Questions d'économie de la Santé

n°271 - September 2022

The Healthcare Consumption Profiles and Complementary Health Insurance of the Beneficiaries of the Disabled Adult Allowance (AAH)

Sylvain Pichetti and Maude Espagnacq (IRDES)

The Disabled Adult Allowance (*Allocation Adultes Handicapés*, AAH), a minimum social benefit that provides disabled persons over the age of twenty with an income of €956 per month, is paid to 1.2 million beneficiaries in France. Less insured than the French population (96%), 87% of these persons had complementary health insurance in 2018, but only 11% benefitted from the free Universal health insurance scheme (*Couverture Maladie Universelle*, CMU), and 13% from the Health Insurance Vouchers Scheme (*Aide à la complémentaire santé*, ACS) [Cabannes, 2022].

Since 2019, the Complementary Health Solidarity (*Complémentaire Santé Solidaire*, CSS) scheme has replaced these schemes in order to increase the diffusion of public health insurance, and, given their resources, the beneficiaries of the Disabled Adult Allowance (AAH) are most often eligible to benefit from the CSS with a financial contribution. Yet, some beneficiaries of the Disabled Adult Allowance still do not benefit from this scheme. To identify the characteristics of those who do not benefit from this insurance, this study focused on the exhaustive population of the 35,000 beneficiaries of the AAH, who were on the scheme between 2014 and 2018 without ever having complementary health insurance. Although this population only amounts to 3% of all of the beneficiaries of the AAH, it has specific characteristics and is potentially exposed to the risk of high out-of-pocket payments.

A typology of the healthcare expenses of these beneficiaries who have no complementary health insurance was produced to characterise their healthcare consumption profiles. The real out-of-pocket payments were compared with those simulated with cover by the Complementary Health Solidarity (CSS). Depending on the profiles, the proportion of persons for whom the patient contribution would be lower than their financial contribution linked to their membership of the CSS scheme varied significantly. The beneficiaries of the AAH without complementary health insurance are very often beneficiaries of the long-term illness (*Affection de longue durée*, ALD) scheme, which lessens the advantages of having coverage. Incidentally, those who require specific assistive devices find that their needs are poorly covered by the Complementary Health Solidarity (CSS), which does not cover the additional fees outside the scope of the "*100% Santé*" health insurance measure. In total, only the persons who undergo periods of hospitalisation, in particular in psychiatric facilities—given the duration of their stays—would have a clear interest in paying a financial contribution to benefit from the CSS and cover their hospital out-of-pocket payments. Hence, improving –via the CSS– the cover of the specific needs of the beneficiaries of the AAH is a major factor in encouraging beneficiaries to apply for it, despite the financial contribution, rather than taking out private complementary insurances that might provide better solutions for specific needs, but at a higher cost. This would also limit the proportion of beneficiaries of the AAH who still have no complementary health insurance scheme and whose access to healthcare may be restricted as a result of their limited financial resources

The Disabled Adult Allowance (AAH) is a social benefit that aims to provide an income for disabled persons over the age of 20 until the age of retirement. In 2022, 1.2 million people are beneficiaries of the AAH in France (National Family Benefits Fund (Caisse Nationale des Allocations Familiales, CNAF)). This population has specific socio-demographic

characteristics, as three-quarters of them are isolated adults, and most of them childless (Mordier, 2013; Cabannes and Richet-Mastain, 2020). Most of the beneficiaries have never worked and therefore are not eligible for a disability pension. Also, these beneficiaries have specific health profiles: 46% of them described the state of their health as poor or very poor, and 88% of them declared that they had at least one health-related problem or chronic disease (Calvo, 2021). Psychiatric diseases are frequently present in this population (45%), particularly psychotic disorders (20%), followed by depressive disorders (15%), and mental retardation disorders (8%) (National Health Insurance Fund (CNAM), 2019). Despite a deteriorated state of health, the beneficiaries of the AAH have less access to dental, ophthalmological, and gynaecological treatment compared with the general population, and therefore less frequently use preventive treatments or screening (for cervical, breast, and colon cancer) [Lengagne et al., 2014; Penneau et al., 2015].

Health coverage of the AAH beneficiaries

As the Disabled Adult Allowance (AAH) is not allocated to beneficiaries by the health insurance system (*Assurance Maladie*), no copayment exemption is specifically associated with it (see Inset 1). As they have statutory health cover, the beneficiaries of the AAH have to pay copayments for outpatient and hospital treatment unless they suffer from a chronic condition (*Affection de Longue Durée*, ALD) or they are covered by the disability pension scheme when they have worked and made sufficient contributions. The long-term illness (ALD) scheme exempts patients from patients' copayments for treatments associated with the disease that is exonerated (see Figure), and the disability pension is associated with a complete reimbursement of patients' copayments. Aside from the patient's copayment, the insured individual's contribution may be augmented by the hospital daily rates and extra fees. The latter include overrun fees charged by healthcare professionals and cost overruns for assistive devices that feature on the List of Refundable Products and Services (*Liste des Produits et Prestations Remboursables*, LPPR) [see Figure]. These out-of-pocket payments may be reimbursed by complementary health insurances.

According to the survey conducted by the French Directorate for Research, Studies, Evaluation and Statistics (*Direction de la Recherche, des Études, de l'Évaluation et des Statistiques*, DREES), which focused on the beneficiaries of minimum social benefits, the beneficiaries of the AAH are more likely to have complementary health insurance than beneficiaries of the Active Solidarity Income (*Revenu de Solidarité Active*, or RSA) or beneficiaries of the Specific Solidarity Allowance (*Allocation de Solidarité Spécifique*, ASS) [87% compared with 81%]. And yet they are still less well covered than the general population (96%) [Cabannes, 2022]. These studies also show that 63% of the beneficiaries of the AAH have private health insurance whilst only 24% have public health insurance schemes.

