Research
Assessment
Management, Inc.

Angela Feebles
301/589/6242

April 11, 1988

Mr. Lex Frieden
504 W. Taylor Run Parkway
Alexandria, VA 22314

Hotel OK
Mon Jan 13 - Wed Jan 15

Dear Mr. Frieden:

Research Assessment Management Inc. (RAM) was awarded a contract by the National Institute on Disability and Rehabilitation Research (NIDRR) in February, 1988 to provide support services to coordinate and convene a two-day National Invitational Working Group Meeting on public and private health insurance practices and policies which effect individuals with disabilities. Under this contract, RAM is responsible for performing the following tasks: to coordinate logistical arrangements for the meeting referenced above; to help coordinate production of three papers being prepared for the meeting; to document and prepare a report on the proceedings of the Working Group meeting, for use in developing the report on public and private health insurance that NIDRR is to submit to the Congress by no later than February 1, 1990.

The Working Group meeting is being convened to bring together experts in public and private health insurance, health policy and the health care and health related needs of persons with disabilities. (See enclosed "Description-Working Group" for more details. The charges to the Working Group are:

- To assist in defining the scope of the problem in existing public and private health insurance policies and practices as it affects persons with disabilities;

- To generate a list of recommended issues that must be addressed in the Final Report to congress; and,

- To generate a list of recommended methods and resources that will assist in substantiating the information and data that must be included in the Final Report to Congress.

The primary objective of this conference is to identify the scope of the problem/the state of the art relative to public and privated health insurance policies and practices that effect disabled individuals and their families. Successful achievement

1320 Fenwick Lane Suite #702, Silver Spring, Maryland 20910 301-589-8242

of this objective necessitates participation of attendees for the full two-day duration of the meeting.

You were selected by NIDRR to be invited to participate in the Working Group Meeting. If you are interested and decide to participate in the meeting for its full duration, your round trip transportation to the meeting site, meals and lodging will be paid for by the contract,as described under the subsequent sections of this letter.

All participants are asked to please submit a brief (approximately one paragraph) biosketch for inclusion in the final agenda. Your biosketch should minimally include: your full name and title, agency affiliation, your current responsibilities with your agency, and any relevant research or activities you have been or in which your are currently engaged that might contribute to the overall success of the Working Group meeting.

Dates and Location of the Meeting

The National Invitational Working Group Meeting will be held on June 14 and 15, 1988 at the Holiday Inn Capitol-Smithsonian Area, located at 5500 C Street, SW, Washington, D.C. A copy of the tentative meeting agenda is enclosed for your information. It is contained in the Description-Working Group Meeting under the heading, "Meeting Plan."

Registration

Registration for participants of the Working group meeting will be from 7 a.m. to 9 a.m. on Tuesday, June 14, 1988 just outside of the meeting room. There is no registration fee for participation in the Working Group meeting. This meeting will begin promptly at 9 a.m. on Tuesday, June 14, and adjourn at 5:00 p.m. on Wednesday, June 15, 1988.

Hotel Reservations

A block of sleeping rooms has been reserved by RAM for the Working Group meeting invitees at a special group rate. Therefore, hotel reservations must be made through our office. Someone from our office will be calling you (if they have not done so already) to obtain information that is necessary to ensure that each and every participant has a sleeping room reserved. Be sure to complete and return the enclosed Working Group meeting Registration Form to secure your sleeping room reservation. The reservation RAM makes for you guarantees your single accommodation for late arrival on your indicated date of arrival. Therefore, if you are unable to attend for some unforseen reason at the last minute, please advise RAM immediately (and no later than 24 hours before your scheduled arrival date) so that your reservation can be cancelled.

Your sleeping room will be billed to RAM's master account for room and tax only for the nights of Monday, June 13 and Tuesday, June 14, 1988. Any incidental charges, such as telephone calls, beverages or meals/snacks you bill to your room, will be due and payable by you when you check out of the hotel on Wednesday, June 15, 1988.

Your sleeping room rental will be deducted from your Federal per diem rate, and the balance will be provided as reimbursement for your meals up to a maximum of $67.50 for the two days.

The hotel check-in time is 3:00 p.m. Room assignment prior to that time is on an availability basis. Check-out is 12:00 noon. Any deviation from this must be requested through the Front Desk to avoid an additional night's rental charge; and will be approved based upon expected occupancy for that day.

Travel Arrangements

Your air fare will be prepaid by RAM and your airplane ticket mailed directly to you. RAM is required by contract to provide the most direct and economical means of transportation to the meeting. RAM will not be able to accommodate the scheduling of any side trips. The rates we have secured are excursion fares. To change scheduling after tickets have been purchased usually results in fare increases. If individuals change their flight schedules, they will be responsible for paying the difference between the excursion fare secured by RAM and the new rate, plus any associated penalties.

Attendees who drive their personal vehicles to the meeting site will be reimbursed for their mileage at the rate of 20.5 cents per mile. These attendees will need to indicate their beginning and ending odometer reading on the Travel Reimbursement Form which will be provided in the on-site meeting packet.

Parking is available in the self-park garage under the hotel at the following rates:

Registered Hotel Guests	$6.00/day
Non-Registered Hotel Guests	$8.00/day
Early Bird Discount Rate	$5.75/day
(for people arriving in the garage prior to 8:00 a.m.)	

To help defray parking, tolls, or taxi expenses, meeting participants will be reimbursed for actual ground transportation expenses incurred attending the Working Group meeting up to a

maximum of $30.00. Receipts are required as back-up documentation of these covered expenses. You should note these expenses on the Travel Reimbursement Form you will receive in your on-site meeting packet.

RAM project staff will be available to assist you with any logistical problems or questions you might have. So feel free to call upon us at 301/589-8242. Otherwise, we look forward to seeing you on Monday, June 13, 1988!

Sincerely,

Angela Peebles D.B.

Mrs. Angela Peebles
Project Director

Enclosures

NATIONAL INVITATIONAL WORKING GROUP MEETING ON PUBLIC AND PRIVATE HEALTH INSURANCE PRACTICES AND POLICIES EFFECTING DISABLED INDIVIDUALS

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

OSERS NIDRR

NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH

HOLIDAY INN-CAPITOL
550 C STREET, SW
WASHINGTON, DC

JUNE 14-15, 1988

Sponsored by:

Office of Special Education and Rehabilitative Services
National Institute on Disability and Rehabilitation Research

Organized by:

Research Assessment Management, Inc.
1320 Fenwick Lane, Suite 702
Silver Spring, Maryland 20910
301/589-8242

President:

Adrienne M. McCollum, Ed.D.

Project Director:

Angela Peebles, M.Ed.

NATIONAL INVITATIONAL WORKING GROUP MEETING ON PUBLIC AND PRIVATE HEALTH INSURANCE PRACTICES AND POLICIES EFFECTING DISABLED INDIVIDUALS

June 14 - 15, 1988

Tuesday, June 14

7:00 - 9:00 a.m.
Columbia Foyer — Registration

9:00 - 9:30 a.m.
Columbia South — Welcome and Introductions - Robert Funk, NIDRR
Meeting Moderator/Chair

9:30 - 10:15 a.m.
Mission of Working Group - Robert Funk, NIDRR and
Robert Griss, NIDRR
Study Consultant

1. DEMOGRAPHICS/HEALTH CARE NEEDS AND UTILIZATION

10:15 - 10:45 a.m.
"Disability and Health Insurance in the United States"

Mitchell P. LaPlante, Ph.D.
Director, Disability Statistics Program, N531
University of California, San Francisco

10:45 - 11:00 a.m.
Break

11:00 - 12:15 p.m.
Discussion Period

Robert Funk, NIDRR
Moderator

12:15 - 1:45 p.m.
Lunch

2. PRIVATE HEALTH INSURANCE

1:45 - 2:15 p.m.
"Underwriting and Actuarial Considerations Associated with Providing Health Care Coverage of Special Risk Groups"

A. Frank Thompson, Ph.D.
Associate Professor of Actuarial Science
University of Cincinnati,
College of Business Administration
Senior Associate
Z. Lew Melnyke Co., Inc.

Z. Lew Melnyke Ph.D.
Professor of Finance
University of Cincinnati,
College of Business Administration
President
Z. Lew Melnyke Co., Inc.

Narendar V. Rao
Research Assistant
University of Cincinnati,
College of Business Administration

2:15 - 3:15 p.m.
Discussion Period

Robert Funk, NIDRR
Moderator

3:15 - 3:30 p.m.
Break

3. PUBLIC HEALTH INSURANCE

3:30 - 4:00 p.m.
Presentation by Writer

Richard Nugent

4:00 - 5:00 p.m.
Discussion Period

Robert Funk, NIDRR
Moderator

5:00 p.m.
Adjourn

Wednesday, June 15

9:00 - 9:15 a.m.
Opening Remarks — **Robert Funk, NIDRR**

A. EVOLUTION OF HEALTH INSURANCE IN THE UNITED STATES

9:15 - 10:15 a.m.
Discussion Period

Group will participate in a 60 minute discussion of the evolution of health insurance (public and private) and the forces which have operated to shape existing health care programs and public and private insurance policy in the United States. The purpose is to assist the Working Group to understand the context of existing health care programs and insurance policy. The Working Group will evaluate this topic for inclusion in the Final Report to Congress.

10:15 - 10:30 a.m.
Break

B. PARTICIPANT GENERATED ISSUES/RECOMMENDATIONS/EXPECTED OUTCOMES

10:30 - 12:00 p.m.
Discussion Period - Establish Priority List

Group will participate in a 90 minute discussion to review the deliberations and presentations from Day 1. The Group shall generate issues and recommendations for Working Group evaluation and discussion. The Group shall establish a priority list for discussion, review and consensus development that includes the Expected Outcomes.

The Issues and recommendations generated by the participant will be listed on flip charts and posted for continued review. The Expected Outcomes will also be listed for review.

- Definition of "individuals with handicaps".
- Scope of health care.
- Research topics/areas.
- Projected topical outline for Report.
- Federal and state policy options.

12:00 - 1:30 p.m.
Lunch

1:30 - 2:45 p.m.
Discussion Period - Evaluation Priority List

Group shall participate in a 75 minute discussion of the priority list of issues generated in the above session. The purpose is to discuss the issues and recommendations raised by the participants and the Expected Outcomes and evaluate them for inclusion in developing the Final Report to Congress.

The Group will review each issue, recommendation and Expected Outcomes listed on the flip charts and conduct a Group discussion, analysis and evaluation as a method of reaching a consensus and, if appropriate, minority opinions. The points discussed and conclusions reached during this process will be listed on the flip chart with the appropriate issue, recommendation and Expected Outcome. This information will be recorded for inclusion in the Meeting Report.

2:45 - 3:00 p.m.
Break

3:00 - 4:15 p.m.
Discussion Period - Evaluation Priority List

Continue above - 75 minutes

4:15 - 5:00 p.m.
Discussion Period - Wrap-up and Consensus

Group shall participate in a 45 minute discussion to clarify the Group consensus of the priority list of issues, recommendations and the Expected Outcomes.

The Group will review the consensus statements and potential minority opinions for each issue, recommendation and Expected Outcome. These statements will be recorded for inclusion in the Meeting Report.

5:00 p.m.
Adjourn

Medicaid expenditures for the disabled under a work incentive program

by Roxanne M. Andrews, Martin Ruther, David K. Baugh, Penelope L. Pine, and Marilyn P. Rymer

Congress enacted Section 1619 of the Social Security Act to enable the disabled receiving Supplemental Security Income (SSI) to obtain jobs and still retain Medicaid health benefits. Congress intended this work incentive to remove the fear of the severely disabled that by obtaining employment they would lose Medicaid benefits. Based on data from 11 States, our analysis found that Medicaid expenditures for Section 1619 enrollees were relatively small and only one-half the average Medicaid expenditure for the disabled. Retaining Medicaid appears to provide a significant work incentive because Medicaid expenditures represent 13 percent of Section 1619 enrollees' earnings.

Introduction

It is widely believed that some disabled persons are discouraged from working for fear of losing their Medicaid benefits (Berkowitz, 1981; Better, Fine, Simison, et al., 1979; Walls, Masson, and Werner, 1977). To counteract this, in 1980, Congress enacted Section 1619 as a temporary provision of the Social Security Act. Under this provision, some Supplemental Security Income (SSI) beneficiaries may work and continue to receive SSI and/or Medicaid benefits. This provision had been extended several times on a temporary demonstration basis and was made permanent in November 1986 under the Employment Opportunities for Disabled Americans Act, Public Law 99-643 (Rocklin and Mattson, 1987).

At the request of the House Ways and Means Committee, the Department of Health and Human Services (DHHS) prepared a report examining the impact of Section 1619 on the SSI and Medicaid programs (DHHS, 1986). This article is the result of the Health Care Financing Administration's (HCFA) study included in the report. This study examined the Medicaid use and costs of Section 1619 enrollees and compared them with the total disabled population covered by Medicaid. The study indirectly provided evidence concerning the work incentive issue by indicating the level of need for health care. Presumably, the greater the need for health care, the greater will be the incentive of continuing Medicaid coverage for the disabled worker. The Social Security Administration (SSA) prepared a study for the report to Congress that directly examined the work incentive value of Section 1619 (SSA, 1986).

Overview of Section 1619

Prior to the Section 1619 provision, disabled SSI enrollees were ineligible for both SSI benefits and Medicaid coverage if they were gainfully employed, even though their earnings did not totally offset their SSI benefit amount. Under Section 1619(a) of the Social Security Act, disabled persons covered by SSI who earn more than the $300-per-month "substantial gainful activity" (SGA) level may receive a special SSI payment and maintain Medicaid coverage. The special payments are calculated in the same manner as the SSI payments. Section 1619(b) allows the disabled person to continue receiving Medicaid coverage even though the individual's earnings exceed the amount where the SSI cash payment would be reduced to zero. Several criteria must be met for this continued coverage, such as, the person is still blind or disabled and would be inhibited from continuing employment without Medicaid coverage. The person must also demonstrate a need for Medicaid coverage either through use of medical services during the prior 12 months or expected use over the next 12 months. There is no distinction made by the Medicaid program between the Section 1619(a) and 1619(b) enrollees.

Section 1619 presents a dilemma for the SSI program. SSI has a very strict definition of disability: the inability to engage in substantial gainful activity because of a physical or mental impairment. The definition involves both medical and vocational attributes of the person. There is no recognition for partial or temporary disability. Thus, prior to Section 1619, the law did not allow persons to work and earn above the SGA level and to continue to receive SSI benefits. The dilemma then, is how to reconcile the SSI program definition of inability to work with the Section 1619 incentives to work.

From a practical viewpoint, if the structure of the SSI program discourages disabled persons from attempting to work, provisions to eliminate disincentives, such as Section 1619, may both lower expenditures and provide revenues to Federal (and perhaps State) programs. Earnings of Section 1619 enrollees are subject to income tax, providing additional State and Federal revenues. In addition, SSI cash payments are reduced to these working disabled, thereby reducing program expenditures. The Medicaid program may be positively affected because the program enrollees may use fewer Medicaid services when they work. The Section 1619 incentive also resolves the dilemma the disabled face of potentially losing their SSI and Medicaid benefits if they work.

In the long term, the number of disabled persons covered by SSI may be reduced as Section 1619 enrollees gain work experience and move to higher

Reprint requests: Martin Ruther, Office of Research, Health Care Financing Administration, 6325 Security Boulevard, 2-C-13 Oak Meadows Building, Baltimore, Maryland 21207.

paying jobs and jobs providing some health insurance benefits. It remains to be seen whether these long-term benefits will be achieved, given the marginal employability of many of these disabled persons. However, even without achieving the long-term benefits, the reduction in SSI payments, increased tax revenues, and the psychological benefit to the disabled who are able to achieve employment should be considered.

Section 1619 program enrollees

According to SSA program data for August 1985 (SSA, 1986) there were 816 Section 1619(a) and 7,954 Section 1619(b) enrollees. Approximately 80 percent of the enrollees were under 40 years of age, 70 percent white, and 58 percent male. These demographic characteristics greatly differ from the disabled SSI population, who are older (only 40 percent under 40 years of age), comprise slightly fewer white people (60 percent), and fewer males (40 percent).

The disabling condition of 64 percent of the Section 1619(a) and 49 percent of the 1619(b) enrollees fell under the medical code designation of mental disorder (mental retardation, psychosis, or neurosis). This compares with 48 percent for the disabled SSI enrollees. More than one-half of the Section 1619 enrollees work in private businesses or companies and approximately one-fourth work in sheltered workshops. More than one-half are employed in clerical, sales, or service occupations. In August 1985, the Section 1619 enrollees had an average income of $655 per month, with the Section 1619(a) enrollees earning $475 per month, while the Section 1619(b) enrollees earned an average of $674 per month.

Approximately 10 percent of the Section 1619 enrollees are in Medicaid-certified nursing facilities. These institutionalized Section 1619 enrollees would be covered by Medicaid even if Section 1619 did not exist.

Data sources

The primary source of data for our analysis of Medicaid use and costs of Section 1619 enrollees was a four-State Medicaid data base, developed by the Office of Research at HCFA, called Tape-to-Tape. This data base is unique because it provides person-level data on the Medicaid program that have been largely unavailable. The second source of data was aggregate recipient utilization and expenditure data from seven States. The two sources of Medicaid data used for the analysis come from a total of 11 States that contained approximately one-half (49.8 percent) of the Section 1619 SSI recipients in the SSA records for May 1982. The two data sources are described next in more detail.

Tape-to-Tape data

The Tape-to-Tape data used are for calendar year 1982 for Georgia and California, Federal fiscal year 1982 for New York, and calendar year 1981 for Tennessee. The Tape-to-Tape data base was created by extracting data from the Medicaid Management Information System (MMIS) in each State and creating uniform person-level files.

Persons making up the Section 1619 population were identified in each State by using a May 1982 SSI enrollment file. Other estimates of the Section 1619 population indicate that the May 1982 file was incomplete, identifying only 59 percent of the population. Using social security numbers, the May 1982 file was matched to Medicaid enrollment records on the Tape-to-Tape data base. Because match rates were high, Medicaid records were found for most of the persons identified in the SSI file. As a result, the Medicaid data file used in this study contains about one-half of the total Section 1619 population in the four Tape-to-Tape States. Because the SSI file appears to be a representative sample of the total Section 1619 population, Medicaid utilization and expenditure rates obtained from the sample should be accurate.

