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Explaining the Non-take-up of a French Health Insurance Vouchers Program (*Aide à l'acquisition d'une complémentaire santé*, ACS)

Results of a Survey Conducted in 2009 among Potential Beneficiaries in Lille

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The Health Insurance Vouchers Scheme (*Aide à l'acquisition d'une complémentaire santé* (ACS)) was introduced in 2005 as a financial incentive to help poor individuals obtain complementary health coverage and as a means of improving access to health care. This financial support is entitled for households with income just above the eligibility threshold for the free Complementary Universal Health Coverage (*Couverture maladie universelle complémentaire* (CMU-C)). Despite an increase in the number of beneficiaries since its introduction, the non-take-up of ACS entitlements remains high; only 22% of eligible persons had claimed the allowance in 2011 (CMU Fund, 2012). In this context, it is essential to understand the reasons for non-take-up in order to improve the scheme's efficiency and allow low income households access to complementary health insurance. To this effect, and as a follow-up to a social experiment, a survey was conducted in Lille in 2009 among individuals potentially eligible for ACS so as to gain a better understanding of their characteristics and determine motivations or barriers to using the scheme.

The results of this survey showed that the sample population identified in Lille as being entitled to ACS were confronted with both socio-economic difficulties and important health care needs. The ACS take-up rate was low with only 18% of respondents having taken steps to obtain it. The reasons most frequently evoked for non-take-up were: ineligibility, lack of information, the complexity of procedures, and the cost of complementary health insurance for persons without coverage even after deducting the value of the "health voucher".

Widespread access to complementary health insurance (CHI) is a core factor in the National Health Strategic Plan announced on September 13th 2013 by the Minister for Health, Marisol Touraine. The National Health Insurance covers on average 75.5% of health expenditures but only 63% of routine care, reimbursements essentially concerning hospital expenditures and those of the 15% of the population suffering from a long-term illness

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Health Insurance Vouchers Scheme (*Aide à l'acquisition d'une complémentaire santé*, ACS)

The Health Insurance Vouchers Scheme (ACS) introduced on January 1st 2005 provides financial assistance in the purchase of individual CHI contracts referred to as "accountable" contracts only. It addresses households with monthly incomes up to 35% over the Universal Complementary Insurance scheme (CMU-C) eligibility threshold in 2014 (between 716 € and 967 € per month for a single person) and the amount granted varies according to the age of the person covered by the contract*.

A year after its introduction, the ACS scheme registered 200,000 beneficiaries whereas the number of potential beneficiaries initially estimated by the government was about 2 million individuals. The number of beneficiaries has since increased, and at the beginning of this study in December 2008, registered slightly under 600,000 beneficiaries. Despite this increase, the non-take-up rate for ACS remains high: over 80% at the end of 2008 according to CMU Fund estimates (2009). According to the latest estimates provided by the INES micro-simulation model (INSEE-Social Studies), the rate is evaluated at 78% for the ACS in 2011 (CMU Fund, 2012).

For further information, see the CMU Fund web site: http://www.cmu.fr

* Since its introduction in 2005, the scope of eligible individuals and the amount of voucher provided has been revised several times.

CONTEXT

This study is based on a survey conducted as a follow-up to a social experiment initiated by the PSL, *Université Paris Dauphine* at the *Laboratoire d'économie et gestion des organisations de santé* (Leda-Legos) in collaboration with IRDES and was firstly published in 2011 (Guthmuller *et al.*, 2011; Guthmuller *et al.*, 2014). The survey was financially supported by the *Haut Commissariat aux Solidarités actives contre la pauvreté*(Office of the High Commissioner for Active Solidarity against Poverty) within the framework of a call for social experimentation projects in 2008, the Health Chair, a joint initiative by PSL, Université Paris Dauphine, ENSAE and MGEN under the aegis of the Fondation du Risque (Risk Foundation) and the CMU Fund. Both the survey and social experiment would have been impossible without the help of the National Health Insurance Fund for Salaried Workers (CNAMTS), the *Caisse primaire d'assurance maladie* (CPAM) of Lille-Douai (local health insurance branch), the Lille Family Allowance Fund (*Caisse d'allocations familiales* (CAF)) and the North-Picardy Regional Health Insurance Fund (*Caisse régionale d'assurance maladie*, CRAM). The findings of the survey data resulted in a report for the CMU Fund (Guthmuller *et al.*, 2013).

