Structural Barriers in Access to Public Income and Health Insurance for People with Disabilities

Ellen Meara, PhD

October 16, 2024

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

Motivation: Little Policies Have Big Effects

- Much attention to key federal and state laws

- Program regulations & procedures can have big effects
  - Marginalized populations, including those with disabilities, often affected

Today – administrative features/failures in:

a. Disruptions due to age eligibility in Medicaid & private insurance
b. Part D Low Income Subsidies for prescription drugs
c. Changing application formats and review for federal disability insurance (If we have time)

Age-Specific Eligibility Thresholds and Insurance Gaps among Young Adults, Colorado 2014-2018 (under revision)

Mercedes V. McMahon MPH, Megumi J. Okumura MD, Sara L. Toomey MD Mphil Msc, Christina H. Chan MS, Kathryn P. Gray PhD, Mary Beth Landrum PhD, Ellen Meara PhD, Aly**na T. Chien MD MS**

The National Institutes of Child Health and Human Development funded this study (R01HD103720; **PI: Alyna Chien**).

Insurance Gaps in Young Adults

- Gaps are associated with:foregone vaccines & meds, ED visits & hospitalizations, worse self-rated health (Horne et al. (2022), Banerjee et al. (2010), Bednarek et al. (2003), Gresenz et al. (2007), Ross et al. (2006))

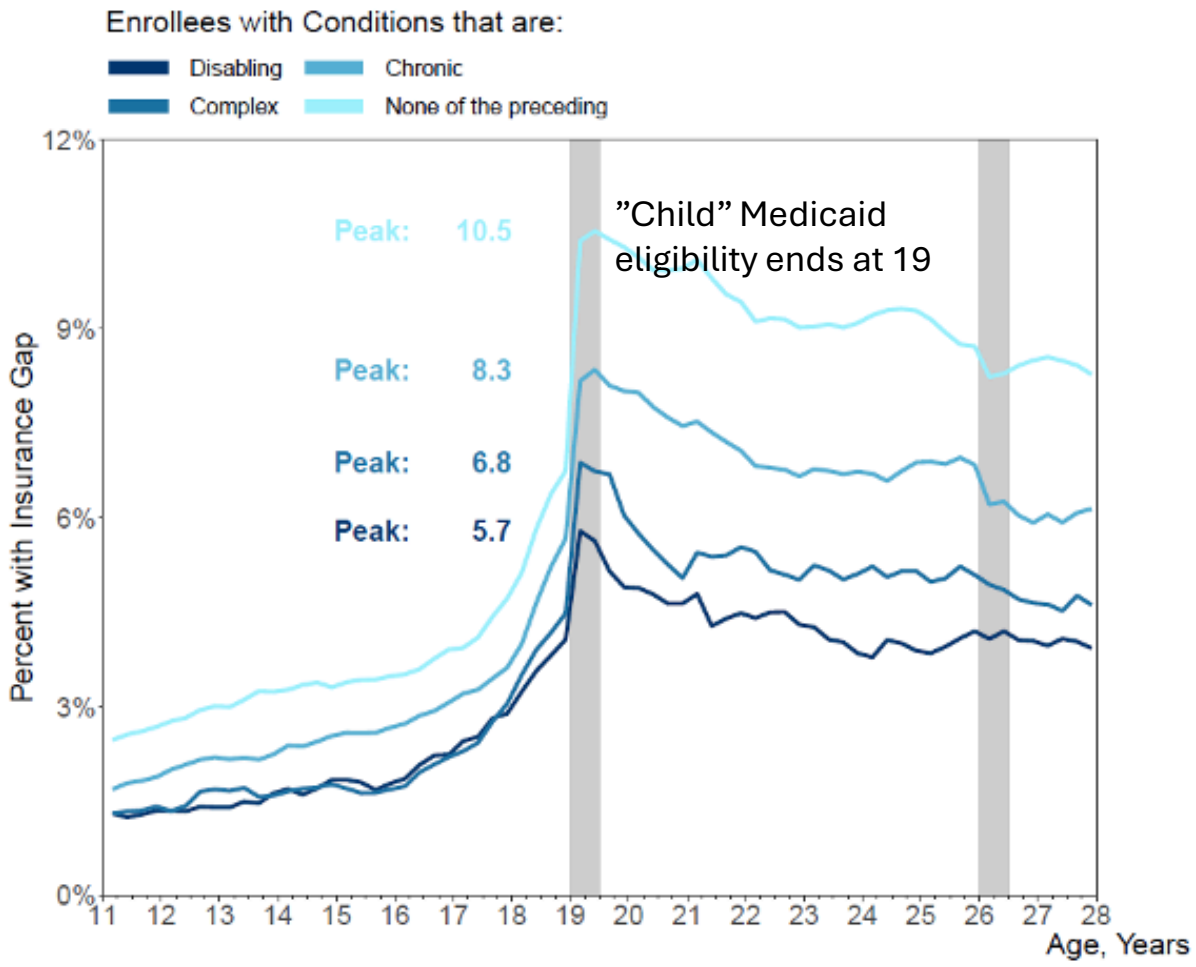
- Prior literature has little info on presence of disability or conditions that often contribute to disability

- We characterized insurance gaps of 3 months or more at age 19 (end of child Medicaid coverage) and 26 (end of adult dependent coverage in commercial insurance*) by severity of condition.
  - Colorado All-payer claims, 2014-2018 (post ACA, pre-pandemic)

*Per the Affordable Care Act, since 1/1/2014, former foster care youth are aligible for Medicaid until age 26.

