Questions d'économie de la Santé

n°229 - January 2018

Complementary Health Insurance in 2014: 5% Had no Cover and 12% of the Poorest 20% of Households Had no Cover

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In 2012 and 2014, nearly 5% of the French population had no Complementary Health Insurance cover. Despite the existence of assistance schemes for the poorest, the absence of Complementary Health Insurance was often linked to income, and was more common among the unemployed, non-working people of working age, and young adults.

Nearly seven out of ten private-sector employees had employer-based Complementary Health Insurance. Certain categories of employees — employees with fixed-term contracts (Contrat à Durée Determinée, or CDD), commercial employees, and unskilled workers — were much less likely to be covered by employer-based insurance. The vast majority of the self-employed, civil servants, and pensioners, a high proportion of whom had health insurance cover, had individual insurance policies and reported that they were less likely to have sufficient healthcare cover than private-sector employees who had group health insurance cover.

In 2014, according to data from the European Health Interview Survey-The Health, Health Care and Insurance Survey (EHIS-ESPS), 95% of the French population had Complementary Health Insurance, of which 7% had Universal Complementary Health Insurance (Couverture Maladie Universelle Complémentaire, or CMU-C) [Célant, Rochereau, 2017] (see Graph 1 and 2). The percentage of people without cover (5%)[1] remained largely unchanged since 2008, despite the increase in the poverty rate during this period, thanks to the role played by Universal Complementary Health Insurance (CMU-C), which covered the needs of a large number of those who joined the ranks of the poor[2].

The absence of health insurance cover was closely linked to income

The absence of health insurance cover was closely linked to financial resources and the individuals' social background. Despite the existence of Universal Complementary Health Insurance (CMU-C) and the Health Insurance Voucher Plan (the Aide au Paiement d'une Complémentaire Santé, or ACS), more than 12% of people in the first income quintile had no health insurance cover, compared with 5% in the second income quintile, 3% in the third, and 2% in the fourth and fifth income quin-

[1] This figure and the subsequent figures were calculated after the removal of non-respondents. When survey participants were asked whether they had Universal Complementary Health Insurance cover or Universal Complementary Health Insurance (CMU-C), 1.7% of the individuals surveyed did not provide a response.

[2] According to the CMU Fund statistics, the number of beneficiaries of Universal Complementary Health Insurance (CMU-C) rose by 700,000 between 2008 and 2014, while the number of poor people rose by a million.

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I1

The European Health Interview Survey (EHIS)-The Health, Health Care and Insurance Survey (ESPS)

The Health, Health care and Insurance Survey (ESPS), conducted every two years by the Institute for Research and Information in Health Economics (Institut de Recherche and Documentation en Économie de la Santé, or IRDES), provides insight into health, access to healthcare, and health insurance in France. Cluster sampling is used to select potential respondents: a simple random sample of the permanent sample of health insurance beneficiaries (Échantillon Généraliste de Bénéficiaires, EGB) makes it possible to select a sample of insured persons in the three principal health insurance schemes — the French National Fund of Health Insurance for Employees (Caisse Nationale d'Assurance Maladie pour les Travailleurs Salariés, or CNAMTS), the French Social Security Scheme for the Self-Employed (the Régime Social des Indépendants, or RSI), and the NHI Fund for Farmers and Agricultural Workers (Mutualité Sociale Agricole, or MSA). Since 2006, the beneficiaries of Universal Complementary Health Insurance (CMU-C) have been oversampled in relation to the rest of the population. In 2014, the sample also included individuals (students and civil servants) from subschemes (sections locales mutualistes, or SLM), which may have led to slight variations in the coverage rates by age, compared with the preceding surveys. The survey was subsequently administered to individuals and members of their household — 23,000 people belonging to 8,000 households. The questions were asked in telephone interviews or in face-to-face interviews and, in the case of certain modules, via a self-administered paper questionnaire returned by post.