(LTI) [Bras and Tabuteau, 2012]. The lack of CHI coverage and the resulting out-of-pocket (OOP) payments constitute a major barrier to the use of health care services, in particular for the poorest households. Numerous studies have underlined that low-income households have greater difficulties in accessing health care in France in comparison with other European countries, particularly in terms of preventive and specialist care, and the role played by CHI (Dourgnon *et al.*, 2012a; Jusot *et al.*, 2012; Jusot, 2013; Devaux, 2013).

Several schemes entitled to low-income households have been introduced to favour widespread access to CHI (Jusot *et al.*, 2012). Since 2000, the Complementary Universal Health Coverage scheme (*Couverture maladie universelle complémentaire*, CMU-C), offers free CHI to households with an income level below 716 euros per month for a single person (5% of the population); since 2005, the Health Insurance Vouchers Scheme (*Aide à l'acquisition d'une complémentaire santé*, ACS) aims to improve access to CHI for households with incomes at the margin of the CMU-C eligibility threshold (insert). It consists in providing financial assistance to lower the cost of the annual premium for a privately purchased CHI policy. If the CMU-C has effectively reduced the rate of unmet care needs for financial reasons among the poorest populations (Dourgnon *et al.*, 2012b), the ACS scheme has had a more mitigated success due to the low take-up rate. According to the latest estimates (INSEE-Social Studies), only 22% of households entitled to ACS had claimed the allowance in 2011 (CMU Fund, 2012).

The non-take-up of ACS constitutes a barrier to the generalisation of complementary health insurance coverage in France, financial reasons being the main reason evoked for non-take-up. Despite a rapid decrease in the number of persons without CHI coverage over the last 5 years, 4% of the individuals are still without coverage today despite the fact that the majority would be entitled to ACS (Dourgnon *et al.*, 2012a). In addition, two thirds of individuals failing to claim their entitlement are in fact covered by a privately subscribed CHI policy. As such, they would be entitled to fully benefit from ACS, which would allow them either to lower the cost of their CHI contract or improve the quality of their coverage level.

In this context, understanding the non-take-up of ACS is essential to improve the scheme's efficiency and allow low income households access to CHI. Three factors can explain foregone aid: lack of knowledge of the program; failure to claim, either by choice because the voucher is not sufficiently advantageous (the purchase of CHI remains expensive for numerous households even after deducting the value of the health voucher), or under constraint (discouragement one faced with complex procedures or fear of stigmatisation); or non-collection: one completes the application procedure but does not receive the voucher (Odenore, 2012). These factors also depend on social and cultural environments that may create barriers to individuals' ability to gather the information required to apply for a benefit. The decision to apply for social benefits varies according to individual characteristics (Remler *et al.*, 2001). There may be "triggering factors" such as a sudden drop in income or the deterioration of health status (van Oorschot, 1991). Such factors can be pertinent to explain the non-take-up of a health insurance scheme such as the ACS as the costs time wise required in applying for it (seeking information on the scheme and its eligibility criteria, completing and returning the forms, gathering the necessary supporting documents…) are immediate whereas the benefits of CHI coverage may be situated in the future, that is to say when a health problem occurs (Remler *et al.*, 2001).

In order to gain knowledge of the characteristics of individuals eligible for ACS and the determinants conditioning the take-up or non-take-up of this program, a specific survey was conducted in September 2009 among low income individuals in the city of Lille, identified as potentially eligible for ACS in view of their 2007 declared income transmitted to the Family Allowance Fund (*Caisse d'allocations*

familiales, CAF) in 2008 (Method and Context insert). This survey was conducted as a follow-up to a social experiment aimed at testing the impact of modifications to the ACS scheme on potential beneficiaries (Guthmuller *et al.*, 2011; Guthmuller *et al.*, 2014). The aim of the survey was to further and complete this analysis by profiling potential ACS beneficiaries and studying their motivations in applying for ACS and inversely, persistent barriers. Studies on the population of potential ACS beneficiaries cannot be conducted using general population survey results as the ACS target population sample size is too limited.

