

Disability Policy Research Forums

Forum Number Four:

“How Will Health System Reform Address the Needs of Working-Age People with Disabilities?”

Speakers:

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How Will Health System Reform Address the Needs of Working-Age People with Disabilities?

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March 26, 2009

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Motivation

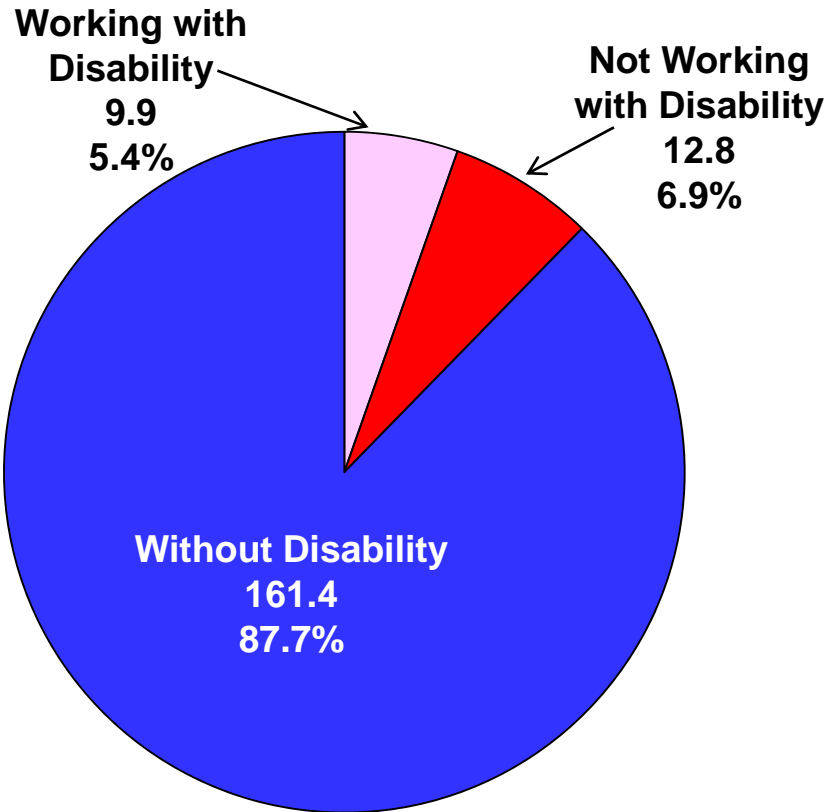
- **Current health care system poses special challenges for working-age people with disabilities and chronic conditions**
- **Focus of health care reform is on:**
 - Reducing the number of uninsured
 - Containing cost growth
- **Will these reforms address the key issues facing those with disabilities and chronic conditions?**
- **People with disabilities offer a litmus test for reform proposals**

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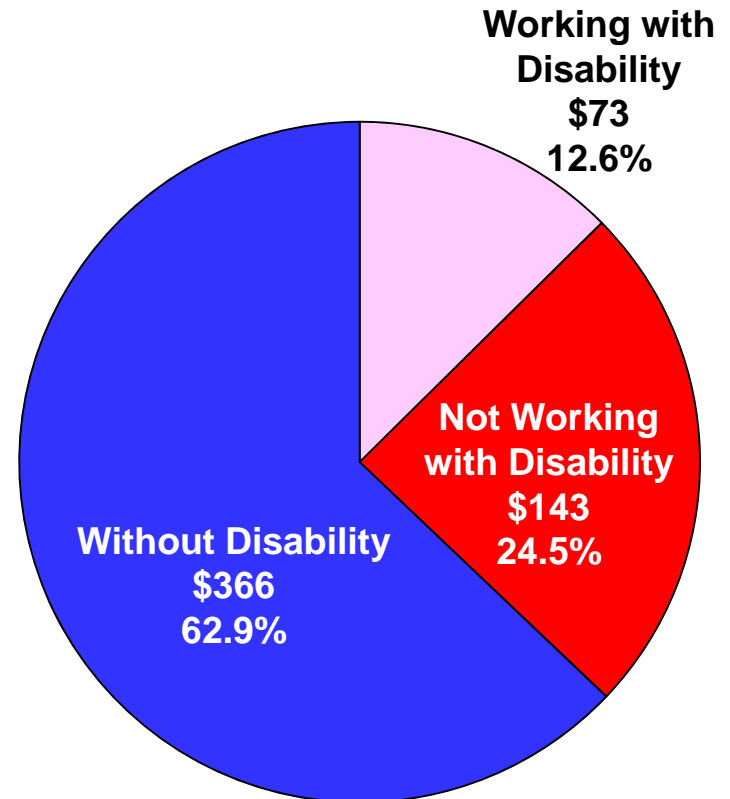
Overview of Presentation

