Questions d'économie de la Santé

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The Non-Coverage of Complementary Health Insurance in France in 2019

Initial Findings of the European Health Interview Survey (EHIS)

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Although the number of individuals without complementary health insurance is at its lowest level – having dropped from almost 14% of the population aged 15 years and over in 1996 to 3.6% in 2019 –, the current organisation of complementary health insurance and recent reforms aimed at employed individuals leaves part of the population by the wayside. Hence, the segment of the population that does not have an employer complementary health insurance policy and does not benefit from the Complementary Health Solidarity (CSS, *Complémentaire Santé Solidaire*) has to pay the high premiums of individual policies, in particular the elderly. We describe the 2.5 million French persons without complementary health insurance in 2019, based on the findings of the 2019 European Health Interview Survey (EHIS).

In 2019, self-employed workers, the unemployed, and economically inactive persons were most often uninsured by a complementary health insurance. The poorest retired persons, who pay high premiums in proportion to their financial resources, were also most often uninsured. The employer complementary health insurance mandate implemented in 2016 has resulted – by reducing inequality coverage among private-sector employees – in a reduction in the number of uninsured persons among the less well-off middle classes. Nevertheless, the individuals' economic and social situation remains the main determinant of being insured, due to the cost of policies but also to the complexity of administrative procedures.

In France, the role played by private health insurance in the mixed public/private insurance system is very specific. Its complementary function, which consists of covering healthcare costs in the same "basket of care" as the public health insurance scheme, applies to almost all of the available healthcare. This insurance is widely present throughout the population, as 96.4% of individuals had complementary health insurance (CHI) in 2019. It funded a significant part of the healthcare expenses, that is 13.4% of the consumption of healthcare and medical goods in 2019. In comparison with other countries in the Organisation for Economic Cooperation and Development (OECD), France is conjointly the country in which private insurance is most widespread in the population and among those in which it makes the greatest financial contribution to healthcare expenses[1] (DREES, 2021).

In a country in which mandatory universal public insurance funded on average 78% of the healthcare expenses in 2019 and significantly contributed to reducing standard of living inequalities (Fouquet and Pollak, 2022), the unique

[1] Private health insurance in France accounts for 14% of standard healthcare expenses (OECD aggregate), just behind Slovenia (16%) and Canada (15%), and on the same level as Ireland (14%). The Netherlands (62%), Switzerland (49%), and the United States (39%) cannot be compared with France because in these countries private healthcare insurance plays the role of the main insurance scheme, which, in the case of the Netherlands and Switzerland, is highly regulated by the State.

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role of complementary health insurance attests to the limitations of public healthcare insurance to enable everyone to access to essential healthcare without financial barriers and to reduce the low –but real– risk of having catastrophic out-of-pocket expenses[2] (Adjerad and Courtejoie, 2020). This particularity results in public decision-makers to attempt to reduce the financial obstacles to accessing healthcare by limiting public expenditure and keeping the current organisation of the mixed public-private insurance system. Many schemes have been implemented in order to facilitate the diffusion of CHI – even attempts to generalise it –, while regulating the CHI market: a universal CHI or low-cost insurance for the poorest individuals (Universal Complementary Health Insurance; *Couverture Maladie Universelle,* CMU-C) in 2000, Health Insurance Vouchers Scheme (*Aide à la Complémentaire Santé*, ACS) in 2005, merged into Complementary Health Solidarity (*Complémentaire Santé Solidaire,* CSS, in 2019); financial incentives for the implementation of employer CHI (introduced in 1979), followed by the employer CHI mandate (in 2016), which will be extended to public-sector workers in 2024; a regulation of the portability of employer CHI contract for unemployed and retired persons; a prohibition on increasing the premium of one insured person beyond that applied to the pool of insured by the same policy (the Loi Evin, 1989); and, lastly, increasingly greater regulation of the solidarity-based and responsible contracts (*contrats solidaires et responsables)* along the lines of the latest reform called 100% Health Care *(100 % Santé)* as of 2019. The latter reform implies that individuals covered by these policies can access a basket of care that includes dental, optical, and audiology treatments without any out-of-pocket payments.