With regard to Universal Complementary Health Insurance, the Health, Health care and Insurance Survey (ESPS) identified the contracts in each household and, in each case, compiled a list of the persons who had coverage and recorded the means by which insurance cover was obtained (via a company or on an individual basis), the premium paid, the insured's opinion on the coverage, and the length of time the contract had been in force. When a respondent stated that he or she had changed the contract during the previous twelve months, the respondent was asked why he or she had done so, and what had changed in terms of the cover and the premium. A module aimed at people without a Universal Complementary Health Insurance policy recorded the reasons for an absence of cover and made it possible to clarify whether they had previously had coverage, and, if this was the case, the length of time the contract had been in force, and the reason for the loss of cover.

The medical information and information on Universal Complementary Health Insurance was complemented by geographic, demographic, economic, and family data: age and gender, income, occupation, occupational category, level of education, the composition of the household, and the type of household.

In 2014, the Health, Health Care and Insurance Survey (ESPS) was the basis of the European Health Interview Survey (EHIS) and was thus called the EHIS-ESPS survey. Nevertheless, all the data that has been used for this published article, particularly data relating to Universal Complementary Health Insurance, originates from a set of questions in the Health, Health Care and Insurance Survey (ESPS), which allows for comparisons with the preceding surveys (http://www.irdes.fr/esps).

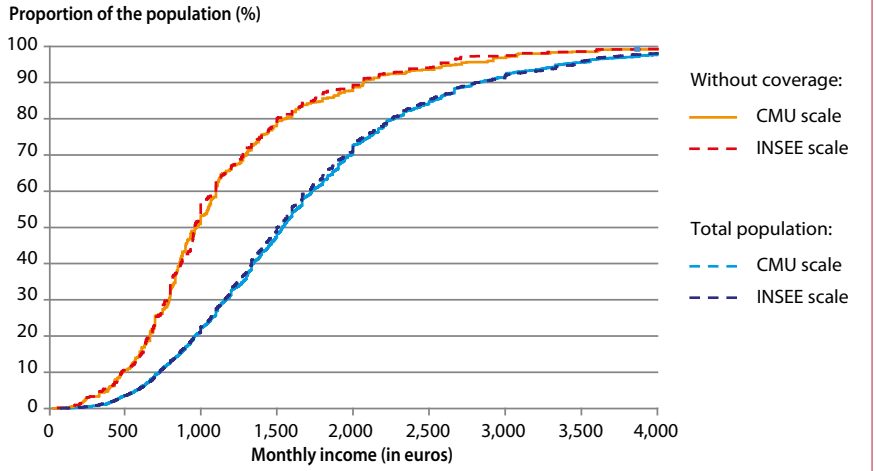
tiles. Furthermore, in 2014, nearly 16% of the unemployed had no Complementary Health Insurance and 25% were beneficiaries of Universal Complementary Health Insurance (CMU-C). These survey results were obtained prior to the generalisation of Complementary Health Insurance to private-sector employees and the new rules aimed at improving the continuation of coverage in the event of short-term unemployment[3].

The percentage of people who had no Complementary Health Insurance cover was 9% among homemakers, 11% among other inactive persons, 8% among people without qualifications, and 7% among single-parent families.

A high concentration of persons without Complementary Health Insurance cover was observed among people with low incomes (see Graph 1). Half of the individuals who had no cover had an income of less than 970 euros per consumption unit and were therefore, in principle, eligible for Universal Complementary Health Insurance (CMU-C) or the Health Insurance Voucher Plan (ACS), and three quarters had an income of less than 1,400 euros per consumption unit.

G1

Distribution of individuals who have no Universal Complementary Health Insurance according to their income



Reading: Half of the people who had no Universal Complementary Health Insurance had an income of less than 1,000 euros per month, compared with 20% in the entire population. 80% cent of the people without coverage had an income of less than 1,500 euros per month, compared with 50% in the entire population. The greater the difference between the two distribution curves according to income (the curve representing those without coverage and the curve representing the entire population), the higher the concentration of people without coverage at the bottom of the income scale.

Note: The INSEE (National Institute of Statistics and Economic Studies) and CMU scales are weighting systems that assign a coefficient to each member of a household and make it possible to compare the incomes of households of varying sizes and compositions. The scales assign a weight of 1 for the first adult in the household. In the INSEE scale, the weights assigned to the other members of the household are 0.5 when they are aged 14 or over, and 0.3 when they are under 14. In the CMU scale, the assigned weights do not take age into account: they are 0.5 for the second person, 0.3 for the third and fourth person, and 0.4 for additional persons.