- **Current system for financing health care for people with disabilities**
 - Private-public system with holes
- **Illustrative examples**
 - A hole to be filled (coverage and access problems before and after Social Security Disability Insurance [SSDI] entry)
 - A current patch (Medicaid Buy-In)
- **How would leading reform proposals address the holes?**

Working-Age People with Disabilities: Numbers and Costs



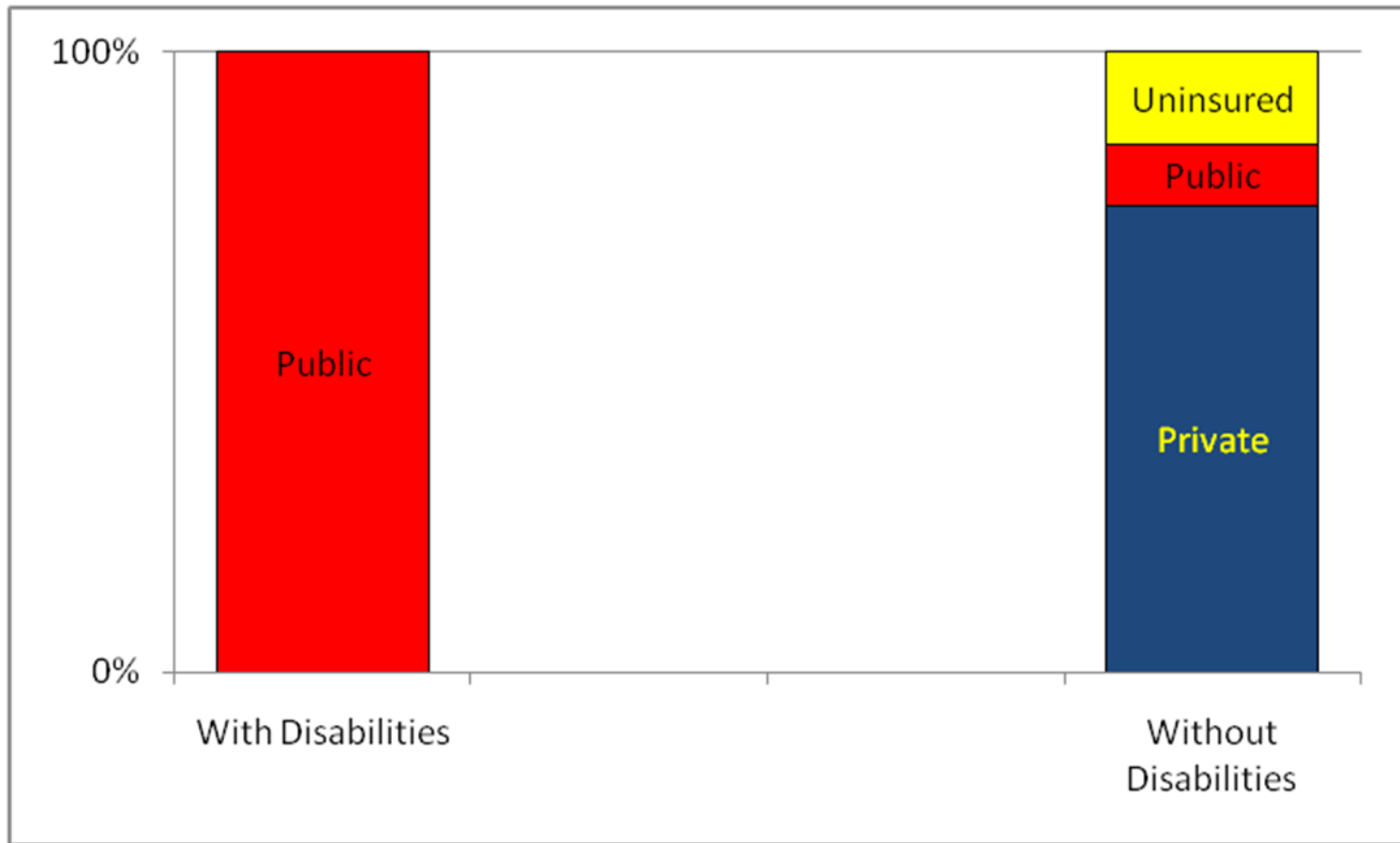
People Age 18–64 (millions)