The policy of strong regulation and quasi-generalisation of CHI has led to an improvement of CHI coverage in the population. But it has also highlighted the limitations of the complex and costly organisation of the current two-tier system of health insurance, which raises questions about solidarity and effectiveness (HCAAM, 2022):

- With regard to solidarity, the funding of CHI does not depend on the households' ability to pay: the premiums primarily depend on the age of the insured individuals (for individual policies) or of the pool of insured individuals (for group policies). Hence, the funding of CHI increases with the risk of illness and reinforces social inequality in the standard of living. The mutualisation of healthcare expenses provided by CHI between healthy and sick individuals is relatively low in comparison with that provided by public insurance (Franc and Pierre, 2015).
- In terms of efficiency, the management costs of this dual system, leads France has the highest management

I Changes in the collection of data relating to complementary health insurance status in surveys aimed at the general population

The health and social protection surveys aimed at the general population are essential tools for studying complementary health insurance (CHI) coverage. They make it possible to analyse the diffusion of CHI and the type of policies taken out according to the economic and social situation of individuals, the main factor behind taking out CHI and the level of coverage provided. Yet, this information is not – or rarely – analysed in medical-administrative databases. They also make it possible to study the insurance according to the state of health and healthcare requirements of the individuals– information that cannot be solely accessed through medical-administrative databases due to the many obstacles to healthcare access. Lastly, they provide information about the opinions and preferences of the individuals, and, in particular, with regard to the assessment of insurance policies, risk preferences, which only surveys aimed at the general population or experimentations successfully highlight.

The last decade has been marked by a notable change in these surveys. The 2019 European Health Interview Survey (EHIS), which is representative of the French population aged 15 years and over, is characteristic of this context (Leduc et al., 2021). It followed the IRDES Health, Health Care and Insurance Surveys (ESPS), which were conducted between 1988 and 2014, with the last survey year serving as a basis for the 2014 European Health Interview Survey (Célant et al., 2017); the 2017 Statistics on Income and Living Conditions survey (SRCV), conducted by the National Institute of Statistics and Economic Studies (INSEE), contained questions relating to CHI (Fouquet, 2020). We have presented in this article a very synthetic description of the way in which the collection of information about CHI has changed over the last decade.

The ESPS surveys (1988-2014). Information about CHI was collected from all the members of the households that participated in the survey. The reference person who was sampled initially responded on the telephone, on his/her behalf and on behalf of the other members of the household, about each person's insurance status. A paper questionnaire, which had to be filled out by the individuals who had taken out the policies, was then sent to the homes of the participants in order to collect more precise information about the policies and the insured parties (principal and right holders).

The SRCV survey (2017). Information about CHI was collected in person by an interviewer from all the individuals aged 15 years and over in the households participating in the survey; questions about the insurance of those under the age of 15 were also asked. Questions about the type of insurance and the status of the insured persons were asked, but the survey did not provide information about the identity of the principal insured person when the insured persons declared that they were right holders.

The 2019 European Health Interview Survey (EHIS). Information about CHI coverage was collected on the telephone or in person from all the sampled individuals who took part in the survey: this concerned individuals aged 15 years and over in a household who responded in person (except when the individual was underage). Hence, in contrast with the ESPS surveys, it was not possible, when the respondent was a right holder, to obtain information about the coverage (type of insurance, coverage, premium, etc.) from the person who took out the policy or the person's employment status, which provide invaluable information for recoding the types of insurance (individual/group).

The developments in the means of collecting information about CHI coverage and the various clearances that can be carried out means that caution must be exercised when comparing CHI statuses over time, in particular with regard to the type of individual or group insurance. Having or not having CHI, whatever the type of insurance, is information that is less subject to changes in the way in which questions are phrased in the different surveys.

[2] Catastrophically high healthcare expenses are considered in this article as extremely high healthcare expenses (sometimes several thousand euros) that have to be paid by the insured parties after the intervention of the public health insurance scheme. They concern healthcare risks that are not really covered by the French Social Security system, such as the financial contribution to the hospital when the patient's contribution is due (in the event of medical or resuscitation hospitalisations, for example, particularly in the case of Covid-19), as well as frequent use of ambulatory healthcare and medical schemes.

costs in the OECD, just after the United States.

