

Cost Sharing for Health Care: France, Germany, and Switzerland

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Introduction

Patients with health insurance are seeing their costs at the point of service escalate as insurers increase deductibles, copayments, and other cost-sharing features. Assuring that patients with health insurance are not burdened with excessive out-of-pocket costs is a key challenge for those interested in health care reform. This issue brief looks at how the health care systems in France, Germany, and Switzerland limit the cost-sharing requirements imposed on citizens using care. Cost sharing at the point of service is required in each of these countries, but a number of different policies limit its impact on people and families with significant health care needs. The policies in these countries may provide lessons for U.S. policymakers considering options for reform.

Overview

Countries typically have three long-term objectives for their health care systems:

- Assure general access to health care services without regard to income,
- Provide high quality and high value health care, and
- Maintain long-term financial stability of the health care system.

The challenge is to achieve all of these objectives at the same time.¹ Issues of affordability and equity are key concerns as a country determines a health care system for its population. Most health care systems require participants to contribute some amount toward the cost of covered services or goods that they use. However, deciding what those amounts, known as “cost sharing,” should be, and whether and on what basis exemptions and limits to cost sharing should apply, is a difficult and often political process.

Cost sharing, the unreimbursed amounts that health plan participants are required to pay when they use health care services, has become an increasing feature of health plans. In the United States, rising costs have led employers to increase the cost-sharing provisions of their health plans, and consumer-driven health plans, while a small share of the health insurance market, also include greater consumer cost sharing. Although cost sharing is designed to reduce utilization of unnecessary health care services and increase the cost-consciousness of consumers, it may discourage people from using necessary health care and can be inequitable for the very sick and the low income.

To address issues of equity for the chronically and acutely ill, for the low income, and for certain populations and health services that the sponsors of health plans may wish to encourage, health plans around the world include mechanisms to exempt or limit cost sharing based on such factors as a person’s income, medical condition, or age. In some countries (e.g., France, Germany), individuals may purchase (or the government may purchase for them) supplemental insurance² that pays the cost sharing for certain services, while in other countries (e.g., Switzerland) supplemental insurance is prohibited from covering the cost sharing of the national compulsory program.

This issue brief describes cost sharing and its limits or exemptions used in France, Germany, and Switzerland, with some background on cost sharing in the United States.

These examples of cost-sharing limits may be useful as policymakers and others in the United States consider health reform proposals and as cost-sharing increases in both public and private health plans prompt an exploration of how to make such increases more equitable for the low income and those with chronic or high-cost illnesses. Each country description in this issue brief includes an overview of the country's health care system, an overview of the system's cost sharing, information about the system's cost-sharing exemptions and limits, and more detailed information about the cost sharing by type of service. Data from the Organisation for Economic Co-operation and Development (OECD) about insurance coverage and out-of-pocket payments is included.

The Role of Cost Sharing in Health Systems

Cost sharing is the financial contribution that patients are required to make when they use health care services, amounts that are not reimbursed by their health plan. The *direct forms of cost sharing* include:

- copayments (a flat amount that the consumer must pay per service or item),
- coinsurance (a percentage of the charge that the consumer must pay), and
- deductibles (an amount the consumer must pay out-of-pocket before coverage begins, usually applied for a specific time period, such as yearly).

In addition, individuals may incur other out-of-pocket health care costs related to their health care. Sometimes called *indirect cost sharing*, these indirect out-of-pocket costs are typically not included in the definition of "cost sharing." Some examples are:

- excess charges when patients go to health care providers not included in their health plan (known in the U.S. as "balance billing"),
- charges in excess of some amount (e.g., the cost of prescription drugs in excess of a reference price),
- excess charges when patients go directly to a specialist when the health plan requires a primary care visit first,
- health care services not covered by the health plan, and
- health plan premiums.

The arguments given for requiring cost sharing (deductibles, copayments, and coinsurance) are to discourage the use of unnecessary health care services, to provide a source of financing, and, for statutory health care systems, to make coverage or service expansions more politically palatable. The arguments against cost sharing are that it discourages people from using health care (which may worsen their conditions and lead to more expensive care later), and it is inequitable for the low income, the unemployed, and those with considerable health care costs. Unlike health plan

premiums, cost-sharing features are often difficult for plan participants to understand and to predict the costs they will be required to pay under their health plan if they use health care services, leaving them with unexpected out-of-pocket medical expenses. The balancing act for a health care system that includes cost sharing is how to do so without preventing access to health services and leaving people with medical debt.

The Role of Cost-Sharing Exemptions and Limits

Some health systems with cost sharing include protection mechanisms that exempt or limit patient cost sharing based on factors such as a person's income, medical condition, or age. These protections may apply to specific health care services, or to the aggregate use of health care. The larger the cost-sharing amounts required of patients, the more important any cost-sharing exemptions and limits become.

The various mechanisms used to protect individual or household finances against cost sharing include such *explicit protection mechanisms* as:

- complete exemption from cost sharing or reduced cost-sharing limits for certain persons (e.g., children, pregnant women, the low income, the disabled, war veterans, those in nursing homes, the unemployed, families with many dependents) or for those with certain medical conditions (e.g., pregnancy, chronic illness, rare diseases),
- out-of-pocket maximums, which are typically annual limits on the total cost-sharing amounts individuals or families are required to pay; these limits can apply to a specific service or an aggregate of services, and can be means-tested or apply to the whole population,
- cost-sharing discounts for choosing the services of certain providers (e.g., when individuals contract with "gate-keeping" primary care physicians) or for choosing generics rather than more expensive brand-name drugs, and
- tax relief for cost-sharing expenditures or health insurance premiums (e.g., tax deductions for amounts over a deductible or for certain individuals such as the low income or the disabled).

