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WEBINAR

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>>> Good afternoon, I'm Carol Eubanks.

Early findings from the CHRIL collaborative on health reform and independent living a partnership on research and information organizations.

This webinar is being recorded and will be available on demand within a couple of days.

You go to the CHRIL website at CHRIL.org where you will find all of the materials for the presentation including the PowerPoint, the audio, and any other supplemental materials that may be posted subsequent to this presentation.

Today you will have an opportunity to ask questions during the webinar.

You can do that in several ways.

You can enter your question into the text field on the main screen of the webinar.

The presenter will see your question and may be able to answer it during the presentation or if not during the times that we pause for questions and answers.

You can also ask your questions by phone.

You can wait to ask that question until your prompted to do so and you will be given instructions on how to ask the question at that time.

In addition, if you are participating in the full screen captioning feature of this webinar, which some participants prefer, you can enter your question into the text field or chat box on that screen and it will be transferred into the main screen of the webinar so that the presenter will see your question and be able to respond to it.

There is a PowerPoint presentation for today's webinar.

It's on the screen now so if you are participating by web, you will see the first slide of the presentation on your screen.

If you are participating by telephone only, you will still want to have a copy of that PowerPoint with you so that you can refer to the slides as we proceed.

The presentation is posted at CHRIL.org.

And one final bit of housekeeping.

At the end of the webinar, there will be a link to an evaluation.

We take evaluations very seriously and use them to improve the work that we do in the future.

We will be very grateful if you will take those few moments to complete the evaluation.

The CHRIL is funded by a five year disability and rehabilitation research program grant from the national institute on disability, independent living and rehabilitation research.

The CHRIL brings together disability advocates and researchers from four institutions, Washington State University, the University of Kansas, George Mason University, and independent living research utilization at TIRR Memorial Hermann to systematically investigate and disseminate essential findings about how the Affordable Care Act's implementation affects working age adults with disabilities.

The CHRIL website is a at CHRIL.org.

Now let me provide you with background and context.

CHRIL's project objective is to provide disability stakeholders with accurate, current and actionable information on how recent changes in heal policy directly or indirectly impact the community living and participation of working‑age adults with disabilities.

The CHRIL research activities include the following.

Documenting the experiences of working age adults with disabilities in obtaining and maintaining health insurance, and identifying the impact of insurance on their access, health and function through phone interviews, internet surveys, and analysis of the urban institute's health reform monitoring survey.

Assessing the health insurance information, training and technical assistance needs of centers for independent living and other disability stakeholders through internet surveys, phone interviews of CIL directors and down hall meetings at national independent living conferences.

Analyzing post reform insurance coverage trends among work‑age adults with disabilities using the national health interview survey.

Identifying gaps in coverage and potential areas of undue cost burden for people with disabilities by analyzing health care expenditures, including premium costs, deductibles and co‑pays using the medical expenditure panel survey.

Finally, assessing the impact of the Affordable Care Act on disability program enrollment and work force participation by testing how the Medicaid expansion influences SSI activity using the American community survey.

Today's agenda consists of three presentations.

Presentation number one, access to preventive services for work‑age adults with mobility limitations I presented by Gil Gimm.

An associate professor at George Mason university and a co‑investigator of the CHRIL.

He worked for five years at the top funded research group if federal disability policy including as the project director for the evaluations of the Medicaid buy‑in program and the demonstration to maintain independence and employment.

Presentation number two, acute, chronic and current uninsurance among adults with disabilities, 2008‑2015, was presented by Elizabeth Wood.

Ms. Wood is a research associate with the CHRIL.

She is currently completing her doctorate at the University of North Carolina at Chapel Hill.

And presentation number three, Medicaid expansion, access to care and employment for people with disabilities, national findings, presented by Jean Hall.

Dr. Jean Hall a co‑investigator of the CHRIL is a research professor and director at the institute for health and disability policy at the University of Kansas.

And professor in the University of Kansas medical center, Department of Health policy and management.

Dr. Hall received her PhD in disability studies and has an extensive background in the evaluation of health care programs especially for people with disabilities or chronic illnesses.

So with that, I will now turn it over to our first presenter, Dr. Gil Gimm.

>> Thank you, Carol.

Again, I'm Gilbert Gimm.

Associate professor at George Mason University in Fairfax, Virginia.

And I'm delighted today to share some of our early findings on access to preventive services for working‑age adults with physical mobility limitations.

Just a few words before we get into the heart of the research, first I wanted to acknowledge my co‑author, this is joint research with Elizabeth Wood who will be presenting shortly after this presentation.

Second, I wanted to just extend a thanks to needler for their support of the CHRIL collaborative and the research being presented at today's webinar.

So we will move now to slide number eight, the next slide.

Which summarizes the research questions for this particular topic.

So when looking at access to preventive services with working age adults with physical limitations, we were guided by three main research questions.

The first was to what extent does health insurance coverage vary for working age adults with mobility limitations.

Other non‑physical types of limitations, and no limitations at all.

