



The effect of expanding access to health insurance on the health and mortality of Social Security Disability Insurance beneficiaries

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ABSTRACT

We use a social experiment to estimate the impact of expanding health insurance coverage on the health and mortality of newly entitled SSDI beneficiaries who lacked health insurance. Our intent-to-treat estimates show that expanding health insurance has significant effects on self-reported health at one year following health insurance enrollment, positive effects on mental health and physical health at one year following health insurance enrollment, and no significant effects on mortality within our observation period. About 30% of control group members obtained health insurance coverage within one year following enrollment. We use two-stage least square models to estimate the impact on those who would not have obtained health insurance coverage without the demonstration project and find larger effects on self-reported health and mental health among these SSDI beneficiaries. Finally, we examine distributional impacts to show that mean impacts miss meaningful effects.

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1. Introduction

Several recent studies conclude that the information on the impact of health insurance on health is limited, and have argued for social experiments as a means of gathering reliable data to inform policy.¹ We use a social experiment to estimate the impact of expanding health insurance coverage on the health and mortality of newly entitled Social Security Disability Insurance (SSDI) beneficiaries who did not have health insurance when we contacted them to participate in the study. The data for our analysis is from the recently completed Accelerated Benefits (AB) demonstration project funded by the Social Security Administration (SSA) and

conducted by MDRC. The AB demonstration used a random assignment design to estimate the costs and benefits of providing SSDI beneficiaries who did not have health insurance coverage with a health benefits package during the SSDI program's 24-month Medicare waiting period.

Early results from the demonstration show that the AB health benefits package increased health care utilization and reduced unmet health care needs among beneficiaries. The AB health insurance package led to a 22 percentage point (46%) increase in beneficiaries who received a diagnostic test; a 10 percentage point (50%) increase in beneficiaries who underwent surgery; an 18 percentage point (25%) reduction in beneficiaries reporting any unmet medical need; and a 40 percentage point (53%) reduction in beneficiaries reporting an unmet need for a prescription drug (Michalopoulos et al., 2011). We examine whether these early findings translate into improvements in health within the first year and reduced mortality among beneficiaries within the first few years following random assignment.

We find evidence that offering the health benefits package led to improvements in health among beneficiaries we targeted for the study. We find at least a 10 percentage point (nearly 30%) reduction in the percentage of beneficiaries who reported poor health in response to a commonly used health question. We find a 16 percentage point (88%) increase in the percentage of beneficiaries

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¹ Levy and Meltzer (2008) conclude that “the central question of how health insurance affects health, for whom it matters, and how much, remains largely unanswered at a level of detail to inform policy” and there is a need for social experiments. Quasi-experimental studies have provided information on a specific populations (Card et al., 2009; Finkelstein and McKnight, 2008), but acknowledge a need for social experiments. The RAND health insurance study (Keeler et al., 1985; Newhouse, 1993) and the Oregon Medicaid experiment (Finkelstein et al., 2011) are two U.S. social experiments that we are aware of on the topic, and they recognize a need for additional social experiments to inform policy.

reporting their health as somewhat better or much better after the first year of receiving the health benefits package. Our analyses of the Qualitymetrics Short Form 36 (SF-36) health indices show small mean impacts for both the physical health measure and the mental health measure (1.5 and 2.4 points respectively).² While the mean impacts appear small, we find statistically significant differences in the distributions of the SF-36 physical and mental health measures. This result is driven by the differences between the 30th and 50th percentiles of the distributions for the SF-36 physical health scores, and the 50th and 80th percentiles for the SF-36 mental health scores, rather than differences in the tails. The relatively larger impacts in these areas of the health distribution are along two meaningful health margins: mental health scores indicative of clinical depression, and physical and mental health scores that are indicative of meeting the SSDI disability standard. Our intent-to-treat (ITT) estimates show a 9 percentage point (14%) reduction in SF-36 mental health scores that are indicative of clinical depression and a 7.2 percentage point (13%) reduction in SF-36 scores indicative of an SSDI disability. Thus, we conclude that solely focusing on mean outcomes using SF-36 physical and mental health measures could potentially understate the benefits of expanding health insurance coverage to newly entitled SSDI beneficiaries.