What are the characteristics of potential ACS beneficiaries?

The characteristics presented are those from a sample of 1,038 potential ACS beneficiaries in Lille aged 18 and over interviewed in September 2009. They were compared with the characteristics of 2008 IRDES Health, Health Care and Insurance Survey (ESPS, 2008) respondents aged 18 and over, available in the 2010 survey report. The aim of this comparison was to underline the socio-economic and health specificities of potential ACS beneficiaries in relation to the general population. Certain differences can nevertheless be related to survey sampling methods using CAF beneficiary records and to the specific characteristics of survey respondents. However, the diversity of targeted benefits guaranteed the heterogeneity of the targeted population in terms of age group (minimum old-age pension, Adult Disability Allowance, etc.). Finally, the survey concerned individuals identified as potentially eligible for ACS on the basis of 2007 declared income held by the CAF at the time of the survey. The examination of 2008 resources registered in CAF records after the survey showed that part of sample had finally proved ineligible for ACS.

A population confronted with social and economic difficulties

The average age of survey respondents was 45.5 years old (46.8 in the 2008 ESPS) and 45% of the sample were men. We noted certain specificities in terms of family situation: single persons were largely over-represented in relation to the general population (25.8% against 19.0% in ESPS 2008), and more particularly women (18.2% against 11.1%). This was also the case for couples with children (54.4% against 40.7%), whereas couples without children, seniors for the most part (10.1% against 29.1 %), were under-represented, and single-parent families very marginally over-represented (9.7% against 8.2%).

The majority of working-age respondents were in employment and in a proportion comparable with that observed

Method

Survey conducted among the eligible population registered with the CPAM of Lille-Douai

Context

This study is based on a sample of 4 209 health insurance beneficiaries registered with the Lille-Douai local health insurance fund (CPAM) that had participated in a social experiment in 2009 (Guthmuller *et al.*, 2011; Guthmuller *et al.*, 2014). It concerned health insurance beneficiaries identified as potentially eligible for ACS (the Health Insurance Vouchers Scheme) within the framework of a national information campaign on the ACS scheme launched in 2008, based on 2007 declared income entitling them to benefits delivered by the Lille CAF (Family Allowance Fund) in 2008. The analysis presented here is essentially based on beneficiaries' responses to a survey conducted as a follow-up to the social experiment in September 2009 in order to collect information on social characteristics, health status, use of health care services and complementary health insurance coverage as well as subjective reasons for the non-take-up of ACS.

The survey

Among the 4,209 health insurance beneficiaries that participated in the social experiment, only the individuals living in an ordinary household (outside institutions), with a fixed or mobile telephone number, neither under guardianship nor curatorship, were retained. Among the 3,249 individuals making up the survey's reference population, only 1,449 interviews were conducted. This loss of numbers is primarily due to the number of individuals who could not be reached after several attempts, wrong numbers and, to a lesser extent, refusals to participate in the survey, abandonments during the course of the survey and difficulties mastering or understanding French. To these conventional stumbling blocks a final reason for exclusion can be added a posteriori: the fact of benefiting from the Complementary Universal Health Coverage (CMU-C). On the basis of 2007 declared incomes, 156 randomly selected persons who were contacted were in fact CMU-C beneficiaries at the time of the survey and were thus excluded from the sample.

Survey data linked with CAF and CPAM data

The survey data was linked with CPAM administrative data. Information contained in the National Health Insurance records allowed us to calculate for each beneficiary (registered LTI or not) the remaining out-of-pocket payments (OOP) for all ambulatory care reimbursed in 2008 (OOP payment = cost of care – reimbursement amount).

Furthermore, 2008 income declarations entitling individuals to CAF benefits in 2009 were collected from the CAF in 2011 so as to re-evaluate respondents' eligibility for ACS in 2009. In addition, knowledge of certain benefits perceived in 2008, such as Housing Benefit, Adult Disability Allowance (AAH) or Infant Care Benefit (PAJE), makes it possible to refine eligibility calculations.