Some health systems have *implicit protection mechanisms* that can reduce cost sharing and other patient out-of-pocket costs. An important implicit protection mechanism is the availability of private health insurance. Private health insurance can function as an alternative to a national statutory health insurance program, as in Germany where individuals above a certain income level are allowed to choose between the public or private coverage. Private health insurance can also be supplementary to a statutory health program, either by paying for cost sharing (available in France and Germany but prohibited in Switzerland), or by paying for other out-of-pocket costs not covered or not covered in full by the statutory national plan, such as upgraded hospital accommodations, dental care, cosmetic surgery (available in France, Germany, Switzerland).³ In addition, a means-tested public program in France provides coverage of cost sharing and other out-of-pocket costs. Other examples of implicit protection

mechanisms include premium subsidies and the substitution of generic drugs for brand name drugs by doctors and/or pharmacists.⁴

Cost Sharing and Cost-Sharing Exemptions and Limits in the United States

In the United States, private coverage (including both employer-sponsored coverage and coverage purchased directly by individuals, which together cover about 70% of the total population) typically requires patient cost sharing (deductibles, copayments, and coinsurance) and provides cost-sharing exemptions or limits in the form of annual out-of-pocket spending maximums which do not vary according to income.

Medicare (a public program for the aged and disabled) requires patient cost sharing; its protection mechanisms include income-related exemptions and limits for premiums and cost sharing and, under the Part D Prescription Drug Program, a reduced enrollee coinsurance amount once out-of-pocket spending reaches a certain level. Medicare beneficiaries can purchase private supplemental insurance to pay for Medicare's cost sharing, with some policies paying for benefits that Medicare does not cover.

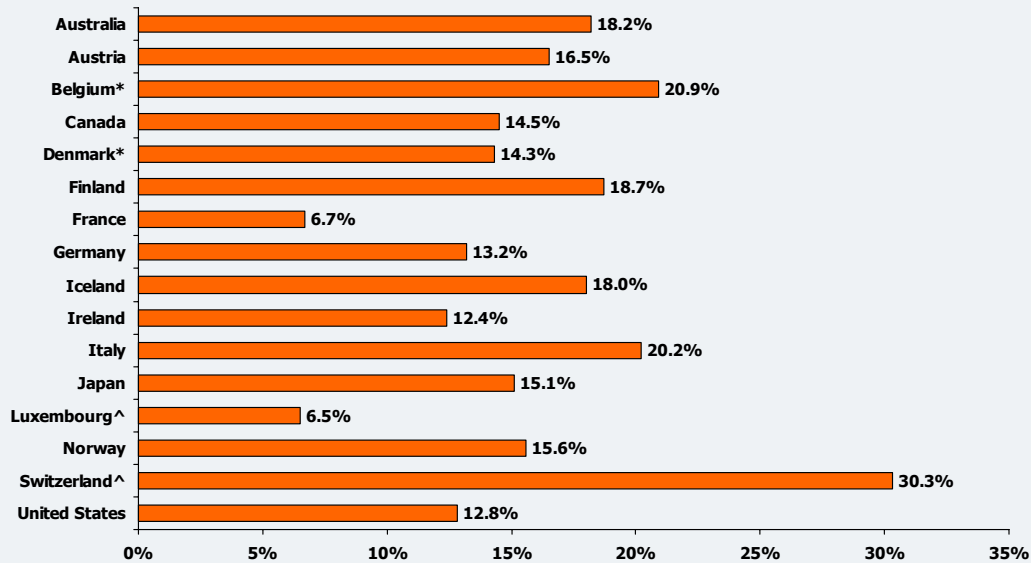
Medicaid and the State Children's Health Insurance Program (SCHIP) (which are public programs for the low income) allow states to impose cost sharing in certain circumstances, with certain exemptions and limits. For children, Federal Medicaid rules prohibit cost sharing depending on the child's age, family income, and type of service. For adults, Medicaid cost sharing depends on income and type of service (e.g., pregnancy-related services are exempt from cost sharing). Under both Medicaid and SCHIP, the total amount of cost sharing and premiums cannot exceed 5% of family income, or lower for the low income.⁵

In Massachusetts, which mandates that its residents have creditable health coverage, those whose income is \$63,612 or less for a family of 4 in 2008 (300% or less of the Federal Poverty Level) can purchase coverage from the state's Commonwealth Care program with premiums and cost sharing that vary by income.⁶

Multi-Country Cost-Sharing Studies

Most of the data in this issue brief is from the Organisation for Economic Co-operation and Development (OECD), which collects and studies data on 30 countries. The OECD household out-of-pocket payments data is a category that includes more than just cost sharing. This category includes expenditures for cost sharing (copayments, coinsurance, and deductibles), self medication (medications and medical services not covered by the health plan), and other expenditures paid directly by private households. The OECD has recently begun to collect data on cost sharing alone (just copayments, coinsurance, and deductibles), but so far has released data for only a handful of countries; OECD anticipates having cost-sharing data for more countries over the next couple of years. Household out-of-pocket payments as a percent of total country expenditures on health in 2006 varied widely; for example, Luxembourg was 6.5% and Switzerland was 30.3%; France was 6.7%, Germany was 13.2%, and the U.S. was 12.8%).⁷ Note that these are not the percent of income that individuals or households pay, but the aggregate percent of country-wide expenditures paid by out-of-pocket household spending.

Household Out-of-Pocket Payments as a Percentage of Total Expenditures on Health, U.S. and Selected Countries, 2006



* Differences in methodology; see "Comparability over time" at <http://www.ecosante.org/OCDFENG/411.html> and "Notes on Data Comparability" at <http://www.ecosante.org/OCDFENG/503.html> (Belgium) and <http://www.ecosante.org/OCDFENG/506.html> (Denmark).

^OECD estimate.

