

Disability Status and Health Equity

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ASHEcon - Economics of Health Equity Interest Group: 1st Workshop
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Overview for today

- Disability as a Disparity Population (Nicole)
- How Should We Think About Disability? (Nicole)
- The Role of Policy (Ari)
- What Can Research Do? (Ari)
- Opportunities and Challenges (Harold)
- Q&A/Discussion (Everyone)

Focus on U.S. today, but a worldwide issue



Disability as a Disparity Population



What's Missing?

Health Disparity Populations

NIH defines health disparity populations as racial and ethnic minority populations (see above OMB directive), less privileged socioeconomic status (SES) populations, underserved rural populations, sexual and gender minorities (SGM), and any subpopulations that can be characterized by two or more of these descriptions.



Disability as a Disparity Population

- Disability is typically thought of as an output of disparities - not an input into them
- How and when should we think about causality?
 - Fundamental problem of causal inference re: disparities
 - Other differences between disabled and non-disabled populations (race, age, etc.)
 - What do we attribute to impairment versus injustice?
- Despite that, there is ample evidence that many groups of people with disabilities have poor health and healthcare outcomes, in relative and absolute terms



Disability as a Disparity Population

- Strong evidence of disparities in **access** to preventative/screening services, cancer diagnosis and treatment, reproductive care and many other services (Iezzoni et al. 2021)
- Higher rates of smoking, obesity, diabetes, cardiovascular disease, many other health outcomes **unrelated to primary diagnosis** (Krahn et al. 2015)
- People with disabilities (PWD) overrepresented in public insurance programs, Medicare and Medicaid; heavily affected by policy choices

Access disparities in Medicare

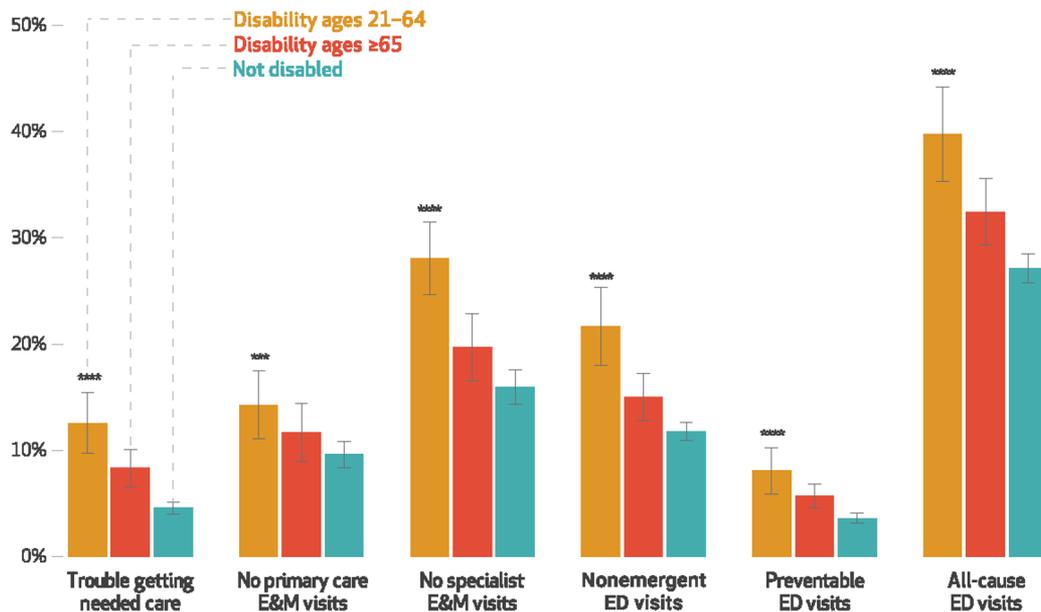
Ambulatory Care Access And Emergency Department Use For Medicare Beneficiaries With And Without Disabilities

By Kenton J. Johnston, Hefei Wen, Karen E. Joynt Maddox, and Harold A. Pollack, *Health Affairs* 40, NO. 6 (2021): 910-919

- Disparities evident in self-reported and realized access to care
- Even among the insured; even when risk adjusted
- PWD receive less ambulatory care, but have more non-emergent, preventable ED visits
- ED may substitute for specialty care to solve access issues, unlike for non-PWD
- Under new payment models, PCP's may be penalized for excess ED visits