Among the 1,449 households interviewed, data collected during the survey could not be linked with CAF data for 301 respondents who were no longer CAF beneficiaries in 2011. These individuals were younger (37 years old on average against 45 years old for 2011 beneficiaries), more often employed and 42% had a university degree (against 10% of beneficiaries interviewed). They were also more numerous to declare very good or good health. Other than non-CAF beneficiary respondents in 2011, 110 respondents were excluded from the analysis because their incomes per consumption unit (CU) was above the second living standard decile in 2008 (= 13,330€ in 2008; INSEE, 2010) so as to focus the analysis on low income individuals potentially eligible for ACS. The final sample was thus made up of 1,038 individuals.

For further information, consult the available report on the CMU Fund web site (Guthmuller *et al.*, 2013).

within the general population (53.8% against 59.6% in ESPS 2008). However, our sample population was more often in a precarious situation. Among the employees, 33.4% worked part-time (against 16.9% of the employed population recorded by the Job Survey conducted by INSEE in 2008), 26.0% had precarious work contracts (fixed-term contracts, temporary employment, seasonal contracts, government-subsidised contracts) against 11.7% of the salaried population in 2008 (Job Survey), and 26.0% feared losing their jobs (against 8% of employees according to ESPS 2008). Furthermore, the unemployed represented 11.7% of our sample against only 5.7% of heads of household in ESPS 2008. We also counted a greater number of inactive individuals in our survey sample (19.9% against 4.5%), due to the higher number of individuals unable to work because of disability (12.5 %). Inversely, the retired population was largely under-represented (14.6% against 30.1%) that can be explained by this population's fairly high standard of living and the procedure used for targeting eligible populations. As individuals were identified by means of Family Allowance benefits perceived, non-beneficiaries were automatically excluded. The precariousness of our sample population was also underlined in responses to questions on anticipated resources and expenditures in the following twelve months: over half the sample believed they would be subject to financial ups and downs (31.2 %) or lower resources (17.0 %). A very large majority anticipated probable difficulties in meeting regular living expenses over the next twelve months (77.3% of respondents), health expenses (66.8%) and other more exceptional expenditures (51.3%).

A little over a quarter of the population interviewed declared having difficulties in reading or writing for a variety of reasons (non-exclusive): 15.8% due to health problems (poor vision, disability, cognitive impairments, and mental health disorders), 12.2% reported being (partially or totally) illiterate and 3.0% of having difficulties related to poor knowledge of the French language. Finally, 4.5% reported having specific difficulties understanding the technical terms and administrative jargon.

A population with a deteriorated health status but in contact with the health care system

The respondent population was in poorer health than the general population: 41.6% reported a poor self-perceived health status (against 27.5%, ESPS 2008), 35.6% reported suffering from a chronic disease (against 27.1%), 32.9% of being functionally limited (against 19.7%), 47.7% reported following a regular treatment and 27.7% declared benefiting from 100% Social Security reimbursements due to a health problem (against 16.4%).

Despite these social problems, this population maintained a regular contact with the health care system. 96.2% of respondents had registered a "preferred GP" with the Social Security, a rate comparable with that in the general population (94.4 % in ESPS 2008). Over the last twelve months, 88.5% had consulted a general practitioner at least once (against 84%) and 51.2% a specialist (against 50.7%). Access to health care for this population is clearly difficult: 12.7% reported having foregone a GP consultation or required medical care over the last twelve months. Although lower than the rates measured in ESPS 2008 (16.6 %), the notion of unmet care needs is complex and reflects a gap between expectations regarding the health care system and the care actually delivered (Dourgnon *et al.*, 2012a). This difference can thus indicate lower expectations in our respondent population. Foregoing care for financial reasons is marginally more frequent than among the general population (10.3% of our sample against 9.8% in ESPS 2008). The same applies to foregoing care as a result of the waiting periods before health insurance becomes effective (4.1% against 2.8%). On the other hand, certain forms of foregoing care are reported at a comparable frequency to that observed in the general population, such as those related to the complexity of procedures (1.2% against 1.0%) or waiting to see whether their condition improves through time (2.8% against 2.5%). As in the general population, unmet care needs primarily concern dental care (reported by 7.3% of the sample) followed by eye wear and contact lenses (4.4 %), but also a significant proportion of specialist care needs (8.4%) and medication (3.3%), revealing real difficulties in accessing health care, principally for financial reasons.