State agency survey data

To supplement Tape-to-Tape data, Federal fiscal year 1984 data were collected from Medicaid agencies in States having high proportions of Section 1619 recipients. These States provide a broader range of more timely data. The seven surveyed States are: Florida, Louisiana, Maryland, Nebraska, Pennsylvania, Texas, and Washington. Because the data from these States are limited in scope and in uniformity, they were used to supplement the more detailed analysis provided by the Tape-to-Tape data.

Participating States were provided with information from SSI program files to identify the Section 1619 SSI recipients in their State enrollment and claims files. The States summarized Federal fiscal year 1984 Medicaid recipient, utilization, and expenditure data on the Section 1619 population on data collection forms provided to them. The States provided the comparison data for the disabled population from the HCFA-2082 form that States submit to HCFA with aggregate counts of recipients, utilization, and expenditures by health service category.

Method of analysis

The methodological approach was to present total expenditure data and then to analyze differences in expenditures per enrollee by comparing Section 1619 patterns with those of the Medicaid disabled population. Because many of the Section 1619 enrollees receiving long-term care services would be covered by Medicaid regardless of Section 1619, total expenditures excluding long-term care services were also examined.

The data are further examined by type of service. Four summary classes of services are used: inpatient hospital care (acute hospitals, but not psychiatric and chronic hospitals); long-term care (psychiatric hospitals, chronic hospitals, skilled nursing facilities,

and intermediate care facilities); ambulatory visits (physician visits, outpatient department visits, emergency room visits, and other practitioner visits); and other services (for example, home health visits, dental visits, drugs, laboratory and X-ray services, and durable equipment).

In examining expenditure rates for the individual health services, we broke down expenditure per enrollee into its utilization and expenditure components to determine which component contributed to higher or lower costs for the Section 1619 populations. We examined whether the differences in expenditure per enrollee can be explained by differences in the proportion of enrollees receiving the service (user rate), the level of use per service user (e.g., number of visits per user), or the cost per unit of service (e.g., cost per visit). The relationship between these rates is shown here.

$$\frac{\text{Expenditures}}{\text{Enrollee}} = \frac{\text{User}}{\text{Enrollee}} \times \frac{\text{Service units}}{\text{User}} \times \frac{\text{Expenditures}}{\text{Service units}}$$

Enrollees are persons who applied for Medicaid coverage and were enrolled in the program. They may or may not have used Medicaid-covered services during a given period of time. Recipients are Medicaid enrollees who received at least one Medicaid service during a given period of time. Users are Medicaid recipients who received at least one specific type of service during a given period of time. Specific types of services, for example, are hospital, physician, and outpatient department services.

The analysis for the survey States followed the analytical plan used for the Tape-to-Tape analysis, where possible. Because of limitations in the data provided by the States, the number of enrollees was unknown. Therefore, total recipients of any health service was used as a proxy for enrollees. Expenditure rates were analyzed as "per recipient" rather than "per enrollee."

Findings: Tape-to-Tape States

Population characteristics

The Section 1619 enrollees in the Tape-to-Tape States accounted for 0.17 percent of the disabled in the States. (The number of enrollees shown in Table 1 was doubled to compute this percentage, because only one-half of the Section 1619 enrollees were identified in these States.) Section 1619(a) enrollees represented nearly 12 percent of the total Section 1619 enrollees in the States (derived from Table 1). This was higher than the nationwide figure of 5 percent for 1982, based on SSI administrative records. The number of Section 1619(a) enrollees in each State was too small to support reliable results, therefore, most of the following analysis focuses on the overall Section 1619 population.

Table 1

Medicaid enrollment, by disability group: Tape-to-Tape States, calendar year 1982

	Tape-to-Tape States				
Disability group	Total	California	Georgia	New York[1]	Tennessee[2]
Disabled	960,997	458,875	97,821	312,799	91,502
Total Section 1619	822	429	69	279	45
1619(a)	96	65	4	24	3
1619(b)	726	364	65	255	42

[1]Data shown are for Federal fiscal year 1982.
[2]Data shown are for calendar year 1981.

NOTES: Data are based on number of persons ever enrolled during the year. Excludes enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Analysis of expenditures

As shown in Table 2, the total expenditures for Section 1619 enrollees identified in the Tape-to-Tape

Table 2

Total Medicaid expenditures for Section 1619 enrollees and disabled enrollees, by Tape-to-Tape States: Calendar year 1982

	Section 1619		All disabled	
Tape-to-Tape States	Total in thousands	Total in thousands excluding long-term care	Total in thousands	Total in thousands excluding long-term care
Total	$861	$689	$2,815,364	$1,724,536
California	380	338	1,307,809	856,463
Georgia	87	87	243,197	145,423
New York[1]	365	249	1,120,872	649,467
Tennessee[2]	29	15	143,486	73,183

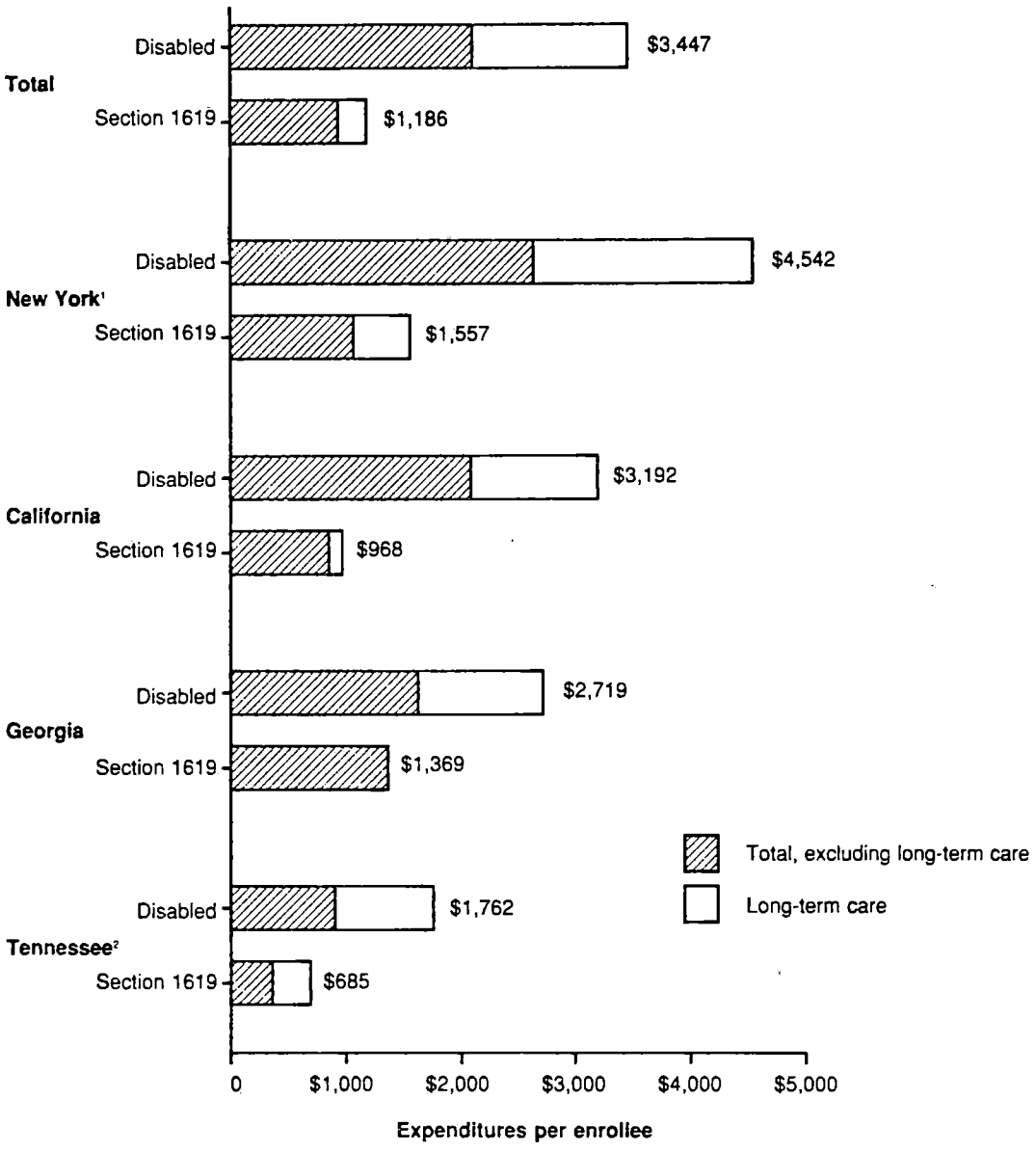
[1]Data shown are for Federal fiscal year 1982.
[2]Data shown are for calendar year 1981.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Figure 1

Total Medicaid expenditures per enrollee for Section 1619 and total disabled enrollees: Tape-to-Tape States, 1982



[1] Federal fiscal year 1982.

[2] Calendar year 1981.

NOTE: Section 1619 is a provision of the Employment Opportunities for the Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicaid Tape-to-Tape project.

States was $861,000. Total expenditures excluding long-term care came to $689,000 for the four States. The expenditures displayed in Table 2 are probably about one-half the actual Medicaid expenditures for the Section 1619 enrollees in the four States, because only one-half of these enrollees were identified in the Tape-to-Tape data files.

The expenditures for the disabled population totaled $2.8 billion for the four States, and $1.7 billion excluding long-term care. These data indicate that less than 80 cents out of every $1,000 spent on Medicaid services (excluding long-term care) for the disabled was for Section 1619 enrollees. (Because only one-half the Section 1619 enrollees were identified in the Tape-to-Tape States, Section 1619 expenditures presented in Table 2 were doubled to compute this ratio.)

As displayed in Figure 1, the average total expenditure per enrollee was considerably higher for the disabled than for the Section 1619 enrollees, $3,447 in comparison to $1,186. The disabled had more than twice the Section 1619 rate for total expenditures per enrollee after excluding long-term care costs, $2,105 versus $944 (Table 3 and Figure 1). Although the total expenditures per enrollee were consistently at least twice as high for the total disabled as for Section 1619 enrollees in the four States, note that the expenditure rates ranged greatly between the States—from $1,577 in New York to $685 in Tennessee for the Section 1619 enrollees. Such variation is typical of Medicaid expenditure rates because the States have widely varying programs (eligibility criteria, service coverage, and reimbursement methods) and the cost of medical care varies greatly by State (Sawyer, et al., 1983).

Type of health service

In every service category, the disabled had higher costs per enrollee than the Section 1619 enrollees, as the data in Table 3 indicate. The magnitude of these differences for each service is displayed as the ratio of expenditure per disabled enrollee to expenditure per Section 1619 enrollee. Excluding long-term care, the highest ratio across the four States combined was for inpatient hospital services. The hospital expenditure rate for the disabled averaged more than 3 times the rate for Section 1619 enrollees. The category "other services," which includes laboratory services, home health, prescription drugs, and X-rays, was next in size. The disabled averaged 1.7 times the expenditure rate of Section 1619 enrollees for these other services. The difference between the two groups was lowest for ambulatory visits, for which the disabled enrollees averaged 1.4 times the expenditure rate for Section 1619 enrollees.

We next examine why expenditure per enrollee was higher for the disabled population than for Section 1619 enrollees. We analyze which factors—utilization or expenditure per unit of service, or both—explain the higher average expenditures for the disabled and the relative importance of these factors.

The expenditure per enrollee for inpatient hospital services of the disabled, $1,215, was much higher than that of Section 1619 enrollees, $379 (Table 4). This can be largely attributed to higher proportions of the disabled receiving hospital services (22 percent) as compared with the Section 1619 enrollees (10 percent). The other two rates displayed—days of care per user and expenditure per day—were higher for the disabled population, although the difference between the disabled and Section 1619 enrollees for expenditure per day was relatively small.

Ambulatory services consist of several different types of services. Three of these are examined in detail because the disabled had higher expenditure per enrollee rates than the Section 1619 enrollees for these services, and because these services represented 49 percent of overall ambulatory expenditures of the disabled. The other individual ambulatory services are too small in terms of expenditures to warrant separate analysis. The services examined are visits to physicians and outpatient departments, and use of prescribed drugs.

As shown in Table 4, for all three services the disabled had higher expenditures per enrollee than Section 1619 enrollees. The major factor explaining the higher expenditure for the disabled for physician visits compared with the Section 1619 enrollees was the greater number of such visits per user. Of lesser importance was the proportion of enrollees who were users. Expenditure per physician visit was lower for the disabled than for the Section 1619 enrollees. Outpatient visits per user and expenditure per

Table 3

Medicaid expenditures per enrollee for type of service, by disability group: Total Tape-to-Tape States, calendar year 1982[1]

Disability group	Total	Total excluding long-term care	Inpatient hospital	Long-term care	Ambulatory visits	Other services
Section 1619	$1,186	$944	$379	$242	$237	$329
Disabled	3,447	2,105	1,215	1,341	320	570
(Ratio)	(2.9)	(2.2)	(3.2)	(5.5)	(1.4)	(1.7)

[1]New York is Federal fiscal year 1982; Tennessee is calendar year 1981.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 4

Medicaid use and expenditure rates, by type of service and disability group: Total Tape-to-Tape States, calendar year 1982[1]

Type of service and disability group	Expenditure per enrollee	User rate	Units of service per user	Expenditure per unit of service
Inpatient hospital				
Section 1619	$379	0.10	[2]11.9	[2]$318
Disabled	1,215	0.22	[2]15.9	[2]358
Physician visits				
Section 1619	78	0.46	8.0	22
Disabled	107	0.51	11.6	18
Outpatient department visits				
Section 1619	66	0.26	6.3	38
Disabled	109	0.29	8.3	46
Prescription drugs				
Section 1619	100	0.58	14.1	12
Disabled	206	0.73	24.9	11

[1]New York is Federal fiscal year 1982; Tennessee is calendar year 1981.
[2]Unit of service is hospital day.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 5

Summary of factors contributing to differences in Medicaid expenditure per enrollee for disabled and Section 1619 enrollees, by type of service: Total Tape-to-Tape States, calendar year 1982[1]

Type of service	Expenditure per enrollee	Factors		
		User rate	Units of service per user	Expenditure per unit of service
Total	H	H	DNA	DNA
Inpatient hospital[2]	H	H	H	+
Physician visits	H	+	H	—
Outpatient department visits	H	+	H	H
Prescription drugs	H	H	H	—

[1]New York is Federal fiscal year 1982; Tennessee is calendar year 1981.
[2]Unit of service is hospital day.

NOTES:
H = Disabled 15 or more percent higher than Section 1619.
+ = Disabled 0-15 percent higher than Section 1619.
– = Disabled 0-15 percent lower than Section 1619.
DNA = Data not applicable.
Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986. Tape-to-Tape States are California, Georgia, New York, and Tennessee.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

outpatient visit were the major factors in the higher outpatient department expenditure per enrollee for the disabled. The higher expenditures for prescription drugs for the disabled is largely attributable to the higher proportion of enrollees using services and prescriptions per user.

In summary, the expenditure rate for the disabled was consistently higher than the rate for Section 1619 enrollees, regardless of service (Table 5). The number of service units per user was an important factor in explaining this difference for all types of service. A higher user rate was a major factor only for inpatient hospital services and prescription drugs. Expenditure per unit of service was a major factor only for outpatient department visits.

Findings: Survey States

The findings from the survey States show similar patterns to those of the Tape-to-Tape States, despite the need to use different per capita measurements (per enrollee in Tape-to-Tape versus per recipient in the survey). These patterns are briefly described here.

Section 1619 recipients are a very small proportion of all Medicaid disabled recipients (Table 6). They

Table 6

Number of Medicaid recipients, by disability group and survey State: Federal fiscal year 1984

Survey State	Disability group	
	Section 1619	Disabled
Total	951	479,994
Florida	196	99,784
Louisiana	160	63,861
Maryland	90	35,584
Nebraska	23	9,117
Pennsylvania	214	123,760
Texas	128	106,979
Washington	140	40,909

NOTE: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 7

Total Medicaid expenditures for Section 1619 recipients and disabled recipients, by survey State: Federal fiscal year 1984

Survey State	Section 1619		Disabled	
	Total in thousands	Total in thousands excluding long-term care	Total in thousands	Total in thousands excluding long-term care
Total	$3,803	$856	$2,018,918	$829,930
Florida	223	155	279,167	151,573
Louisiana	1,542	77	289,162	121,618
Maryland	115	115	102,380	77,528
Nebraska	96	51	48,403	18,950
Pennsylvania	932	213	605,304	186,417
Texas	420	94	500,047	192,247
Washington	476	151	194,455	81,597

NOTE: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 8

Medicaid expenditures per recipient for type of service, by disability group: Total survey States, Fiscal year 1984

Disability group	Total	Total excluding long-term care	Inpatient hospital	Long-term care	Ambulatory visits	Other services
Section 1619	$3,999	$900	$387	$3,098	$201	$311
Disabled	4,206	1,729	889	2,477	373	466
(Ratio)	(1.05)	(1.92)	(2.30)	(0.80)	(1.86)	(1.50)

NOTES: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986. The seven survey States are Florida, Louisiana, Maryland, Nebraska, Pennsylvania, Texas, and Washington.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

make up only 0.2 percent of the disabled recipients in the survey States.

Section 1619 Medicaid expenditures are about $1 of every $1,000 spent on the disabled, excluding long-term care expenditures. The total expenditure, excluding long-term care was $856,000 for Section 1619 recipients and $829.9 million for the disabled (Table 7).

Total expenditures per capita, excluding long-term care, were nearly twice as high for the disabled as for the Section 1619 recipients (Table 8). The expenditure for the disabled per recipient (excluding long-term care) was $1,729 compared with $900 for the Section 1619 recipients.

The ratio of expenditures per recipient was greatest for inpatient hospital care (Table 8). The inpatient hospital expenditure rate for the disabled was 2.3 times that for Section 1619 recipients, $889 as compared with $387. Next in relative size was ambulatory visits, with the disabled having 1.86 times the expenditure rate of that for Section 1619 recipients, $373 versus $201. The disabled had a 1.5 times higher expenditure rate than Section 1619 recipients for other services, $466 as compared with $311.