EXHIBIT 2

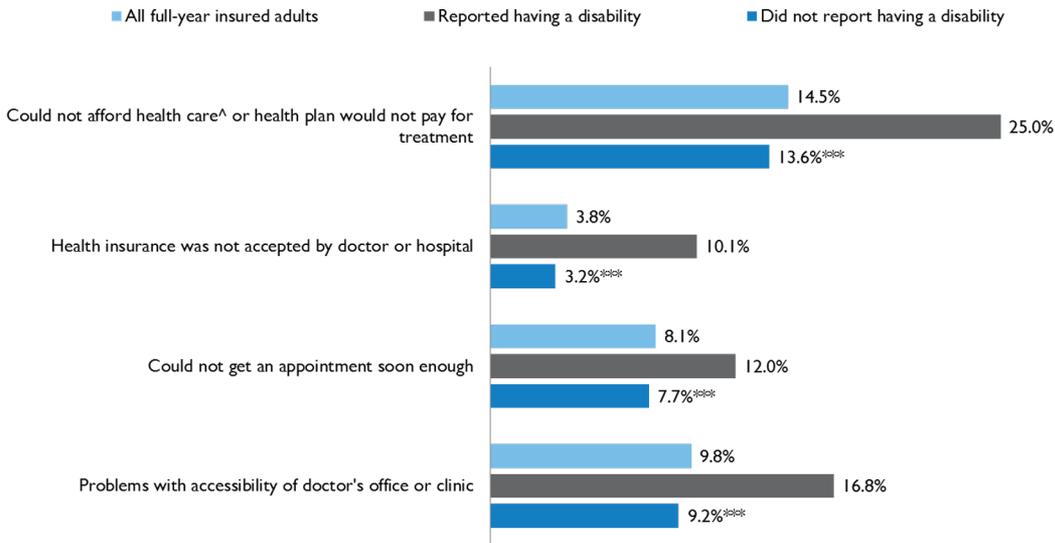
Risk-adjusted rates of ambulatory care access and emergency department (ED) use among Medicare beneficiaries ages twenty-one and older, by disability status, 2015-17



SOURCE Authors' analysis of data from the 2015-17 Medicare Current Beneficiary Survey. **NOTES** Unweighted patient years, sample $N = 20,294$; weighted patient years, sample $N = 76,474,524$. E&M is evaluation and management. Significance indicators are for risk-adjusted difference by disability status. **** $p < 0.01$ ***** $p < 0.001$

Reasons for access disparities

Figure 2. Reported Reasons for Unmet Needs for Health Care in the Past 12 Months among Adults Ages 18 to 64 Insured for All of the Past 12 Months, Overall and by Disability Status, March 2015



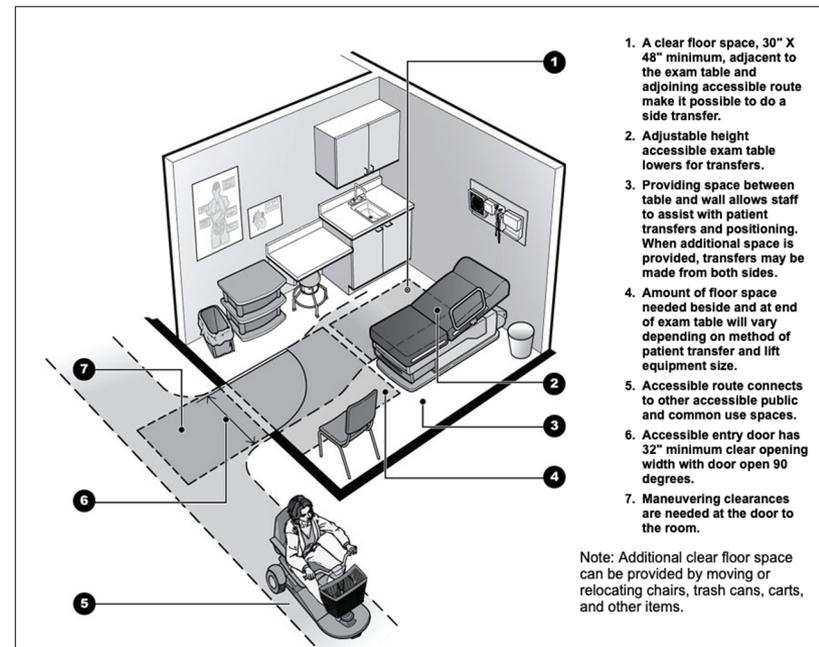
Source: Health Reform Monitoring Survey, quarter 1 2015.