Notes: Includes countries with per capita total health care expenditures in excess of \$2,500 in U.S. \$ Purchasing Power Parity. Includes total country household out-of-pocket payments and total country health expenditures; OECD household out-of-pocket payments includes cost sharing (copayments, coinsurance, and deductibles), self medication, and other expenditures paid directly by private households.

Source: Organisation for Economic Co-operation and Development. OECD Health Data 2008, from the SourceOECD Internet subscription database updated October 2008. Copyright OECD 2008, <http://www.oecd.org/health/healthdata>. Data accessed on 12/12/2008.

A 2003 study by the European Commission Directorate General for Employment and Social Affairs found that in all of the 15 European Union countries studied, cost sharing applied to prescription drugs and dental care. About half of the countries (typically those with systems of social health insurance, such as Austria, Belgium, France, Germany) applied cost sharing to physician and inpatient care, while the half with tax-funded health care systems (such as Denmark, Greece, Italy, Portugal, Spain, and the UK) typically did not.

- For physician care, cost sharing tended to be copayments or coinsurance, plus any balance billing by physicians not contracted with the health plan; protection mechanisms included exemptions, reduced rates, or out-of-pocket maximums,
- For inpatient care, cost sharing tended to be in the form of a copayment per day, sometimes also with coinsurance; protection mechanisms included annual out-of-pocket maximums,
- For prescriptions, coinsurance was the most common form of cost sharing, with other countries using copayments, deductibles, and reference pricing (a form of indirect cost sharing); protection mechanisms include exemptions or reduced rates depending on clinical condition, income, or age, and per prescription or annual out-of-pocket maximums,
- For dental care, cost sharing tended to be copayments or coinsurance; protection mechanisms included exemptions for children.⁸

A 2007 study by the World Bank found that of the 25 high-income countries studied (those with per capita GDP of more than US\$16,000 in purchasing power parity), all required some form of cost sharing which, except for the U.S., Greece, and Austria, was less than 22% of total country health expenditures and often less than 10%. For both tax-financed systems and social health insurance systems, the study found no clear trend over time in increases or decreases in cost sharing. The countries used a variety of cost-sharing mechanisms, and several exempt significant population groups from cost sharing on the basis of income, clinical condition, age, or drug type. The study indicated that “political opportunism seems to guide decisions on the extent and type of cost-sharing mechanism more often than rational arguments regarding technical efficiency.”⁹

Background on the Health Care Systems of France, Germany, and Switzerland

The three countries whose cost sharing and protection mechanisms are described in this issue brief, France, Germany, and Switzerland, have statutory national health insurance systems financed mainly through social security contributions by employers and employees (France and Germany) or premiums paid by individuals (Switzerland). This is in contrast to predominantly tax-financed health systems in countries such as Canada, the United Kingdom, and the Scandinavian countries. All three countries have compulsory coverage of all country residents, although in Germany some high-income, employed people can choose between the statutory program and private health insurance.

All three countries require cost sharing, with Switzerland’s proportion of total national expenditures from cost sharing higher than most other OECD countries (e.g., 2006 household out-of-pocket payments as a percent of total health care expenditures were 30.3% in Switzerland, compared to 6.7% in France, 13.2% in Germany, and 12.8% in the U.S.). Out-of-pocket spending as a percentage of total household consumption in 2006 was 1.3% in France, 2.4% in Germany, and 6.0% in Switzerland (the U.S. was 2.8%). Household out-of-pocket payments per capita in 2006 were \$232 in France, \$445 in Germany, and \$1,305 in Switzerland (\$857 in the U.S.).¹⁰ A recent survey by the Commonwealth Fund found that for adults with any chronic conditions, the share of those with out-of-pocket costs under US \$500 were 48% in France, 57% in Germany, and 31% in the U.S.; the share of those with out-of-pocket costs over US \$1,000 were 5% in France, 13% in Germany, and 41% in the U.S.¹¹ Although not considered a form of cost sharing, Swiss health care premiums are discussed in this issue brief because the deductibles required by Swiss health plans depend on the chosen premium amount.

All three countries use various protection mechanisms to limit cost sharing for the low income, certain population groups, and those with certain medical problems. In addition, private supplemental insurance may pay the cost sharing for patients in France and Germany, but not in Switzerland where private plans are prohibited from covering the cost sharing of the public program.

As of December 15, 2008, the euro (used in France and Germany) was worth \$1.37 in U.S. currency. The Swiss franc (CHF) was worth \$0.86 in U.S. currency and 0.63 in euros.¹²

France

Health System Overview

France has a statutory national health insurance system with compulsory coverage of French residents through health insurance funds whose participants are determined primarily according to their occupation. Coverage is provided to all with uninterrupted residence in France for at least 3 months and their dependents (spouses, dependent children, civil partners, etc.). Retirees and unemployed are covered by the funds corresponding to their occupations; the uninsured are covered by the largest of the health insurance funds.¹³ The percent of the total French population with public coverage in 2006 was 99.9% (61 million).¹⁴

In addition, 88.4% (54 million) of the population had voluntary private health insurance in 2006 which is supplementary, rather than an alternative, to the public insurance program and is typically obtained through employers.¹⁵ Most of the private health insurance contracts cover coinsurance and many also cover the hospital copayment. Private contracts may also cover dental services, upgraded hospital accommodations, physician charges in excess of the official payment amount, contact lenses. A means-tested public supplementary insurance program is provided to the low income.¹⁶

Features of the French health system include patient cost sharing, direct payment by patients to physicians with subsequent reimbursement (minus any cost sharing) from the health insurance funds, and balance billing by about one-third of physicians (typically specialists located in major cities).¹⁷

The French system is financed by employer/employee payroll taxes, dedicated income taxes, taxes on alcohol and tobacco, and individual out-of-pocket payments; it is free for low-income families. The proportion of total country health care expenditures paid out-of-pocket by households in 2006 was 6.7%; 79.7% was paid by public funds, 12.8% by private insurance, and 0.8% by other private funds.¹⁸

