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What is This?
Gaps in Timely Access to Care Among Workers by Disability Status: Will the Patient Protection and Affordable Care Act Reforms Change the Landscape?

Jody Schimmel Hyde, PhD1 and Gina A. Livermore, PhD1

Abstract
The Patient Protection and Affordable Care Act (ACA) is salient for workers with a disability because of their significant health care needs, relatively low incomes, and the complex interactions among work, federal disability benefits, and eligibility for public health insurance. Using data from the 2006–2010 National Health Interview Surveys, in this study, we document the characteristics and health insurance profiles of workers with a disability and consider the extent to which these factors are correlated with the ability to access adequate and timely health care. We find significantly higher rates of reported difficulties accessing timely health care for cost-related and structural reasons among employed adults with self-reported health conditions limiting the ability to work than among their non-work-limited peers, even after controlling for personal characteristics and health insurance coverage. The findings suggest that although the ACA will improve access to health insurance, it remains to be seen whether it will substantially reduce the likelihood that workers with disabilities will experience barriers to health care access relative to their non-disabled peers.

Keywords
access to care, workers, employment, Affordable Care Act, disparities

Introduction
For individuals with disabilities, health insurance coverage is often critical to help pay for the range of services and supports they require to manage complex medical issues. Working-age adults with disabilities have health care expenditures that are significantly higher than their peers (Mitra, Findley, & Sambamoorthi, 2009; Olin & Dougherty, 2006; Pumkam, Probst, Bennett, Hardin, & Xirasagar, 2013), meaning that without insurance coverage, individuals with disabilities will experience very high out-of-pocket costs or might forgo necessary medical treatment. Individuals with disabilities often report greater difficulties accessing care (Henning-Smith, McAlpine, Shippee, & Priebe, 2013; Iezzoni, 2011; Smith, 2008), even after controlling for insurance coverage (Hanson, Neuman, Dutwin, & Kasper, 2003; Iezzoni, Frakt, & Pizer, 2011; Miller, Kirk, Kaiser, & Glos, 2014).

Workers with disabilities face unique challenges in balancing health and work. They may have greater need for services that are not covered by typical private plans, including personal assistance services and durable medical equipment, resulting in a higher need for non-covered care (Henry, Long-Bellil, Zhang, & Himmelstein, 2011). Their complex medical conditions may require greater health maintenance effort and utilization of medical care, which might interfere with their work schedule or make a full-time job impossible. Studies assessing implications of the Massachusetts health care reform found that workers with disabilities, especially those with private insurance coverage, frequently reported experiencing a large burden to simultaneously manage their health and employment, substantial unmet need, and high out-of-pocket medical care costs (Gettens & Henry, 2013; Gettens, Henry, & Himmelstein, 2012; Gettens, Mitra, Henry, & Himmelstein, 2011; Henry et al., 2011).

Along with increased need for medical care, individuals with disabilities may also have a decreased likelihood of having comprehensive health insurance coverage. They more often are engaged in part-time employment than non-disabled workers (Livermore & Honeycutt, 2013) and therefore are less likely to receive coverage from their own

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They are also less likely to be married (Livermore & Honeycutt, 2013), reducing the likelihood of access to coverage from a spouse’s employer. Those who receive federal disability benefits from Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) are at risk of losing their associated eligibility for public health insurance from Medicare or Medicaid (respectively) if their earnings are too high. Programs such as the Medicaid Buy-In, which have higher income eligibility limits to allow employed individuals with disabilities to take up Medicaid, have experienced relatively low take-up (Kehn, 2013). In addition, before the Patient Protection and Affordable Care Act (ACA), individuals with disabilities likely would not have been eligible for privately purchased coverage due to their preexisting conditions.

The ACA will expand options for obtaining health insurance, but it remains to be seen whether the new coverage options will be sufficient to meet the health needs of workers with disabilities. Even if uninsurance is reduced, it is possible that underinsurance will remain. Cost-related access barriers may remain or worsen if services required by those with disabilities are not covered by employer or newly available coverage resulting from the ACA. Structural barriers, including a lack of transportation or available providers, may not be mitigated by coverage expansions, as these issues are often more directly connected to disability status than insurance coverage.