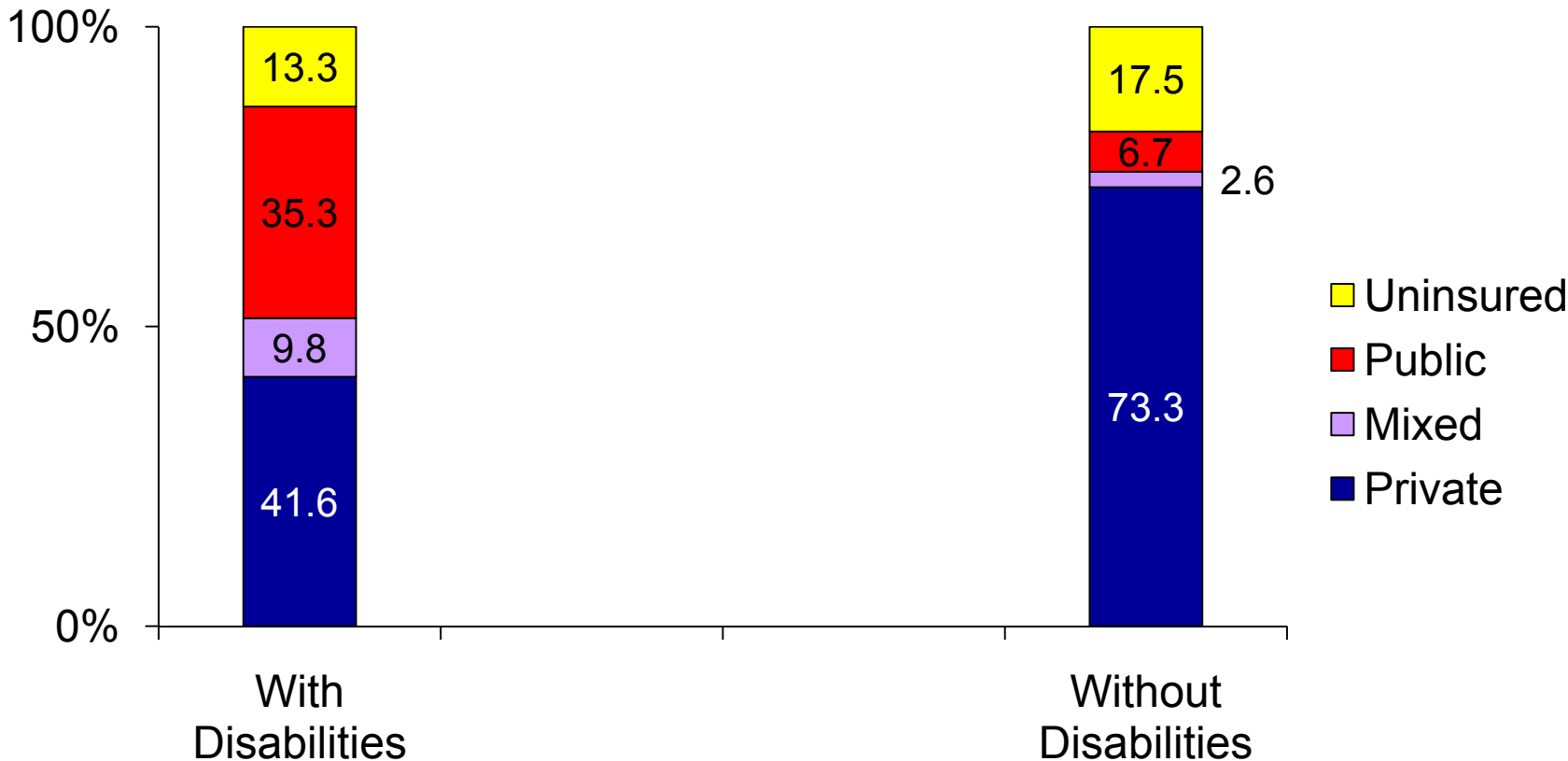
Expenditures (billions)