Conclusion

The higher utilization and expenditure levels of the disabled population compared with the Section 1619 enrollees can be partly attributed to differences in demographic composition. Section 1619 enrollees are mostly young adults, younger overall than the general Medicaid disabled population, and they have a larger proportion of males than the general disabled population (Department of Health and Human Services, 1986). Both of these characteristics are associated with lower Medicaid utilization and expenditures (O'Brien et al., 1985). In addition, the fact that they are able to work makes it likely that their health status is better than those disabled persons unable to obtain work. It is also possible that working has a retarding effect on the use of health services.

This study provides indirect evidence that Section 1619 is a work incentive by contrasting health care costs to earnings. Section 1619 enrollees in the Tape-to-Tape States had average annual total Medicaid expenditures of $1,186 ($944 excluding long-term care), and, based on SSI administrative data, average annual earnings of $8,988 for 1982. These health care costs are a substantial part of this income, representing 13 percent of earnings (11 percent excluding long-term care) and excludes attendant care needed by some disabled. These data substantiate the SSA (1986) finding that only 2.8 percent of Section 1619 enrollees are able to earn a high enough income to obtain coverage equivalent to Medicaid. Because most Section 1619 enrollees do not receive employer health benefits (Social Security Administration, 1986),

the working disabled would have the full burden of these health care costs or need to obtain expensive nongroup health insurance without Section 1619's Medicaid coverage. It seems, then, that Section 1619 does act as a work incentive because it provides a significant benefit to the disabled who attempt to work.

In conclusion, Section 1619 provides benefits both to the disabled and to the Federal and State governments. As a work incentive, it provides the opportunity for the disabled to attempt to work with the safeguard of having their health care coverage maintained. The disabled benefit personally from the program by engaging in gainful activity in their communities. Government agencies benefit from Section 1619 in terms of reduced SSI cash payments, increased revenues through income taxes on enrollees' earnings, and the eventual reduction of the number of disabled enrollees as a few of them move into jobs with higher pay and health benefits. In evaluating the work incentive program established by Section 1619, these benefits must be weighed against the financial cost of the program.

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NEWS RELEASE

FOR IMMEDIATE RELEASE
MAY 25, 1988

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SOCIAL SECURITY WORK INCENTIVES ACT INTRODUCED IN HOUSE TO AID DISABLED WORKERS REENTER WORKFORCE

WASHINGTON, D.C., May 25,...A group of U.S. Congressmen, including Sacramento Rep. Robert T. Matsui and Rep. Steve Bartlett (R-TX), today introduced legislation to remove disincentives that are currently keeping disabled workers from reentering the workforce.

There are approximately 4 million disabled workers in America. About 250,000 reside in California. Many of these individuals who would like to return to the workforce in some capacity have not done so out of fear of losing their health care and income benefits.

Under current law, disabled beneficiaries completely lose their income benefits nine months after their earnings exceed $75. The measure introduced today would not completely eliminate these benefits once a disabled worker has returned to the workforce. Instead, it would adopt a formula that would reduce a worker's benefits on the basis of his or her earnings after returning to work. The measure also clarifies existing confusion over Medicare coverage that has prevented some workers from going back to work.

"This bill breaks down the barriers which are preventing America's disabled from once again becoming active, productive members of our society," Rep. Matsui said. "It makes policy sense, economic sense, and common sense."

The measure, known as the Social Security Work Incentives Act of 1988, would also allow those who choose to go back to work to receive Medicare benefits for 48 months. After the 48 months have expired, those who are "disabled but working" would be able to purchase Medicare coverage.

-more-

Under the Medicaid program, low-income individuals with disabilities would receive assistance in paying the premium. If the person's income is less than 150% of the current poverty level, Medicaid would pay the full premium. If the worker's income is between 150% and 300% of the poverty level, the worker will pay a portion of the premium and Medicaid would pay the rest.

Today's measure parallels the very successful changes Congress made in the Supplemental Security Income (SSI) program in 1986.

Rep. Matsui said that the bill would eventually take many disabled beneficiaries off the public rolls and help them feel they are a part of society again.

The bill was introduced in the House of Representives today by Reps. Steve Bartlett (R-TX), Robert Matsui (D-Calif), Willis Gradison (R-Ohio), Sander Levin (D-Mich), Robert Lagomarsino (R-Calif) and Geroge Wortley (R-NY).

# # #

BARTLETT INTRODUCES LEGISLATION TO REMOVE WORK DISINCENTIVES

Rep. Steve Bartlett (R-Texas) on May 25 introduced legislation to help remove federal disincentives to the increased employment of people with disabilities by ensuring continued access to health insurance through Medicare.

The Social Security Work Incentives Act of 1988, H.R. 4680, would apply to recipients of Social Security Disability Insurance Benefits (SSDI), those who are judged unable to work due to a physical or mental impairment. Under current law, if an SSDI recipient returns to work, SSDI cash benefits are cut off after their income reaches a certain level, and Medicare coverage ends 48 months after they begin working. For a disabled person unable to obtain insurance, this loss of coverage is a significant disincentive to attempting to return to work, believes Bartlett.

H.R. 4680 provides that disabled SSDI recipients who have exhausted their 48 months of Medicare coverage due to a trial work period may have continued coverage under Medicare through a buy-in arrangement at a cost based on their income. Those earning over 300% of the poverty level would pay the full Medicare premium, covering the government's cost. Those earning below 150% of the poverty level would have their Medicare premium paid by the state Medicaid program. Those in between would pay a share of the premium of a sliding scale based income.

"Many disabled SSDI recipients are in the prime of their work years and want to try to go back to work," said Bartlett. "But the potential loss of Medicare after 48 months is a tremendous disincentive. As long as disabled persons remain unemployed, they collect cash benefits as well as Medicare health insurance. But if they try to go back to work, they lose their cash benefits as their income increases. The government should be encouraging people who are able to work to do so, rather than [encouraging them to] remain unemployed."

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Section-by-Section of the "Social Security Work Incentives Act of 1988" (H.R.4680)

Section 1: Title

Section 2(a)and (b): When a person who is receiving Social Security disability benefits returns to work, that person will be shifted into a new status, entitled "disabled and working," once his/her earnings exceed the SGA dollar level established by the Secretary. The person will be permitted to stay in "disabled and working" status so long as s/he continues to have the disabling impairment that is the basis for eligibility and s/he meets all of the other non-disablity requirements of the Act.

Once the person is in disabled and working status, his/her monthly benefit will be reduced by one dollar for every two dollars earned, after exclusion of the first $85.00. For a person receiving disability benefits on his/her own account, the deductions are made against all benefits received on the same account. Reductions are made first to the wage earner's benefit then, after it is exhausted, to dependents' benefits on a proportional basis. Where the person is receiving disability benefits as a dependent of a deceased, retired or disabled worker, the reduction is made only to the benefit of the dependent who is disabled and working.

Where a person is receiving both Social Security and SSI and is eligible for both Social Security "disabled and working" status and benefits under §1619(a), the reductions shall first be taken from the §1619(a) SSI benefit until it is exhausted.

In determining the amount of the reduction in any month, the Secretary shall use the person's earnings from either the first or second month preceding the month involved.

Section 2(c): The Act provides that where a person is entitled to receive more than one Social Security benefit, the person will receive the higher of the benefits. In calculating which is higher where the person is in "disabled and working" status, the Secretary will treat that benefit as if it had not been reduced.

Section 2(d): Normally, the Secretary may attempt to collect overpayments from any beneficiary receiving benefits on the same record. This rule is changed where the person who is receiving "disabled and working" benefits receives the benefits as a disabled adult child of a deceased, retired or disabled worker. In these cases, the Secretary will only be able to recoup benefits or otherwise secure

repayment from the person who is (or was) in "disabled and working" status.

Section 2(e): The current provisions for a 9 month trial work period are eliminated.

Section 2(f): The provision of the Act requiring that benefits be rounded to next lower $1 is included here.

Section 2(g): Individuals who are in "disabled and working" status will continue to receive Medicare benefits for 48 months in which they are in "disabled and working" status. The Secretary is required to provide the individual with notice not later than the 45th month that (i) s/he has a certain number of months of Medicare eligibility remaining in disabled and working status and (ii) that after the 48th month, the person will have the opportunity to buy into the Medicare program.

If a person is already receiving Medicare either under a trial work period or an extended period of eligibility on the effective date of these provisions, those months of Medicare will be counted against the 48 month period.

Section 2(h): The provisions take effect for months after June 30, 1989. An individual who is receiving disability benefits on the date of enactment and is also working on that date will not be subject to these rules if his/her earnings do not exceed $250 at that time and for so long as they do not exceed $250/month.

Section 3(a): This section permits individuals who are in "disabled and working" status, regardless of whether they continue to receive a cash benefit, to buy-in to Medicare after the 48 months of Medicare coverage under "disabled and working" status is exhausted. The Secretary shall determine when the enrollment periods will occur. However, every individual will have the option of enrolling during the 10 month period which begins 3 months before the 48th month and ends 7 months after the 48th month.

Section 3(b): Medicare will be the secondary payor where the person is also covered under an employer's health plan.

Section 4(a): In cases where the individual's income and resources qualify the individual, the state Medicaid program will pay all or part of the Medicare premiums for the individual.

Section 4(b): A person will be considered to be a "qualified disabled and working individual" if (a) s/he is entitled under this new provision to buy-in to Medicare, (b) s/he is not otherwise eligible to receive Medicaid, (c) his/her income does not exceed 300% of the official poverty

Line, and (d) his/her resources do not exceed the allowable SSI levels.

Section 4(c): If a person who is a qualified disabled and working individual has income which exceeds 150% of the poverty line, the State Medicaid plan will pay a portion of the Medicare premium and the individual will pay rest. The amount which the State pays will be established on a sliding scale.

Section 4(d): Defines the term "Medicare cost-sharing" in Medicaid to include premiums paid as a result of these provisions.

Section 4(e): The effective date is July 1, 1989.

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Fact Sheet on the SSDI Work Incentive Bill (H.R.4680)

1. This bill is parallel to P.L 99-643 which authorized cash payments and Medicaid coverage to SSI recipients who work despite their disability. Data from the Social Security Administration (SSA) shows sharply rising numbers of people participating in the Section 1619(a) and (b) program. The early data must be carefully interpreted. All persons in the "trial work" status at the end of June, 1987 are now in the 1619(a) (cash benefits and Medicaid) count. The 1619(b) figures (continued Medicaid coverage only), show a 20 percent growth between June and September, 1987.

2. This legislation eliminates the "substantial gainful activity" (SGA) test under which DI beneficiaries who earn $300 or more a month are determined to be recovered and dropped from the disability rolls. Instead, after "disregarding" the first $85 of benefits, beneficiaries who are disabled and working would lose $1 in benefit payments for each $2 earned. (The disregard is identical to the Section 1619 disregard for SSI recipients and is comparable to the $75 per month definition of trial work).

3. This legislation eliminates the "trial work" period and the "extended period of eligibility" (EPE).

4. This legislation continues the existing law allowance for all impairment-related work expenses.

5. This legislation requires an annual evaluation to determine the working beneficiary's continued disability status.

6. This legislation retains the 24-month waiting period before a SSDI beneficiary becomes eligible for Medicare.

7. This legislation continues Medicare coverage for a cumulative total of 48 months after the beneficiary returns to work. This is the same as current law coverage which authorizes Medicare for 24 months after the end of the trial work period (9 months) and EPE (15 months) periods for beneficiaries who are terminated solely due to SGA.

8. This legislation permits beneficiaries to continue Medicare coverage through a "buy-in" arrangement after they exhaust their eligibility under current law.

   Individuals with earnings over 300 percent of the poverty level ($17,310 in 1988) will pay the full Medicare premium.

   Individuals with earnings between 150 and 300 percent of the poverty level ($8,555-$17,310 in 1988) would pay a subsidized rate with the State Medicaid program paying the difference. The individual's cost would be on a sliding scale reasonably related to the individual's earnings.

Individuals with earnings below 150 percent of the poverty level ($8,555 in 1988) would have their entire Medicare premium paid by Medicaid. In addition, individuals below 150 percent of the poverty who also meet the SSI resource test would be covered by Medicaid.

9. This legislation establishes Medicare as the secondary payor after employment-based health insurance.

10. This legislation would not create the substantial "induced demand" for benefits by working disabled people assumed by the SSA actuaries in the Disability Advisory Council's Report. The 24 month waiting period for Medicare coverage, which was not considered in the actuaries' estimate, will be a significant deterrent to working disabled people filing for DI.

Table 19a: Health insurance status of working-age persons with a work disability who are on SSI or SSDI

Survey of Income and Program Participation

Table 2: Working-age persons with a work disability who DID NOT WORK, WHO RECEIVE SSI OR SSDI

Self-reported Health Insurance Status

Health Condition Mainly Responsible for Work Limitation	Total	column pct	Private only	row pct	column pct	Private & Medicare	row pct	column pct	Private & Medicaid	row pct	column pct	Medicare only	row pct	column pct
Arthritis or rheumatism	429,458	9.16	144,123	33.56	12.18	60,763	14.15	7.72	0	0.00	0.00	44,889	10.45	6.52
Back or spine problems	608,321	12.98	142,449	23.42	12.04	126,338	20.77	16.04	12,998	2.14	7.99	95,374	15.68	13.86
Blindness or vision problems	160,402	3.42	23,530	14.67	1.99	33,910	21.14	4.31	8,239	5.14	5.06	5,632	3.51	0.82
Cancer	108,799	2.32	35,756	32.86	3.02	15,970	14.68	2.03	0	0.00	0.00	12,762	11.73	1.85
Deafness	44,711	0.95	10,715	23.97	0.91	0	0.00	0.00	3,964	8.87	2.44	14,654	32.77	2.13
Diabetes	152,368	3.25	40,447	26.55	3.42	27,845	18.27	3.54	0	0.00	0.00	18,425	12.09	2.68
Heart trouble	794,409	16.95	251,703	31.68	21.27	187,734	23.63	23.84	21,220	2.67	13.04	132,523	16.68	19.25
Hernia	12,303	0.26	4729	38.44	0.40	0	0.00	0.00	0	0.00	0.00	4,105	33.37	0.60
High blood pressure	167,341	3.57	70,168	41.93	5.93	4,661	2.79	0.59	3,595	2.15	2.21	3,748	2.24	0.54
Kidney stones or problems	65,226	1.39	12,791	19.61	1.08	13,038	19.99	1.66	0	0.00	0.00	6,007	9.21	0.87
Lung or respiratory problems	310,393	6.62	71,270	22.96	6.02	71,311	22.97	9.06	8,050	2.59	4.95	22,434	7.23	3.26
Mental illness	191,277	4.08	9,487	4.96	0.80	20,747	10.85	2.63	0	0.00	0.00	26,283	13.74	3.82
Mental retardation	261,694	5.58	26,712	10.21	2.26	5,340	2.04	0.68	46,065	17.60	28.31	29,693	11.35	4.31
Missing appendages	56,463	1.20	5,312	9.41	0.45	6,982	12.37	0.89	0	0.00	0.00	22,838	40.45	3.32
Nervous or emotional problems	189,578	4.05	37,955	20.02	3.21	14,076	7.42	1.79	0	0.00	0.00	44,763	23.61	6.50
Paralysis (any type)	119,411	2.55	13,940	11.67	1.18	5,068	4.24	0.64	0	0.00	0.00	29,008	24.29	4.21
Senility	22,743	0.49	7847	34.50	0.66	4,536	19.94	0.58	0	0.00	0.00	10,361	45.56	1.51
Stiffness of appendage	179,679	3.83	79724	44.37	6.74	17,170	9.56	2.18	0	0.00	0.00	13,620	7.58	1.98
Stomach trouble	43,145	0.92	16,647	38.58	1.41	8,466	19.62	1.08	0	0.00	0.00	0	0.00	0.00
Stroke	180,729	3.86	36,058	19.95	3.05	47,007	26.01	5.97	0	0.00	0.00	46,627	25.80	6.77
Thryoid trouble	14,824	0.32	4,361	29.42	0.37	0	0.00	0.00	0	0.00	0.00	4,575	30.86	0.66
Tumor, cyst, or growth	32,800	0.70	3,894	11.87	0.33	0	0.00	0.00	4,371	13.33	2.69	17,446	53.19	2.53
Other	540,022	11.52	133,568	24.73	11.29	116,548	21.58	14.80	54,229	10.04	33.32	82,507	15.28	11.99
Total	4,686,096	100%	1,183,186	25.2%	100%	787,510	16.8%	100%	162,731	3.5%	100%	688,274	14.7%	100%

Source: Data generated by Bureau of Economic Research, Rutgers University, from SIPP (1984).