In this study, we seek to add to the existing literature by assessing the extent to which workers with disabilities are able to access timely and appropriate health care and the adequacy of health care coverage in obtaining such care. We use our findings to hypothesize about the likely implications of the ACA for workers with disabilities and the extent to which its reforms will be able to reduce disparities in access to care for that group relative to their non-disabled counterparts. We use nationally representative data from the National Health Interview Survey (NHIS) from 2006 through 2010 to assess reported differences in access to care between workers with and without a disability. Specifically, we consider two cost-based measures, the likelihood of delaying care in the past year due to cost and the likelihood of not receiving medical care in the past year for cost-related reasons, as well as a measure of structural access difficulty. In comparing rates of access difficulties by employment status, we control for a wide set of demographic, socioeconomic, and job-related characteristics associated with access to isolate the effect of having a disability to the extent possible.

We find that even after controlling for important factors such as the source of insurance coverage, demographics, income, and the characteristics of one’s job, gaps in access among workers based on disability status persist. It is important to note that our analyses are descriptive and are intended to assess the determinants and rates of access difficulties. The findings neither provide evidence of causal linkages nor estimate behavioral responses to the ACA. Nonetheless, they provide a set of estimates that benchmark the health care access experiences of workers with and without disabilities before the ACA reforms; this benchmark can be used to assess the ACA’s success for this population in the future.

In the next section, we describe the changes resulting from the ACA that we think are most salient to workers with disabilities and the challenges they face. Following that, we describe our data and methods. We then present the reported gaps in access difficulties based on disability status, then describe some of the observable differences in characteristics between the groups that might drive some of those gaps. We also show the results from regression models that estimate difficulties accessing care after controlling for differences in demographic, socioeconomic, and job characteristics. Finally, we conclude with a discussion of the implications of our findings.

**ACA Changes Most Relevant to Health Care Access Among Workers With Disabilities**

The ACA has fundamentally altered the health insurance landscape in important ways for workers with disabilities. The overall direction of the reforms is to benefit workers with disabilities, as coverage has been expanded on numerous fronts. In this section, we describe some of the coverage changes that are most salient to workers with disabilities and our analysis. We focus on coverage expansions and discuss the extent to which expanded coverage may translate into improved access to care among workers with disabilities in the discussion of our findings.

One large change from the ACA that benefitted individuals with disabilities broadly is the removal of preexisting condition clauses that previously might have denied interested individuals from obtaining coverage. In addition, the legislation banned charging differential premiums based on health status (Kaiser Family Foundation, 2012). These reforms improved insurance options and coverage affordability for individuals with disabilities broadly and were necessary when coupled with the mandate requiring that individuals have health insurance starting in 2014.

The development of state/federal health insurance exchanges and the ability to purchase private group coverage outside of an employment setting is another large benefit for workers with disabilities. The majority of workers in this country receive health insurance through an employer (their own or their spouse’s), but rates of coverage vary dramatically depending on whether one works part-time (Employee Benefit Research Institute, 2013). Because workers with disabilities often have health problems limiting their ability to hold full-time positions, they often work part-time (Livermore & Honeycutt, 2013). In addition,
depending on the nature of one’s condition, workers with disabilities may have temporary interruptions in employment or need to change jobs. The ability to purchase group coverage outside of the employment setting allows those job transitions to occur without a loss of coverage.

The ACA offers sliding-scale subsidies to individuals who purchase health insurance based on their household income relative to poverty; these subsidies are available to those with household income up to 400% of the federal poverty guideline (Kaiser Family Foundation, 2012). Making health insurance affordable for those with low incomes was necessary in conjunction with the individual mandate and may be particularly beneficial for workers with disabilities, many of whom have low income due to relatively low-skilled positions, part-time work, working less than a full year, or restraining earnings to maintain federal disability benefits.

Under the ACA, Medicaid coverage will be expanded to those whose household income is effectively under 138% of the federal poverty guideline (Kaiser Family Foundation, 2012). In most states, many workers with a disability and income in this range would have already had the availability of Medicaid coverage through the Buy-In program (Kehn, 2013). But the expansion will still benefit individuals in states without a Buy-In program or workers who have a disability that is not significant enough to meet the Buy-In medical eligibility standards. Workers who receive SSDI but are in the 2-year waiting period for Medicare might also benefit from the Medicaid expansion (Health and Disability Advocates, 2010).

A final piece of the ACA that will likely benefit workers with disabilities when it is implemented is the requirement for employers with 50 or more full-time employees to offer coverage to their workers (Kaiser Family Foundation, 2012). The extent to which this will benefit workers with disabilities depends on the likelihood that they work for small versus large firms; we discuss this point in what follows.