Hence, while the percentage of persons uninsured dropped from 14% in 1996 to 3.6% in 2019 in the population aged 15 years and over (see Graph 1), individuals' economic and social situation remains the main determinant of being CHI uninsured and of the level of CHI coverage. The recent reforms, which promote the diffusion of CHI according to the employment status of individuals, increases the risk segmentation among the CHI market, thereby reducing the solidarity between healthy individuals and sick individuals, who are more likely to be unemployed. The likely impact of such reforms on individual policies premiums may also increase the difficulties in taking out CHI for the poorest persons and the elderly. Indeed, while the employer CHI mandate implemented in 2016 had lowered the number of uninsured persons by around one per cent and access to CHI for private-sector employees was improved (Fouquet, 2020; Perronnin, 2019; Pierre and Jusot, 2017), the transfer of insured –most often in good health–, generated by this reform, from the individual to the group market, has led to a higher concentration of insured in poor health in the individual insurance market. And the *100% Santé* reform has led to a rise in coverage amounts of the individual policies. Due to competition, this has accelerated the convergence of pricing practices of the various types of CHI companies (DREES, 2019), by generalising actuarial pricing based on age in the individual CHI market, to the detriment of the elderly.

Although non CHI coverage is at its lowest level, the current system –which facilitates access to CHI by one's employment status– runs the risk of a loss of cover and may lead to the

SOURCE

The 2019 European Health Interview Survey (EHIS)

The 2019 EHIS was a survey of the health of populations that was conducted in every European country, piloted by Eurostat on the European level, and by the Directorate for Research, Studies, Assessment and Statistics (*Direction de la Recherche, des Études, de l'Évaluation et des Statistiques*, DREES) in France. The survey was representative of the population aged 15 years and over living in a standard household (excluding institutions) and gathered information about the socioeconomic situation of the individuals, their state of health, their healthcare use, their lifestyles, their alcohol and tobacco consumption, and, in France, their complementary health insurance (CHI). In 2019, the French survey was extended to overseas *départements* and regions (DROM - Guadeloupe, Guyana, Mayotte, Martinique, and the Réunion). As the data were not available yet, the scope of the analyses presented in this *Issues in Health Economics* only concerned mainland France.

The "Métropole" section. The survey's "Métropole" section was conducted by the DREES and the Institute for Research and Information in Health Economics (IRDES), with the help of the company Kantar. Almost 15,000 persons took part in the survey, representing a response rate of 57%. The individuals were questioned on the telephone between May 2019 and January 2020 (around 8,000 persons), and, when an individual's phone number was unavailable, the interview was conducted in person (representing around 7,000 persons). The sampling was carried out by the French National Institute of Statistics and Economic Studies (INSEE) in the Housing and Individual Demographic Files (*Fichiers Démographiques sur les Logements et les Individus*, FIDELI), in which information about the declarable income of the individuals was also collected.

Questions about complementary health insurance (CHI). Questions about CHI were addressed to the person sampled when they were an adult, or to another adult person in the household if the person was unable to respond. Information was collected about whether the person was a beneficiary of Universal CHI (CMU-C) or covered by private CHI, the type of CHI (an individual or group private-sector or public servant policy), the fact of being the principal insured person or a right holder (as well as the main insured person, where appropriate), the premium amount, opinions about the cover provided, and the reasons for being uninsured.

METHOD

Study sample

The Table below presents the characteristics of the sample used to carry out the analyses. The sample comprised 14,151 individuals aged 15 years and over living in mainland France.

In order to obtain the most reliable information about the fact of having or not having CHI coverage, the information relating to CHI coverage (having insurance, benefitting from Universal CHI (CMU-C), or having an individual or group policy) was first rectified and recoded according to the employment status declared by the individuals interviewed-the persons who took out the CHI. Weighting based on the proportion of the beneficiaries of Universal CHI (CMU-C) in the general population was also carried out and a method for the imputation of outliers of CMU-C was used. Hence, in 2019, 3.6% of the individuals in the sample were not CHI-insured; 6.2% benefitted from the CMU-C, 37.8% had a company policy, 50.2% were insured with an individual policy, and 2.2% had an unspecified private policy (individual or group).