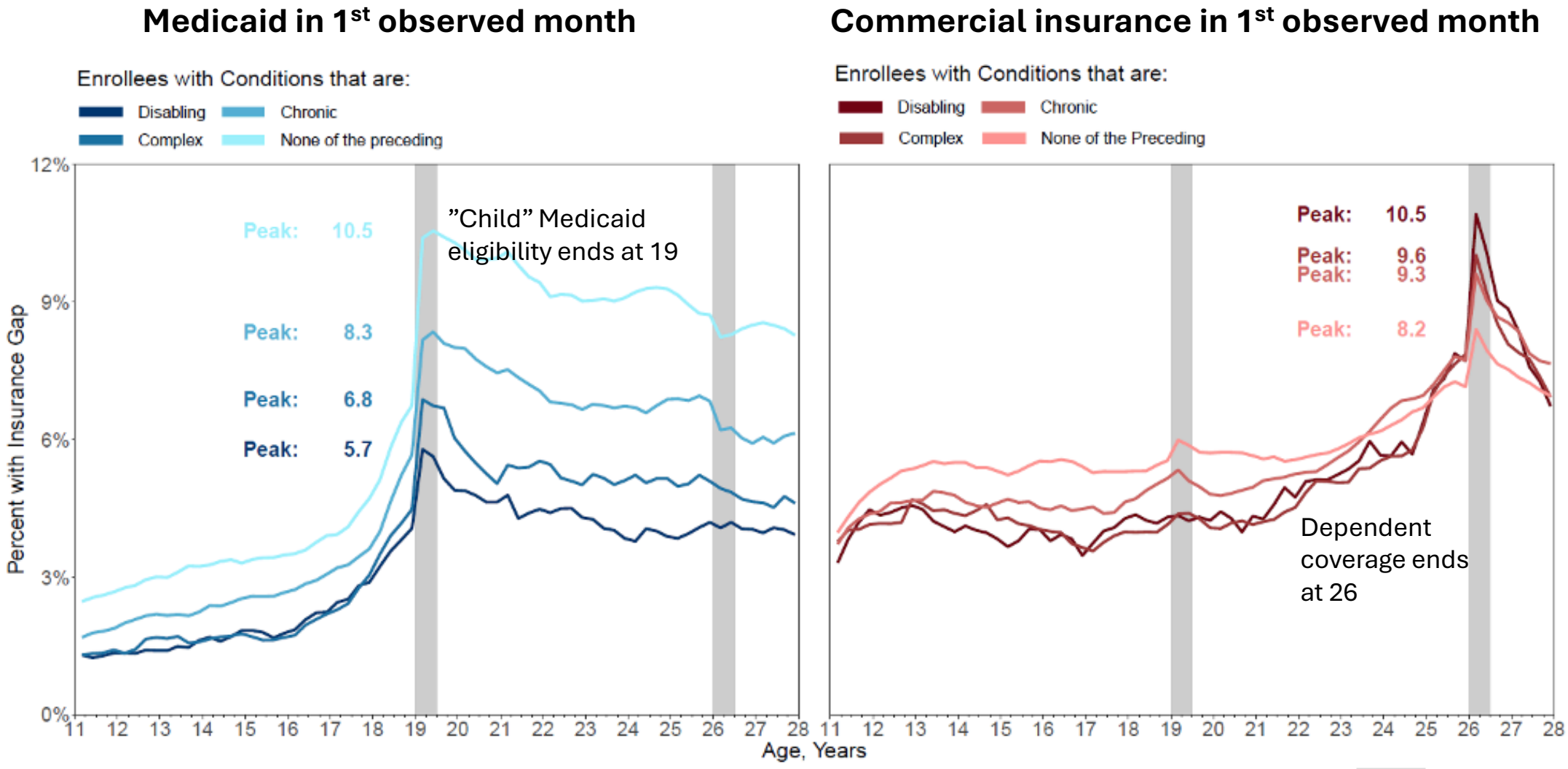
% with Insurance Gap, Colorado 2014-18

Medicaid in 1st observed month



Childhood-onset chronic, complex, or disabling health conditions are mutually exclusive categories. In Medicaid group, 25.0% had chronic, 17.1% had complex, and 12.4% had disabling conditions. In Commercial group, 25.1% had chronic, 13.0% had complex, and 5.3% had disabling health conditions. Insurance gaps defined as periods of insurance lasting at least 3 months followed by insurance coverage of at least 1 month. Insurance gaps were defined as periods of uninsurance lasting ≥3 consecutive months and were both preceded and followed by ≥1 month of insurance. $N_{medicaid}$: 649,346 enrollees, 24,668,220 person-months. $N_{Commercia}$: 576,596 enrollees, 18,008,505 person-months.

% with Insurance Gap, Colorado 2014-18



Childhood-onset chronic, complex, or disabling health conditions are mutually exclusive categories. In Medicaid group, 25.0% had chronic, 17.1% had complex, and 12.4% had disabling conditions. In Commercial group, 25.1% had chronic, 13.0% had complex, and 5.3% had disabling health conditions. Insurance gaps defined as periods of insurance lasting at least 3 months followed by insurance coverage of at least 1 month. Insurance gaps were defined as periods of uninsurance lasting ≥3 consecutive months and were both preceded and followed by ≥1 month of insurance. $N_{medicaid}$: 649,346 enrollees, 24,668,220 person-months. $N_{Commercia}$: 576,596 enrollees, 18,008,505 person-months.

Insurance Gaps in Young Adults

- Youth with disabilities are least likely to experience coverage gaps as they approach Medicaid age cutoffs
- Young adults with disabilities in private coverage are most likely to experience coverage gaps as they approach age 26
- Worth understanding what processes/policies are at play
  - Parents advocating for 17 and 18 year olds?
  - Policies of Medicaid programs or providers serving Medicaid enrollees?

*Per the Affordable Care Act, since 1/1/2014, former foster care youth are aligible for Medicaid until age 26.