We selected 2006–2010 for our analysis because they were the most recent years available that contained cross-wave consistent measures of employment characteristics. We recognize that some provisions of the ACA were implemented in 2010, and likely affected access, including the federal plan to offer coverage to those with preexisting conditions previously uninsured and the extension of adult-dependent coverage up to the age of 26 (Kaiser Family Foundation, 2012); those provisions were implemented late in the year (July and September, respectively). Because the number of workers with disabilities in each year is relatively small, we chose to include 2010 in our analysis despite the enactment of these provisions; year-specific analysis did not suggest that insurance coverage rates overall in 2010 were dramatically different than in earlier study years.

The NHIS includes two nationally representative samples in each year; one based on all members in each household and another in which one adult and one child (if relevant) are selected for more in-depth questioning. Each sample contains its own set of sampling weights to produce population estimates. We selected the version based on one adult and child per household, using only the data from adults, because several of the measures we intended to use were only asked of the respondents receiving the more in-depth interview. In each of the study years, we identified those who were working age (ages 18–64). Using the age-eligible group of sample adults, we then identified respondents who indicated they were working (or had a job but were not working) during the past 1 to 2 weeks. An alternative measure of employment would have identified individuals employed at any time over the past year; this measure yielded an employment rate that was about 7 percentage points higher than the 71% employment rate based on our chosen one. Because job characteristics related to the current employer and health insurance is measured at a point in time, we used the measure of employment based on the past 2 weeks.

We use a measure of disability that is based on a self-report of a physical, emotional, or mental problem that limits the kind or amount of work performed or causes the person to be unable to work at all. We selected this measure because it is highly correlated with employment, and our sample is limited to workers. Others have shown that self-reported work limitation measures are strong proxies for other measures of disability and are unbiased predictors of the outcomes of SSDI and SSI disability eligibility determinations (Benitez-Silva, Buchinsky, & Rust, 2004; Bound, 1991). Nonetheless, it may not perfectly align with workers’ disability status; we cannot verify the extent to which this measure identifies some individuals with no or very temporary disabilities as having a work limitation, or fails to identify others with significant disabling conditions who do not consider them to be work-limiting. Among the work-limited

### Data and Methods

#### Sample Selection

We pooled data from the 2006–2010 annual waves of the NHIS, which is sponsored by the National Center for Health Statistics (NCHS). The NHIS is a nationally representative cross-section of the non-institutionalized U.S. population that not only collects information on health status, health behaviors, and insurance status but also contains information about the demographic, socioeconomic, and employment characteristics needed for our analysis. We derived our dataset from the Integrated Health Interview Series (IHIS) produced by the University of Minnesota. The IHIS contains cross-wave, cleaned, and consistent measures of core variables from multiple waves of the NHIS.
sample, fewer than 10% reported having difficulty completing at least one of six activities of daily living (eating, bathing, dressing, toileting, getting in and out of bed, and getting around one’s home). An additional 15% reported having at least one functional limitation, including limitations in activities that might be performed in the workplace, such as stooping, reaching, climbing a flight of stairs, or grasping an object, as well as difficulties going out or engaging in social activities.

Using our measures of disability and employment, the total sample of employed adults from 2006–2010 is 71,179, of which 2,550 (3.5%) had a disability (see Table 1). Employment rates (not shown) differed significantly based on the report of a disability; 24% of those with a disability reported working, compared with 77% among those without a disability. This mirrors the gap in employment rates reported during this time period between these two groups (U.S. Census Bureau, 2013).

Measures of Health Care Access

We consider two cost-related measures of access to care: (a) whether the individual had delayed care in the past year due to cost and (b) whether the individual needed but could not afford care in the past year. Overall, 11.0% of the employed sample reported delaying care due to cost, and 7.9% reported needing but not being able to afford care. These two measures also overlapped; 6.4% reported both delaying care due to cost and not being able to afford needed care. An additional 4.6% reported delaying care due to cost but indicated that they did not need care that they could not afford. We also analyzed another measure of access to care, a composite measure of various structural access difficulties. We identified all survey respondents who indicated that they delayed care in the past year for any of five reasons: (a) lack of transportation, (b) could not get appointment soon enough, (c) office hours were not convenient, (d) could not get through by phone, or (e) the wait at the doctor’s office was too long. One in 10 workers overall (10.6%) reported experiencing at least one structural access issue in the year preceding their NHIS interview. Among those who reported a structural access issue, approximately 20% identified difficulty getting an appointment soon enough as the sole cause. Another 20% identified a long wait at the doctor’s office as the sole cause of delaying care, while nearly 12% identified inconvenient office hours as being the sole cause of their access issues. The remaining combination of responses each comprised less than 10% of the total reporting a structural access issue.

