IssueBRIEF

Repealing or replacing the ACA's provisions: How would adults with disabilities fare?

Purvi Sevak,[1] Hunter College; Jody Schimmel Hyde, Mathematica Policy Research; Matthew Kehn, Mathematica Policy Research, November 2017

Introduction

Health insurance reform has been at the center of political debate for several decades. It took center stage during the 1990s, when efforts at comprehensive reform failed. Two decades later, substantial policy changes resulting from the passage of the Patient Protection and Affordable Care Act of 2010 (ACA) have brought the issue to the forefront again. Efforts to fully or partially reverse the changes implemented as part of the ACA began almost immediately after its passage, continuing with renewed vigor in 2017 as part of a budget reconciliation package for the 2018 federal fiscal year. On October 12, 2017, after those efforts failed, President Trump signed an executive order paving the way for insurance companies to offer less comprehensive plans, and his administration stated its intent to eliminate subsidies to insurers. Analysts indicate this will seriously impact the functioning of the ACA (Committee for a Responsible Federal Budget 2017). Current proposed legislation for comprehensive tax reform includes a repeal of the individual health insurance mandate that is a cornerstone of the ACA.

The proposed and implemented changes—and their potential effects on health insurance coverage—have been discussed extensively, and in several cases they have been "scored," with potential impacts estimated by the Congressional Budget Office (CBO).[2] Yet, due to the fast pace at which reforms have been proposed, there has been relatively little focus on their potentially far-reaching consequences.

In this brief, we focus on the effects the proposed policy changes could have on individuals with disabilities and individuals with chronic conditions that could become disabling.[3] We begin by discussing the likely effects on coverage and access to care, and then review the potential effects the coverage changes would have on employment. Health insurance is crucial for people with disabilities, because timely access to medical care helps them manage their complex health needs. Yet, many with disabilities report significant problems accessing care (Henning-Smith et al. 2013; Iezzoni 2011; Smith 2008; Hanson et al. 2003; Iezzoni et al. 2011; Miller et al. 2014). As noted by the National Council on Disability in January 2016: "For people with disabilities and their families, the quality, availability, and types of health care and-long term services available to a person can have profound consequences on many other areas of life, including where one lives and how one pursues or maintains employment."[4]

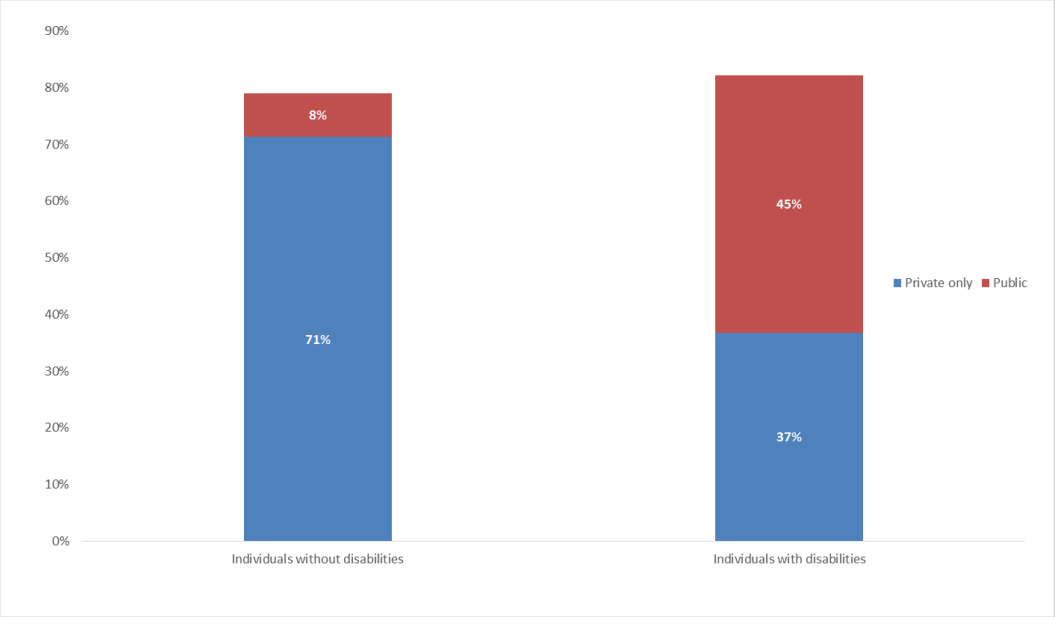
What health insurance options did adults with disabilities have before the ACA?