Our second main question was, to what extent does access to preventive services vary for working age adults with these three groups.

And then lastly, what factors are associated with the use of preventive service measures in the past year.

And we will look in particular at blood pressure checks, flu shots and dental care.

Now moving to slide number nine.

So the background context in motivation for they are search really came about in looking at disparities in access to care of ‑‑ for working age adults with disabilities.

And some of the early work has really been pioneered and led by Lisa Iezzoni in the 2011 paper.

She documented the extent of disparities in health and services among adults with disabilities as well as the heterogeneity or just shared variety of different forms of disability type.

More recently there has been additional evidence of disparities in the receipt of preventive services and other types of medical care in a specific populations.

Some recent work that Liz and I have done that has been published in the disability and health journal this past July looks at some of these disparities for younger and older dual eligible beneficiaries.

Many younger dual eligible beneficiaries have disabilities.

And earlier work by Amanda Reichard in 2013 as well.

Other works have looked at populations with working age adults with hearing impairments that have a better access to certain types of preventive services, but for adults with multiple limitations there are greater barriers in terms of accessing services.

And then finally we look specifically at adults with physical mobility limitations because there may be other dimensions of access to care where barriers may be present.

So for example, in some the work by Mahmoudi and Meade and Lisa Iezzoni, there are documentation of various barriers of accessing physician offices, exam tables, et cetera.

We are now moving to slide number 10.

So for they are search, we looked at the medical expenditure panel survey, otherwise known as the MEPS data set which is a nationally representative survey of civilian non‑institutionalized adults and children living in the United States.

So these are individuals who are living in a home or community based setting.

The MEPS data set has been fielded each year since 1996 and collects its responses through in‑house in‑person interviews.

The MEPS data is sponsored for the agency of health care equality.

In our analytic sample, we looked at data and pooled observations from the years 2004 to 2013.

And in looking at working age adults between the ages of 18 and 24 years old, our sample consists of 81,466 working age adults.

In this population, we identified three comparison groups.

The first which is the largest consists of working age adults that had no reported limitation and so that represents the 59,000 individuals.

The second group are those adults with a physical or mobility limitation and that's roughly 6,000 individuals.

And then finally our third comparison group consists of working age adults with other types of limitations that are non‑physical.

This is roughly 9600 individuals.

And this includes adults who have cognitive hearing and vision limitations as well as those who indicated they had a type of limitation but did not specify a particular type.

We are moving now to slide number 11.

So briefly a little bit about methods before we jump into the mean results.

The methods for the study, we conducted logistic regression analyses for working‑age adults in these three groups.

Those with a physical limitation, other non‑physical limitation, and no limitation.

And we looked at the Association of The type of limitation and of the receipt of three preventive service measures.

Using this multi‑varied analysis approach allows us to account for other observable confounding factors such as age, education, employment status, having a usual source of care and type of coverage.

And then the MEPS is very specific about the application of survey weights so we followed the MEPS guidelines and incorporated the survey weights to adjust for the survey design.

And then lastly we verified the survey questions were consistent and across panels and tested our models for goodness of fit.

We are now turning to slight number 12.

So to give you just a snapshot of some of our descriptive findings, on this slide we highlighted three columns for you.

The three comparison groups that I mentioned, the no limitation consists of roughly 59,000 individuals.

Followed by working age adults with a physical limitation, the 6,000.

And then lastly the third column those with other type of non‑physical limitation.

Including a little over 9600 individuals.

And the first observation just from this descriptive snapshot shows that private insurance coverage is less prevalent among those with either a physical limitation, 42%, or non‑physical limitation, 57%, relative to our comparison group working age adults with no limitation.

And a lot of the difference comes up if we look at the rows immediately below.

So for Medicare only, Medicaid only and dual eligible, you see higher prevalence rate in the physical limitation column, the one in the middle with 6,000 individuals.

Roughly 13%, 15%, and 7% respectively which is higher than the other two comparison groups.

And then the third and final observation is related perhaps to private coverage being lower for working age adults with a physical limitation.

We also see that dental coverage is correspondingly lower at 37.6% in this sample.

Compared to the 48% in the other limitation group.

And 57% for the no limitation main group.

So we are now turning to slide number 13.

And this slide gives a descriptive snapshot of the three preventive service measures that we are interested in analyzing.

And again this is a descriptive snapshot that does not yet account for confounding factors.

But if we take a look again at our three groups, the columns, those with no limitation in the first column, physical limitations in the second column and non‑physical limitation in the third, we see that there is some good news in terms of the prevalence of two of the preventive service measures.

Specifically flu shots in the past year had blood pressure checks in the past year.

We see a higher prevalence rate among working age adults with a physical limitation.

At 40.3% and 92% respectively.

And this is higher than for the non‑limitation group at 25.1% and 72.9%.

As well as of the non‑‑ the other non‑physical limitation group.

So in terms of just a descriptive snapshot, we see that working age adults with physical limitation appear to have a higher prevalence of these two specific preventive service measures.