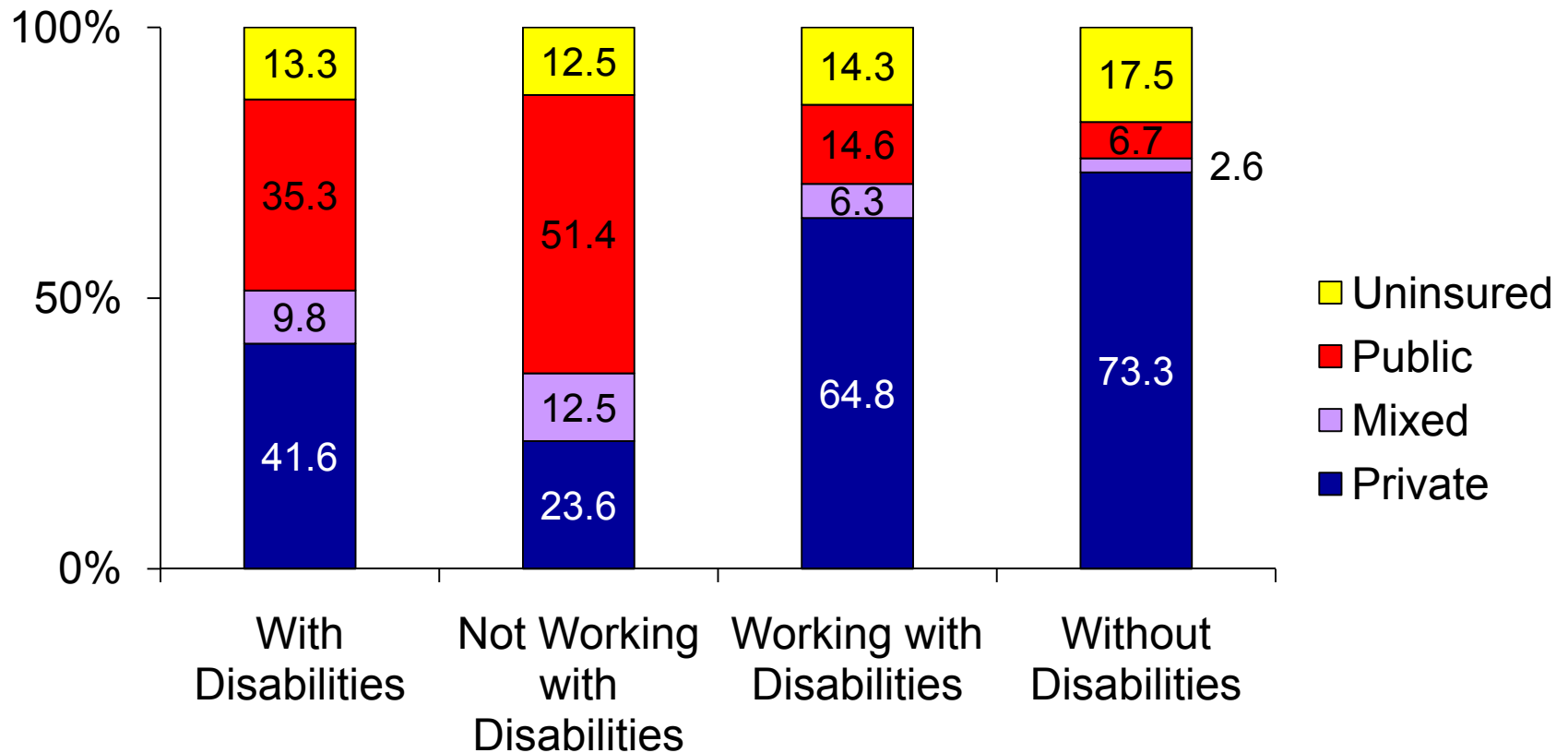
Common Assumptions About Health Care Financing for Working-Age Adults



Reality Is Much More Complex



Reality Is Much More Complex (cont.)



