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Complementary Health Insurance in France in 2006: Access is Still Unequal

Results of the 2006 French Health, Health Care and Insurance Survey (ESPS 2006*)

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In 2006, more than 9 out of 10 people in France reported being covered by complementary health insurance. Of those not covered, more than one in two reported financial difficulties. Access to complementary health insurance therefore remains difficult and expensive for low income households and, indeed, these households declare the lowest rate of coverage. On the contrary, households with the highest incomes, especially those of managers, benefit from easier access to complementary insurance due to higher financial resources and more frequent access to group health insurance contracts.

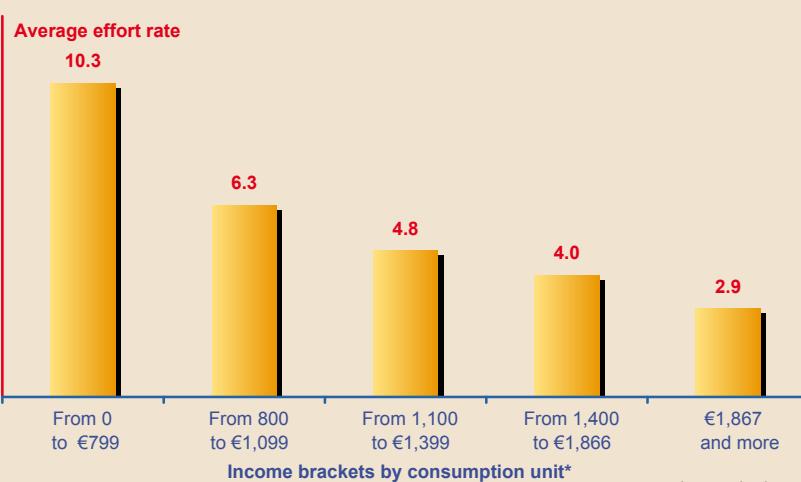
For the first time, the data of the French Health, Health Care and Insurance Survey (ESPS*) have been used to calculate the effort rate, i.e. the share of income that households devote to complementary insurance coverage. This effort rate varies from 3% for the wealthiest households to 10% for the poorest (excepting the beneficiaries of supplementary universal health insurance*). However, in spite of an effort rate three times higher, the contracts covering the poorest households provide lower levels of guarantee on average than the contracts of the wealthiest households.

In addition, for 14% of the population the lack of complementary coverage was a major factor for foregoing healthcare for financial reasons in 2006.

In France more than 20% of healthcare and medical products expenditure are paid by patients, the rest being reimbursed by Health Insurance. Complementary health insurance providers finance more than half patients' out-of-pocket payments. In the end, nearly 9% of health expenditure is supported by the patients. Although optional, supplementary health coverage has become a key factor in access to healthcare, especially that least well reimbursed by the mandatory Health Insurance, namely dental prostheses, optical and specialist care in case of consultations with extra-statutory fees. The essential role played by complementary health insurance in healthcare access was confirmed by the introduction, on 1 January 2000, of universal supplementary health insurance (CMU-C), providing free supplementary coverage for persons with low financial resources. As for households with incomes slightly higher than the income cut-off for CMU-C, they have been able to benefit since 2005 from the complementary health insurance acquisition system (ACS)¹, which takes the form of a voucher that significantly reduces the cost of supplementary health insurance.

The specific questioning of the 2006 ESPS survey, which specifically addresses the topic of the surveyed households' supplementary health insurance cover, permits to update the overall data on access by beneficiaries to supplementary health insurance, in relation to

Average effort rate for the purchase
of complementary health insurance, according to income



Source: IRDES - Data: ESPS 2006

* See box Method, page 3.

¹ Recently renamed «Chèque Santé» (health cheque).

their socioeconomic characteristics (Allonier *et al.*, 2008).

