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Background

According to article L. 863-5 of the Social Security Code, the Fonds CMU "shall provide the Government with an annual assessment of the changes in the price and contents of contracts that provide entitlement to the tax credit", the initial name given to the additional health aid system (ACS). For the purposes of this appraisal, the Fonds CMU has set up a pilot study with a steering committee made up of complementary health-insurance organisations and representatives from their federations, representatives from the DREES and the IRDES. To this end, the IRDES has set up a new complementary health insurance contract classification grid and has undertaken an analysis of the price of contracts depending on the types of guarantee they provide.

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Helping the poor to acquire a complementary health insurance: an initial appraisal of the ACS system

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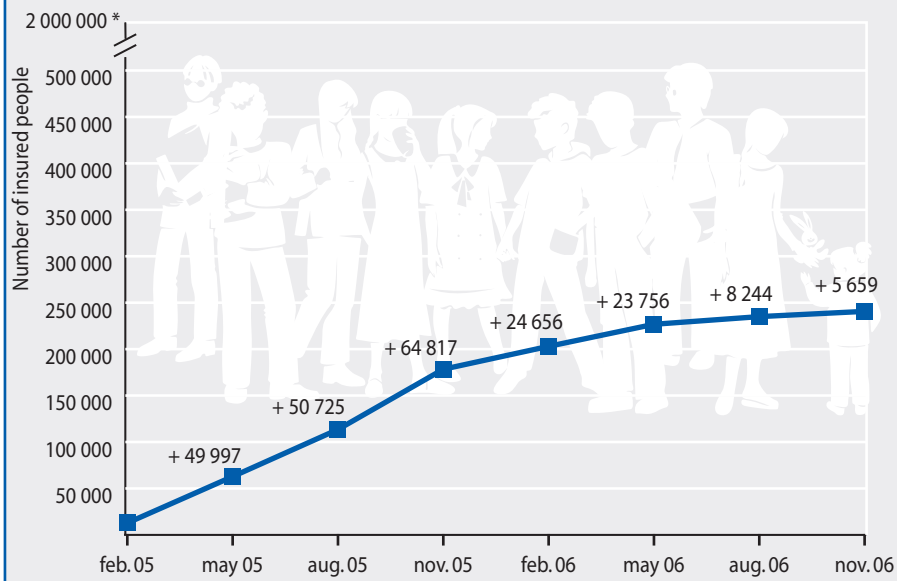
This study is an appraisal of the complementary health insurance acquisition assistance system called Aide complémentaire santé (ACS), first set up in January 2005. The objective of this financial aid is to help people who have an income just below the threshold enabling them to benefit from universal complementary health coverage (CMUC) to obtain complementary health insurance coverage.

Despite a regular increase in uptake, one year after being set up the system concerned only a little over 200,000 people. This result was far below the 2 million people initially targeted by the measure and announced by the government when it was implemented. The analysis of the contents and price of the complementary health insurance contracts demonstrates that subscribing households, even after having benefited from the ACS, are still contributing considerable sums with respect to their total income. The system currently leaves beneficiaries paying almost 60% of the price of the contract, i.e. an average of €389 a year, which represents around 4.5% of their annual income. This is an overhead which is much higher than that borne on average by other insured households, despite the fact that they choose cheaper contracts which therefore offer average or even poor levels of reimbursement for traditionally poorly refunded care such as eye and dental treatment.

Development of the number of beneficiaries of the complementary health insurance acquisition aid system



* Number of people targeted by the system

Source: Fonds CMU-ACS contract survey

The first appraisal report of the Universal Health Insurance Coverage[1] in 2001 underlined the negative impact "of an income threshold which some deem insufficient, in particular with respect to various other basic welfare benefits, such as the basic state pension/invalidity allowance and the allowance for disabled adults; this "threshold effect" acts as a real cut-off point. It was precisely the negative consequences in terms of health care of these threshold effects which led to the creation of a complementary health insurance acquisition aid system in August 2002[2]. This system was only really implemented when it was included in the health insurance reform act of August 2004. Formerly called "tax credit", the system is now called Aide complémentaire santé (ACS) and features in article 56 of the act.