On the other hand, the row at the bottom which is highlighted in red, dental check up in the past year, shows the opposite relationship.

Working age adults with physical limitation have a lower prevalence of dental checkups in the past year at 47.2% compared to the 64.6% and 55.7% findings than the other two comparison groups.

However, again, this is a descriptive nap‑shot so it doesn't ‑‑ snapshot so it doesn't fully control for observable factors in the analyses.

We will now turn to the multi‑variant results to provide those findings ‑‑ multi‑variate results to provide those findings.

So once we apply the logistic progression analysis which allows us to control for these other factors such as demographics, health status, type of coverage, et cetera, we find that adults 18‑64 years old with physical mobility limitations and non‑physical limitations had a greater likelihood of a blood pressure check in the past year than adults with no limitations.

However, we didn't see any significant difference on the likelihood of having a flu shot or dental visits in the past year.

So applying this more rigorous analytic method we see that the ‑‑ we see that good news for the blood pressure check in the past year continues to hold, but we don't see a significant increase in the likelihood for the other two preventive service measures.

In addition, in our regression analysis model, we include a number of co‑variates and one that was particularly important was if working age adults was currently married.

Those adults currently married in our sample had a significantly higher likelihood of receiving all three of these preventive service measures in the past year.

And then lastly having any health insurance, of course, raised the likelihood of having a flu shot or dental visit in the past year, but private coverage in Medicaid increased the likelihood of a blood pressure check.

We will turn now to slide number 15.

So some of the main implications of this, so if we go back to our early slide on the research questions, these findings confirm the earlier work on disparities and access to care.

So we certainly do see heterogeneity on adults with physical limitations and lower family income, employment, and lower prevalence of private insurance coverage.

We also see the percent of adults with blood pressure checks and flu shots was higher in the group with physical mobility limitations than the other two groups.

And this suggests that out of pocket expenses may be a potential barrier to accessing dental care.

Lastly, because of the significant estimate or coefficient estimate with respect to current marital status, the finding do such that social networks in marital status has a role in the receipt of preventive care services and may have direct policy implications for supporting care givers to encourage the receipt of preventive services in this population.

We are now turning to slide 16.

So just a couple of limitations as researcher, it's important to disclose because we are using a pooled observations and logistic regression models we cannot draw inferences even though we do see significant associations with respect of ‑‑ receipt of services.

These are self‑reported measures of physical mobility limitations.

And so because of that and the way the question is worded in the MEPS data set, it may not necessarily represent a specific type of disability, for example, a musculoskeletal disorder.

So we can't see the ICD10 code that's associated with a self‑reported physical mobility limitation.

And then lastly, our sample is restricted to a community dwelling adult.

Therefore we cannot generalize these findings to a broader population that would include adults in institutional settings.

We are moving now to slide number 17.

So in terms of future research and next steps, we are in the process now of conducting robustness checks sensitivity tests.

And we are exploring one or two other service measures including cancer screenings, including mammograms and other types of cancer screening measures and as I mentioned these are early findings so we hope to include that in some of the work we will be completing shortly.

And then lastly marital status and living arrangements seem to play a role in the receipt of preventive services.

So additional research will be done incorporating these measures.

So let's turn it now to slide number 18.

And I will turn it over to Carol who will help us with moderating questions.

>> All right, thank you.

We reached our first Q&A.

If you have a question for Dr. Gilbert Gimm, and you are on the phone you can press star pound to indicate a question.

You can submit your questions in the chat box on the bottom of the webinar platform and I will voice those questions.

And if you are on the full screen CART captioning, we are logged into the chat there and you are welcome to use that chat box as well.

Looks like we have one question from Judy.

Did access to transportation come up at all in your analyses?

The federal transit administration has an initiative related to rides to wellness.

>> Thank you for your question, Judy.

The short answer is, the MEPS survey question did not specifically ask about transportation as one of the potential barriers in terms of access to the services.

Particularly in this population transportation is a critical factor that influences access to preventive care.

In this particular paper we were not able to assess transportation per se, but in the earlier paper that Liz and I co‑authored in the July 2016 issue of disability and health journal, there was a survey question asked in the MEPS for a sub group of dual eligible adults that asked them what were some of the reasons why they were unable to obtain timely access to medical care.

And reasons included things like affordability, provider was not in a particular network.

And difficulty accessing physician office.

So in that response, we hypothesize that transportation is very much a part of some of the respondent's who face a barriers in accessing the care.

For they are search on access to care preventive services, transportation was not included as a survey question in MEPS.

>> Good.

We do have one phone question.

Luke.

>> I apologize.

I did not have a question.

I misunderstood the recording.

>> Okay, that's fine.

And I want to remind you again that if you are on the phone and have a question, press star‑pound to indicate you have a question.

I actually have one that has come in for you, Gil, and it's this.

Do you have any hypotheses cost aside or did any of your research point to reasons dental exams weren't higher?

Did your work lead to any ideas around difficulty of receiving dental care from a wheelchair or the difficulty of transferring to the dentist chair?

>> Thank you for that question.

