

Chapter 5.18

Disability Determinations and Personal Health Records

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ABSTRACT

Newly disabled workers are often unemployed, uninsured, and indigent. They are in desperate need of Social Security OASDI monthly benefits, and the Medicare health insurance that follows 24 months after benefits begin. Applicants must prove that their medical conditions (excluding drug and alcohol abuse) have resulted in severe functional limitations that prevent them from any gainful employment. Delays and denials of benefits result when applicants cannot find or retrieve medical records from providers familiar with their medical history, health status, and functional limitations. The disability application workflow is complex, particularly for applicants with cognitive and mental health impairments. Health information technology (HIT) has been used to automate care delivery workflow through provider-controlled, electronic health record systems (EHRs). Disability applicants' workflow could, just as well, be automated through consumer-controlled, unbound, and intelligent

personal electronic health record systems (PHRs), which are not tethered to a health plan or employer network, and which automatically exchange information updates with authorized providers' EHRs. Applicants' PHRs may later prove helpful with self-management of chronic conditions prior to Medicare coverage and with periodic reevaluations of their medical status.

INTRODUCTION

"A 20-year-old worker has a 3 in 10 chance of becoming disabled before reaching retirement age" (<http://www.socialsecurity.gov>) by a condition that prevents work or that limits the kind or amount of possible work (Burkhauser & Houtenville, 2006). In 2004, an estimated 7.9% (or about one in 13) civilian noninstitutionalized, men and women, aged 18-64 in the United States reported a disability that limits work; about one in four people with disabilities lived in families with incomes below the poverty line (Houtenville, Erickson, & Lee, 2005).

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About 46.6 million people or 15.9 percent of the U.S. population have no health insurance (Hadley, 2007). Approximately 18,000 Americans die prematurely each year because they lack health insurance (DeNavas-Walt, Proctor, & Lee, 2006). A telephone survey of people with disabilities found that those who were uninsured were more likely than others to do without or delay necessary care, including prescription drugs and preventive healthcare services that would reduce their future need for healthcare (Hanson, Neuman, Dutwin, & Kasper, 2003). Newly disabled and unemployed workers who no longer have private health insurance coverage are exceptionally vulnerable to deteriorating health and untimely death. If they qualify for Social Security disability benefits, they get a modest income for themselves and their dependents and, after 24 months, Medicare Part A (<http://www.socialsecurity.gov/disability/3368>).

Disability benefits have expanded and contracted since their institution during the Great Depression (<http://www.ssa.gov/history/brief-history3.html>). In 1935, President Roosevelt signed the Social Security Act (SSA), creating a contributory system in which workers prepared for their retirement through taxes that they paid while employed. In 1956, an amendment to the Act provided benefits to disabled workers aged 50-64 and disabled adult children. In 1960, President Eisenhower signed an amendment permitting SSA disability benefits for disabled workers of any age and their dependents. In 1996, President Clinton signed a bill (P.L. 104-121) that changed eligibility for SSA disability benefits from a medical condition that prevents work, to a medical condition other than drug addiction or alcoholism that prevents work.

About 48.4 million people received Old Age, Survivors, and Disability Insurance (OASDI) monthly benefits in December 2005. Disabled workers and their dependents were 17% of OASDI beneficiaries, their average monthly benefits were \$938. In 2005, OASDI payments exceeded \$44 billion a month, approached \$521

billion for the year, and represented 4.2% of the U.S. gross domestic product. At the same time, employees, self-employed workers, and employers contributed \$593 billion to the OASDI trust funds (SSA, 2007).

Two recent studies indirectly suggest the importance of SSA disability benefits. In Sweden, 197 individuals granted disability pensions reported less illness, larger social networks, and less work and family role limitations than 96 individuals who did not receive disability pensions (Ydreborg, Ekberg, & Nordlund, 2006). In the U.S., a survey of 4,918 veterans found that their odds of impoverishment were reduced considerably if they applied for and received VA benefits for posttraumatic stress disorder (Murdoch, van Ryn, Hodges, & Cowper, 2005).

The findings of a third study (McWilliams, Meara, Zaslavsky, & Ayanian, 2007) are directly relevant to the impact of Medicare coverage following (by 24 months) qualification for SSA disability benefits. McWilliams et al. (2007) used longitudinal data from the nationally representative Health and Retirement Study to assess self-reported healthcare use and expenditures from 1992 through 2004 among 5,158 adults who were privately insured or uninsured before age 65 and of Medicare eligibility. Previously uninsured Medicare beneficiaries with hypertension, diabetes, heart disease, or stroke required more intensive and costly healthcare, and died earlier than previously insured Medicare beneficiaries with these same chronic conditions. There were no differences in morbidity or mortality between previously uninsured and insured Medicare beneficiaries without chronic conditions.

Chapter Overview

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