Overview of Cost Sharing

Prior to the Health Insurance Reform Act of Aug 13, 2004, most cost sharing was in the form of coinsurance fees. Since 2006, copayments have been levied for a variety of services including consultations with health professionals, days of hospital care, prescription drugs, expensive treatments, and ambulance trips. Overall, household out-of-pocket payments as a proportion of total national health care expenditures have declined over time, from 30.3% in 1960, 17.6% in 1970, 12.8% in 1980, 11.4% in 1990, 7.1% in 2000, and 6.7% in 2006.¹⁹

Patient cost sharing under the French statutory health program includes:²⁰

- 20% coinsurance for hospital services, plus a daily copayment of €16 (€12 in a psychiatric unit) with a 30-day limit on the cost sharing,

- 30% coinsurance for outpatient physician services, plus a copayment of €1 per consultation, limited to €50 per year,
- a copayment of €18 for serious medical interventions (with a minimum rate of €91),
- Typically 35% for prescription drugs, depending on the type of drug and whether it is on the national formulary, and
- 30% coinsurance for dental services; 35% coinsurance for transportation, eye care, hearing aids, orthopedics; 40% coinsurance for laboratory services
(More detail is provided under “Cost Sharing by Type of Service,” below.)

In addition, French patients incur other out-of-pocket medical costs for the following:

- Costs of goods and services not eligible for reimbursement by the insurance funds (such as a single room in a hospital),
- Extra billing for physicians allowed to charge more than the official amount,
- Differences between actual price charged and the official reimbursement level for such items as dental prostheses, medical devices, eyeglasses,
- Differences between the retail and the reference price for certain prescription drugs,
- Care to patients who do not choose to contract with a gate-keeping primary care doctor, for which the health insurance fund provides lower reimbursement rates,²¹
- Advance payments for ambulatory care -- patients must pay the provider and then receive total or partial reimbursement from their health insurance fund. Although the patient is reimbursed, having to pay the full amount initially can be a financial barrier to care.²²

Cost-Sharing Exemptions and Limits

Cost sharing in France is limited by exemptions and limits under the statutory national insurance program and by supplemental insurance. About 8.5% of the population is exempted from coinsurance: 6.8% for serious illness and 1.7% for other reasons.²³

The French system includes the following classes of exemptions and limits on cost sharing.²⁴

1. ***Health status exemptions from cost sharing.*** When person is suffering from one of 30 specified serious and chronic illnesses (e.g., diabetes, severe hypertension, AIDS, cancer, psychiatric illness), they are exempted from cost sharing for medical goods and services used in the treatment of that illness. Also if a person has a serious and disabling illness not on the list but that requires

medical treatment for longer than 6 months or is particularly expensive, that person is exempted from cost sharing:

- In order to qualify for copayment exemption, persons with a long-term illness must follow a care protocol designed by the practicing physician and the insurance fund's consulting physician and signed by the patient.
- Patients with debilitating or chronic illness are exempted from paying coinsurance if they consult physicians who accept the national reimbursement amount as payment in full. If they consult a physician who does not do so, a portion of their coinsurance is reimbursed by supplementary health insurance.

2. **Cost-sharing exemptions for certain persons:**

- Certain disabled persons and, in some cases, their family members
- Children for certain services, handicapped children, and child victims of sexual abuse
- War veterans
- Persons in nursing homes or residential homes for the handicapped
- Pregnant women
- Newborns in their first 30 days
- Persons treated for sterility.

3. **Cost-sharing exemptions for certain treatments.** For example, certain hospital treatments (e.g., expensive surgical procedures) and infertility treatments.

4. **Other cost-sharing exemptions.** Some specific goods and services are exempted from coinsurance for public health reasons, such as exams during pregnancy, flu vaccines for people over 65, MMR vaccines for those under age 13, some cancer screening, dental exams, and normal dental procedures for children age 13-18.

5. **Exemptions from cost sharing for the low income.** Exemptions from cost sharing based on income do not exist. However, since 2000, the Couverture Maladie Universelle (CMU), which provides basic coverage to all those residing lawfully in France who are not covered by the employment-based health funds, also provides supplementary coverage for people with low incomes, as described below. These programs have the same effect as an exemption on economic grounds.²⁵

- **CMU Complémentaire:** The CMU Complémentaire is a national means-tested public supplementary insurance program begun in 2000. About 10% of the population was eligible in 2003; about 7% of the total population benefited from the program. Maximum annual income thresholds starting 7/1/08 were €7,447 for a single person and €15,638 for a family of 4 people. The program covers the patient, spouse, civil partner, and dependent children under age 25. It is renewable each year.

The CMU Complémentaire covers the coinsurance for all medical goods and services, including hospital services. Optical and dental care patient payments are capped. It also protects beneficiaries from extra-billing

(balance billing above the official tariff) and exempts beneficiaries from the requirement to pay providers directly.

- *L'Aide Pour Une Complémentaire Santé*: Since January 2005, those whose incomes slightly exceed the cut-off for the CMU Complémentaire may receive financial assistance to pay for supplemental health insurance. It is available to those not eligible for the CMU if their family income does not exceed 20% of the CMU limit; maximum annual income thresholds starting 7/1/08 were €8,936 for a single person and €18,766 for a family of 4 people. The amount of assistance varies according to the number and age of family members. This assistance is renewable each year.

