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 ever 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.