The appraisal of the system, required by law, involves studying its uptake and analysing the features (prices and coverage) of the insurance contracts which entitle the holder to the ACS, by comparing them to all of the other complementary health insurance contracts on the market. The long-term objective is to detect changes in the overall supply that this system might engender. Indeed, this partial funding of the price of insurance may lead some insurance companies to increase their prices.

For the purposes of this initial appraisal, the Fonds CMU has set up a pilot study with a sample of volunteer complementary health insurance organisations, in order to compare the average levels of coverage and prices for contracts that have been taken out by ACS beneficiaries and by other insurance policyholders. This comparison was carried using a contract classification, based on the level of coverage they offer, which was carried out by the IRDES (*cf.* box page 4).

Two million people targeted by this complementary health insurance acquisition system

The ACS was set up because a significant proportion of people still did not have complementary health cover (7% of the population according to a social health protection survey-ESPS 2004) or had extremely poor cover. For these people, often on very low incomes (Allonier *et al.*, 2004), access to health care is not necessarily guaranteed through the public health insurance system. This new aid therefore "aims to remove the remaining obstacles and difficulties faced by many people in accessing health care and health prevention".[3]

When it was set up in early 2005, the ACS was aimed at a total of 2 million people[4]. The eligible population is defined on the basis of residence and income criteria. When it was set up, it was aimed at all those households in a stable and regular residential situation whose income was greater by a maximum of 15% to the resource threshold that entitled individuals to complementary CMU[5] (*cf.* box above). Among them, some already had an individual complementary health insurance contract, 8 people out of 10 according to the ESPS 2004 survey. The financial assistance depends on the age and composition of the household, and is paid directly to the complementary health insurance organisation. It depends neither on the price of the contract, nor, on its content. Therefore any responsible individual contract[6] is eligible for the ACS. On the other hand, group contracts to which the employer makes a contribution are not eligible for the ACS.

The Aide complémentaire santé (ACS) in practice

How it works

By setting up the ACS, the health insurance reform act of August 2004 made it easier to pay for complementary health insurance. When it was set up in January 2005, the system concerned those households residing in a stable and regular fashion in France and whose income was superior by a maximum of 15% to the resource threshold entitling an individual to complementary CMU coverage (this figure was raised to 20% on 1 January 2007). For example, on 1 January 2005, a person living alone whose monthly income was between €587 and €675 could claim ACS. Those eligible for the system apply to their local state health insurance fund (CPAM) for an attestation and then have to choose their complementary health insurance company. Upon receiving the attestation, this company reduces the premium of the insurer's policy by the same amount as the aid provided by the CPAM. This reduction depends on the size of the family and the age of each of the beneficiaries, €75 for each beneficiary under 25 years, €150 between 26 and 59 years old and €250 for beneficiaries over 60 years old. In January 2006, these figures were raised to €100 for a beneficiary under the age of 25 and €400 for a person over 60 years old. In January 2007, the resource threshold was increased, going from a maximum of 15% above the CMUC eligibility threshold, to 20%. The results of this analysis are based on the criteria in force in 2005.

The notion of tax credit

The expression «tax credit» was meaningful in as much as the financial mechanism involved a transfer between the complementary health insurance organisation supplying the contract and the fund financing universal health cover (Fonds CMU): the organisations subtract the total amount of the aid from the contribution it had to pay into the Fonds CMU for the purposes of complementary CMU. It must be recalled that complementary health organisations have to pay an annual contribution of 2.5% (since 2006) of their healthcare related turnover in France.

1 http://www.social.gouv.fr/htm/actu/cmu/sommaire.htm

2 CNAMTS circular 2002: this aid, financed by the organisations' social action funds, was a partial flat rate financing of the premium for the complementary health insurance policy in the form of a purchasing voucher. Eligible individuals had household resources that did not exceed the threshold for the complementary CMU allowance by more than 10%. The minimum eligible contract had to comply to a set of specifications involving the same set of healthcare criteria as the complementary CMU (no probationary period, no age limit, no medical questionnaire). This system suffered from very low take-up levels: only 7431 people benefited from it.

