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Complementary Health Insurance in France: Wide-Scale Diffusion but Inequalities of Access Persist

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In the context of ever increasing health expenditures and the recent increment in the share of health expenditures no longer reimbursed by the Statutory Health Insurance scheme, wide-scale diffusion of complementary health insurance (CHI) has become a major determinant in maintaining low income and high care need populations' access to health care. Over the last thirty years, the public authorities have instituted laws and implemented schemes aimed at extending access to complementary health coverage to the population as a whole.

Between 1980 and 2008, the percentage of individuals covered by CHI increased considerably: from 69% of the population in metropolitan France to 94%. According to the Health, Health Care and Insurance survey (ESPS), however, almost 4 million individuals remained without complementary health coverage in metropolitan France in 2008.

What are the different means of access to complementary health insurance? Who are the individuals that remain outside the complementary health insurance system? Is non-subscription a reasoned choice or is access to CHI impeded by persisting obstacles? What are the consequences of non-coverage regarding access to health care and health status?

In France, complementary health insurance, with the exception of CMU-C[1] is privately funded. It covers health care and medical goods expenditures not covered by the Statutory Health Insurance scheme, also referred to as out-of-pocket (OOP) payments. Between 1980 and 2008, OOP payments increased from 217 € to 547 € per person per year, at comparative price levels[2] (Eco-Santé, Health Expenditure Accounts 2009). Two factors explain this increase. Firstly, between 1980 and 2008, overall health care and medical goods expenditures increased from 1,085 € to 2,234 € per person per year, at comparative price levels. Secondly, the share of expenditures reimbursed by the Statutory Health Insurance scheme has been progressively eroded by a transfer of costs towards the patients. The reimbursement rate reached its peak in 1980; 80% of health care expenditures were then covered by the Statutory Health Insurance scheme. With the increase in patient contributions and the fixed copayment for hospital care aimed at reducing public health costs, it was reduced to 77% in 1990 where it remained stable until 2005. Since 2006, it has again progressively declined to a rate of 75.5% in 2009. Successive reforms increasing fixed copayments and excesses and further reducing reimbursement rates for certain prescription drugs (insert 1) all contributed to the recent drop in the level of Statutory Health Insurance coverage and the consequent increase in OOP payments. Future reforms will undoubtedly continue to increase private sector contributions to health care funding (complementary health insurance and households).

In view of the constant increase in OOP payments through the progressive decline in Statutory Health Insurance reimbursements, CHI has become determinant in maintaining access to health care. The stakes involved are particularly high for the poorest populations and those with high care needs. To what extent has the percentage of the

[1] See List of acronyms.

[2] The comparative price level represents the nominal price deflated by the general price index to take into account evolutions in purchasing power.

* The authors would like to thank Nicolas Célant for the statistical output.

Insert 1: Recent evolutions in National Health Insurance coverage

Recent National Health Insurance reforms tend towards reducing the share of health care costs covered by the Statutory Health Insurance scheme. Certain cut-backs in social security reimbursements are not covered by 'responsible' CHI contracts (insert 3), and thereby increase patients' overall out-of-pocket payments. This is the case regarding excesses and fixed copayments on consultations and medical acts. Other cut-backs on reimbursements increase the financial contributions of patients not covered by CHI. These cut-backs thus participate in increasing the cost of CHI as is the case for the fixed copayment of 18 € on costly medical acts, the lower reimbursement rate or non-reimbursement of certain prescription drugs and the increase in the fixed copayment for hospital care. The principal measures concerning reimbursements on health care and medical goods are recalled below.

Fixed copayments and excesses: Mintroduced on January 1st 2005, a fixed copayment of 1 € was applied to all consultations or medical acts carried out by a physician, radiological examinations and biological analyses. The cumulative out-of-pocket threshold is fixed at 50 € per person per year.

Since September 1st, 2006, a fixed copayment of 18 € applies to all medical acts costing 91 € or over or with a cost coefficient equal or superior to 50.

Implemented on January 1st, 2008, a 0.5 € excess was applied to prescription drugs and paramedical acts and a 2 € fixed copayment introduced on healthcare-related transport. The cumulative out-of-pocket threshold is fixed at 50 € per person per year.

Individuals aged below 18, CMU-C and State Medical Assistance beneficiaries, pregnant women from the sixth month of pregnancy until the 12th day after giving birth are exempt from copayments and excesses.