Although the AAH income level (€956 per month in 2022) made these beneficiaries eligible to pay for the Health Insurance Vouchers Scheme (ACS) [see Inset 2] rather than eligible for the free universal health insurance scheme (CMU), certain family configurations enabled them to have access to the CMU. Hence, in 2018, 13% of the beneficiaries of the AAH were insured by the Health Insurance Vouchers Scheme (ACS) and 11% of them declared that they benefitted from the CMU (Cabannes, 2022).

The low proportion of beneficiaries of the Disabled Adult Allowance (AAH) covered by a public complementary health insurance scheme raises questions. The recently introduced Complementary Health Solidarity (CSS), which has replaced the ACS and the CMU since the end of 2019 (see Inset 2) — by continuing to provide cover and by offering the same scope of cover, while simplifying the administrative procedures—, aims to

I1

The Disabled Adult Allowance(AAH)

The Disabled Adult Allowance (AAH) is a minimum social benefit whose amount is €956 in 2022, which aims to provide an income for disabled persons. It is paid by the family benefits fund (*Caisses d'Allocation Familiale*) by decision of the Commission for the Rights and Self-Dependency of Disabled Persons (*Commission des Droits et de l'Autonomie des Personnes Handicapées*, CDAPH). The conditions for benefitting from the AAH are based on the criteria of disability, age –over the age of 20 and until the age of retirement–, and financial resources. The AAH is allocated to persons who are disabled at a rate of at least 80% or a rate between 50% and 79%, constituting a "substantial and lasting handicap to employment". Voted in July 2022 and applicable in 2023, the "uncoupling" reform, by ensuring that the income of the spouse is discounted, will enable more persons to benefit from the allowance. However, the new beneficiaries of the AAH may not be eligible to benefit from the participatory Complementary Health Solidarity (CSS), which takes into account the household's entire income.

F

Non-reimbursed healthcare costs (RAC) and exemptions depending on the status of the insured person

Composition of out-of-pocket payments	Legally insured	Chronic condition (ALD)	The Health Insurance Vouchers Scheme (ACS)	The Complementary Health Solidarity (CSS)
The patient's copayment for outpatient care	30%	0% for healthcare associated with the exonerating disease, otherwise 30%	0% for all healthcare	
The patient's copayment for hospital care	20% of the amount refunded or a flat rate of €24 in the event of a diagnosis and exonerating expensive therapeutic treatment (above €120)	0% if the hospitalisation is associated with the chronic condition	0% for all healthcare	
Daily hospital rates	€20 per day in medicine and surgery. €15 per day for psychiatric care	€20 per day in medicine and surgery €15 per day for psychiatric care	Unlimited coverage[a]	
Overrun fees	Yes	Yes	No[b]	
Cost overruns for assistive devices	Yes	Yes	Yes	

[a] Since 2015, after the introduction of "responsible contract"' in France; [b] Unless specifically requested by the insured person.

Sources: National Health Insurance Fund (CNAM) and the *Rapport annuel sur l'Aide au paiement d'une complémentaire santé* (ACS) [2019].

increase the diffusion of public health insurance. At the same time, the "*100% Santé*" reform —which aims to provide access to all, without out-of-pocket payments, for dental and optical prostheses, and hearing aids— encourages the insured individuals to take out a complementary health insurance, as it is the basis for the free access to these "baskets of care". Implemented progressively between 2019 and 2021, the reform "*100% Santé*" has already improved access to healthcare, in particular with regard to dental prostheses and hearing aids, for which the market shares of the "*100% Santé*" offers have reached 55% and 39% respectively (CNAM, 2022).

The characteristics of the beneficiaries of the AAH without complementary health insurance between 2014 and 2018

This study, conducted in order to gain a better understanding of the beneficiaries of the AAH who do not benefit from these reforms (the CSS and the "*100% Santé*" health insurance measure), focuses on the exhaustive population of the 35,000 beneficiaries of the AAH who joined the scheme in 2014 and spent five years on it without ever being affiliated to a public or private complementary health insurance scheme. Although this population only represents 3% of all of the beneficiaries of the AAH, it is potentially exposed to high out-of-pocket payments. Compared with the general population of the beneficiaries of the AAH, the population without complementary health insurance is generally male (59% versus 50%) and more often consists of people who are recognised as having a chronic condition (ALD) [87% versus 71%], but with disease profiles that are not very different from those of the beneficiaries of the AAH covered in 2014 (see Table 1). Like all of the beneficiaries of the AAH, this is a relatively young population with an average age of 45 (see Table 2). It is exposed to slightly higher outpatient expenditures than the population of AAH beneficiaries which is already covered by a complementary health insurance scheme, in line with the higher proportion of people with a chronic condition (ALD) amongst the beneficiaries of the AAH who have no complementary health cover (see Table 2). While the proportion of hospitalised individuals is slightly higher amongst the beneficiaries of the AAH with complementary health insurance (30% versus 25%), the expenses are far lower amongst the persons without complementary health insurance, in particular for psychiatric care, but higher for post-acute care and rehabilitation (*Soins de Suite et de Réadaptation*, SSR) and for care in Medicine, Surgery, and Obstetrics (MCO).

The finding that there is a population without complementary health insurance that has outpatient expenditure that are relatively similar to those of the other beneficiaries of the AAH, but that has lower hospital expenses, calls for a better understanding of their healthcare consumption profiles.

A classification based on the healthcare expenses of individuals made it possible to construct a typology of ten categories that were then grouped into three major categories of healthcare consumption: standard care, predominantly hospital-related expenses, and treatment for disabling conditions (see Inset "Data and Method").