Table 2. (Continued)

Medicaid only	row pct	column pct	Medicaid & Medicare	row pct	column pct	Other	row pct	column pct	No Insurance	row pct	column pct
68,019	15.84	6.71	31,277	7.28	7.33	1296	0.30	4.67	100,423	23.38	16.64
109,907	18.07	10.85	73,580	12.10	17.25	8717	1.43	31.39	57,831	9.51	9.58
51,954	32.39	5.13	24,039	14.99	5.64	0	0.00	0.00	32,856	20.48	5.44
19,155	17.61	1.89	8,133	7.48	1.91	0	0.00	0.00	17,024	15.65	2.82
4,795	10.72	0.47	4,226	9.45	0.99	0	0.00	0.00	10,322	23.09	1.71
33,230	21.81	3.28	3,981	2.61	0.93	0	0.00	0.00	23,254	15.26	3.85
80,885	10.18	7.98	57,046	7.18	13.38	4,713	0.59	16.97	83,172	10.47	13.78
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	3,470	28.20	0.57
44,922	26.84	4.43	14,059	8.40	3.30	0	0.00	0.00	32,896	19.66	5.45
8,807	13.50	0.87	15,884	24.35	3.72	0	0.00	0.00	8,699	13.34	1.44
96,635	31.13	9.54	17,561	5.66	4.12	4,931	1.59	17.76	37,677	12.14	6.24
75,926	39.69	7.49	32,353	16.91	7.59	0	0.00	0.00	35,210	18.41	5.83
121,006	46.24	11.94	58,575	22.38	13.73	0	0.00	0.00	7,392	2.82	1.22
5,269	9.33	0.52	5,519	9.77	1.29	0	0.00	0.00	10,544	18.67	1.75
70,422	37.15	6.95	16,718	8.82	3.92	0	0.00	0.00	5,644	2.98	0.94
28,418	23.80	2.80	23,677	19.83	5.55	0	0.00	0.00	14,316	11.99	2.37
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
41,206	22.93	4.07	4,162	2.32	0.98	3,880	2.16	13.97	19,917	11.08	3.30
4,940	11.45	0.49	0	0.00	0.00	4,231	9.81	15.24	8,861	20.54	1.47
34,113	18.88	3.37	3,871	2.14	0.91	0	0.00	0.00	13,129	7.26	2.18
5,887	39.71	0.58	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
5,100	15.55	0.50	0	0.00	0.00	0	0.00	0.00	1,989	6.06	0.33
102,761	19.03	10.14	31,842	5.90	7.47	0	0.00	0.00	78,907	14.61	13.07
1,013,357	21.6%	100%	426,503	9.1%		27,768	0.6%		603,533	12.9%	

Table 19b: Health insurance status of persons 18-61 with a work disability who are on SSDI as disabled workers but do not receive Medicare presumably because of the two year waiting period

Survey of Income and Program Participation

Table 3: Working-age persons with a work disability who DID NOT WORK, WHO RECEIVE SSDI BUT NOT MEDICARE, AGES 18-61 ONLY

Self-reported Health Insurance Status

Health Condition Mainly Responsible for Work Limitation	Total	column pct	Private only	row pct	column pct	Private & Medicare	row pct	column pct	Private & Medicaid	row pct	column pct	Medicare only	row pct	column pct
Arthritis or rheumatism	73,211	7.91	30,309	41.40	7.71	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Back or spine problems	114,423	12.36	46,945	41.03	11.95	0	0.00	0.00	8,546	7.47	22.99	0	0.00	0.00
Blindness or vision problems	34,278	3.70	9,272	27.05	2.36	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Cancer	28,874	3.12	13,573	47.01	3.45	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Deafness	8,434	0.91	2,946	34.93	0.75	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Diabetes	24,946	2.69	9,235	37.02	2.35	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Heart trouble	154,852	16.72	94,858	61.26	24.14	0	0.00	0.00	8,627	5.57	23.20	0	0.00	0.00
Hernia	0	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
High blood pressure	28,316	3.06	15,274	53.94	3.89	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Kidney stones or problems	13,278	1.43	4,579	34.49	1.17	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Lung or respiratory problems	61,273	6.62	23,626	38.56	6.01	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Mental illness	36,645	3.96	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Mental retardation	59,156	6.39	11,696	19.77	2.98	0	0.00	0.00	10,308	17.43	27.73	0	0.00	0.00
Missing appendages	10,544	1.14	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Nervous or emotional problems	45,781	4.94	11,273	24.62	2.87	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Paralysis (any type)	18,094	1.95	13,940	77.04	3.55	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Senility	3,803	0.41	3803	100.00	0.97	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Stiffness of appendage	51,840	5.60	12141	23.42	3.09	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Stomach trouble	12,131	1.31	7,966	65.67	2.03	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Stroke	27,516	2.97	18,366	66.75	4.67	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Thryoid trouble	0	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Tumor, cyst, or growth	7,089	0.77	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Other	111,435	12.04	63,092	56.62	16.06	0	0.00	0.00	9,698	8.70	26.08	0	0.00	0.00
Total	925,919	100%	392,894	42.4%	100%	0		0%	37,179	4.0%	100%	0		100%

Source: Data generated by Bureau of Economic Research, Rutgers University, from SIPP (1984).

ON SSDI BUT NOT ON MEDICARE AGES 18-61 CONTINUED

Medicaid only	row pct	column pct	Medicaid & Medicare	row pct	column pct	Other	row pct	column pct	No Insurance	row pct	column pct
7,466	10.20	3.40	0	0.00	0.00	0	0.00	0.00	38,966	53.22	9.32
31,928	27.90	14.53	0	0.00	0.00	4436	3.88	100.00	32,201	28.14	7.70
9,424	27.49	4.29	0	0.00	0.00	0	0.00	0.00	15,582	45.46	3.73
7,029	24.34	3.20	0	0.00	0.00	0	0.00	0.00	8,271	28.65	1.98
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	5,488	65.07	1.31
4,945	19.82	2.25	0	0.00	0.00	0	0.00	0.00	10,765	43.15	2.58
4,745	3.06	2.16	0	0.00	0.00	0	0.00	0.00	46,622	30.11	11.15
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	130,412	460.56	31.20
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	8,699	65.51	2.08
23,715	38.70	10.79	0	0.00	0.00	0	0.00	0.00	17,116	27.93	4.09
14,094	38.46	6.42	0	0.00	0.00	0	0.00	0.00	22,552	61.54	5.40
37,152	62.80	16.91	0	0.00	0.00	0	0.00	0.00	1,852	3.13	0.44
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	10,544	100.00	2.52
28,863	63.05	13.14	0	0.00	0.00	0	0.00	0.00	5,644	12.33	1.35
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	4,154	22.96	0.99
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
27,912	53.84	12.71	0	0.00	0.00	0	0.00	0.00	11,787	22.74	2.82
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	4,165	34.33	1.00
9,150	33.25	4.16	0	0.00	0.00	0	0.00	0.00	4,078	14.82	0.98
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
5,100	71.94	2.32	0	0.00	0.00	0	0.00	0.00	1,989	28.06	0.48
8,166	7.33	3.72	0	0.00	0.00	0	0.00	0.00	37,123	33.31	8.88
219,689	23.7%	100%	0		0%	4,436	0.5%	100%	418,010	45.1%	100%
219,689	23.7%		0			4,436	0.5%		418,010	45.1%	

Table 19c: Health insurance status of working-age persons with a work disability who are not on SSI or SSDI and are not employed

Survey of Income and Program Participation

Table 1: Working-age persons with a work disability who DID NOT WORK, and DID NOT RECEIVE SSI AND DID NOT RECEIVE SSDI

Self-reported Health Insurance Status

Health Condition Mainly Responsible for Work Limitation	Total	column pct	Private only	row pct	column pct	Private & Medicare	row pct	column pct	Private & Medicaid	row pct	column pct	Medicare only	row pct	column pct
Arthritis or rheumatism	656,839	11.62	430,216	65.50	14.85	0	0.00	0.00	22,320	3.40	33.98	0	0.00	0.00
Back or spine problems	1,261,323	22.31	621,134	49.24	21.44	3,678	0.29	13.82	16,323	1.29	24.85	0	0.00	0.00
Blindness or vision problems	140,712	2.49	70,085	49.81	2.42	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Cancer	103,717	1.83	91,063	87.80	3.14	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Deafness	60,977	1.08	30,801	50.51	1.06	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Diabetes	276,151	4.89	146,607	53.09	5.06	0	0.00	0.00	4,722	1.71	7.19	0	0.00	0.00
Heart trouble	609,716	10.79	360,980	59.20	12.46	8,371	1.37	31.46	0	0.00	0.00	0	0.00	0.00
Hernia	63,929	1.13	24840	38.86	0.86	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
High blood pressure	276,812	4.90	101,577	36.70	3.51	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Kidney stones or problems	65,539	1.16	22,434	34.23	0.77	4,998	7.63	18.78	0	0.00	0.00	2,431	3.71	13.53
Lung or respiratory problems	285,565	5.05	126,526	44.31	4.37	0	0.00	0.00	9,886	3.46	15.05	0	0.00	0.00
Mental illness	148,240	2.62	57,005	38.45	1.97	0	0.00	0.00	4,942	3.33	7.52	0	0.00	0.00
Mental retardation	86,330	1.53	29,960	34.70	1.03	0	0.00	0.00	0	0.00	0.00	4,464	5.17	24.85
Missing appendages	29,248	0.52	17,798	60.85	0.61	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Nervous or emotional problems	224,971	3.98	52,250	23.23	1.80	4,126	1.83	15.51	0	0.00	0.00	0	0.00	0.00
Paralysis (any type)	64,116	1.13	45,300	70.65	1.56	0	0.00	0.00	0	0.00	0.00	5,127	8.00	28.55
Senility	4,645	0.08	4645	100.00	0.16	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Stiffness of appendage	264,647	4.68	117585	44.43	4.06	0	0.00	0.00	3,379	1.28	5.14	0	0.00	0.00
Stomach trouble	127,117	2.25	58,457	45.99	2.02	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Stroke	141,796	2.51	91,825	64.76	3.17	0	0.00	0.00	0	0.00	0.00	5,939	4.19	33.07
Thryoid trouble	17,497	0.31	13,109	74.92	0.45	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Tumor, cyst, or growth	34,323	0.61	21,541	62.76	0.74	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Other	708,259	12.53	360,977	50.97	12.46	5,437	0.77	20.43	4,120	0.58	6.27	0	0.00	0.00
Total	5,652,469	100%	2,896,715	51.2%	100%	26,610	0.5%	100%	65,692	1.2%	100%	17,961	0.3%	100%

Source: Preliminary data generated by Bureau of Economic Research, Rutgers University, from SIPP (1984).

DID NOT RECEIVE SSI AND DID NOT RECEIVE SSDI CONTINUED

Medicaid only	row pct	column pct	Medicaid & Medicare	row pct	column pct	Other	row pct	column pct	No Insurance	row pct	column pct
72,583	11.05	7.27	5,426	0.83	31.84	22,798	3.47	16.51	107,845	16.42	7.12
230,217	18.25	23.05	9,753	0.77	57.23	41,506	3.29	30.05	354,344	28.09	23.38
31,410	22.32	3.14	1,864	1.32	10.94	0	0.00	0.00	37,353	26.55	2.46
8,269	7.97	0.83	0	0.00	0.00	0	0.00	0.00	4,385	4.23	0.29
20,572	33.74	2.06	0	0.00	0.00	0	0.00	0.00	9,604	15.75	0.63
33,515	12.14	3.36	0	0.00	0.00	9,239	3.35	6.69	82,069	29.72	5.41
59,809	9.81	5.99	0	0.00	0.00	27,450	4.50	19.88	153,106	25.11	10.10
6,084	9.52	0.61	0	0.00	0.00	0	0.00	0.00	33,005	51.63	2.18
71,341	25.77	7.14	0	0.00	0.00	8,680	3.14	6.28	95,215	34.40	6.28
13,773	21.01	1.38	0	0.00	0.00	1,321	2.02	0.96	20,581	31.40	1.36
95,776	33.54	9.59	0	0.00	0.00	2,956	1.04	2.14	50,422	17.66	3.33
32,626	22.01	3.27	0	0.00	0.00	10,713	7.23	7.76	42,654	28.77	2.81
29,256	33.89	2.93	0	0.00	0.00	0	0.00	0.00	22,651	26.24	1.49
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	11,450	39.15	0.76
51,792	23.02	5.19	0	0.00	0.00	3,908	1.74	2.83	112,896	50.18	7.45
4,326	6.75	0.43	0	0.00	0.00	0	0.00	0.00	9,363	14.60	0.62
0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
35,316	13.34	3.54	0	0.00	0.00	0	0.00	0.00	108,367	40.95	7.15
38,342	30.16	3.84	0	0.00	0.00	0	0.00	0.00	34,642	27.25	2.29
8,322	5.87	0.83	0	0.00	0.00	4,707	3.32	3.41	31,002	21.86	2.05
4,388	25.08	0.44	0	0.00	0.00	0	0.00	0.00	4,388	25.08	0.29
3,702	10.79	0.37	0	0.00	0.00	0	0.00	0.00	9,079	26.45	0.60
147,434	20.82	14.76	0	0.00	0.00	4,833	0.68	3.50	181,295	25.60	11.96
998,853	17.7%	100%	17,043	0.3%	100%	138,111	2.4%	100%	1,515,716	26.8%	100%

17.7% 0.3% 2.4% 26.8%

Table X: Estimates of Disabled Population by Age Group Based on Different Indicators of Disability (in thousands)

	Children (0-17)	Working-age (18-64)	Elderly 65+	Total
I. Degree of Activity Limitation (HIS, 1986)				
A. Some activity limitation	3,168	19,107	10,698	32,972
B. Major activity limitation	2,292	13,730	6,258	22,281
1. Unable to carry on major activity	251	6,086	2,933	9,270
2. Limited in amount or kind of major activity	2,042	7,644	3,325	13,011
C. Limited, but not in major activity	876	5,377	4,440	10,692
II. Work Disability (SIPP, 1984)				
A. Full time employed with work disability		5,633		
B. Part-time employed with work disability		1,978		
C. Not working with work disability		10,338		
		17,949		
III. Work Disability (SSA Survey of Disability and Work, 1978)		21,900		
IV. Work Disability (Census, 1980) ages 16-64		12,300		
Work Disability (Census, March Supplement, 1982)		13,110		

	Children (0-17)	Working-age (18-64)	Elderly 65+	Total
V. Functional Limitations (SIPP, 1984)				
A. some limitation		21,839*	15,465	37,304
B. severe		5,997*	7,539	13,537
VI. Need for Personal Assistance (SIPP, 1984)		2,747	4,450	7,197
VII. Beneficiaries of SSA Disability Programs (SSA Administrative Records, 1987)				
A. Disabled Workers		2,719		
B. Disabled Adult Children		550		
C. Disabled Widows or Widowers		107		
D. Disabled or Blind SSI recipients	250	2,091	**	
		5,467		
E. Minus dual enrollees		1,079		
F. Unduplicated total		4,388		
VIII. Institutionalized population				

* Age range for this indicator is 15-64

**Blind and disabled SSI recipients are combined with elderly SSI recipients over 65 who may or may not be disabled.

Table Y: Age Distribution of Persons with Major Activity Limitations (in thousands)

Age Group	Persons with Limitations in Major Activity	Percentage of Persons with Major Activity Limitations by Age Group	Percentage of All Persons in Each Age Group with Major Activity Limitations	Total No. of Persons in Non-institutionalized U.S. Population
under 18	2,292	10.3%	3.6%	63,132
18-64	13,730	61.6%	9.4%	145,678
65+	6,258	28.1%	22.7%	27,538
All ages	22,281	100%	9.4%	236,348

Source: Health Interview Survey (1986)

Table Z: Percent of Population under 65 by Health Insurance Status

	Private Insurance	Medicaid	Medicare	Uninsured
Age:				
0-17	72.5%	10.7%	0%	14.0%
18-64	78.6%	4.0%	1.2%	14.8%
65+	73.8%	6.4%	95.6%	0.9%
Family income:				
less than $5000	30.1%	35.9%	2.9%	31.1%
$5000-$9999	36.7%	23.2%	3.0%	36.6%
$10,000-$19,999	72.4%	4.1%	1.5%	20.3%
$20,000-$34,999	89.6%	1.1%	0.6%	7.1%
$35,000-$49,999	94.2%	0.4%	0.3%	3.6%
$50,000+	95.8%	0.3%	0.2%	3.2%
Employment status:				
currently employed	85.3%	0.9%	0.2%	12.5%
unemployed	47.0%	11.8%	0.6%	38.3%
not in labor force	65.2%	11.7%	6.4%	16.8%

Source: "Health Care Coverage by Sociodemographic and Health Characteristics, U.S., 1984", Data from the National Health Survey, Series 10, No. 162, Tables 1, 5, 7, 9, 15, 17.

