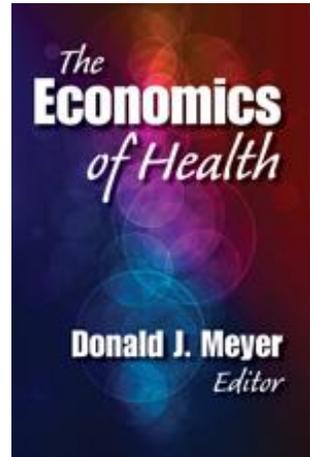

Upjohn Institute Press

The Potential Effects of the Affordable Care Act on Disability Insurance and Workers' Compensation



Marcus Dillender
W.E. Upjohn Institute for Employment Research

Chapter 5 (pp. 81-102) in:
The Economics of Health
Donald J. Meyer, editor.
Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 2016
<http://dx.doi.org/10.17848/9780880994644/ch5>

5

The Potential Effects of the Affordable Care Act on Disability Insurance and Workers' Compensation

Marcus Dillender

W.E. Upjohn Institute for Employment Research

The passage of the Affordable Care Act (ACA) represents one of the largest overhauls to the United States health care system since the introduction of Medicare and Medicaid. Among the reform's many provisions are an employer mandate, an individual mandate, an expansion of Medicaid, subsidies for low-income people to purchase coverage, and the establishment of health insurance exchanges. The ACA also reforms the individual market and implements many measures aimed at reducing medical costs.

Despite its many changes to the health care system, the ACA largely ignores related social insurance programs that also provide health care. Two programs in particular—federal disability and workers' compensation—deal with people with medical issues and have overlapping agendas with health insurance. Disability insurance provides health insurance for people who are unable to work for over a year due to health concerns, while workers' compensation insurance pays medical expenses for people injured at work. Unlike traditional health insurance, both programs also provide cash assistance to beneficiaries.

Although the ACA does not address these programs, it could have potentially major spillover effects on both federal disability and workers' compensation. First, the ACA could affect the likelihood that people apply for these programs since health insurance may substitute for the types of services they provide. This would affect the number and types of people receiving benefits as well as overall costs. Second, the ACA has several features that will change the types of insurance plans people

have, such as eliminating copays for preventive care and taxing expensive, high-benefit plans. These features could result in healthier people or more cost shifting. Finally, the ACA implements many changes that alter medical resources. Since both disability and workers' compensation tap into the same systems as health insurance, changes that affect the medical system more generally will affect these programs as well.

This chapter discusses the implications that the ACA has for federal disability insurance and workers' compensation insurance. I do not attempt to determine whether the net impact of the costs of these programs will be positive or negative, as there is much uncertainty about the implementation and impact of the ACA. Instead, I discuss various aspects of the ACA, federal disability insurance, and workers' compensation, and I consider the possible interactions between the ACA and these social insurance programs.

THE AFFORDABLE CARE ACT

Implementation of the ACA began immediately after it was signed into law in 2010 and will continue until 2020. Table 5.1 summarizes various aspects of the law.

The employer mandate requires that companies with 50 or more full-time employees offer affordable coverage to their full-time employees or pay a penalty. The penalty for not offering health insurance is \$2,000 per employee after the first 30 employees. Employers' plans must pay for at least 60 percent of covered health care expenses, and employees must pay no more than 9.5 percent of family income for the coverage. To prevent employers from offering plans that meet these requirements but do not meet employees' needs, the ACA also assesses firms that offer coverage a separate penalty of \$3,000 for each employee who receives subsidized coverage through the exchanges.

The individual mandate requires nearly everyone to have health insurance or pay a penalty. The penalty for not having health insurance eventually rises to the maximum of \$695 per uninsured person or 2.5 percent of household income over the filing threshold. To avoid the penalty, nonexempt individuals must maintain minimum essential coverage, which is defined as employer-sponsored coverage, government-

sponsored coverage, or coverage purchased through the individual marketplace. Everyone is subject to the mandate except the following groups: people with incomes below 100 percent of the federal poverty level, people not required to file income taxes, people with religious objections, American Indians, undocumented immigrants, and incarcerated persons.

In addition to requiring that individuals purchase insurance, the ACA also established health insurance exchanges. These marketplaces opened in 2013 and allow people to compare plans from the individual market on a single website. The ACA issued several reforms for the individual market as well, including requiring insurers to accept all who apply for coverage, restricting the number of factors that could be used for pricing, and requiring certain coverage. To make insurance more affordable for people whose employers do not offer insurance and who are ineligible for Medicaid, the ACA provides subsidies for those making up to 400 percent of the federal poverty level.

In addition to subsidizing coverage for people not eligible for Medicaid, the ACA originally required that states expand Medicaid so that all households with incomes below 133 percent of the federal poverty level would qualify. The federal government would pay for the full cost of these newly eligible people in the first three years and no less than 90 percent thereafter. However, in June 2012, the Supreme Court ruled that the federal government could not require states to expand their Medicaid coverage; thus, the expansion of Medicaid is optional (Kaiser Family Foundation 2012). As of July 2014, 26 states and the District of Columbia have opted to expand Medicaid (Kaiser Family Foundation 2014).