Notes: Problems with accessibility include being unable to get to a doctor's office or clinic when it was open, taking too long to get to a doctor's office or clinic from home or from work, or having no way to get to a doctor's office or clinic.

*** Estimate differs significantly from those reporting a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

[^] Defined as general doctor care.

Features of an Accessible Examination Room



Source: ADA.gov



Where is the disability literature in economics?

Labor & Public Economics

- Long-run decline in employment among PWD, despite Americans with Disabilities Act
- Effects of anti-discrimination laws (e.g., Button 2018)
- Growth of the SSDI program, work disincentives (e.g., Autor & Duggan 2003, Leibman 2013, Maestas Mullen & Strand 2013, many more...)
- SSI program, growth among children with mental health dx (e.g., Aizer, Gordon & Kearney 2013) and well-being of households receiving SSI (e.g., Deshpande 2016)
- DI administrative burden/targeting (e.g., Deshpande & Li 2019)
- Reliance on SSDI, SSI has limited opportunities for income growth, wealth creation (e.g., Burkhauser & Daly 2011; Meyer & Mok 2016; Moore & Ziebarth 2014)

Health Economics

- Recent papers on effects of Medicaid policies (e.g., privatization) on health/care outcomes of PWD (Layton et al. forthcoming; Duggan, Garthwaite & Wang 2021)
- Treatment of pain and opioids (Cutler, Meara & Stewart 2017, 2020); role of place effects in opioid abuse among SSDI pop (Finkelstein, Gentzkow & Williams 2021)



**How should we think
about disability?**



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***Defining Disability Depends on
Context***



Americans with Disabilities Act/504

Definition of Disability

- Physical or mental impairment that substantially limits one or more major life activities;
- a person who has a history or record of such an impairment, or
- a person who is perceived by others as having such an impairment.

Definition is interpreted broadly, encompassing everything from autism to asthma - intent is to provide broad civil rights coverage, not especially useful for measuring disparities

Definition Used in Federal Surveys

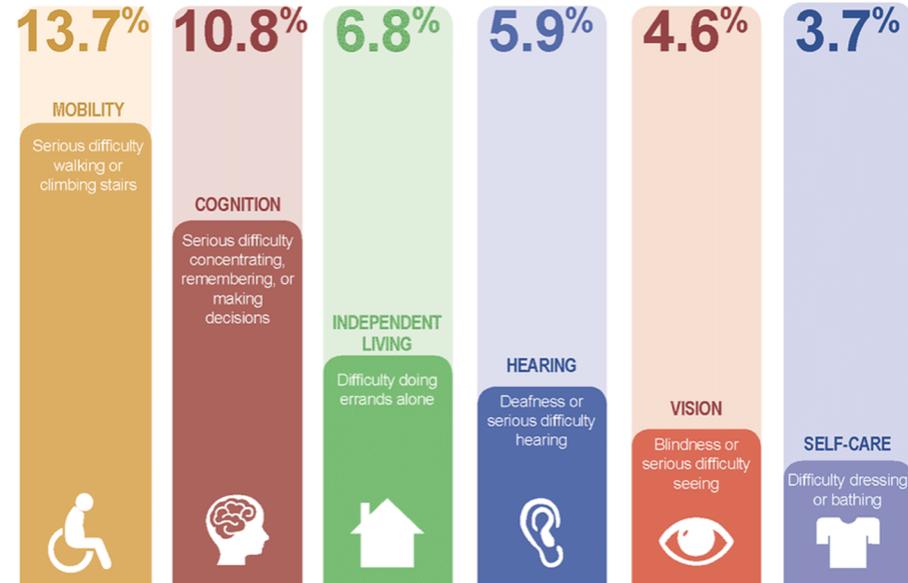
- 6 questions on functional limitations
- Yes on any one → disability
- Federal standard since 2008

26% of adults in the United States have some type of disability
(1 in 4)