Analytic Approach

Workers with and without disabilities differ in terms of demographic, socioeconomic, and health characteristics.
Table 1. (continued)

<table>
<thead>
<tr>
<th>Percentage in category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector of employment</td>
</tr>
<tr>
<td>Public</td>
</tr>
<tr>
<td>Private</td>
</tr>
<tr>
<td>Self-employed</td>
</tr>
<tr>
<td>Industry</td>
</tr>
<tr>
<td>Goods-producing</td>
</tr>
<tr>
<td>Service-producing</td>
</tr>
<tr>
<td>Occupation</td>
</tr>
<tr>
<td>Management, business,</td>
</tr>
<tr>
<td>professional</td>
</tr>
<tr>
<td>Services</td>
</tr>
<tr>
<td>Sales</td>
</tr>
<tr>
<td>Office/administrative</td>
</tr>
<tr>
<td>Blue-collar and military-related</td>
</tr>
<tr>
<td>Firm size</td>
</tr>
<tr>
<td>1–24</td>
</tr>
<tr>
<td>25–49</td>
</tr>
<tr>
<td>50–249</td>
</tr>
<tr>
<td>250 and above</td>
</tr>
<tr>
<td>Self-reported health status</td>
</tr>
<tr>
<td>Excellent/very good</td>
</tr>
<tr>
<td>Good/fair</td>
</tr>
<tr>
<td>Poor</td>
</tr>
<tr>
<td>Number of bed days in past year</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>1 to 5</td>
</tr>
<tr>
<td>More than 5</td>
</tr>
</tbody>
</table>

Source. Authors’ calculations based on the 2006–2011 Integrated Health Interview Study.

Note. FPL = federal poverty level.

*aBased on NHIS sample pooled from 2006 through 2010 that includes one adult and child per household, as opposed to the full NHIS, which surveys all members in a sampled household. Only adult respondents were considered in our analysis by virtue of restricting our sample to ages 18 to 64. bWeighted numbers are based on the weighted values from each National Health Interview Survey (NHIS) interview wave divided by 5 (the number of survey years included) to yield a national estimate across the years of our study. cChi-square test rejected the null hypothesis that the distribution across categories shown was the same regardless of disability status. In other words, the distribution for the variable shown is statistically different by disability status.

These same factors might also affect the likelihood of experiencing difficulties accessing health care. For this study, we are interested in understanding the extent of access disparities after controlling for these differences. To do so, we estimated logistic regression models of the likelihood of each of the access measures described above (two cost-related measures and the composite measure of structural access difficulties). The key independent variable in these models was an indicator for having a disability.

Our regression model controls for a range of personal characteristics that might influence the use of medical care and likelihood of accessing it. We added groups of these measures to the model in a stepwise fashion to ascertain whether certain factors were more likely to explain observed access gaps. This exercise is for illustrative purposes only. Our preferred specification is the model with all covariates ultimately included. We first incorporated demographic factors (age, gender, race, Hispanic ethnicity, education, marital status, and living arrangements). We then controlled for health insurance coverage source (employer-provided; Medicaid; other public [non-Medicaid], including Medicare, veteran’s benefits, and other public sources; other private coverage, including privately purchased coverage; and uninsured). Following insurance coverage, we added a measure of household income relative to the federal poverty level (FPL). Finally, we included controls for employment status, including an indicator for part-time work, whether the job offered paid sick days, whether the job paid hourly (vs. salary), whether it was self-employment or in the public sector, the industry and occupation category for the position, and the number of employees at the firm. Although not a part of our core specification, we then controlled for health using measures of self-reported health status and the number of days in the past year that the person could not get out of bed. Because poor health is innately tied to the frequency with which one would seek services, and thus, would increase the likelihood of access difficulties during a 1-year period, we were interested in ascertaining what gaps persisted once we accounted for health status.