Characteristics of the sample

	Numbers	% weighted
Complementary health insurance		
Uninsured	513	3.6
CMU-C	794	6.2
Company policy	5,140	37.8
Individual policy	7,393	50.1
Unknown private policy	311	2.2
Age		
15 to 25 years	1,868	14.5
26 to 35 years	1,787	13.7
36 to 45 years	2,168	16.0
46 to 54 years	2,439	16.8
55 to 64 years	2,455	15.2
65 to 74 years	2,110	13.5
75 years and over	1,324	10.4
Total	**14,151**	**100.0**

	Numbers	% weighted
Self-perceived health		
(very) good	10,034	71.1
Quite good	2,969	21.1
(Very) poor	1,148	7.8
Chronic condition		
Yes	5,506	37.7
Non	8,645	62.3
Household type		
Couple with children	5,479	39.2
Couple without children	4,100	27.7
Single-parent family	1,288	9.2
Single person	2,748	19.9
Others	536	4

	Numbers	% weighted
Employment status		
Employed	7,096	53.6
Private-sector workers	*4,397*	*33.9*
Public-sector workers	*1,701*	*12.2*
Self-employed workers	648	4.9
Retired persons	4,001	26.1
Unemployed persons	805	4.6
Students	1,254	9.3
Homemakers	456	3.2
Other without employment	539	3.1
Risk preferences		
Low aversion	1,079	7.9
Intermediary aversion	7,914	55.7
High aversion	5,039	35.5
Not specified	119	0.8

aggravation of difficulties in accessing CHI for individuals who do not benefit from the Complementary Health Solidarity (CSS, *Complémentaire Santé Solidaire*), in particular the elderly, or during professional transitions (unemployment or retirement). This study set out to analyse the 2.5 million French persons without CHI in 2019 for various reasons – Sexpensive insurance policies, renunciation of their entitlement to the CSS (one third of non-use), and also out of choice. It is based on data from the 2019 European Health Interview Survey (EHIS) [see Inset Source p. 3] whose results have been compared with previous surveys (see Inset p. 2).

Less than 4% of the French population without CHI in 2019 and a non-coverage rate that continues to gradually decline…

According to the European Health Interview Survey, 3.6% of the French population aged 15 years and over was not CHI insured in 2019. The percentage of persons uninsured was comparable to 2017 (3.7% according to the Statistics on Income and Living Conditions Survey conducted by INSEE (SRCV survey) and reached 4.5% to 5% between 2010 and 2014, according to the Health, Health Care and Insurance Surveys (ESPS) [see Graph 1]. Only a small percentage of the French population had no CHI over recent years and the trend is continuing in this direction. While the employer CHI mandate has certainly contributed to this trend from 2016, this is at the beginning of the 2000s, with the introduction of the CMU-C and the ACS schemes, that the non-coverage rate significantly diminished in France: almost 14% of the French population aged 15 years and over was uninsured in 1996, 11% in 2000, and around 6% in 2008.

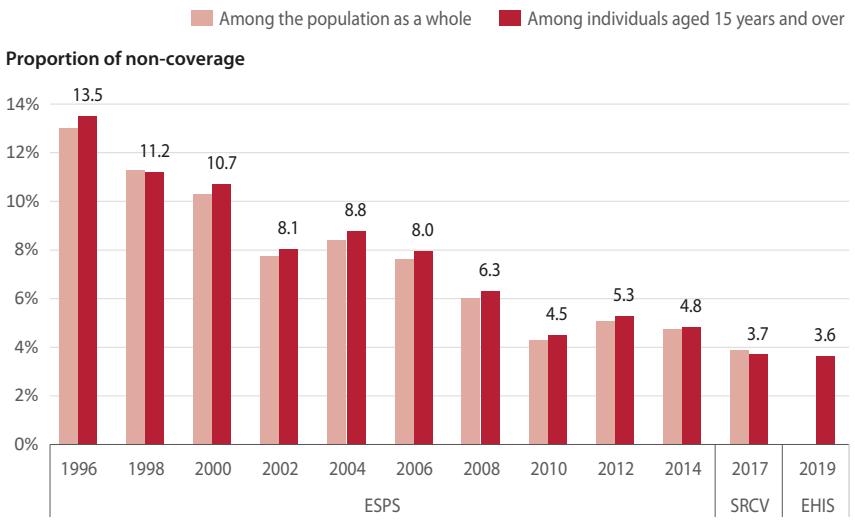
… but the poorest persons remain most often uninsured

Although the percentage of persons without CHI is relatively low in the general population, the poorest individuals were more likely to be uninsured in 2019. Almost 11% of the individuals aged 15 years and over in the first decile of standard of living decile (income per Consumption unit, CU) had no CHI (see Graph 2)[3]. This applied to 6% of those in the second decile, and 4.2% of those in the third decile. As of the fourth decile, the percentage of persons without CHI was still lower than that observed in the general population. Compared to the percentage of people uninsured in the 2017 and 2014 surveys, the non-coverage rate remains the same for the poorest 10% of individuals, but since 2017, the individuals in the second, third, and fourth deciles were more often insured. Although these findings need to be treated with caution, given the differences in gathering income data in the various surveys[4], they corroborate those of the 2017 Employer-provided Complementary Health Insurance Survey (PSCE) Survey. The latter showed that the 2016 employer-mandate led to an improvement in the access to group CHI contract for workers on the lowest wages (Perronnin, 2019), which matches the expected effects (Pierre and Jusot, 2017).