The percentage of people living with disabilities is highest in the South



Percentage of adults with functional disability types





SSDI/SSI Definition

The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months

2021 SGA is \$1,310 for non-blind disabled and \$2,190 for blind disabled



Models of Disability



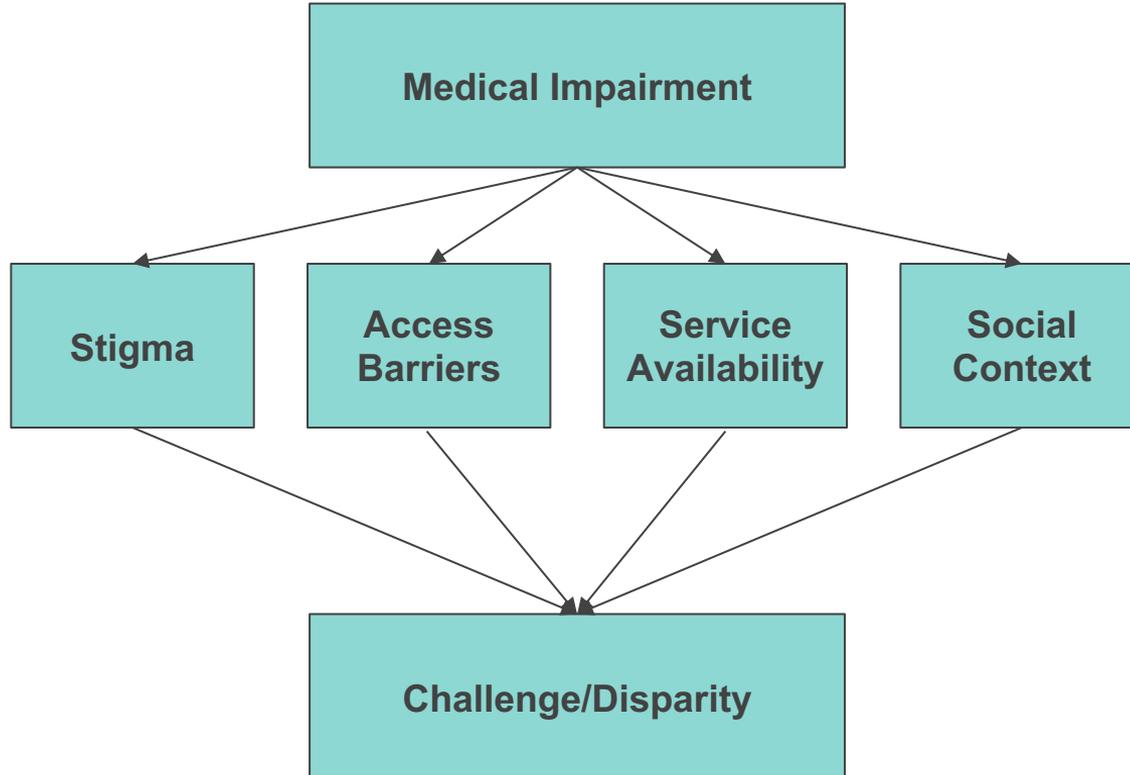
Medical Model of Disability

Medical Impairment



Challenge

Social Model of Disability





Implications of the Social Model

- Disability is context-dependent; arises from the **interaction** between health problems/functional impairments and the environment;
- Shifts responsibility for problems of disability from the purely individual/clinical to also include systems-level/societal factors;
- There are contexts in which we do want to think in terms of the medical model - but whenever we think systems-level factors may influence outcomes we should bring in social model thinking



The Role of Policy





Quality Measurement: Risk Adjustment vs Measure Stratification

- Risk adjustment
 - Various disability dxs important factor in risk-adjustment for outcomes in quality measures
 - If providers not held harmless for complexity, may seek to avoid PWD or stint on care to discourage adverse selection
 - May control away differences in quality that providers/payers should be held accountable for
- Measure Stratification
 - Stratification by disability status can hold providers, payers accountable for disparities
 - Risk that providers may be reluctant to serve ppl with most severe disabilities to improve quality measure performance
 - Lack of stratification results in providers/payers not prioritizing disability disparities
- Optimally, some combination needed
- Which approach to take depends on definition of disability, outcome and assumptions regarding attribution & opportunity for greater equity/amelioration

