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## Take-up Rate of a Subsidising Scheme for Acquiring a Complementary Health Insurance in France: Key Findings from a Social Experiment in Lille

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The subsidising scheme for acquiring a complementary health insurance (ACS), introduced in 2005, aimed at targeting households with an income level situated just above the eligibility threshold for Universal Complementary Health Insurance (CMU-C). Even if the number of beneficiaries has slowly progressed, ACS take-up rates remain low. In order to understand the underlying motives behind poor take-up, a social experiment was carried out in Lille among a sample of statutory National Health Insurance (NHI) beneficiaries potentially eligible for ACS in terms of income.

The results of this experiment show that increasing the subsidy slightly improves ACS take-up and allows a better targeting of eligible households. They equally confirm the complexity of the ACS scheme and its poor performance in targeting its designated population: only 17% of NHI beneficiaries included in the experiment applied for ACS. Moreover, only 9% of beneficiaries invited to attend an information briefing on the ACS scheme did so, and for the others, the invitation proved to be more a source of discouragement than an incentive. Finally, only 55% of ACS applicants were effectively entitled to the voucher, notably because incomes were above the eligibility threshold. This high level of uncertainty regarding eligibility to the scheme is undoubtedly an additional obstacle in an already complex application process.

**H**ealth expenditures are only partially covered by the French Social Security system and access to care is partly dependant on the possession of complementary health insurance (Perronnin *et al.*, 2011; Jusot and Wittwer, 2009; Boisguérin *et al.*, 2010). So as to limit the financial barriers restricting low-income households' access to care, the public authorities instituted the Complementary Universal Health Coverage (CMU C) in 1999 offering the

poorest households the right to free complementary health insurance (Definitions insert).

The problem of poor households whose income was slightly above the CMU-C cut-off rapidly became apparent. The ACS scheme was introduced on January 1<sup>st</sup> 2005 (Law of August 13<sup>th</sup> 2004) as an incentive for low-income households to acquire good quality complementary health insurance (CHI), but also to finan-

cially compensate those that had already purchased a policy. In January 2009, ACS eligibility concerned households whose income level was situated between the CMU-C threshold and 20% above this

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threshold. In practice, eligible households can apply for ACS at their local branch of the National Health Insurance (CPAM) to benefit from the 'health voucher' (Definitions insert). On purchasing a contract the CHI company deducts the voucher amount from the total cost of the contract. This is only valid for private contracts and does not apply to employer-provided CHI.

The population targeted for ACS was estimated at around 2.2 million individuals in 2007 (Hcaam, 2007). Even if the number of effective ACS beneficiaries has slowly progressed since its introduction, the take-up rate nevertheless remains low. At the end of 2008, 596,626 attestations of eligibility had been delivered by local CPAM branches and of these, only 441,948 beneficiaries had effectively pur-

chased CHI (CMU Fund, 2011). This reality is all the more surprising in that a large majority of NHI beneficiaries entitled to ACS are actually covered by a private CHI policy and as such could benefit from a reduction in the cost of their contract.

In order to understand the motives underlying the failure to apply for ACS and to test possible modifications to the scheme that could improve the take-up rate, a social experiment was set up by Paris-Dauphine University in January 2009 among 4,209 NHI beneficiaries registered at the Lille-Douai CPAM. In terms of income, all were potentially eligible for ACS, already received benefits from the Lille Family Benefits Fund (CAF) but had not exercised their rights to ACS at this date.

### Understanding the low ACS take-up rate by means of a social experiment

This controlled social experiment was set up in order to test the two main hypotheses put forward to explain low ACS take-up rates. The first suggests a lack of information on the very existence of the ACS scheme, the way it works or the application process involved. This is the main theory explaining the low take-up rate among individuals already covered by a private CHI contract.

The second hypothesis suggests that the financial aid provided in the form of an annual lump-sum voucher is insufficient: even after deducting the amount from the total cost of a contract, CHI remains too expensive for numerous households. In effect, prior to setting up the experiment, the voucher covered approximately 50% of the average cost of a CHI contract (CMU Fund, 2008); before deduction, CHI premiums could represent 8 to 10% of a low-income household's disposable income (Grignon, Kambia-Chopin, 2010; Jusot *et al.*, 2011; Perronnin *et al.*, 2011).