The results we report from the logistic regression models are the group-specific predicted probabilities of reporting a difficulty with access. Because of the non-linear nature of logistic models, the estimated mean effect is not the same as the effect evaluated at the mean values of the independent variables. For this reason, the predicted probabilities were generated with all covariates except the one indicated, and evaluated at the sample means. This procedure controls for observed differences by disability status. All of the reported confidence intervals and $p$ values take into account the complex design of the survey; all estimates were generated using Stata 12. Consistent with NCHS recommendations, we divided the wave-specific survey weights provided in each survey round by 5 to create pooled weights and produce estimates that reflect the national working-age population in 2006–2010 (NCHS, 2013).

Differences in Individual Characteristics, by Disability Status

Workers with disabilities and their non-disabled counterparts differed dramatically, and some of the key differences between the two groups may be correlated with health care use and access difficulties (see Table 1). Relative to those not reporting a work limitation, workers with disabilities
were older and had lower household incomes. They were less than half as likely to report themselves to be in excellent or very good health and much more likely to report fair or poor health. In addition, they reported spending more than 5 days in bed during the past year 5 times more often than those without a disability; this aligns with their self-report of worse health.

Workers with disabilities were only slightly more likely to be uninsured than their non-disabled peers (20.1% vs. 17.5%) due in large part to their public coverage rates, which were more than 3 times as high as those of workers without disabilities; 10.5% of those with disabilities had Medicaid compared with 2.8% among those without, and an additional 12.6 and 3.8% had other public coverage, respectively. At the same time, however, workers with a disability had a much lower rate of employer-sponsored coverage (55.9% vs. 70.6%). The difference in employer-sponsored coverage is not surprising in light of job characteristics; relative to those without disabilities, workers with disabilities were more likely to work part-time (42.5% compared with 20.3%), more likely to be paid by the hour instead of a salary (63.1% vs. 57.0%), and less likely to have paid sick time (41.7% vs. 56.2%). They were also somewhat less likely to work in the private sector (in favor of being self-employed or in the public sector) but concentrated in blue-collar occupations.

Finally, workers with disabilities were slightly more likely than their non-disabled counterparts to work in small firms; 43.7% versus 38.5% work in firms with 24 or fewer employees. Notably, the proportion of workers in firms of 50 people or fewer, which the ACA exempts from the employer mandate, was also only slightly higher among those with disabilities (53.8% vs. 49.9%). Thus, it appears that workers with a disability stand to gain as much as those without disabilities through that component of the ACA reforms.

**Differences in Difficulties Accessing Care Among Workers, by Disability Status**

Similar to what has been documented for individuals with disabilities more broadly, workers with disabilities experienced difficulties accessing health care at relatively high rates (see Table 2). Nearly one in three (32.1%) reported delaying care in the past year due to cost, and one-quarter (25.2%) indicated that they needed but could not afford care. Before controlling for observable differences between the groups, cost-related access difficulties were approximately 20 percentage points higher among those with disabilities than those without, meaning that those with disabilities were about 3.5 times more likely to report needing but not being able to afford medical care in the past year and 3.0 times more likely to report delaying care due to cost during that time. Workers with disabilities were about twice as likely to report delaying care due to a structural access reason in the past year (20.6% vs. 9.8%).

Controlling for demographic characteristics (see Table 2, Model A) reduced the disparities between workers with and without disabilities by a small amount; the difference in reported delays in care due to cost, for example, declined from 21.7% to 18.6%. The changes in differences were similar for needing but not being able to afford care and delaying care for structural access reasons.

We next controlled for insurance coverage (source among those with coverage as well as uninsurance) in addition to demographic characteristics (see Table 2, Model B). The addition of insurance coverage does little to reduce the difference in reported access difficulties. This is somewhat surprising given the large differences between the two groups in terms of source of coverage.

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**Table 2. Reported Difficulties Accessing Care, by Disability Status, Unadjusted and Regression Adjusted Differences.**

