The Affordable Care Act (ACA): What Are the Implications for the Employment of People with Disabilities?

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Motivation

- Current health care system poses special challenges for people with disabilities who work or could work

- Focus of ACA is on:
  - Reducing the number of uninsured people
  - Containing cost growth

- Will the reforms, as enacted, improve employment outcomes?

- Are additional reforms needed? If so, what?
Overview of Presentation

- Current system of financing health care for people with disabilities
- Illustrative examples:
  - A hole to be filled (coverage and access problems before and after enrolling in Social Security Disability Insurance [SSDI])
  - A current patch (Medicaid Buy-In)
- How does the ACA address holes?
- What are the implications for employment?
Working-Age People with Disabilities: Numbers and Costs

Source: Analysis of 2005 Medical Expenditure Panel Survey Data for people age 18 to 64. Disability is defined as any physical impairment or activity limitation of long duration, or participation in SSDI, Supplemental Security Income (SSI), or Medicare.

People Age 18–64 (millions)

- **Working, with Disability**: 9.9 (5.4%)
- **Not Working, with Disability**: 12.8 (6.9%)
- **Without Disability**: 161.4 (87.7%)

Expenditures (billions)

- **Working, with Disability**: $73 (12.6%)
- **Not Working, with Disability**: $143 (24.5%)
- **Without Disability**: $366 (62.9%)
Common Assumptions About Health Care Financing for Working-Age Adults
Reality Is Much More Complex

Source: Analysis of 2005 Medical Expenditure Panel Data for people age 18 to 64.

Source: Center for Studying Disability Policy

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Source: Analysis of 2005 Medical Expenditure Panel Data for people age 18–64. Insurance coverage and employment status are examined at any time during the year; “uninsured” means not covered for the entire year.
Hole #1: Employment Disincentives/Dependence Incentives

- Public coverage is often contingent on not working
- Individual private coverage is too expensive or unavailable
- More employers not offering coverage
- Employers have a disincentive to hire or retain those with high health care costs
- Employer-sponsored plans limit coverage for specialists, services, and equipment that people with disabilities often need
Hole #2: Life Events That Affect Coverage

- Job changes
- Transition from employment to SSDI
- Mobility across states
- Transition from youth to adulthood
Hole #3: Limitations of Public Coverage

- Coverage for many services requires low income and assets
- Payment policies restrict provider availability
- Access to care is often problematic, and care coordination is often poor
- Financing favors institutional care over home and community-based care
Illustration of Holes #1 and #2

- Coverage and access problems before/after SSDI entry
  - Livermore, Stapleton, and Claypool’s “Health Insurance and Health Care Access Before and After SSDI Entry” (2009), sponsored by The Commonwealth Fund
  - Health, health care, and health insurance of SSDI entrants in each of the three years before and after SSDI entry
  - 1994–1996 National Health Interview Survey (NHIS) data linked to SSDI, Medicare, and National Death Index data
Key Findings for SSDI Entrants

- There were 985,000 entrants in 2010 (updated)
- Most entrants move from “working” to “not working” over a one-year period
- Use of health care greatly increases
- Many delay or forgo care because of cost or lack of coverage
- Mortality is high
  - 13 percent die within two years after entry
Coverage for SSDI Entrants, 1994–1996

Source: Based on Livermore et al. (2009).
Patches for the Transition from Work to SSDI

- COBRA
- Medicaid Buy-In
Medicaid Buy-In Program

- Optional state program under Medicaid
- In 2011, 42 states + DC have Buy-In programs
- About 200,000 enrollees

Note: This research is funded by the Centers for Medicare & Medicaid Services (CMS). The views presented here are those of the authors and not necessarily those of CMS, its staff, or any state agency.
Medicaid Buy-In Program (cont’d.)

- Sliding-scale premium
- Upper income limit varies
  - E.g., 250% of the federal poverty line (FPL)
- Upper asset limit varies
- Coverage varies
How Does the Buy-In Work?

- Encourages employment by allowing people with disabilities to “buy into” Medicaid without giving up higher earnings or assets

- Patch for:
  - SSDI beneficiaries during the waiting period for Medicare
  - People who have to spend down to qualify for Medicaid
  - SSI beneficiaries whose income or assets exceed 1619(b) limits
  - Individuals not in SSDI/SSI who would otherwise fit the Social Security Administration’s disability definition if not for higher income or assets
Who Participates in the Buy-In?

Are Buy-In Participants Employed?