The employer-based system for obtaining health insurance was the predominant source of coverage in the United States before the ACA, and it presented unique challenges for individuals with disablities

often lacked coverage because preexisting conditions made them ineligible for non-group coverage or because such coverage was prohibitively expensive (Sommers 2006; Pizer et al. 2009). Those who did work often had part-time jobs or other positions not covered by employer-sponsored plans (Livermore and Honeycutt 2013). Workers experiencing a new work-limiting disabling condition may also become "job locked," unwilling or unable to move to new jobs out of fear of losing health insurance entirely or ending up with lower quality coverage. Individuals with disabilities might feel "stuck" in a job if they have no guarantee they can buy affordable and quality coverage in the market.

The lack of coverage options in employer and non-group markets has elevated the importance of publicly provided health insurance for adults with disabilities. Although individuals with disabilities had rates of coverage (82 percent) comparable to those for individuals without disabilities (79 percent), the *type* of coverage was dramatically different between the two groups (Figure 1). Employer-sponsored coverage was the predominant source among those without disabilities, and public coverage was the more common source of coverage among those without disabilities.

Figure 1. Working-age adults with disabilities were as likely as working-age adults without disabilities to have insurance coverage, but a much higher share were covered by public plans



Source: Authors' calculations based on the 2009 American Community Survey (ACS) accessed at IPUMS-USA, University of Minnesota, www.ipums.org.

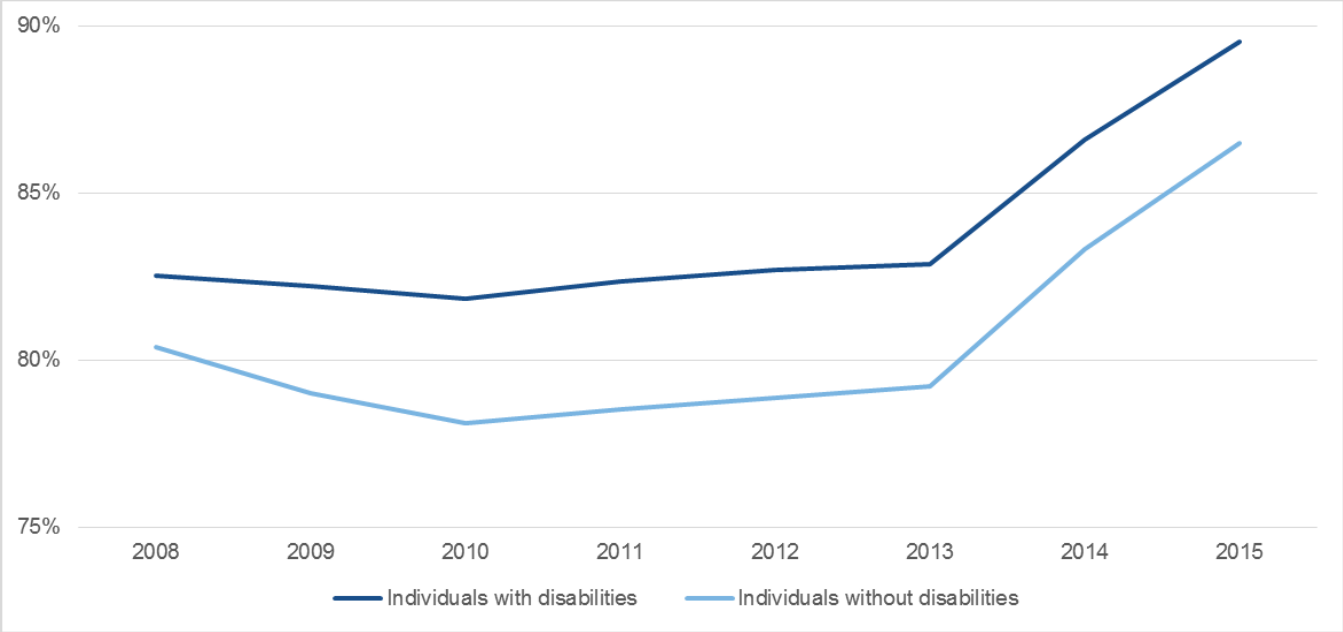
Notes: Limited to working-age adults (ages 18 to 64). Public insurance includes Medicare and Medicaid, and private insurance includes employer-provided, individually purchased, and other plans. Insurance coverage rates vary across sources of nationally representative survey data, in part because of differences in question wording.

