**When is it rational for French adults with disabilities to opt for a publicly subsidized complementary health insurance?**

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**Context**

Disability Allowance for Adults (*Allocation Adulte Handicapé,* AAH) is a minimum subsistence income for French adults with disability over the age of 20 and for whom their permanent disability rate is at least of 80%. 86% of AAH beneficiaries are covered by a complementary health insurance, but this proportion is lower than in French general population (95%). In this article, we assume that Health Vouchers Scheme (*Aide à la Complémentaire Santé, ACS*) would enable to increase the proportion of AAH beneficiaries covered by a complementary health insurance. All AAH beneficiaries are eligible to ACS, but the non-take-up remains high. Beyond problems of lack of information and complexity of the procedure, one may hypothesize that the ACS premium remains costly (on average 209€ per year) for a low-income population. In this article, one of our hypotheses is that AAH beneficiaries may be tempted to compare the level of their out-of-pocket payment with the ACS premium (209€ on average) before deciding to get the ACS coverage. If the premium outweighs the level of their out-of-pocket payments, they will not accept to join ACS, considering that ACS entitlement is not a rational decision. In this article, we choose to focus on AAH beneficiaries who stay for a long period (2014-2018) in the AAH scheme and who have regular healthcare expenditure **without never benefitting from a complementary health insurance**. From this population, we define several profiles of healthcare consumers, and we analyze for which types of profiles it would be rational to get the ACS coverage.

**Data and methods**

Exhaustive data from National Public Health Insurance for the 2014-2018 period were used. Beneficiaries who were covered by the AAH scheme in 2014 and remain covered over a five-year period but who do not have complementary health insurance are followed (N=34 898). Data on healthcare costs, public reimbursements by National Public Health Insurance and out-of-pocket payments include outpatient care as well as inpatient care, for different disciplines: medicine, surgery, obstetrics, psychiatry and follow-up/rehabilitation care. We calculate for each person the proportion of each health expenditure item and deduce from those data a classification, which is an Ascendant Hierarchical Classification (AHC) applied to the dimensions of a Principal Component Analysis (PCA).

**Results**

From our classification, three types of healthcare consumers are distinguished. **AAH beneficiaries concerned by routine care** (45.5% of the sample) are characterized by low levels of annual out-of-pocket payments (from 94€ in the "*pharmacy only*" class to 212€ in the "*GP, pharmacy, dentist, optical care*" class). In those classes, between 69% and 88% of AAH beneficiaries have lower out-of-pocket payments than the price of ACS premium (209€), which should give them little incentive to get an ACS coverage.

**AAH beneficiaries with long hospital stays** (39,6% of the population) are exposed to higher out-of-pocket payments (from 324€ in the "*pharmacy, medicine, surgery, psychiatric hospitalizations*" class to 826€ in the "*Psychiatric hospitalizations*" class). ACS entitlement which exempts beneficiaries from hospital copayments and daily rates seems "rational" for a higher proportion of individuals, from 48% to 77% in the "Psychiatric hospitalizations" class.

Finally, **AAH beneficiaries with disability-related consumption** only weight for 15% of the sample but those beneficiaries are exposed to relatively high out-of-pocket payments (from 280€ in "treatment apparatus and equipment, pharmacy" class to 371€ in "prosthetics and treatment apparatus and equipment" class) mainly explained by extra fees (cost overruns or overrun fees). As ACS does not fund cost-overruns, the question of ACS entitlement arises for persons in those classes because the basket of healthcare provided by ACS does not necessarily correspond to their needs.