Cut-backs in prescribed drug reimbursements: an orange label was created in 2006 to reduce the reimbursement level of certains prescribed drugs to 15% for which the Medical Service Rendered[1] was judged insufficient by the French National Authority for Health[2]. Certain prescription drugs were no longer reimbursed following this reform.

Increase in the fixed hospital care copayment: the hospital care copayment represents patients' financial contribution to the accommodation costs incurred during hospitalisations. On January 1st 2010, the hospital care copayment, fixed by ministerial decree, was increased from 17 € to 18 € per day's stay in a hospital or clinic and from 12 € to 13.50 € in psychiatric care units.

[1] *CE's note: Service médical rendu (SMR).*

[2] *The Haute Autorité de santé (HAS) is a public body of scientific and medical expertise, totally independent from government, the National Health Insurance and the pharmaceutical industry, one of whose missions is to assess the medical utility of prescription drugs.*

population covered by CHI increased? Who are the individuals that currently remain outside the complementary health insurance schemes? Are they healthy individuals who, by choice, would rather invest their money in other goods, or on the contrary, is access to CHI denied to certain individuals by the persistence of certain barriers?

Using data from INSEE's Health survey and the Health, Health Care and Insurance survey (ESPS), the diffusion of complementary health insurance in France is presented over a 30 year period. Then, from the ESPS survey data, inequalities of access to CHI and the way it is correlated with access to health care is described.

Schemes favouring the diffusion of complementary health insurance

In parallel with the increases in OOP payments, a series of laws and public health schemes have been implemented to encourage the diffusion of complementary health insurance at individual and collective level by limiting beneficiaries' contributions and inciting the mutualisation of risk. These schemes have consisted in subsidising employer-provided contracts and certain individual contracts and even, as in the case of the CMU-C, offering free complementary health coverage. In 1985, exemptions from social contributions for employer and employees and tax exemptions on employee contributions were respectively formalised in the French Code of Social Security and the General Tax Code. The 1989 Evin Law instituted the preservation of employee rights to complementary health insurance on withdrawal from the labour market (insert 2). The 1994 Madelin Law favoured independent workers access to complementary health insurance through tax deductions (insert 3). In 1999, the Universal Health Care Coverage Act[3] introduced free access to complementary health insurance for the poorest households by means of the CMU-C. Since 2002, complementary health insurance companies benefit from tax incentives if they refrain from administering health questionnaires on complementary health policy subscriptions (introducing the notion of 'social solidarity') thereby limiting risk selection on individual contracts. The 2003 Fillon Law encouraged the diffusion and mutualisation of complementary health insurance to all employees through tax exemptions on mandatory employer-provided contracts. Since the 2004 National Health Insurance reforms, the ACS[4] scheme provides financial assistance in acquiring complementary health insurance to households with income levels at a maximum 26% (20% in 2008) above the income threshold permitting access to CMU-C.

[3] CMU, see List of acronyms.

[4] See List of acronyms.

SOURCES AND METHOD

The Health, Health Care and Insurance (ESPS) survey

Since 1988, the ESPS survey provides an overview of health status, health care and social protection in the population of metropolitan France according to its social characteristics. It interrogates households including at least one beneficiary of the three main National Health Insurance Funds (salaried workers, self-employed, and Agricultural Workers and Farmers[1]).

The survey is conducted from the Permanent Sample of National Insurance Beneficiaries[2] that monitors health care and medical goods consumption. Every two years, half of this sample is contacted to participate in the ESPS survey. The selection protocol allows the same individuals to be interviewed again: in other words, the registered beneficiaries and the members of their households still cohabiting at four year intervals. The survey is conducted in two waves; the first in spring from April to June and the second in the autumn from October to December. It combines telephone or face-to-face interviews and self-administered questionnaires.

In 2008, 66% of the households contacted accepted to participate in the survey; that is around 8,200 households and 22,200 individuals.

The open question on the reasons for non-subscription to complementary health insurance asked to individuals identified as not being insured is as follows: 'Why is (Christian name) not covered by complementary health insurance?' The spontaneous response is coded by the interviewer using the following list: 1. Is covered by Social Security at 100%; 2. Not worth it: no health problems and prefers to pay for care as and when needed; 3. Would like to be covered but can't afford it; 4. Is in the process of subscribing; 5. Neglect or lack of time; 6. Other – Specify:…; 7. Doesn't know.