I2

The Health Insurance Vouchers Scheme (ACS) and the Complementary Health Solidarity (CSS)

Implemented in 2005 and reformed in 2015, the Health Insurance Vouchers Scheme (ACS) was a financial benefit scheme for less well-off people (monthly income under €1,007 for a person living alone in mainland France on 1 April 2019), making it possible to purchase individual complementary health insurance policy. The certificate enabled beneficiaries to benefit from a cheque whose amount varied in accordance with the beneficiary's age: €100 for persons under 16, €200 for persons aged 16–49, €350 for those aged 50–59, and €550 for persons over the age of 60. In 2018, after this financial support, the average cost of an ACS policy was around €209 per person per year (ACS, 2019). The coverage provided by the ACS included both an exemption from the patient's copayment for all outpatient and hospital treatments, and also complete coverage of the hospital daily rates by the complementary health insurance (ACS, 2019). The Health Insurance Vouchers Scheme (ACS) also restricted doctors' additional fees (Verniolle, 2016) as well as non-reimbursed dental and optical costs. However, the cost overruns of the products on the List of Refundable Products and Services (LPPR) were not covered (ACS, 2019).

Introduced in November 2019, the Complementary Health Solidarity (CSS) combined the former schemes –the free universal health insurance scheme (CMU) and the Health Insurance Vouchers Scheme (ACS)– and provided a new simplified scheme. The CSS is managed, according to the beneficiary's wish, either by the health insurance body responsible for the beneficiary's compulsory insurance, or by an approved complementary health insurance provider on the national list of insurance management bodies. The medical insurance coverage is free of charge up to the income limits of people who were formerly eligible to benefit from the CMU (financial resources below €753 per month for a single person), and is acquired on payment of a financial contribution for people with income between the old thresholds of the CMU and the ACS (since 1 July 2022, between €798 and €1,077 per month for a single person). The financial contribution of the persons varies with age: it varies from €96 per year for a person aged 29 and under to €360 for a person aged 70 and over.

The level of coverage of the Complementary Health Solidarity is equivalent to the coverage provided by the Health Insurance Vouchers Scheme (ACS): it corresponds to that of the free universal health insurance scheme (CMU), and the dental, optical, and hearing aids "baskets of care" have been aligned with the "baskets of care" in the "*100% Santé*" health insurance measure (also implemented in 2019).

Gradually introduced between 2019 and 2021, the reform "*100% Santé*" provides coverage without patients' out-of-pocket payments for dental prostheses, optical care, and hearing aids.

At the end of 2018, 5.63 million persons benefitted from the free universal health insurance scheme (CMU) and 1.27 million persons had subscribed to an ACS policy (Cabannes and Richet-Mastain, 2020). At the end of 2019, 6.9 million persons benefitted from the Complementary Health Solidarity (CSS) program, including 5.7 million with no financial contribution and 1.2 million with. In May 2022, 7.2 million persons were covered by the CSS, including 5.7 millions with no financial contribution and 1.5 million with (the French Department of Social Security, DSS, 2022)

T1

Frequency of the diseases of beneficiaries of the Disabled Adult Allowance (AAH)

CHI: complementary health insurance	Beneficiaries of the AAH Covered by CHI in 2014	Beneficiaries of the AAH Not covered by CHI
Cardiovascular diseases	8.8	10.5
Treatment of vascular risk	14.7	11.2
Diabetes	9.3	11.4
Cancer	4.7	4.3
Psychiatric illnesses	44.1	47.2
Psychotropic drugs	16.5	14.8
Neurological or degenerative diseases	13.1	15.4
Chronic respiratory diseases	9.5	8.8
Rare or inflammatory diseases, or HIV	5.3	8.8
Terminal chronic kidney disease (CKD)	1	1.6
Liver or pancreatic diseases	3.3	4.9
Other long-term illnesses	11.3	14.1
Maternity care	1	0.5
Without an identified disease	15.4	8.6

Reading: 44.1% of the beneficiaries of the Disabled Adult Allowance (AAH) with public or private complementary health insurance had a mental health disability whilst 47.2% of the beneficiaries of the AAH without complementary health insurance were in this situation.

Sources: the French Health System's' inter-scheme consumption database (DCIR), 2014–2018; calculations: IRDES.

Download the data

Almost 40% of the beneficiaries of the AAH without complementary health insurance had a healthcare consumption profile characterised by predominantly hospital-related expenses

The beneficiaries who had a healthcare consumption profile largely composed of standard healthcare were in the categories "General practitioner (GP), specialist, and medicine", "GP, medicine, specialist, dentistry, and optical care", and "Medicine". These beneficiaries represented a high proportion of the sample (45.5% of the sample as a whole) [see Table 3]. In these categories, the healthcare consumption mainly consisted of consultations with general practitioners and specialists. Expenditure on drugs accounted for a large proportion of the expenditure in the category "GP, medicine, specialist, dentistry, and optical care", and in the category "Medicine". The persons who had a healthcare consumption profile largely composed of standard healthcare were slightly less likely to have a chronic condition (ALD) than those people with a different profile.

The beneficiaries of the AAH who had a profile composed of predominantly hospital-related expenses (39.6% of the population) were mainly grouped into four categories: the category "MCO and medicine", the category "MCO, hospitalisation for psychiatric care, specialist, and medicine", the category "Hospitalisation for psychiatric care", and the category "post-acute care and rehabilitation, and physiotherapy". Unsurprisingly, hospitalisation expenses accounted for a high proportion of the healthcare consumption in these categories, as well as consultations with specialists in the category "MCO, hospitalisation for psychiatric care, specialist, and medicine". Most of the beneficiaries of the AAH in these categories had a chronic condition (ALD).