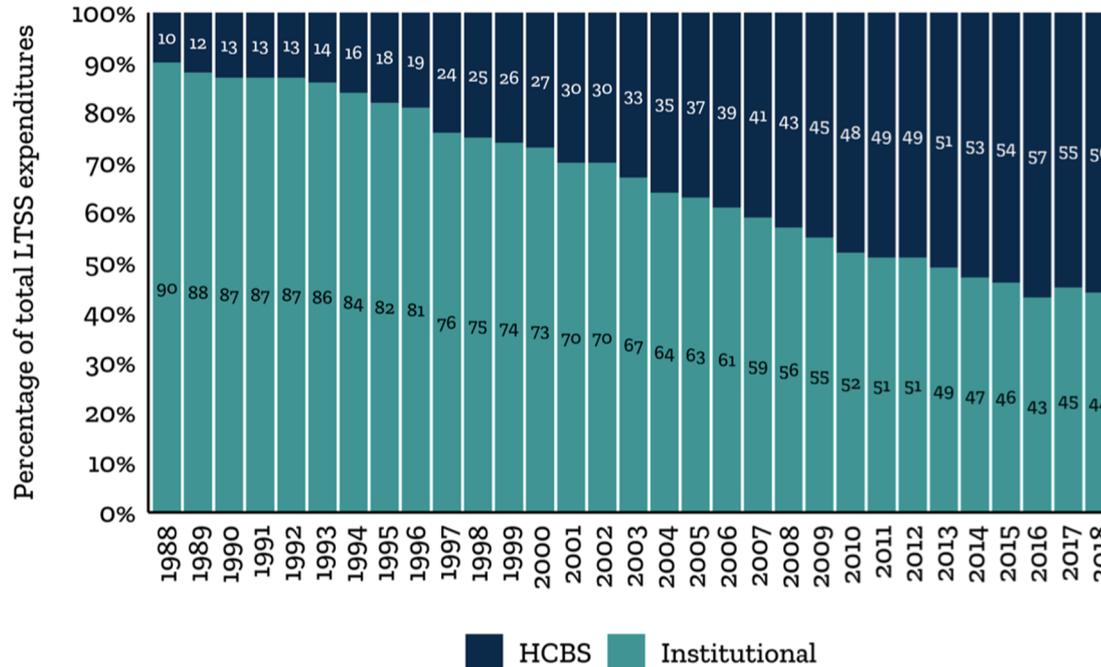


Challenges in the Medicaid Program

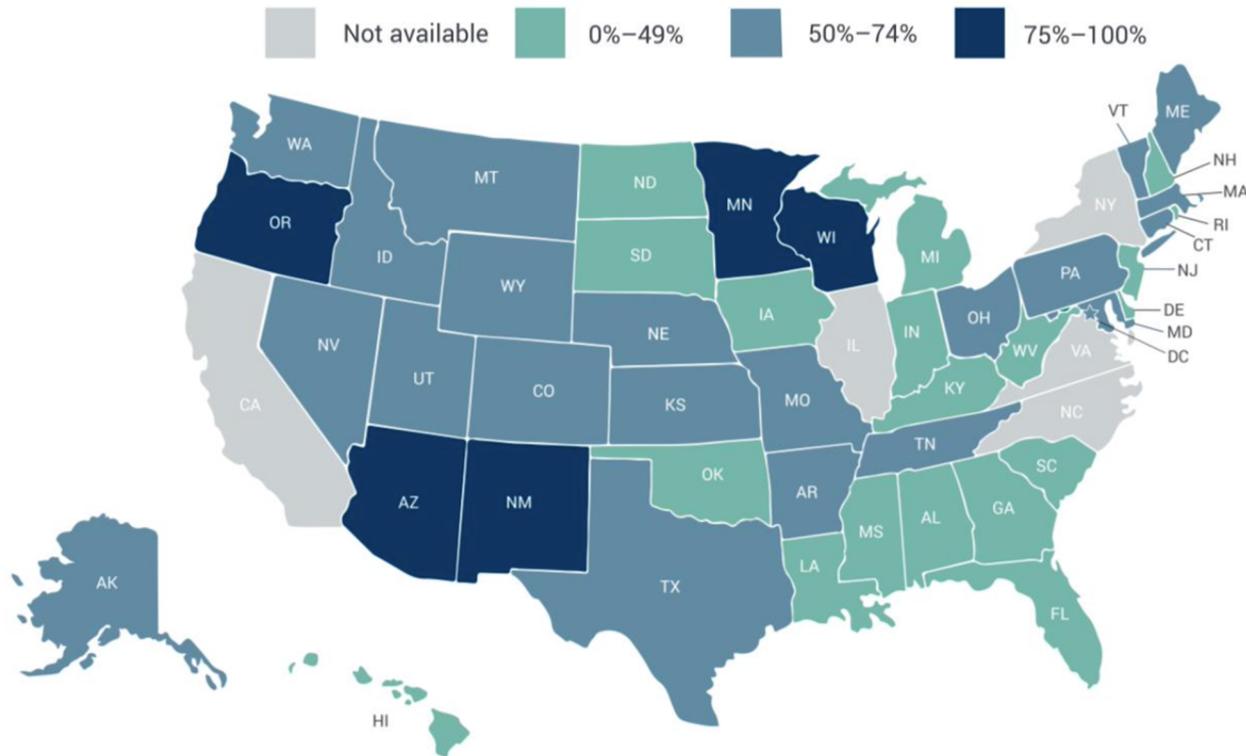
- Medicaid is the only payer for many services PWD need, including LTSS - but comes with means-testing that restricts economic advancement
- Lower payment rates and resulting difficulties in accessing providers
- Institutional bias in Medicaid
 - *Olmstead*
 - Shift towards HCBS major focus in disability policy
 - HCBS associated with better outcomes - also presents new challenges. Research frontier!
- Growing Shift Towards MLTSS raises key payment & quality questions