And it's difficult to answer that outright.

So I think the access to dental care, there are a couple of things going on.

So there may be sort of a physical environmental barrier that's related to accessing care in a dentist office.

That certainly is one potential hypothesis or pathway that might explain the lower prevalence of a dental visit in the past 12 months.

But I think another big part of it is just the out of pocket cost and affordability.

Because dental care or dental services is not usually part of a sort of traditional health insurance package, it's likely to be the case that it's more difficult from an affordability standpoint to access the dentist than it would be for a primary care physician if you have health insurance.

So that's the second factor.

And then, of course, Judy's question earlier about transportation, that's of course relevant timely access to transportation is important for physician office visits, but also important for dental visits.

So any of these three factors are potential pathways that could help to explain the lower prevalence.

But, of course, within the MEPS data itself, we are not able to tease out those individual causes.

But thank you for the question.

>> Thank you.

I don't see any other questions at this time so why don't we go ahead and turn it over to our second presenter, Elizabeth Wood.

>> Thank you.

Hi, everybody.

I'm Elizabeth Wood.

I'm a research scientist here at the collaborative on health reform and independent living specifically I'm one of our west coast branch representatives at the Department of Health policy and management at Washington State University in Spokane.

Today we will be talking about acute chronic and current uninsurance among adults with disabilities from 2008‑2015.

I wanted to acknowledge here that while I'm doing the presenting, this is not all me.

There is also Helen Gardner who contributed to this she was one of our CHRIL interns this sum sore she did work with us.

She came to D.C. with us for the conference and right now she is a registered nurse in Texas and doing her Bachelors in nursing at ham Houston State University.

I wanted to acknowledge her contributions especially to the literature review.

The background is probably very familiar to most of the people on this call.

Essentially health insurance is important to health.

The risks associated with not having health insurance seem to be worse for people with disabilities because of the limited resources, the income that can be reduced either by employer bias or by the disability itself or by working with programs that have income limits and assets as well.

And then also these high health care needs that are often associated with or co‑morbid with disability.

In fact we know out of people with disabilities who don't have health insurance, full two‑thirds of them routinely are postponing getting the care that they need because they can't afford it.

So we know that the Affordable Care Act in general is reducing rates of uninsurance.

We think that it has the potential to reduce rates of uninsurance for people with disabilities specifically, but we are just now starting to get this 2014 and 2015 data.

I haven't seen a lot of analyses of the Affordable Care Act or the ACA and the sub population.

So the objective of they are search was to answer questions about uninsurance and working age adults with disabilities.

When I say working age, I'm referring here to people between 18 and 64.

There are different eligibilities obviously associated with that age range versus people who are younger or older and a different set of health insurance options that are available.

So one thing we wanted to know is are working age adults with disabilities who are formerly uninsured complying with the individual mandate by obtaining coverage?

We wanted to know whether over time rates of uninsurance among this population changed after the ACA was implemented and we looked at that both on adjusted rates, longitudinally and a multi‑variate analysis and we looked at whether formerly uninsured people with disabilities were obtaining coverage and if so where are they getting coverage after the ACA.

So I'm going to touch on the methods very briefly here so I'm absolutely happy to give into more detail in the questions if it's helpful for people.

We used a very similar data set to the MEPS.

It's the NHIS.

The national heal interview survey and pooled all of the years from 2008 to 2015 in order to increase our sample size and to give us that time trend option.

We tagged people as having a disability in this data set if they indicated any of the following.

That they had limitations in their ability to work.

And that includes people who said I'm work limited but didn't say they were completely work disabled.

If they said they had difficulty performing activities of daily living.

Or they had difficulty performing instrumental activities of daily living.

This is pretty broad definition of disability and when we get to the end I will talk a little bit more about the implications of that for the findings.

An important piece of they are search, a variable you should understand is prior year uninsurance.

So in the NHIS it's one interview that they do with you and they ask you in the year before you came in here today and the 12 months before that, what was your insurance coverage like?

And we broke this down into a categorical variable that has three levels.

So we said for that year before they came in to the survey they were either acutely uninsured meaning they were uninsured for part of the prior year.

But they also had coverage for part of that year.

They could be chronically uninsured meaning they were uninsured for all of that prior year and then indeed potentially could have been insured for longer than but that's not something we are have access to with the data or people who were continuously insured.

For those 12 months before they came in to the NHIS, they always had insurance coverage.

It may not have been the same type of insurance coverage but they never had a ‑‑ upon insurance.

This variable is how we were getting at the question of mandate compliance.

Did somebody who didn't have coverage in 2013 get coverage in 2014?

I want to point out, of course, we couldn't assume that those people who were uninsured one year and got coverage the next were doing it because they were thinking about the individual mandate.

There are a lot of other good reasons I would say probably better reasons to get health insurance than the mandate.

But it's a policy lever that we wanted to see how it was affecting people with disabilities.

So the first finding I will share is a line of unadjusted rates of current uninsurance and this is among our sample population of working age adults with disabilities.