The ACA also implements a variety of measures aimed at reducing Medicare costs. It has established the Independent Payment Advisory Board (IPAB), which will make recommendations to cut Medicare costs if they grow larger than the per capita GDP plus one percentage point. If Congress fails to pass an alternative proposal with the same cost savings, the IPAB recommendations will become law. The IPAB can also make nonbinding recommendations about private health spending. In addition to the IPAB, the ACA also encourages physicians and hospitals to form accountable care organizations (ACOs), which are sets of providers that bear responsibility for the cost and quality of care delivered to Medicare patients. Any Medicare savings from this coordinated

Table 5.1 Summary of Major Changes under the Affordable Care Act

Employer mandate	
Provisions	Employers with 50 or more full-time employees must offer a health insurance plan to all full-time employees or pay an annual penalty. ^{a,b}
Full-time definition	30 or more hours per week ^b
Penalties	Two types of penalties: <ul style="list-style-type: none"> • Must pay \$2,000 per full-time employee (after first 30 employees) for not offering any insurance options • Must pay \$3,000 for not offering affordable coverage, for all employees receiving a tax credit for insurance purchased on exchange^{a,b}
Contribution requirement	Insurance plan must pay for at least 60% of covered health care expenses for a typical population, and employees must pay no more than 9.5% of family income for employer coverage. ^a
Individual mandate	
Provisions	All people must purchase health insurance or pay a penalty.
Penalty for not buying	The penalty is the greater of <ul style="list-style-type: none"> • For 2014, \$95 per uninsured person or 1% of household income over the filing threshold • For 2015, \$325 per uninsured person or 2% of household income over the filing threshold • For 2016 and beyond, \$695 per uninsured person or 2.5% of household income over the filing threshold.^b
Subsidized insurance	For anyone earning up to 400% of poverty level whose employer does not offer health insurance, covers less than 60% of the actuarial value, or whose employee share exceeds 9.5% of income. ^a

Exemptions	Income below 100% of the federal poverty level; not being required to file income taxes; having religious objections; having a coverage gap shorter than three months; or being an American Indian, undocumented immigrant, or incarcerated person. ^a
Medicaid	
To qualify	Expanded so that people with a household income below 133% of the poverty level will qualify. ^a
Individual market	
Can charge different premiums based on	Family structure, geography, age, and tobacco use. ^a
Guaranteed issue	Yes ^a
Marketplaces created	State Exchanges, which allow individuals and small businesses to compare and purchase private insurance that meets coverage standards. ^a

SOURCE: ^aKaiser Family Foundation (2013); ^bKolstad and Kowalski (2012).

care would be shared with providers. Additionally, the ACA reduces Medicare payments to hospitals with high rates of potentially preventable readmissions. In doing so, it alters hospitals' incentives to provide high-quality and cost-effective care on the first admission. Finally, the ACA increases the government's resources to fight fraud, which could save money, since the Congressional Budget Office estimates that each additional dollar spent on fraud prevention reduces \$1.75 of Medicare spending (Zuckerman 2010).

As they were intended to do, these reforms have increased health insurance coverage. By June 2014, around 10.3 million more adults had health insurance because of the ACA (Sommers et al. 2014). This number is expected to grow over the next several years. The Congressional Budget Office and the Joint Committee on Taxation predict that the ACA will result in 19 million people having insurance in 2015 who otherwise would not. They expect this number to increase to 26 million by 2017 (Congressional Budget Office 2014). The anticipated cost of the ACA net of any savings is \$1,383 billion for 2015–2024. The vast majority of these costs come from increased spending on Medicaid, as well as subsidies for people purchasing insurance in the marketplace. Schoen et al. (2011) estimate that the ACA could lead to a 70 percent decrease in the underinsurance rate, while Hill (2012) estimates that the ACA will reduce out-of-pocket spending for people with individual insurance.

FEDERAL DISABILITY INSURANCE

Basic Program Information

Federal disability insurance pays benefits to people under the full retirement age who are unable to work because they have a medical condition that is expected to last at least one year or result in death. Disabled people are potentially eligible for two different programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). The SSDI program provides benefits to individuals who have paid into the Social Security system and meet certain minimum work requirements, and the SSI program is means tested and does not

have work or contribution requirements, but it restricts benefits to individuals with certain asset and resource limitations (Moulta-Ali 2013).

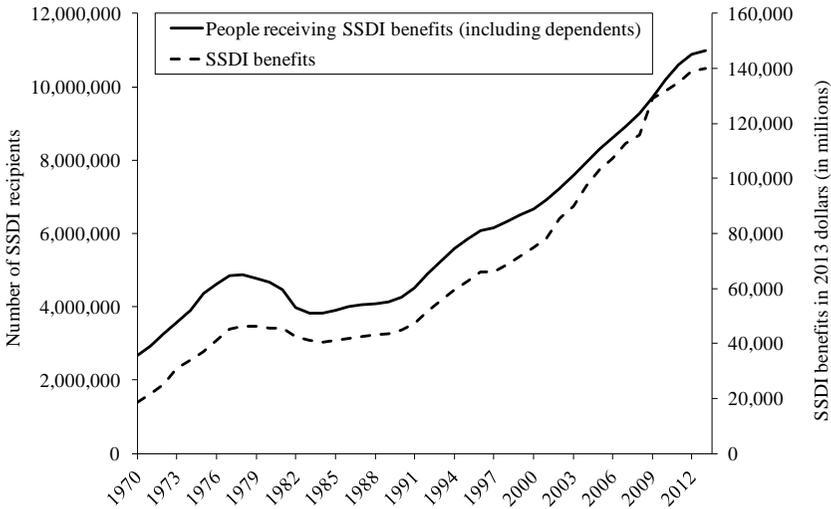
With SSDI, the benefit amount is related to the disabled worker's former earnings in covered employment. The average benefit amount as of 2012 was \$1,130 for disabled workers (Social Security Administration 2013). SSDI recipients can receive health insurance coverage through Medicare but only after a two-year waiting period that begins the day they qualify for benefits. After a disabling event, individuals must wait at least five months before receiving cash benefits.