Shift Towards HCBS in Medicaid Policy

Figure IV.3. Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, FY 1988 to 2018



Percentage of Medicaid LTSS Spending for HCBS by State, FY 2018



Source: MACPAC, 2021, analysis of Murray, C., Tourtellotte, A., Lipson, D., and A. Wysocki. 2021. *Medicaid long term services and supports annual expenditures report: Federal fiscal years 2017 and 2018*. Chicago, IL: Mathematica.

April 9, 2021



Challenges at the Point of Care

- Lack of accessibility play an important role in PWD delaying or not receiving care (Henning-Smith et al, 2013; Bauer et al, 2016; NCD, 2021)
 - Access Board Medical Device Standards for Medical Diagnostic Equipment
- >80% of physicians report perception that disabled people have lower quality of life (Iezzoni, 2021) - concern that this will lead to lower quality treatment
 - Major concern in Crisis Standards of Care policymaking (Ne'eman, Stein, Berger & Dorfman, 2021)
 - Issue in cost-utility analysis (disability rights critique of the QALY)
- HRSA and NIH have declined to recognize PWD as a “medically underserved population” or “health disparity population” - major impact on encouraging providers to specialize in PWD, researchers to study



What can research do?



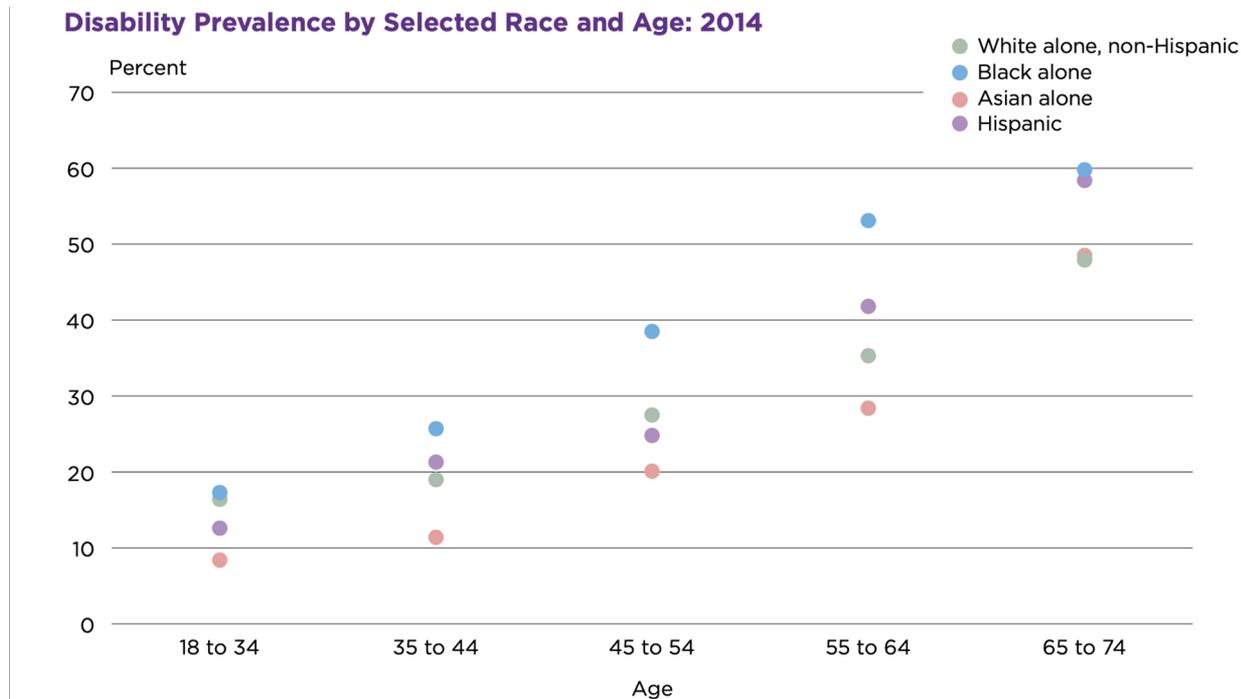


Need for development of best practices re: control variables

- Age-adjustment is obviously a necessity, esp for functional definitions of disability;
- Consistent with IOM disparities definition, 'post-treatment' variables like SES should not be adjusted for except to explore mechanisms;
- Further discussion needed regarding how to approach differences in disability prevalence across demographic groups (i.e: race)



Need for development of best practices re: control variables