- 70 percent of Buy-In participants reported earnings; their average annual earnings were $8,582 in 2007

- In total, participants earned $631 million and were charged $27 million in premiums in 2007

Buy-In Participants Have Relatively Low Medicaid Expenditures

Buy-In Lessons Learned

- Fills certain coverage and service gaps
- Encourages increases in employment and earnings, at least for some people
- Allows states to tailor the program to their environment
- Relates to other system-wide changes
Buy-In Lessons Learned (cont’d.)

- Program is not portable across state lines (eight states have no program)

- The various means (and trade-offs) of obtaining Medicaid coverage can be confusing
Recap

- Three “holes” in health care financing for working-age people with disabilities
  - #1: Employment disincentives/dependence incentives
  - #2: Life events that lead to coverage gaps
  - #3: Limitations of public coverage

- Patches exist but are imperfect
Will the ACA Increase Employment?

- To what extent will the ACA fill the holes, and how?

- Are work disincentives increased, reduced, or unchanged?
Key ACA Provisions

- Preserves (strengthens?) employer coverage
  - Firms with 50+ employees must offer coverage or pay a fee
  - Guaranteed issue and community rating phased in
  - Annual and lifetime limits phased out
  - Employees may opt out
  - Children covered up to age 26

- Medicaid for all under 133% FPL
Key ACA Provisions (cont’d.)

- Health insurance exchanges (HIEs) provide individual coverage
  - Children covered up to age 26
  - Guaranteed issue and community rating
  - Subsidies for those with incomes below 400% FPL
    - If employer coverage is unavailable
    - Subsidy declines with income

- CLASS Act
  - Up to $50/day for nonmedical services/supports
  - Voluntary payroll deductions (by default)
  - Five-year waiting period
Hole #1: Employment Disincentives/Dependence Incentives

- Public coverage is less contingent on not working
  - Medicaid available to those with low income and assets
    - Disability not an eligibility requirement
    - Low earnings OK
      - $1,207/mo. for an individual
      - $1,630/mo. for a couple)
  - HIE subsidies provided to those with individual insurance
    - Bias toward individual coverage
    - Subsidy creates implicit tax on earnings

- Individual private coverage is available via HIEs and is subsidized
Hole #1: Employment Disincentives—Dependence Incentives (cont’d.)

- Will more employers offer coverage?
  - Required payments will increase coverage
  - Premium increases might reduce coverage

- Employers have more incentive to hire or retain workers with high health care costs
  - Phase in of guaranteed issue and community rating
  - Phase out of annual and lifetime limits

- Employer plans will continue to limit coverage for specialists, services, and equipment that people with disabilities often need
  - But CLASS support available for some
Hole #2: Life Events That Affect Coverage

● Job changes
  – Employer coverage is affected
  – Guaranteed issue and community rating help
  – HIE coverage changes only if availability of employer coverage changes

● Transition from employment to SSDI
  – HIE coverage fills the gap
  – Better access to care needed to work, under HIE and CLASS
  – Less incentive to continue working?
Hole #2: Life Events (cont’d.)

- Mobility across states remains a problem
  - HIE
  - Medicaid

- Transition from youth to adulthood
  - Medicaid eligibility less likely to change
  - Parental coverage can last to age 26
  - Parental coverage eventually lost
Hole #3: Limitations of Public Coverage

- Coverage for many services requires low income and assets *unless person is eligible for CLASS*
- Payment policies restrict provider availability
- Funding for improving care coordination, especially for “duals,” might be effective
- Reduction in Medicaid institutional bias
  - Money Follows the Person extended
  - Home- and community-based services for people with income up to 300% of the SSI standard
  - Community First Choice option
  - State Balancing Incentive Program
Summary

● The ACA maintains, but might weaken, the link between employment and private coverage

● Guaranteed issue, community rating and phase-out of annual and lifetime limits would increase employer incentive to hire and retain workers with high health care costs

● The ACA will increase access to acute care that people might need to stay at work or return to work
Summary (cont.)

- For some, the ACA will also increase access to critical services and supports via CLASS.
- The ACA makes it easier to obtain coverage without entering SSDI or SSI (but might encourage SSDI entry).
- The ACA reduces, but does not eliminate, transition issues.
What Next?

- Dismantle or strengthen the Medicaid Buy-In?
- Allow some workers to use the HIE rather than employer-based coverage
- Phase out employer-based coverage
- Pay more attention to services that support work
- Reward work
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