Scope: People living in standard households in mainland France.

Sources: IRDES-DREES, EHIS-ESPS 2014.

Download the data

There were more people without cover among those who rated their health as poor

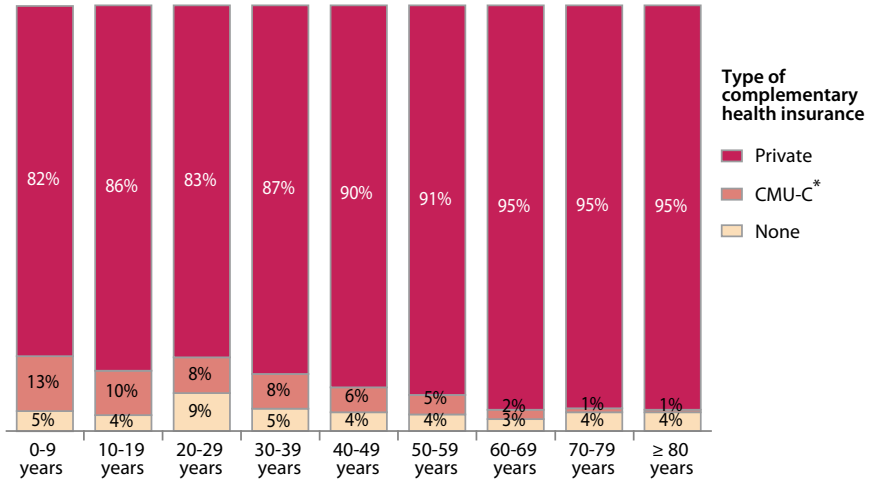
Among people who rated their health "poor or very poor", nearly 9% had no Complementary Health Insurance, compared with 4% of those who rated their health as "very good, good, or average". Likewise, 7% of people who had an illness or disability that seriously limited their ability to perform daily tasks had no cover, compared with 3% of those who were moderately limited and 4% of those who were not limited. However, there was no correlation between those with or without a chronic condition and health insurance cover. Lastly, the percentage of people without cover was almost identi-

[3] In addition to the generalisation of employer-sponsored Universal Complementary Health Insurance to all private-sector employees, the Law on safeguarding employment of 14 June 2013 improved the continuation of coverage for the unemployed. Employees were subsequently able to maintain their coverage for a maximum period of twelve months, compared with six months prior to the introduction of the law; the cover is entirely financed by their former employer. Ex-employees were previously required to pay the employee contributions to health insurance.

cal among people with chronic conditions (Affections de Longue Durée, or ALD) and those without chronic conditions. Similar results were also observed when individuals' socio-economic characteristics were examined (Pierre, Jusot, 2015). The link between health and the absence of cover may be explained by the negative impact of the absence of cover on access to healthcare and so on health, greater difficulty in accessing Complementary Health Insurance, and by the priority given to health, which may influence both the attention paid to health and the decision to take out insurance.

G2

Universal Complementary Health Insurance cover according to age



* CMU-C: Universal Complementary Health Insurance.

Reading: Among children aged 0 to 9 years old, 82% were covered by private Universal Complementary Health Insurance, 13% by the CMU-C, and 5% had no cover at all.

Scope: People living in standard households in mainland France.

Sources: IRDES-DREES, EHIS-ESPS 2014.