More than 9 out of 10 people are covered by complementary health insurance

According to the ESPS survey, nearly 93% of the French population report having complementary health insurance, 4% of them being covered by universal supplementary health insurance (CMU-C). The ESPS survey nonetheless underestimates the proportion of CMU-C beneficiaries since, according to ministerial statistics, the coverage rate of metropolitan France's population was 7.5% in 2006. This underestimation is due to the under-representation of those the most exposed to economic fragility, which is common to surveys in general population. In order to obtain a survey sample large enough to carry out specific studies on CMU-C beneficiaries, an additional sample of the latter (1,700 people) was interviewed in 2006. This sample has not been taken into account in this analysis.

Managers have access to complementary group contracts more often than workers

More than half of working people's complementary health insurance contracts (excluding CMU-C) are taken out through companies (61%). Households of managerial staff are by far the most frequent beneficiaries of group contracts: 77% of contracts taken out by them are group policies *versus* 54% for unskilled workers and 44% for the households of shop employees.

Employers generally sponsor an average of 50% of group contracts' premiums (Couffinhal *et al.*, 2004), amounting to a substantial payment in kind for the employees². Beneficiaries' appreciation is made evident by comparing the price/quality ratio of, respectively, group contracts and individual contracts: 84% of group contracts beneficiaries think they enjoy a good price/quality ratio (including 23% very good) *versus* nearly 78% for contracts taken out individually (of which 11% feel they are very good).

² Furthermore, these policies are exempted of social and tax charges.

B ACKGROUND...

The French Health, Health Care and Insurance Survey (ESPS*) carried out by IRDES every two years on the general population draws up a table of the health status, healthcare consumption and health insurance in France.

It comprises in particular specific questions on the supplementary health insurance policies taken out by the households surveyed.

By linking these data with socio-demographic characteristics and respondents' health status, the ESPS provides a unique source of information on complementary health insurance.

It permits the creation of a global view of access to supplementary health insurance coverage and the level of guarantees in the policies. Thus, it forms a relatively complete triptych of the topic alongside the survey on company supplementary health insurance carried out by IRDES and the DREES survey on supplementary health insurance companies.

A greater financial effort for modest and elderly households

For the first time, the weight of a complementary health insurance contract in the household budget has been studied in the ESPS survey (Kambia-Chopin *et al.*, 2008). This burden, known as effort rate, corresponds to the share of household income devoted to purchasing a complementary health insurance contract. It should be pointed out that effort rate could only be evaluated for beneficiaries of an individual contract, i.e. a contract not taken out through a company. Indeed, it is more difficult to collect data pertaining to group contracts as employees do not always know the amount of their premium, which is often deducted directly from their salary. We have also excluded CMU-C beneficiaries as they do not have to pay for their complementary health insurance.

Consequently, when focusing solely on individual contracts, households' effort rate increases substantially when income decreases. It is 2.9% for the wealthiest households and increases progressively to reach 10.3% for the poorest households. Although the poorest households' effort rate is high, the sums they devote to purchasing complementary health insurance are less than those spent by better-off households. Therefore in spite of making greater financial efforts, the poorest



SOURCES

Presentation of the ESPS survey

Survey objectives

Since 1988, the French Health, Health Care and Insurance Survey (ESPS*) has questioned Metropolitan France's residents on their health status, their use of health services and their health insurance cover. Due its frequency, the scope of its questions and their longitudinal dimension, it participates in evaluating health policies, monitoring public health problems in the overall population and it is useful in assisting research in health economics and social sciences. The specific characteristic of ESPS is that it is based on a single survey, composed of a sample of persons covered by Health Insurance. This procedure permits in particular matching survey data with those taken from the service files of the Health Insurance administrations, thereby providing more accurate knowledge of healthcare consumption in terms of volume and expense.

The sampling mode guarantees constant representativeness of the French metropolitan population through time. Thus it not only permits taking regular snapshots of health and access to healthcare and supplementary insurance, it also permits monitoring individual itineraries.

New questions and the first results of the 2006 survey

In 2006, the ESPS survey questioned 8 000 households and 22 000 individuals. Besides a standard socio-demographic module (age, sex, household composition, socio-professional category, income, occupation, education), it includes highly detailed information on state of health, the patient's experience of the healthcare system, supplementary health insurance coverage and other aspects of socioeconomic status. New questions have been incorporated for respondents relating to the reform of attending physician, respiratory health, living conditions during childhood and the state of parents' health.