It goes from 2008 to 2015.

Now in the years before the ACA rolls out its coverage expansions, so in 2014 we got Medicaid expansion in participating states and we've got the federal and state health insurance marketplaces.

In the years before that, between 2008 and 2013, we see an uninsurance rate that hovers at about 17% plus or minus a percentage point.

In 2014, it drops to 12% and 2015 it drops to 9%.

So I was cautiously encouraged by this.

It really looks like after these coverage expansions rolled out, we were seeing a lower rate of uninsurance among working age adults with disabilities.

So I decided to look at this a different way.

Looking at ‑‑ is that line showing you the current uninsurance rates among people with a history of uninsurance.

So the people who were missing coverage for part or all of that year before they came into the survey did they get coverage?

And consistently again from 2008 to 2013 it's about 75% plus or minus a percentage point.

So another way to think of that would be if in 2007 you didn't have coverage, the odds are about three out of four you didn't have coverage in 2008.

That is a race you that drops in ‑‑ ratio that drops in 2014 and 2015.

In 2014 it's 58% in 2015 it's 59%.

I think it's unclear at this point whether there is anything meaningful to that difference between 58 and 59.

This is less encouraging to me what it says essentially if you ignore everything else that is going on and look at the unadjusted rates it goes from 75% chance that you are still uninsured in the next year to about a 58 to 59% chance.

That's a lot of ongoing uninsurance for a population that ought to have coverage.

So I wasn't as enthused about that.

Let's go to the next slide.

But there is a lot going on between 2008 and 2015 other than the Affordable Care Act and there is a lot that can change for individuals and for social factors for economic factors, all of that kind of thing what do you do?

We will do our multi‑variate analyses.

The first one I did was trying to isolate the effect of time period.

So our dependent variable is being uninsured.

The independent variable is whether the respondent was contributing data before the Affordable Care Act or after the Affordable Care Act.

We control for a bunch of other factors including your standard sociodemographic, age, gender, race, marital status, family income ‑‑ self‑rated health and needing help with ADLs or IADLs.

Notably also we included the variable about prior year uninsurance.

So when we ran that, we found that controlling for these other factors respondents in the post ACA time period were significantly less likely to report being uninsured.

So we separate out all of the effects of income and of education and of employment and age and something is different.

After the ACA occurs.

Unfortunately, we also found that prior year uninsurance was tremendously predictive of current uninsurance there are a lot of people who didn't have coverage then and still don't have coverage now.

And this was true before and after the ACA.

We found that respondents were more likely to be uninsured and this is something that's backed up by other studies.

More likely to be uninsured if they were Hispanic, low income, working part time or living in the south.

So we know that a lot of uninsured people with disabilities are still not getting coverage.

But if they do get coverage, where is it coming from?

This is a table of unadjusted coverage types post ACA looking at people who were continuously insured versus being previously uninsured.

And these types of coverage are represented at different rates in every single case.

Between these two groups.

Those who always had coverage and those who had not had coverage in that prior year.

So obviously uninsurance rates are much higher for those who had been without coverage before.

The people who were continuously covered were much more likely to be on private employer or union sponsored coverage.

They were more likely to be on private coverage that was purchased individually but not through the marketplace and less likely to be on marketplace coverage.

More likely to be on Medicaid.

More likely to be on Medicare and which makes sense, more likely to be dual eligible.

So I decided to pull out a couple of the major policy relevant coverage types for this population and try to pull apart what was happening there a little bit more.

So I ran four separate models using as the dependent variable whether or not they had this coverage.

Did you or did you not have Medicaid.

Did you or did you not have Medicare.

Market police coverage and employer sponsored private coverage.

Controlled for all of the same things except the earlier model controlled for whether it was before or after the ACA.

This is just looking at people post ACA because there is a big difference in the coverage options available after that point.

So looking at the binary coverage types and looking at what the effect is of prior year uninsurance on the kind of coverage you get.

So in other words, does the kind of coverage ‑‑ lacking coverage before make a difference as to what kind of coverage you did get if you did get coverage?

And we found that prior year uninsurance was actually highly predictive of enrollment in the health insurance marketplaces.

Both for people who were acutely uninsured and people who were chronically uninsured.

People who were uninsured for part of the year had slightly higher odds of having enrolled in Medicaid, but the increasing odds of that were nothing like what they were for the marketplaces.

And people who were uninsured for part of the year ‑‑ so acutely uninsured actually have lower odds of having enrolled in Medicare and lower odds of having enrolled in employer sponsored coverage.

And intriguingly respondents who were chronically uninsured actually didn't have significantly different odds of enrolling in Medicaid, Medicare or employer sponsored coverage relative to those who were continuously insured.

The only thing that predicted was your odds of going on to the health insurance marketplaces.

So another way to conceptualize this is to controlling for everything else people who were uninsured for part of the year are tending to go to health insurance marketplaces and to Medicaid.

People who are uninsured for all of the prior year are tending to go to the marketplaces.