3 *Cf.* On the National Health Insurance website, the objectives of the aid http://www.ameli.fr

4 This figure was reassessed at the end of 2005 by the Commission for the Future of Health Insurance to 1.7 million.

5 The CMUC is a free complementary health insurance cover targeted at people who live in France in a stable and regular fashion and whose income is less than a set amount which depends on the size of the household. In 2005, for a person living alone, this income was €587; this was raised to €598 in 2006.

6 To be deemed responsible a contract must exclude from its refunds the national flat rate participation of one euro and any sums deemed payable by the National Health Insurance for treatment not included in the patient's medical file or carried out without the prior recommendation of the registered GP. It must on the other hand refund, at least in part, services related to health prevention and consultations and prescriptions with the registered GP.

One year on, only 10% of the target population benefits from the system

On 28 February 2006, after being in place for more than one year, the system had only been taken up by around 10% of the target population, a total of 203,000 people. The graph on the first page shows how the number of beneficiaries evolved over the period between February 2005 and November 2006. It shows that ACS take-up was regular but relatively slow.

The distribution of ACS beneficiaries among the various kinds of complementary health insurance organisations is very similar to that of complementary CMU beneficiaries. On 30 November 2005, 76.1% were insured by mutual insurance companies, 20.4% by commercial insurance companies and 3.5% by provident institutions. On the other hand, in terms of the age structure, it would appear that ACS beneficiaries are significantly older: the population is clearly made up of people aged 60 and over (14% as against 4% in the population of complementary CMU beneficiaries) and fewer young people (41% of 16 to 24-year-olds as against 56%).

ACS beneficiaries opt for contracts which provide low to average cover

In order to draw up a classification of contracts according to the level of coverage they provide, the study is based on a sample of the most commonly subscribed packages from 13 complementary health insurance organisations (*cf.* method box page 4). This selection from within the portfolio of contracts provided by insurers does not reflect the diversity of the supply across the complementary health insurance market as a whole. On the other hand, it illustrates the choices made by policyholders by showing how they are broken down into the various different classes that have been defined.

Six classes of contract were defined. They roughly follow a proportional logic: the coverage offered in general increases with the level of the class.

In this six class typology, the contracts entitling holders to the ACS are mainly contracts which offer average to poor guarantees for dental prostheses and eyewear glasses care (for more information on the coverage proposed by the six classes, *cf.* method box). Thus 82.4% of ACS contracts belong to classes 2 and 3, whereas these two classes only include 64.3% of the contracts taken out by other policyholders.

For the purposes of comparison, the CMUC exit contract[7], which is offered for one year to any former beneficiary of the CMUC whose file was managed by a complementary health insurance organisation, belongs to class 4. This contract therefore gives an indication as to the levels of coverage that the public authorities deem necessary to provide adequate access to healthcare. A clear majority of ACS contracts therefore offer levels of reimbursement that on the whole are lower than this.

Despite the aid, the proportion of coverage paid for by system beneficiaries is still high

On the basis of the available data, the average price of contracts taken out by ACS beneficiaries is evaluated at €632. The deduction, the amount of which is dependent on the size of the households in question and the age of each beneficiary, is on average €243. Therefore, the outstanding remaining amount payable by a beneficiary on the price of the contract (€389) represents 60% of the total price. This outstanding remaining amount (ORA), paid by the households, represents around 4.5% of their annual income (determined on the basis of the system eligibility criteria). In comparison, the average amount that non-beneficiary households devote to complementary health insurance is €950 (ESPS, 2004); this sum, which is payable in full by the households, represents 3.5% of the annual average income (€27,500).