Hole #1: Public Coverage Has Significant Limitations

- Coverage for many services is depends on 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

Hole #2: Employment Disincentives— Dependence Incentives

- **Public coverage is often conditioned on not working**
- **Individual private coverage is too expensive or unavailable**
- **More and more employers do not offer 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 #3: Life Events Lead to Coverage Gaps and Changes

- Job changes
- Mobility across states
- Transition from employment to SSDI

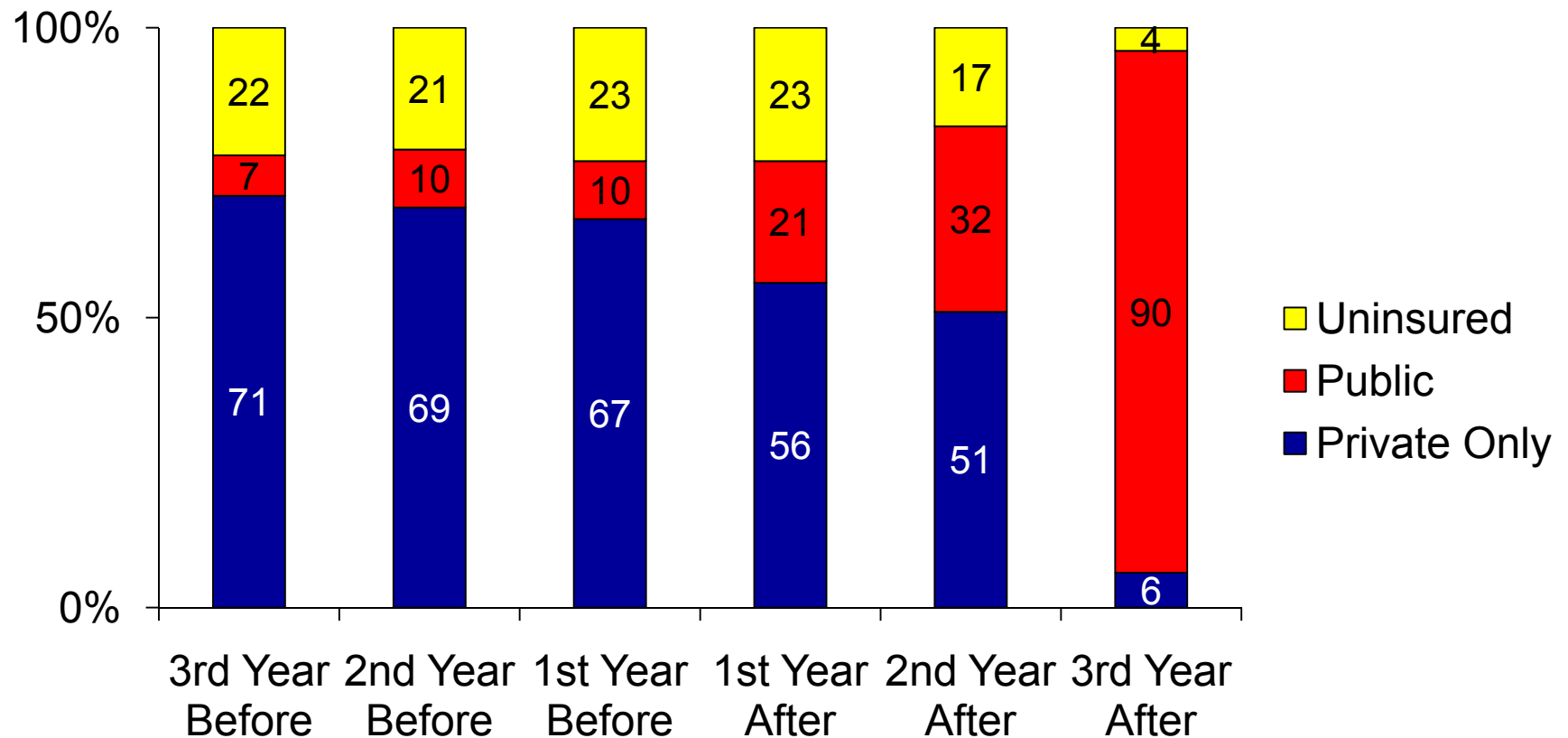
Illustration of Holes #2 and #3: Coverage and Access Problems Before/After SSDI Entry

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

Key Findings for SSDI Entrants

- **800,000 entrants per year**
- **Most entrants move from “working” to “not working” over a one-year period**
- **Health care use greatly increases**
- **Many delay or forgo care because of cost or lack of coverage**
- **Mortality is high**
 - **13 percent die by 24 months after entry**