The gradient of non-coverage according to income level is also reflected by the individuals' social situation. Single-parent families and complex households[5] were more often uninsured: this applied to 9% and 7% of them respectively, versus 5% for individuals who lived alone and less than 3% for individuals in couples, with or without children. 13% of the population aged 15 years and over of foreign nationality were uninsured, compared with 5% of naturalised French persons, and less than 3% of persons born in France. Inequality of coverage

G1

Evolution in the percentages of persons without CHI between 1996 and 2019 in mainland France



Sources: ESPS Survey (1996–2014), IRDES; 2017 SRCV, INSEE, and the 2019 EHIS, DREES-IRDES.

Scope: Population in mainland France insured under the French Social Security System (*Régime Général*) (including the Sécurité Sociale Indépendants, formerly the RSI) and the NHI Fund for Farmers and Agricultural Workers (*Mutualité Sociale Agricole*, MSA). The beneficiaries of the *Aide Médicale Gratuite* (before 2000), *Couverture Maladie Universelle* (CMU-C), and the *Aide à la Complémentaire Santé* (ACS) since 2000 and 2004 were considered as insured.

Download the data

[3] Although the vast majority of persons in the first decile were theoretically eligible to benefit from Universal complementary health insurance (CMU-C), and subsequently Complementary Health Solidarity (CSS, *Complémentaire Santé Solidaire*), the absence of insurance may be explained by a phenomenon of renunciation of entitlement, as well as by the various definitions of the notion of income in the survey (declarable income in 2019) and the rules of eligibility for the CMU-C (the income over the twelve months preceding the CMU-C application).

[4] The income in the 2014 EHIS-ESPS survey comprised the income declared in the survey by the individuals. The income declared in the 2017 SRCV and 2019 EHIS surveys came from fiscal sources. Taking into account the missing values and absence of response are not comparable.

[5] These are shared households and family reunifications, with the exception of the following specific situations: couples with or without children, single-parent families, and persons living alone.

were reflected throughout the territory: 9% of the inhabitants of high-priority urban areas (*Quartiers Prioritaires de la Politique de la Ville*, QPV) had no CHI coverage.

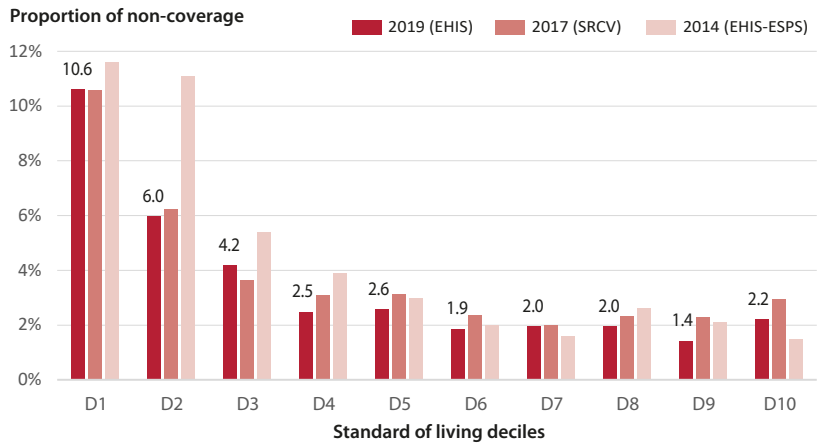
Individuals out of the job market, particularly the unemployed, were most often CHI uninsured

