

Will Health Care Reform Increase the Employment of People with Disabilities?¹

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Working-age people with disabilities in America have a low employment rate and a high rate of dependence on public programs—a situation fueled, at least in part, by the challenges of the current health care financing system (Goodman et al. 2007; Hill et al. 2003). We might be on the brink of major health care financing reform, driven by rapid growth in the number of uninsured Americans and the cost of health care. Any reform is likely to have a profound impact on people with disabilities because many have considerable health care needs. Major reform might mitigate, or even eliminate, some of the challenges that limit the employment of this population, but there is no guarantee. The real effect will likely depend on many legislative and regulatory details that have not yet been settled. So far, however, the consequences of reform for the employment of people with disabilities have not been widely discussed.

In this brief, we first dispel the twin misconceptions that (1) people with disabilities cannot work and (2) they are all insured by public programs. We describe the challenges that the current system creates for those who work or attempt to work and then discuss the existing “patches” intended to address these challenges. We conclude with a discussion of the extent to which the leading reform proposals would further address these challenges.

Current Financing of Health Care for the Working-Age Population with Disabilities

A large share of the working-age population has a disability of some sort. Estimates vary with the definition of disability and the source of data. Based on our analysis of Medical Expenditure Panel Survey (MEPS) data for 2005, in that year 12 percent of those age 18 to 64 not residing in institutions had a functional limitation, had a limitation in an activity of daily living or instrumental activity of daily living, had a noncorrectable hearing or vision impairment, had a health-related work limitation, and/or were receiving disability benefits from Supplemental Security Income (SSI) or Social Security Disability Insurance (DI). Although most of these individuals were not working, a large minority (44 percent) were.

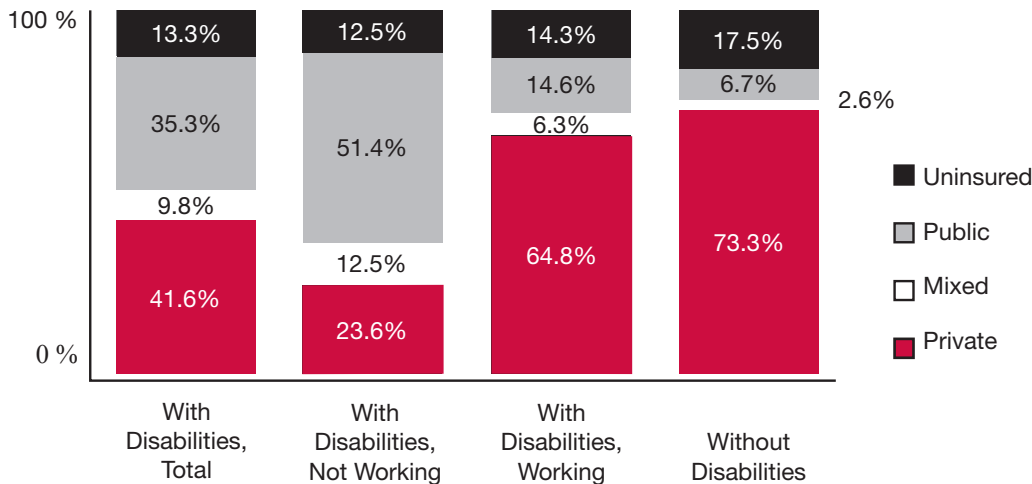
This same population accounts for a disproportionately large share of all health care expenditures for the working-age population—an estimated 37 percent (\$216 billion) in 2005, based on the MEPS. On a per-capita basis, their expenditures are over four times as high as those for their counterparts without disabilities (\$9,500 versus \$2,300 in 2005).

Working-age people with disabilities are less likely than others to have private coverage (primarily through their employer or a spouse’s employer) but are more likely to have public coverage (primarily Medicaid, Medicare, and veterans’ health care) (Figure 1, first vs. fourth bars). Most notably, 13 percent of them are uninsured; although this percentage is lower than for those without disabilities, it is substantial given the relatively high health care needs of this population.