So a couple of limitations and of course there are always more than this, but some I will highlight is they are search used a very broad definition of disability.

This might not be the same findings that you would see if for instance you were looking at people who were eligible for SSI.

There is a lot of different definitions of disability and this has captured a population of people that, for instance, some of them are working part time, some of them are working full time, it's not a completely work disabled population.

And it may not be disabled according to certain federal expectations.

A second limitation that I will highlight is that with the data set it remains unclear to what degree people with disabilities are using expanded Medicaid versus traditional Medicaid.

That's not a distinction I can pull out with the data I have right now.

And finally, of course, there is a lot of other things that are going on and I can't necessarily say the ACA had this affect.

We observed an association and I think we control for a lot of the things that can determine what kind of coverage somebody gets, but we also know that there are a lot of factors that go into coverage decisions and especially in this country work force decisions are so closely linked to coverage decisions.

So it's very likely that if people are going on to the marketplaces versus Medicaid, for instance, or if they are going into employer sponsored coverage versus the marketplace, they are making educated guesses about their own disability, their own expectations of their future earnings and their future ability to work.

Their own expectations about their future health care needs.

So those aren't things that I can per se measure and they may be contributing here.

Last slide, please.

Or next slide.

I guess we have two.

So some takeaways.

Even after the implementation of ACA, those who had coverage were likely to keep it.

That's good.

But those who lacked coverage were unlikely to obtain it which is not encouraging.

There are still some working age adults with disabilities whose coverage problems have not been resolved by reform.

Relative to what we were looking at before 2014, having a 9% uninsurance rate seems great because it's literally half of what it was before these coverage expansions.

Having almost one in ten working age adults with disabilities, not having insurance coverage is a major concern.

Finally Medicaid is the major source of coverage for these newly insured working age adults with disabilities.

It accounts for about 20% of those people.

Marketplace is only covering about 7%, but health insurance marketplace actually play this major role when you control for other factors.

I think that was something I would like to explore more and perhaps qualitatively to essentially see how do people make that decision when they are trying to figure out what kind of coverage they want.

What are the factors that they are weighing.

What do they know or not know about the coverage options that are available to them.

And things like that.

We are starting to see with ACA not everyone who is eligible for coverage is taking it up.

And there is a lot of factors that go into that including people just not being aware of what they are eligible for or for instance believing that they won't be able to afford coverage and I think especially given the population of people with disabilities who have had such a negative experience in the self‑pay private market, there may be this persisting understanding that market is not for them.

Not for us.

So that's something I'm going to try to explore a little more to say, okay, for that 9%, what's going on there?

Let's go to the last slide, please.

So if you think of something after this, you can reach me at Liz.wood@wsu.edu.

Or if you want to follow up on this or other projects I'm working on you can check out my website at www.Elizabeth‑wood.com.

And I will turn it over for questions.

>> Thank you, thank you very much.

Okay, if you have a question and you are on the phone, you press star‑pound to indicate you have a question.

You can also submit those questions in that chat box and we see some coming in now.

And I will voice those questions.

Don't forget, if you are on the full screen cart captioning we are logged into chat there and you are welcome to use that chat box as well.

We have a question.

The first one, some e‑mailed with questions.

There is considerable negative press about the ACA.

The law is frequently presented as unpopular and also presented as being dismantled at some point in the not too distant future.

Do you have any sense these high profile depictions ever the law have any effect on enrollment of persons in this population?

>> Sure.

That's an excellent question.

And especially very pertinent in an election year.

I think it does make a difference.

I think that especially if you are a person with high health care needs, you do not want the rug yanked out from under you in terms of your coverage because one thing that we are figuring out about health insurance is that it's not apples to apples.

Not every type of coverage is going let you see the same provider.

Not every type of coverage is going to cover the same medications, the same durable medical equipment.

Have the same turn around time on specialist visits.

So people may be reluctant to get into a type of coverage that they see as vulnerable.

And I think that's absolutely something that is subject to what's been going on with how the ACA is discussed.

>> Okay, here is another one.

Do you have any hypotheses even speculation about the impact of the health navigator program in changing the level of enrollment on the part of individuals with disabilities?

>> I do.

And this is something that I wish we had more data on because I always love to get my hands on data.

But what we have seen in other populations actually if you look at for instance just low income people in general, having somebody to help them get coverage through the health care portals is hugely predictive of whether they will follow‑through.

So there are thing ‑‑ there seems to be a sub population of people who go out there and they go to healthcare.gov or go to their state's equivalent and they are considering getting coverage and find it too confusing and they give up.

But if they have somebody helping them with this, it's a much higher conversion rate from people saying, I'm interested in this.

To people actually finding coverage.

I would suspect as well a higher rate of people finding coverage that's a good fit for their needs.

Yeah, I would think that the health navigator program would be something useful.

That's my gut instinct and not something that I can backup with hard data at this point.

>> And you mentioned the health navigator program, for those who may not know what that is, could you briefly summarize?

>> Sure.

I mean, there are a couple of different things going on with health navigators.