While not a statutory cost-sharing exemption or limit under the national health insurance system, supplemental health insurance achieves the same result by paying for cost sharing and other patient out-of-pocket expenses. A majority of the French population (88.4% in 2006) has varying amounts of supplemental health insurance, mostly paid for employers or by the state for those receiving public assistance.²⁶ Supplemental insurance covers cost sharing that is not eligible for reimbursement by the public system, copayments for ambulatory doctor visits, the per diem charge for hospital care, extra billing by certain authorized ambulatory doctors, the differences between actual prices charged and official reimbursement tariffs (especially high for dental prostheses and eyeglasses), goods and services not on the insurance funds' reimbursement lists, and the cost of facilities such as a single room in a hospital.²⁷ The state provides supplemental coverage free to the low income. The French government has requested supplementary insurers not to pay for the financial penalties incurred by individuals who do not contract with "gate-keeping" primary care physicians.

Cost Sharing by Type of Service²⁸

- **Inpatient Hospital Services**

Cost Sharing: 20% coinsurance of total bill and daily copayment of €16 (€12 in a psychiatric unit). Extra billing for single room or physician services in private hospitals, unless medically justified.

Cost-Sharing Exemptions and Limits: 85% of inpatient stays are exempted from coinsurance. Cost sharing does not apply if:

- The general rules of exemptions apply (See Cost-Sharing Exemptions and Limits, above),
- No coinsurance if hospitalized more than 30 consecutive days,
- Surgery costs over a certain threshold,
- Pregnant women hospitalized during last 4 months of pregnancy for childbirth and for 12 days after childbirth,
- A newborn hospitalized within 30 days of birth.

- **Outpatient Physician (General Practitioner and Specialist)**

Cost Sharing: 30% coinsurance plus a flat-rate copayment of €1 per consultation. A flat-rate of €18 for surgery costing equal to or more than €91.

Cost-Sharing Exemptions and Limits: A limit of €50 per person per year. See Cost-Sharing Exemptions and Limits, above.

- **Prescription Drugs**

Cost Sharing: 35% for most prescription drugs; may be 65%, 85%, 100%, or 0% depending on the type of drug and whether it is on the national formulary. Patients must pay amounts over the reference price for drugs included in the reference-priced generic groups. Copayment of €0.50 for each container of prescription drugs, with a limit of €50 per year.

Cost-Sharing Exemptions and Limits: See Cost-Sharing Exemptions and Limits, above.

- **Paramedical Services (Nurses, Physiotherapists, etc.)**

Cost Sharing: Copayment of €0.50 for each treatment, no more than €2 a day, with a limit of €50 per year.

- **Dental**

Cost Sharing: 30%.

Cost-Sharing Exemptions and Limits: See Cost-Sharing Exemptions and Limits, above.

- **Laboratory Services**

Cost Sharing: 40% plus a flat-rate copayment of €1.

Cost-Sharing Exemptions and Limits: See Cost-Sharing Exemptions and Limits, above.

- **Eye Care, Hearing Aids, Orthopedics**

Cost Sharing: 35%. Glasses depend on the complexity of the lenses; hearing aids depend on age and handicap.

Cost-Sharing Exemptions and Limits: See Cost-Sharing Exemptions and Limits, above.

- **Transportation**

Cost Sharing: 35% except for emergency cases. €2 per trip with a maximum of 2 trips a day and an annual ceiling of €50.

Cost-Sharing Exemptions and Limits: See Cost-Sharing Exemptions and Limits, above.

Germany

Health System Overview

Germany has a statutory national health insurance system with compulsory coverage of all German residents through health insurance funds whose participants are determined primarily based on their occupation. Up to a certain income level, all employees are required to join one of about 250 statutory health insurance funds; persons earning a higher gross income amount are allowed to join a private plan.²⁹ Subject to certain conditions, the statutory system also covers pensioners, the unemployed, the disabled, trainees, farmers, artists and writers, and students; spouses and children are also covered, subject to certain rules. The percent of the total German population with public coverage was 89.5% in 2006.³⁰

Private health insurance, both primary and supplemental coverage types, covered 26.1% of the German population in 2006.³¹ Those with private insurance as their primary coverage (10.3% in 2006) included public employees, the self-employed, and employees above an income threshold (€48,150 per year in 2008) who chose to opt out of the public program. Private insurance that supplemented the public program covered 15.8% of the population in 2006, covering, for example, cost sharing, certain dental services, and certain hospital and outpatient services.³²

Some features of the German system include patient cost sharing, direct payment to providers by the health insurance funds, and free choice of providers.³³

The German system is financed by employer/employee payroll taxes (employees pay half, depending on their income), taxation, and individual out-of-pocket payments. The proportion of total health care expenditures paid out-of-pocket by households in 2006 was 13.2%; 76.9% was paid by public funds, 9.2% by private insurance, and 0.7% by other private funds.³⁴

Overview of Cost Sharing

Copayments and exemptions from copayments have typically been used in the German health care system, most traditionally for pharmaceuticals.³⁵ Over time, more services have been covered by cost sharing (including hospital care, rehabilitative treatment, and preventive spa treatment), and cost sharing has become more differentiated and sophisticated (e.g., copayments for pharmaceuticals have used reference pricing since 1989 and were price-related, then package-size-related; different levels of user charges for crowns and dentures are related to use of preventive annual checkups).³⁶ Overall, household out-of-pocket payments as a proportion of total national health care expenditures have remained fairly steady, from 13.9% in 1970, 10.3% in 1980, 11.1% in 1990, 11.2% in 2000, rising to 13.2% in 2006.³⁷

Patient cost sharing under the statutory health program includes:³⁸

- Copayment of €10 per day for hospital care and post-hospital rehabilitation treatment, limited to 28 days per year,

- Copayment of €10 per quarter for the first visit to a physician in the quarter and for each contact with other physicians seen without referral during the same quarter,
- Coinsurance of 10% of the pharmacy sales price for prescription drugs, with a minimum of €5 and a maximum of €10, not to exceed the cost of the product,
- Copayment of €10 per quarter for the first visit to the dentist's office,
- Copayment of €10 per day for outpatient rehabilitation services,
- Coinsurance of 10% for non-physician care, eye care, hearing aids, orthopedics and transportation, subject to certain limits and requirements.