Insurance Coverage for SSDI Entrants, 1994-1996



Patches for the Transition from Work to SSDI

- **COBRA**
- **Medicaid Buy-In**

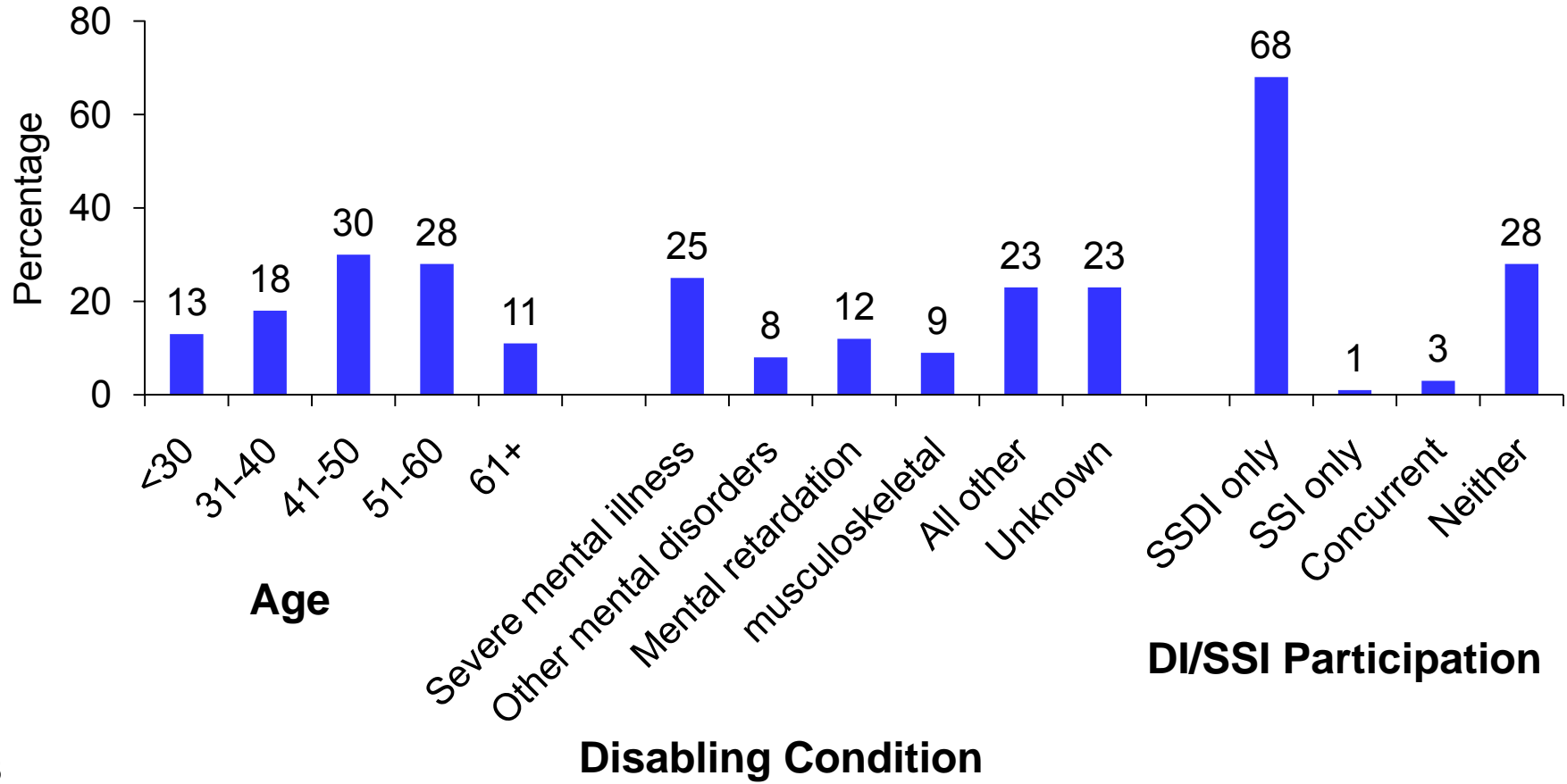
An Important Patch: The Medicaid Buy-In Program

- **Optional state program under Medicaid**
- **Authorized by the BBA of 1997 and the Ticket Act of 1999**
- **Currently offered by 41 states**
- **More than 215,000 individuals have enrolled**

How Does Medicaid Buy-In Work?

