

# DISABILITY INSURANCE AND HEALTHCARE REFORM: EVIDENCE FROM MASSACHUSETTS

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The unfolding reforms to the U.S. healthcare system laid out by the Affordable Care Act (ACA) in 2010 will fundamentally alter the costs and benefits of applying for federal disability benefits through the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. SSDI recipients are entitled to health insurance coverage through the Medicare program, but only after they satisfy a two-year waiting period that begins with the date they qualify for benefits. SSI recipients are entitled to Medicaid coverage immediately upon qualifying for benefits. Applicants to both programs may face substantial uncertainty about whether their disabilities qualify for benefits and how long they may have to wait for a disability determination.

Because at present most non-elderly adults in the United States obtain health insurance coverage through their employer, individuals who experience the onset of a work-limiting health condition face a difficult dilemma: attempt to keep working in spite of an uncomfortable impairment in order to maintain employer-sponsored health insurance (ESHI) or stop working in order to apply for SSDI or SSI and risk an extended period of uninsurance. Some of these individuals may be able to obtain subsidized coverage through a spouse's employer. Others may be able to retain their employer coverage temporarily under COBRA provisions, but at full cost during a period without labor earnings. If the disincentive arising from loss of health insurance coverage presently discourages labor force withdrawal and disability benefit application, then the ACA's introduction of affordable health insurance coverage outside of employment could free workers from "employment lock," and consequently increase both disability-related labor force withdrawal and disability applications.

On the other hand, the introduction of affordable coverage options outside of SSDI and SSI could reduce the relative value of disability benefits for those who didn't have ESHI or were uninsured at the time of disability onset, and hence could decrease federal disability applications. Indeed, health insurance benefits are more valuable than cash benefits for many beneficiaries (Mashaw, 1997). Which of these two countervailing effects is likely to dominate the other is an important empirical question.

The recent implementation of healthcare reform in the state of Massachusetts (MA) offers a unique opportunity to forecast the impact of the ACA on SSDI and SSI applications. The MA reform shares many key features with the ACA reform, most notably, a new individual coverage mandate, an expansion of subsidized coverage for low-income individuals, the creation of an insurance exchange as a source of lower-cost individual coverage, and new requirements

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for employers. The MA reform legislation was passed in April 2006 and phased in primarily between October 2006 and July 2007. The reform was associated with an increase in the rate of insurance coverage among the nonelderly in MA from 88 percent in 2004–2006 to 94 percent in 2008–2009, an increase of 6 percent or, alternatively, a decrease in the uninsurance rate of 48 percent (Kolstad and Kowalski, 2012). The ACA is expected to increase insurance coverage by a similar magnitude (Truffer et al., 2010).

In this paper we use administrative data from the Social Security Administration (SSA) to examine changes in SSDI and SSI application rates in MA before and after the reform relative to a group of comparison states that are similar in size, demographic composition and geographic location. We find that disability applications increased modestly in MA relative to neighboring states in the first year following the completion of the reform with no statistically significant difference thereafter. However, this result masks substantial heterogeneity at the county level: total SSDI and SSI applications increased in counties that had high levels of health insurance prior to the reform and decreased in counties with low levels, although applications for SSDI only (i.e., excluding “concurrent” applications for both SSDI and SSI) increased everywhere. Because health insurance coverage in the rest of the U.S. is generally lower than the level in MA prior to the 2006 reform, our results imply that the ACA may lead to a net decrease in DI applications in the U.S., with some shift, at least initially, in the composition of new applications to SSDI.

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