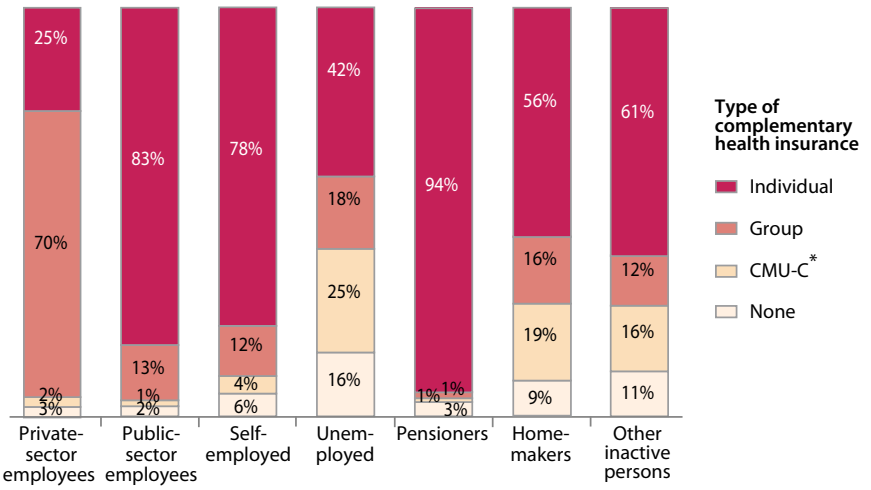
Download the data

Fewer young adults were covered by private complementary health insurance

The percentage of people without Complementary Health Insurance cover was higher among young adults (20–29 years old), and was 9% (see Graph 2). The percentage of beneficiaries of Universal Complementary Health Insurance (CMU-C) was higher among those under 20, with a maximum of 13% for those under 10. However, the percentage was very low for people aged 60 or older (2% for people aged 60–69 and almost zero for the higher age groups), because the beneficiaries of the Solidarity Allowance for the Elderly (Allocation de Solidarité pour les Personnes Âgées, or Aspa - the minimum pension for elderly) had incomes that were higher than the Universal Complementary Health Insurance (CMU-C) income eligibility cap. The percentage of people with private Complementary Health Insurance cover was 83% in the 20–29 age group and increased with age, reaching 95% among people aged over 60 years old. However, while pensioners had as much access as the rest of the population to Complementary Health Insurance cover, the cover was relatively expensive due to age-related pricing, which was employed almost systematically in individual insurance policies[4].

G3

Universal Complementary Health Insurance cover according to employment status



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Scope: People living in standard households in mainland France.

Sources: IRDES-DREES, EHIS-ESPS 2014.

Download the data

A large majority of working people had health insurance cover

In 2014, only 3% of private-sector employees had no cover, 70% had group health insurance cover, and 25% had an individual insurance policy (see Graph 3). Although they did not have access to group health insurance cover (except as the beneficiary of an employee), a large majority of the other categories of working people also had health insurance cover: 88% of self-employed people who benefited from tax incentives ("Madelin" contracts), and more than 95% of public-sector employees had private Complementary Health Insurance cover, compared with 95% of private-sector employees. 4% of self-employed people, 2.4% of private-sector employees and only 1.4% public-sector employees had Universal Complementary Health Insurance (CMU-C). After taking into account the beneficiaries of Universal Complementary Health Insurance (CMU-C), the percentage of those without cover was 5.5% among the self-employed, 3.3% for private-sector employees, and only 1.4% for public-sector employees.

[4] In 2013, 91% of those who had an individual insurance policy had a contract whose premium was age related (Barlet et al., 2016).

Employer-sponsored Complementary Health Insurance was less common among commercial employees, unskilled workers, younger employees, and women

The percentage of people with group health insurance cover sponsored by the employer varied considerably among private-sector employees. Hence, nearly 87% of executives stated that they had this type of cover, compared with 77% of people in an intermediate profession, 69% of skilled workers, and 65% of administrative employees (see Table). Lastly, only 53% and 51% of commercial employees and unskilled workers respectively had such a health insurance contract. When they were covered by a group health insurance contract, they were most often covered as beneficiaries: 33% for commercial employees, 24% for administrative employees, and 22% for unskilled workers, compared with 15% for the entire population of employees covered by a group health insurance contract. Variations between occupational categories had already been observed in the 2009 Employer-sponsored Complementary Health Insurance Survey (Enquête Protection Sociale Complémentaire d'Entreprise, or PSCE). The survey revealed that employees and workers were less likely than executives to be offered health insurance by their employer, and, moreover, were less likely to take out group health insurance when it was offered to them. This may be due to the fact that some employees and workers may consider the cover inadequate and prefer, when they have the possibility to do so, to be covered under their spouse's company Complementary Health Insurance or an individual health insurance policy.