The beneficiaries of the AAH with treatment profiles linked to disabling conditions (15%) appeared in three categories: the category "Nursing care and medicines", the category "Protheses, treatment apparatuses, and facil-

T2 **A comparison between the beneficiaries of the Disabled Adult Allowance (AAH) without complementary health insurance and beneficiaries of the AAH with complementary health insurance in 2014**

	Beneficiaries of the AAH covered by complementary health insurance in 2014			Beneficiaries of the AAH who were not covered by complementary health insurance between 2014 and 2018		
	Whith ALD[a] (71%)	Without ALD (29%)	Combined	With ALD (87%)	Without ALD (13%)	Combined
Average age	45	44	**45**	45	42	**45**
Percentage of women	49	51	**50**	40	46	**41**
Total annual expenditure	10,713	2,828	**8,458**	7,911	2,533	**7,213**
Annual outpatient expenditure	4,302	1,491	**3,498**	3,853	1,407	**3,535**
Without hospitalisation (%)	59.9	78.1	**64.8**	68.7	82.3	**70.4**
Hospitalisation in MCO[b] (%)	30.1	19.6	**26.9**	24.6	15.9	**23.5**
Annual expenditure on MCO[c]	5,057	2,453	**4,518**	5,674	3,393	**5,473**
Hospitalisation for psychiatric care (%)	13.3	2.7	**10.2**	8.4	2.0	**7.6**
Annual expenditure on psychiatric[c] treatment	33,204	26,666	**32,715**	28,643	25,623	**28,536**
Hospitalisation for SSR[d] (%)	4.7	1.8	**3.8**	2.6	1.0	**2.4**
Annual expenditure on SSR[c]	10,129	8,029	**9,854**	10,324	6,186	**10,107**

[a] ALD: chronic condition; [b] MCO: Medicine, Surgery, and Obstetrics; [c] The average hospital expenditure was calculated for persons who were actually hospitalised; [d] SSR: Post-acute care and rehabilitation.

Reading: The beneficiaries of the Disabled Adult Allowance (AAH) without complementary health insurance had a total annual expenditure of €7,266, lower than that of the beneficiaries of the AAH with complementary health insurance (€8,458).

Sources: The French Health System's' inter-scheme consumption database (DCIR), 2014–2018; Calculations: IRDES.

Download the data

DATA AND METHOD

Data

The exhaustive data from the French health insurance system (inter-scheme consumption data, DCIR) were used over the period 2014–2018. They made it possible to identify the persons who were exclusively on the Disabled Adult Allowance (AAH) scheme via a "*petit régime*" code. The beneficiaries of the AAH who had other entitlements to health insurance, such as a disability pension or a professional activity, were not identified by this source (Verboux et al., 2020). The beneficiaries of the AAH aged between 20 and 65 identified in 2014, who remained on the scheme over a five-year period and never had complementary health insurance, constituted the study population. The information relating to the absence of complementary health coverage was reconstituted using data from the National Health Insurance Fund (CNAM), by matching the variable relating to the history of a person's subscriptions to complementary health insurance with the type of complementary health policy. The data relating to healthcare expenses reimbursed by mandatory health insurance and out-of-pocket payments are related to the outpatient and hospital sectors. Three types of hospital stays were considered: Medicine and Surgery (*Médecine et Chirurgie*, MC), post-acute care and rehabilitation (*Soins de Suite et de Réadaptation*, SSR), and hospitalisations in psychiatric facilities.

The study population comprised all of the beneficiaries of the AAH who joined the scheme in 2014 and who stayed on it for five years without ever having complementary health insurance, that is 34,898 individuals.

Method

The method used was an Ascendant Hierarchical Classification (AHC) applied to the dimensions a Principal Component Analysis (PCA). The individuals were grouped using the Ward criterion, which, at each step of the aggregation, minimised the loss of inter-class inertia. The categorisation was carried out according to the individuals' healthcare expenses.

For each individual, the total expenditure in the outpatient and hospital sectors was calculated for the entire period of 2014–2018. The proportion of each area of expenditure was then calculated: medicine, general practitioners, specialist doctors, biology, optical care, dental prostheses, ortheses and prostheses, apparatuses and equipment for treatment, physiotherapy, nursing medical acts, other outpatient expenses, hospitalisation in Medicine, Surgery, and Obstetrics (MCO), hospitalisation in psychiatric facilities, hospitalisation for follow-up and rehabilitation care, and transport. The classification was therefore carried out according to the structure of the individuals' healthcare consumption.

The AHC introduces 16 continuous variables, i.e. 16 factorial axes. Ten categories made it possible to distinguish the varied healthcare consumption profiles (see Table 1), which can be grouped into three categories:

- Standard healthcare.
- Profiles associated mainly with hospital expenses.
- Profiles associated with disabling conditions.

The "real" annual out-of-pocket payments were calculated after reimbursement by mandatory health insurance. The out-of-pocket payments after CSS were simulated based on the individuals' real expenses, taking into account the rules on exemption and the coverage provided by the CSS, and the '100% Santé' health insurance measure (total exemption from patient's copayments, except for medicines reimbursed at 15%, the absence de additional fees, coverage of hospital daily rates, and zero out-of-pocket payments for dental, optical, and auditory care). The advantages of the CSS were calculated as the difference between the real out-of-pocket payments and the simulated CSS out-of-pocket payments. Then each individual was allocated a financial contribution that depended on his or her age in accordance with the pricing rules of the participatory Complementary Health Solidarity (CSS) scheme (€96 for persons aged 29 and under, €168 for persons aged 30 to 49, €253 for persons aged 50 to 59, €300 for persons aged 60 to 69, and €360 for persons aged 70 and over). The percentage of beneficiaries for whom the amount paid by the CSS was higher than their financial contribution was then calculated for each of the ten categories.

It is therefore assumed that the Complementary Health Solidarity (CSS) works perfectly, which implies that there are no administrative problems with regard to reimbursements and no additional fees are ever applied to the services provided to the beneficiaries.