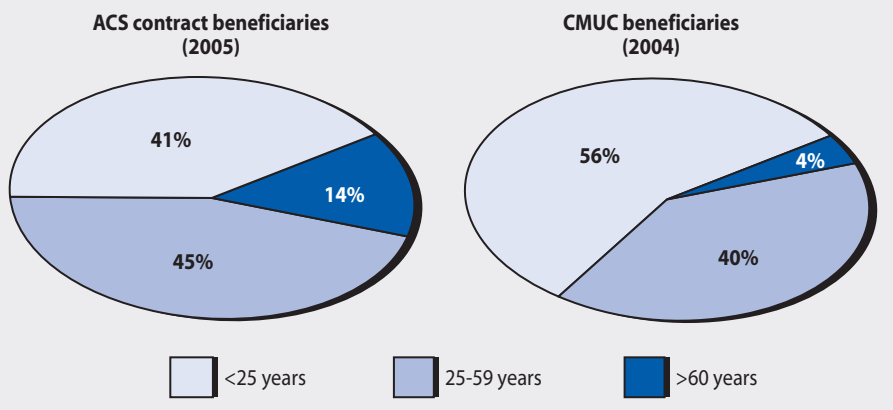
7 This contract provides the same levels of reimbursement as the CMUC, with the difference that health care providers are not obliged to apply conventional tariffs. The price of the contract only depends on the number of people covered. It was €300 in 2005 and €340 in 2007 for a person living alone.

Breakdown of ACS contracts compared to other contracts

Level of coverage	ACS contracts (in %)	The other most heavily subscribed individual contracts in 2005 (in %)
Class 1	0.77%	0.52%
Class 2	40.55%	25.19%
Class 3	41.86%	39.13%
Class 4	13.03%	18.94%
Class 5	3.72%	16.04%
Class 6	0.06%	0.18%
Total	100%	100%

Note: this table was drawn up on the basis of the 20,686 individual contracts for which the level of coverage was known and which were therefore possible to classify.

Comparison by age group between ACS contract beneficiaries and CMUC beneficiaries



Source: Fonds CMU- ACS contract survey

Construction of the contract coverage level classification on the basis of a survey carried out with complementary health insurance organisations

For this initial appraisal, the steering committee brought together by the Fonds CMU decided to carry out an exploratory survey in 2006 on the data from 2005.

This pilot study concerned 13 volunteer complementary health insurance organisations which were selected in order to build up a general contract typology: eight mutual insurance companies, one providential institution and four insurance companies. Taken together, these organisations represent a considerable proportion of the complementary health insurance market (18% of the total turnover).

For the survey, the organisations had to transmit to:

- the list of coverage provided by the five most popular packages taken out by all insured people (ACS or not) or the description of the various options in the case of modular contracts, that is contracts for which the subscriber can choose the level of coverage he wants for each healthcare category;
- for each of these packages, the breakdown between ACS beneficiaries on the one hand and other policyholders on the other;
- for each household insured by the organisation and benefiting from ACS, the contract taken out, the price of the contract as applied to the household, the deduction obtained for the tax credit, the number of beneficiaries and the age of the subscriber.

The analysis was a two-step process:

1-Classification of the contracts

Only those packages for which we had both a list of guarantees and their relative proportion in the portfolio were used for the analysis. Because modular contracts offer a wider range of possible guarantees which lead to them taking up a larger proportion of subscriptions, we selected packages such that they cover around 80% of subscriptions. A total of 75 insurance packages were used to create the classification. Furthermore, 13 packages were placed in highlighted contract groups, because they were among the packages most heavily subscribed by ACS beneficiaries (even if their relative weighting in the organisation's portfolio was low).

To establish the classification, we selected a certain number of guarantees which the steering group deemed particularly significant in assessing the level of coverage provided by the contract;

- reimbursement of hospital fees (medicine, surgery);
- reimbursement of consultations with practitioners;
- reimbursement of drugs only covered at 65% of their value by the social security system;
- complex eyewear glasses guarantees (multifocal or progressive clear lenses, regardless of the power of the cylindrical or spherical correction [-8, + 8];
- dental care coverage (ceramo-metallic dental prosthesis).

We classified the 75 contracts according to the levels of coverage presented above, such that overall logic in the way the guarantees were set out could be seen more clearly. To study this logic more closely, we drew up an ascending hierarchical classification, consolidating the contracts in accordance with the five guarantees set out above. The results of the classification are presented in the table below.