To test both hypotheses, three groups were randomly constituted from the 4,209 NHI beneficiaries participating in the experiment; a control group and two treatment groups (Methods insert). Each participant was sent a letter of information on ACS with a slightly different proposal for each group. The control group (1,394 beneficiaries) received a letter of information proposing the standard voucher amount in force at the time; the second group (treated group 1) equally received a letter of information on ACS but with an increased voucher amount (1,412 beneficiaries) and the third group (treated group 2), in addition to the same increase in the voucher amount, were invited to attend an information briefing on the ACS scheme. The voucher increase (treated groups 1 and 2) represented a 62.5% to 75% increase of the standard voucher amount in force at the time according to age group (Methods insert). The information briefings (treated group 2) were conducted prior to indivi-

## DEFINITIONS

### The CMU-C and ACS\*

The **Universal Complementary Health Insurance (CMU-C)** was instituted by the Law of July 27<sup>th</sup> 1999. This means-tested scheme gives the poorest households the right of access to free complementary health insurance. On January 1<sup>st</sup> 2009, households with an annual income inferior to 7,447€ in metropolitan France were eligible (the income threshold was increased to 7,611€ on January 1<sup>st</sup> 2011). Eligibility is calculated on the basis of twelve months income prior to application. On December 31<sup>st</sup> 2009, 4,173,817 individuals benefitted from the scheme.

The **Complementary Health Insurance Subsidy (Aide complémentaire santé - ACS)** was instituted by the Law of August 13<sup>th</sup> 2004. On January 1<sup>st</sup> 2009, it applied to households with an annual income ranging between 7,447 and 8,936€, in other words between the CMU-C threshold and up to 20% above this threshold. Calculation of income level is based on the twelve month period prior to application. The income threshold for ACS eligibility has increased considerably since its introduction. Until January 1<sup>st</sup> 2007 it was fixed at 15% above the CMU-C threshold rising to 26% since January 1<sup>st</sup> 2011 with a further increase to 30% planned for January 1<sup>st</sup> 2012.

After an application has been examined by the CPAM concerned, an eligible household receives financial aid in the form of a lump-sum voucher (*chèque santé*) that can be exchanged as part payment for a private CHI contract from any Complementary Health Insurance company (individuals benefitting from employer-provided CHI are not eligible for ACS). Applications must be renewed each year.

The subsidy, or voucher amount, varies according to the beneficiary's age. It was increased considerably on August 1<sup>st</sup> 2009 and the age brackets reviewed. The table below shows the subsidy scales in force between January 1<sup>st</sup> 2009 and January 1<sup>st</sup> 2010, that is to say during the period the social experiment was conducted. For information, the CMU Fund established the average annual cost of a CHI contract subscribed to by ACS beneficiaries (those that have used their voucher) at 764€ in 2009 (CMU Fund, 2010).

ACS subsidy scales in force on January 1<sup>st</sup> 2009 and 2010

Subsidies in force on January 1 <sup>st</sup> 2009		Subsidies in force on January 1 <sup>st</sup> 2010	
Under 25 years old	100€	Under 16 years old	100€
25-59 years old	200€	16-49 years old	200€
60 and above	400€	50-59 years old	350€
		60 and above	500€

\* For further details, cf. CMU Fund web site, <http://www.fonds-cmu.fr/>

## CONTEXT

This social experiment on ACS (Aide complémentaire santé) was initiated by the Paris-Dauphine University Laboratory for the Economics and Management of Health Organisations (Leda-Legos) in collaboration with IRDES. Its realization was made possible through the support of the National Health Insurance Fund for Salaried Workers (CNAMTS), the Lille-Douai branch of the Health Insurance Fund (CPAM), the Lille Child Benefit Fund (CAF) and the North-Picardie Regional Health Insurance Fund (CRAM). Financial support was provided by the High Commissioner for Active Solidarity against Poverty (Ministry of Youth and Active Solidarity) within the framework of the 2008 call for social experimentation projects and that of the Allianz Risk Foundation Health, Risks and Insurance Chair.

duals' application for ACS. Whatever the group, an ACS application form, to be returned to the Lille-Douai CPAM, was included.