[1] *CE's note: Caisse nationale d'assurance maladie des travailleurs salariés (Cnamts), Régime social des indépendants (RSI) and Mutualité sociale agricole (MSA).*

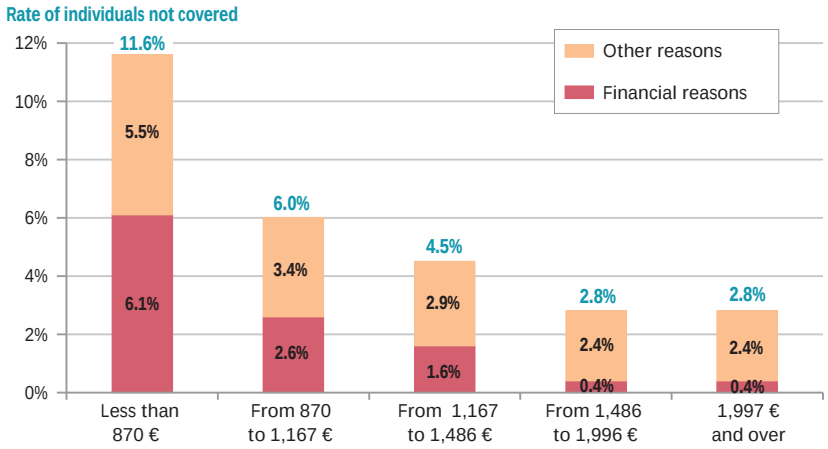
[2] *CE's note: Échantillon permanent des assurés sociaux (EPAS).*

Insufficient income levels: primary factor explaining non-subscription to complementary health insurance

The diffusion of CHI coverage has expanded considerably over the last thirty years. A little over two out of three individuals were thus covered in 1980 and almost nine out of ten in 1999, just before the introduction of the Universal Complementary Health Insurance Coverage (CMU-C). After the institution of the CMU-C followed by the ACS scheme, the percentage of individuals benefitting from complementary health coverage continued to progress reaching 94% in 2008.

According to the Health, Health Care and Insurance survey (ESPS), however, 6 % of the population in metropolitan France (4 million persons) remained without complementary health insurance in 2008. The primary reason for non-subscription evoked by survey respondents was financial. Of the individuals without complementary health coverage, 46% expressed the desire to benefit from CHI but were unable to for financial reasons, 22% preferred not subscribing and paying health care costs when necessary and 14% declared benefitting from 100% coverage from the Statutory Health Insurance scheme. Over one in two primary causes of non-subscription to CHI evoked by the poorest households, and one in six among the wealthiest households, was financial (graph 1). Moreover, according to the 2008 ESPS survey, in the poorest households (under 870 € per consumption unit CU[5]), 12% of individuals did not benefit from CHI coverage against only 3% in the wealthiest households (1,997 € and over per CU). A certain number of these households could, however, benefit from CHI through schemes such as the CMU-C and the ACS.

G1 **Percentage of individuals without complementary health insurance according to household income level**



Source: Health, Health Care and Insurance survey 2008 (IRDES).

Failure to apply for CMU-C

A study carried out by LEGOS (Dufour-Kippelen *et al.*, 2006), using ESPS survey data, estimates that in 2006, from 700,000 to 1.2 million potential CMU-C

[5] The income per consumption unit (CU) permits, using an equivalence scale, standard of living comparisons between households of different sizes and composition. We use the OECD scale weighted in the following manner: 1 CU for the first adult in the household; 0.5 CU for other household members aged 14 and above; 0.3 CU for children aged less than 14.

Insert 2: Modes of access to complementary health insurance

There exist several modes of access to complementary health insurance coverage. Individuals on very low incomes have access to the Universal Complementary Health Insurance Coverage (CMU-C)* or State Medical Assistance[1] if they are unable to prove three months legal, regular residence in France. Up to a maximum of 26% above the CMU-C income cut-off, households can benefit from the ACS scheme that provides financial assistance in the acquisition of CHI (50% of the cost of the contract), or they can choose to purchase a private CHI policy.

On the actual CHI market, individuals can have access to CHI through an employer-provided group contract or for the self-employed, an individual contract with possible financial assistance (Madelin Law, 1994) [insert 3].