Before the ACA, public coverage was primarily available only to those meeting the eligibility requirements of federal disability programs. Medicaid was often given to Supplemental Security Income (SSI) recipients, and Medicare was available to Social Security Disability Insurance (SSDI) beneficiaries once they completed a 24-month waiting period. Because few other avenues offered public coverage, there was some anecdotal evidence that adults with disabilities who lacked other coverage options could have sought federal disability benefits primarily as a way to get insurance—so-called health-insurance motivated disability enrollment (Kennedy and Blodgett 2012). Yet, although SSI and SSDI can be a valuable avenue to health insurance coverage, they also create a disincentive to work. Eligibility for both SSI and SSDI is predicated on the inability to engage substantially in the labor market for an extended period of time due to a disability. For workers with disabilities who might have otherwise tried to stay in the labor market, the need for reliable health insurance coverage may have driven them away from work. In addition, the fear of losing the associated health insurance benefits might dampen the efforts of those already receiving SSDI to get back to work.[5]

How did the ACA change the coverage landscape?

Between 2010 and 2014, the ACA implemented changes that made the coverage outlook brighter for all Americans. (More information about the most salient provisions can be found in Box 1). As a result of those changes, health insurance coverage levels have gone up throughout the country—for people with or without disabilities (Figure 2). Coverage increases began in 2010, reversing the declines of the Great Recession. Faster expansions in coverage took place in 2014. By 2015, 41 percent of working-age individuals with disabilities had obtained coverage through Medicaid and 11 percent were getting it through the health insurance marketplaces.

Figure 2. Health insurance coverage rates for working-age individuals increased after ACA implementation, regardless of disability status



Source: Authors' calculations based on the American Community Survey (ACS) accessed at www.ipums.org, the website of IPUMS-USA, University of Minnesota.

Notes: Limited to working-age adults ages 18 to 64. Health insurance coverage includes public, employer-provided, and individually purchased plans. Insurance coverage rates vary across sources of nationally representative survey data, in part because of differences in question wording.

Box 1. KEY PROVISIONS AND CHANGES RESULTING FROM THE ACA

- Medicaid expansions. In 31 states and the District of Columbia, Medicaid coverage became available to childless adults with household incomes up to 138 percent of the federal poverty line.
- Individual and employer mandate. The ACA requires everyone to have some form of public or private insurance or to pay a penalty for going without it, and it imposes fines on employers who do not offer affordable coverage to their employees.
- Tax credits/subsidies for adults with low incomes who are purchasing coverage. Subsidies are available to make insurance more affordable for people who have low incomes but do not qualify for Medicaid or have insurance through an employer.
- Marketplaces for purchasing individual insurance. Also known as health insurance exchanges, these "one-stop shops" were designed to give consumers and employers an easy way to compare plans and select an affordable choice.
- Provisions required of all plans. All health plans offered on the exchanges must cover 10 essential health benefits (EHBs), including prescription drugs and treatment of mental health and substance abuse; must not preclude enrollment based on preexisting conditions; must offer coverage for dependents up to age 26; and may have annual or lifetime limits on EHBs

How would repealing or replacing certain ACA provisions affect coverage of individuals with disabilities?