Coverage for working-age people with disabilities relies heavily on their employment status. Those who are not employed are much more likely to have public coverage and much less likely to have private coverage than those who are

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Figure 1. Type of Health Coverage Among Working-Age People with Disabilities vs. Without Disabilities, by Employment Status



Source: Analysis of 2005 MEPS, persons age 18–64. Insurance coverage and employment status are examined at any time during the year. “Uninsured” means not covered for the entire year.

employed (Figure 1, second vs. third bars), and the coverage of the latter is very similar to that of those without disabilities (Figure 1, third vs. fourth bars). Many of the health care financing challenges faced by workers with disabilities reflect the link between employment and insurance.

Challenges and “Patches” in the Current System

The current financing system for the working-age population is a dual system that offers (1) employer-based coverage for workers and their families and (2) public coverage for the poor and those judged unable to support themselves because of a medical condition. This structure discourages work by people with disabilities and encourages dependence on public coverage.

For those with disabilities who work or want to work, the option of private coverage is not always available or viable. Many work for small employers that do not offer health insurance; when insurance is offered, some are ineligible because of limited working hours. Once coverage is obtained from an employer, many might fail to pursue better opportunities because changing jobs can lead to disruption in or loss of coverage—a situation known as “job lock.” In addition, private coverage is currently designed to provide acute care and to restore health. Services that people with chronic conditions need to maintain or enhance functioning—such as assistive technologies, outpatient mental health services, and personal assistance—may have limited coverage, if any. Furthermore, the rising cost of health care has encouraged employers to limit employer coverage and discouraged them from hiring or retaining workers with high health care needs. Many workers with disabilities are therefore pushed toward public coverage, which may be their only realistic option.

However, public programs also have gaps in coverage for people with disabilities. Many of those who stop working for medical reasons will eventually qualify for Medicare after obtaining DI benefits—but only after a 29-month waiting period. The waiting period was designed to ensure that the financial burden of care during this transitional period remains with private insurers, but it often falls on workers and their families. Based on data from the mid-1990s, 20 percent of DI entrants had no coverage in the three years leading up to entry or immediately afterwards, and 13 percent died before becoming Medicare eligible (Livermore et al. 2009). Youth with disabilities encounter another version of this problem as they seek to become more independent: they might lose coverage for critical services that were previously financed by a parent’s policy or the State Children’s Health Insurance Program before they can obtain coverage on their own. Furthermore, because public programs usually have income and asset limits, many with disabilities who could work and earn more have a strong incentive to stay under such limits to maintain public coverage.

The above challenges might help explain why employment rates for people with disabilities have been falling since the mid-1980s, despite major medical and technological advances that enable many people with significant impairments to be very productive. Some of these challenges have long been recognized, and there have been substantial efforts to “patch” them. For example:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allows workers to continue their employer coverage for up to 18 months after leaving a job, provided that they pay the full premium (including the employer’s share); it also extends coverage throughout the Medicare waiting period for those who enter DI.²

² The 2009 American Recovery and Reinvestment Act provides nine months of subsidies for COBRA coverage, but availability is scheduled to expire soon.

- The Health Insurance Portability and Accountability Act of 1996 imposes limits on the period during which employer group plans can exclude coverage of pre-existing conditions.
- The Mental Health Parity Acts of 1996 and 2008 require private group health plans of 50 or more employees to provide mental health coverage that is comparable to coverage for other conditions. Some states have stronger requirements.
- The Medicaid Buy-In (MBI) option, implemented in more than 40 states, allows workers with disabilities who meet the medical eligibility requirements for DI and SSI to pay a premium to enroll in Medicaid, even if their income and assets would ordinarily disqualify them. (Liu et al. 2008).

However, these patches have never fully addressed the challenges faced by workers with disabilities, and the patches are currently under strain from the rapid rise in the cost of health care. For instance, COBRA coverage is becoming less and less affordable to those who qualify, and states are under increasing budget pressure to cut back on optional programs such as MBI.

Health Care Reform: Better Patches?

Any health care financing reform enacted in the near future will likely maintain the current dual system of employer-based and public coverage, while attempting to better patch the gaps in between. The three leading proposals are those that have emerged from the Senate Finance Committee; the Senate Committee on Health, Education, Labor, and Pensions (“HELP Committee”); and three committees in the House of Representatives.