In 2019, three years after the implementation of the employer CHI mandate for private-sector employees and before the introduction of an employer CHI mandate for public-sector employees, 1.5% and 2.5% of private- and public-sector workers respectively was CHI uninsured (see Graph 3). The non-coverage rate of private sector employees was already scarce before the 2016 reform: 3.1% in 2014. In comparison with the individuals who are not affected by these reforms, 3.2% of students were uninsured in 2019, and the same applied to 3.7% of retired persons, 5.5% of self-employed workers, 7.5% of homemakers and other economically inactive persons, and 14% of the unemployed. 16% of the short-term unemployed (under one year) were uninsured and there were 20% among them unemployed for more than one year but under two. After two years of unemployment, the reduction in income as a result of the end of the unemployment benefits meant that some of the unemployed persons were driven into poverty. Therefore, they benefitted most often from the public scheme (CSS), to such an extent that the proportion of uninsured was as low as 7.6%. 13% of the unemployed who were private-sector employees in their last job had no CHI in 2019. 16% of those who had been unemployed for under one year, and potentially eligible for portability[6], were uninsured (21% for those who had

[6] Portability concerns individuals who were unemployed for at least one year and who were last employed in the private sector under the condition that they were of course covered by their company policy, and that they received unemployment benefits. The duration of this portability depended on the length of time they had spent in their former employment and could not be longer than one year. The data provided by the 2019 European Health Interview Survey (EHIS) identified temporarily unemployed individuals who were formerly private-sector employees, but it did not precisely identify those who were eligible for portability.

G2

Percentage of persons without CHI in 2019, in 2017, and 2014 according to the standard of living deciles (income per consumption unit)

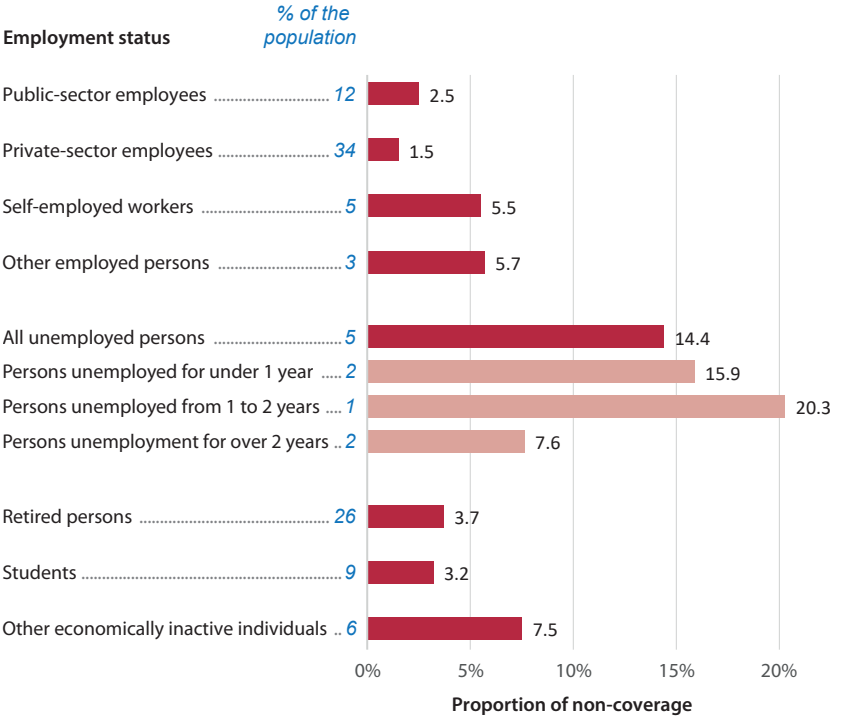


Sources and scope. 2019 : EHIS Survey (DREES-IRDES) matched with income data provided by the General Directorate of Public Finances (DGFiP), population of mainland France aged 15 years and over; 2017: SRCV Survey matched with income data provided by the DGFiP, French population in mainland France aged 15 years and over; 2014: ESPS-EHIS survey, income declared by individuals, French population in mainland France aged 15 years and over who provided information about their income.

Download the data

G3

Percentages of uninsured persons in 2019 according to the employment status of the individuals and whether the individuals were affected or not by the reforms aimed at the generalisation of CHI



Source: The 2019 EHIS (DREES-IRDES).
Scope: Population in mainland France aged 15 years and over.

Download the data

G4

Percentages of non-coverage of health insurance according to the standard of living (income per CU) and employment status

Source: The 2019 EHIS, DREES-IRDES.