Application forms received by the CPAM and the vouchers effectively granted were monitored for six consecutive months following the start of the experiment. This permitted an evaluation of the different letters of information in terms of their impact on ACS take-up rates within each

group. To test the impact of increasing the voucher amount, the number of returned applications and the percentage of effective attestations of eligibility delivered were then compared between the control group and treated group 1. The same indicators were then compared for treated groups 1 and 2 to test the effect of inviting participants to an information briefing.

### A 10% increase in the voucher amount results in a 2% increase in the probability of applying for ACS

Participants' reactions are first of all measured by the number of application forms returned to the Lille CPAM. Of the 4,209 NHI beneficiaries involved, only 701 returned applications forms were monitored giving a fairly modest take-up rate of 17% (table 1).

Reading of table 1 permits the comparison of application return rates by group. 16% of the control group returned a completed ACS application form (222 applications). The take-up rate in treated group 1, who benefitted from the increased voucher amount, was higher than in the control group<sup>1</sup>, 19% applications. The increase

<sup>1</sup> At 5% significance threshold.

in the financial aid thus appears to have a positive, though limited, impact on the probability of take-up. This impact can be measured by the elasticity of the probability<sup>2</sup> of returning a completed application form in relation to the financial aid proposed. This indicator accounts for NHI beneficiaries' sensitivity to the voucher amount and shows that a 10% increase in the subsidy results in a 2% increase in the probability of completing and returning an application form.

### A voucher increase allows the more precise targeting of NHI beneficiaries effectively eligible for ACS

Beyond the rate of completed application forms, and within the experimental framework, one can also question the percentage of individuals effectively entitled to ACS since a number of appli-

<sup>2</sup> This elasticity is calculated as the relationship between the growth rate of the probability of completing an application between the control group and treated group 1 on the one hand, and the voucher amount growth rate between the national standard and the increased voucher amount for individuals aged under 59 (this rate being slightly lower than for individuals aged 60 and over). It is established at 0.22.

**T1** Number and return rate of completed ACS application forms, by group of NHI beneficiaries (the insured)

	Number of insured included in the experiment	Completed ACS application		
		Number	Percentage of applications in relation to the number of individuals in the group	Confidence intervals at 95%
Control group	1,394	222	15.9%	(14.0%; 17.8%)
Treatment group 1	1,412	262	18.6%	(16.5%; 20.6%)
Treatment group 2	1,403	217	15.5%	(13.6%; 17.4%)
Of which with briefing <sup>a</sup>	125	35	28.0%	(20.0%; 36.0%)
Without briefing <sup>a</sup>	1,278	182	14.2%	(12.3%; 16.2%)
<b>Total</b>	<b>4,209</b>	<b>701</b>	<b>16.7%</b>	<b>(15.5 %; 17.8%)</b>

<sup>a</sup> The insured in Group 2 were respectively divided into 2 groups 'with briefing' and 'without briefing' according to whether they attended an ACS information briefing.

**Reading guide** (top line). Among the 1,394 insured in the control group, 222 (15.9%) returned a completed ACS application form.

**Source:** Paris-Dauphine data on the ACS experiment in collaboration with the Lille-Douai CPAM.

cations were refused. In total, 55% of returned applications were in fact eligible for ACS (table 2), 10% were eligible for CMU-C but not ACS (in cases where household income was below the minimum ACS threshold) and 35% were refused because their income levels were too high (table 3). Among the 4,209 beneficiaries included in the experiment, 9% were effectively eligible for ACS, 2% for CMU-C, 6% were refused both ACS and CMU C, and 83% failed to apply.

A comparison of the number of ACS allocations according to group gives similar results to those obtained in comparisons between returned applications. The gap between the control group and treated group 1, however, is considerably accentuated. The rate of ACS allocations in relation to the number of participants is 11% in treated group 1 against 8% in the control group (table 2). Similarly, the number of ACS allocations in relation to the number of completed applications

is 58% in treated group 1 against only 50% in the control group (table 2).