Loss of Subsidized Drug Coverage and Mortality Among Low-Income Medicare Beneficiaries

Eric Roberts, José Figueroa, MD, MPH, Ellen Meara, Lilly Estenson, MSW, Jessica Phelan, MS, Dominic Ruggiero, MS, Rachel Werner, MD

Grants from the Agency for Healthcare Research and Quality (R01HS029453, Eric Roberts PI) and National Institute on Aging (R01AG081151, José Figueroa PI)

Part D Low Income Subsidy (LIS)

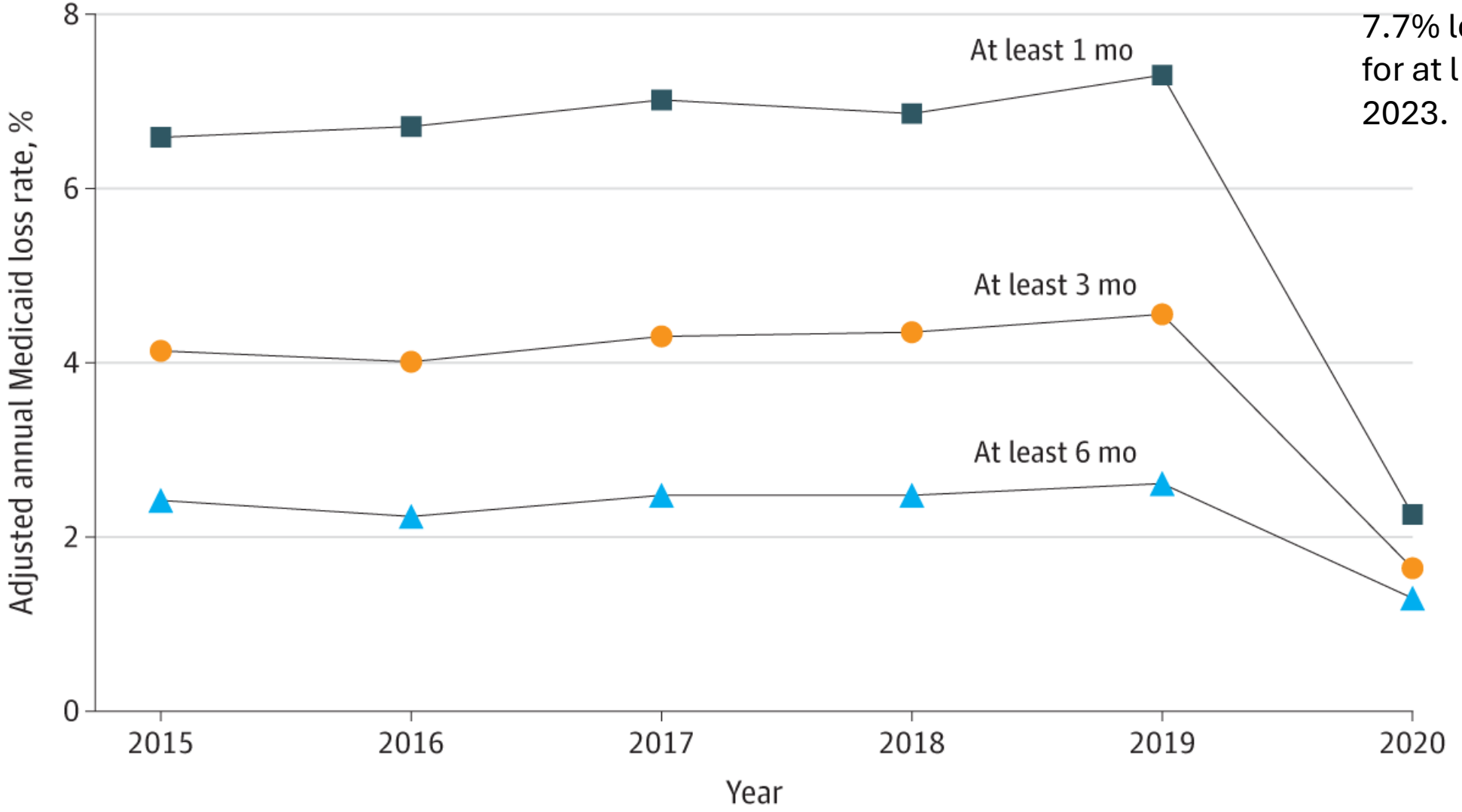
85% of LIS recipients are auto-enrolled due to Medicaid

Beneficiary applies for Medicaid➔ State determines eligibility and enrolls in Medicaid➔ SSA auto-enrolls Medicaid beneficiary in LIS (these beneficiaries are ”deemed eligible” for Medicaid)

Each year 7-8% of dual Medicare-Medicaid eligible beneficiaries lose Medicaid for ≥ 1 month

”Deemed eligible” beneficiaries keep LIS for at least 6 months, and up to 18 more months based on the month of Medicaid loss…

Adjusted Annual Medicaid Coverage Loss Rate, All Dual-Eligible Beneficiaries, 2015-2020



7.7% lost Medicaid for at l month in 2023.