A population less covered by complementary health insurance

The survey population is more frequently lacking complementary health insurance coverage than the general population: 12.2% of our sample against 6% of the ESPS 2008 population. Furthermore, 63.9% of respondents are covered by private insurance contracts (against 52% of the French population including ACS beneficiaries) and 23.1% within the framework of employer-provided CHI or through a member of their family (34% in the general population)[1].

An important distinction is made between private and group CHI contracts, since benefitting from a group contract is one of the ineligibility criteria for ACS. This distinction suggests that among the population initially identified as potentially eligible for ACS within the national postal information campaign in 2009 and who participated in the survey, one quarter proved ineligible for ACS.

The health and socio-economic determinants of non-take-up

The ACS take-up rate in our sample is low: 18.1% of respondents had taken steps to obtain ACS but increased to 25% when individuals benefitting from employer-provided CHI and those subsequently identified as ineligible on account of their 2008 declared incomes were excluded. Within this context, what are the characteristics of potential ACS beneficiaries who nevertheless fail to claim their entitlement?

In order to identify the key determinants of non-take-up, ACS beneficiaries were compared to non-beneficiaries

[1] In 2008, 7% of individuals were covered by the CMU-C.

using the following indicators: demographic factors (age, gender, family composition); socio-economic factors (occupation, reading and writing difficulties, anticipated financial difficulties in the future, declared income in 2008); health status (self-perceived health status, activity limitations, chronic disease) and attitudes towards health care (foregoing care for financial reasons); profile in terms of health insurance coverage (complementary coverage, exemption through the LTI scheme, CMU-C coverage the preceding year). A logistic regression was carried out so as to study the determinants of having taken steps *versus* not having taken steps to obtain ACS (1/0) [Table]. This analysis was conducted on the whole survey population and on the restrained population of individuals not covered by a group contract, beneficiaries' not being eligible for ACS.

The impact of income level and difficulties undertaking administrative procedures

Among the demographic factors, the impact of family composition on the non-take-up of ACS is limited to households with children that are more likely not to undertake administrative procedures than single households. On the other hand, all other things being equal, take-up or non-take-up probability rates between men and women are not significantly different, and there is no apparent age effect.

Employment effect is primarily observed through individuals unable to work because of disabilities, distinguished by a lower ACS take-up rate than the reference category (working-age population).

The probability of not taking-up ACS varies according to income. Individuals identified as eligible for ACS on 2008 declared incomes after the survey are more likely to initiate procedures, suggesting that certain households did not apply because they knew beforehand that their income levels were above ACS targets. Persons who believed their income level would remain stable in the following twelve months year were more likely to apply than those who estimated an increase or

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Probability of not having undertaken procedures to obtain ACS

		Total sample		Sample excluding group contract beneficiaries	
		N: 1,038		N: 810	
		Odds-ratio	Pr > Chi2	Odds-ratio	Pr > Chi2
Woman		0.9	0.57	0.91	0.64
Age		1	0.6	1.01	0.38
Household composition	*Single person*	*Ref.*		*Ref.*	
	Single-parent family	1.16	0.63	1.28	0.45
	Family with children	**1.58**	**0.06**	**1.54**	**0.09**
	Family without children	1.27	0.45	1.27	0.46
Occupation	*Employed*	*Ref.*		*Ref.*	
	Unemployed	0.74	0.27	0.79	0.43
	Disabled	**0.52**	**0.04**	**0.52**	**0.05**
	Retired	1.13	0.74	0.99	0.98
	Other inactive	0.71	0.31	0.7	0.33
Income per CU in 2008	*< to eligibility threshold to CMU-C*	*Ref.*		*Ref.*	
	< to eligibility threshold to ACS	**0.55**	**0.04**	**0.5**	**0.03**
	> to eligibility threshold to ACS	0.64	0.13	**0.58**	**0.09**
Anticipated resources	Will stay the same	**0.71**	**0.07**	**0.63**	**0.02**
	Will increase or decrease	*Ref.*		*Ref.*	
Difficulties coping with the coming year...	... regarding living expenses	0.99	0.96	0.95	0.84
	... regarding health expenses	**0,65**	**0,03**	**0,63**	**0,04**
Difficulties of reading or of writing		1.08	0.68	0.97	0.87
HEALTH STATUS, USE OF HEALTH CARE SERVICES AND COMPLEMENTARY HEALTH COVERAGE					
Self-perceived health status	Very good	1.45	0.21	1.17	0.64
	good	1.21	0.43	1.05	0.86
	Fair	*Ref.*		*Ref.*	
	Poor or very poor	1.24	0.45	1.09	0.77
Activity limitations		1.33	0.22	1.38	0.19
Declaration of a chronic disease		0.77	0.24	0.69	0.11
100% reimbursements under the LTI scheme		1.08	0.73	1.03	0.9
Foregone care for financial reasons		0.81	0.43	0.86	0.6
Had out-of-pocket payments in 2008		**0.41**	**0.06**	**0.45**	**0.1**
Complementary health coverage in 2008	*Not covered*	*Ref.*		*Ref.*	
	Individual contract	0.81	0.36	0.82	0.37
	Group contract	**1.94**	**0.04**	-	-
CMU-C beneficiary during the preceding year		**0.47**	**0.05**	**0.42**	**0.03**
RELATIONSHIP WITH ADMINISTRATIONS AND SOCIAL BENEFITS					
Difficulties finding information		1.08	0.69	1.16	0.44
Social isolation		1.1	0.74	1.28	0.44
Administrative difficulties		**1.48**	**0.03**	**1.55**	**0.02**
Difficulties due to health problems		1.69	0.27	1.57	0.35
Have foregone aid or social benefits		**1.69**	**0.04**	**1.65**	**0.03**
Pseudo R^2		0.0861		0.0724	
Percentage of correctly classified predicted probabilities		82.10%		79.60%	