The exceptional financial aid offered to the individuals in treated groups 1 and 2 appears to have more successfully targeted eligible beneficiaries, that is to say the poorest individuals in the experiment sample, since the rate of refusals due to income levels above the eligibility threshold is much lower in treated groups 1 and 2 than in the control group (table 3).

T2

## Notification of eligibility for ACS, by group of insured

	Notification of eligibility for ACS						
	Number of insured included in the study	Number of completed applications for ACS	Number	Percentage of notifications delivered in relation to the number of insured in the group	Confidence interval at 95%	Percentage of notifications delivered in relation to the number of completed applications in the groupe	Confidence interval at 95%
Control group	1,394	222	110	7.9%	(6.5%; 9.3%)	49.6%	(42.9%; 56.2%)
Treated group 1	1,412	262	152	10.8%	(9.1%; 12.4%)	58.0%	(52.0%; 64.0%)
Treated group 2	1,403	217	125	8.9%	(7.4%; 10.4%)	57.6%	(51.0%; 64.2%)
Of which with briefing <sup>a</sup>	125	35	22	17.6%	(10.8%; 24.4%)	62.9%	(46.0%; 79.6%)
Without briefing <sup>a</sup>	1,278	182	103	8.1%	(6.6%; 9.6%)	56.6%	(49.3%; 63.9%)
<b>Total</b>	<b>4,209</b>	<b>701</b>	<b>387</b>	<b>9.2%</b>	<b>(8.3%; 10.1%)</b>	<b>55.2%</b>	<b>(51.5%; 58.9%)</b>

<sup>a</sup> The insured in Group 2 were respectively divided into 2 groups 'with briefing' and 'without briefing' according to whether they attended an ACS information briefing.

**Reading guide** (top line). Among the 1,394 insured in the control group, 110 obtained ACS; that is 7.9% of the application forms originally sent and 49.6% of completed applications.

**Source:** Paris-Dauphine data on the ACS experiment in collaboration with the Lille-Douai CPAM.

T3

## Motives behind the refusal of ACS, by group of insured

	Resources below the ACS eligibility threshold giving rights to CMU-C					Resources above the ACS eligibility threshold		
	Number of insured included in the study	Number of completed ACS applications	Number	Percentage of CMU-C granted in relation to the number of insured in the group	Percentage of CMU-C granted in relation to the number of completed applications in the group	Number	Percentage of ACS refusals in relation to the number of insured in the group	Percentage of refusals in relation to the number of completed applications in the group
Control group	1,394	222	25	1.8%	11.3%	87	6.2%	39.2%
Treated group 1	1,412	262	25	1.8%	9.5%	85	6.0%	32.4%
Treated group 2	1,403	217	21	1.5%	9.7%	71	5.1%	32.7%
Of which With briefing <sup>a</sup>	125	35	2	1.6%	5.7%	11	8.8%	31.4%
Without briefing <sup>a</sup>	1,278	182	19	1.5%	10.4%	60	4.7%	33.0%
<b>Total</b>	<b>4,209</b>	<b>701</b>	<b>71</b>	<b>1.7%</b>	<b>10.1%</b>	<b>241</b>	<b>5.8%</b>	<b>34.7%</b>

<sup>a</sup> The insured in Group 2 were respectively divided into 2 groups 'with briefing' and 'without briefing' according to whether they attended an ACS information briefing.

**Reading guide** (top line). Among the 1,394 insured in the control group, 25 obtained the right to CMU-C as their incomes were below the ACS eligibility threshold, that is to say 1.8% of the group and 11.3% of completed ACS applications.

**Source:** Paris-Dauphine data on the ACS experiment in collaboration with the Lille-Douai CPAM.

### The invitation to an information briefing appears to impede ACS take-up but active participation in the briefing has a positive impact

The rate of returned applications was 15.5% among treated group 2 whose members received an invitation to an information briefing as well as a voucher increase. This rate is slightly lower than that for the control group, but not significantly. On the contrary, the rate is significantly lower in treated group 2<sup>3</sup>. Somewhat unexpectedly, the invitation to the briefing appears to have impeded take-up thus cancelling out the positive effect of the voucher increase.