The SSI program pays a flat cash benefit to aged, blind, and disabled individuals who have very limited income and assets. The benefit amount for SSI as of 2012 was \$698 for eligible individuals and \$1,048 for eligible couples (Social Security Administration 2014a). Individuals on SSI receive health insurance through the Medicaid program. Unlike SSDI recipients, SSI recipients receive cash benefits and health insurance immediately upon qualifying for benefits. As of 2012, around 86 percent of the people receiving SSI benefits were disabled (Center on Budget and Policy Priorities 2014).

Figure 5.1 shows the number of SSDI recipients, including dependents and the money spent on SSDI over time. The number of people on federal disability has swelled in recent decades. In 1970, approximately 2.7 million people, or about 1.3 percent of the population received SSDI. By the end of 2012, approximately 10.9 million people, or 3.5 percent of the population, received SSDI. Total SSDI benefits paid in 2012 were \$137 billion (Social Security Administration 2013). Autor and Duggan (2006) find that this rapid increase in the number of people receiving SSDI can be attributed to congressional reforms to disability screening that enabled workers with low mortality disorders to more easily qualify for benefits, a rise in the after-tax SSDI benefit, and an increase in female labor force participation, which expanded the pool of eligible workers.

Figure 5.2 shows SSI applicants and new recipients over time. While the number of people newly receiving SSI because of their age has decreased slightly over time, the number of new disabled recipients has increased. As of 2012, around 8.3 million people received SSI, while total SSI benefits paid were \$49 billion (Social Security Administration 2013).

Figure 5.1 SSDI Beneficiaries and Benefits by Year



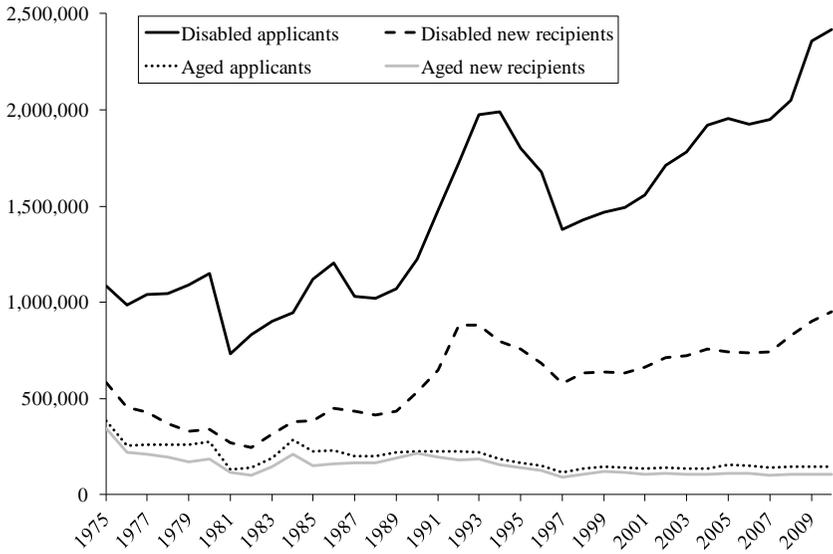
SOURCE: Social Security Administration (2014c).

Social Security and Medicare are both funded from a 15.3 percent payroll tax on earnings that is split equally between employees and employers. Of the 15.3 percent, 1.8 percent of the payroll tax goes into the disability trust fund to pay for SSDI, and 2.9 percent goes toward Medicare; the rest of the tax goes in the Old Age and Survivors Insurance Fund (Moulta-Ali 2013). SSI is financed through the general revenue of the United States. Medicaid, which SSI recipients receive, is funded jointly by state and federal government.

The ACA’s Potential Effect on Disability Insurance

The ACA will likely exert two countervailing forces on people’s decisions to apply for disability insurance. Applicants to both SSDI and SSI face uncertainty about whether or not they qualify for benefits, and they may have to wait long periods of time for their disability status to be determined. During this time, applicants cannot work. Since employer-sponsored insurance has traditionally been better than the other forms of insurance available, people may have had to go without

Figure 5.2 SSI Applicants and New Recipients by Year



SOURCE: Social Security Administration (2014d).

high-quality, affordable health insurance to apply for disability coverage. However, the insurance exchanges and subsidized coverage from the ACA promise affordable health insurance outside employment. Similarly, the ACA mandates that insurance companies accept all who apply, which will increase coverage options for those with a disability. Improving coverage options for those with a disability could free workers from employment lock, thereby reducing the costs of applying for disability coverage. This would cause the number of disability applications to rise, especially those for SSDI, since those applicants will have to wait an additional two years after receiving benefits before they receive Medicare coverage. On the other hand, a lack of good health insurance alternatives to employer-sponsored health insurance is one reason people apply for SSDI. By creating good health insurance opportunities apart from employer-sponsored coverage and Medicare, the ACA lowers the benefit of applying for disability. This could result in fewer people applying for disability.