T3

Healthcare consumption profiles of the beneficiaries of the AAH without complementary health insurance obtained from the classification

	Categories	Standard healthcare			Hospitalisation				Disabling conditions		
		GP[a], specialist and medicine	GP, medicine, specialist, dentistry, and optical care	Medicine	MCO[b] and medicine	MCO, hospitalisation for psychiatric care, specialist, and medicine	Hospitalisation for psychiatric care	SSR[c] and physiotherapy	Nursing care and medicines	Protheses, apparatuses for treatment and facilities	Apparatuses for treatment and facilities, medicine,
Number		8,236	5,022	2,620	4,650	4,564	2,743	1,876	2,519	1,578	1,090
Share of the population		24%	14%	8%	13%	13%	8%	5%	7%	5%	3%
Chronic condition (%)		89%	69%	93%	87%	87%	96%	92%	95%	86%	94%
Average age		47	43	44	46	45	41	43	48	40	43
Average annual expenditure (€)		2,446	1,211	4,259	12,079	4,992	27, 640	8,134	13,128	2,896	7,807
Composition of the category											
Treatment apparatus		5.5	1.4	0.8	4.5	3	0.3	4.3	7.2	**11.5**	**61.1**
Biology		5.1	**8**	1.4	3	4.4	0.5	2.1	1.4	2.1	1.6
Dental care		2.5	**9.3**	0.5	1	2.7	0.6	1.2	0.6	1.7	0.7
Dental prostheses		0.2	0.6	0	0.1	0.2	0	0.1	0	0.1	0
General practitioner		**13**	**21.7**	4.3	4.1	7.8	1.1	4.1	3.3	4.7	4
Specialist		**9.1**	**19.5**	2	5.7	**10.9**	1.6	4.6	2.5	4.7	2.4
Nurses		1.2	1.1	0.3	2	2	1.9	1.4	**52.3**	1	2
Optical care		1.1	**4.7**	0.2	0.5	1.4	0.2	0.8	0.3	1.5	0.4
Other treatments		0.6	5.4	0.1	0.4	0.4	0.1	1.1	0.4	0.5	0.3
Medicine		**53.9**	**18.9**	**87.8**	**12**	**26.1**	8.1	10.6	**13.4**	8.6	**8.3**
Physiotherapy		0.9	3.9	0.2	1.4	1.1	0.2	**24.3**	3.7	4.8	5.1
Protheses and ortheses		1.3	1.7	0.2	2.6	1.1	0.2	4.3	1.3	**48.8**	3.7
MCO		4.1	2.6	1.3	**55**	**24.1**	2.2	7.4	7	6.1	**7.3**
Hospitalisations for psychiatric care		0.3	0.1	0.2	0.5	**10.7**	**80.9**	0.2	3.1	0	0
Hospitalisations for SSR		0.1	0.1	0	2.3	1.4	0.2	**13.1**	1	0.7	0.7
Transport		1.2	0.8	0.6	4.9	2.8	1.8	**20.3**	2.5	3.2	2.4

[a] GP: General practitioner; [b] MCO: Medicine, Surgery, and Obstetrics; [c] SSR: Post-acute care and rehabilitation.

Reading: The highlighted cases indicate the variables that contributed the most to the category. In category 1, expenditure on medicine represented on average 53.9% of the expenditure, whilst consultations with GPs constituted 13% of the expenditure, and consultations with specialists 9.1%.

Sources: The French Health System's' inter-scheme consumption database (DCIR), 2014–2018; calculations: IRDES. Download the data

ities", and the category "Treatment apparatuses and facilities, medicine, and MCO". These beneficiaries of the AAH were characterised by specific healthcare consumptions, with a predominance of nursing care or a high consumption of treatment apparatuses and facilities. The persons associated with these categories were more likely to have a chronic condition (ALD) than those who had a standard healthcare profile.

In all the categories, the beneficiaries of the AAH without copayment exemption had lower expenses than those of the beneficiaries of the long-term illness (ALD) scheme, but had higher out-of-pocket payments.

The "basket of care" provided by the Complementary Health Solidarity (CSS) would not make it possible to reduce the costs of technical aids

Lastly, we sought to assess patients' out-of-pocket payments, associated with the absence of complementary health cover and verify whether their expenses would be covered by public complementary health insurance. To achieve this, we compared the current level of their patients' out-of-pocket payments with the patients' contributions they would have to pay if they had public complementary health insurance —for which most of them were eligible–, by simulating the reimbursements provided by the Complementary Health Solidarity (CSS) and the "*100% Santé*"health insurance measure, by applying the regulations in force in 2022.

The beneficiaries of the AAH without complementary health insurance who had expenses resulting from disabling conditions had out-of-pocket payments somewhere between €352 and €500 per annum on average, including when they were associated with acquisitions of technical aids (between €352 and €500 per annum on average in the category "Protheses, treatment apparatuses, and facilities", Table 4). These out-of-pocket payments mainly comprised cost overruns for the acquisition of technical aids (€371 on average for the whole of the category "Protheses, treatment apparatuses, and facilities").

The persons without any complementary health insurance who featured in the category "Protheses, treatment apparatuses, and facilities" would see, if they were covered by the complementary health cover (CSS), their out-of-pocket payments decrease on average by €164, for those who were beneficiaries of the long-term illness (ALD) scheme, and by €365 for those who are not, in particular with regard to the cost overruns for the acquisition of technical aids. Nevertheless, this result conceals disparities. Indeed, given the exemption from patient's copayments and the possibility of choosing basic models without cost overruns, wheelchair users can acquire this technical aid without out-of-pocket payments. Hence, most of the beneficiaries of the AAH who use a wheelchair do not have out-of-pocket payments, so the Complementary Health Solidarity (CSS) would have no effect on them. For people who have out-of-pocket payments due to a state of health requiring the purchase of a wheelchair with cost overruns, the cost is €1,500 on average. As the "basket of care" provided by the CSS does not cover the technical aid requirements exceeding the List of Refundable Products and Services (LPPR)

T4

Real out-of-pocket payments (OOP) of the beneficiaries of the Disabled Adult Allowance (AAH) and simulated out-of-pocket payments with the Complementary Health Solidarity (CSS), average reduction of the OOP obtained with the CSS (in euros)