The Universal Complementary Health Insurance (CMU-C) and the subsidising scheme for acquiring CHI (ACS): schemes favouring access to CHI among the poorest.

The Law of July 27th 1999, instituting Universal Health Coverage (CMU), extended access to the Statutory Health Insurance scheme to all legal and regular residents in France providing they have been residents for at least three months as from January 1st 2000. This refers to the basic CMU. At the same time, the public authorities created the State Medical Assistance for individuals unable to prove legal, regular residence in France.

The basic CMU is complemented by the CMU-C: it provides the right to free complementary health coverage. Eligibility is determined by income level. On January 1st 2011, the income threshold in metropolitan France is fixed at 634 € per month for a single person (620 € in 2008).

The CMU-C covers fixed copayments on ambulatory care (consultations and prescriptions), but not extra fees, contributions towards the cost of hospital care and the fixed daily copayment for hospital stays and, within certain limits fixed by the law, extra fees for prostheses (namely dental or optical). It provides 100% coverage on care expenditures without advance payment and health professionals are under the obligation to respect conventional Social Security tariffs.

According to the CMU fund, the number of CMU-C beneficiaries in 2009 was estimated at 3,645,913 in metropolitan France and 4,223,788 including French overseas territories.

The ACS scheme was introduced on January 1st, 2005 to incite households just above the CMU-C eligibility income threshold to acquire complementary health coverage. In 2008, the ACS is accessible to individuals with incomes not exceeding 20% of the CMU-C eligibility threshold (26% on January 1st 2011). Subsidy amounts were very rapidly increased, notably in favour of individuals aged over 60. On January 1st 2011, it amounted to 100 € per year for individuals aged less than 16, 200 € for the 16-49 age group, 350 € for the 50-59 age group and over 500 € for individuals aged 60 and over. The ACS finances on average 50% of the costs of a complementary health insurance contract (CMU Fund, 2010).

In May 2010, 516,499 individuals had used an ACS certificate. Before the ACS eligibility threshold was increased to a maximum 26% above the CMU-C income cut-off, the target population was estimated at 2.2 million potential beneficiaries (Hcaam, 2007).

* The Statutory Health Insurance and CHI providers are granted annually 340€ per beneficiary (public funds), costs exceeding this amount are born by the beneficiary's insurance provider.

[1] *CE's note: Aide médicale d'État (AME).*

CONTEXT

The synthesis of evolutions in access to complementary health insurance in France presented here is part of a broader research programme on health insurance and health inequalities conducted by IRDES. Concerning the number of individuals not covered by complementary health insurance, this study is based on three concordant data sources: the Health, Health Care and Insurance survey (ESPS) conducted by IRDES, the Health survey and the Household Budget survey conducted by INSEE.
Hence, in 2003, according to the Health Survey, 10% of individuals were not covered by CHI, 8.5% according to ESPS 2002 and 2004. They were 8% in 2006 (Jusot et al., 2011), according to the Household Budget survey, on the assumption that all eligible households for CMU-C had effectively applied, and 7% in ESPS 2006.

Insert 3. Group contracts

On the complementary health insurance market, individuals can either purchase a private contract or benefit from an employer-provided group contract. On withdrawal from the labour market, insurance companies are required to respect conditions fixed by the Evin Law facilitating the portability of group contracts: obligation to offer an equivalent individual contract whilst limiting the increase of overall premium costs to 50% of the original cost (employer participation included).

The Fillon Law of August 21st 2003, implemented on December 31st 2008, restricted tax advantages (tax exemptions for employers and employees) to mandatory and 'responsible' contracts thereby encouraging mutualisation. 'Responsible' contracts do not reimburse the different copayments and fees in excess of conventional tariffs if healthcare is provided outside the coordinated pathway. At the minimum, they cover patient contributions to the costs of medical care (30% of the statutory reimbursement rate for consultations and visits and white label bar coded prescription drugs, and 35% of the statutory reimbursement rate for medical analyses…).

The advantages of group contracts: Dcompared with the cost of individual private contracts, companies' bargaining power and economies of scale reduce the overall average cost of employer-provided contracts. Furthermore, tax and social security contribution exemptions from which they benefit reduces the cost for both employees and employers. These contracts are an important aspect of company wage policies, especially in large companies. Finally, employer-provided contracts, often subject to mandatory subscription, are mutualised since employees are insured independently of health status. These advantages reduce average CHI subscription costs for the employees but abrogate the possibility of choosing non-subscription in the case of good health.