Two papers empirically examine which effect dominates. Gruber and Kubik (2002) study how health insurance factors into the likelihood that people apply for SSDI using Health and Retirement Study data. They find that people who have access to insurance from a source other than their own employers, such as insurance through a spouse's employer or retiree coverage, are 26–74 percent more likely to apply for SSDI benefits than those without such alternative sources of coverage.

Maestas, Mullen, and Strand (2014) study what happened to disability applications after the Massachusetts health insurance reform, which has a structure that is very similar to the ACA. They find that disability applications increased in Massachusetts relative to neighboring states in the first year following health insurance reform. After the first year, there was no statistically significant effect of the reform on total applications. These results suggest that there may have been pent-up demand for disability benefits for people who had been working with impairments. Despite finding no evidence of long-term changes in the aggregate, they find important county-level heterogeneity. They find that SSDI and SSI applications increased in counties with high levels of health insurance coverage prior to the reform and decreased in counties with low levels of coverage. Since Massachusetts had higher insurance coverage than the rest of the country before its health insurance reform, Maestas, Mullen, and Strand conclude that the ACA may lead to a net decrease in disability insurance applications.

Just as the need for health insurance has resulted in some people being tied to employers, it can lead to some people being tied to disability insurance. Coe and Rupp (2013) examine how access to health insurance for disabled individuals in both the nongroup market and Medicaid affects the exit from disability. They find that SSI beneficiaries with some Medicaid expenditures are more likely to exit disability when they have more health insurance options available to them, as are SSDI recipients who do not have access to supplemental health insurance outside Medicare.

Gruber and Kubik (2002) suggest that the ACA would lead to an increase in disability applicants. However, results from the Massachusetts reform suggest that the ACA will likely affect certain people and areas differently than others. The results of Coe and Rupp (2013) suggest that the ACA may reduce disability lock for some people and

allow them to return to work, which would reduce the number of people receiving disability benefits.

The ACA has the potential to affect disability insurance in ways not directly related to altering claiming incentives, such as through the ACA provisions that aim to reduce Medicare costs. These provisions, which were discussed in the second section of the chapter, directly affect SSDI beneficiaries, since Medicare is their health insurance. Many speculate that the IPAB may eventually cut Medicare reimbursement rates for doctors (Vaida 2012). While this would reduce costs to the Medicare program, it may also make it more difficult for SSDI recipients to receive medical care, since doctors may be less likely to accept Medicare patients. Cutting costs and improving care are goals of ACOs and reasons for not reimbursing preventable readmissions. Both these measures have the potential to decrease costs while improving the care that SSDI recipients receive.

In addition to decreasing the costs of applying for SSDI, improving health insurance options during the two-year waiting period may also increase the health care access of SSDI recipients. The two-year waiting period is often a concern, since SSDI recipients have health issues. Riley (2006) studies health insurance and health care access during the waiting period and finds that 26 percent of SSDI beneficiaries lacked health insurance during this period. He also finds that SSDI beneficiaries without health insurance had more problems accessing health care than those with health insurance. Weathers and Stegman (2012) and Michalopoulos et al. (2012) study a Social Security program that provides health insurance coverage to SSDI beneficiaries while they await Medicare eligibility. Weathers and Stegman find that these accelerated benefits increased mental health and physical health one year after enrollment. Although they find no evidence of changes in mortality, they point out that this increased health could lower costs once people are on SSDI. Michalopoulos et al. find that the accelerated benefits program resulted in people having fewer unmet medical needs and reduced out-of-pocket spending on medical care. They also find that accelerated benefits enrollees were more likely to search for work. These results indicate that the ACA may cause SSDI recipients to be healthier and more likely to exit disability.

By providing greater access to health care, the ACA may make it easier for people to obtain the documentation necessary to prove they have a disability. As part of the application for disability, applicants need to provide medical records about their disabilities, as well as contact information for all the relevant health care professionals, laboratory and test results, and the names of medicines they take (Social Security Administration 2014b). Making the documentation of a disability easier could result in more people applying for coverage or an increase in the acceptance rate among those who apply for benefits.

WORKERS' COMPENSATION

Basic Program Information

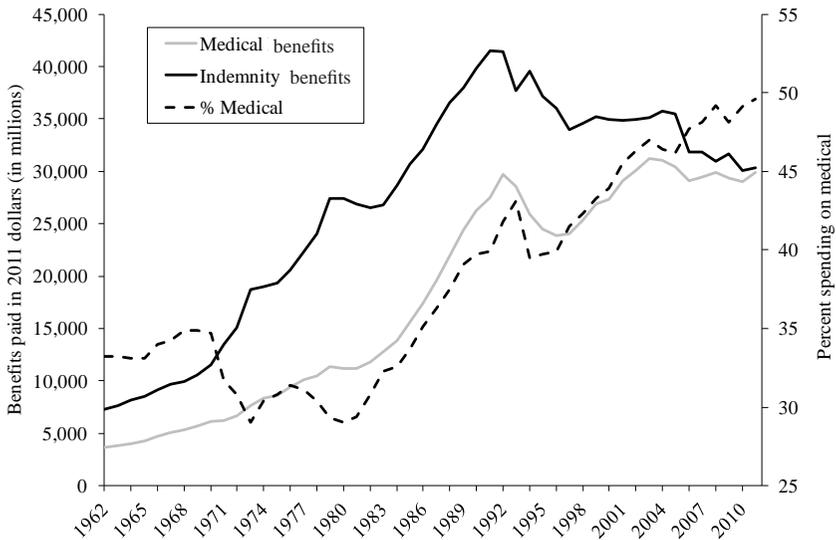
Workers' compensation pays all medical bills for individuals with work-related injuries and diseases. Unlike federal disability, workers' compensation is a state-level program. Therefore, all workers' compensation programs are a little different from each other. In some states, private insurance companies administer workers' compensation, while in others, the states are the sole providers of insurance. For workers who miss more than three to seven days of work, workers' compensation also replaces lost wages through indemnity benefits. The injured workers' weekly benefits are a function of their weekly earnings and are subject to state-level maximums. In all states except Texas and Oklahoma, workers' compensation insurance is mandatory for employers.