(More detail is provided under "Cost Sharing by Type of Service," below.)

In addition, German patients are responsible for direct payments for goods and services not covered by any form of insurance, including most over-the-counter pharmaceuticals (e.g., those for "petty diseases" like the common cold and travel-related diseases), technologies and pharmaceuticals determined to have limited or unproven medical benefit, services related to sterilization, eyeglasses except for children under age 18 and the severely visually impaired, artificial insemination, and travel costs for taxis and hired cars for outpatient treatment.

Cost-Sharing Exemptions and Limits

The number of people fully exempt from copayments tripled between 1993 and 2000, from 10% to about 30% of the population; in 2001, 47% of prescriptions were exempted from copayments.³⁹

The German system includes the following classes of exemptions and limits on cost sharing:⁴⁰

1. **Exemptions for certain persons.** Children and adolescents are exempt up to age 18 (except for crowns and dentures, orthodontic treatment, and transportation); pregnant women are exempt.
2. **Cost-sharing limits for the low income.** The annual limit for patient cost sharing is 2% of annual assessed gross disposable income. Once the contribution limit is reached, the insured is exempted from cost sharing for the remainder of the year. The assessed income figure is arrived at by deducting an exempt amount for each family member from family gross income, and is dependent on family size and whether the family member is an adult or child (larger amounts are deducted for children).
 - The exempt amount for the first dependant living in the same household is 15% of an annual reference figure, or €4,410 in 2006; the exempt amount for each subsequent dependant is 10% of the same reference figure, or €2,940 in 2006; for each child the exempt amount is €3,648, except that the first child of a single parent is subject to the higher, first dependant's exempt amount of €4,410.

- Family gross income means family disposable income before deductions: the sum of all income that accrues to the insured and any live-in dependants and is available for meeting living expenses, including rental income and capital gains.
 - *Income tax.* Relief from income tax is granted for out-of-pocket health care spending over €600 per year and a certain percentage of annual household income.
3. ***Cost-sharing limits for social assistance recipients.*** For recipients of welfare benefits, war victims' benefits, or benefits under the Pension Supplement Act, the contribution limit is a percentage of the standard benefit rate for a head of household: 2% if they do not have a chronic illness (or €82.80 in 2006), and 1% if they have a chronic illness (or €41.40 in 2006). The household assessable gross disposable income used to establish the contribution limit is the standard benefit rate for the head of household only (€345/month, or €4,140/year).
- Cost-sharing limits for chronically ill patients.*** Patients in ongoing treatment for the same illness have an annual contribution limit of 1% of annual gross income. The exemption applies for all family members living in the same household. Chronic illness is defined as illness medically treated at least once a quarter for at least a year, and meeting at least one of three criteria:
- Patient requires Level II or III care,
 - Patient has at least a 60% disability or a 60% incapacity to work, or
 - Continuous medical care is required (medical or psychotherapeutic treatment, drug treatment, technical nursing, and provision with therapies and aids) without which a life-threatening worsening of the illness, a reduction in life expectancy, or a lasting impairment of quality of life would result.
4. ***Other cost-sharing adjustments.*** Copayments are reduced or a bonus is paid for insured persons who see their family doctor first. Women younger than 35 and men younger than 45 on April 1, 2007 can reduce their copayment ceiling to 1% by having regular recommended preventive and early detection check-ups (this provision starts 1/1/08).⁴¹

While not a statutory cost-sharing exemption or limit under the national health insurance system, private supplemental health insurance achieves the same result by paying for cost sharing and other patient out-of-pocket expenses, though it is not purchased in Germany to the extent as is done in France. Since 2003, more policies have started covering cost sharing, including copayments for medical aids, remedies, and hospital stays; coverage of copayments for pharmaceuticals are offered less frequently. In addition, some private health insurers offer supplementary insurance that covers amenities that the insurance funds do not cover, such as hospital rooms with two beds or treatment by the hospital head-of-service.⁴²

Cost Sharing by Type of Service⁴³

- **Inpatient Hospital and Inpatient Rehabilitation Services**

Cost Sharing: Daily copayment of €10, up to the maximum number of days.

Cost-Sharing Exemptions and Limits: Limit of 28 days daily copayment per calendar year, subject to the Cost-Sharing Exemptions and Limits, above.

- **Outpatient Physician (General Practitioner and Specialist)**

Cost Sharing: €10 per quarter for the first visit to the physician in the quarter, and for each contact with other physicians seen without referral during the same quarter.

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above. No cost sharing for children and adolescents or health care during pregnancy. Copayment reductions for early detection measures.

- **Prescription Drugs and Bandages**

Cost Sharing: 10% of the pharmacy sales price, with minimum of €5 and maximum of €10, not to exceed the cost of the product. Reference pricing was introduced in 1989, where the insurance funds reimburse pharmacies up to a certain amount for reference-priced drugs, and the patient pays the difference between the reference price and the market price, in addition to the cost sharing. Over-the-counter drugs, life-style drugs, and certain uneconomical drugs are not covered.

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above. Not charged for children and hardship cases.

- **Dental**

Cost Sharing: €10 per quarter for the first visit to the dentist's office. 50% cash subsidy for the cost of routine care, which rises to 60% if insured has undergone dental check-ups at least once a year during the past 5 years after age 18, and to 65% if check-ups during past 10 years. Orthodontic treatments: 20% coinsurance.

Cost-Sharing Exemptions and Limits: Coinsurance reductions for regular routine treatments. For orthodontic treatment, the 20% coinsurance is reduced to 10% for subsequent children in families with more than one child in need of orthodontic care.

- **Outpatient Rehabilitation Services:**

Cost Sharing: €10 per day

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above.