		Long-term illness		Annual average expenditure	The real annual patient's copayment (TM)/TM CSS (1)	Real annual additional fees*/CSS (2)	The real annual amount of hospital daily rates /CSS (3)	Real annual out-of-pocket payments (OOP) / OOP CSS (1)+(2)+(3)	Average simulated CSS reimbursement	3rd quartile of the simulated CSS reimbursement	% of persons for whom the CSS reimbursement would be higher than the financial contribution to the participatory CSS
				€	€	€	€	€	€	€	
Categories	General practitioner (GP), specialist, and medicine	With	89%	2,590	89/5	58/6	5/0	153/11	142	179	40%
		Without	11%	1,251	170/8	40/3	2/0	212/11	201	263	60%
	GP, medicine, specialist, dentistry, and optical care	With	69%	1,499	88/4	117/9	3/0	208/13	195	238	48%
		Without	31%	583	124/4	94/3	1/0	218/7	210	254	60%
	Medicine	With	93%	4,333	64/2	20/2	4/0	88/4	84	84	23%
		Without	7%	3,286	159/6	7/2	2/0	168/8	160	151	39%
	Medicine, Surgery, and Obstetrics (MCO), and medicine	With	87%	13,123	156/4	76/20	122/0	354/24	330	404	71%
		Without	13%	5,141	258/4	54/9	47/0	359/13	346	406	75%
	MCO, hospitalisation for psychiatric care, specialist, and medicine	With	87 %	5,422	157/6	92/8	71/0	320/14	306	390	47%
		Without	13%	2,138	238/8	95/3	20/0	353/12	341	447	61%
	Hospitalisation for psychiatric care	With	96%	27,907	167/4	72/3	582/0	821/7	814	1,085	88%
		Without	4%	21,063	419/4	60/7	469/0	949/11	938	1,144	83%
	Post-acute care and rehabilitation (SSR), and physiotherapy	With	92%	8,447	115/4	111/47	158/0	384/51	333	358	56%
		Without	8%	4,553	245/4	94/40	83/0	422/44	378	423	62%
	Nursing care and medicines	With	95%	13,350	173/6	86/33	63/0	321/38	283	350	57%
		Without	5%	8,685	328/6	57/8	30/0	415/14	401	342	59%
	Protheses, apparatuses for treatment, and facilities	With	86%	3,060	73/3	252/185	27/0	352/188	164	186	41%
		Without	14%	1,898	145/4	348/131	7/0	500/135	365	518	72%
	Apparatuses for treatment and facilities, medicine, and MCO	With	94%	8,037	113/3	128/88	36/0	278/91	187	205	43%
		Without	6%	4,359	265/6	55/36	10/0	330/41	289	177	38%

* The additional fees category included both overrun fees charges by physicians and the cost overruns for the acquisition of technical aids, for example.

Reading: In the first category, the average expenditure of persons on the Disabled Adults Allowance (AAH) scheme with a chronic condition (ALD) was €2,590 per year. In this category, the average patient's out-of-pocket payments for persons on the ALD scheme was €153 per year. The current patient's out-of-pocket payment is mainly composed of patient's copayments (€89) and additional fees (€58). With an unchanged consumption, the Complementary Health Solidarity (CSS) would make it possible to reduce the average patient's out-of-pocket payment to €6 for persons on the ALD scheme. The average benefit provided by the CSS is €142 for the persons in this category. In this category, the proportion of persons for whom the benefits of the Complementary Health Solidarity (CSS) exceed the amount of the financial contribution is 40%.

Sources: The French Health System's' inter-scheme consumption database (DCIR), 2014–2018; calculations: IRDES.

Download the data

rate and the "*100% Santé*" health insurance measure only covers hearing aids on the list of technical aids, these average additional costs are not reduced. Conversely, hearing aid users were unable to benefit from full cover before the reform. In the hypothesis that behaviours remain unchanged, the reform would have enabled, on the one hand, a quarter of them to select hearing aids with no out-of-pocket payments, and, on the other, it would have reduced the average out-of-pocket payments for all the users from €2,000 to €500. But the reform seems to have changed behaviours, in particular by steering the market towards the "basket of care" without patients' out-of-pocket payments (National Health Insurance Fund, CNAM, 2022), so much so that the real benefits would probably be even higher.

In the category "Protheses, treatment apparatuses, and facilities", 72% of the beneficiaries of the AAH who are not exempted from patients' copayments under the long-term illness (ALD) scheme would benefit from a Complementary Health Solidarity (CSS) reimbursement greater than the amount of their financial contribution. This CSS reimbursement would absorb some of the additional expenses for technical aids that are within the scope of the "*100% Santé*" health insurance measure, as well as the patients' copayments arising from consultations with specialists. On the contrary, only 41% of the beneficiaries of the AAH exempted by the ALD scheme in this category benefitted from a Complementary Health Solidarity (CSS) reimbursement higher than their financial contribution, which can be explained, in particular, by a smaller reimbursement of the patient's copayment that was already covered by the ALD scheme.

The persons who had a healthcare consumption profile associated with the category "Nursing care and medicines" had patients' copayments that were on average high (€181 in this category), while overrun fees were more moderate. Hence, the advantage of the Complementary Health Solidarity (CSS) would be the coverage of these patients' copayments (the simulated CSS reimbursement would be on average €289). By joining the CSS scheme, 60% of the persons in this category would benefit from a reduction in the patients' out-of-pocket payments that is greater than the amount of their financial contribution.

The beneficiaries of the AAH with a standard healthcare profile had lower out-of-pocket payments (€155 on average per year). Amongst the standard healthcare profiles, the out-of-pocket payments were the lowest in the category "Medicine" (€88 for persons on the ALD scheme and €168 for those who were not exempted), average in the category "GP, specialist, and medicine", and higher in the category "GP, medicine, specialist, dentistry, and optical" (€208 and €218).

In the categories associated with standard healthcare consumption, the out-of-pocket payments were mainly due to patients' copayments and overruns fees charged by physicians. The overrun fees were greater in each category for the beneficiaries of the ALD scheme than for the beneficiaries without exemption, which can be explained by more frequent consultations of specialists for patients with chronic conditions than for other insured persons. Furthermore, the overrun fees had a greater impact on the patients' out-of-pocket payments in the category "GP, medicine, specialist, dentistry, and optical care", which is more likely to include healthcare with additional fees.