Beginning early in 2017, Republican legislators have introduced a series of bills to repeal or replace the ACA.[6] In the summer and early fall of 2017, Republican congressional leaders made several attempts to dismantle some or all of the provisions of the ACA.[7] Across the U.S. population as a whole, the CBO estimated that the proposed reforms would lead to millions of people losing comprehensive insurance, although a precise estimate would depend on the specific details of how the reforms would be implemented (CBO 2017). So far, these proposals have not been made into law, but legislators have signaled their continued interest in reforms.

Following those attempts, an executive order signed by President Trump on October 12, 2017, expanded options for "bare bones" plans sold by associations across state lines; these "association plans" would be cheaper than marketplace plans, but would cover fewer services.[8] On the same day, the Trump administration indicated that it would stop making cost sharing reimbursement (CSR) payments to insurers. Under the ACA, CSRs had allowed insurers to offer reduced co-pays and deductibles for consumers with low incomes who sought to purchase plans through the marketplace (Committee for a Responsible Federal Budget 2017).

Taken together, the reforms implemented to date and those that legislators have suggested remain under consideration in future legislation will likely mean that fewer individuals with disabilities will have coverage; those that do will pay more for coverage, and fewer people will have the comprehensive coverage that they need to meet their health care needs. In this section, we describe aspects of the proposed reforms and the executive order that are particularly salient to adults with disabilities.

- **Reducing minimum standards for insurance plans.** The goal of allowing associations to sell new plans without mandated benefits is to offer consumers lower cost plans that are less comprehensive than required by the ACA. Others have proposed achieving that objective by eliminating essential benefits provisions, the prohibition on lifetime and annual dollar limits, and/or the requirement for individual and group plans to cover preventive benefits without cost sharing. Yet, minimum standards were meant to give people continued access to services that are essential for maintaining good health, independence, and employment—such as care for mental health and substance abuse, rehabilitative services, and chronic disease management.

Moreover, unraveling these ACA provisions would likely yield plans that do not meet the complex health care needs of persons with disabling or chronic conditions, and ultimately segment the market into separate plans for those with a substantial need for health care and those who do not expect to spend much on health care. This segmentation would ultimately lead to more expensive—perhaps prohibitively expensive—plans for people seeking comprehensive coverage.

- **Reducing CSR payments or individual subsidies.** Under the ACA, the federal government used CSRs as subsidies to insurers to offer plans with lower cost-sharing to individuals with low incomes. Uncertainty about the legality and future of subsidy payments, starting with a lawsuit by the House of Representatives in 2014, has led some insurers to substantially increase premiums and in states like Delaware, Iowa, Nebraska, and Virginia contributed to insurers like Aetna leaving the marketplace altogether (Committee for a Responsible Federal Budget 2017; Goldstein, 2017). Eliminating CSR payments, which the administration has signaled it will do, will create significant revenue shortfalls for insurers, and is likely to cause more increases in premiums and exits from the ACA marketplaces as early as 2018 (Kaiser Family Foundation 2017).

- **Creating high-risk pools.** To lower premiums for the majority of the population that is healthy, some proposals have promoted allowing insurance companies to practice medical underwriting that would allow them to exclude people with certain conditions. For example, these conditions could include heart disease, cancer, diabetes, developmental disabilities or other conditions that are associated with higher risk of significant medical expenditures. These people would obtain coverage in separate markets known as high-risk pools. To help these individuals and insurance companies bear the higher costs of their coverage and care, high risk pools could have a cap on premiums but would require large subsidies from the federal government to the insurance companies.

Experience with high-risk pools has shown them to be prohibitively expensive both for consumers and the government. In the 35 states with high-risk pools before the ACA, plans had many exclusions, yet consumers paid premiums that were on average 50 to 100 percent higher than typical premiums, and states collectively spent over $1 billion per year to offset the

losses insurance companies faced in the high-risk pools. Insurers participating in the temporary high risk pool that the ACA established from 2010 to 2014 had losses of $2 billion for 2014 alone (Pollitz 2016). Based on this evidence, it seems likely that new pools will need to operate differently and be funded much more fully than they were in the past to keep the most vulnerable from falling through the cracks (Altman 2017).