This result, however, needs clarifying with regards to the attendance rate for the briefing. Among the 1,403 beneficiaries in

<sup>3</sup> At 5% significance threshold.

T4

#### Probability of attending an ACS information briefing (treated group 2)

	Odds-ratios
<b>Working conditions</b>	
Age	1.14 ***
Age <sup>2</sup>	0.99 ***
Female	0.84
<b>Insurance scheme</b>	
<i>Employed</i>	<i>Ref.</i>
Disability	0.62
Retirement	0.61
Unemployed	0.84
Child under 3 on insurance	1.55
CMU-C in 2007	0.94
CHI in 2008	0.63 **
Long-term illness in 2008	1.88 **
<b>Ambulatory care expenditures in 2008</b>	
Below 200€	0.60 *
Between 200 and 700€	0.47 **
Between 700 and 2,000€	1.00
<i>Above or equal to 2,000€</i>	<i>Ref.</i>
N	1,403

Significance threshold: \* 10%; \*\* 5%; \*\*\* 1%.

Source: Paris-Dauphine data on the ACS experiment in collaboration with the Lille-Douai CPAM.

treatment group 2, only 125 attended the information briefing to which they were invited (9%). Of these, 35 completed and returned an ACS application form. The take-up rate is thus 28% of the NHI beneficiaries that attended the briefing. On the contrary, among the 1,278 beneficiaries in treatment group 2 that did not attend the briefing, the take-up rate was only 14%.

These results could lead to the conclusion that on the one hand, the information briefing had a positive impact on the ACS take-up rate among those that participated and on the other, that among those that failed to attend the briefing, some were under the impression that attendance was obligatory prior to application and as a result failed to apply because they had missed the briefing.

An analysis of the factors determining briefing attendance reveals that attendees have a specific profile: they are in the upper age brackets, more frequently benefit from 100% NHI coverage within the framework of a long-term chronic illness<sup>4</sup>, are not covered by CHI at the beginning of the experiment and had higher health expenditures in 2008 (table 4). One could thus ask whether this higher take-up rate is not more to do with profile rather than the fact of having attended the briefing.

In order to answer this question, data matching methods<sup>5</sup> were used to confirm the effectiveness of the information briefing: participants' rate of application for ACS is 10 to 12 percentage points higher. This shows that having attended the briefing significantly increases the probability of returning a completed application form whatever the beneficiaries' observable characteristics.

This demonstration is nevertheless insufficient as the available variables do not perfectly characterise the individuals concerned. They evidently differ in many other ways, some of which can explain

<sup>4</sup> Copy editor's note: ALD scheme (Prise en charge à 100% pour une affection de longue durée).

<sup>5</sup> The principle involved comparing the rates of returned applications between the 2 sub-groups (those that had attended the briefing and those that had not) with the closest observable characteristics among individuals that had attended. For further details see Guthmuller *et al.* (2010).

their propensity to both attend the briefing and complete an application form, such as the level of importance they attach to their health. In other words, it is possible that the positive effect on the take-up rate attributed to attending the briefing is in reality due to unobserved variables. Currently available data is insufficient to allow further investigation of this possibility.

### A scheme that fails to reach its target population, notably due to its complexity

This social experiment notably demonstrates the difficulty of setting up an information campaign regarding the ACS scheme that in the end, fails to reach its target population.

Despite the postal information campaign targeting all NHI beneficiaries potentially eligible to ACS, less than one out of five individuals returned a completed application form (17% return rate). Another troubling factor is that application return rates and individuals' sensitivity to the amount of financial aid proposed are very similar among NHI beneficiaries already covered by CHI (66% of the sample) and individuals not previously covered by CHI (33%)<sup>6</sup>. Yet, ACS is presented as a windfall for individuals having already purchased a CHI contract<sup>7</sup> and from whom one could have expected a massive take-up rate, more especially with the voucher increase. Finally, within treated group 2, only 9% of individuals invited to the briefing actually participated.