All three proposals share fundamental features that are also supported by the Obama administration. They are designed to maintain or expand employer coverage, but they are also intended to expand individual coverage options for those who do not have employer coverage and to increase public support for those who cannot afford private coverage. The committees propose to achieve these objectives through:

- State-run health insurance exchanges (HIEs), which allow individuals and small groups to purchase coverage
- Regulations to prevent insurers from restricting access or charging higher premiums to those with high-cost conditions
- Coverage requirements and/or financial incentives for individuals and employers
- Premium subsidies for households with low incomes (up to 400 percent of the federal poverty level [FPL]), plus premium credits for some small employers

- Medicaid coverage for all families with incomes below a specified threshold, ranging from 133 to 150 percent of FPL (Kaiser Family Foundation 2009)

Although reform proposals will differ in the details, these common features are likely to appear in any forthcoming legislation and will shape the functioning of the health care system for years to come—a system in which the role of employers in providing coverage is likely to be as strong or stronger than it is today. The current work disincentives for individuals with disabilities may change under the reform, but they will not necessarily diminish for all and might increase for some.

Disincentives in private coverage. As more employees are induced or required to offer coverage, it would seem more likely for workers with disabilities to be covered by employer-sponsored insurance. But if the cost of insuring those with high health care needs must be shared by employers and co-workers, as under the current system, the disincentive to hire them will remain strong or even increase. Job lock may also continue if health plan options vary by employer.

HIEs may provide a mechanism to address both of these issues. If workers with disabilities are allowed to opt out of their employer’s group plan and purchase individual coverage from the HIE, with the employer making premium contributions commensurate with those for other workers, the disincentive to hire them would diminish and workers could change jobs without a disruption in coverage.³

It appears, however, that none of the proposals provides such an option. Instead, if an employer offers group coverage, the employee is required to accept the offer or receive no employer contribution. As the legislative process continues, this requirement might be relaxed in ways that facilitate purchase of individual coverage through HIEs by workers with major health care needs. A public plan option, such as that proposed by the HELP Committee, might also allow states to develop their own approaches to making non-employer coverage available to such workers.

Disincentives in public coverage. Providing Medicaid for all people with incomes under a threshold (higher than the current one) would mean that they need not enter SSI or DI to obtain coverage; they would therefore have less incentive to enter or remain on the rolls. However, the work disincentives would remain for those with income above the Medicaid threshold but below the subsidy ceiling. Because the premium subsidy decreases with income, it represents an implicit tax on earnings at the margin—one that increases as earnings increase and income rises toward 400 percent FPL, after which the subsidy disappears. How this disincentive compares to the disincentive under the current system depends on the future of optional programs such as the MBI, under which participants

³ The potential of HIEs to solve this problem could be limited by the affordability of the individual plan options under the HIEs (net of the employer contribution) and the adequacy of the coverage. If many workers with expensive medical conditions opt out of employer plans and join individual plans, premiums for such plans would likely become unattractive to others unless the government provided assistance of some sort.

already pay sliding-scale premiums to obtain coverage. So far, no proposal has addressed the status of MBI.

The leading proposals do not eliminate the Medicare waiting period for new DI beneficiaries, but increased availability of individual coverage via HIEs would presumably increase access to coverage and ease the financial burden for those transitioning from employment to DI. This would be a major improvement for those who suffer extreme medical or financial hardship under the current system and would likely allow some to obtain care that helps them return to work, rather than transition to DI. But it also means that workers will no longer be discouraged from entering the rolls due to loss of coverage during the often lengthy DI application period and Medicare waiting period.

Coverage of needed services. The leading proposals include provisions designed to improve the availability of services needed to maintain or enhance functioning. The most ambitious provision is the Community Living Assistance Services Supports (CLASS) program, included in the HELP Committee’s proposal. CLASS would be paid for by a payroll tax, although individual

workers could opt out. Whether this or similar provisions remain in the final legislation will depend on their expected impact on cost.

As coverage expands, demand for covered services will increase, and pressure to contain rising costs will grow. The proposals have features that are designed to address cost growth, but the consequences of these features for people with disabilities are unclear. One possible consequence is that growth in expenditures for acute care will preclude covering additional services needed to maintain or enhance functioning. This outcome could make it more difficult for some people with disabilities to work, although some might seek to earn more so that they can pay for such services themselves.

Overall, the health care reform proposals appear to strengthen the patches already in place in the private and public systems, filling gaps that undermine the work efforts of people with disabilities. Though access to coverage will likely improve, work disincentives will remain. The extent to which they continue to be a challenge for people with disabilities will depend on many legislative and regulatory details yet to be specified.

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