- **Changes to Medicaid.** Much of the proposed legislation to repeal the ACA has recommended reversing the Medicaid expansions immediately or phasing them out over time. Limiting or ending the expansions would jeopardize insurance coverage for people with disabilities and low incomes. Reduced access to public coverage would also require many low income individuals with disabilities to apply for SSI or SSDI to obtain insurance coverage through Medicaid or Medicare, respectively. Recent research provides some evidence that this could occur (Burns and Dague 2016; Chatterji and Li 2016; Hyde et al. 2017; Schmidt et al. 2017).

- **Repealing the individual mandate.** Many legislators have argued for eliminating the individual mandate established under the ACA. The intent of the individual mandate was to expand the risk pool for those purchasing coverage, including many more people with minimal health care needs who might not otherwise purchase coverage. By broadening the risk pool, the individual mandate makes coverage more affordable for those with high expected expenditures. Eliminating the mandate would drive lower-risk individuals out of the marketplace and raise costs for those who remain.

Some proposals have been designed to alleviate the negative effects of the individual mandate's repeal on the individual market by offering a continuous coverage incentive. That approach would require insurers to charge consumers a penalty if they purchase coverage again after a lapse in coverage. For individuals who have episodic health conditions, including some types of mental illness, or for those who experience the limitation of new disabilities, maintaining continuous coverage may be challenging. This would mean such groups would face higher premiums when they sought new coverage.

How did health insurance expansions affect working for individuals with disabilities, and what does that signal for future reforms?

The employment rate of workers with disabilities has always lagged behind the rate in the general working-age population. In 2015, the employment rate among working-age individuals with disabilities was 35 percent—less than half the rate of 76 percent among individuals of working age who did not have disabilities (Lauer and Houtenville 2017). Recently, however, that gap has seemed to narrow (UNH 2017). Although researchers have not linked that change to ACA reforms, such a link is plausible.

To date, only one published study has estimated the impact of the ACA on the employment status of individuals with disabilities (Hall et al. 2017), and it offers inconclusive evidence.[9] The authors compared employment rates in states that expanded Medicaid to rates in those that did not. They found that employment rates among individuals with disabilities were higher in 2015 in expansion states than in non-expansion states, providing evidence consistent with the hypothesis that Medicaid expansions are associated with higher rates of employment. The authors, however, did not observe that employment *increased* faster in expansion states relative to non-expansion states from 2013 to 2015. Thus, their findings could simply reflect different labor markets in expansion and non-expansion states.

Economic models on labor market behavior do not clearly predict the impact of expanded health insurance coverage on the employment of individuals with disabilities. On the one hand, employment might increase if wider availability of coverage allows people who might have otherwise sought federal disability benefits to remain in the labor force. Several studies have considered this relationship, with mixed findings (Maestas et al. 2014; Burns and Dague 2016; Chatterji and Li 2016; Schimmel Hyde et al. 2017; Schmidt et al. 2017). In addition, employment might increase if, over a longer period, newer or better coverage leads to better health. In the Oregon Medicaid Experiment, access to Medicaid was associated with improvements in mental health (Finkelstein et al. 2012). On the other hand, expanded access to health insurance could decrease the likelihood of employment if newly available coverage lessens the need to stay connected to the labor force. Which effect is larger may depend on the nature of the coverage provided, as well as other services and supports available to workers with disabilities.

Conclusions

Proposed reforms to the ACA would likely mean that fewer people with disabilities would have coverage at all. For those who did, a smaller number would have the comprehensive coverage necessary to meet their health care needs, and their coverage would cost more. However, neither current economic models nor evidence from studies on the effect of the ACA conclusively predict what consequences health reforms would have on the employment status of individuals with disabilities. It could be that health reforms have heterogeneous effects across the group, reflecting the large range of health conditions and disabilities. For some, the reassurance from expanded access to health insurance could make it easier to enter the labor market and exit federal disability rolls; for others, this same reassurance could encourage them to leave the labor force.