These results immediately question the number of letters that actually reached the

<sup>6</sup> In effect, the return rate for applications among individuals already covered by CHI is 16% in the control group and 19% in treated group 1 against 15% and 18% respectively among individuals without CHI coverage; these differences are not significant. Similarly, we observe not difference in the elasticity between take-up rate and voucher amount according to CHI coverage (0.23 for individuals initially covered by CHI against 0.21 for those not covered).

<sup>7</sup> It should nonetheless be reminded that individuals covered by employer-provided CHI are not eligible for ACS. However, taking into account the social characteristics of the population targeted by ACS, this ineligibility criteria cannot alone explain the very low ACS take-up rate among individuals initially covered by CHI.

individuals concerned. The actual figure is unknown but a percentage of undelivered letters due to address change is a possibility despite the files being transmitted by the Lille-Douai CPAM and the Lille Family Benefits Fund)<sup>8</sup>, espe-

<sup>8</sup> CE's note: Caisse d'allocations familiales, CAF.

cially since mobility is closely correlated to precariousness.

It also illustrates the difficulty facing a CPAM in adequately communicating on the existence of a scheme and the administrative procedures involved in order to benefit from it. The low success rate of

the postal information campaign and the complexity of the ACS scheme undoubtedly require setting up a means of providing direct information on a one-to-one basis. At the same time, our results showed that the invitation to participate in an information briefing held at the CPAM site discouraged certain beneficia-

## METHOD

### The Paris-Dauphine ACS experiment at the Lille-Douai CPAM

#### Context

This social experiment conducted by Paris-Dauphine University was implemented at the Lille-Douai CPAM as, before the experiment was set up, it offered a specific service for NHI beneficiaries applying for CMU-C that were in fact entitled to ACS. During the course of an information briefing to which they were invited, they were proposed an increased voucher amount on the purchase of CHI. Financed by the Social Aid Fund, this specific aid was thus aimed at improving ACS take-up rates but did not concern all the population eligible for ACS. Only individuals that had previously applied for CMU-C, had been refused on the income criteria and had effectively attended the information briefing to which they had been invited were entitled to benefit from this offer. In January 2009, the Lille-Douai CPAM accepted to implement an experiment based on their previous practices. This social experiment aimed at testing the impact of a general increase in the ACS subsidy amongst a population sample entitled to this increase and to conduct information briefings.

#### Selection of the population to be included in the experiment

Launched in January 2009, the experiment relied on the national postal information campaign launched in 2008 to inform NHI beneficiaries of the ACS scheme, organised at local level by each CPAM. All potentially eligible NHI beneficiaries attached to the Lille-Douai CPAM were identified at the end of 2008 on the basis of 2007 resources entitling them to family allowance benefits from the Lille Family Benefits Fund<sup>1</sup> in 2008. This was achieved with the aid of a computer search query originally conceived by the Grenoble Observatory on non take-up of social rights and public services (ODENORE) (Revil, 2008). 4,209 individuals were randomly selected to participate in the experiment among the NHI beneficiaries potentially eligible for ACS attached to Lille-Douai CPAM that had not taken up their rights at the end of 2008.

#### Experiment design

The 4,209 NHI beneficiaries selected were randomly divided into three groups. Individuals in the first group (1,394 insured), corresponding to the control group received a letter by post\* (end of January 2009) informing them of the National ACS scheme in force on that date; individuals in the second group (1,412 insured), corresponding to the first treated group (treated group 1), received the same type of letter (beginning of February 2009) stipulating an increase in the voucher amount; individuals in the third group (1,403 insured), corresponding to the second group treated (treated group 2), received by post (in February/March 2009) the same offer as the previous group plus an invitation to attend an information briefing to be held at Lille-Douai CPAM, formalised by a second letter sent the following week. The voucher increase represented a 62.5% to 75% increase on the national subsidy in force according to age group. The financial aid proposed to each age group is presented in the table below<sup>\*\*</sup>.

Equally enclosed in the letters sent by the Lille-Douai CPAM was an application form for ACS that potentially eligible persons were invited to return for

\* CE's note: Caisse d'allocations familiales, CAF.

\*\* Les montants de la majoration correspondent à ceux de l'aide exceptionnelle qui était accordée par la CPAM de Lille-Douai, ce qui explique le caractère non homogène du taux de majoration. La majoration du chèque était proposée pour une durée de deux ans, le montant de l'aide supplémentaire étant diminué de 50 % la deuxième année.