Reading: Individuals reporting administrative difficulties have 50% more chance of not taking-up ACS (Odds ratio = 1.48). On the contrary, individuals with high OOP payments after Statutory National Health Insurance reimbursements in 2008 have 60% more chance of taking up ACS (Odds ratio = 0.41).

Source: ACS social experiment data at Université Paris-Dauphine to CPAM of Lille-Douai.

Realisation: Université Paris-Dauphine and IRDES. Download the Excel© file on the IRDES web site.

decrease in income. Anticipated change in resource levels thus appears to be a barrier to ACS take-up and can notably be explained by the duration of the ACS scheme eligibility period. Fearing the risk of no longer falling within the target threshold, individuals are less likely to undertake application procedures.

Certain indicators of difficulty in carrying out administrative procedures have an impact on take-up rate: individuals who fail to claim their ACS entitlement are more numerous to report difficulties understanding administrative jargon (4.9% against 2.6% of applicants), and having problems with administrations (29.2% deplored being constantly redirected from one organism to another, and 19.1% unsuitable opening hours). All other things being equal (Table), our analysis showed that difficulties concerning administrative procedures in general are a significant factor in the non-take-up of ACS. Similarly, individuals who failed to claim their entitlement were more likely to declare having foregone other aids or benefits because the procedures were too complicated.

The role of health status, future health expenditures and social protection

If perceived health status has no impact on ACS take-up rates, individuals suffering from a chronic disease appear more likely to apply for ACS, this effect reaching the significance level of 10% when non-significant variables are excluded from the model. Outside the "need" effect induced by chronic disease, the results suggest the existence of an inverse effect concerning activity limitations, even if the 10% significance level is not reached. Thus, for individuals with activity limitations, completing the application procedure may prove too complicated whereas suffering from a chronic disease generates considerable health expenditures requiring complementary health insurance coverage.

In a consistent manner, respondents afraid of being confronted with important health expenditures during the course of the following year more frequently applied for ACS, probably as a result of greater health insurance needs. Similarly, individuals previously faced with high out-of-pocket payments were more likely to apply. On the contrary, having foregone care for financial reasons had no positive impact on ACS take-up rates.

ACS take-up rates between individuals covered by private CHI contracts and those who are not are comparable. In other words, we found the same take-up rates among individuals wishing to reduce the cost of existing CHI premiums or those applying to have access to CHI.

Similarly, the fact of already benefiting from 100% National Health Insurance coverage and being exempt from the majority of health fees is not significantly linked with ACS take-up, which again can be explained by two contrasting effects. Benefiting from 100% reimbursements can reduce demand for complementary health insurance and thus ACS take-up rates. In addition, being registered on the LTI scheme also indicates high care needs leaving patients with substantial out-of-pocket payments which can lead to a greater demand for complementary health insurance (*Haut conseil pour l'avenir de l'Assurance maladie,* HCAAM, 2011).