It is likely that the limited evidence available on the ACA's effects on employment reflect that it is still too soon after the ACA's implementation to get a full picture of its impacts.[10] If provisions in the ACA led to changes in work activity among those with disabilities, we would expect those to emerge over months or years as people learn about coverage changes, change jobs as a result, or opt for different kinds of work as their health status changes. The almost constant debate over repeal and the more recent efforts by the president to unravel aspects of the ACA have likely led to uncertainty instead of action. This uncertainty is likely to limit peoples' capacity to make major decisions about either working or entering a disability program. To the extent that more changes to the ACA are implemented, we will likely never have a true view of the legislation's long-term effects on employment.

In addition to minimizing the potential positive effects of the ACA on employment for individuals with disabilities, efforts to repeal or replace provisions in the ACA will negatively affect the well-being of this vulnerable group. Less comprehensive coverage, more restrictions on coverage, more expensive plans, and fewer plans to choose from may be especially problematic for those managing complex conditions, many of whom have scant financial resources to draw on. Going forward, it is imperative that policymakers carefully consider how their proposed legislative changes will affect people with disabilities, who are working, seeking work or whose conditions preclude the possibility of work.

References

Altman. Drew. "High Risk Pools as Fallback for High Cost Patients Require New Rules." *Wall Street Journal*, January 23, 2017.

Burns, Marguerite, and Laura Dague. "The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation." Working paper, University of Wisconsin-Madison, 2017.

Centers for Medicare & Medicaid Services. "Information on Essential Health Benefits (EHB) Benchmark Plans." Available at https://www.cms.gov/cciio/resources/data-resources/ehb.html. Accessed October 13, 2017.

Chatterji, Pinka, and Yue Li. "Early Effects of the 2010 Affordable Care Act Medicaid Expansions on Federal Disability Program Participation." Cambridge, MA: National Bureau of Economic Research, NBER Working Paper 22531, August 2016.

Committee for a Responsible Federal Budget. "The ACAs Cost Sharing Reductions (CSRs): A Primer." August 29, 2017. Available at http://www.crfb.org/blogs/acas-cost-sharing-reductions-csrs-primer. Accessed October 13, 2017.

Congressional Budget Office. "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants." September 25, 2017.

Goldstein, Amy. "Aetna exiting all ACA insurance marketplaces in 2018," *The Washington Post*, May 10, 2017. Available at https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004_story.html?utm_term=.d98feb537293. Accessed November 29, 2017.

Gooptu, A, A.S. Moriya, K.I. Simon, and B.D. Sommers. "Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014." *Health Affairs*, vol. 35, no.1, 2016, pp. 111–118.

Hall, J. P., A. Shartzer, N.K. Kurth, and K.C. Thomas. "Effect of Medicaid Expansion on Workforce Participation for People with Disabilities." *American Journal of Public Health*, vol. 107, no. 2, 2017, pp. 262–264.

Hyde, Jody Schimmel, Priyanka Anand, Maggie Colby, Lauren Hula, and Paul O'Leary. "The Impact of

Affordable Care Act Medicaid Expansions on Applications to Federal Disability Programs." Mathematica Disability Research Consortium Working Paper 2017-01, 2017.

Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." 2015. Available at https://www.kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient/. Accessed October 13, 2017.

Kennedy, J., and E. Blodgett. "Health Insurance-Motivated Disability Enrollment and the ACA." *New England Journal of Medicine,* vol. 367, 2012, p. e16.

Kaestner, R., B. Garrett, A. Gangopadhyaya, and C. Fleming. "Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply." Cambridge, MA: National Bureau of Economic Research, NBER Working Paper 21836, 2015.

Lauer, E.A, and A.J. Houtenville. *Annual Disability Statistics Compendium: 2016*. Durham, NH: University of New Hampshire, Institute on Disability, 2017.

Leung, P., and A. Mas. "Employment Effects of the ACA Medicaid Expansions." Cambridge, MA: National Bureau of Economic Research, NBER Working Paper 22540, 2016.