Amount of financial aid (ACS) offered within the framework of the experiment

	Control group	Treated groups 1 and 2
Under 25 years old	100	175
25 to 59 years old	200	350
60 and over	400	650

effective eligibility assessment. In effect, the files provided by the CAF only permitted targeting the population susceptible of being eligible for ACS without guaranteeing their effective eligibility since, as indicated previously, the CAF files were based on 2007 income levels whereas ACS eligibility is based on the twelve months income prior to application.

#### Information briefings

Information briefings were held before applications were assessed by the CPAM. Around a dozen briefings were organised from February to April 2009, at a rhythm of two per week on Thursday and Saturday mornings. This is why letters to the second treated group were sent in successive waves over a two month period so as to manage the flow of households that had responded positively to the invitation to attend a briefing.

These briefings were aimed at informing NHI beneficiaries on the ACS scheme and the formalities required to benefit from it. They were conducted by a social worker hired specifically for the job, and were observed by an anthropologist.

#### Experiment data collection

The return of application forms to the CPAM and notifications of entitlement to ACS were observed between January 21<sup>st</sup> (date on which the first wave of letters was sent) and July 30<sup>th</sup> 2009 (experiment end date) by the Lille-Douai CPAM benefits department<sup>\*\*\*</sup>. Data collected by the CPAM provides information on each NHI beneficiary included in the experiment sample: the experiment group they belong to; whether an ACS application form has been returned to the CPAM or not; if after assessment they were notified of their entitlement to ACS by the CPAM; in the case of refusal, whether it was due to above-threshold resources or on the contrary below-threshold resources entitling them to CMU-C. Finally, for the insured in treated group 2, information briefing attendance was also recorded.

#### Experiment data matched with Lille-Douai administrative data

These data were then matched with CPAM administrative data containing information on the age, gender, the NHI scheme on 31<sup>st</sup> December 2008 (employed, retired, unemployed, disability pension beneficiary, Disable Adult's Allowance or pension, Long-term Illness scheme beneficiary), ambulatory care expenditures in 2008, status concerning CHI before the beginning of the experiment and CMU-C beneficiaries in 2007. These complementary data notably enabled a check on whether the randomly constituted experimental groups resulted in a similar distribution of observable variables (see Wittwer *et al.*, 2010; Guthmuller *et al.*, 2010 and 2011).

\*\*\* Voir Wittwer *et al.* (2010) pour plus d'informations sur le personnel mobilisé à la CPAM de Lille pour la mise en œuvre pratique de l'expérimentation et une analyse qualitative de leur opinion sur l'expérimentation.

ries from applying. This certainly legitimates the idea of using third party organisations (associations, mutual benefit organisations, social workers...) to diffuse the information (Chauveaud and Warin, 2009).

Moreover, only 55% of the application forms returned to the Lille-Douai CPAM received notification of eligibility for ACS, which resulted in only 9% of NHI beneficiaries included in the experiment actually obtaining ACS. This refusal rate is inordinately high for a population pre-selected in terms of income level and their rights to family allowance benefits. This is an essential factor to take into account. The cost of procedures to be undertaken by potentially eligible individuals is certainly reinforced by the low probability of their being successful. This is common to all means-tested schemes but particularly reinforced in the case of ACS given the complexity of eligibility criteria and the narrowness of the target in terms of standard of living.

These intuitions are confirmed by the qualitative analysis conducted to collect information on the needs and expectations of individuals targeted by ACS. It involved on the one hand, observations conducted during the information briefings and on the other, in-depth interviews with potential beneficiaries some of whom had attended the information briefing (insert opposite; for a detailed presentation see Wittwer *et al.* 2010

\* \* \*

The choice of conducting a controlled experiment on a realistic scheme, implemented *in vivo*, provides a pragmatic view of policies aimed at improving access to ACS. The difficulties involved in setting up a social experiment and its high costs explain its limitation to a single site and 4,209 NHI beneficiaries. The population studied is thus only representative of the population potentially eligible for ACS in Lille; a population that undoubtedly has its specific characteristics. Similarly, the effectiveness of the proposed modifications to the ACS scheme is dependant on the institution that initiates them and the relationship it has with its NHI bene-