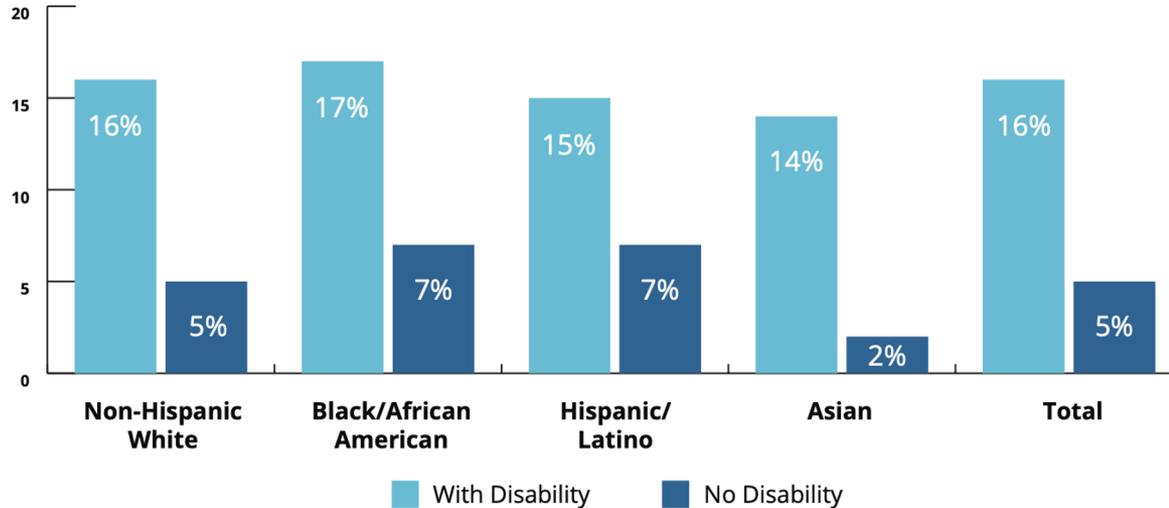


Source: U.S. Census Bureau, Social Security Administration Supplement to the 2014 Panel of the Survey of Income and Program Participation, September–November 2014.



Disability as a mechanism in other disparities

Adults Who Did Not Get Medical Care because of Cost in the Last 12 months, by Disability Status and Race



Source: National Health Interview Survey, 2015



Key Directions for Further Research

- How will payment design choices/shift away from FFS impact disability health equity?
 - Real concerns regarding stinting and advantageous selection
- What proportion of disability disparities can be explained by other non-SES differences between disabled and non-disabled populations? (i.e., age, race, etc.)
- What pathways do disability disparities operate through? (i.e., insurance, SES status, geography, etc.)
- Experimental methods may represent useful approach to evaluating public and clinician stigma



How can research be used to improve health equity for PWD

- Include PWD in health research and work to increase # of disabled researchers;
 - PAR/CBPR Models are worth making use of
- Evaluate health policies by their effect on disparities by disability status;
 - Particular priority in payment reform discussions, where PWD may face greater risks & greater opportunity to benefit
- Outcome measures must correspond to priorities of people with disabilities & families - do not assume typical function as the objective (Ne'eman, 2021)
- PWD a “high-cost, high-need” population, but cost-cutting may not be the solution offering largest welfare gains, esp when accounting for equity considerations

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NEXT
Harold Pollack
Q&A