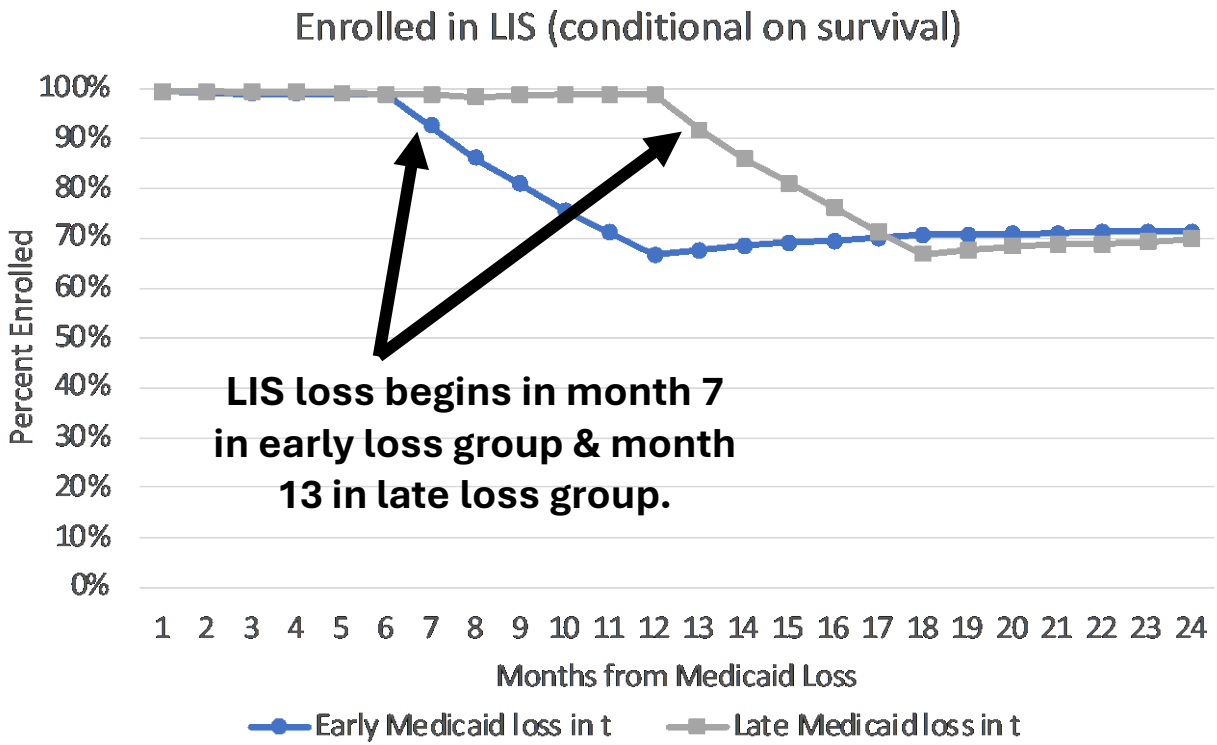
Ma et al. JAMA Network Open 2024

Part D Low Income Subsidy After Medicaid Loss

If dual eligible beneficiary loses Medicaid:

- Early (January-June of year t), LIS ends in January of year t+1 (6 -12 months after Medicaid loss)

- Late (July-December of year t), they lose LIS in January of year t+2 (12 -18 months after Medicaid)

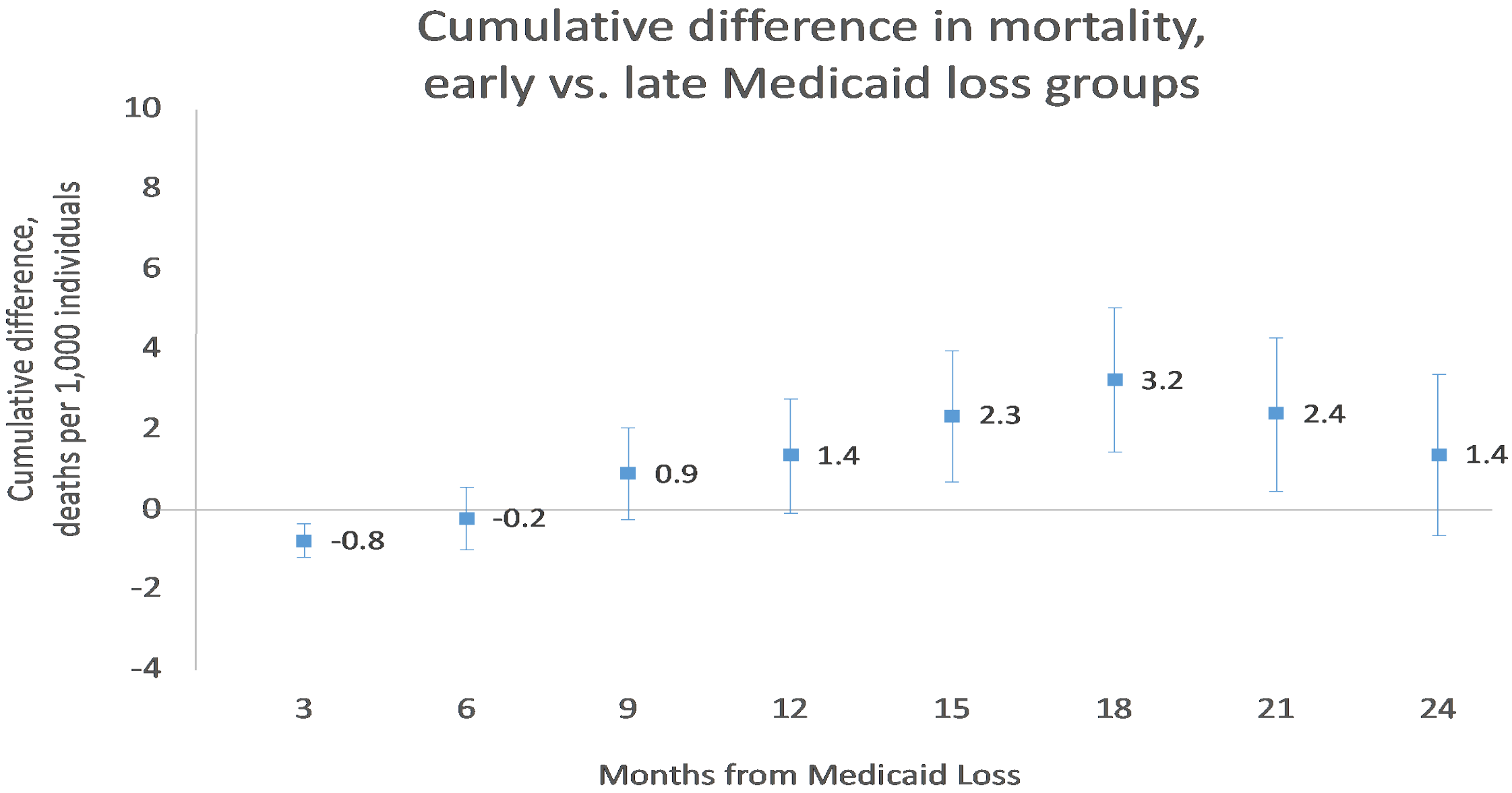


Percentages are out of the number of beneficiaries surviving to a month following Medicaid loss.

