income) and the *Gini* of gross income

– RE is a difference between *Gini*'s of incomes before and after health payments