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The coverage status of private-sector employees according to their socio-demographic and medical characteristics

	Without cover	At least one group contract	Individual policies only	CMU-C
Age				
< 30 years	6.6%	60.5%	30.1%	2.8%
30-39 years	3.0%	72.1%	21.8%	3.1%
40-49 years	2.3%	73.0%	22.8%	1.9%
≥ 50 years	2.2%	70.8%	24.9%	2.1%
Gender				
Men	3.6%	72.6%	21.7%	2.1%
Women	3.0%	66.3%	27.9%	2.8%
Socio-professional category				
Executives	0.9%	87.4%	11.3%	0.5%
Intermediate professions	2.3%	76.9%	20.1%	0.7%
Administrative employees	4.0%	65.1%	28.2%	2.7%
Commercial employees	4.5%	52.8%	38.5%	4.2%
Skilled workers	3.5%	68.7%	25.3%	2.6%
Unskilled workers	7.5%	51.1%	34.4%	6.9%
Level of education				
No degree	6.1%	59.0%	28.1%	6.7%
VTC/TSC	4.1%	63.1%	29.6%	3.2%
A-levels	2.7%	69.9%	26.3%	1.1%
Higher education	2.0%	79.2%	18.0%	0.9%
Health status				
Very good	2.8%	71.4%	24.0%	1.9%
Good	3.2%	72.4%	21.8%	2.7%
Average	2.8%	69.0%	24.9%	3.3%
Poor, very poor	5.6%	64.4%	23.7%	6.4%
Activity limitation				
No activity limitation	3.1%	71.7%	22.9%	2.3%
Moderate	1.9%	69.9%	24.3%	4.0%
Severe	5.6%	63.2%	25.3%	5.9%
Chronic condition				
No chronic condition	1.8%	70.9%	24.2%	3.1%
At least one	3.3%	71.4%	22.9%	2.4%
Combined	3.0%	66.3%	27.9%	2.8%

Sources: IRDES-DREES, EHIS-ESPS 2014. Download the data

Employer-sponsored Universal Complementary Health Insurance was less common among young employees (60% of employees aged under 30 compared with more than 70% of those aged 30–60). This is partly due to the lower proportion of permanent contracts (Contrats à Durée Indéterminée, or CDI) in this age group. Women were less likely to be covered by a group health insurance contract than men (66% compared with 73%). Two thirds of the difference arose from the variations in the breakdown by socio-professional category according to gender: women were more likely to be administrative and commercial employees and less likely than men to be executives. While the occupational composition of the female workforce composition was similar to that of men, there was a difference of two points. However, a difference to the disadvantage of women remained among executives (3 points), commercial employees (5 points), and unskilled workers (8 points). The generalisation of employer-sponsored Complementary Health Insurance since 2016 should lead to a reduction in these differences.

Individuals covered by group health insurance contracts were more satisfied with their reimbursements

The levels of reimbursement provided by the contracts were a key determinant of access to healthcare and out-of-pocket health care costs ultimately borne by individuals, particularly when free pricing led to significant additional fees compared with conventional rates. The European Health Interview Survey-The Health, Health Care and Insurance Survey (EHIS-ESPS) asked respondents for their views on the coverage they received. Only the policyholders were included in the survey. In nearly 8 cases out of 10, they completed the questionnaire on Complementary Health Insurance and therefore expressed their views on the contract. Private-sector employees who had a group health insurance contract differed sharply from individuals with an individual insurance policy (private-sector employees with an individual insur-

ance contract, public-sector employees, self-employed people, and pensioners). The former were much more likely to consider that their contract provided a very good or fairly good level of reimbursement of the additional fees charged by specialists: 78% compared with 60% for private-sector employees with an individual insurance contract, 63% for self-employed people, 57% for pensioners, and only 51% for public-sector employees. The same observation applied to optical expenses (81% compared with 57% for other private-sector employees and self-employed people, and around 50% for pensioners and public-sector employees) and dental expenses (71% compared with 50% for other private-sector employees and self-employed people, and around 46% for pensioners and public-sector employees). These differences were corroborated by a survey of Complementary Health Insurance providers, conducted by the French Centre of Research, Studies, and Statistics (Direction de la Recherche, des Études, de l'Évaluation et des Statistiques, or DREES), which showed that individual insurance policies generally provided cover that was less adequate than that provided by group health insurance contracts (Barlet et al., 2016).