## Qualitative analysis

### Needs and expectations of persons potentially eligible for ACS

In addition to the quantitative analysis of individuals' take-up of ACS and attendance at an information briefing, a qualitative analysis was equally conducted. It contributed in collecting data on the needs and expectations of individuals targeted by ACS using two complementary methods: observations carried out during some of the information briefings and in-depth interviews with potential ACS beneficiaries, some of whom attended the briefing (see Wittwer *et al.* 2010, for a detailed presentation).

Two types of profile were identified among individuals that attended the briefing:

1. Individuals who grasped the information provided and self-assessed their eligibility for ACS:
  - certain were able to make this assertion during the course of the briefing and in consequence did not return an application form.
2. Individuals that had difficulty understanding the scheme and the application process:
  - the briefing did not dissipate their difficulties: certain individuals undoubtedly need individual assistance (the social worker was not in a position to do so during the briefing);
  - this does not presume that application forms were not submitted since certain individuals in this case sought assistance from a social worker or a CPAM receptionist as revealed by the subsequent interviews;
  - others abandoned the procedures.

These factors reveal that beyond the information concerning the existence of the ACS scheme, its complexity together with related administrative

procedures discourages a percentage of eligible individuals. The ACS is a complex scheme. An essential prerequisite to understanding the interest of the scheme is an understanding of the social protection system and its different modes of health care expenditure reimbursement (by the Statutory Health Insurance scheme and the complementary health insurance companies).

In addition, the application process is effectuated in two phases: first, the application for ACS completed and returned to the CPAM (equivalent to an application for CMU-C). Second, the choice of a CHI, that assumes being able to make that choice in an abundant and competitive market offering contracts with different guarantee levels, difficult to interpret notably by part of the population that has difficulty with administrative and *a fortiori* insurance terminology. In addition, this choice must take into account future health care needs that are not always easy to evaluate.

The observations carried out during the briefings equally reveal one of the scheme's obstacles; the difficulty understanding administrative terminology. Numerous individuals thus attended the briefing without really understanding its purpose. Some participants believed they had been summoned, whilst others were eager to gain information and not miss an opportunity to 'exercise a right to financial aid', without necessarily grasping the exact nature of this aid. Postal communications between the CPAM and its users thus remains problematic for this fringe of the population and constitutes an obstacle to the widespread diffusion of the information.

ficiaries, especially in the lower income bracket. Nothing goes to say that the same experiment conducted with a similar population would have given the same results in another CPAM. Finally, as with all experiments, it is limited in time. It does not allow the observation of the eventual long-term repercussions of increasing the voucher amount associated with the slow diffusion of information.

This experiment shows that increasing the voucher amount slightly improves the ACS take-up rate and better targets effectively eligible populations. One can thus assume that the increase in the standard amount of financial aid instituted on January 1<sup>st</sup> 2010 will have a positive impact on the ACS take-up rate among eligible individuals aged 50 and over (Definitions insert). As this national increase is lower than that proposed within the framework of our experiment, one can expect the impact to be consi-

derably lower. This experiment equally suggests that the core reason behind the poor take-up rate is not the cost of complementary health insurance but more the lack of access to information concerning the scheme and the complexity of the application process. It nevertheless equally shows the difficulty of reaching a target population by means of a postal information campaign such as that implemented at national level in 2008-2009, and the counter-productive nature of the invitation to an information briefing. Finally, it suggests that the uncertainty surrounding the eligibility factor aggravates the low ACS take-up rate. In view of this, extending the target population on January 1<sup>st</sup> 2011 (Definitions insert) may be a first step in encouraging ACS take-up. The policies tested here nevertheless have a modest impact that would not resolve the problem and other forms of intervention and alternative policies no doubt need to be envisaged. ♦

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## A CRONYMS

- [ACS] Aide à l'acquisition d'une complémentaire santé: 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)
- [CPAM] Caisse primaire d'Assurance maladie: Local branch of the National Health Insurance
- [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)