- **Non-Physician Care (midwives, physical therapists, home nursing)**

Cost Sharing: 10%; home nursing limited to 28 days per year.

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above.

- **Eye Care, Hearing Aids, Orthopedics**

Cost Sharing: 10% of cost, with minimum of €5 and maximum of €10, not to exceed the cost of the product. Vision aids are limited to children up to age 18 and to insured persons with severe vision impairments, except for therapeutic vision aids used for treatment of eye injuries or eye diseases.

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above.

- **Transportation**

Cost Sharing: Inpatient treatment or emergencies: 10% of travel expenses with a minimum of €5 and maximum of €10 per trip, not to exceed the actual cost; ambulatory treatment: 100%.

Cost-Sharing Exemptions and Limits: Subject to the Cost-Sharing Exemptions and Limits, above.

Switzerland

Health System Overview

Switzerland has a statutory national health insurance system with compulsory basic coverage of all Swiss residents through plans purchased by individuals from a choice of about 90 competing private health insurance funds. All residents and their dependents are required to have coverage, unless they have health insurance in a member country of the European Union.⁴⁴ In 2007 nearly all of the 7.6 million Swiss residents were covered by compulsory basic health insurance.⁴⁵

In addition, 32.5% of the population voluntarily purchased private supplemental insurance in 2005,⁴⁶ which paid for certain out-of-pocket costs not covered or not covered in full by the health insurance plans; Swiss supplemental insurance is prohibited from covering the cost sharing required by the compulsory system. Other types of insurance in the Swiss system include disability insurance, statutory mandatory accident insurance for employed persons, and military insurance.

The 26 autonomous Swiss cantons (i.e., states) that make up the Swiss Confederation are responsible for organizing health care in their geographic areas, including providing and regulating care, preventing disease, providing health education, and implementing health-related federal laws. As a result, the cantons have slightly different health systems. Health insurance premiums are community-rated within cantons, and insurers must accept all applicants. Other features of the Swiss health insurance system include patient cost sharing, free choice of provider within cantons, and choice of insurer within a canton during an annual open enrollment period.⁴⁷

The Swiss system is funded by premium payments and out-of-pocket payments by individuals, and by government funding. Means-tested premium subsidies are available for low-income individuals and large families.⁴⁸ The proportion of total health care expenditures paid out-of-pocket by households in 2006 was 30.3%; 60.3% was paid by public funds, 8.5% by private insurance, and 0.9% percent by other private funds.⁴⁹

Overview of Cost Sharing

In Switzerland, out-of-pocket household payments as a proportion of total health care expenditures have remained relatively stable over the past 20 years: they were 37.6% in 1985, 35.7% in 1990, 33.0% in 1995, 31.4% in 1996 (the year the most recent health reform law was implemented), 32.9% in 2000, and 30.3% in 2006.⁵⁰

Cost sharing in the Swiss health insurance system includes annual deductibles, coinsurance with a maximum annual limit, and inpatient hospital copayments.⁵¹

- The standard annual deductible under the compulsory basic plans is CHF 300 for adults; there is no deductible for children under age 18. Individuals can reduce their premium costs by electing plans with a higher deductible (deductibles of CHF 500, 1,000, 1,500, 2,000, and 2,500 for adults; CHF 100, 200, 300, 400,

500, 600 for children). Health plans may offer different deductibles for young adults (ages 18 to 25).

- Enrollees must pay coinsurance of 10% on all covered expenses once the deductible has been met, up to a maximum of CHF 700 per calendar year for adults and CHF 350 for children under age 18. Coinsurance is 20% for brand prescription drugs if an interchangeable generic exists.
- Individuals who do not live with family members or are in single-occupant households pay a fee of CHF 10 per day for inpatient hospital stays, which is not counted toward the annual coinsurance limit. This payment is not required for maternity hospital stays.

For the standard compulsory basic health plan, the maximum annual out-of-pocket cost for an adult would be CHF 1,000, or the sum of the standard annual deductible (CHF 300) and the maximum coinsurance (CHF 700). For a child under age 18, the annual maximum would be CHF 350 (no deductible and the maximum CHF 350 for coinsurance). Inpatient hospital copayments would be in addition to these amounts. (More detail is provided under “Cost Sharing by Type of Service,” below.)

In addition, Swiss patients incur out-of-pocket costs for health care not covered by the health plans.

Cost-Sharing Exemptions and Limits

The Swiss system includes the following cost-sharing exemptions and limits:⁵²

1. **Coinsurance limit.** The 10% coinsurance on all covered expenses once the deductible has been met (20% on brand prescription drugs if an interchangeable generic exists) is limited to CHF 700 a calendar year for adults and CHF 350 for children under age 18.
2. **Children.**
 - Children under age 18 do not pay a deductible under the standard basic compulsory plan. In plans that offer a deductible for a reduced premium, the deductible for children ranges from CHF 100 to CHF 600.
 - While the 10% coinsurance on all covered expenses applies to children as well as adults, children have an annual coinsurance maximum that is half that of an adult, CHF 350 compared to CHF 700 for adults. Families with several children insured by the same plan have an aggregate maximum of CHF 1,000 for all children.
3. **Maternity benefits.** No cost sharing is required for services related to a normal pregnancy and delivery, costs related to a healthy newborn while the mother is in the hospital, 1 post-natal exam, and 3 breast-feeding advice sessions.
4. **Preventive measures.** No deductible is required for certain preventive measures (mammography, for example), depending on the canton.

5. **Limited choice of providers.** Insurers can offer policies with a limited choice of providers that make enrollees totally or partly exempt from deductibles and coinsurance.