Individuals under 30 changed their health insurance contract more frequently

Ten per cent of Complementary Health Insurance policyholders stated that they had changed their insurance provider or the contract with an existing provider during the previous twelve months; 2% previously had no cover and 86% were already covered by a contract with an existing provider. The main reasons that led respondents to change their contract or insurance provider were: a change in employment status (29%), the excessive cost of the previous contract (25%), and the inadequate cover provided by the previous contract (10%). Changes linked to a change in family situation or dissatisfaction with the insurance provider were less common (7% and 5% respectively).

Changes of contract were more frequent among those with group health insurance (13%), due to occupational mobility, than among those with individual health insurance (only 8%). Among individuals under 30, changes were largely linked to a change in employment status, as half of the policyholders changed their contract. However, among people aged 65 or over, the cost of the contract was by far the most frequently cited reason (56% of the cases).

The anticipated effects of the generalisation of employer-sponsored complementary health insurance

The generalisation of employer-sponsored Complementary Health Insurance may have two effects: on the one hand, an end to residual situations in which there is an absence of cover among private-sector employees and their beneficiaries; and on the other, the modification of reimbursement levels and the provision of more advantageous pricing[5] for those who were covered by an individual insurance policy and who will be covered by a group health insurance contract.

The generalisation of employer-based Complementary Health Insurance will

I2

Social protection and Universal Complementary Health Insurance in France

In France, private health insurance complements the social security reimbursements. Public and private insurance providers cover the same types of treatment, given to the same patients, by the same healthcare professionals (Paris and Polton, 2016). The co-payments are largely statutory (patients' contributions, daily hospital charges, etc.), but they can also arise from free pricing (additional fees, dental prostheses, glasses, etc.). In a small minority of cases, private insurance can also provide additional cover, by reimbursing the cost of treatment that is not covered by social security reimbursements (certain non-reimbursed dental treatment, a private room in a health establishment, osteopathy, self-medication, etc.).

Universal Complementary Health Insurance covers 13% of healthcare costs, but the proportion varies greatly according to the type of healthcare: 74% for optical care, 41% for dental care, and 5% for hospital treatment (Beffy et al., 2017). However, even in the case of hospital treatment, the financial risks can occasionally be high in the absence of Universal Complementary Health Insurance. This is particularly the case for people who are not exempt from patients' contributions towards the cost of hospital treatment, such as for example some of the elderly who are hospitalised in medical units. This is why Universal Complementary Health Insurance cover is considered a key factor in helping to remove the financial barriers to healthcare (Dourgnon, 2011). The public authorities have therefore sought to foster the dissemination of Universal Complementary Health Insurance via exemptions from social security charges and taxes in companies' group health insurance policies at the end of the 1970s and the beginning of the 1980s, in health insurance contracts for the self-employed in 1994 (the 'Loi Madelin'), and via the introduction of Universal Complementary Health Insurance (CMU-C) in 2000 and the Health Insurance Voucher Plan (ACS) in 2005. Pricing has also been regulated by "solidarity-based and responsible" contracts. Taking out a solidarity-based contract and pricing is not conditional on health status. "Responsible" contracts have to exclude certain non-reimbursed healthcare costs from their reimbursements in order to encourage patients to comply with the treatment process (GP or family doctor), set coverage caps to avoid an inflationary effect on the coverage of healthcare costs (glasses, additional fees, etc.), and also provide maximum coverage in order to improve access to healthcare.

In 2012, in the preceding edition of the Health, Health Care and Insurance Survey (ESPS), the percentage of people without Universal Complementary Health Insurance was 5% (Célant et al., 2014). A little over half of the respondents stated that they had very good or fairly good cover for their glasses and a little under half stated that they had very good or fairly good cover for additional fees for consultations with specialists and dental prostheses. Between 2012 and 2014, several measures aimed at extending health coverage and improving the reimbursements were introduced. Signed in January 2013, the National Inter-Professional Agreement (Accord National Interprofessionnel, or ANI), which extended the availability of compulsory company Universal Complementary Health Insurance to all private-law employees, was subsequently incorporated into the Law on safeguarding employment, passed in June 2014. The income thresholds for entitlement to Universal Complementary Health Insurance (CMU-C) and the Health Insurance Voucher Plan (ACS) were increased by 8.75% in July 2013. In July 2015, major changes to the Health Insurance Voucher Plan (ACS) were introduced: ACS beneficiaries now select their Universal Complementary Health Insurance policy from among three standard contracts provided by a limited number of Universal Complementary Health Insurance providers, selected after a call for tenders. Lastly, as of 1 April 2015, "responsible" contracts have to reimburse patient's contributions for almost all forms of treatment, and the cost of unlimited hospital stays, and cap reimbursements for glasses and extra billing by physicians.