2-Analysis of the amount of premiums before and after deduction of the ACS

The second phase involved analysing the price of the contracts under study, before and after deduction, depending on, among other factors:

- the number of beneficiaries of the contract;
- the age of the policyholder;
- the guarantees on offer (summarised in the form of one of the six classes of coverage).

The complementary insurance organisations that participated in the study transmitted usable data on 25,084 contracts covering 44,921 individuals. Set against the total number of beneficiaries at the date on which the survey was carried out (203,000 beneficiaries), our sample represents almost 22% of the total population.

The average prices of the con-tracts, before and after deduction, were calculated according to the number of beneficiaries, by age bracket and level of coverage; then the variations in contract prices were analysed through linear regression depending on the same variables.

This analysis brought out the individual influence of each explanatory factor. It also highlighted that the factor that best explains the variability of the contracts is the number of beneficiaries, followed by the age and the level of coverage.

Result of the classification: characteristics of the six classes of contract

Contract class	Hospital fees	Walk-in fees	Drug reimbursement	Progressive multifocal lenses	Fixed dental prostheses (as% of the conventional tariff)
Class 1	100%	Below PCCT	Below PCCT	≤ PCCT	≤ PCCT
Class 2	100%	100%	100%	≤ PCCT or from PCCT to €100	≤ PCCT
Class 3	from 100 to 150%	100%	100%	from €100 to €150	from PCCT to 150 %
Class 4	> 150%	from 100% to 150%	100%	from €150 to €230	from 150% to 225%
Class 5	from 100% to 150% or > 150%	from 100% to 150%	100%	from €150 to €230 or >€230	> 225%
Class 6	> 150%	> 150%	100%	> 230 €	from 150% to 225% or more than 225%

Note: Complementary health insurance can refund cost-sharing that are left by public health insurance, i.e patient's contribution on conventional tariff (PCCT) and charges that exceed this tariff.

Reimbursements are expressed in the form of a percentage of the conventional tariff and, for optical care, in euros. The reimbursements for hospital fees, walk-in fees and drug costs include the Social Security reimbursements. Reimbursements for multifocal progressive lenses and fixed dental prostheses are paid in addition to the Social Security refund.

Interpretation guide: class three contracts refund: between 100% and 150% of the conventional tariff (CT) (including Social Security reimbursement) for hospital fees, the patient's contribution (PC) for walk-in fees, from €100 to €150 in addition to the Social Security refund for the reference eye care and an amount between the patient's contribution and 150% of the CT for the reference dental care.

The proportion of the contract price paid by the household decreases as the number of contract beneficiaries increases

On average, each ACS contract cover 1.8 people; 69% of these contracts only cover a single person, 10% two people and 21% three people or more.

The number of people covered is a major explanatory factor behind the disparity in contract prices. The price of the contract increases more slowly as the number of people it covers increases, going on average from €513 for a single person covered to €719 for two people (an increase of 56%), to €837 for three people (+31%) and up to €1,264 when the number of people covered is greater than or equal to seven. From the sixth beneficiary onwards, the increase in contract price is negligible, at around 2%.

Alongside this, the total deduction applied to the contract increases automatically along with the number of beneficiaries as the respective ages of the members of the household increase. For example, from five beneficiaries upwards, the cost of any additional person is more than offset by the additional deduction applicable to him; the proportion of the contract price payable by the policyholder is therefore reduced. However, this only concerns 12% of policyholders.

All in all, the benefits offered by the ACS are greater as the size of the household increases and the system is therefore particularly advantageous to families with many children.

Price and outstanding remaining amount on an ACS contract according to the number of beneficiaries

Number of beneficiaries	Average price of the contract (€)	Change in contract price	Average outstanding remaining amount (ORA)	change in average ORA	Average rate of ORA
1	€513	-	€334	-	62%
2	€719	56%	€447	51%	59%
3	€837	31%	€511	32%	58%
4	€968	16%	€ 556	8%	54%
5	€1069	9%	€563	0%	49%
6	€1144	2%	€555	-9%	45%
7 or more	€1264	2%	€ 530	-19%	38%

Source: Fonds CMU-ACS contract survey

* All of the contracts are taken into account thanks to an "all other things being equal" analysis, a statistical method that enables the number of beneficiaries per contract and policyholder age to be taken into account.