There is actually several agencies out there that are looking at helping people obtain the coverage.

There are states that do it.

There are ones with the federal level specifically for us there is a national disability navigator program which is part of the American association health and disability, one of our partners here.

So they not only are interested in this, they actually have a lot of fact sheets out there for people informally who are helping people with disabilities get coverage.

For instance, fact sheets about what kind of coverage you're eligible for.

What kinds of things you need to be looking for.

If you are somebody with mental or behavioral health needs what kind of mental health parody legislation may be affecting you.

Stuff that is very targeted to this population as well as in general.

Navigators who will help people figure out whether marketplaces, Medicaid or other are what they are going to do for their coverage.

>> Wonderful.

Thank you.

If you are on the phone, don't forget you can press star pound to ask your question.

It doesn't look like we have any more right now.

I'm watching and waiting.

Any other questions?

I don't see any others at this time.

So I will turn it over now to Dr. Jean Hall.

>> Thank you.

My name is Jean Hall.

I'm at the University of Kansas.

I guess that makes me part of the Mid West contingent of the CHRIL team.

I like to acknowledge my co‑authors of this work.

Adele Shartzer.

Noelle Kurth here at the University of Kansas and Kathleen Thomas at the University of North Carolina.

I will switch gears and look more specifically at Medicaid expansion and how that's affected access for care.

As we heard little is known about the specific experiences of people with disabilities after the Affordable Care Act implemented coverage expansions in the insurance place.

What we do know is marketplace coverage cannot exclude people with pre‑existing conditions any more so some people with disabilities are accessing insurance in that way.

And we know that Medicaid expansion has the potential to support employment because the earnings ‑‑ no longer the strict earnings threshold in asset restrictions that were in place with categorical Medicaid.

Categorical Medicaid before the Affordable Care Act required impoverishment.

They had to go through a process and have restrictive earnings and assets less than $2,000 a year.

So what we hope is that perhaps coverage expansion under the Affordable Care Act can end the cycle of health insurance disable enrollment.

Which means that people with disables have historically applied for federal disability cash assistance in the form of SSI or SSDI to get the health insurance.

So our research observatives were to examine insurance coverage, access to care and employment among adults with disabilities before and after the coverage expansion under the Affordable Care Act.

We wanted to document differences between states with and without Medicaid expansion.

And combine our findings with other findings from the larger CHRIL project to fully understand the impact of the Affordable Care Act on people with disables.

So for this particular project we used data from the urban institute's health reform monitoring survey.

HRMS.

A nationally representative internet survey of adults fielded periodically since 2013.

Designed to oversample people who are low income and consequently have more chronic conditions and it's designed to allow comparisons between Medicaid expansion and non‑expansion states.

For our analysis we had a sample of 2,740 adult respondent was disability.

Ages 18‑64 and used the screening system ‑‑ that question was do you have a physical or mental condition impairment or disability that affects your daily activities or that requires you to use special equipment or devices such as a wheelchair, TTD or communications device.

Pretty broad definition of disability.

We also used aggression mod ‑‑ regression models to look at the pre‑ACA period in 2013 and the post ACA period 2014 to 2013.

And we wanted to look specifically at insurance coverage among our sample group access to care and employment overall.

And by statement of expansion for those 2,740 individuals.

And our models controlled for a host of demographic factors including age, gender, race, ethnicity, primary language, education level, marital status, household income, self‑reported health status, U.S. region, metropolitan status and we controlled for local area employment rates.

What we found was that significantly greater percentages of people with disabilities reported having a usual source of care after implementation of the Affordable Care Act.

Almost 10% gain from 74% to 84.5%.

So we know that the Affordable Care Act has played some role in the ability of people with disabilities to access health care.

Much like Liz saw there was a drop in uninsurance rates.

But we also found that after the Affordable Care Act respondents who lived in Medicaid expansion states were significantly less likely to report having been uninsured for the whole year.

And 2.6% difference.

And more likely to be employed 6.1% difference compared to those in non‑expansion states.

So if we go to the next slide, you can see a graphic.

This table shows the first column is adults with a disability of living in Medicaid expansion states and the second is those living in non‑expansion states and the first row is employment status and working as pay employee or self‑employed 38% of adults living in expansion states reported being employed compared to 31.9% in non‑expansion states.

And then you look at the third line, people who report not working ‑‑ a disability that number was much higher, significantly higher among people living in non‑expansion states.

So again they had to continue to report having a disability in order to be able to access health insurance potentially.

And then the last line in the chart shows that people living in Medicaid expansion states were much less likely to report being uninsured for the full year.

Next slide, please.

So what we can determine from these findings is that people were less likely being uninsured when they lived in Medicaid expansion states and re‑enforces the importance of expansion coverage to people with disabilities Medicaid has always been important but it looks like Medicaid expansion is an additional round of care that people didn't have in the past.

Also we know that prior to the Affordable Care Act many people with disabilities were locked into poverty to maintain ‑‑ those strict asset education.

With Medicaid expansion they can work, accumulate assets and maintain the Medicaid coverage which is important.