Disability Risks Of Chronic Illness and Impairment

by

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TABLE 1: DISABILITY RISKS OF SELECTED IMPAIRMENTS AND CHRONIC CONDITIONS, BY GENDER: UNITED STATES CIVILIAN NONINSTITUTIONALIZED POPULATION, 1983-1986 (FOUR-YEAR AVERAGE)

	Both Genders				Males				Females			
		Percent				Percent				Percent		
Chronic Condition	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care
All selected chronic conditions	393899	11.7	8.5	2.6	163803	12.5	9.4	2.0	230096	11.2	7.9	3.1
Skin and musculoskeletal												
Rheumatoid arthritis	1223	51.0	39.4	14.9	321	43.9	33.6	*4.4	902	53.6	41.5	18.7
Osteoarthritis/other arthropathies	29245	19.6	13.8	5.3	10351	18.3	13.7	3.4	18893	20.4	13.8	6.3
Intervertebral disk disorders	3987	48.7	38.2	5.3	2212	50.4	39.3	3.6	1775	46.6	36.8	7.4
Osteomyelitis/bone disorders	2998	21.0	15.7	5.9	1116	15.4	12.4	*1.5	1882	24.3	17.7	8.5
Bursitis	4539	6.2	4.5	*0.7	1812	6.1	4.1	*0.0	2727	6.2	4.7	*1.2
Psoriasis and dermatitis	11329	1.9	1.3	*0.1	4578	1.5	*0.9	*0.0	6751	2.2	1.5	*0.2
Skin cancer	1459	*2.3	*1.7	*0.9	874	*2.8	*2.5	*1.5	586	*1.6	*0.6	*0.0
Other selected skin and musculoskeletal	27747	2.1	1.6	0.4	11502	2.8	2.2	0.4	16245	1.6	1.2	0.5
Impairments												
Absence of arm(s)/hand(s)	84	43.1	*39.0	*4.1	78	46.5	*42.1	*4.4	*6	*0.0	*0.0	*0.0
Absence of leg(s)	289	83.3	73.1	39.0	234	82.6	71.2	35.0	*56	*86.3	*81.2	*55.8
Absence of fingers, toes, feet	1811	7.0	4.5	*1.3	1410	5.5	*3.5	*0.9	401	*12.3	*8.1	*2.9
Other absence, NEC	1031	20.8	13.3	*4.4	451	19.9	14.2	*2.6	581	21.4	12.7	*5.8
Complete paralysis of extremities	617	52.7	45.5	26.1	340	50.6	47.3	23.7	277	55.3	43.3	28.9
Cerebral palsy	274	69.7	62.2	22.8	189	70.3	62.7	*20.4	85	68.3	61.1	*28.2
Partial paralysis of extremities	578	59.6	47.2	27.5	319	66.8	53.1	27.3	259	50.8	40.1	27.7
Paralysis of other sites	247	47.8	43.7	*14.1	138	60.0	60.0	*10.9	109	*32.4	*23.0	*18.0
Curvature of back or spine	4689	14.7	10.6	1.4	1443	15.4	11.6	*1.2	3246	14.4	10.1	*1.4
Other impairment of back	9898	27.7	19.4	2.8	4550	27.0	20.3	2.0	5348	28.2	18.6	3.5
Impairment of upper extremities	3106	27.9	17.0	2.9	1728	25.8	14.7	*1.0	1377	30.6	19.9	5.4
Impairment of lower extremities	10893	26.5	15.6	4.8	5622	26.3	15.8	2.5	5271	26.7	15.4	7.3
Other orthopedic impairment	316	58.7	46.2	*14.3	154	56.6	41.8	*10.0	161	60.8	50.3	*18.4
Speech impairment	2469	18.3	17.4	*2.3	1633	18.8	18.3	*1.6	836	17.4	15.6	*3.7
Blind in both eyes	396	64.5	58.8	38.1	191	74.8	70.5	48.1	205	54.9	47.8	28.8
Cataracts	5173	10.6	6.4	4.4	1633	10.2	5.9	*2.2	3541	10.8	6.6	5.4
Glaucoma	1707	14.9	8.4	5.1	727	12.8	*7.0	*3.7	980	16.5	9.4	6.1
Other visual impairment/retinal disorders	8596	14.0	10.0	5.4	5076	11.0	8.0	3.2	3520	18.3	12.9	8.6
Deaf in both ears	1700	16.4	11.3	*3.2	959	13.5	10.0	*3.0	741	20.1	12.9	*3.5
Other hearing impairment	19254	4.6	2.7	0.9	10854	4.4	2.6	0.7	8400	4.8	2.8	1.2
Other selected impairments	1371	13.6	10.3	*2.5	756	15.9	11.5	*3.3	615	10.7	*9.0	*1.7
Digestive												
Ulcers	4469	9.7	7.0	*1.0	2107	11.8	9.2	*0.9	2362	7.8	5.1	*1.1
Abdominal hernia	4830	12.5	9.1	2.4	2427	11.3	7.7	*1.2	2403	13.7	10.6	3.6
Enteritis and colitis	2392	7.2	5.1	*0.8	721	8.7	*6.1	*0.4	1671	6.6	4.6	*1.0
Cancer of digestive sites	228	45.3	40.3	15.9	107	45.1	37.3	*10.5	121	45.4	42.8	*20.6
Other selected digestive disorders	20556	3.6	2.9	0.8	7296	3.1	2.5	*0.3	13260	3.9	3.1	1.1

** Figure has low statistical reliability or precision (relative standard error exceeds 30 percent)*

Source: National Health Interview Surveys, 1983-1986; original tabulation from public use tapes.

TABLE 1: DISABILITY RISKS OF SELECTED IMPAIRMENTS AND CHRONIC CONDITIONS, BY GENDER: UNITED STATES CIVILIAN NONINSTITUTIONALIZED POPULATION, 1983-1986 (FOUR-YEAR AVERAGE)--CONTINUED

Chronic Condition	Both Genders				Males				Females			
		Percent				Percent				Percent		
	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care	Persons (1,000s)	Limited In Any Activity	Limited In Major Activity	Needing Personal Care
Circulatory												
Rheumatic fever	1536	15.7	11.5	*1.9	537	11.2	*9.6	*0.6	999	18.2	12.6	*2.6
Ischemic heart disease	6948	35.0	26.1	8.1	3978	36.1	26.4	4.4	2970	33.6	25.9	13.0
Heart rhythm disorders	7404	7.2	4.7	1.5	2735	8.1	5.6	*1.4	4669	6.7	4.1	1.5
Other heart disease	4708	46.9	35.1	13.6	2075	48.7	37.8	11.7	2633	45.4	33.1	15.0
Hypertension	28689	12.4	8.9	2.2	12242	9.9	7.5	1.2	16446	14.2	9.9	2.9
Cerebrovascular disease	2599	38.2	33.3	22.9	1269	39.6	36.3	20.3	1331	36.8	30.4	25.3
Arteriosclerosis	3008	12.1	9.4	5.1	1532	12.0	9.6	*3.8	1476	12.2	9.2	6.5
Phlebitis, varicose veins	7891	5.5	3.9	0.8	1584	7.5	6.3	*0.8	6306	4.9	3.3	*0.8
Other selected circulatory	11519	3.8	2.7	1.2	5153	4.0	2.8	*0.8	6365	3.6	2.7	1.5
Respiratory												
Chronic bronchitis	11196	3.6	2.5	0.6	4465	3.4	2.6	*0.5	6732	3.8	2.5	*0.7
Asthma	8869	20.6	12.6	1.3	4069	19.1	12.6	*0.7	4800	21.8	12.7	1.7
Hay fever	20431	1.5	1.1	*0.0	9424	1.7	1.3	*0.0	11007	1.3	0.8	*0.1
Sinusitis	31969	0.4	0.3	0.1	13455	0.5	*0.4	*0.1	18514	0.4	*0.3	*0.1
Emphysema	2074	43.6	29.8	9.6	1399	44.0	31.3	*8.4	675	42.8	26.8	12.2
Lung or bronchial cancer	200	74.8	63.5	34.5	110	79.9	65.2	*32.4	90	68.7	61.4	*37.1
Other selected respiratory	9097	5.5	4.1	1.2	3763	8.1	6.5	*1.4	5334	3.7	2.3	*1.0
Miscellaneous												
Diabetes	6096	35.4	27.9	9.4	2609	32.3	25.0	5.8	3487	37.8	30.1	12.0
Anemias	3409	4.6	3.4	*0.3	547	*1.5	*1.3	*0.0	2862	5.2	3.8	*0.3
Kidney disorders	3559	9.6	7.8	2.4	1187	9.0	7.2	*1.0	2371	9.9	8.1	3.2
Female genital disorders	6379	3.7	2.4	*0.2	.	.	.	.	6379	3.7	2.4	*0.2
Mental retardation	1202	84.1	80.0	19.9	762	86.9	83.9	18.7	440	79.3	73.2	22.0
Epilepsy	1162	41.0	29.0	6.3	578	36.4	29.3	*2.0	584	45.5	28.7	10.5
Multiple sclerosis	171	70.6	63.3	40.7	*48	*36.7	*36.7	*20.0	123	84.0	73.8	48.9
Migraine headache	7934	2.9	2.2	*0.3	2023	4.0	3.2	0.0	5911	2.6	1.9	*0.4
Cancer of female breast	443	27.4	17.3	*4.6	.	.	.	.	443	27.4	17.3	*4.6
Cancer of genitourinary sites	302	41.8	34.7	*8.5	100	55.3	45.7	*15.3	202	35.2	29.3	*5.1
Other selected miscellaneous	15602	4.0	2.9	1.0	4251	4.7	3.3	*0.6	11352	3.8	2.7	1.1

* *Figure has low statistical reliability or precision (relative standard error exceeds 30 percent)*

Source: National Health Interview Surveys, 1983-1986; original tabulation from public use tapes.

TABLE 2: DISABILITY RISKS OF SELECTED IMPAIRMENTS AND CHRONIC CONDITIONS IN THE WORKING AGES: UNITED STATES CIVILIAN NONINSTITUTIONALIZED POPULATION, 1983-1986 (FOUR-YEAR AVERAGE)

	Ages 18-69				Ages 18-44				Ages 45-69			
		Percent				Percent				Percent		
Chronic Condition	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care
All selected chronic conditions	286710	8.6	5.4	1.3	139267	4.7	2.0	0.6	147443	12.3	8.6	2.0
Skin and musculoskeletal												
Rheumatoid arthritis	969	40.1	26.5	9.7	252	34.8	15.1	1.5	716	41.9	30.5	12.6
Osteoarthritis/other arthropathies	20725	14.3	9.5	2.3	4813	7.0	3.0	0.9	15913	16.5	11.4	2.8
Intervertebral disk disorders	3616	40.7	19.1	4.6	1659	37.8	11.6	3.9	1957	43.2	25.4	5.1
Osteomyelitis/bone disorders	2308	14.1	8.9	2.9	948	10.3	5.4	0.8	1360	16.8	11.3	4.3
Bursitis	3904	4.3	2.7	0.6	1465	3.0	1.3	0.0	2438	5.1	3.4	1.0
Psoriasis and dermatitis	7837	1.4	0.5	0.0	5090	0.9	0.2	0.0	2747	2.2	1.2	0.1
Skin cancer	988	1.8	0.0	0.6	206	0.0	0.0	0.0	782	2.3	0.0	0.7
Other selected skin and musculoskeletal	20476	1.7	1.1	0.1	11228	0.4	0.1	0.0	9248	3.2	2.2	0.3
Impairments												
Absence of arm(s)/hand(s)	64	51.6	18.0	5.4	17	82.7	0.0	0.0	46	39.8	24.8	7.4
Absence of leg(s)	207	72.9	54.9	32.7	59	71.2	23.7	24.7	148	73.5	67.3	35.8
Absence of fingers, toes, feet	1416	5.4	2.8	1.1	605	4.8	2.7	0.0	811	5.8	2.9	1.9
Other absence, NEC	730	17.1	12.0	2.8	301	16.3	11.0	3.4	428	17.7	12.7	2.4
Complete paralysis of extremities	421	50.8	39.8	21.9	133	65.8	38.2	35.6	288	43.9	40.6	15.6
Cerebral palsy	157	58.2	46.7	28.0	134	55.7	46.3	29.8	23	72.9	49.2	17.2
Partial paralysis of extremities	336	55.0	46.6	22.2	94	64.0	37.0	7.4	242	51.5	50.3	28.0
Paralysis of other sites	196	42.0	24.1	9.5	64	36.9	16.4	15.9	132	44.4	27.8	6.5
Curvature of back or spine	3472	13.4	6.3	1.3	2242	11.5	3.9	0.8	1230	16.8	10.7	2.2
Other impairment of back	8703	21.3	8.9	2.2	5087	16.4	5.4	1.0	3617	28.2	13.9	4.0
Impairment of upper extremities	2491	19.8	10.2	1.9	1356	18.1	7.5	0.9	1135	21.9	13.3	3.0
Impairment of lower extremities	8166	15.8	7.9	2.0	4648	11.9	4.6	0.8	3518	20.9	12.2	3.5
Other orthopedic impairment	247	39.5	23.3	7.9	133	37.6	19.1	0.0	114	41.9	28.3	17.2
Speech impairment	1186	11.2	7.6	3.3	701	10.1	5.6	3.0	484	12.7	10.5	3.7
Blind in both eyes	180	71.9	58.6	26.7	76	63.2	48.6	8.8	105	78.2	65.9	39.7
Cataracts	1784	8.4	5.6	1.8	207	9.2	1.4	0.0	1577	8.3	6.1	2.0
Glaucoma	853	9.4	8.6	2.1	158	5.5	3.7	1.6	695	10.3	9.8	2.2
Other visual impairment/retinal disorders	5766	8.3	5.4	1.6	2993	4.7	1.6	0.4	2773	12.2	9.4	2.8
Deaf in both ears	868	15.8	8.2	1.7	235	21.7	13.2	3.1	633	13.7	6.4	1.2
Other hearing impairment	12979	2.2	1.2	0.2	4832	2.4	0.6	0.1	8146	2.1	1.5	0.2
Other selected impairments	906	12.3	6.8	2.7	364	8.5	2.6	0.8	542	14.8	9.7	4.1
Digestive												
Ulcers	3843	8.0	6.4	0.7	1977	3.1	2.2	0.0	1866	13.2	10.8	1.5
Abdominal hernia	3299	9.8	5.3	1.0	922	6.0	0.9	0.0	2377	11.2	7.0	1.4
Enteritis and colitis	1772	5.8	3.3	0.5	983	4.4	2.1	0.0	789	7.5	4.8	1.0
Cancer of digestive sites	143	46.8	39.6	11.1	6	49.0	49.0	0.0	136	46.7	39.2	11.6
Other selected digestive disorders	15138	2.8	1.9	0.2	7394	1.3	0.8	0.0	7744	4.1	3.0	0.5

* *Figure has low statistical reliability or precision (relative standard error exceeds 30 percent)*

Source: National Health Interview Surveys, 1983-1986; original tabulation from public use tapes.

TABLE 2: DISABILITY RISKS OF SELECTED IMPAIRMENTS AND CHRONIC CONDITIONS IN THE WORKING AGES: UNITED STATES CIVILIAN NONINSTITUTIONALIZED POPULATION, 1983-1986 (FOUR-YEAR AVERAGE)--CONTINUED

Chronic Condition	Ages 18-69				Ages 18-44				Ages 45-69			
		Percent				Percent				Percent		
	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care	Persons (1,000s)	Limited In Work	Unable To Work	Needing Personal Care
Circulatory												
Rheumatic fever	1284	12.5	9.1	1.9	575	7.5	4.5	0.8	709	16.6	12.9	2.7
Ischemic heart disease	4401	31.6	20.9	3.5	370	29.9	15.0	4.1	4031	31.7	21.4	3.5
Heart rhythm disorders	4893	5.3	3.7	0.5	2540	2.1	1.1	0.3	2353	8.8	6.4	0.8
Other heart disease	2800	39.9	29.2	4.9	850	16.5	8.3	1.6	1951	50.1	38.3	6.3
Hypertension	21489	9.6	6.7	0.8	6245	3.6	1.9	0.2	15245	12.1	8.7	1.0
Cerebrovascular disease	1334	32.5	28.1	14.1	173	14.4	10.7	4.2	1161	35.2	30.8	15.6
Arteriosclerosis	1395	12.0	9.7	1.9	48	5.9	0.0	0.0	1347	12.2	10.0	2.0
Phlebitis, varicose veins	6232	4.8	3.2	0.5	2574	2.8	0.9	0.3	3658	6.2	4.9	0.6
Other selected circulatory	9796	2.3	1.8	0.4	5245	0.5	0.3	0.1	4551	4.3	3.5	0.8
Respiratory												
Chronic bronchitis	6553	2.9	1.7	0.3	3815	0.9	0.4	0.1	2738	5.6	3.4	0.6
Asthma	5292	12.6	5.7	0.9	3409	10.1	2.8	0.8	1883	17.3	10.9	1.3
Hay fever	15754	0.8	0.2	0.0	11114	0.8	0.2	0.0	4640	0.9	0.2	0.0
Sinusitis	25779	0.3	0.1	0.0	16079	0.1	0.0	0.0	9699	0.5	0.3	0.1
Emphysema	1399	38.7	28.1	7.0	116	14.2	11.6	5.9	1283	40.9	29.6	7.1
Lung or bronchial cancer	99	72.7	69.9	17.6	15	73.1	73.1	20.3	84	72.7	69.4	17.1
Other selected respiratory	5892	4.8	4.0	0.9	3782	0.8	0.3	0.1	2110	11.8	10.6	2.5
Miscellaneous												
Diabetes	4182	29.0	20.1	4.1	884	18.9	6.9	1.8	3298	31.7	23.6	4.7
Anemias	2427	2.8	1.8	0.0	1642	1.2	0.8	0.0	785	6.1	3.9	0.0
Kidney disorders	2735	7.5	5.5	1.4	1468	3.1	1.5	0.0	1267	12.6	10.3	3.0
Female genital disorders	5473	2.5	0.8	0.1	4066	1.3	0.3	0.0	1406	5.9	2.4	0.2
Mental retardation	520	75.3	53.1	37.4	393	75.9	48.0	37.9	127	73.6	69.0	36.1
Epilepsy	762	37.0	30.6	6.7	535	34.0	25.5	5.5	227	44.0	42.8	9.3
Multiple sclerosis	155	58.9	44.6	37.5	72	48.2	39.8	28.8	82	68.3	48.8	45.1
Migraine headache	6990	2.0	1.1	0.2	4879	1.7	0.8	0.2	2111	2.5	1.9	0.3
Cancer of female breast	307	22.1	14.6	2.7	59	21.4	7.7	0.0	247	22.3	16.2	3.4
Cancer of genitourinary sites	234	29.3	28.3	1.7	109	7.1	7.1	3.5	125	48.8	46.8	0.0
Other selected miscellaneous	12389	2.6	2.0	0.5	6827	1.2	0.8	0.3	5562	4.3	3.4	0.8

** Figure has low statistical reliability or precision (relative standard error exceeds 30 percent)*

Source: National Health Interview Surveys, 1983-1986; original tabulation from public use tapes.

3/3/88
draft-3

DESCRIPTION - WORKING GROUP MEETING

Background
Purpose/Charge
Meeting Plan

BACKGROUND

For the last decade and one-half Congress has considered and enacted a range of efforts to remove disincentives to employment and community living for persons with disabilities. This includes the enactment in 1986 of legislation to permanently establish section 1619 of the Social Security Act to provide public health insurance to eligible individuals of Supplemental Security Income who wish to undertake substantial gainful employment.

In 1986 Congress also amended the Rehabilitation Act of 1973 to mandate that:

> The Director (NIDRR) shall conduct a study of health insurance practices and policies which affect individuals with handicaps. Not later than February 1, 1990 the Director shall submit a report of the study to the appropriate committees of the Congress. (Section 202(m) of the Rehabilitation Act Amendments of 1986).

A review of literature, legislative history and individual interviews indicates that this statutory mandate resulted from a Congressional awareness of the extent to which the integration of disabled people into productive employment and community living is directly affected by existing policies and practices in the provision of health insurance in the private and public sectors.

To meet Congressional needs, it is expected that the 202(m) report will:

1. Analyze and discuss the range of problems, policies and practices in the provision of health insurance on the private and public level that affects the ability of persons with disabilities to lead productive and independent lives;

2. Analyze and discuss potential solutions to resolve the problems disabled persons and families face in obtaining necessary health care coverage; and,

3. Propose recommendations that Congress may undertake to address these health insurance issues.

Development of the report for submission to Congress is proceeding through the following four general phases.

PHASE I: (Through March 31, 1988)

With the assistance of a consultant, conduct a literature review and conduct interviews with experts to (a) develop an understanding of the extent of the knowledge and data that exists in the area of private and public health insurance as it relates to disabled people; and (b) develop a detailed outline/report of the scope of the problem and the projected report to Congress.