Early vs. Late Medicaid Loss Groups

Beneficiary characteristics at baseline (2015-2017)	Early Medicaid Loss (April-June)	Late Medicaid Loss (July-September)	SMD
N	**969,606**	**920,158**	
Age, %			
<65 years	445,428 (45.9%)	427,606 (46.5%)	0.011
65-74 years	295,848 (30.5%)	288,836 (31.4%)	0.019
75-84 years	155,580 (16.0%)	140,260 (15.2%)	0.022
≥85 years	72,750 (7.5%)	63,456 (6.9%)	0.023
Sex, %			
Male	429,170 (44.3%)	406,360 (44.2%)	0.002
Female	540,436 (55.7%)	513,797 (55.8%)	0.002
Race and ethnicity, %			
Non-Hispanic White	536,721 (55.4%)	499,722 (54.3%)	0.021
Non-Hispanic Black	203,402 (21.0%)	195,216 (21.2%)	0.006
Hispanic	173,476 (17.9%)	167,023 (18.2%)	0.007
Other or Unknown	56,007 (5.8%)	58,197 (6.3%)	0.023
Original reason for Medicare entitlement, %			
Age	382,045 (39.4%)	367,257 (39.9%)	0.010
Disability	571,178 (58.9%)	538,275 (58.5%)	0.008
End-stage renal disease (ESRD)	6,076 (0.6%)	5,961 (0.6%)	0.003
Disability and ESRD	10,307 (1.1%)	8,665 (0.9%)	0.012

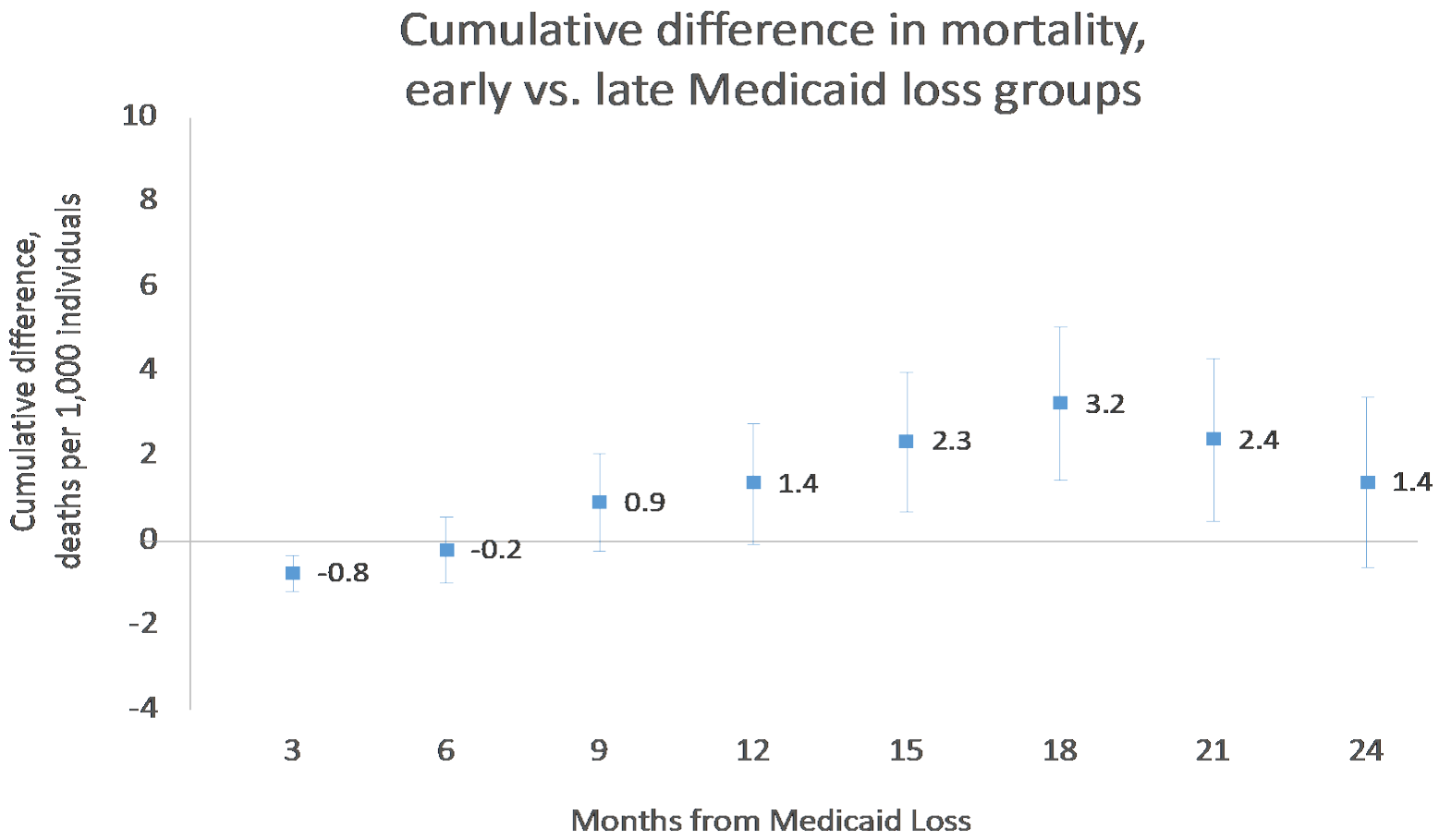
SMD = standardized mean difference



Difference in deaths per 1000 beneficiaries in early vs. late loss Medicaid cohorts by month from Medicaid loss (denominator is constant in all months from Medicaid loss).

Intention-to-treat Estimates

- Minimal to no difference in mortality through 6 months after Medicaid loss
- After 18 months, cumulative mortality in early loss group was **higher by 3.2 deaths/1,000 people**



Difference in deaths per 1000 beneficiaries in early vs. late loss Medicaid cohorts by month from Medicaid loss (denominator is constant in all months from Medicaid loss).

Which Groups were Most Affected by LIS Loss?