And therefore we think that Medicaid expansion may serve the dual purpose for people with disables of being a work incentive program as well as insurance program for a population that's historically been discouraged from working.

And that third point is really important for states that have not yet chosen to expand Medicaid and those more conservative states like where I live in Kansas we often hear policy makers say that they don't want to expand Medicaid because people won't have to work any more to get insurance.

That it will be a free ride for them.

What we find for people with disabilities is that if they live in a state that expends Medicaid, they are actually more likely to work.

So at least for people with disabilities that argument doesn't cut it any more, I don't think.

And finally, more people with disabilities in all states reported improved access to care after the Affordable Care Act and we hope that in the long term that will decrease some the health disparities this population has experienced for a very long time.

We do have some limitations.

This is again a survey so data are self‑reported and some may not report a disability and we think that in many cases now if the disability is not required to qualify for health insurance, people may not be reporting it.

And we know that a small number of states actually implemented early Medicaid expansions during 2013 which may have led to an underestimate of expansion effects in our models.

And finally our early work seems to indicate that there may be different outcomes for people with psychiatric disabilities when we pull them out of the overall disabled population that we identified.

And we want to look at that more but it seems like they may be less likely to work with expansion states and looking for reasons why that may be true.

Even though it's not on this slide I want to throw in a plug.

We will be continuing our research for the next four years and our team will be collecting primary data next year and two years from now we will be interviewing people about their experiences with the Affordable Care Act coverage expansions for the medical expansion, marketplace or experience ‑‑ of not being able to get health insurance some if you or someone you know is interested in participating in the activities, go to the next slide and you will see my e‑mail contact information but also again the website for the CHRIL project.

There is a link at that website to learn more about participating in our research.

And finally if anyone is interested the heal reform monitoring survey instrument is available on‑line as is some of the data from the survey.

So anyone out there who wants to take a look themselves, there you go.

>> Wonderful.

All right.

So we have our final questions, if you have a question and are on the phone, press star‑pound to indicate that you have a question.

Don't forget to submit your questions in the chat box on the bottom of the webinar platform.

And if you are on the full‑time CART captioning full screen CART captioning, we are logged into the chat there and you are welcome to use that chat box as well.

Bring on your questions.

We will give people some time to think about what they learned today and it could be question for Dr. Hall or any of the other presenters.

Any questions anybody?

I have an e‑mail question.

Here you go.

Dr. Hall and other presenters, this goes somewhat beyond your presentation topic we have been discussing a complete and comprehensive insurance program for older persons and persons with disables of all ages back to and before the book on the topic, a broader and more comprehensive program remains a dream even with the ACA.

Given your experience in the arena, do you have more home of a comprehensive program in the future?

>> I can say yes, have hope.

I can say that we are doing some additional research.

We are hoping to look at states that have more or less generous benchmark coverage in the marketplace or in their Medicaid expansions to see if we can demonstrate that certain aspects of coverage are associated with better outcome for people with disabilities and to the extent that we can demonstrate that those outcomes are cost savings for the insurers then maybe at some point there will be an effort to include that coverage more broadly.

So we are looking at habilitative services and some forms of long term services and supports hopefully.

That's the study that we have planned.

>> Luke, do we have any phone questions?

>> This is Annette Shea from the administration for commune living.

I have a question.

Can you hear me?

>> Yes.

>> Go aright ahead.

>> Hi, Jean.

I just have a question regarding the increase in employment outcomes for those in expansion states.

Did you ‑‑ there is one thing ‑‑ one nuance that I'm curious about the impact of and is that the way the sort of ‑‑ there is a general standardized way that application was made available.

There is a question when someone is applying for coming through sort of the connector and applying, there is a question that asks, are you ‑‑ would you want your eligibility determined based on a disability?

If someone says yes, they go through a different doorway and if they qualify for some of the states, have their existing what you characterize as traditional Medicaid, the income threshold vary by state.

And so the expansion may have included a broader pool of people because they are more traditional Medicaid, had a lower threshold and then some had higher threshold.

So I'm wondering if that was a factor in any of the data that you reported?

>> Well, we don't have a large enough sample to look at that kind of fine grain difference between states.

I know that in the states that have not expanded the income threshold, the FPL level is 85% on average across the 18 or 19 states.

So up to 138% in the expansion states is substantially higher than what people can earn in the non‑expansion states and assets are unlimited for the expansion.

But we don't know the gateway that they used to get on to the expansion.

>> Thank you.

>> That's something we can ask in our own survey, though.

>> Any other questions?

>> All right, I don't see any questions.

Oh, someone is typing, just a moment.

No other phone questions.

I think we don't have any audio questions and I don't see any other questions coming in so I think we can start wrapping this up.

Also on slide 41, you will find the evaluation survey link to today's webinar.

We would appreciate if you would fill it out.

We like to give feedback to improve our programs with that I will keep this link open so you can click it and go straight out to the survey and take the survey.

And I think that's it.

Thank you very much.

And bye, everybody!