Injured workers receiving indemnity benefits usually first receive temporary total disability (TTD). They receive these benefits until they are able to return to work or are evaluated for permanent disability benefits. They will be evaluated for permanent disability benefits after they have reached the state limit for temporary benefits or the physician has determined they have reached "maximum medical improvement." Permanent disability benefits comprise two separate types of benefits: permanent total disability (PTD) and permanent partial disability (PPD). PTD and PPD benefits in that injured workers receive benefits based on their average weekly wages subject to the state maximum. Workers stop receiving benefits when they have healed, returned to work, or

reached the state maximum number of weeks for PTD eligibility. With PPD benefits, workers are generally given a partial impairment rating or assigned a fixed schedule of benefits. People are typically allowed to work while receiving PPD benefits. (See McInerney and Simon [2012] for a more thorough discussion of different benefit types and Hunt [2004] for a discussion of the adequacy of those benefits.)

In 2011, nearly 126 million workers were covered by workers' compensation insurance (Sengupta, Baldwin, and Reno 2013). Employers paid over \$77 billion for coverage, and workers received over \$60 billion from the system. The majority of workers' compensation cases—around 76 percent—are medical-only cases and do not involve payments for missed work. Figure 5.3 shows workers' compensation spending on medical and wage replacement over time. Spending for wage replacement has been falling since the early 1990s, while medical spending has continued to rise. The share of medical benefits as a percentage of the total benefits paid for workers' compensation has risen from around 30 percent in the early 1980s to approximately 50 percent in 2011.

Figure 5.3 Workers' Compensation Medical and Indemnity Benefits by Year



SOURCE: Sengupta, Baldwin, and Reno (2013).

The ACA's Potential Effect on Workers' Compensation

The ACA will change the incentive to claim workers' compensation by expanding health insurance coverage, which reduces the benefit of filing for workers' compensation, regardless of whether the injury is work related. People without health insurance have an increased incentive to claim that their medical issues are work related even if they are not so that workers' compensation will pay the bills. Thus, having health insurance may lower the incidence of people misclassifying non-work-related injuries. If an injury occurs at work, health insurance may still deter workers from filing a claim for workers' compensation if it is costly, and there are several reasons to believe that it is. First, employers may dissuade their employees from filing workers' compensation because they fear it will increase their premiums. Second, injured workers might not want to deal with the associated paperwork, or they may fear that they will be called on to prove that their injury was caused by work, which is not always easy to do. Filing with health insurance, meanwhile, requires no burden of proof. Third, there may be a stigma associated with filing a workers' compensation claim.

According to some studies, a large percentage of workers do not file a workers' compensation claim because they have health insurance. Biddle and Roberts (2003) surveyed Michigan workers identified by physicians as likely having work-related injuries. Of these injured workers, only 30 percent filed for workers' compensation. Of the 70 percent who did not file for workers' compensation, 36 percent said that having health insurance was the reason. However, Lakdawalla, Reville, and Seabury (2007) show that people with health insurance are generally more likely to receive workers' compensation. They hypothesize that large firms may be more likely to provide workers with information about workers' compensation and to encourage them to use it.

Heaton (2012) studies the impact of Massachusetts's health insurance reform on workers' compensation by projecting how many emergency room bills would have been paid for by the state's workers' compensation system in the absence of the 2006 reform based on 2005 Massachusetts data. Heaton finds that the health care reform resulted in workers' compensation paying for 5–10 percent fewer emergency room medical bills. He finds similarly sized decreases for both the overall patient population and those with relatively serious medical conditions.

In Dillender (2015a), using administrative medical claims data from Texas, I study the effect of health insurance on young adults filing workers' compensation claims. I compare individuals just before and after they turn 26, the age at which young adults lose access to dependent coverage under the ACA. This approach yields estimates of the causal effect of health insurance on workers' compensation filing. I find that immediately after people turn 26, initial claims filed for injuries with easy-to-delay reporting increase, while the overall amount of medical treatment that workers' compensation pays for increases by 8 percent. Despite these increases, overall workers' compensation medical costs do not increase dramatically for 26-year-olds because the majority of this increased care is for less expensive services. These results suggest that health insurance affects workers' compensation filing, particularly at the intensive margin, but not necessarily for the types of services that drive medical costs.