On the other hand, the probability of applying for ACS was higher among individuals benefiting from CMU-C the year before the survey but who were no longer eligible. Already familiar with social assistance claims or better informed, application procedures are thus facilitated. Individuals covered by employer-provided CHI are less likely to apply as part of the cost of their premium is often paid by the employer. They are also undoubtedly better informed concerning ACS eligibility criteria and thus aware they are not entitled to ACS.

How do respondents' justify their non-take-up of ACS?

What knowledge do respondents have concerning the ACS scheme? What are the main reasons explaining the non-take-up of ACS? A first question allowed us to determine whether respondents knew about the ACS scheme and if not, by what channels they would have liked to have been informed. A second question asked them whether they had applied for ACS and if not, why? Moreover, several prior questions had already been asked to the whole sample concerning their relationship to aid and social benefits.

Two thirds of respondents had no knowledge of the scheme

The low ACS take-up rate can primarily be explained by a lack of information: two thirds of the sample reported not being aware of the scheme's existence despite the information letter sent by the CPAM (*Caisse primaire d'assurance maladie*, local health insurance branch) six months earlier (Guthmuller *et al.*, 2011; Guthmuller *et al.*, 2014). Among these, 92.6% would have liked to have been informed by their CPAM. Other channels of information frequently mentioned were the media (63.0%), GPs and health services (50.6%), far ahead of the social services (31.9%), CHI providers (3.1%) or diverse institutions and administrations (2.0%). Lack of information was consistently cited as the reason for non-take-up of ACS by 39.9% of persons who had not undertaken application procedures.

Uncertainties regarding eligibility

Lack of knowledge and uncertainty regarding eligibility are also important barriers. 40.6% of individuals not having undertaken application procedures believed "they were not eligible for ACS". This motive was often justified: certain individuals identified as potential ACS beneficiaries in the CAF records were aware of the eligibility criteria and knew beforehand they were not eligible. For example, the percentage of individuals declaring "not being eligible for ACS" was higher among respondents covered by employer-provided CHI (47.1% against 38.4% of the others, Graph). Among these, however, many had poor knowledge of the modalities of their employer-provided CHI contract. In effect, among public

service agents as well as retirees and the unemployed still covered by their previous company's CHI policy, the majority wrongly believed they were still covered by a group contract and as a result were not entitled to ACS.

The complexity of procedures to be undertaken

The complexity of procedures is also an important barrier: this is the reason given by 18.1% of the sample (Graph) to explain non-take-up. In a consistent manner, 75.6% of respondents reported encountering difficulties in claiming social benefits in general, clearly due to a lack of information which was the case for 42.1% of the sample. Respondents also appeared to have difficulty finding the right person to help them. In general, information was obtained from the media (59.1% of the sample), administrative brochures (54.2%) family and friends (51.3%) rather than from benefit-provider organism reception desks (38.2%) or social workers (24.4%).

Other than the lack of information, administrative red tape is also mentioned: 67.9% of respondents report encountering logistic difficulties, 34.4% considered the forms to be too complicated and 28.3% complained being constantly redirected from one organism or reception desk to another. 17.7% considered that administration opening hours were not adapted and 12.3% that they were difficult to access. 10.1% declared having received no help in completing procedures because they did not know who to ask for help within their close circle, suggesting a degree of social isolation. Finally, in 2.6% of cases, understanding or mastering the French language, health or cognitive problems were the main sources of difficulty.

For 36.9% of respondents, this lack of information and the difficulties encountered often resulted in foregoing social assistance, more often due to the complexity of procedures (20.2% of the sample) but also through negligence or because they didn't feel like it (6.6%), discouragement or a fatalistic attitude (5.3%). This discouragement was expressed by the feeling that they were not benefiting from all the aids to which they were entitled (33.0 %) or the impression they were "never entitled to anything" (11.4%). Finally, if the cost of CHI is rarely invoked (5.6%), it is the fourth reason given by individuals without coverage (16.3%).