Scope: Population in mainland France aged 15 years and over. Only the groups of individuals sufficiently represented in each standard of living quintile are represented: the unemployed, students, and other economically inactive individuals have not been included.

Download the data

been unemployed between one and two years, and 9% for those who had been unemployed for more than two years).

Retired persons face the greatest social inequalities in CHI coverage

Almost 11% of retired persons was uninsured among the poorest retired persons (in the first standard of living quintile) in 2019, compared with 1.2% of the wealthiest (in the last standard of living quintile) [see Graph 4]. Indeed, it is very expensive to take out CHI for retired people, who take out individual policies for which the premiums are based on age and which provide a ratio of benefit versus contribution that is less good than that provided by group insurance (DREES, 2021). Group policies, which apply to a working-age population, provide CHI for a insured in better health status, and benefit, in addition, to the bargaining power and the financial participation of employers.

Among employed persons, whatever their employment status (public- or private-sector employees, self-employed workers, etc.), those in the first standard of living quintile are more often uninsured than the most well-off workers (see Graph 4). Private-sector employees were the least often uninsured in 2019: 4.6% of uninsured persons among the private-sector employees in the first standard of living quintile, compared with 6.8% for public-sector workers and 9.1% for self-employed workers. In addition, the non-coverage of private-sector workers was mainly observed among those in the first standard of living quintile, while the gradient of non-coverage was more marked and more continuous for the other categories of employed individuals and retired persons . All the same, when are insured, the private-sector employees working in the least well-paid activity sectors have, on average, the least generous company policies (Perronnin, 2019).

Administrative complexity increases inequalities in coverage

Individuals who declared having no one they can depend on in case of difficulty were twice as often uninsured than the other persons (8% versus 4%). While some poor uninsured individuals cannot benefit from the public schemes due to threshold effects, these results also raise the issue of individuals who do not apply for them due to the difficulties for some of them to filling out administrative forms that are often complex. 8% of individuals who declared that it is impossible or always difficult to correctly fill out medical forms[7] was uninsured (compared with 4% for the others), while 42% of them were in the first standard of living quintile and 28% of them declared that they were in poor or very poor health (see Table). Hence, administrative difficulties increase inequalities of coverage: 14% of the individuals living in the poorest households (in the first standard of living quintile) was uninsured when they declared always or generally having difficulties with regard to these questionnaires, compared with 8% and 7%, respectively, for those who declare having only few or scarce difficulties.

Less differences in coverage according to gender, age, state of health, and risk preferences

Although, on average, men were slightly more often uninsured than women (4.3% versus 3.1%), they were even more often without CHI when they were in precarious situations: 20% of unemployed men did not have complementary health insurance compared with 8% of unemployed women. This was also the case for 10% of the men in the first standard of living quintile, compared with 6.9% of women (see Graph 5). Men in poor self-perceived health were also more likely than women to have no insurance: 7.5% compared with 3.8%. The same applied to men who lived alone, with or without children: 7.2% and 8.3% of them respectively had no insurance compared with 3% and 3.7% respectively of women in the same situation.

[7] These medical forms are the questionnaires individuals are asked to complete during a hospital admission, at the dentist's, or to take out a loan or insurance.

T

Health insurance, standard of living, self-perceived health, and risk aversion according to the ability of individuals to correctly fill out a medical form

	Complementary health insurance			Income per consumption unit					Self-perceived health			Risk aversion			Total
	Uninsured	CMU-C	Private CHI	Q1	Q2	Q3	Q4	Q5	(Very) good	Quite good	(very) poor	Low	Average	High	Numbers
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	
Correctly completed medical forms*															
Always, generally difficult	8	13	80	42	25	16	10	8	39	33	28	10	39	49	883
Sometimes difficult	5	11	85	30	26	18	16	9	57	27	15	8	55	36	1,506
Always, generally easy	3	5	92	18	20	21	21	20	76	19	5	8	58	34	11,555

*Questionnaires that individuals are asked to complete upon admission to a hospital, at the dentist's, or to take out a loan or insurance.

Source: The 2019 EHIS, DREES-IRDES.