The first results of the 2006 ESPS survey are presented in a report, along with an initial evaluation of the Preferred Doctor reform and an analysis of the weight of household out-of-pocket expenditure on individual supplementary health insurance coverage. A full presentation of this report is available on the IRDES website:

www.irdes.fr/EspaceRecherche/BiblioResumeEtSommaire/2008/rap1701.htm



Source: IRDES - Data: ESPS 2006

households take out contracts with lower guarantees on average than those taken out by the wealthier households.

Effort rate varies considerably according to householder professional category: it is more than 6% of income for shop employees and unskilled workers *versus* less than 4% for managers and the intellectual professions (*cf.* chart below).

Furthermore, the older the householder, the more the amount of the premium represents a financial effort. The effort rate is 7.1% for households whose head is older than 65, and more than 3.2% when they are less than 30. Elderly persons with greater healthcare needs devote a large share of their income to purchasing supplementary benefit.

Absence of complementary coverage mainly depends on the level of income and social status

In 2006, more than 7% of French residents declared that they did not benefit from complementary health coverage. The rate of non-beneficiaries varies according to age. Although it is low at the beginning of life (about 6% up to 19 years old), it increases for the 20-29 age group (11%), then lowers with age from 30 to 60 years old (about 5% from 50 to 59 years old), and then increases (12% for 80 years old and older). However, the rate of non-coverage by complementary health insurance is most affected by social situation, especially income. Indeed 14.4% of persons living in households with less than €800 per month have no complementary coverage. This rate falls regularly as income increases. This rate is only 3% for the wealthiest households (those with a monthly income per consumption unit higher than €1,867). These results confirm the decisive role of income in access to complementary health coverage (Marical, de Saint Pol, 2007).

Similar differences can be seen according to social status. Fewer than 5% of persons living in a household whose reference person is a manager are not covered, whereas this proportion is about 15% in households of shop employees and unskilled workers. This difference results not only from lower financial resources, but also from less access to complementary group contracts (Francesconi *et al.*, 2006).

With 18% of persons not covered, the unemployed form the group for which access to complementary health insurance is the most

difficult. In addition to the difficulty caused by their weak financial resources, they are unable to benefit from a group contract³.

More generally, financial reasons are the main motive given by more than half of those concerned (53%) to explain the lack of private supplementary health insurance. The other reasons given are good health (17%) or, on the contrary, the fact of benefiting from 100% coverage in the case of protracted illnesses (14%).

³ It should be noted that although the unemployed do not have access to group contracts, in the framework of the Evin law of 31 December 1989 and under certain conditions, they can benefit from the extension of the contract they had through their last employer. Nonetheless this situation is not widespread, in most cases, only employees actually working in the company are covered by its group contract.



Income per consumption unit

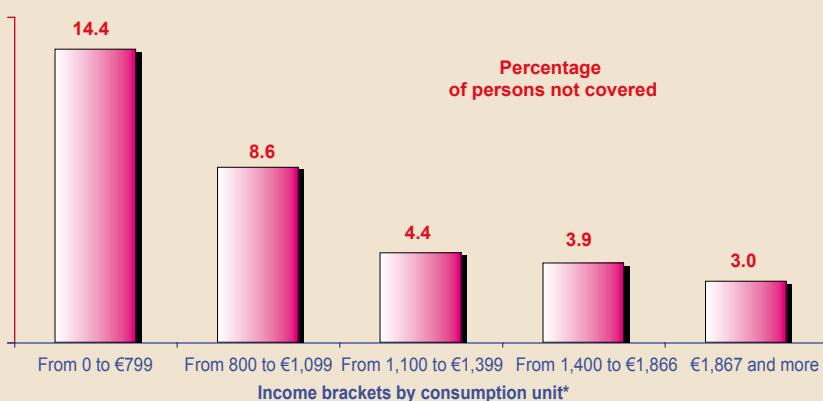
By using a scale of equivalence, the income per consumption unit (CU) permits comparing the living standards of households of different sizes and compositions.

