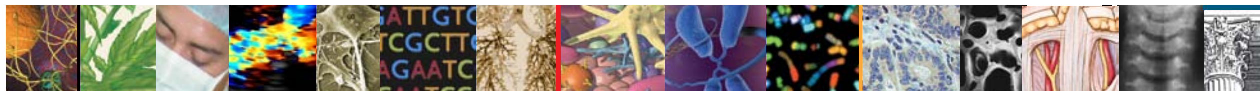

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Health Insurance–Motivated Disability Enrollment and the ACA

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The United States relies on employer-based health insurance to cover working-age adults and their families. As a result, Americans who are unable to engage in full-time work because of a chronic health condition must not only seek out wage replacement but also pursue alternative sources of health insurance. Health insurance is often more valuable than cash benefits to disabled workers who have high levels of medical needs. However, purchasing private insurance is rarely an option, owing to high costs and structural barriers such as lifetime spending caps, waiting periods, and exclusions of preexisting conditions from coverage. Disabled workers often apply for public financial disability benefits in part to obtain public health insurance — a uniquely American phenomenon that we call health insurance–motivated disability enrollment (HIMDE).

We believe that HIMDE is an important driver of the unsustainable growth in enrollment in public assistance programs for people with disabilities. The Social Security Administration currently has programs — such as the Ticket to Work and Medicaid Buy-In programs — that address this problem by preserving health insurance benefits for disability-program enrollees who return to work. These programs cannot address the systemwide cost and structural factors contributing to HIMDE, but certain reforms included in the Affordable Care Act (ACA) do address such factors — meaning that stabilization of federal disability programs through a reduction in HIMDE is an unacknowledged but important benefit of the ACA.

The Social Security Administration operates two large disability programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Both define disability as the inability to engage in substantial gainful activity due to a medically determinable physical or mental impairment. SSDI eligibility and benefit levels are determined by work history and funded by payroll taxes, whereas SSI eligibility and minimum benefit levels are based on low income and funded by general tax revenues. Some 7.8 million working-age adults receive SSDI benefits, 4.5 million

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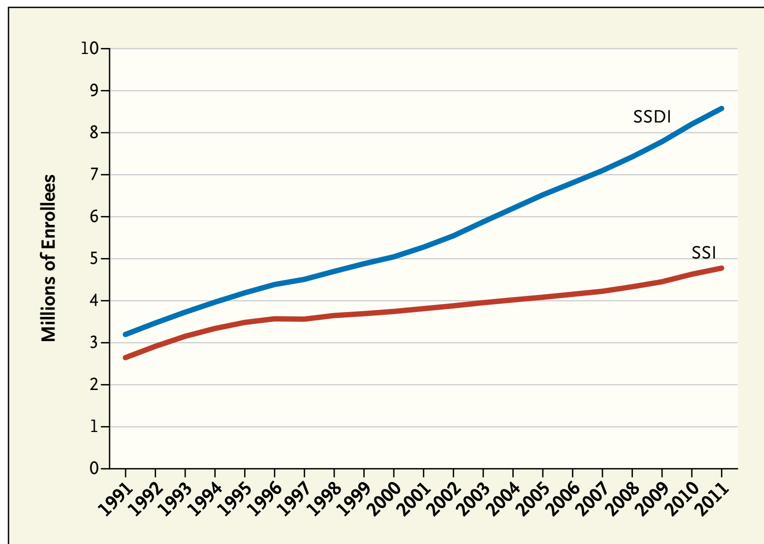

SSDI and SSI Program Enrollment among Adults 18 to 64 Years of Age, 1991–2011.
SSDI denotes Social Security Disability Insurance, and SSI Supplemental Security Income.

receive SSI benefits, and 1.6 million receive both. Enrollment in both programs has grown substantially in the past two decades (see graph). SSDI's current benefit payments exceed program revenues, and the disability portion of the Social Security Trust Fund may be exhausted within the next 4 years.[1]

Although Medicare and Medicaid funds are not as immediately vulnerable as SSDI, the cost of these programs is a perennial concern. Unsustainable enrollment growth in disability programs contributes to this cost because Medicare and Medicaid coverage are closely linked to receipt of SSDI and SSI: SSDI beneficiaries receive Medicare 24 months after their financial benefits start, and most new SSI beneficiaries are simultaneously deemed eligible for Medicaid coverage.

Because of these eligibility linkages, SSDI and SSI enrollees historically lost their public health insurance, as well as their transfer income, when they returned to work. Since the mid-1980s, the U.S. Congress and the Social Security Administration have experimented with program changes to encourage people to return to work. Among these changes are programs that allow former enrollees whose earnings exceed the income threshold to keep their public health insurance. The Ticket to Work and Work Incentives Improvement Act allows SSDI beneficiaries who are reentering the workforce to keep their Medicare coverage for as long as 8.5 years while their income support is gradually withdrawn. This law also authorizes optional Medicaid Buy-In programs for disabled workers, which are currently available in 32 states. Despite these programs, returning to work is the exception rather than the rule: in 2009, only 1% of SSDI beneficiaries left the program's rolls.[2]

The ACA contains multiple major reforms that should affect HIMDE more than previous efforts have done. Most important, it will increase insurance-coverage options for disabled workers, which could both reduce new health insurance–motivated applications for disability benefits and increase the percentage of enrollees who return to work. The law contains several policy changes that benefit various subgroups of people with disabilities. Extending parents' health insurance coverage for children to the age of 26 may encourage young adults with developmental disabilities to enter the workforce. Prohibiting insurance rescission and eliminating lifetime caps on insurance payouts may make private insurance more attractive for adults with progressive chronic conditions. Eliminating preexisting-condition exclusions will open the private insurance market for the first time to many adults with chronic illness and disability. Offering premium credits and cost-sharing credits will improve coverage and affordability for all workers, including those with disabilities. Capping annual deductibles at $2,000 for individuals and $4,000 for families should help to reduce out-of-pocket costs. Consequently, fewer disabled workers will need to rely on public insurance obtained through disability benefits.

Although nearly all employers with 50 or more workers offer health insurance, only 42.1% of firms with fewer than 50 workers offered insurance in 2008 and 2009.[3] As the private insurance market becomes more accessible and affordable for people with disabilities, they will be able to afford to work for these smaller firms that do not currently offer insurance. As a result, disabled workers who are younger or healthier or have higher levels of education will be more likely to enter or remain in the labor market instead of applying for disability benefits.

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In addition to making the private insurance market more accessible, the ACA will also change the public insurance landscape for disabled workers. The law originally required all 50 states to provide Medicaid coverage for persons with incomes below 138% of the federal poverty level, but the Supreme Court has ruled that such an expansion is not mandatory.[4] The effect of Medicaid expansion on HIMDE will therefore vary by state. States that currently have very low income-eligibility thresholds or do not cover childless adults will dramatically increase the number of adults eligible for Medicaid if they opt to expand their programs. Adults with potentially work-limiting disabilities residing in these states will be able to obtain Medicaid without first obtaining SSI through disability eligibility.

Despite these changes, there is unlikely to be an immediate large and sustained drop in enrollment in disability programs, owing to various economic and demographic factors. The aging of the U.S. population, tight economic conditions driving disabled workers out of the job market, and the raising of the retirement age will all increase pressure on disability programs even as HIMDE decreases after the ACA's implementation. Through its influence on the public and private insurance markets, the ACA will reduce HIMDE, addressing one major source of disability-program growth. As the ACA is implemented and evaluated, we urge health services and disability researchers to consider a reduction in HIMDE as an important measure of the success of health care reform for Americans with disabilities.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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