Self-employed workers can equally benefit from cost deductions when they acquire CHI (Madelin Law, 2004).

beneficiaries had not exercised their rights. According to the authors of this study, the majority were already covered by a private CHI policy. Fear of lower reimbursement rates from the CMU-C or potential problems arising during the transfer from one CHI scheme to another, and a more general reticence to undertake administrative procedures, would explain why these individuals had not exercised their CMU-C eligibility rights. 14% of these individuals would nevertheless choose to remain without CHI.
The reasons for non-subscription most frequently evoked were good health among the younger respondents, the language barrier for foreign nationals, embarrassment or stigmatisation felt by degree holders having previously held positions of responsibility and the fact that certain health professionals refuse CMU-C patients.

Failure to apply for ACS

The CMU Fund[6] currently estimates the percentage of individuals having exercised their right to benefit from the ACS scheme at one in four: in May 2010, before the ACS eligibility income threshold was increased from 20% to 26% above the income cut-off for CMU-C on January 1st 2011, the ACS scheme counted 516,499 beneficiaries out of a target population of 2 million individuals. This scheme has thus failed to reach its target. Two hypotheses are commonly advanced to explain this: on the one hand, the lack of information on the existence of the scheme and the attached administrative procedures (Guthmuller *et al.*, 2010); and on the other, the financial assistance proposed is insufficient so that even after deducting the subsidy, the cost of CHI remains too high for a considerable number of low income household (Grignon and Kambia-Chopin, 2009). The level of uncertainty regarding eligibility to the scheme is an additional aggravating factor.

A threshold effect that goes beyond the ACS scheme

In 2008, the CMU-C income eligibility threshold was 620 € per CU and 20% above this threshold for eligibility to the ACS scheme (26% in 2011), that is to say 744 € per CU. A large number of households are thus not eligible to either the CMU-C or ACS schemes whereas they belong in the first income quartile (≤ 870 € per CU). These households thus have to pay for the totality of CHI costs which represents a considerable financial burden. An IRDES study based on the 2006 ESPS survey results and published in 2008 (Kambia-Chopin *et al.*, 2008) demonstrates that the financial burden, that is to say the percentage of household income allocated to CHI varies from 3% for the wealthiest households (1,867 € and over per CU) to 10% for the poorest households (less than 800 € per CU). A LEDA[7]-LEGOS study based on data from the INSEE 2006 Household Budget survey (Jusot *et al.*, 2011) provides similar rates of 2 % and 8 % for the upper and lower deciles (excluding the population eligible for CMU-C).

Employment, a privileged but inegalitarian mode of access to CHI

According to the 2008 ESPS survey, two thirds of employees with complementary health insurance benefit from employer-provided contracts (insert 3). It should equally be noted that according to the French Federation of Insurance Companies[8], three quarters of independent workers benefit from a Madelin CHI contract (Hcaam, 2010). Employment is a major means of access to complementary heath insurance. Employees, employers and insurance companies all have a shared interest in employer-provided contracts. Economies of scale and companies' bargaining power reduce the gross global costs by 10 Euros per person per month compared to a private contract for identical guarantees (Garnero, Rattier, 2009). In addition, these contracts benefit from social contribution and tax exemptions if subscription is mandatory. Finally, company-provided contracts are often partially subsidised by the employer. In financial terms, these CHI contracts are thus

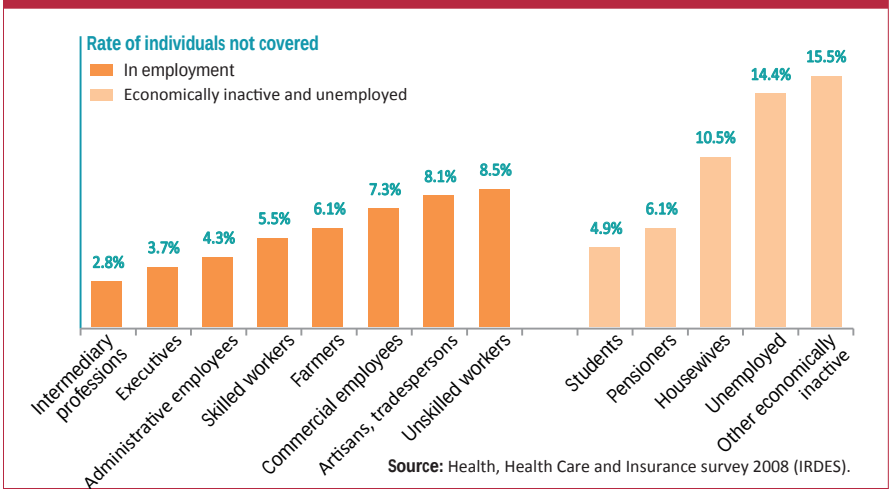
6 Copy editor's note: Fund for financing universal health coverage.