- Full (vs. partial) Medicaid enrolled
- Top quintile HCC* risk scores (i.e. highest expected spending)
- Beneficiaries who were receiving the following drug types at baseline:
  - chronic lung disease drugs,
  - CVD drugs, and
  - antiretrovirals

*HCC = Hierarchical Condition Category

Intention-to-treat Estimates & Effect of LIS Loss

	Early - Late Medicaid Loss		*Δ Mortality / Δ LIS*
Subgroup	**First stage (1): LIS enrollment loss (January t+1)** **Percentage points (95% CI)**	**ITT estimate (2): 18-month mortality** **Deaths per 1000 (95% CI)**	**Effect of LIS loss on 18-month mortality** **Deaths per 1000**
All dual-eligible beneficiaries	36.4 (36.3, 36.5)	3.2 (1.4, 5.1)	8.8
Full duals at baseline	38.3 (38.1, 38.4)	4.8 (2.1, 7.5)	12.5
Partial duals at baseline	34.4 (34.3, 34.6)	1.8 (0.5, 3.2)	5.2

Summary: Part D LIS After Medicaid Loss

- Loss of LIS, precipitated by early loss of Medicaid, increases mortality by as much as 8.8 deaths per 1000 at 18 months (10% rise)

- Mortality increases amplified in higher-risk subgroups:
  - Full-benefit Dual Beneficiaries, Highest quintile of HCC risk scores
  - Those on medications for chronic lung disease, cardiovascular disease, and HIV
- Small administrative differences matter among disabled population
  - Decisions by SSA to deem eligibility for LIS to Medicaid enrolled beneficiaries (for 6 to 18 months past Medicaid loss) saved lives when people experienced interruptions in Medicaid coverage.

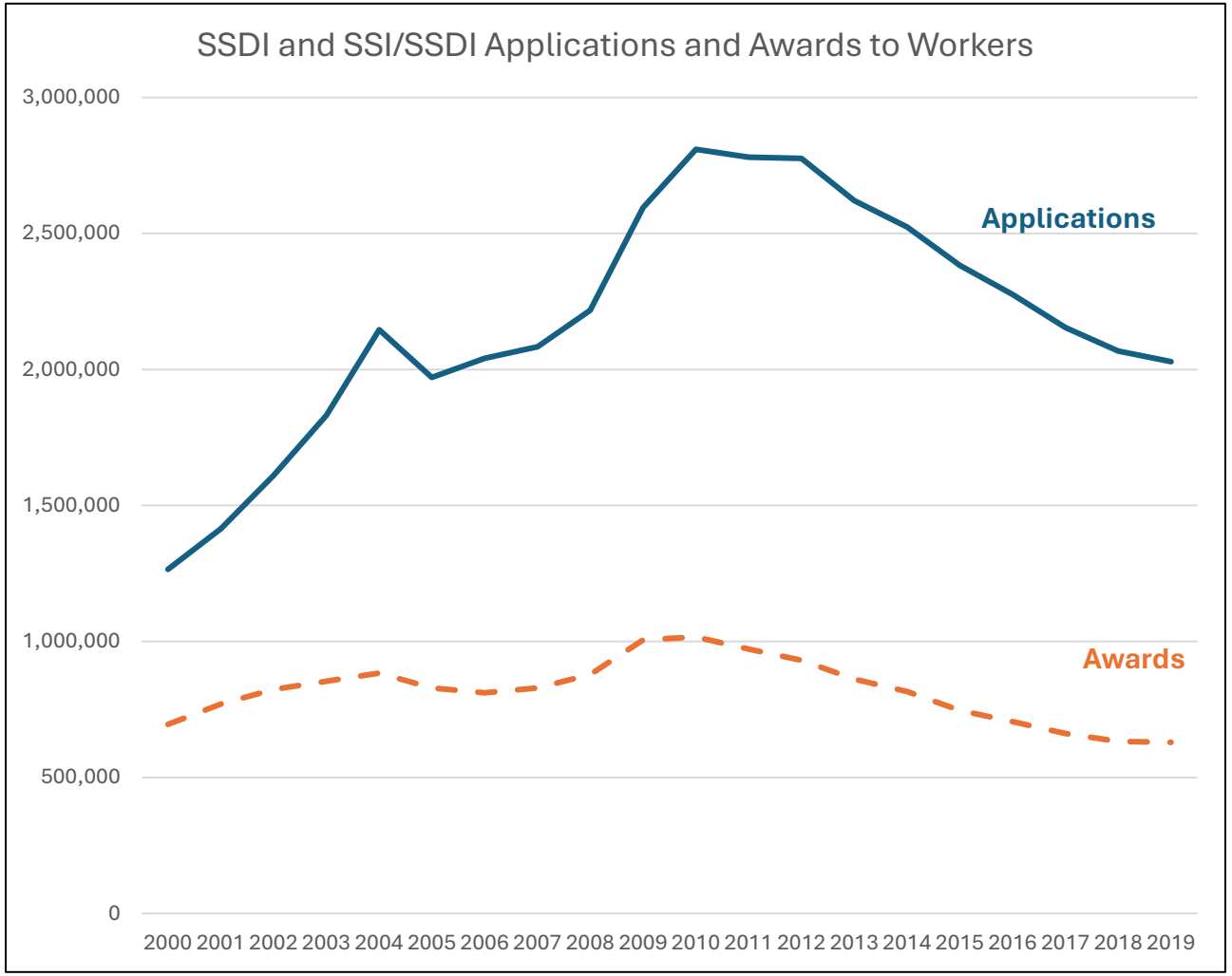
Structural Barriers to Receipt of Income Support and Health Insurance among Adults with Disabilities (ongoing work)