Levitt, Larry, Cynthia Cox, and Gary Claxton. "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments." The Kaiser Family Foundation. Available at https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/. Accessed October 13, 2017.

Levy, A. R., B.K. Bruen, and L.C. Lu. "The Potential Employment Impact of Health Reform on Working-Age Adults with Disabilities." *Journal of Disability Policy Studies,* vol. 24, no. 2, pp.102–112.

Livermore, G., and T. Honeycutt. "Employment and Economic Well-Being of People with and Without Disabilities Before and After the Great Recession (Employment Measurement and Policy Rehabilitation Research and Training Center Working Paper). Washington, DC: Mathematica Center for Studying Disability Policy, 2013.

Maestas, Nicole, Kathleen J. Mullen, and Alexander Strand. "Disability Insurance and Health Reform: Evidence from Massachusetts." *American Economic Review: Papers and Proceedings.* vol. 104, no. 5, 2014, pp. 320–335.

Pollitz, Karen. "High Risk Pools for Uninsurable Individuals." Kaiser Family Foundation Issue Brief, July 2016. https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/ Accessed October 13, 2017.

Schmidt, Lucie, Laura Shore-Sheppard, and Tara Watson. "The Impact of the ACA Medicaid Expansion on Disability Program Participation" Unpublished manuscript, 2017.

University of New Hampshire Institute on Disability. *Job Gains for Americans with Disabilities Contribute to Strength of Labor Market.* nTIDE July 2017 Jobs Repo

Endnotes

[1] Please send all comments or questions to Purvi Sevak at psevak@hunter.cuny.edu.

[2] See Congressional Budget Office, "Labor Market Effects of the Affordable Care Act: Updated Estimates." *The Budget and Economic Outlook: 2014 to 2024*, February 2014, pp.117–127.

[3] When referring to individuals with disabilities in this brief, we are also including individuals with potentially disabling conditions.

[4] See https://ncd.gov/newsroom/2016/report-release-impact-affordable-care-act-2015-status-report.

[5] SSDI beneficiaries who return to work and lose cash benefits may keep receiving Medicare premium-free for 93 months after the start of a trial work period as long as they still have a disabling condition. After that period ends, they can continue their coverage by paying Medicare premiums.

[6]For a comprehensive timeline of proposals, see http://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare.

[7] For example, see H.R. 1628 American Health Care Act of 2017 at https://www.congress.gov/bill/115th-congress/house-bill/1628.

[8] See https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition.

[9] Studies of the impact of the Medicaid expansions on employment within a broader working-age population have revealed no statistically significant impacts (Gooptu et al. 2016; Kaestner et al. 2015; Leung and Mas 2016). However, given the relative importance of health care and health insurance for individuals with disabilities, it is likely that any employment impacts of health reforms would be larger on the working-age population with disabilities than on the broader working-age population.

[10] Moreover, it is challenging to detect the impact of the ACA provisions because it is difficult to identify a comparison group in order to adequately measure what would have happened in the absence of such a large-scale policy change.

This issue brief is the third in a series on *Advancing Policy to Support Workers with Disabilities*. This Roosevelt House series, edited by Professor Purvi Sevak, seeks to synthesize research that can inform policymakers and other stakeholders of the potential impacts of a range of policy changes on the employment status of individuals with disabilities. Research to support the series is funded by the Rehabilitation Research and Training Center on Employment Policy and Measurement, housed at the Institute on Disability at the University of New Hampshire, with partners at the Association of University Centers on Disability, Hunter College, the Kessler Foundation, and Mathematica Policy Research. The Center conducts research and translates it for the policy community in order to improve the employment outcomes of people with disabilities.

Acknowledgements

This series is funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), in the U.S. Department of Health and Human Services (HHS), under cooperative agreement 90RT5037. The findings and conclusions are those of the authors and do not represent the policy of HHS or NIDILRR. The authors declare that they have no competing interests and retain sole responsibility for any errors or omissions.