7 CE's note : Laboratoire d'économie de Dauphine

8 CE's note: Fédération française des sociétés d'assurance (FFSA).

G2

Percentage of individuals not covered by complementary health insurance by profession



Source: Health, Health Care and Insurance survey 2008 (IRDES).

more advantageous than private contracts and offer higher coverage levels. According to the Provident Society Barometer conducted by the CREDOC[9] in December 2008, employer-provided CHI is an indirect form of remuneration greatly appreciated by employees: 92% of the employees benefitting from CHI thus prefer to receive employer contributions in the form of non-taxable benefits rather than their equivalent in salary (Loones, 2009).

However, we are forced to admit that company-provided CHI is a source of inequality not only between economically active and inactive populations but also between different employee categories. According to the 2008 ESPS survey, among private sector employees benefitting from CHI, 76% of executives and 69% of intermediary professions benefit from a group contract against only 58% of unskilled workers and 53% of employees in the commercial sector. The Employer-sponsored Complementary Health Insurance surveys (PSCE) conducted in 2003 and 2009 equally show inequalities in employee access to company-provided CHI according to company size, sector of activity and socio-professional category (Guillaume and Rochereau, 2010).

In general, access to CHI varies considerably according to job status (among the economically active) and socio-professional category (graph 2). Hence, 10.5% of housewives, 14% of unemployed and 15.5% of other economically inactive individuals (excluding children and retirees) do not benefit from CHI against 5% of economically active individuals. Among economically active individuals in employment, the percentage of individuals without CHI is slightly higher among non-salaried workers: 8% of self-employed workers and 6 % of farmers are not covered against 5% of salaried workers. Among salaried workers, the percentage of individuals without CHI is considerably higher in the commercial sector and among unskilled workers (7% and 8.5% respectively) than among intermediary professionals and executives (3% and 4% respectively). Hence, access to company-provided CHI and the global rate of CHI policies held appears to be related, confirming the importance of the role played by company-provided CHI in the overall access to CHI.

Individuals without CHI consume less health care and more frequently self-report poor health

The 2008 ESPS survey results confirm that access to health care and health status are correlated to the fact of having CHI coverage or not. Hence, among the individuals covered by private CHI, 84% consulted a GP over the past twelve months, 76% a dental surgeon over the past twenty four months and 50% a specialist over the last twelve months. These rates are respectively 84%, 68% and 40% for CMU-C beneficiaries and 74%, 57% and 37% among individuals without CHI. The rate of individuals foregoing care, essentially dental and optical care for which Statutory Health Insurance reimbursement rates are extremely low, is 30% among individuals without CHI and 21% for CMU-C beneficiaries against 14% of individuals with private CHI.

These results are in accordance with numerous studies that conclude that CHI coverage increases health care consumption (Buchmueller *et al.*, 2002). It nevertheless remains difficult to determine to what extent this increased consumption is due to a 'worthwhile' improvement in access to care or an 'unnecessary' overconsumption of care[10]. An IRDES study (Lengagne and Perronnin, 2005) conducted on the basis of ESPS 2000 and 2002 data concludes that CHI has a positive impact on access to dental and optical care.

Furthermore, evaluations concerning the institution of the CMU-C show that it has improved access to care among individuals that did not previously benefit from complementary health coverage (Grignon *et al.*, 2008).

According to the 2008 ESPS survey, individuals without CHI more frequently self-report poor health than individuals covered by private CHI contracts but not necessarily more than CMU-C beneficiaries: 37% of individuals without CHI self-report fair to very poor health against 39% of CMU-C beneficiaries and 27% of private CHI policy holders. Individuals without CHI are moreover 27% to declare functional activity limitations and 34% to declare suffering from a chronic disease against 28% of CMU-C beneficiaries in both cases, and respectively 20% and 28% among private CHI policy holders

* * *

Since the end of the 1980s, policies implemented to extend access to complementary health insurance to the population as a whole have resulted in a decrease in the number of individuals not covered by CHI from 31% in 1980 to 6% in 2008.