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Has disability</th>
<th>No disability</th>
<th>Difference*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage delaying medical care due to cost in past year</td>
<td>Has disability</td>
<td>No disability</td>
<td>Difference*</td>
</tr>
<tr>
<td>Unadjusted M</td>
<td>32.1</td>
<td>10.3</td>
<td>21.7</td>
</tr>
<tr>
<td>Adjusted M (controlling for groups of covariates, added sequentially, as shown)</td>
<td>28.1</td>
<td>9.5</td>
<td>18.6</td>
</tr>
<tr>
<td>A. Demographics only</td>
<td>26.0</td>
<td>8.1</td>
<td>17.9</td>
</tr>
<tr>
<td>B. Demographics and insurance status</td>
<td>23.9</td>
<td>7.8</td>
<td>16.2</td>
</tr>
<tr>
<td>C. Demographics, insurance status, and income</td>
<td>23.3</td>
<td>7.6</td>
<td>15.7</td>
</tr>
<tr>
<td>D. Demographics, insurance status, income, and job characteristics</td>
<td>15.6</td>
<td>7.3</td>
<td>8.3</td>
</tr>
<tr>
<td>E. Demographics, insurance status, income, job characteristics, and health status</td>
<td>15.6</td>
<td>7.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Percentage needing but not able to afford medical care in past year</td>
<td>Has disability</td>
<td>No disability</td>
<td>Difference*</td>
</tr>
<tr>
<td>Unadjusted M</td>
<td>25.2</td>
<td>7.3</td>
<td>17.9</td>
</tr>
<tr>
<td>Adjusted M (controlling for groups of covariates, added sequentially, as shown)</td>
<td>21.3</td>
<td>6.4</td>
<td>14.9</td>
</tr>
<tr>
<td>A. Demographics only</td>
<td>18.2</td>
<td>5.1</td>
<td>13.1</td>
</tr>
<tr>
<td>B. Demographics and insurance status</td>
<td>16.0</td>
<td>4.8</td>
<td>11.3</td>
</tr>
<tr>
<td>C. Demographics, insurance status, and income</td>
<td>15.6</td>
<td>4.7</td>
<td>10.9</td>
</tr>
<tr>
<td>D. Demographics, insurance status, income, and job characteristics</td>
<td>9.3</td>
<td>4.4</td>
<td>4.9</td>
</tr>
<tr>
<td>E. Demographics, insurance status, income, job characteristics, and health status</td>
<td>9.3</td>
<td>4.4</td>
<td>4.9</td>
</tr>
<tr>
<td>Percentage delaying care due to structural access reason in past year</td>
<td>Has disability</td>
<td>No disability</td>
<td>Difference*</td>
</tr>
<tr>
<td>Unadjusted M</td>
<td>20.6</td>
<td>9.8</td>
<td>10.8</td>
</tr>
<tr>
<td>Adjusted M (controlling for groups of covariates, added sequentially, as shown)</td>
<td>20.3</td>
<td>9.6</td>
<td>10.7</td>
</tr>
<tr>
<td>A. Demographics only</td>
<td>20.3</td>
<td>9.6</td>
<td>10.7</td>
</tr>
<tr>
<td>B. Demographics and insurance status</td>
<td>19.9</td>
<td>9.6</td>
<td>10.4</td>
</tr>
<tr>
<td>C. Demographics, insurance status, and income</td>
<td>19.2</td>
<td>9.4</td>
<td>9.8</td>
</tr>
</tbody>
</table>

Source. Authors’ calculations based on the 2006–2011 Integrated Health Interview Study.

Note. Demographic controls included age, gender, race, ethnicity, educational attainment, marital status, and number of members in the household. Health status controls included self-reported status and number of days spent in bed in the past year. Income was measured as household income relative to the FPL based on household composition. Job characteristic controls included full-time status, sector of employment, whether working full-time, whether paid hourly, whether job had paid sick leave, industry, occupation, and firm size. In all cases, categorical variables were entered with each category as a single variable to allow for maximum flexibility in estimation.

FPL = federal poverty level.

*All estimated differences were significant with a p value < .01.
Controlling for income relative to the FPL (see Table 2, Model C) and for employment characteristics (see Table 2, Model D) further reduced the adjusted probability of reporting each of the access difficulties among workers with disabilities. Thus, the overall gap between the two groups fell slightly as these variables were added.

After controlling for all of the selected observables (see Table 2, Model D), the measured gap in cost-related access between workers with and without disabilities was significantly smaller than the unadjusted gap, although large differences persisted. The difference in the proportion reporting delaying care due to cost between workers with a disability and those without fell from 21.7% to 15.7%; the gap for needing but not being able to afford care fell from 17.9% to 10.9%. The gap in reporting a structural access difficulty changed little once accounting for all of the covariates in Model D; 10.8% unadjusted compared with 9.8% in the fully controlled model.