We use the OECD scale which applies the following weighting:

- 1 UC for the first adult of the household;
- 0.5 UC for the other persons of 14 or older;
- 0.3 UC for children under 14.

Example : a household composed of a father, mother, child of 16 and another of 12 has a UC of 2.3 (1+0.5+0.5+0.3). The household income per UC is equal to the total household income divided by 2.3.

Proportion of persons without complementary health coverage according to income by consumption unit



Source: IRDES - Data: ESPS 2006

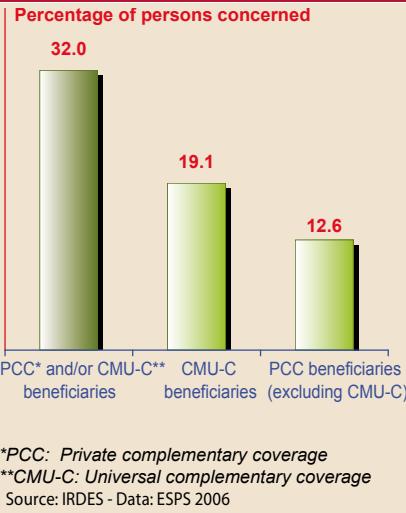
14.4% of people from households whose income per consumption unit (CU) is lower than €800 are not covered by complementary health insurance. This rate of non-coverage may appear high due to the presence of beneficiaries of universal supplementary health coverage (CMU-C*) in this income bracket. However, as the income cut-off for being eligible to universal health insurance coverage is quite low (about €600 by CU), only 16% of people whose income per CU is lower than €800 benefit from it. In addition, a certain number of potential CMU-C beneficiaries do not claim their rights and do not have any complementary health coverage.

The lack of complementary health insurance is a major cause of abandoning healthcare

In 2006, one person in seven in metropolitan France declared they had renounced healthcare for financial reasons in the twelve months preceding the survey. Nearly one renouncement in five is declared as definitive, as the others are postponed. Renouncements (and postponements) mainly concern a limited number of health services, those for which the share remaining to be paid by those covered is the highest. Of the people declaring they had abandoned healthcare, 63% mentioned dental care, 25% spectacles and 16% specialist care.

Not having a complementary insurance is a major factor of renouncement: 32% of not-covered declared they had renounced healthcare, versus 19% of universal complementary health coverage (CMU-C*) beneficiaries and 13% of private scheme beneficiaries (excluding CMU-C). The rate of renouncement also varies according to household income (24% for the first income bracket versus 7.4% for the last) and according to social status: the households of shop employees, administrative employees and unskilled workers are those who declare having renounced most (respectively 21%, 19% and 19%); whereas managers and farmers renounce least (respectively 9% and 5.4%).

Rates of renouncement to health care according to type of complementary health coverage



In spite of the existence of universal supplementary health insurance (CMUC-C) in the one hand, and of an income-tested subsidy for the purchase of a complementary insurance (ACS) in the other hand, access to complementary health coverage remains expensive for modest households in France. The introduction of new medical deductibles since January 2008 may lead to a greater burden on household budgets. Benefiting from complementary health insurance will therefore increasingly become an asset in seeking healthcare. A large number of studies have been planned at IRDES to analyse the position of complementary health insurance in our current health system. These works include monitoring the increased use of ACS, and the analysis of the position of complementary group contracts in employees' salaries, on the basis of a new survey carried out among employees at the end of 2008. New questions in the 2008 ESPS survey should also provide better knowledge, by 2010, on the application of the Evin Law of 1989, which requires complementary health insurance providers to extend group contracts to employees leaving for retirement or who are dismissed.

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GLOSSARY

- French Health, Health Care and Insurance Survey (ESPS): Enquête Santé et protection sociale (ESPS)
- **Effort rate:** taux d'effort
- **Universal Complementary Health Insurance (CMU-C):** Couverture maladie universelle (CMU-C)
- **Complementary health insurance acquisition system (ACS):** Aide à l'acquisition d'une complémentaire santé
- **Medical deductibles:** franchises médicales
- **Consumption unit:** unité de consommation



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