ESPS survey results tend to show that non-subscription to CHI is more of an imposition than a choice. In effect, the majority of studies evoke financial difficulty rather than

[9] CE's note: Centre de recherche pour l'étude et l'observation des Cconditions de vie (French Research Centre for the Study and Monitoring of Living Standards).

[10] In economics we speak of moral hazard. Once insured, individuals consume more health care than warrant their medical needs.

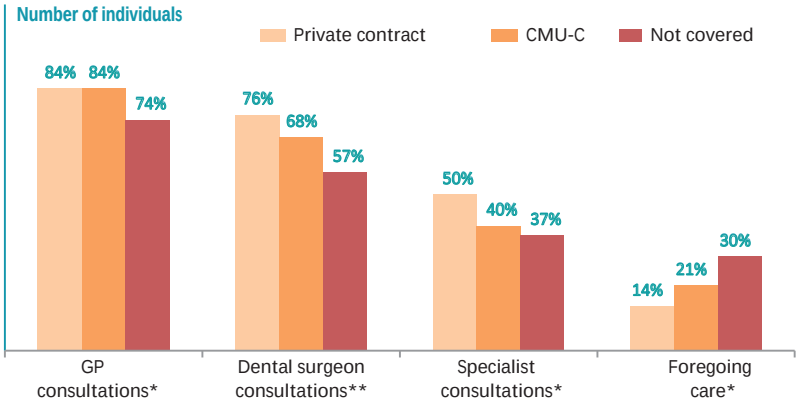
the absence of health problems in explaining non-subscription rates. Despite the CMU-C and ACS schemes, the poorest households are more frequently those not covered by CHI. It is equally more frequent among the economically inactive population, unskilled workers and employees than among executives. Finally, individuals without CHI more frequently self-report poor health and more frequently forego care.

The results of the 2009 Employer-sponsored Complementary Health Insurance survey to be published in extenso in an IRDES report, confirm the inequalities in CHI coverage among employees according to company size, business sector and equally employees' socio-professional status (Guillaume and Rochereau, 2010).

According to the High Council for the Future of Health Insurance[11], the global public costs of CHI subscription incentives amount to 1.7 billion Euros for the CMU-C and ACS and 5.2 billion Euros in social contribution and tax exemptions for company-provided contracts and 'Madelin Law' contracts. Despite these policies, inequalities persist both in terms of access to CHI and the level of guarantees proposed. One may thus question the overall effectiveness of these incentives. Understanding the motives underlying non-subscription and its consequences on access to health care for the individuals concerned is equally important. A new questionnaire to be included in the 2010 ESPS survey specifically addressing individuals without CHI should provide further information on the reasons behind non-subscription and its consequences in terms of health care. ♦

[11] CE's note: Haut Conseil pour l'avenir de l'Assurance maladie, HCAAM.

G3 Rate of individuals using care and foregoing care according to access to CHI



*over the last twelve months ; ** over the last 24 months

Source: Health, Health Care and Insurance survey 2008 (IRDES).

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- Régime des salariés indépendants : www.le-rsi.fr
- Mutuelle sociale agricole : www.msa.fr
- Institut de recherche et documentation en économie de la santé : www.irdes.fr

ACRONYMS

- **[ACS] Aide complémentaire santé:** ACS (Financial aid for purchasing a supplementary health insurance cover)
- **[CHI]: Complementary health insurance**
- **[CMU] Couverture maladie universelle:** Universal health care coverage
- **'[CMU-C] Couverture maladie universelle complémentaire:** Universal complementary health care coverage (free of charge complementary health insurance for low income individuals)
- **[ESPS] Enquête santé protection sociale:** Health, Health Care and Insurance survey
- **[INSEE] Institut national de la statistique et des études économiques:** French National Institute of Statistics and Economic Studies
- **[LEGOS] Laboratoire d'économie et de gestion des organisations de santé:** Laboratory for the Economics and Management of Health Organizations (Paris-Dauphine University)
- **OOP: Out-of-pocket**

IRDES INSTITUT DE RECHERCHE ET DOCUMENTATION EN ÉCONOMIE DE LA SANTÉ
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