David M. Cutler, **Marema Gaye**, Ellen Meara, **Rand Obeidat**

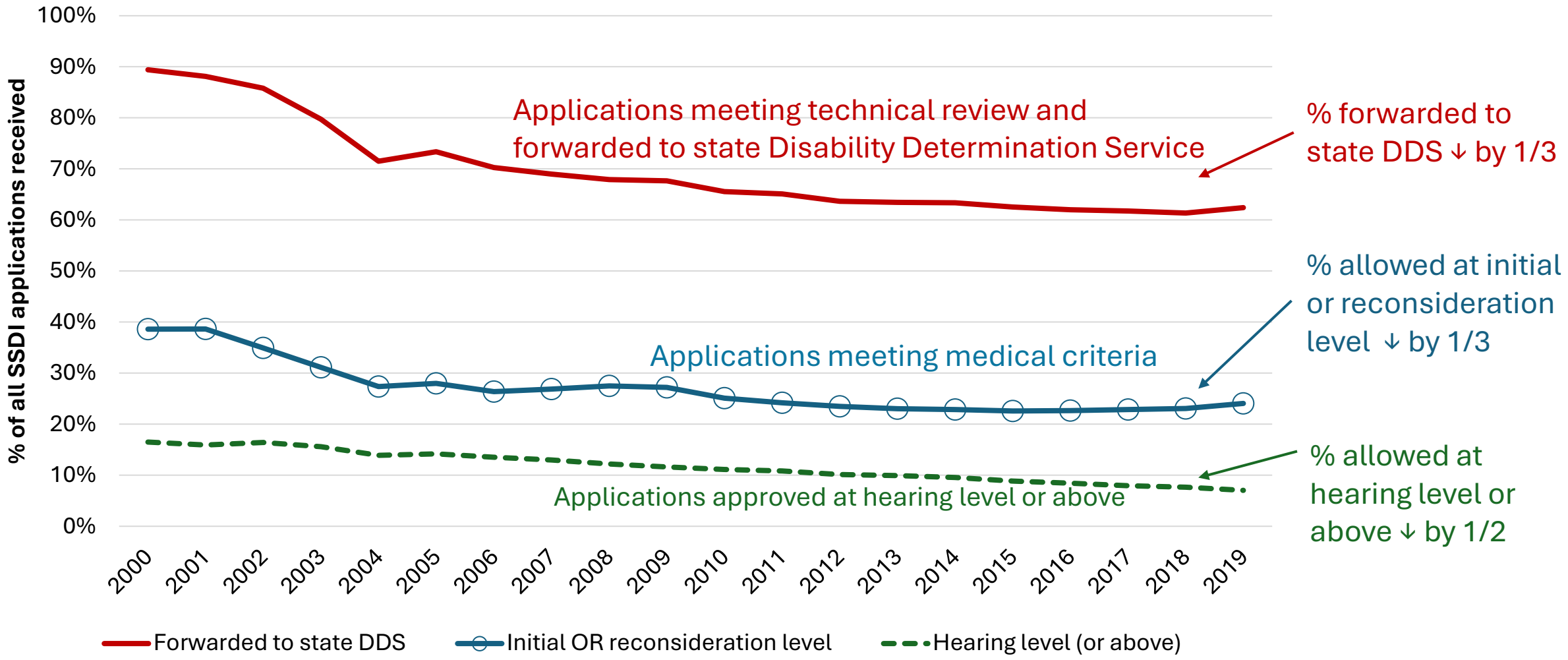
The research reported herein was performed pursuant to grant RDR23000006, NB24-01 (Cutler, Meara Obeidat PIs) from the US Social Security Administration funded as part of the Retirement and Disability Research Consortium (Nicole Maestas and Angelo Viceisza Pis). The findings and conclusions expressed are solely those of the author(s) and do not represent the views of SSA, any agency of the federal government, or author(s) affiliations.

Motivation: SSDI Awards Peaked in 2010

- Research questions
  1. How have outcomes of SSDI applications changed over time and across adjudicative levels?
  2. How has the composition of new SSDI awardees changed as allowance rates fall?



Disability Applications are Less Likely to be Allowed/Forwarded at Every Step



Why is Eligibility Tightening & Who is Affected?

Why?

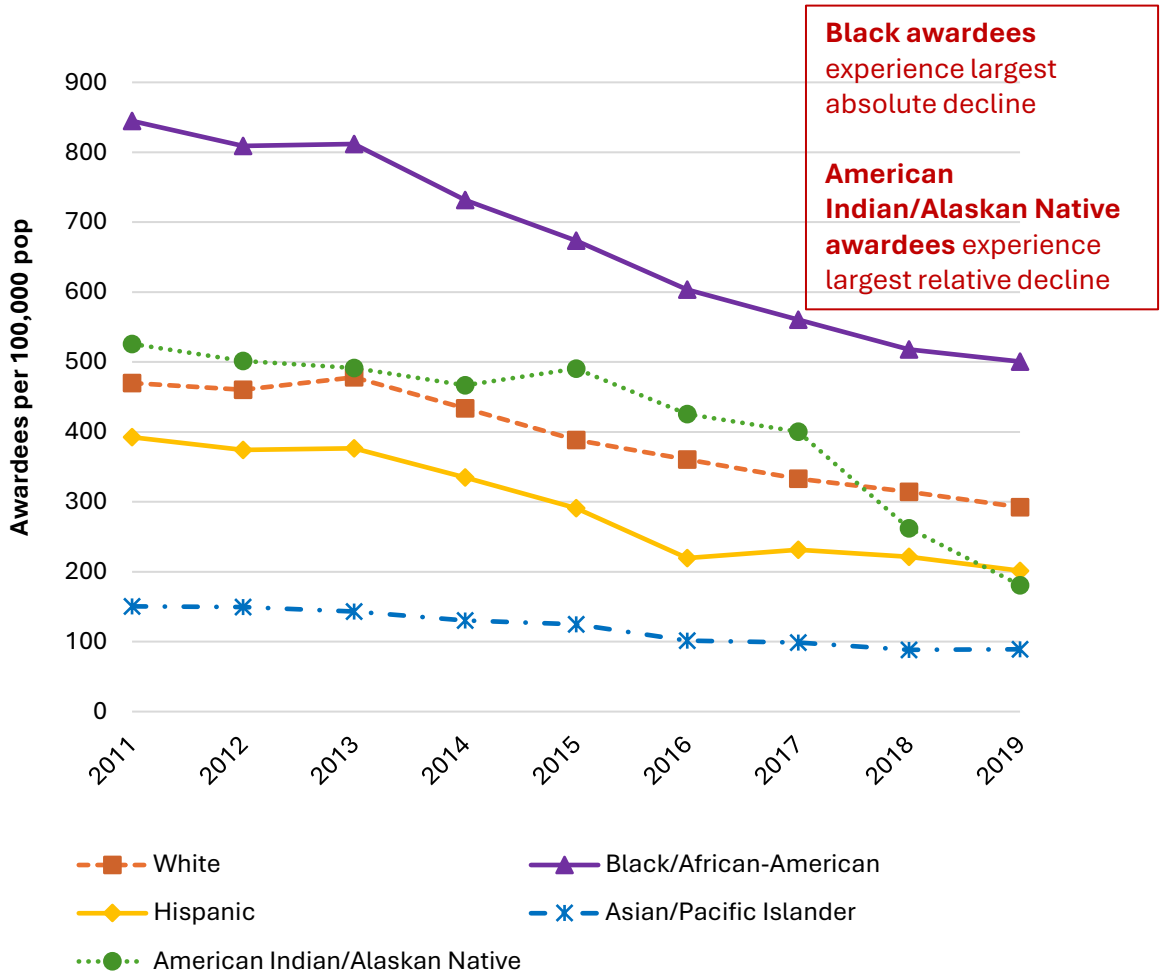
- Office closures (over 100 field office closures since 2000 & complete closure in pandemic) Deshpande & Li (2019)
- Standardized procedures Maestas (2019)
- Possible changes in the way applications were processed (e.g. joint consideration of SSI/SSDI)