Approximately 30% of control group members reported that they had obtained some type of health insurance coverage in the 12-month follow-up survey. Thus, our estimate of offering the AB health benefits package might understate the impact of the health benefits package among those who are unable to obtain health insurance during the first year of the Medicare waiting period. We use a two stage least squares (2SLS) model to estimate the effect of the AB health benefits package among those unable to access health insurance within a year of the waiting period. When compared to our ITT estimates, our 2SLS estimates are substantially larger for our self-reported health outcome measures, the mental health score, the percentage of people with a mental health score indicative of clinical depression, and the percentage of individuals with a combination of physical and mental health scores indicative of an SSA-defined disability.

We do not find evidence that expanding access to health insurance coverage led to a statistically significant reduction in mortality within the 2–3 years following enrollment in the AB project. These findings appear to be consistent with those presented in the summary of the literature in *Levy and Meltzer (2008)*. We conclude that if there were impacts on mortality within this time period, the impacts were too small to detect given the sample size for our study.

Our analysis is limited to newly entitled SSDI beneficiaries who do not have health insurance at the time of recruitment, and they are not representative of broader populations. Specifically, they have a health condition that is severe enough to qualify for SSDI benefits. While our sample is not representative of the entire population of SSDI beneficiaries or even uninsured individuals, our results provide rigorous evidence for a well-defined subgroup that would likely be affected by changes in health policy envisioned in the Affordable Care Act (ACA). In addition, our sample size may not be large enough to detect some dimensions of health insurance effects that are important to some policymakers. However, our sample size is large enough to show significant and substantive impacts of expanding access to health insurance on the health of beneficiaries.

2. SSDI program and Medicare coverage

The SSDI program is the largest U.S. social insurance program that provides benefits to individuals with a disabling health condition. In 2009, the program paid benefits to approximately 9.7 million people and paid out \$118 billion in benefits (*Social Security Administration, 2010*). To qualify for the program, individuals must meet SSA's definition of disability and they must meet the program's insured status requirements. The Social Security Act defines a disability as the inability to engage in work that is substantial gainful activity (SGA) due to a medically determinable physical or mental impairment that is expected to last for a continuous period of not less than 12 months or result in death. SSA generally identifies SGA as monthly earnings that exceed a specified level; in 2010, the level was \$1000 per month for the non-blind and \$1640 for the blind. To meet the insured status requirements, an individual must have worked long enough, and recently enough, in a job covered by Social Security.

The program includes a 5-month waiting period for cash benefits, and most individuals must complete an additional 24-month waiting period before Medicare coverage begins.³ The 5-month waiting period begins the first full month following the month that SSA determines that the individual meets the SSDI definition of disability. The Congress included the 24-month waiting period when they added Medicare to the SSDI program in order to contain costs, prevent a shift from private coverage to government sponsored coverage, minimize administrative problems, and target benefits toward those with long lasting and severe conditions.

While many SSDI beneficiaries are able to maintain or obtain health insurance coverage during the waiting period, some do not have health insurance coverage. Studies have estimated that between 24% and 27% of beneficiaries lack health insurance coverage during the Medicare waiting period (*Muller, 1989; Riley, 2006; Short and Weaver, 2008*). Other studies show that beneficiaries who do not have health insurance coverage are much more likely to experience financial hardship and unmet medical needs than those who have health insurance during the waiting period (*Riley, 2006; Livermore et al., 2010; Williams et al., 2004*). Organizations have used some of these findings to recommend eliminating the waiting period in order to help beneficiaries obtain the health care they need to stabilize their disabling health condition and facilitate a return to employment (*Consortium for Citizens with Disabilities, 2008*).

The Congress has considered reducing or eliminating the Medicare waiting period, but they have not passed legislation (*Szymendera, 2007*). However, in 1999 the Congress re-authorized Section 234 of the Social Security Act, allowing SSA to conduct projects that test various changes to the SSDI program including altering the 24-month Medicare waiting period. In 2006, SSA awarded a contract to MDRC to conduct a demonstration project that uses an experimental design to evaluate the impact of altering the 24-month waiting period called the Accelerated Benefits (AB) demonstration.

3. The Accelerated Benefits demonstration

The AB demonstration project included two treatment groups and one control group. Participants in the first treatment group, the AB group, received the AB health benefits package. Individuals

² The SF-36 health survey consists of 36 questions covering several facets of health. Responses to certain questions are used to compare physical, mental, and overall health across participants.

³ There are some exceptions to the 24-month waiting period, including individuals with end stage renal disease, amyotrophic lateral sclerosis, or with a prior period of SSDI entitlement.

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