The largest reduction in the unadjusted access disparities occurred after controlling for health status, using self-reported health status and the number of days spent in bed during the past year (see Table 2, Model E). Because health status is innately connected to our measure of disability (a health limitation affecting one’s ability to work), we do not include these variables as part of our preferred specification in Model D. Nonetheless, the inclusion of these measures is instructive and shows that accounting for health status reduced the observed differential by nearly 50% or more for all three of the access difficulty measures. The significantly worse health status of workers with a disability relative to their non-disabled counterparts therefore explains much of the gap, suggesting that the former group had significantly higher health needs and therefore likely more exposure to the medical system over the course of the year that would report in an observed access difficulty during a year-long period. Nonetheless, access issues are reported at much higher levels among workers with disabilities than among those without, even accounting for health status.

Interestingly, the relative differentials observed between the groups as a whole persist even when stratifying the regression-adjusted results by insurance status and household income. We expected that the relative disparity among those in excellent health might have been smaller than those in poor health, and similarly for the highest income group (relative to lower income groups) or those with employer-provided health insurance coverage (relative to the uninsured).

Figure 1 contains a panel for each of our three access measures. The full length of the bar shows the regression-adjusted proportion of workers with a disability within each category who reported an access difficulty, holding constant all other individual characteristics at the overall sample mean. We have divided each bar into two portions; the portion on the left shows the same probability of reporting an access difficulty among workers without a disability, and the portion on the right shows the gap between workers with and without disabilities. For example, the top row of the first panel shows that 11.7% of workers with a disability who had employer-sponsored health coverage reported delaying care due to cost in the first year, but only 3.4% of workers without a disability did (leading to an adjusted gap of 8.3 percentage points).

Strikingly, Figure 1 shows that regardless of insurance coverage or household income relative to FPL, workers with disabilities were approximately twice as likely to report having delayed care due to cost in the past year or to report needing but not being able to afford care during that time. The relative likelihood varies within each of these categories in expected ways—those with private coverage were less likely to report an access difficulty than the uninsured, similar to those with excellent health relative to those with worse health and those with high incomes relative to incomes below poverty—but the relative differential is always about the same. We observed a similar pattern for the predicted probability of reporting a structural access difficulty, though in that case, workers with a disability reported difficulty about twice as often.

Discussion and Policy Implications

Our analysis showed that, similar to the broader population, workers with disabilities are significantly more likely to report difficulties accessing medical care than their non-disabled peers. Differences in personal characteristics by across disability status groups account for some of the observed gaps, but even after controlling for demographic, insurance coverage, income, and employment differences, workers with disabilities are nearly 3 times as likely as workers without disabilities to report experiencing difficulty accessing care for a cost-related reason and about twice as likely to report experiencing at least one structural access issue in the past year. This pattern held across key subgroups based on insurance coverage source and household income.

All else equal, workers with disabilities are likely to require more health care and therefore have greater interaction with the health care system. Workers with disabilities in our sample were 3 times more likely to report at least one doctor visit in the 2 weeks before their NHIS interview than their non-disabled peers (36% vs. 13%), 5 times more likely to report seeking care 10 or more times in the past year (36% vs. 7%), and 3.5 times as likely to have been in the hospital for at least one night in the past year (18% vs. 5%).

Because of this, it is not surprising that they report a higher likelihood of experiencing difficulties accessing care during a 1-year period, even holding constant individual characteristics correlated with use.

Given these findings, we return to our original question—How much will the ACA reforms help in reducing access
Figure 1. Regression-adjusted difficulties accessing care, by disability status, among key subgroups.

Source. Authors’ calculations based on the 2006–2011 Integrated Health Interview Study.

Note. Based on Model D shown in Table 2 with a set of control variables that excludes health status. The leftmost portion of each bar is the adjusted probability of reporting an access difficulty among workers without a disability. The rightmost portion is the gap between workers by disability status, and the full length of the bar (in other words, the sum of the left and right percentages) is the adjusted probability of reporting an access difficulty among workers with a disability. FPL = federal poverty level.
disparities among workers based on disability status? Our work shows that the likelihood of access difficulties is highly correlated with insurance coverage source, but coverage patterns are likely to change substantially as ACA reforms are implemented. The data at hand, however, do not allow us to predict the magnitude of coverage shifts for the population of workers with disabilities that might result from ACA implementation; so, our conclusions should be taken as suggestive.