Overall, the empirical studies suggest that workers' compensation will pay for less medical care once more people have health insurance. In Dillender (2015a), I find evidence that the claiming behavior of people with minor medical needs is influenced by having health insurance. This would suggest that the overall savings to workers' compensation would be modest. Heaton (2012), however, finds evidence that people with greater medical needs respond to health reform, which suggests that the cost savings to workers' compensation could be large. Thus, while the evidence strongly suggests that the ACA will decrease the likelihood that health care is paid for by workers' compensation, the size of the cost savings to workers' compensation is difficult to assess. Also, if people with more severe medical issues respond to workers' compensation, indemnity claims may also respond by falling slightly as a result of the ACA; however, no research has explored if and how indemnity claims are affected by health insurance.

By influencing some people to file claims with health insurance instead of workers' compensation, the ACA may result in cost savings to the workers' compensation system. However, the ACA may also change the type of insurance plans people have by encouraging the use of more high-deductible plans—for example, with a 40 percent excise tax on health plans with individual premiums above \$10,200 and family premiums above \$27,500 starting in 2018 (Zuckerman 2010). Since people will lack first-dollar coverage, they may be more likely to shift

claims onto workers' compensation, which will still provide first-dollar coverage.

The changes to Medicare discussed previously also have implications for workers' compensation, especially if the IPAB curtails Medicare costs by cutting reimbursement rates. Many states tie workers' compensation reimbursement rates to Medicare reimbursement rates. By cutting Medicare reimbursement rates, the ACA would also lower workers' compensation reimbursement rates in many states unless state governments react by changing their laws. Thus, the ACA will lower the amount of money spent on medical care. However, this may cause providers in these states to be less likely to accept workers' compensation patients since they will receive less money for treating them. Even in states that do not tie their reimbursement rates to Medicare, changes in Medicare rates may affect workers' compensation. Auerbach, Heaton, and Brantley (2014) argue that when Medicare pays physicians less, it may cause physicians to increase prices for other payers or provide more services to other patients that provide higher margins. If Medicare no longer pays providers for certain readmissions, it may have the same effect if it decreases physicians' profits from Medicare patients.

Auerbach, Heaton, and Brantley (2014) also argue that the ACA could change the composition of the labor force. A large literature in economics finds that the need for health insurance has induced people to participate in the labor force (Antwi, Moriya, and Simon 2013; Blau and Gilleskie 2001; Buchmueller and Carpenter 2012; Dillender 2015b; Nyce et al. 2013; Strumpf 2010). Prior to the ACA, there were few good health insurance options for the near elderly outside employment. Auerbach, Heaton, and Brantley argue that the exchanges and subsidies will allow older people to retire sooner, which may reduce costs, since older workers typically take longer to recover from injuries and require more treatment.

POTENTIAL EFFECTS OF THE ACA ON BOTH PROGRAMS

As both disability insurance and workers' compensation insurance tap into the same medical resources that health insurance does, they will both be affected by the aspects of the ACA that affect the medical

system more generally. One potential impact of the ACA is to improve the health of the general population. Research typically finds that health insurance improves health (Card, Dobkin, and Maestas 2009; Doyle 2005; Finkelstein et al. 2012), and Courtemanche and Zapata (2014) find that people reported being in better health as a result of the Massachusetts reform. The ACA also has a focus on prevention by eliminating copayments for preventive services and including an annual wellness visit as a part of Medicare. This has the potential to lower the likelihood that people become disabled or suffer an injury while at work.

The ACA has various strategies to make medical treatment less expensive, such as with the Patient-Centered Outcomes Research Institute, which focuses on identifying effective treatments. The ACA also implements rules that establish electronic health records, which could also reduce costs while improving care. By identifying effective treatments and digitizing medical records, the ACA has the potential to lower costs for medical care paid under both disability insurance and workers' compensation.

A potential issue with the dramatic increase in insurance coverage promised by the ACA is that it will put more stress on existing medical resources. Hofer, Abraham, and Moscovice (2011) point out that there was already a shortage of primary care doctors before the ACA and suggest that the increased demand from the ACA could increase the shortages. Huang and Finegold (2013) find that certain areas will be hit hard by an increase in demand, while other areas will be able to meet the demand. They estimate that 7 million people live in areas where demand for primary care may exceed supply by 10 percent after the ACA. Physician shortages may increase wait times for injured and disabled people before they can receive medical care.

CONCLUSION

By overhauling the health insurance system and making many broad changes to medical care, the ACA promises to change the health care landscape. In this chapter, I describe the changes taking place because of the ACA, as well as their implications for two major social insurance programs with large medical components. I review the con-

siderable evidence that suggests that expanding health insurance could affect claiming behavior for both disability and workers' compensation. For disability insurance, some evidence suggests that expanding health insurance may have countervailing effects on overall disability coverage. For workers' compensation, the evidence points to health insurance covering some of the costs that workers' compensation insurance was previously paying.

Apart from affecting claiming behavior, the ACA will likely affect these social insurance programs in other ways as well. The ACA's many cost-saving measures will likely have spillover effects for both disability insurance and workers' compensation, especially those measures that aim to identify the most effective treatments. The aspects of the ACA that aim to improve population health may also result in fewer work-related injuries and less disability, thereby saving money for both programs. One negative aspect of the ACA for both of these programs may be that the increase in insurance coverage puts more strain on medical resources, which could make seeing a doctor more difficult.

