

WORKING PAPER

Executive Summary

APRIL 2013, WP 2013-10

CENTER *for*
RETIREMENT
RESEARCH
at BOSTON COLLEGE

DOES ACCESS TO HEALTH INSURANCE INFLUENCE WORK EFFORT AMONG DISABILITY CASH BENEFIT RECIPIENTS?

BY NORMA B. COE AND KALMAN RUPP

There are two health insurance systems in the United States for working-age individuals: (1) employer-sponsored coverage for employed individuals and their families; and (2) public health insurance (both Medicaid and Medicare) for individuals who are unable to work. It is well-documented that tying health insurance to employment has adverse side-effects, often referred to as “job-lock” (Gruber 2000, Gruber and Madrian 2004). The evidence is clear and unambiguous that health insurance is a central determinant of retirement decisions, and the literature suggests that health insurance decreases job turnover by 10 percent to 35 percent (Gruber and Madrian 1994, Madrian, 1994, Buchmueller and Valletta, 1996). The same adverse side effects could apply to welfare recipients or the disabled population; tying health insurance coverage to cash benefits may exacerbate already strong incentives to never leave the welfare/disability rolls. Evidence suggests that “welfare-lock” is statistically significant, but relatively small in magnitude (for example, Ellwood and Adams 1990, Yelowitz 1995).

To date, little work has tried to estimate the size or importance of “DI-lock.” Congress since the mid-1980s has repeatedly extended Medicaid and/or Medicare eligibility to SSI and DI recipients who leave the rolls due to work. However, there remains concern that few recipients may know about these program extensions and thus remain “DI-locked” due to fear of losing health insurance (Livermore, Roche, and Prenovitz 2009).

This paper estimates the remaining impact of “DI-lock” on earnings and leaving the disability rolls due to work by using state differences in health insurance access and price. These differences arise due to regulation in the non-group health insurance market (guaranteed issue and community rating), the presence of a Medicaid buy-in program for the disabled, and the generosity of the Medicaid eligibility rules. These state-level changes provide exogenous variation in the access and affordability of health insurance in the public and non-group health insurance markets.

To assess the relationship between health insurance access and work behavior among disability recipients, we use a unique administrative dataset that contains health insurance claims, earnings history and disability benefit history. This paper employs a difference-in-difference and triple-difference framework and tests five separate hypotheses relating to work effort among individuals on the disability rolls. These hypotheses are derived from the job-lock literature and the interactions between SSI, DI, Medicaid and Medicare programs.

Hypotheses and Findings

First, there may be an overall relationship between health insurance and work effort.

Hypothesis 1: Beneficiaries in states with easier access to health insurance will be more likely to work than their peers in states where health insurance is more difficult to access.

Findings: True and False. While we find statistically significant effects between state Medicaid policy and earnings among SSI beneficiaries, the effects are quantitatively small.

While changes in health insurance access could impact all disabled beneficiaries, certain subgroups may be more responsive than others. Some likely candidates are: (1) individuals with disabilities that require high and consistent medical spending and thus gain more from health insurance; and (2) beneficiaries without access to spousal health insurance coverage.

Hypothesis 2: Disability beneficiaries with moderately high medical spending will be more likely to work in states with easier access to health insurance, compared to individual with relatively low medical spending.

Findings: True. We find significant effects from the presence of Medicaid buy-in programs on the likelihood of positive earnings based on medical utilization differences. Beneficiaries with moderate or high medical expenditures are more likely (by 0.3-2.7 percentage points) to have positive earnings in states with Medicaid buy-in programs than their counterparts with no medical spending. SSI beneficiaries with moderate or high medical expenditures are also more likely to have positive earnings (by 2.0-3.7 percentage points) in states with more generous Medicaid programs. The relationship between strict health insurance regulation and earnings among beneficiaries is more nuanced. DI-beneficiaries with moderate or high medical expenditures in states with strict regulation are less likely (by 0.7 to 3.8 percentage points) to have positive earnings, with SSI-beneficiaries with moderate medical expenditures are more likely to have positive earnings.

The job-lock literature has shown that individuals with access to health insurance coverage from other means – such as a spouse’s employer – do not exhibit the same decreased job turnover rates due to health insurance access. From the administrative data, we know whether a DI- beneficiary with Medicare coverage also has private insurance, which makes Medicare the secondary payer, but we do not know the source of the insurance (spouse, previous employer, etc.).