These legislative and regulatory changes should significantly alter the Universal Complementary Health Insurance landscape in the coming years. The data from the Employer-sponsored Complementary Health Insurance Survey (PSCE), conducted by the French Centre of Research, Studies, and Statistics (DREES) and the Institute for Research and Information in Health Economics (IRDES) in 2017, will make it possible to assess some of the effects of these changes.

[5] This is related to the fact that the overall cost per employee tends to be lower in the case of company health insurance (Garnero, 2012), which may in part be due to companies' negotiating power. On the other hand, employees' contributions are deductible from taxable income. The benefit of the employer's contribution for employees is less evident, as it can be to the detriment of the employees.

inevitable be advantageous to employees without insurance, even though some of them made a conscious decision not to take out insurance. Nevertheless, few people will benefit from this, as the percentage of employees without health insurance was very low in 2014[6].

And what will be the situation for those who do not benefit from the generalisation of employer-sponsored Complementary Health Insurance?

The generalisation of group health insurance does not apply to the other categories of workers — public-sector employees and the self-employed — and pensioners. They will not be able to benefit from the potential benefits of extending this type of cover, unless their spouse or another member of the household is a private-sector employee and their contract can be extended to cover family members. Although a large majority of these workers have health insurance, they are more likely to report that the reimbursement of additional fees for consultations with specialists, glasses, and dentures is inadequate. By introducing an obligation to reimburse patients' contributions for almost all forms of treatment and capping certain forms of coverage, the specifications for responsible contracts may help narrow the gap between group and individual contracts. Capping coverage for specialist care and dental treatment also aims to reduce additional costs and hence the financial barriers to healthcare for those who have inadequate cover. Furthermore, the simplification of the contract offer and improving the value for money[7] in the Health Insurance Voucher Plan (ACS) should help improve healthcare for the poorest working people and pensioners. In the case of pensioners, who have to pay higher premiums due to their age, the scheme created by the Evin Law[8] has been made more flexible in order to enable workers to maintain their cover when they retire, but this only applies to new retirees.

* * *

Between 2012 and 2014, there was little change in the Complementary Health Insurance landscape. The percentage of people without coverage remained stable (5%) and there were disparities in the coverage rates according to individuals' social background, and in the cover, depending on whether individuals did or did not have access to group Complementary Health Insurance. While Complementary Health Insurance has continued to spread and average out-of-pocket healthcare costs are among the lowest in Europe, France is distinguished by mixed results with regard to social inequalities in healthcare. In particular, France has one of the highest levels of social inequality in access to specialist care and dental treatment (Devaux, 2015). Assessing the effect of the modifications introduced in 2013 and 2014, particularly with regard to group Complementary Health Insurance, is a key issue. The data from the 2017 Employer-sponsored Complementary Health Insurance Survey (PSCE) will contribute to this assessment ♦

[6] This point was examined in the 2017 Employer-sponsored Complementary Health Insurance Survey (PSCE).

[7] In the 2015–2016 report on the Health Insurance Voucher Plan (ACS), the CMU Fund stated (with regard to the overhaul of the scheme in 2015) that "despite the increase in the level of cover provided by the ACS contracts, there has been an average price drop of 10%".

[8] The scheme created by the Law of 31 December 1989, and amended by the decree of 21 March 2017, provides for the portability of company contracts for pensioners

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Director of the publication: Denis Raynaud • **Technical senior editor:** Anne Evans • **Associate editor**: Anna Marek • **Translators**: David and Jonathan Michaelson (JD-Trad) • **Layout compositor**: Damien LeTorrec • **Reviewers**: Paul Dourgnon, Aurélie Pierre, Catherine Pollack • **ISSN** : 2498-0803.