References

- Antwi, Yaa Akosa, Asako S. Moriya, and Kosali Simon. 2013. "Effects of Federal Policy to Insure Young Adults: Evidence from the 2010 Affordable Care Act's Dependent-Coverage Mandate." *American Economic Journal: Economic Policy* 5(4): 1–28.
- Auerbach, David I., Paul Heaton, and Ian Brantley. 2014. *How Will the Patient Protection and Affordable Care Act Affect Liability Insurance Costs?* Santa Monica, CA: RAND Corporation.
- Autor, David H., and Mark G. Duggan. 2006. "The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding." *Journal of Economic Perspectives* 20(3): 71–96.
- Biddle, Jeff, and Karen Roberts. 2003. "Claiming Behavior in Workers' Compensation." *Journal of Risk and Insurance* 70(4): 759–780.
- Blau, David M., and Donna B. Gilleskie. 2001. "Retiree Health Insurance and the Labor Force Behavior of Older Men in the 1990s." *Review of Economics and Statistics* 83(1): 64–80.
- Buchmueller, Thomas, and Christopher Carpenter. 2012. "The Effect of Requiring Private Employers to Extend Health Benefit Eligibility to Same-Sex Partners of Employees: Evidence from California." *Journal of Policy Analysis and Management* 31(2): 388–403.

- Card, David, Carlos Dobkin, and Nicole Maestas. 2009. "Does Medicare Save Lives?" *Quarterly Journal of Economics* 124(2): 597–636.
- Center on Budget and Policy Priorities. 2014. "Policy Basics: Introduction to Supplemental Security Income." Washington, DC: Center on Budget and Policy Priorities. http://www.cbpp.org/sites/default/files/atoms/files/Policy_Basics_SocSec-IntroToSSI.pdf (accessed September 4, 2015).
- Coe, Norma, and Kalman Rupp. 2013. "Does Access to Health Insurance Influence Work Effort among Disability Cash Benefit Recipients?" Center for Retirement Research Working Paper 2013-10. Boston: Boston College, Center for Retirement Research.
- Congressional Budget Office. 2014. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014." Washington, DC: Congressional Budget Office. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf (accessed September 4, 2015).
- Courtemanche, Charles J., and Daniela Zapata. 2014. "Does Universal Coverage Improve Health? The Massachusetts Experience." *Journal of Policy Analysis and Management* 33(1): 36–69.
- Doyle, Joseph J. Jr. 2005. "Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks." *Review of Economics and Statistics* 87(2): 256–270.
- Dillender, Marcus. 2015a. "The Effect of Health Insurance on Workers' Compensation Filing: Evidence from the Affordable Care Act's Age-Based Threshold for Dependent Coverage." *Journal of Health Economics* 43: 204–228.
- . 2015b. "Health Insurance and Labor Force Participation: What Legal Recognition Does for Same-Sex Couples." *Contemporary Economic Policy* 33(2): 381–394.
- Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, and Katherine Baicker. 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics* 127(3): 1057–1106.
- Gruber, Jonathan, and Jeffrey Kubik. 2002. *Health Insurance Coverage and the Disability Insurance Application Decision*. NBER Working Paper No. 9148. Cambridge, MA: National Bureau of Economic Research.
- Heaton, Paul. 2012. *The Impact of Health Care Reform on Workers' Compensation Medical Care*. RAND Institute for Civil Justice Technical Report. Santa Monica, CA: RAND Corporation.
- Hill, Steven C. 2012. "Individual Insurance Benefits to Be Available under Health Reform Would Have Cut Out-of-Pocket Spending in 2001–08." *Health Affairs* 31(6): 1349–1356.
- Hofer, Adam N., Jean Abraham, and Ira Moscovice. 2011. "Expansion of Cov-

- erage under the Patient Protection and Affordable Care Act and Primary Care Utilization.” *Milbank Quarterly* 89(1): 69–89.
- Huang, Elbert S., and Kenneth Finegold. 2013. “Seven Million Americans Live in Areas Where Demand for Primary Care May Exceed Supply by More than 10 percent.” *Health Affairs* 32(3): 614–621.
- Hunt, H. Allan, ed. 2004. *Adequacy of Earnings Replacement in Workers’ Compensation Programs*. Washington, DC: National Academy of Social Insurance and Kalamazoo, MI: W. E. Upjohn Institute for Employment Research.
- Kaiser Family Foundation. 2012. “A Guide to the Supreme Court’s Decision on the ACA’s Medicaid Expansion.” Menlo Park, CA: Henry J. Kaiser Family Foundation.
- . 2013. “Summary of the Affordable Care Act.” Last modified April 25, 2013. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- . 2014. “Status of State Action on the Medicaid Expansion Decision, 2014.” Menlo Park, CA: Henry J. Kaiser Family Foundation. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/> (accessed September 4, 2015).
- Kolstad, Jonathan T., and Amanda E. Kowalski. 2012. “Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform.” NBER Working Paper No. 17933. Cambridge, MA: National Bureau of Economic Research.
- Lakdawalla, Darius N., Robert T. Reville, and Seth A. Seabury. 2007. “How Does Health Insurance Affect Workers’ Compensation Filing?” *Economic Inquiry* 45(2): 286–303.
- Maestas, Nicole, Kathleen Mullen, and Alexander Strand. 2014. “Disability Insurance and Health Insurance Reform: Evidence from Massachusetts.” *American Economic Review: (Papers and Proceedings)* 104(5): 329–335.
- McInerney, Melissa, and Kosali Simon. 2012. “The Effect of State Workers’ Compensation Program Changes on the Use of Federal Social Security Disability Insurance.” *Industrial Relations: A Journal of Economy and Society* 51(1): 57–88.
- Michalopoulos, Charles, David Wittenburg, Dina A. R. Israel, and Anne Warren. 2012. “The Effects of Health Care Benefits on Health Care Use and Health: A Randomized Trial for Disability Insurance Beneficiaries.” *Medical Care* 50(9): 764–771.
- Moulta-Ali, Umar. 2013. “Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).” Washington, DC: Congressional Research Service.
- Nyce, Steven, Sylvester J. Schieber, John B. Shoven, Sita Nataraj Slavov, and