Other features of the Swiss health care system provide assistance with out-of-pocket health care costs:

- **Premium subsidies and reductions.** Low-income individuals and families are eligible for means-tested premium subsidies, funded with federal and canton funds. Each canton is responsible for administering the subsidies by establishing eligibility, setting total spending amounts, etc. In 2004, 40% of Swiss households (or, one-third of all individuals) received premium subsidies.⁵³

In addition, individuals and families can reduce their premium payments by:

- Enrolling in a health plan with a deductible higher than the standard CHF 300,
 - Enrolling in a restricted network health plan such as a health maintenance organization (HMO) or a general practitioner physician network,
 - Enrolling in a bonus insurance plan where enrollees pay a 10% higher premium in the first year but pay a discounted premium in subsequent years if they do not submit any health care expenses for reimbursement,
 - Choosing a health insurance plan with reduced premiums for children (0 to 18) or young adults (19-25).⁵⁴
- **Old age, survivors, and invalidity (i.e., disability) insurance.** These statutory national programs provide pensions to qualified individuals that they can use to purchase health insurance and pay cost-sharing amounts. In addition, the Swiss cantons provide means-tested supplementary benefits to those with old-age, survivors, or invalidity insurance that consist of monthly benefit payments and non-contributory reimbursement of costs due to sickness and disability. Under the invalidity insurance, recipients can receive rehabilitation services, medical measures to treat congenital disease until age 20, and medical equipment such as hearing aids, guide dogs for the blind, orthopedic equipment, etc.⁵⁵
 - **Supplemental insurance.** Swiss residents can purchase private supplemental insurance to pay for some out-of-pocket costs or costs not covered in full by the health insurance plan. However, supplemental insurance is prohibited from covering the cost sharing required by the compulsory basic insurance.⁵⁶ In 2005, about one-third (32.5%) of the population purchased voluntary supplemental health insurance coverage that covered private or semi-private hospital rooms, or a free choice of doctor.⁵⁷ Supplemental insurance is purchased by individuals, who are then eligible for tax deductions on premiums up to a threshold. Premiums are risk-adjusted, and insurers have the right to refuse coverage. The scope of benefits varies based on the plan and insurer, but typical coverage guarantees either semi-private or private hospital accommodations and choice of hospital doctor. Some plans also cover expenses not covered by compulsory basic insurance, such as routine dental services or treatment by naturopaths.

Cost Sharing by Type of Service⁵⁸

Standard Cost Sharing: All services listed below, except for maternity care, are subject to the standard deductible (CHF 300 for adults, 0 for children), or a larger deductible as provided under the plan chosen by the individual, plus 10% coinsurance up to a maximum.

Standard Cost-Sharing Exemptions and Limits: The required 10% coinsurance is limited to a calendar year maximum of CHF 700 for adults and CHF 350 for children.

- **Inpatient Hospital Services**

Cost Sharing: Inpatient hospital services and general ward accommodations are covered by basic health insurance, subject to the standard cost sharing indicated above. Private rooms or semi-private wards must be paid for out-of-pocket or by voluntary supplemental health insurance. Single individuals or those who do not live with at least one member of their family must pay CHF 10 per day during inpatient hospital stays, which does not count toward the annual maximum coinsurance limit.

Cost-Sharing Exemptions and Limits: Subject to the standard cost-sharing limit provided above. No per day fee is required for routine maternity or newborn care.

- **Physician Services**

Cost Sharing: Standard cost sharing.

Cost-Sharing Exemptions and Limits: Standard cost-sharing limit.

- **Prescription Drugs**

Cost Sharing: Prescription drugs approved by the Federal Office of Public Health are subject to the standard cost sharing, but the coinsurance is 20% (rather than 10%) for proprietary medicines if an interchangeable generic exists. Drugs not on the list of approved medications must be paid for out-of-pocket or by voluntary supplementary insurance.

Cost-Sharing Exemptions and Limits: Standard cost-sharing limit for approved drugs.

- **Dental**

Cost Sharing: Dental care is covered, subject to the standard cost sharing, for those who develop a serious mouth or jaw disease or if a severe generalized disorder causes dental problems. Annual check-ups, cleanings, fillings, and other routine care are not covered and must be paid for out-of-pocket or by voluntary supplemental insurance.

Cost-Sharing Exemptions and Limits: Standard cost-sharing limit for covered services.

- **Eye Care**

Cost Sharing: Eye glasses and contact lenses are subject to standard cost-sharing requirements, with coverage limited to CHF 180 per year for children up to age 18 and CHF 180 every five years for individuals 19 and older. For patients with very defective vision and with certain medical conditions, basic insurance covers a higher level of costs.

Cost-Sharing Exemptions and Limits: The standard cost-sharing limit would not apply because the benefits are limited.

- **Maternity**

Cost Sharing: Basic compulsory health insurance covers the costs of maternity care and birth, one post-natal exam, and breast-feeding advice sessions, with no cost sharing required. It also contributes CHF 100 towards the cost of group post-natal classes.

Cost-Sharing Exemptions and Limits: No cost sharing – see above.

- **Medical Aids and Devices**

Cost Sharing: Basic compulsory health insurance covers certain aids and appliances such as fixed dressings, inhalers, and prosthetics, subject to the standard cost sharing. Hearing aids and prostheses may also be covered by the Invalidity Insurance.

Cost-Sharing Exemptions and Limits: Standard cost-sharing limit for covered services.

- **Medical Transportation and Rescue**

Cost Sharing: 50% coinsurance for medically necessary transportation (e.g., an ambulance) up to an annual maximum of CHF 500. For rescue if in mortal danger (e.g., mountaineering accident, heart attack), 50% coinsurance up to an annual maximum of CHF 5,000.

Cost-Sharing Exemptions and Limits: The standard cost-sharing limit would not apply because of the benefit limits.

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Endnotes

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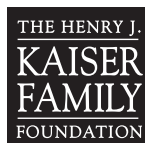
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