The reduction in uninsurance resulting from the ACA reforms will surely benefit workers, regardless of disability status. Uninsurance rates were at nearly 20% among workers in our sample; to the extent that new coverage options through the ACA reduce uninsurance, we expect to see overall improvements in accessing care and reductions in cost-related access difficulties. These improvements might especially benefit those with complex medical conditions, who may previously have been denied coverage due to pre-existing condition restrictions. The fact that workers both with and without disabilities will see reductions in access difficulties does not minimize the importance of the gained coverage among both groups.

The question that remains is what type of coverage individuals will obtain, and our findings suggest this is likely where workers will vary substantially based on disability status. We found that workers with disabilities were significantly more likely to be members of the lowest income groups. This suggests that a larger proportion of this group should be eligible for coverage through the ACA Medicaid eligibility expansions. This assumes that individuals with disabilities are about equally concentrated in the 27 (and possibly growing number of) states that have expanded Medicaid through the ACA. Disproportionate growth in Medicaid coverage among previously uninsured workers will likely make significant strides in reducing disparities based on disability status. Medicaid coverage often provides personal assistance services and other types of services needed by individuals with disabilities (Gettens & Henry, 2013), and we found relatively low rates of access difficulties among workers with public coverage. Moreover, to the extent that Medicaid coverage can be maintained even as workers with disabilities enter and exit the labor force, there may be fewer instances of delayed care due to lack of coverage. However, it remains to be seen whether rapid growth in Medicaid enrollment can be absorbed by the existing pool of providers or whether provider shortages will become common. If the latter, we would expect structural access disparities to become more prevalent.
Other alternatives for coverage include that purchased through state- and federal-based insurance exchanges and employer-based coverage. We are unable to draw many conclusions about changes to these sources based on our data. Because workers are about equally likely to work for small firms regardless of disability status, we do not believe the small firm exemption from the employer mandate is likely to differentially affect workers with disabilities. The extent to which increased coverage through either source will reduce disparities in access among workers by disability status will depend on the services covered and the proportion of the cost borne by the worker. To the extent that those with disabilities differentially work for firms that provide high-deductible health plans or lesser coverage, then it is possible that the reduction in access gaps will not be as large as reductions in coverage gaps. Our findings showed that the differences in access between workers with and without disabilities covered by employer plans were roughly comparable to the differences in access for those covered by public insurance. In the case of exchange-based insurance, premium subsidies will be available for those with low incomes. Considering the results stratified by household income in our sample, these subsidies may disproportionately benefit workers with disabilities.

The NHIS offers one of the few nationally representative samples with detailed information on employment, disability, insurance coverage, health care access, demographics, and health care utilization. Nonetheless, we are limited in our ability to assess the potential effects of the ACA reforms with these data. As noted previously, the purpose of this study is to benchmark the health insurance coverage and prevalence of health care access difficulties among workers with and without disabilities before the ACA. As reforms are enacted, it will be possible to assess their impacts on access issues for a group that is growing in size and, therefore, policy importance. Our findings suggest that it is likely that the ACA will reduce difficulties in accessing health care overall, with the possibility of more gains accruing to workers with disabilities than their non-disabled counterparts. This is highly speculative though and depends in large part on how broadly Medicaid is expanded, what employers do in response to ACA implementation, and the types of benefits that will be available in the newly defined insurance exchanges and revised employer plans.

The findings also suggest that even after ACA reforms are implemented, relative to their non-disabled peers, workers with disabilities will still disproportionately experience difficulties accessing care. This will occur even if uninsurance rates fall dramatically because of these workers’ more frequent interaction with the medical system and greater need for services that are not usually covered in private plans. Proposals to offer tailored wrap-around coverage to meet the unique needs of individuals with disabilities, perhaps through the exchanges, have been considered, but to our knowledge, such coverage is not yet available. In addition, the ACA will introduce new challenges for people with disabilities. For example, churning between Medicaid and exchange-based coverage as income moves around the coverage thresholds might be a new and unintended consequence of the ACA reforms and might be particularly problematic for workers managing complex health conditions or needing to take time out of the labor force to address their health issues. Given the monumental undertaking of implementing the ACA, and the significant challenges that have already been encountered in its implementation, it seems unlikely that additional changes designed to directly benefit workers with disabilities will occur in the near future.

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Authors’ Note

The contents of this report do not necessarily represent the policy of the U.S. Department of Education or any other federal agency (Education Department General Administrative Regulations, 75.620 [b]). The authors are solely responsible for all views expressed and any errors or omissions.

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