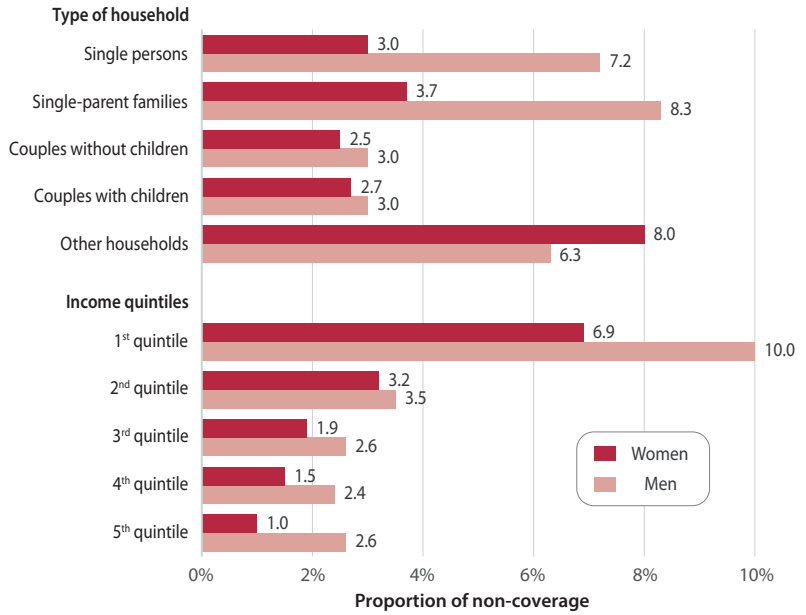
Scope: French population on mainland France aged 15 years and over.

Download the data

Young persons aged between 15 and 24 were more likely to be uninsured (4.6%) and middle-aged individuals (45–54) were least likely uninsured (2.8%). Young persons, who are more often in precarious situations, also have moderate healthcare needs. Their lower coverage may be financially constrained, but also chosen[8]. Non-coverage were most frequent among individuals in poor or very poor health: 5.4% versus 3.4% for those in good or very good health, but this gap disappeared all things being equal, when the economic and social status is taken into account. 4.5% of the least risk averse and 3.8% of the most risk-averse were uninsured, but risk preferences were not more significantly –all things being equal[9]– linked with the non-coverage among the general population, although it was the case before the 2016 employer CHI mandate (Pierre and Jusot, 2017). The recent CHI reforms have made this cover practically obligatory so that individual preferences no longer account for the decision of being CHI insured. Preferences may, however, explain the levels of CHI coverage in individual policies and the decision to take out supplementary health cover in addition to group policies.

G5

Non-coverage rate between men and women according to the standard of living (income per CU) and the household type



Source: The 2019 EHIS, DREES-IRDES.

Scope: Population in mainland France aged 15 years and over. Only the groups of individuals sufficiently represented in each standard of living quintile are represented: the unemployed, students, and other economically inactive individuals have not been included.

Download the data

* * *

In 2019, almost 4% of the population aged 15 years and over in metropolitan France had no CHI. Although noncoverage in the general population is relatively low and continues to gradually decrease, the most precarious individuals, and in particular those in the first standard of living decile, as well as the unemployed and economically inactive individuals, remain more likely uninsured. Hence, the proportion of individuals without CHI was three times higher among the retired persons in the first standard of living quantile (11%), four times among the unemployed (14%), and even six times higher (20%) among persons unemployed for between 12 and 24 months.

[8] A lack of insurance among young persons was more frequent among those who declared less aversion to risk.

[9] The following variables were introduced: age, gender, nationality, employment status, income per consumption unit, nationality, residential region, suffering from a chronic condition, self-perceived health, and risk preferences, organised in the following ways: high, average, or low risk aversion. This is the closets model to that created before the ANI reform by Pierre and Jusot (2017)

While the 2016 employer CHI mandate has resulted –by reducing insurance inequalities among private-sector employees– in a reduction of the non-coverage among the less well-off middle classes, the reform has had no effect on the populations that are more likely to be uninsured: self-employed workers, the long-term unemployed, and economically inactive individuals. It has also led to a decrease in non-coverage by choice, which remains however for student populations. The CHI coverage rate is also particularly high among the least wealthy retired persons, who have to pay high insurance premiums regarding their resources when they do not benefit from the public scheme (CSS), despite the fact that they are the ones who would most to gain from CHI given their health risks, and, in particular, their risk of hospitalisation. Risk segmentation between the individual and group CHI markets and the increase in individual policies premiums are now at the heart of issues relating to access to CHI and will need to be carefully studied, as the CSS, which have merged the two former CHI public schemes (CMU-C and ACS). ♦

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