Interpretation guide: contracts covering 2 beneficiaries cost €719 on average, i.e. 56% more than a contract covering one person. After the ACS has been deducted, the outstanding remaining amount payable by the insured is €447, which represents 59% of the initial price, i.e. 51% more than the outstanding remaining amount payable by a single insured person.

Price and outstanding remaining amount on an ACS contract according policyholder age

Age of policyholder	Average price of the contract (€)	Change in contact price*	Average outstanding remaining amount (oh a)	Change in average ORA*	Average rate of ORA
16-24 years	€288	-	€212	-	+70%
25-29 years	€346	+19%	€200	-7%	+54%
30-39 years	€385	+11%	€235	+22%	+58%
40-49 years	€445	+14%	€295	+26%	+64%
50-59 years	€500	+18%	€350	+29%	+67%
60 or more	€667	+40%	€420	+28%	+59%

Source: Fonds CMU-ACS contract survey

* All of the contracts are taken into account thanks to an "all other things being equal" analysis, a statistical method that enables the number of beneficiaries per contract and policyholder age to be taken into account.

Interpretation guide: contracts covering a person who belongs to the 25 to 29 age bracket cost on average €346, i.e. 19% more than a contract covering a person aged between 16 and 24. After the ACS has been deducted, the outstanding remaining amount payable by the insured is €200, which represents 54% of the initial price, i.e. 7% less than the outstanding remaining amount payable by a younger insured person (16 to 24 years).

The average remaining amount increases along with the age of the policyholder

In this survey, only the age of the policyholder of the contract was used. Therefore, in order to analyse the effect of age on the price of the contract accurately, the study is limited to those contracts that cover a single person, which represent 69% of ACS contracts.

The majority of the policyholders of these contracts are people aged over 50: 24% are between 50 and 59 years old and 35% are aged 60 or more. The respective proportions of policyholders belonging to the 30-39 year and 40-49 year age brackets are 14% and 17%. People under the age of 30 are considerably less represented (10%).

The average price of the contract increases regularly with the age of the policyholder, going from €288 among the 16 to 24 year olds to €667 for people aged 60 or more. The average outstanding remaining amount goes from €212 for 16 to 24-year-olds to €420 for those aged over 60. While the ACS is beneficial to every age group, the benefit depends on age. When given as a percentage of the price of the contract, the average outstanding remaining amount (ORA) rate after deduction is highest for the 16 to 24-year-olds (70%) and the 50 to 59-year-olds (67%). It is lowest for the 25 to 29-year-olds (54%). For those aged 60 and more, this outstanding remaining amount is 59%.

This non-linear progression of the deduction effect is a reflection of the threshold effects introduced by the three age brackets defined by the system. The outstanding remaining amounts on the contract prices, which on average are lower for the 25 to 29-year-olds than for the 16 to 24-year-olds, can be explained by the sudden rise in the deduction between these two age brackets. The outstanding remaining amount then the increases at a relatively constant rate (from +22% to +29% every 10 years). After the age of 60, the price of contracts increases greatly (+40%).

This increase is offset, to a large extent, by the deduction provided for in the scheme for this age group. Nevertheless this oldest group has to pay 59% of the price of their contract[8].

The outstanding remaining amount varies irregularly according to contract coverage

The prices of contracts increase along with the levels of coverage they provide. The average prices of contracts covering a single person run from €392 for class 1 contracts to €862 for class 6 contracts (see box). The price increase is not, however, regular (see table) and cannot be directly interpreted. This is because there is considerable variation in the guarantees between classes and moving from one class to a higher class may represent a very strong or a very small disparity in terms of coverage. Furthermore, we observe a decrease in the average price of contracts between class 3 and class 4, which may be explained by the specific nature of class 4: this category includes CMU exit contracts, the price of which is determined by law, and contracts subscribed by people benefiting from the specific Alsace Moselle system[9].