PHASE II: (April 1 Through September 30, 1988)

Continue reviewing, revising and clarifying the Phase I outline/report and obtain substantive input and analysis by individuals with expertise in health insurance, health policy and the health care needs of persons with disabilities at a "Working Group Meeting".

PHASE III: (October 1, 1988 Through October 30,1989)

Award a contract to convene advisory panels, conduct research, evaluate solutions and recommendations, and complete the development of the Final Report to Congress.

PHASE IV: (October 1, 1989 Through February 1, 1990)

Conduct internal Executive Agency review of the Final Report prior to submission to Congress.

PURPOSE/CHARGE

The Working Group Meeting is being convened to bring together experts in public and private health insurance, health policy and the health care and health related needs of persons with disabilities.

The charges to the Working Group are:

1. To assist in defining the scope of the problem in existing public and private health insurance policy and practices as it affects persons with disabilities;

2. To generate a list of recommendations of issues that must be addressed in the Final Report to Congress; and,

3. To generate a list of recommendations of methods and resources that will assist in substantiating the information and data that must be included in the Final Report to Congress.

Specifically the Working Group shall:

1. Discuss and evaluate the scope and content of the Phase I Outline/Report;

2. Discuss and evaluate papers and presentations by participant/writers; and,

3. Develop and make recommendations of methods and resources that will assist in completing the Final Report to Congress.

The deliberations, recommendations, presentations and papers of this Working Group Meeting will be compiled in a meeting report. This Meeting Report, the revised Phase I Outline/Report and other related research will form the basis for the Final Report to Congress. The Final Report to Congress will be completed by the Phase III contractor, as noted above.

Attendance at the Working Group Meeting is by invitation only and is limited to twenty participants. The writers will be selected from among the participants and will be requested to prepare a paper in their area of expertise that evaluates and/or expands upon the Phase I Outline/Report. The meeting Chair will be selected from among the participants.

The papers, the Phase I Outline/Report, a set of questions and issues and related materials will be provided to all twenty participants in advance of the Meeting for their review and meeting preparation.

MEETING PLAN

DAY 1

A. Welcome and Introductions

B. Mission of Working Group

Overview of the study, the Phase I Outline/Report and expected outcomes of the Meeting.

C. Demographics/Health Care Needs and Utilization

Presentation by Writer

Have writer provide a 20 minute synopsis of their paper and discussion of the topic area. The purpose is to evaluate the Phase I Outline/Report sections: Definition of the Population; Health Care Status; Health Care and Health Related Needs; and Health Care Utilization

Discussion Period

Presentation is followed by a 40 minute discussion period. During this period participants can ask questions, provide reactions to the paper and presentation, evaluate the relevant Phase I Outline/Report sections, and identify additional information. The purpose is to evaluate the definition and data provided; clarify terms; and, gather recommendations for inclusion in the Final Report to Congress.

D. Private Health Insurance

Presentation by Writer

Have writer provide a 20 minute synopsis of their paper and a discussion of the topic area. The purpose is to describe the private health insurance system and underwriting practices and discuss its strengths and limitations for meeting the health care and related needs of persons with disabilities.

Discussion Period

Presentation is followed by a 40 minute discussion period. During this period the participants can ask questions, provide reactions to the paper and presentations, and discuss additional information that will assist in understanding the strengths and limitations of the private health insurance system for meeting the needs of persons with disabilities. The purpose is to evaluate and clarify important issues and gather recommendations for inclusion in the Final Report to Congress.

E. Public Health Insurance

Presentation by Writer

Have writer provide a 20 minute synopsis of their paper and discussion of the topic area. The purpose is to describe the public health insurance system and its strengths and limitations for meeting the health care and health related needs of persons with disabilities.

Discussion Period

Presentation is followed by a 40 minute discussion period. During this period the participants can ask questions, provide reactions to the paper and presentation, and discuss additional information that will assist in understanding the strengths and limitations of the public health care financing system for meeting the health care and health related needs of persons with disabilities. The purpose is to evaluate and clarify important issues and gather recommendations for inclusion in the Final Report to Congress.

F. Evolution of Health Insurance in the U.S.

Discussion Period

Have Chair lead a 45 - 60 minute period to discuss the evolution of health insurance (public and private) and the forces that have operated to shape existing health care programs and public and private insurance policy in the United States. The purpose is to assist the Working Group to understand the context of existing health care programs and insurance policy. The Working Group will also evaluate this topic for inclusion in the Final Report to Congress.

DAY 2

A. Participant Generated Issues and Recommendations

Discussion Period

Have Chair (30 minutes) begin discussion by reviewing the work, issues and recommendations from Day 1 and by requesting participant generated issues and recommendations for Working Group evaluation and discussion. Establish a priority list for discussion and review by the Working Group.

Discussion Period

Have Chair lead a 90 minute discussion of the list of issues generated in the above session. The purpose is to discuss and evaluate issues and recommendation raised by the participants and evaluate them for inclusion in the Final Report to Congress.

Discussion Period

Continue above - 90 minutes.

Discussion Period

Have Chair lead a 90 - 120 minute discussion of the participants on the materials, Phase I Outline/Report, and issues and recommendations discussed during the previous day and one-half. The purpose is to clarify and reach consensus on the issues and recommendations and the scope of the Final Report to Congress.

WORKING GROUP MEETING

PARTICIPANTS

Federal From D.C. Area

1. Lex Frieden
   Executive Director
   National Council on the Handicapped
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   Suite 814
   Washington, DC 20591
   202/267-3846

   Note: Electric Wheelchair User
****

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   Note: Eletric Wheelchair User
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   Note: Electric Wheelchair user - travels with an attendant

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- limited mental health care
- durable medical equipment (other than eyeglasses/hearing aids)
- physical therapy.

The maximum lifetime benefit per covered person for eligible services ranges from $250,000 to $1 million. Indiana and New Mexico place no limit on the value of pool benefits that may be received.

Nearly all of the pools exclude coverage for a pre-existing condition for which medical advice or treatment was recommended or received within a specified period of time (generally six months) before the effective date of enrollment. In Connecticut and Montana, the waiting period is 12 months. A few of the pools allow the waiting period to be waived if the individual has recently satisfied the pre-existing condition exclusion under previous insurance coverage. The rationale behind the waiting periods is the same as it is for private policies: to guard against adverse selection, whereby an individual who anticipates needing medical treatment joins just before the treatment is begun.

Pool Participation

As Table 2 illustrates, the seven risk pools that are fully operational have collectively experienced a steady, moderate growth in total enrollment over the last three years. As of the end of 1986, total pool enrollment reached 21,573, an increase of 5 percent over 1985 which, in turn, was an increase of 7 percent over the 1984 level.

The largest risk pool by far is the Minnesota Comprehensive Health Association with 11,784 enrollees as of December 31, 1986 -- just over half of the total nationally. Each of the remaining active pools had 1986 enrollments equal to less than a third of Minnesota's. Taken individually, state health risk pools have been growing at an uneven rate. Since 1984, pools in Florida and North Dakota have been growing very rapidly, while those in Minnesota and Wisconsin have had more modest increases. In Connecticut and Indiana, enrollment has stabilized or begun to drop.

In a few states, it is possible to point to specific factors that probably contributed to the change in enrollment. In Florida, for instance, enrollment has climbed since January 1, 1987, when the waiting period for pre-existing conditions was reduced from 12 to 6 months and after the state waged a public media campaign. In Indiana, pool participation has been declining at a rate of 1 percent over the last two and one-half years. An official of the Mutual of Omaha Insurance Company, which administers the pool for the state, attributes the decline in enrollment to the large premium increases imposed each year since 1984. Similarly, a recent sharp decline in Connecticut's enrollment is probably linked to higher cost-sharing requirements. State insurance officials and representatives of lead insurance carriers in other states could not point to specific factors operating to increase or decrease the number of enrollees.

Enrollee Profile

Only three states (Florida, Indiana and North Dakota) are able to provide even limited demographic information on pool enrollees, while a fourth (Wisconsin) has very detailed information (see Table 2).

According to the data supplied by the four state respondents, females constitute a majority (54 percent) of pool enrollees. Not surprisingly, pools also favor older individuals who would be more likely to have chronic medical conditions. Only 32 percent of participants were under age 40. Participation

Table 2

Table 18. Number of persons with and without health-care coverage, by age and health characteristics: United States, 1984

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in appendix I. Definitions of terms are given in appendix II]

Characteristic	All ages	Under 65 years					65 years and over
		Total	Under 18 years	18–24 years	25–44 years	45–64 years	
	Number of persons in thousands						
COVERED, ALL PERSONS[1,2]	199,253	173,144	53,025	20,703	59,800	39,616	26,109
Respondent-assessed health status							
Excellent	79,598	75,475	28,873	9,631	26,201	10,770	4,123
Very good	52,247	46,940	13,116	6,189	17,625	10,010	5,307
Good	45,107	36,889	9,208	4,010	12,154	** 517	8,217
Fair	15,403	9,970	1,314	731	3,026	4,899	5,433
Poor	6,138	3,225	172	110	675	2,268	2,913
Limitation of activity due to chronic conditions							
Limited	28,456	18,283	2,728	1,217	5,464	8,875	10,172
In major activity	19,704	13,295	1,937	866	3,696	6,797	6,408
In other activity	8,752	4,988	791	352	1,767	2,078	3,764
Not limited	170,797	154,861	50,298	19,485	54,337	30,741	15,936
Annual bed days							
None	107,230	90,663	24,559	10,632	30,336	25,136	16,567
1–7 days	67,485	63,365	23,315	8,145	23,016	8,888	4,120
8–30 days	17,496	14,222	4,396	1,548	4,759	3,519	3,274
31 days or more	5,768	3,931	439	297	1,429	1,766	1,837
Annual physician contacts							
None	47,898	43,264	10,615	5,651	16,751	10,247	4,634
1–3 contacts	95,470	85,477	28,925	10,184	28,647	17,721	9,993
4–7 contacts	31,926	25,488	8,927	2,562	7,681	6,318	6,439
8 contacts or more	23,538	18,607	4,498	2,272	6,606	5,231	4,931
Annual hospital episodes[3]							
None	181,695	160,741	50,545	19,419	55,675	35,102	20,954
1 episode	13,633	10,017	2,139	1,080	3,376	3,422	3,616
2 episodes or more	3,925	2,386	341	203	750	1,092	1,539
Annual hospital days[3]							
1–6 days	10,008	7,928	1,868	1,012	2,720	2,328	2,080
7–15 days	4,671	2,870	415	187	964	1,303	1,802
16 days or more	2,826	1,572	185	80	435	871	1,255
NOT COVERED, ALL PERSONS[1,2]	29,784	29,555	8,662	6,943	9,740	4,210	229
Respondent-assessed health status							
Excellent	10,382	10,334	3,672	2,628	3,168	865	48
Very good	7,071	7,033	2,009	1,881	2,465	677	*38
Good	8,666	8,605	2,439	1,950	2,942	1,274	61
Fair	2,676	2,626	416	379	904	928	49
Poor	786	758	59	57	206	435	*28
Limitation of activity due to chronic conditions							
Limited	3,305	3,215	400	320	1,157	1,338	90
In major activity	2,430	2,359	273	223	865	998	71
In other activity	874	856	128	97	291	340	*18
Not limited	26,479	26,340	8,262	6,623	8,584	2,872	139
Annual bed days							
None	17,812	17,644	4,880	4,205	5,791	2,768	168
1–7 days	8,646	8,628	2,999	2,120	2,748	761	*17
8–30 days	2,222	2,203	568	451	799	385	*20
31 days or more	735	716	103	93	304	216	*19

Source: National Center for Health Statistics, "Health Care Coverage by Sociodemographic and Health Characteristics, United States, 1984", Data From the National Health Survey, Series 10, No. 162, p. 44.

See footnotes at end of table.

Table 3

Survey of Income and Program Participation

Table 18: Working-age persons with a work disability
by self-reported health status and by health condition

Health Condition Mainly Responsible for Work Limitation	Total	column pct	Self-reported Health Status: Excellent	row pct	column pct	Very good	row pct	column pct	Good	row pct	column pct
Arthritis or rheumatism	1,799,570	10.03	20,742	1.15	2.18	160,153	8.90	8.35	443,350	24.64	9.20
Back or spine problems	3,880,419	21.63	211,902	5.46	22.31	559,504	14.42	29.18	1,192,000	30.72	24.73
Blindness or vision problems	480,673	2.68	73,144	15.22	7.70	51,165	10.64	2.67	130,847	27.22	2.71
Cancer	327,452	1.83	4,923	1.50	0.52	8,034	2.45	0.42	49,291	15.05	1.02
Deafness	295,141	1.65	48,301	16.37	5.08	79,216	26.84	4.13	123,872	41.97	2.57
Diabetes	605,230	3.37	1,027	0.17	0.11	32,827	5.42	1.71	75,661	12.50	1.57
Heart trouble	2,271,992	12.66	35,816	1.58	3.77	102,741	4.52	5.36	467,742	20.59	9.70
Hernia	161,172	0.90	8622	5.35	0.91	36,714	22.78	1.91	31,682	19.66	0.66
High blood pressure	665,562	3.71	18,883	2.84	1.99	37,562	5.64	1.96	154,940	23.28	3.21
Kidney stones or problems	222,603	1.24	4,177	1.88	0.44	0	0.00	0.00	64,008	28.75	1.33
Lung or respiratory problems	1,202,101	6.70	56,408	4.69	5.94	122,269	10.17	6.38	282,304	23.48	5.86
Mental illness	408,526	2.28	15,389	3.77	1.62	45,252	11.08	2.36	119,572	29.27	2.48
Mental retardation	519,325	2.89	100,297	19.31	10.56	67,530	13.00	3.52	195,454	37.64	4.05
Missing appendages	156,565	0.87	27,507	17.57	2.90	32,793	20.95	1.71	46,979	30.01	0.97
Nervous or emotional problems	560,652	3.13	22,272	3.97	2.34	41,164	7.34	2.15	132,604	23.65	2.75
Paralysis (any type)	254,827	1.42	29,564	11.60	3.11	24,980	9.80	1.30	86,719	34.03	1.80
Senility	31,568	0.18	0	0.00	0.00	0	0.00	0.00	9,881	31.30	0.20
Stiffness of appendage	926,052	5.16	66,027	7.13	6.95	148335	16.02	7.74	356,341	38.48	7.39
Stomach trouble	274,280	1.53	4,808	1.75	0.51	6,697	2.44	0.35	29,910	10.90	0.62
Stroke	383,428	2.14	4,908	1.28	0.52	19,214	5.01	1.00	65,091	16.98	1.35
Thryoid trouble	36,481	0.20	4,162	11.41	0.44	0	0.00	0.00	17,496	47.96	0.36
Tumor, cyst, or growth	104,457	0.58	5,055	4.84	0.53	18316	17.53	0.96	14,329	13.72	0.30
Other	2,372,335	13.22	186,038	7.84	19.58	323,173	13.62	16.85	730,365	30.79	15.15
Total	17,940,411	100%	949,972	5.3%	100%	1,917,639	10.7%	100%	4,820,438	26.9%	100%

Source: Data generated by Bureau of Economic Research, Rutgers Univesity, from SIPP (1984) data.

Survey of Income and Program Participation

Table 18: Working-age persons with a work disability
by self-reported health status and by health condition

Health Condition Mainly Responsible for Work Limitation	Total	column pct	Fair	row pct	column pct	Poor	row pct	column pct
			Self-reported Health Status					
Arthritis or rheumatism	1,799,570	10.03	721,560	40.10	12.38	453,765	25.22	10.26
Back or spine problems	3,880,419	21.63	1,132,000	29.17	19.42	785,013	20.23	17.75
Blindness or vision problems	480,673	2.68	135,273	28.14	2.32	90,244	18.77	2.04
Cancer	327,452	1.83	98,714	30.15	1.69	166,490	50.84	3.77
Deafness	295,141	1.65	38,918	13.19	0.67	4,834	1.64	0.11
Diabetes	605,230	3.37	260,587	43.06	4.47	235,128	38.85	5.32
Heart trouble	2,271,992	12.66	795,811	35.03	13.65	869,882	38.29	19.67
Hernia	161,172	0.90	35,917	22.28	0.62	48,237	29.93	1.09
High blood pressure	665,562	3.71	301,696	45.33	5.17	152,481	22.91	3.45
Kidney stones or problems	222,603	1.24	81,438	36.58	1.40	72,980	32.78	1.65
Lung or respiratory problems	1,202,101	6.70	379,725	31.59	6.51	361,395	30.06	8.17
Mental illness	408,526	2.28	147,512	36.11	2.53	80,801	19.78	1.83
Mental retardation	519,325	2.89	108,244	20.84	1.86	47,800	9.20	1.08
Missing appendages	156,565	0.87	35,724	22.82	0.61	13,562	8.66	0.31
Nervous or emotional problems	560,652	3.13	223,425	39.85	3.83	141,187	25.18	3.19
Paralysis (any type)	254,827	1.42	68,817	27.01	1.18	44,747	17.56	1.01
Senility	31,568	0.18	3,803	12.05	0.07	17,884	56.65	0.40
Stiffness of appendage	926,052	5.16	232,779	25.14	3.99	122,570	13.24	2.77
Stomach trouble	274,280	1.53	174,772	63.72	3.00	58,093	21.18	1.31
Stroke	383,428	2.14	122,691	32.00	2.10	171,524	44.73	3.88
Thryoid trouble	36,481	0.20	4,575	12.54	0.08	10,248	28.09	0.23
Tumor, cyst, or growth	104,457	0.58	8,830	8.45	0.15	57,927	55.46	1.31
Other	2,372,335	13.22	717,628	30.25	12.31	415,131	17.50	9.39
Total	17,940,411	100%	5,830,439	32.5%	100%	4,421,923	24.6%	100%

Table 4

Survey of Income and Program Participation

Table 1: Type of assistance needed by health condition responsible for work disability for working-age persons