Who?

- Ongoing work linking Medicare Beneficiary Files (disability-eligible) to individual and zip code characteristics

New SSDI awardees per 100,000 population (45-54 year olds)

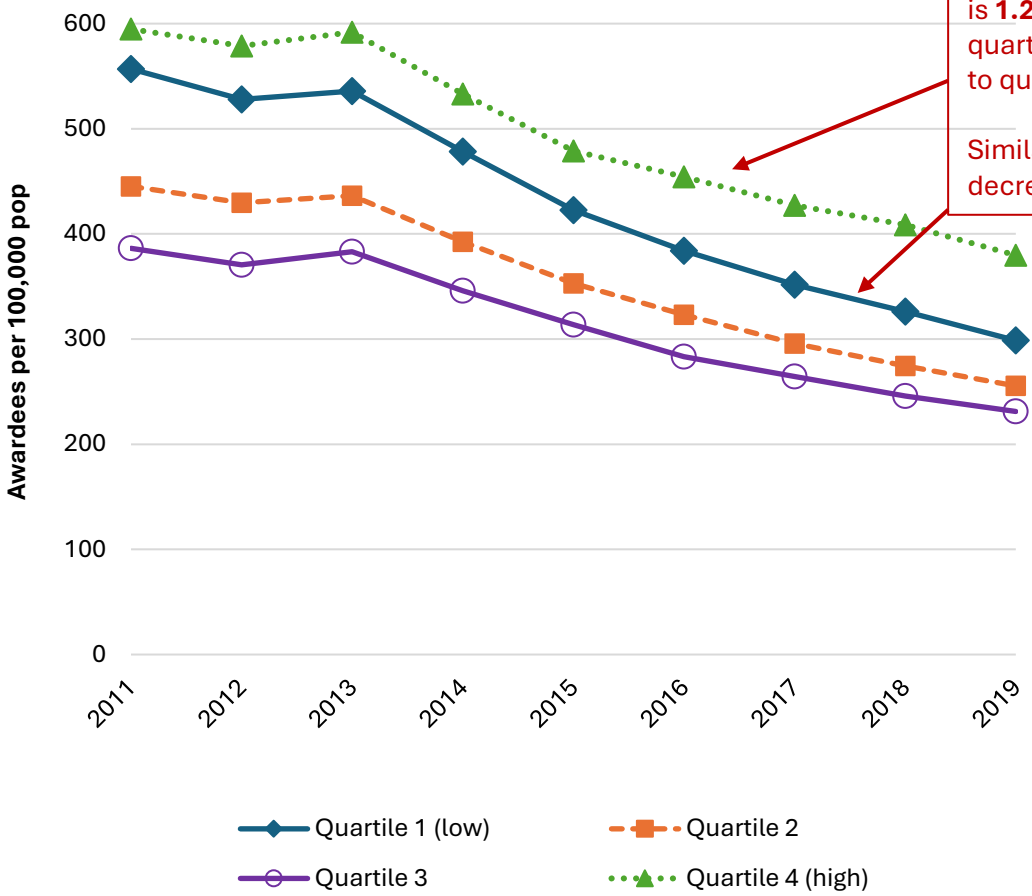
By beneficiary race/ethnicity



Black awardees experience largest absolute decline

American Indian/Alaskan Native awardees experience largest relative decline

By zip code quartile: **foreign-born pop. speaks English well**



Absolute decrease is **1.2x larger** in quartile 1 (relative to quartile 4)

Similar relative decrease

Structural Barriers to SSDI Eligibility

- SSDI allowances have decreased between 2000-2019 due to
  - Fewer applications forwarded/allowed at every level of adjudication
- As number of new SSDI awardees declined after 2010, in absolute numbers:
  - Racial and ethnic minoritized groups experience largest absolute decline in new awardees
  - Awardees in zip codes with the highest levels of poverty and lowest levels of college education (who are more represented in SSDI population) experience largest *absolute* declines in rate of new SSDI awardees
- Understanding source of changes and implications across groups is important area for further work

Conclusions – Little Policies Matter

- Small decisions may literally have life or death consequences, as in the choice to extend LIS when people experience interruptions in Medicaid coverage
- Such interruptions occur throughout the life course of people experiencing disabling conditions.
- Many of these interruptions are the result of small implementation decisions made by those designing and implementing programs to support income and health needs.

Thank you

emeara@hsph.Harvard.edu