- David A. Wise. 2013. "Does Retiree Health Insurance Encourage Early Retirement?" *Journal of Public Economics* 104: 40–51.
- Riley, Gerald F. 2006. "Health Insurance and Access to Care among Social Security Disability Insurance Beneficiaries during the Medicare Waiting Period." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 43(3): 222–230.
- Schoen, Cathy, Michelle M. Doty, Ruth H. Robertson, and Sara R. Collins. 2011. "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent." *Health Affairs* 30(9): 1762–1771.
- Sengupta, Ishita, Marjorie Baldwin, and Virginia Reno. 2013. *Workers' Compensation: Benefits, Coverage, and Costs*. Washington, DC: National Academy of Social Insurance.
- Social Security Administration. 2013. "Annual Statistical Supplement to the Social Security Bulletin, 2013." Washington, DC: Social Security Administration. <http://www.ssa.gov/policy/docs/statcomps/supplement/2013/supplement13.pdf> (accessed September 4, 2015).
- . 2014a. SSI Federal Payment Amounts. Washington, DC: Social Security Administration. <http://www.ssa.gov/oact/cola/SSIamts.html> (accessed September 4, 2015).
- . 2014b. "Social Security Disability Benefits." SSA Publication No. 05-10029. Washington, DC: Social Security Administration. <http://www.socialsecurity.gov/pubs/EN-05-10029.pdf> (accessed September 4, 2015).
- . 2014c. Statistical Tables. Washington, DC: Social Security Administration. <http://www.ssa.gov/oact/STATS/index.html>. <http://www.socialsecurity.gov/OACT/STATS/> (accessed September 4, 2015).
- . 2014d. "2011 Annual Report of the SSI Program." Washington, DC: Social Security Administration. <http://www.ssa.gov/oact/ssir/SSI11/Participants.html#646860> (accessed September 4, 2015).
- Sommers, Benjamin D., Thomas Musco, Kenneth Finegold, Munira Z. Gunja, Amy Burke, and Audrey M. McDowell. 2014. "Health Reform and Changes in Health Insurance Coverage in 2014." *New England Journal of Medicine* 371(9): 867–874.
- Strumpf, Erin. 2010. "Employer-Sponsored Health Insurance for Early Retirees: Impacts on Retirement, Health, and Health Care." *International Journal of Health Care Finance and Economics* 10(2): 105–147.
- Vaida, Bara. 2012. "The IPAB: The Center of a Political Clash over How to Change Medicare." *Kaiser Health News*. Menlo Park, CA: Henry J. Kaiser Family Foundation. <http://khn.org/news/ipab-faq> (accessed September 4, 2015).
- Weathers II, Robert R., and Michelle Stegman. 2012. "The Effect of Expanding Access to Health Insurance on the Health and Mortality of Social Security

Disability Insurance Beneficiaries.” *Journal of Health Economics* 31(6): 863–875.

Zuckerman, Stephen. 2010. “What Are the Provisions in the New Law for Containing Costs and How Effective Will They Be?” Washington, DC: Urban Institute. <http://www.urban.org/uploadedpdf/412194-ppaca-containing-costs.pdf> (accessed September 4, 2015).

The Economics of Health

Donald J. Meyer

2016

W.E. Upjohn Institute for Employment Research
Kalamazoo, Michigan

Library of Congress Cataloging-in-Publication Data

Names: Meyer, Donald J., editor.

Title: The economics of health / [edited by] Donald Meyer.

Description: Kalamazoo, Michigan : W.E. Upjohn Institute for Employment Research, 2016. | Includes index.

Identifiers: LCCN 2016005812 | ISBN 9780880994620 (pbk. : alk. paper) | ISBN 0880994622 (pbk. : alk. paper) | ISBN 9780880994637 (hardcover : alk. paper) | ISBN 0880994630 (hardcover : alk. paper)

Subjects: LCSH: Medical economics.

Classification: LCC RA410 .E2873 2016 | DDC 338.4/73621—dc23

LC record available at <http://lcn.loc.gov/2016005812>

© 2016

W.E. Upjohn Institute for Employment Research
300 S. Westnedge Avenue
Kalamazoo, Michigan 49007-4686

The facts presented in this study and the observations and viewpoints expressed are the sole responsibility of the authors. They do not necessarily represent positions of the W.E. Upjohn Institute for Employment Research.

Cover design by Alcorn Publication Design.

Index prepared by Diane Worden.

Printed in the United States of America.

Printed on recycled paper.