Health Condition Mainly Responsible for Work Limitation	Total Group	column pct	Getting Around	row pct	column pct	Housework	row pct	column pct	Meals	row pct	column pct	Personal Care	row pct	column pct	Number of persons needing assistance by health condition	row pct	column pct
Arthritis or rheumatism	1,800,000	10.03	107,085	5.95	9.71	255,307	14.18	11.77	140,449	7.80	9.71	103,532	5.75	12.30	305,307	16.96	11.11
Back or spine problems	3,880,000	21.61	166,377	4.29	15.08	423,142	10.91	19.50	204,074	5.26	14.11	100,289	2.58	11.92	487,340	12.56	17.74
Blindness or vision problems	480,675	2.68	69,585	14.48	6.31	54,549	11.35	2.51	40,663	8.46	2.81	11,928	2.48	1.42	91,425	19.02	3.33
Cancer	327,454	1.82	49,064	14.98	4.45	97,049	29.64	4.47	68,881	21.04	4.76	47,615	14.54	5.66	110,791	33.83	4.03
Deafness	295,144	1.64	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Diabetes	614,478	3.42	29,580	4.81	2.68	59,776	9.73	2.76	49,969	8.13	3.45	25,749	4.19	3.06	76,736	12.49	2.79
Heart trouble	2,274,000	12.67	87,048	3.83	7.89	230,674	10.14	10.63	113,706	5.00	7.86	59,765	2.63	7.10	277,611	12.21	10.11
Hernia	161,174	0.90	0	0.00	0.00	2,085	1.29	0.10	2,085	1.29	0.14	3,966	2.46	0.47	6,052	3.75	0.22
High blood pressure	665,564	3.71	19,421	2.92	1.76	76,129	11.44	3.51	15,335	2.30	1.06	3,521	0.53	0.42	84,049	12.63	3.06
Kidney stones or problems	222,604	1.24	31,873	14.32	2.89	34,186	15.36	1.58	23,605	10.60	1.63	15,760	7.08	1.87	38,292	17.20	1.39
Lung or respiratory problems	1,202,000	6.70	45,086	3.75	4.09	119,863	9.97	5.52	60,474	5.03	4.18	7,554	0.63	0.90	137,893	11.47	5.02
Mental illness	408,528	2.28	24,810	6.07	2.25	32,832	8.04	1.51	51,318	12.56	3.55	20,539	5.03	2.44	71,156	17.42	2.59
Mental retardation	519,326	2.89	41,277	7.95	3.74	115,088	22.16	5.30	167,282	32.21	11.56	97,864	18.84	11.63	199,814	38.48	7.27
Missing appendages	156,567	0.87	17,504	11.18	1.59	22,637	14.46	1.04	22,637	14.46	1.56	14,179	9.06	1.68	39,207	25.04	1.43
Nervous or emotional problems	560,653	3.12	20,869	3.72	1.89	46,980	8.38	2.17	42,968	7.66	2.97	16,875	3.01	2.01	55,966	9.98	2.04
Paralysis (any type)	254,829	1.42	78,567	30.83	7.12	76,176	29.89	3.51	61,433	24.11	4.25	49,948	19.60	5.93	101,509	39.83	3.70
Senility	31,568	0.18	13,703	43.41	1.24	13,703	43.41	0.63	23,343	73.95	1.61	12,983	41.13	1.54	23,343	73.95	0.85
Stiffness of appendage	926,054	5.16	33,221	3.59	3.01	70,322	7.59	3.24	39,743	4.29	2.75	31,893	3.44	3.79	96,581	10.43	3.52
Stomach trouble	274,283	1.53	10,722	3.91	0.97	17,290	6.30	0.80	17,290	6.30	1.20	0	0.00	0.00	21,051	7.67	0.77
Stroke	383,431	2.14	86,133	22.46	7.81	133,919	34.93	6.17	95,209	24.83	6.58	90,639	23.64	10.77	151,187	39.43	5.50
Thryoid trouble	36,482	0.20	0	0.00	0.00	4,361	11.95	0.20	4,361	11.95	0.30	0	0.00	0.00	4,361	11.95	0.16
Tumor, cyst, or growth	104,459	0.58	26,261	25.14	2.38	39,194	37.52	1.81	36,212	34.67	2.50	25,519	24.43	3.03	47,243	45.23	1.72
Other	2,372,000	13.21	145,173	6.12	13.16	244,286	10.30	11.26	165,439	6.97	11.44	101,497	4.28	12.06	320,247	13.50	11.66
Total	17,951,273	100%	1,103,359	6.1%	100%	2,169,548	12.1%	100%	1,446,476	8.1%	100%	841,615	4.7%	100%	2,747,161	15.3%	100%

Source: Data generated by Bureau of Economic Research, Rutgers University, from SIPP (1984) data.

Health Services in the United States

A Growth Enterprise Since 1875

Odin W. Anderson

Health Administration Press
Ann Arbor, Michigan
1985

Contents

2

Preview of the Development of U.S. Health Services

Personal health services have been a growth enterprise in the United States since 1875, to pick an arbitrary but accurate date. The enterprise has taken place essentially in the private sector of the economy, with a mixture of nonprofit and profit enterprises receiving increasing government support and intervention. This mixture has changed over the years, primarily in regard to sources of funding for day-to-day operations and capital funding. Americans manifest a great deal of ambivalence about who is responsible for health care, the individual or the government. Collective solutions have received mixed reactions: life insurance, fire insurance, and community fund drives for hospital construction were accepted easily a long time ago, but private health insurance foundered until people recognized that, like life and fire insurance, it was a prudent way to protect their solvency. Medical care for the poor was regarded as an expression of the noblesse oblige of the physician and the hospital, buttressed by local government and philanthropic organizations.

The personal health services system seems to fall naturally into three major stages of development: 1875 to 1930, 1930 to 1965, and 1965 to the present. I present these stages briefly, giving some attention to public health services and mental hospitals, which preceded and then paralleled the growth of personal health services.

1875 TO 1930

During the latter part of the nineteenth century, physicians and pharmacists were the sole dispensers of professionally recognized health services. On the periphery were midwives, who, by the turn of the century, were

beginning to be replaced by physicians. Also on the periphery were doctors of osteopathy, chiropractors, and others. Dentists developed a separate, parallel profession.

The general hospital as we know it today did not exist. Poorhouses and almshouses took care of the destitute and persons who had no family. Illnesses were treated primarily in patients' houses and physicians' offices. Physicians and pharmacists were entrepreneurs with presumably a code of ethics and professional standards. They were not motivated strictly by profit, but had an implied obligation to persons unable to pay. There were proportionately as many physicians then as there are now. They made their living treating patients for fees, and received very little income from government or philanthropic sources. In no other country have so many physicians and dentists been supported by private, fee-for-service patients. The same was true of pharmacists, who eventually established the peculiarly American corner drugstore to supplement their income from prescriptions. This income was insufficient because there were so many pharmacists and because physicians themselves dispensed drugs. Private practice and fee-for-service thus became firmly embedded in American medical care.

Surgery had become highly developed by 1875 because of operations done in the charity hospitals of the East Coast and Europe. The middle and upper classes, however, would not have been caught dead in these famous hospitals, but that changed with the advent of anesthesia and antisepsis, which made the general hospital a relatively safe and painless place for surgery. The affluent began to seek the services of surgeons, who in turn sought hospital admitting privileges. By 1900 there were 4,000 general hospitals in the United States, whereas there had been only a few score in 1875.

Hospitals were established mostly by voluntary community boards and church bodies. The church bodies, of course, had a long history of caring for the poor, and this tradition was transformed into the modern general hospital. Capital came from the millionaires created by the tremendous industrial development following the Civil War. Only a small minority of general hospitals were built for the poor by municipalities. Voluntary hospitals, because of their charitable and nonprofit charters, were obliged to provide care for the poor who sought help, but by and large the poor were a minority of their patients. The burgeoning economy enabled hospitals to obtain capital funds from philanthropists and operating funds from paying patients. Physicians, particularly those who wanted to perform surgery, made deals with the hospitals to admit their private patients; these patients would pay the hospital charges and the surgeons' fees. In return, the surgeons were provided a free workshop in which to provide free care for the poor, an ideal symbiotic arrangement. American society has a long tradition of voluntary self-help on the community level, and the voluntary hospitals are prime examples of this tradition. The nurturing functions of the family found expression in the voluntary hospital when the home became unequal to the technical demands of increasingly high technology medicine.

The traditional nurturing functions of women were embodied in the trained nurse, who, in her cap and uniform, functioned as the physician's assistant. Industrial development and the growth of cities provided a respectable occupational opportunity for women from rural as well as urban areas. Florence Nightingale was an attractive model. The nursing profession became an alternative to teaching and secretarial positions for women, and it was possibly more honored because of its aura of service. Nurses' hours were long and their pay low, mostly in kind.

Dentists, like physicians, were entrepreneurs who made their way by fees from private patients. Since public concern about dental health was indifferent then, the services of dentists were not in great demand. Dentists also benefited greatly from the appearance of anesthesia and antisepsis. In fact, the first health professional to use ether was a dentist, thus ushering in the use of anesthesia.

During the nineteenth century, most physicians were trained through apprenticeships with practicing physicians. There were also so-called diploma mills, which were established by physicians to train several students at a time in rather primitive arrangements. Later, private and public universities established medical schools. Dentists also had first proprietary schools and eventually schools in universities. Nurses were trained by hospitals, which benefited from the inexpensive labor. Student nurses were under virtually total supervision, reflecting the view of young women's roles at that time. As medical science advanced, a variety of other types of personnel began to appear.

All this took money, but money became available with the growth of the economy. The surplus was increasingly poured into personal health services, which, until the 1930s, Americans bought without the help of government or private insurance. Thus the infrastructure of the personal health services as we know them today—the voluntary hospital and the privately practicing physicians, dentists, and pharmacists—was in place by the 1930s.

Public health services and mental hospitals were not wanted services in the same sense as personal health services. Before 1875, cities and counties had begun to establish health departments because effluents were contaminating the water and causing epidemics of cholera. Later, when communicable diseases in children could be controlled by immunization and pasteurization, the health department expanded its function based on bacteriology and epidemology. The public health nurse for mothers and infants was created by adding public health training to the registered nurse's curriculum. Public health separated itself early from

the private practice of medicine. Public health officers were not allowed to practice medicine.

The building of mental hospitals (usually out in the country) preceded the development of personal health services. Mental hospitals were —and continue to be—more or less separate from personal health services. Mental hospitals were and are largely publicly owned and operated. Like public health departments, they are not a wanted service, judging from the public funding they receive relative to the magnitude of the problem they deal with. Personal health services, through sheer demand and popularity, have cornered the available funding.

This was the situation in 1930, and it is the situation today. The system was shaped by hospital owners, physicians, and philanthropists. Government, except by issuing licenses and setting standards, did nothing to influence the system. The public presumably approved of the structure because they used and paid for it in increasing numbers. The government helped the system indirectly by permitting hospitals to be tax-exempt enterprises. In addition, capital gifts to hospitals were tax-exempt and interest-free. In other words, the private sector subsidized the construction of hospitals, an interesting mixture of nonprofit and profit enterprise that was accepted by the body politic as natural. The personal health services, which are oriented toward acute care, were stimulated enormously by the dynamics of medical science, technology, and money. In the 1930's, this system was poised for even more dynamic expansion than it had experienced since 1875. Relative to the personal health services, public health departments and mental hospitals have barely held their own.

1930 TO 1965

While the period from 1875 to 1930 witnessed the development of the health services infrastructure, the period from 1930 to 1965 is characterized mainly by the emergence of a third party to pay the day-to-day expenses.

The rise of the third party payer was undoubtedly stimulated by the Depression of the 1930s, when both hospital and personal income fell, but it is likely that the third party would have emerged eventually anyway. Hospitals could operate better with a steady income, and families could more readily meet the increasing costs resulting from improved medical technology. Hospitals began to sponsor prepayment plans, which eventually became known as Blue Cross plans. In fact, after 1933, the health services resumed their growth, as reflected in the proportion of the gross national product (GNP) directed to them. Hospital stays were relatively costly and lent themselves well to insurance, since a predictable number of individuals in the population would incur hospital expenses in a year.

At the same time, prepayment for physicians' services in the hospital, mainly surgery, began to appear in the late thirties. Sponsored by state medical societies, these became known as Blue Shield plans. Surgery was also a relatively costly procedure and lent itself to the principle of insurance. State governments continued to sponsor health services for the poor, and eventually a shared program between the federal government and the states emerged. The Emergency Maternal and Infant Care Program for the wives and dependents of servicemen during World War II represented the first national health services program for a conspicuous segment of the population. Congress felt it could do nothing less for our soldiers.

During the forties and into World War II, private insurance companies discovered from the experience of the Blue Cross and Blue Shield plans that hospital care and surgery were insurable. Congress gave the voluntary plans a financial boost by decreeing that health insurance (and pensions) were fringe benefits and thus exempt from the wartime freeze on wages. This is another example of government encouragement of the private sector, since the portion of health insurance paid by the employer is a tax-exempt business expense. Further, signing up for fringe benefits became a condition of employment; this form of compulsion was acceptable, whereas any compulsory government program would have been taboo. After the passage in 1935 of the Social Security Act, which mandated mainly pensions and unemployment insurance, legislation proposing compulsory health insurance was put on the back burner of the congressional stove until 1952, the last year of Truman's presidency.

The Blue Cross and Blue Shield plans and the private insurance companies were spectacularly successful. They went far beyond their own expectations in enrolling employee groups in the major industries, and by 1952 over one-half of the population was covered by some form of health insurance, mainly hospital care and physician services in the hospital. With the election of Dwight Eisenhower in 1952, the venomous controversy over voluntary versus compulsory, government-sponsored health insurance subsided. Eisenhower would not support government health insurance.

A salient aspect of the rise of third party payers is that the organizational structure of health services that had emerged since 1875 was taken as a given; the insurance agencies and the government were concerned with paying its charges. In the case of hospitals, the concept was charges or costs, whichever was lower, since hospital accounting systems were underdeveloped and not uniform. Physicians were paid by voluntary health insurance according to generous fee schedules negotiated by Blue Shield plans. There were no direct negotiations at all with private insurance companies because there were no contracts with them. These reimbursement methods seem irresponsible in retrospect, but then money

flowed freely in a rapidly expanding economy. The public was exhorted by public health departments to "See your doctor early," and maternal and child health programs were promoted. Encouragement was scarcely needed for either major or minor surgery. Admissions to hospitals and visits to physicians increased dramatically between the late thirties and the sixties: hospital admissions increased from 90 per 1,000 persons in the population per year to 145; the percentage of the population who saw a physician in a year increased from 39 to 65. The supply of hospital beds and physicians increased, but not in relation to demand. Physicians became very busy and prosperous. Hospital occupancy rates went up, and hospitals also became prosperous, their chronic deficits notwithstanding.

To add to the stock of hospitals and beds, particularly in rural areas, Congress in 1946 passed the Hospital Survey and Construction (Hill-Burton) Act. This act was supported by such diverse interests as the American Hospital Association (AHA), the American Medical Association (AMA), and labor organizations, which ordinarily worked at cross-purposes in efforts to enact government health insurance. The act was designed as a one-shot grant to hospitals, both public and voluntary, for start-up costs, with grant funds to be matched by the hospitals. Each state for the first time took an inventory of its hospital beds, and grants were made to hospitals within the framework of a loose plan. The act supplied around 25 percent of the expenditures for hospitals, which in turn generated a considerable amount of money from private and public sources, mainly private. The main object of the act, which was very successful, was to buttress the voluntary hospital. The old sources of capital, philanthropy and community fund-raising drives, were diminishing, and public hospitals were regarded as outside the mainstream of the hospital system. This is another instance of government supporting the private, nonprofit sector. The voluntary hospital is an integral part of community life and interweaves the private and public sectors so closely as to make it difficult to differentiate between the two.

By the early 1950s, an engine of finance had been established from private sources for the day-to-day operation of the hospital and physician services and from public and private sources for the supply of hospital beds, physicians, and other personnel. The general economy and the health services economy were booming. The existing health services infrastructure continued to be accepted as a given.

Within the relatively private, nonprofit health services economy, however, there rose a development that was concerned directly with restructuring the delivery of physicians' services and indirectly with hospital care. This was the group practice prepayment plan, which attempted to compete with solo-practice fee-for-service medical delivery, engage a range of specialists on a salary, provide a full range of physician services, from curative to preventive, and serve a known population. The Kaiser-

cal dollar, but only a small portion of this cost could be expected from direct-pay patients. Public medical assistance for the indigent in nursing homes became a prime source of funding for day-to-day operations, and it was buttressed greatly after 1965 by Medicaid. True to the American tradition, the market for nursing homes was met largely by the private sector, both profit and nonprofit, and standards were set by the states together with Medicaid and Medicare. Government was unable or unwilling to supply enough nursing home beds to meet the demand and need. As usual, government bought services from the private sector and paid pretty much what the nursing homes were charging.

1965 TO THE PRESENT

It was not until the latter sixties that there began to be general concern by the big buyers of services—government, employers and labor unions, and insurance and prepayment agencies—over rising expenditures for personal health services. It was the pace of the increase that was alarming, with costs rising faster than the general economy as reflected in the consumer price index and the GNP. The public was mainly interested in reducing out-of-pocket expenditures, and the buyers of services were interested in keeping insurance premiums and reimbursements to providers low. Hospital expenditures were rising at the dizzying pace of 15 percent annually. Expenditures for physicians' services were close behind. Providers said the increase in expenditures was justified in large part because of improved services and increased use, as well as rising labor costs in this labor-intensive enterprise. No one knew what constituted an appropriate level of expenditures, but there seemed to be general agreement that the current level was too high. Theories of costs and expenditures were equally primitive.

This period, then, is characterized by an intense concern with how to manage the health services enterprise so that buyers know what they are buying and providers know what they are offering. The practice of simply paying what the providers asked was being seriously questioned. Further, the payment mechanism was to be used to manage the system. Three methods of doing so emerged, largely in this order: (1) monitoring physician decision making in hospitals, (2) control of hospital beds, and (3) control of hospital reimbursement rates.