As we are hypothesising that the Subsidised Supplementary Heath Insurance (CSS) would eliminate patients' copayments and overrun medical fees for consultations —and the "*100% Santé*" health insurance measure would eliminate the additional fees for optical and dental care—, the out-of-pocket payments would be reduced for the beneficiaries of the AAH with or without exemption by the ALD. Nevertheless, as the real out-of-pocket payments are initially moderate, the CSS and the "*100% Santé*" health insurance measure would only result in a minor reduction in the patients' copayments (between €89 in the "Medicine" category and €148 in the "GP, specialist, and medicine" category). In these categories, the reduction in the patients' out-of-pocket payments resulting from the CSS is rarely greater than the amount of the financial contribution required to obtain the CSS cover; in the 'Medicine' category, only 23% of the beneficiaries of the ALD scheme and 39% of the beneficiaries without exemption would be in this situation.

These simulated CSS reimbursements have to be compared with the average CSS reimbursement per beneficiary, estimated in 2019 at €420. Hence, for the beneficiaries of the AAH without complementary health insurance, the benefits of the CSS would be somewhat reduced in the absence of hospital care.

The benefit of the public complementary health cover is greater for frequently hospitalised persons

The beneficiaries of the AAH who had a profile composed of predominantly hospital-related expenses had far higher out-of-pocket payments: from €320 in the category "MCO, hospitalisation for psychiatric care, specialist, and medicine" for the beneficiaries of the ALD scheme, to €949 for the beneficiaries without exemption in the category "Hospitalisation for psychiatric care". In these categories, the hospital daily rates represented a significant proportion of the non-reimbursed healthcare costs, and more particularly for the beneficiaries of the ALD scheme, reaching €582 in the category "Hospitalisation for psychiatric care". These high amounts are due to long hospital stays: 20 days on average in the category "post-acute care and rehabilitation, and physiotherapy" and 36 days in the category "Hospitalisation for psychiatric care". The insured persons also had high patients' copayments and significant overrun fees in the categories "MCO, hospitalisation for psychiatric care, specialist, and medicine" and "post-acute care and rehabilitation, and physiotherapy".

Because the allocation of the Complementary Health Solidarity (CSS) would eliminate patients' copayments, additional fees, and the hospital daily rates, the resulting reductions in out-of-pocket payments would be high on average: from €316 in the category "MCO, hospitalisation for psychiatric care, specialist, and medicine" to €819 in the category "Hospitalisation for psychiatric care". In the category "Hospitalisation for psychiatric care", 83% of the beneficiaries of the ALD scheme and 88% of the beneficiaries without copayment exemption would benefit from a reduction in patients' out-of-pocket payments that would be higher than their financial contribution to obtain the CSS.

* * *

The population of beneficiaries of the AAH without coverage, which is the focus of this study, should not overshadow the beneficiaries of the AAH who are already mostly covered by private insurance (63%), without generally being aware of the possibility of taking out public health insurance. Indeed, 68% of the beneficiaries of the AAH were not aware of the Health Insurance Vouchers Scheme (ACS) at the end of 2018 (Cabannes, 2022).

For the beneficiaries of the AAH with private cover, whose healthcare consumption profiles are covered by the CSS (dental and optical care, hospitalisation, nursing care, etc.), there is undoubtedly a need to accelerate their transition to the CSS, which would provide them with access to extensive coverage of healthcare costs in exchange for a financial contribution that would definitely be lower than the premium they are currently paying. Indeed, the beneficiaries of the AAH –who have generally left the labour market– who wish to acquire complementary health insurance have to opt for an individual contract with a premium that is higher than the premium they would pay for a group contract obtained through an employer. Furthermore, the beneficiaries of the AAH are young with an average age of 45, which exposes them to a limited financial contribution if they opt for the CSS (€168 for persons aged 30 to 49 and even €96 for persons aged 29 and under).

Nevertheless, the 'basket of care' provided by public complementary health insurance is currently not always tailored to the needs of all the beneficiaries of the AAH, in particular those who are consumers of technical aids. Indeed, the limited "basket of care" may oblige persons with specific needs to take out private complementary health insurance that will provide them with better coverage. The principle of funding technical aids, which has prevailed until now, and which was regulated by coverage of the devices in accordance with the List of Products and Services (LPPR) rate, has recently been subject to a notable exception with the implementation of the "*100% Santé*" reform on the coverage of hearing aids. The hearing care professionals are now obliged to propose devices that are entirely covered by complementary health insurance schemes, and an amount of €800 is allocated if the person selects a more costly device, which facilitates access to care compared with other technical aids that do not benefit from the same funding schemes. The reform "*100% Santé*" with regard to hearing aids has led to a significant improvement in the use of hearing aids, with a 73% increase in the number of patients using them between 2019 and 2021, mainly explained by the increase in the number of beneficiaries of hearing aids as part of the "*100% Santé*" health insurance measure (National Health Insurance Fund, CNAM, 2022). Recent studies of technical aids that are poorly covered and yet very widely used have prompted the idea of extending the "*100% Santé*" health insurance measure to technical devices that would ensure that the

Complementary Health Solidarity (CSS) is more adapted to the needs of persons with disabilities (Espagnacq et al., 2022).

For the beneficiaries of the AAH who have no complementary health insurance, the financial contribution required to acquire the participatory CSS appears to be too costly for coverage that is deemed insufficient, above all if they are consumers of standard healthcare (general practitioners, medicines, nursing care, etc.), which is already amply covered by the compulsory health insurance through the ALD scheme, which exempts patients from paying the patients' copayments. Like other low-income households, the low level of their income as well as the extent of their pre-committed outlays (rent, loan reimbursements, insurance, telephone and Internet subscriptions…) leave them with little room to take on additional costs (Cusset, Prada-Aranguren and Trannoy, 2021). And now that there is a very low eligibility threshold for the free CSS, some of the beneficiaries of the AAH are excluded from coverage, which may block their access to healthcare, in particular in the context of the "*100% Santé*" health insurance measure, which determines the capping of out-of-pocket payments, on condition that complementary health insurance has been taken out beforehand.