Hypothesis 3: Disability beneficiaries with public coverage as a secondary payer will be less responsive to state health insurance access regulations.

Findings: True and False. Our findings indicate that beneficiaries who have Medicare as a secondary payer (and thus do not have private insurance) are more likely to have positive earnings when they live in states with a strictly regulated non-group market, but less likely to have positive earnings in states with a Medicaid buy-in program. SSI-DI beneficiaries are also less likely to have positive earnings in states with a generous Medicaid program. But when we examine exiting the rolls due to work, we find the predicted positive relationship. Overall, disability beneficiaries have an 0.4 percentage point higher likelihood of leaving the rolls due to work when their state introduces Medicaid-buy in programs, and this effect is driven by SSI beneficiaries who are 2.6 percentage points more likely to leave the rolls.

Our final hypotheses are motivated by DI and SSI program interactions. In the first case, an individual on the DI rolls may be eligible for SSI benefits should his DI benefits cease due to earnings, and his earnings remain below a specified level.

Hypothesis 4a: The SGA “cliff” – the point at which one loses cash DI benefits due to earnings – will be more important for individuals who are DI only, compared to potential DI-to-SSI beneficiaries.

Hypothesis 4b: The differential impact of the SGA cliff on earnings between DI only and potential DI-to-SSI beneficiaries will be less important in states with easier access to health insurance in the non-group market.

Findings: False. Our results suggest that beneficiaries who would likely qualify for SSI benefits should they earn above the SGA-limit are just as likely to earn above the SGA limit as beneficiaries who would not likely qualify for SSI benefits. However, we do find evidence that beneficiaries who gain SSI benefits as they work their way off the DI rolls are more likely to earn above the SGA and below the threshold for which they would lose SSI benefits.

Finally, DI and SSI program interactions imply different sizes of the SGA-cliff among beneficiaries who are eligible for both DI and SSI benefits – hereafter referred to as joint beneficiaries. Beneficiaries with relatively high DI benefits will lose a greater proportion of their disability benefits should their earnings cause them to lose DI cash benefits. The size and presumably the importance of the SGA cliff depend heavily on the level of DI benefits.

Hypothesis 5a: Among joint beneficiaries, the SGA cliff will be less important to individuals receiving lower DI benefits.

Hypothesis 5b: Among joint beneficiaries, the SGA cliff and the eventual loss of Medicare coverage will be less important in states with easier access to health insurance coverage, controlling for the ratio of DI to SSI benefits (the size of the SGA cliff).

Findings: True and False. We find no differential impact of the size SGA cliff among joint beneficiaries depending on the relative size of their DI benefits in their likelihood of earning above the SGA, nor do we find a differential impact of health insurance access on earnings. However, we do find that the size of the SGA cliff makes beneficiaries less likely to earn between the SGA and the point at which they would lose SSI benefits, and that generous Medicaid programs help alleviate this lock.

Conclusions

While there is little overall relationship between state health insurance access and beneficiaries working or leaving the disability rolls, we find that heterogeneity is particularly important in this context. We find evidence of remaining DI-lock even after the expansion of Medicaid and Medicare eligibility after beneficiaries leave the disability rolls due to work. Further, our findings suggest that different state-level policies assist the disabled able to leave the rolls in different situations. We find that SSI beneficiaries are the most responsive to health insurance access gained through Medicaid – either through a buy-in program or generous eligibility rules. Further, we find that strict regulation of the non-group market helps alleviate SSI lock among beneficiaries with positive health insurance expenditures and ease DI lock among beneficiaries without access to private health insurance. Finally, we find suggestive evidence to support the hypothesis that potential SSI-eligibility dampens the work disincentives of the SGA cliff, but more research is needed to achieve more definitive conclusions.

© 2013, Norma B. Coe and Kalman Rupp. All rights reserved. The research reported herein was performed pursuant to a grant from the U.S. Social Security Administration (SSA) funded as part of the Retirement Research Consortium (RRC). The opinions and conclusions expressed are solely those of the authors and do not represent the views of SSA, any agency of the federal government, the RRC, the University of Washington, or Boston College.

CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE

Hovey House, 140 Commonwealth Avenue, Chestnut Hill, MA 02467-3808
phone 617.552.1762 fax 617.552.0191 crr@bc.edu crr.bc.edu