- **Encourages employment by allowing individuals with disabilities to “buy into” Medicaid without giving up higher earnings or assets**
- **Patch for:**
 - **SSDI beneficiaries in the waiting period for Medicare**
 - **Individuals who have to spend down to qualify for Medicaid**
 - **SSI beneficiaries whose income or assets exceed 1619(b) limits**
 - **Individuals not on SSDI/SSI who would otherwise fit SSA disability definition were it not for higher income or assets**

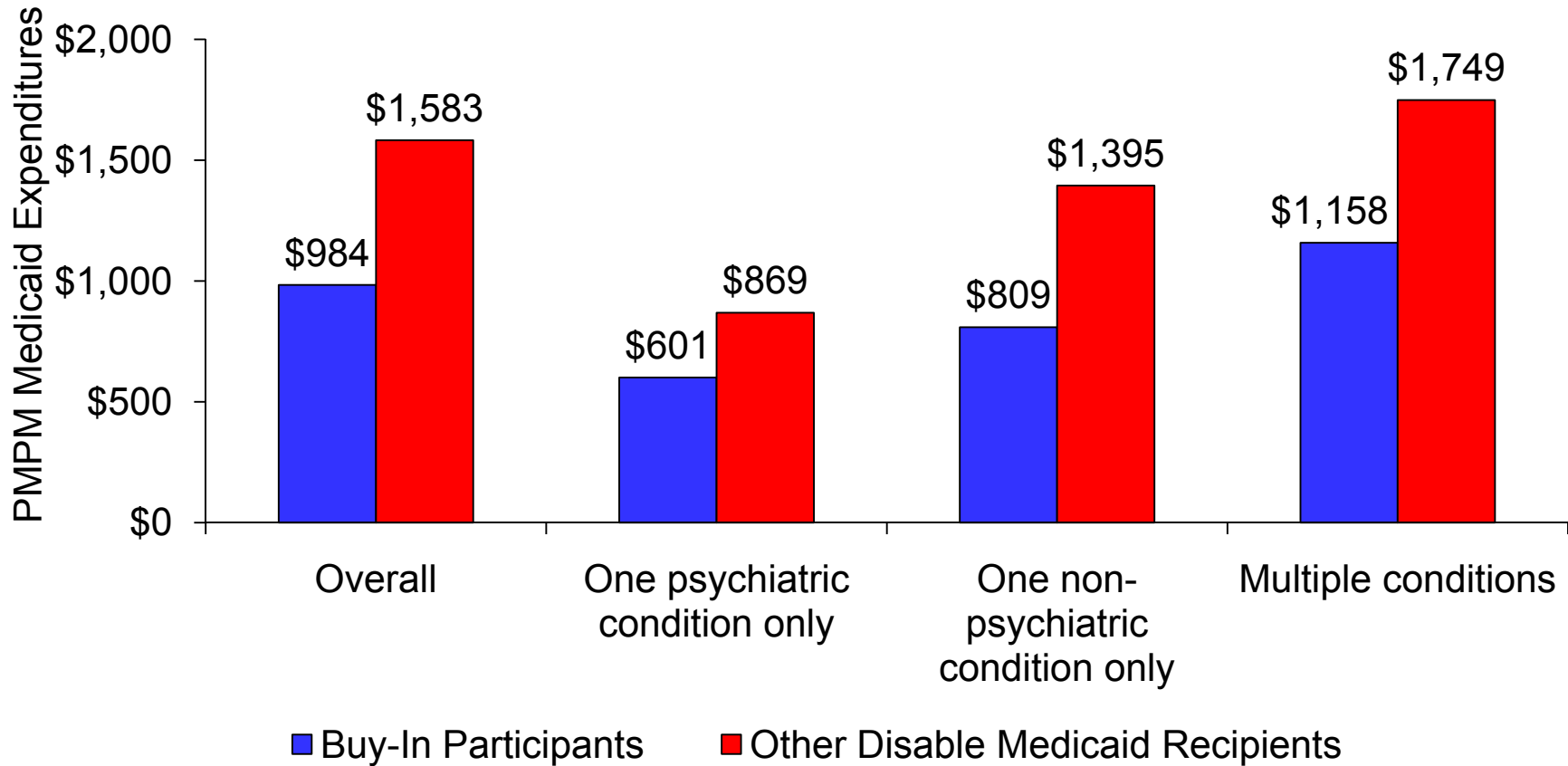
Who Participates in the Medicaid Buy-In?