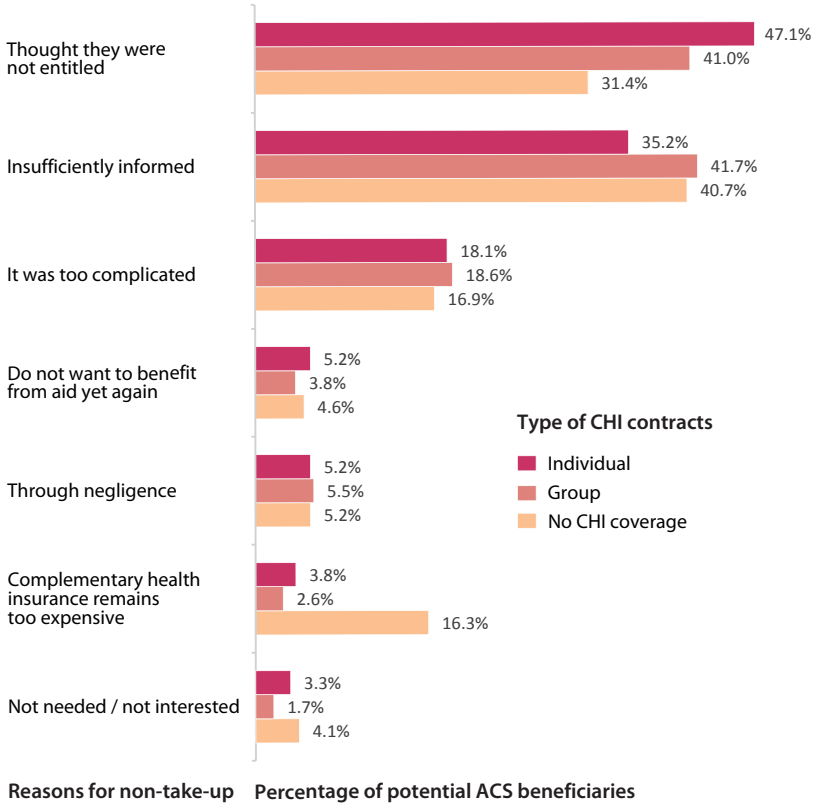
Which findings could be used to improve the scheme?

The study of the characteristics of potential ACS beneficiaries in Lille based on income showed that this population is confronted with social and economic difficulties and high care needs. Almost half the respondents perceived their health status as poor, and 36% suffered from a chronic disease while a quarter benefited from 100% reimbursements under the LTI scheme. 13% declared having foregone care over the last twelve months despite the fact that 85% were covered by CHI.

The ACS take-up rate within the sample was, however, low with only 18% of individuals having applied to obtain it. The three reasons most often cited was the belief they were not entitled to ACS, the lack of information and the complexity of procedures; and for individuals without CHI coverage, the cost of CHI even after deducting the value of the health voucher. In its current form, the ACS scheme insufficiently guarantees access to CHI for households with incomes slightly above the CMU-C eligibility threshold.

The analysis revealed that individuals with high care needs were more likely to have applied for ACS. This result somewhat attenuates the negative effects of the low ACS take-up rate and suggests that increased awareness of the scheme among GPs, or health care providers in

G **Reasons for non-take-up of ACS among the eligible Lille population in 2009**



Source: ACS social experiment data at Université Paris-Dauphine to CPAM of Lille-Douai.
Realisation: Université Paris-Dauphine and IRDES. Download the Excel© file on the IRDES web site.

general, could be an effective means of disseminating information.

Individuals having benefited from the CMU-C in the year preceding the survey were more likely to apply for ACS than individuals reporting difficulties with administrative procedures. This result confirms that access to information and an understanding of procedures are important determinants in the take-up of ACS.

In our survey, a false perception of eligibility is a reason often evoked to explain non-take-up. The re-evaluation of the CMU-C eligibility threshold since the date of the survey (including Adult Disability and Minimum Old-age pension beneficiaries) has probably been an efficient means of reducing this major cause of non-take-up. It would be useful to validate whether this is currently the case. Finally, it seems important to underline the fact that a large majority of respondents benefit from CHI coverage. Using the network of CHI providers as a means of relaying information concerning the ACS scheme would certainly be beneficial. ♦

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