The study also highlights the high level of the out-of-pocket payments for some of the AAH beneficiaries, in particular those who were hospitalised in psychiatric facilities for long periods. Unlike out-of-pocket payments for other amounts, which are actually paid by the users, the hospital daily rates are not always necessarily paid by the patient. Indeed, the levels of out-of-pocket payments highlighted in this study are such that the beneficiaries of the AAH without complementary health insurance will certainly not be in a position to pay for them once they have left the hospital; these debits will therefore be transformed into irrecoverable debts for the hospitals that treated them.

A limitation of this study is that its scope was confined to healthcare, which is only accessible via data from the French Health Insurance system (*Assurance Maladie*), without any overview of the other funding that complements the cover provided by certain schemes included in the LPPR (the Disability Compensation Benefit (PCH), the French association for the promotion of employment of handicapped and disabled individuals (AGEFIPH), etc.). Another limitation is that the benefits of the Complementary Health Solidarity (CSS) scheme were calculated on the basis that the consumption profiles remain unchanged after obtaining the coverage. It may be assumed that the benefits of health insurance with wider coverage and which entirely covers certain standard healthcare treatments might encourage the new beneficiaries of the ACS (Health Insurance Vouchers Scheme) to consume more of certain kinds of care, in particular preventive, dental, and optical care. In this case, the "gain" in terms of patient contributions would be even greater for the individuals who increase their healthcare consumption and a larger proportion of beneficiaries 'would benefit from' having the coverage.

The results of this initial study into the beneficiaries of the AAH without complementary health insurance, conducted over an observation period that predated the implementation of the CSS, will soon be complemented by another study. The latter will focus on the beneficiaries of the AAH who have decided to acquire the CSS coverage and on the changes in their resulting healthcare consumption profile. ♦

FOR FURTHER INFORMATION

- ACS (2019). *Rapport annuel sur l'aide au paiement d'une complémentaire santé. Bilan du dispositif.*
- Cabannes P-Y et Richet-Mastain L. (2020). « Minima sociaux et prestations sociales. Ménages aux revenus modestes et redistribution. Edition 2021 ». Panoramas de la Drees (social).
- Cabannes P-Y et Richet-Mastain L. (2021). « Minima sociaux et prestations sociales. Ménages aux revenus modestes et redistribution. Edition 2020 ». Panoramas de la Drees (social).
- Cabannes P-Y. (2022). « Fin 2018, un bénéficiaire de minima sociaux sur six n'avait pas de complémentaire santé ». Drees, *Etudes et Résultats,* n° 1 232.
- Calvo M. (2021). « Bénéficiaires de minima sociaux : un état de santé général et psychologique dégradé ». Drees, *Etudes et résultats,* n° 1 194.
- Cnam (2019). « Améliorer la qualité du système de santé et maîtriser les dépenses. Propositions de l'Assurance maladie pour 2020 ». *Rapport charges et produits*.
- Cnam (2022). « Améliorer la qualité du système de santé et maîtriser les dépenses. Propositions de l'Assurance maladie pour 2023 ». *Rapport charges et produits*.
- Cusset P-Y., Prada-Aranguren A-G., Trannoy A. (2021). « Les dépenses pré-engagées : près d'un tiers des dépenses des ménages en 2017 ». France Stratégie *La Note d'Analyse*, n° 102.
- DSS (2022). « La complémentaire santé solidaire et l'accès aux soins », *Revue de la complémentaire santé solidaire*, n° 5.
- Espagnacq M., Daniel F., Regaert C. (2022). *Questions d'économie de la santé* à paraître sur le repérage des personnes en fauteuils roulants et sur leurs dépenses.
- Lengagne P., Penneau A., Pichetti S., Sermet C. (2014). L'accès aux soins dentaires, ophtalmologiques et gynécologiques des personnes en situation de handicap en France. Une exploitation de l'enquête Handicap-Santé Ménages. Irdes, *Questions d'économie de la santé,* n° 197.
- Mordier B. (2013). « L'allocation aux adultes handicapés attribuée dans les départements. Des disparités liées au contexte sociodémographique des territoires ». Irdes, *Dossiers Solidarité et Santé,* n° 49.
- Penneau A., Pichetti S., Sermet C. (2015). « Les personnes en situation de handicap vivant à domicile ont un moindre accès aux soins de prévention que celles sans handicap. Une exploitation de l'enquête Handicap-Santé volet Ménages ». Irdes, *Questions d'économie de la santé,* n° 208.
- Penneau A., Pichetti S., Espagnacq M. (2019). « Dépenses et restes à charge sanitaires des personnes en situation de handicap avant et après 60 ans ». Rapports de l'Irdes, n° 571.
- Verboux D., Colinot N., Thomas M., Chevalier S., Gastaldi-Ménager C., Rachas A. (2020). « Pathologies et recours aux soins des personnes ayant un handicap repérable dans le Système national des données de santé ». *Revue d'épidémiologie et de santé publique*, n° 68.
- Verniolle R. (2016). « L'accès à la complémentaire santé pour les personnes disposant de faibles ressources : la CMU-C et l'ACS ». *Regards*, 2016(1), n° 49, p. 121-136.

IRDES INSTITUT DE RECHERCHE ET DOCUMENTATION EN ÉCONOMIE DE LA SANTÉ • 117bis, rue Manin 75019 Paris • Tél. : 01 53 93 43 02 • www.irdes.fr • Email : publications@irdes.fr •

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 Le Torrec • **Reviewers**: Aurélie Pierre, Estelle Augé • **ISSN:** 2498-0803.