Are Buy-In Participants Employed?

- **70 percent of Buy-In participants reported positive earnings; their average annual earnings were \$8,582 in 2007**
- **40 percent of first-time participants saw earnings increase in the year after enrollment relative to the year before**
- **In total, participants earned \$631 million and were charged \$27 million in premiums in 2007**

Are Buy-In Participants More Expensive to Cover?



Lessons Learned: What's Working?

- **Fills certain coverage and service gaps**
- **Incentivizes employment and earnings increase, at least for some people**
- **No evidence to date of higher per member cost to Medicaid**
- **Allows states to tailor program to unique environment**
- **Relates to other system-wide changes**

Lessons Learned: Making a Bigger and Better Patch

- **No portability across state lines (a quarter of states don't have the program)**
- **Does not address limitations of public coverage in general**
- **Various means of obtaining coverage (and tradeoffs) can be confusing**

Summary

- **Three health care financing holes for working-age people with disabilities**
 - Inadequacies of public coverage
 - Employment disincentives – dependence incentives
 - Life events lead to coverage gaps
- **Patches exist, but are imperfect**
- **How will leading health reform proposals affect:**
 - The holes?
 - The patches?

Will Health Care Reform Eliminate the Holes and Make Patches Unnecessary?

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Will Coverage Holes Be Filled by Health Care Reform?

- **Health care reform focuses on covering the millions of Americans who are uninsured (48 million; 90 million were uninsured for some period last year)**
 - **Individual mandate coupled with guaranteed issue**
 - **Subsidies for those unable to afford coverage**
 - **Premium rating practice protections**
 - **Large pooling of risk through Insurance Exchange and other mechanisms**

Will Coverage Holes Be Filled by Health Care Reform? *(cont.)*

- Strong reliance on existing public programs coupled with private employer-based system
- Heavy reliance on prevention/wellness
- Payment reform/cost control (aligning payment incentives)
- Quality improvement/comparative effectiveness
- Unclear but critical to consider: Reinsurance to cover outliers/catastrophic care

Critical Components Generating Controversy: “Public” Plan

- Labor and consumer advocates adamant that public plan serve as benchmark for private plans, hold them accountable, and serve as a safety net
- Business and insurers strongly oppose public plan because of fear of government-run health care
- According to the Commonwealth Fund, a public plan would attract over 100 million people (not including traditional Medicare and Medicaid) by 2010 if private plans are unable to reduce premium differential
- Impact of public plan on subsidies and adverse selection

Critical Components Generating Controversy: Basic Benefit Package

- **Package must be defined to a degree to assess whether coverage is “creditable” under individual mandate (i.e., Mass plan)**
- **Basic benefit package needs to include services for individuals with disabilities:**
 - **DMEPOS and assistive devices**
 - **Rehabilitation services that improve and maintain—not just restore—function**
 - **Mental health services**

Critical Components Generating Controversy: Basic Benefit Package (*cont.*)

- **No guarantee that benefit package will include services to improve function in addition to health status**
- **Adequate benefit package will prevent public insurance from being a “dumping ground” for individuals with disabilities (possible Plan B: reinsurance)**

Critical Components Generating Controversy: Comparative Effectiveness

- **Comparative effectiveness research (CER):**
 - **Pressure to combine effectiveness findings with cost information**
 - **Impact on disability/chronic illness**
 - **Viewed as one of the few levers to save health care money while improving care**

Critical Components Generating Controversy: Long-Term Services & Supports (LTSS)

- **LTSS would help individuals who need a continuum of care throughout their lifetime**
- **LTSS would also focus on home and community-based services rather than institutional care and would help to reduce the institutional bias**
- **With CLASS Act and Community Choice Act, LTSS and HCBC goals would be met**

With Health Care Reform, Are Patches Still Necessary?

- **Medicaid Buy-In**
- **Elimination of two-year waiting period**
- **Medicare Buy-In for those ages 59 to 62**
- **COBRA extension**
 - **Eliminate Medicare as a terminating event**
- **Guaranteed issue of Medigap for people less than 65 years old**