Prices after deduction follow the same trend. The average outstanding amount goes from €156, i.e. 33% of the price, when the contract in question belongs to class 1, to €621, i.e. 72% of the price, when the contract in question belongs to class 6. The variations are greater than those we observe on the price before deduction. This can be explained by the fact that the amount of the deduction is independent of the level of coverage provided by the contract.

The Aide complémentaire santé (ACS) is independent of the class a contract chosen. For a given age and number of beneficiaries, the deduction is identical regardless of the level of coverage provided. The impact is therefore stronger when coverage levels are lower and the price is therefore less high; the ORA rate is significantly lower for class one contracts.

* * *

While the take-up of the ACS scheme has been regular since it began in January 2005, it would be very difficult to talk about takeoff. Only 10% of the target population has joined up. One possible explanation is that the outstanding remaining amount to pay for contracts is still relatively high with regard to the income of eligible households, at 4.5% of annual income as against 3.5% on average for households holding an individual contract (ESPS, 2004). This outstanding remaining amount is particularly high for people living alone, people under the age of 25, and people whose state of health requires a complementary health insurance contract that provides high levels of coverage in particular in eyewear glasses and/or dental prostheses.

The amount of the deduction was re-assessed in 2006, going from €75 to €100 for the under 25's, from €150 to €200 for the 25 to 60 year-olds and from €250 to €400 for the over 60s. At the same time, a scheme was set up whereby patients did not have to advance the costs for medical fees refundable by Social Security, providing that the patients adhered to a parcours de soin (consultation with the GP before consultation with any specialist). However, these measures do not seem to have had the desired accelerating effect, and the growth in the number of ACS beneficiaries even seems to have been slowing down since the beginning of 2006, as the graph on page 1 shows.

On the basis of this observation, the Ministry met with all the partners involved in the ACS scheme in order to look at any communication actions that needed to be set up in order to publicise the scheme better. It was decided to improve targeting and intensify communication operations. In particular, the complementary health insurance organisations were asked to improve access to information on the allowance and its renewal, and on patients' rights to deductions. These measures are crucial given than the target population is due to increase to 3 million individuals, with the CMU thresholds and therefore automatically the ACS thresholds being increased on the one hand, and secondly with the fact that the ACS is now accessible to people whose income does not exceed 20% of the CMU threshold.

Price and outstanding remaining amount on an ACS contract according to level of coverage

Class	Average price of the contract (€)	Change in contact price*	Average outstanding remaining amount (oh a)	Change in average ORA*	Average rate of ORA
1	€392	-	€156	-	+33%
2	€470	+58%	€287	+125%	+59%
3	€542	+25%	€367	+45%	+66%
4	€486	- 2%	€312	-8%	+59%
5	€550	+9%	€394	+17%	+68%
6	€862	+12%	€621	+21%	+72%

Source : Fonds CMU-ACS contract survey

* All of the contracts are taken into account thanks to an "all other things being equal" analysis, a statistical method that enables the number of beneficiaries per contract and policyholder age to be taken into account.

Interpretation guide: class 2 contracts covering a single person cost an average of €470 which, all other things being equal, is 58% more than a contract covering a single person belonging to class 1. After the ACS has been deducted, the outstanding remaining amount payable by the insured is €287, which represents 59% of the initial price, i.e. 125% more than the outstanding remaining amount payable by a class1 contract holder.

Further information

Franc C., Perronnin M. (2006). Note de l'IRDES sur la classification des contrats de couverture complémentaire. In « *Évolution du prix et du contenu des contrats ouvrant droit au crédit d'impôt* ». Rapport au gouvernement, 2006, pp. 39-53.

Allonier *et al.* (2004), *Enquête santé et protection sociale, ESPS 2004*. Rapport IRDES.

8 Recall that the analysis is carried out on the basis of ACS packages available in 2005, before the re-evaluation that was carried out in 2006.

9 The patients' contributions required by the Alsace-Moselle state health insurance scheme are lower than for other areas of the country, which means that the amounts refunded by the complementary health organisations are also lower.