Attempts at rationalization of the personal health services, to use an economic term, were expressed mainly in group practice prepayment plans. These were set up not simply to save money, but to provide high quality and comprehensive services efficiently and conveniently. It seemed that saving money was a secondary although acknowledged consideration. Likewise, the scores of hospital planning councils that were

Permanente plans were established in the West, and the Health Insurance Plan of Greater New York (HIP) was established in the East. In cities like Washington, D.C., Seattle, St. Louis, and Minneapolis-St. Paul, similar plans were established on a more or less cooperative, consumer-owned basis. Initially, opposition on the part of medical societies to these new arrangements was fierce. Gradually, however, they began to take their place in the spectrum of types of health services delivery and in some areas came to be regarded as options in labor-management negotiations for fringe benefits. Their influence appeared to be out of all proportion to their pace of growth (involving around 4 percent of the population), since they became reference points for quality health services at a "reasonable" price. It seems that only in the United States was this diversity of delivery types possible. American physicians have an entrepreneurial propensity, and an ability to raise capital, unlike physicians in any other country. The concept of private group practices, in which physicians live on fees, undoubtedly inspired the concept of group practice prepayment, in which physicians live on premiums divided among the physicians on salaries.

The private engine of finance was aided by the public engine with the passage of the Medicare Act for the aged and the Medicaid Act for the poor in 1965. Medicare is a federal program and Medicaid is a shared federal-state program. Medicare takes the cost of care of the aged off the backs of families and the private sector, and Medicaid, along with assuaging the national conscience, takes the cost of care of the poor off the shaky revenue structure of the states and tries to equalize care for the poor across states. By 1965, private and nonprofit insurance agencies were supplying 40 percent of the cost of day-to-day operations of hospitals and 30 percent of physicians' services. Government, mainly the federal government, was paying for 50 percent of the hospital costs and 20 percent of physicians' services. The stage was set for a spectacular increase in price and use. There were no serious built-in controls on costs. The health services enterprise had become accustomed to being paid what it asked, and the funding sources did not demur because employees, employers, and Congress did not demur either. From 1950 to 1965, expenditures as a percent of GNP rose from 4.6 to 5.9. Expenditures per capita for all services rose from $78 to $198, not accounting for inflation, which was moderate during that period. The private insurance agencies and the government teamed up, as it were, to assure a health service where cost would be of no consequence.

Concomitantly, the proportion of people age 65 and over was increasing, particularly those 75 to 80 and over. Ineluctably associated with aging are chronic illness and disability and the increasing financial helplessness that overtakes families with aged members. By the fifties, expenditures on nursing homes became a visible portion of the national medi-

established in major cities, sponsored by local hospitals and funded in large part by DHEW, were aimed less at saving money than at systematizing hospital relationships and cooperation on the local level. The councils were intended to serve as information clearinghouses on hospital beds and equipment in local areas, the presumption being that the hospitals would recognize their own interests. These councils may have had other effects, but the evidence shows that reducing duplication of services or stabilizing the bed supply was not among them.

The seeming lack of success of the hospital council concept led to the federal program called Comprehensive Health Planning (CHP). This program was to be concerned with facilities planning through the states and incorporated many of the hospital planning councils as agents of the state. Another federal endeavor through the states at this time, the Regional Medical Programs (RMP), was aimed at the delivery of services for heart disease, cancer, and stroke (and related diseases). It attempted to connect practicing physicians to medical schools and major medical centers so physicians could benefit from the latest knowledge concerning these diseases and refer their patients more rapidly. Saving money was not the primary concern, integrating physicians' services was. Both CHP and RMP failed in terms of the nonexistent performance standards implicit, but certainly not explicit, in the legislation. In the meantime, expenditures increased apace; the internal and external dynamics of this tremendous growth enterprise were indeed awesome. Two prestigious government commissions were formed, one on so-called hospital effectiveness (1968) and one on Medicaid and medical care for the poor (1970), the latter actually expanding its vague charge to consider the entire delivery structure and planning. The tone in both reports was confusion and frustration, as well it might be: the commissions were ambiguous about planning, although advocating it, and distressed by the prospect of further government intervention, although helpless to suggest anything else. The Medicaid report did begin to refer to competition among delivery systems as a means of containing rising expenditures.

More specific attempts at containing expenditures, however, were made in the Medicare Act; these also applied to Medicaid. The Medicare Act mandated reviews of physicians' decisions regarding length of stay in hospitals—that is, direct monitoring of professional decision making. From the profession's viewpoint this was a radical step.

On the state level, legislatures began to pass laws calling for certificates of need for hospital beds. The building of new hospitals and the expansion or renovation of old hospitals had to be approved by a state planning agency, a control on supply. State legislatures also began to regulate hospital rate setting, a control on price.

As a result of its 1965 mandate, Congress passed a law in 1972 requiring utilization review of hospital care (that is, physician decision

making) on an areawide basis by committees of physicians. These groups were called Professional Standards Review Organizations (PSROs). To cap all these developments, Congress passed the Health Planning Act, which mandated the creation of over 200 health planning areas; these were administered by health services agencies, whose boards of governors were made up primarily of consumers. Consumers were to be appointed on the basis of race, ethnic background, income, and geographic area. The health services agencies were to determine the appropriateness of hospital construction, distribution, and renovation and the acquisition policies of hospitals regarding expensive equipment such as CAT scanners. Further, the health services agencies were to work up masterplans of the health needs in their areas according to federal guidelines. Plans were then passed on to the appropriate state and federal agencies for review and consideration. Congress intended to place determination of needs and control over the construction of facilities on the local level. Local needs, as determined by health services agencies, would be communicated to upper levels of government, particularly the federal government, which could then negotiate on a long-term basis. Congress and perhaps even the bureaucracy are exceedingly chary of imposing a blueprint on the states and local areas, preferring instead to set up fairly loose guidelines for discussion in order to reach consensus. It was apparently Congress' intent to put a planning apparatus in place before the enactment of some form of national health insurance in order to have a handle on costs and to direct the development of personal health services. Certificates of need and rate control, although functions of the states, became part of the health services agencies' decisions and therefore a concern of the federal government, which can withhold payment from hospitals that do not comply. Even so, the current planning apparatus does not seem to have a firm place in national political policy and continues to exist on sufferance.

Americans look suspiciously at structures, boundaries, and budget caps. It is hoped that the monitoring of physician decision making will lead to a rational, justifiable volume and quality of services at reasonable costs within the planning framework briefly described here.

The latest concept being tried to contain escalating costs is the Health Maintenance Organization (HMO). Old as a concept but relatively new in terms of government support, HMOs embody several types of prepayment plans that attempt to monitor physician decision making, set a fixed premium for comprehensive services, and serve a known population. These plans have shown that they use hospital services less than the fee-for-service system and hence tend to cost less. Competition is thus being carried over to health services delivery, encouraging a choice of plans among employed groups in hopes of tempering the rise in health services costs.

In the meantime, despite PSROs, certificates of need, rate review, and planning, the personal health services economy is growing, expenditures continue to rise, and attempts to manage the system do not seem to have much effect as yet. Between 1965 and 1980, the percent of the GNP spent for all health services increased from 5.9 to 9, per capita expenditures increased from $198 to $865, and the trend is clearly up. The ultimate weapon, of course, is in the hands of the big buyers of services, who can refuse to provide more money. The pluralistic nature of funding, however, makes such a course difficult, even though the federal government is now the source of 40 percent of all expenditures for personal health services. Under the Reagan administration, Congress has been discussing retrenchments.

Some years ago I wrote a book on the private and public financing of personal health services, called *The Uneasy Equilibrium*. The uneasy equilibrium between private and public control and financing continues, but in a much more intense form. The government still does not own, nor does it want to own, the hospitals. It does not want to make physicians into salaried employees, nor would Congress enact such a plan in the foreseeable future. Thus the private sector, if it is politically astute, is playing on Congress' reluctance to set up a highly structured system. The private sector may well continue to be an effective balance to government intervention—a term implying that government is intervening in a normal situation—because the American people want choices, easy access, and the latest technology rather than low cost. To the public, the relationship of health services expenditures to the GNP is an abstraction that has no bearing on their daily lives.

Insurers Step Up Efforts to Reduce Use of Free-Choice Health Plans

YOUR MONEY MATTERS

By Rhonda L. Rundle
Staff Reporter of The Wall Street Journal

Insurance companies have been trying for some time to nudge American workers out of free-choice health plans. Now they are giving them a heavy shove.

Many insurers, including Cigna Corp., Metropolitan Life Insurance Co., and Prudential Insurance Co. of America, are stepping up pressure on companies to shed the traditional free-choice indemnity plans that reimburse employees for most of their medical costs while giving them total control over selecting a doctor.

The pressure is a little bit carrot, with a lot of stick. Insurers are shocking clients with rate increases of 25% or more for the free-choice plans, or in some cases refusing to renew the plans at any price. As a substitute, they are offering their own health maintenance organizations, which are more restrictive but less expensive than the free-choice programs. These plans are potentially more profitable for the insurers and are designed to combat inroads into their business by independent HMOs and other health-care groups.

For some employees the new opportunities to go with an HMO or other physician network may be welcome. But the new pressure may rankle some employees who like the flexibility of free choice plans, but now find them prohibitively expensive. HMOs allow patients to use only those doctors and hospitals the HMO has contracts with, usually at discounted rates, and operate in a way that tends to reduce referrals to specialists and to limit their fees.

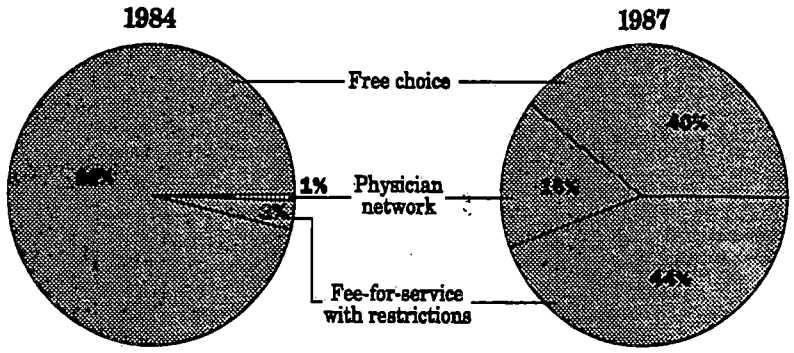
Impact of HMOs

These latest efforts will likely continue the trend away from free-choice plans, which fell to 44% of insurers' commercial business last year from 96% in 1984, according to a study to be published this summer in Health Affairs, a policy and research journal.

The impact on individual states has been even greater. For example, "in a matter of two or three years, the old free-choice indemnity plans won't exist anymore" in California, predicts F.X. McLellan, vice president in Aetna Life Insurance Co.'s Western headquarters in Walnut Creek, Calif. (California already has one of the highest HMO enrollment rates in the country.) Other states leading the way in the disappearance of free-choice plans are Arizona, Washington, Illinois and Florida.

And others states are likely to follow. They have no choice, insurers say: Free-choice plans have simply become too expensive to operate.

The Move Away From Free Choice



NOTE: Physician networks include programs such as health maintenance organizations; fee-for-service plans with restrictions include features such as advance review of hospital admissions; and in free choice plans, employees have total control over the selection of a doctor.

Source: Health Insurance Association of America

For one thing, insurers say that younger workers are more easily lured to independent HMOs because they are less likely than older employees to have formed close physician relationships. But that means that the HMOs are siphoning off companies' youngest, healthiest workers, leaving the free-choice plans with relatively older, sicker employees.

Moreover, as doctors and hospitals increase the number of patients they treat at a discount—namely those enrolled in HMOs—subsequent fee increases fall heavily on the patients in the free-choice plans, who aren't shielded from rising prices.

"The (free-choice) indemnity plan is the most likely candidate" to bear the brunt of such a discounting policy, says Jim Zishka, benefits manager for St. Louis-based Southwestern Bell Telephone Co., a unit of Southwestern Bell Corp.

That, in turn, becomes a vicious circle: As costs for the free-choice plan rise, more employees switch to HMOs, which accelerates the free-choice plan's decline. "Any time the (HMO) plan gets 40% or more, the death spiral for the indemnity plan has set in," says Mr. McLellan of Aetna.

That's what happened at a former Aetna customer, Dataproducts Corp. of Woodland Hills, Calif. As more and more of the company's roughly 2,000 employees joined outside HMOs in recent years, the number of workers in Aetna's free-choice program dwindled. Based in part on its claim to be covering Dataproducts' costliest users of health care, Aetna demanded "significant double-digit" annual rate increases. The computer-equipment maker passed part of the higher costs on to employees, which in turn pushed more of them into HMOs.

After the company's HMO participation hit 60% last year, Aetna refused to renew Dataproducts' free-choice plan at any price, saying that there were so few employees in the plan that one expensive operation would wipe out any potential profits, says Dataproducts' Treasurer Cliff Bickell. The company then dropped its two HMOs and enrolled its workers in Prudential's physician network. Aetna, which does operate some physician networks, doesn't have one near Dataproducts.

Fostering Employee Use

One of the largest companies to adopt an insurer-run physician network so far is Allied-Signal Inc., which recently announced that it was shifting its national work force of 67,000 into a more-restrictive health-care plan run by Cigna. Previously, the Morristown, N.J.-based technology company offered a variety of HMOs and free-choice indemnity plans.

Under the new program, Allied-Signal's employees can select from a network of physicians controlled by Cigna and pay a flat $10 a visit; all hospital costs are paid. Or employees can continue to choose their own doctor and pay more—a lot more. For example, a married employee with children who earns $50,000 a year would pay 3% of his salary, or $1,500 of medical bills, before any insurance kicks in.

"We decided that (the program) is more cost effective and wanted to encourage people to use it," says Joseph Duva, Allied-Signal's employee-benefits director.

Allied-Signal embraced the plan. Last year, the company saw its health-care bill jump 39% to $355 million. "We estimated that costs would reach $614 million by 1990 if we did nothing," Mr. Duva says. "We had to make a complete change."

INTERGOVERNMENTAL HEALTH POLICY PROJECT

FOCUS ON ...

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The Risk Pool Strategy: Comprehensive Health Insurance Associations

EDITOR'S NOTE: This issue of Focus On... examines the track record of comprehensive health insurance associations, or risk pools. Now the law in 15 states, risk pools are designed primarily as a way of helping a small subset of the uninsured population: those people who can afford to buy insurance but are unable to do so because a previous medical condition makes them a "bad risk." The report looks at the basic design of risk pools as well as their benefits structure, eligibilty standards, participants, enrollment growth and costs. It also assesses the successes and shortcomings -- and the unintended side effects -- of risk pools since they first emerged more than a decade ago. The author is Susan S. Laudicina, who is a consultant to IHPP. Research for the paper was done under contract with the Health Industry Manufacturers Association.

Introduction

During the late 1970s, the number of uninsured Americans consistently averaged 25 to 26 million annually, or approximately 13 to 14 percent of the under-65 population.[1] Then, through the first half of the 1980s, the percentage of the population without health insurance crept gradually upward. According to data from the U.S. Bureau of the Census, some 35 million non-aged Americans (or 17 percent) had neither public or private health insurance in 1984.[2] Figures cited by the U.S. Department of Health and Human Services point to about 30 million uninsured individuals (or 15 percent) in 1986.[3]

Several factors have combined in the last eight years to worsen the problem of the uninsured, as well as to heighten its visibility. To begin, cutbacks in federal and state assistance programs since 1981 have resulted in eliminating some individuals from the Medicaid rolls. Unemployment has remained at higher levels in the 1980s (an average of 7.7 percent over the first seven years) than in the 1970s (an average of 6.2 percent over the decade), thus stripping many workers of group health insurance protection. In addition, although it no longer registers in double digits, inflation in health care continues to grow at two to three times the rate of the rest of the economy, pushing the cost of insurance premiums ever higher.

Finally, there has been a general change in the way health services are delivered and paid for. This includes a shift to prospective, or flat-rate, reimbursement under Medicare, more attention to the "prudent buyer" principle by private purchasers of health care, and the rise of competitive mechanisms such

as health maintenance organizations and preferred provider organizations. As one health analyst has observed: "The movement away from cost-based reimbursement and the introduction of more competition into health care has meant that the problems of the uninsured that were more or less masked before the 1980s can no longer remain hidden.... This means that as business and government continue to demand better value for their dollar, the uninsured can expect to find it increasingly difficult to gain access to the health care system."[4]

There is substantial agreement in the research literature about the characteristics of the uninsured:

- Approximately 50 percent are employed at least part of the year and many all year round; when their dependents are included, the employed uninsured account for about 75 percent of the uninsured population.
- About 35 percent are in families whose income is below the poverty line, while roughly the same number are in families whose income is up to twice the poverty line.
- Almost 90 percent of the uninsured with jobs work for employers who do not offer insurance.[5]

As the above profile demonstrates, most of the uninsured and their dependents are not destitute. Rather they are employed -- almost always by small businesses or in the agricultural sector, where health insurance is not automatically provided. In addition, one to perhaps two million of them are uninsured because they have a chronic medical condition or a medical history that makes them an uninsurable risk, according to traditional insurance underwriting standards.

The "Risk Pool" Strategy

Many people in poor health or who are considered to be at high risk of needing extensive health services have experienced difficulty obtaining or affording health insurance in the private market. In response to this problem, 15 states have enacted laws establishing comprehensive health insurance associations, known informally as "risk pools." These associations or pools offer to sell health insurance to people who are otherwise unable to purchase it and who might become medically indigent if they became seriously ill.

Risk pools are independent entities governed by a board and administered by an insurance carrier selected by the board. They build upon the existing health insurance system by relying upon private insurers, and protect any one insurer from bearing the risk alone.

In fact, the term "risk pool" as it is commonly used to define these comprehensive health associations for high-risk individuals is somewhat misleading. The pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all health insurance plans in the state. They do not "pool" health risks by allowing both standard and high-risk patients to be covered by the special policy. Rather, the pools (with one exception) only insure individuals whose medical risks are uniformly high.

Risk pools have become an increasingly popular means of insuring a small segment of the uninsured population. They are politically attractive to state lawmakers because they solve the predicament of residents who can afford to buy insurance but have been denied conventional private coverage because of their medical histories. Moreover, unlike other initiatives that could cost millions in direct state outlays, the pools offer an indirect and apparently limited initial government role.

The 15 risk pools enacted to date have enjoyed the support of a broad cross-section of organizations, including consumer groups, health advocacy groups, organized labor, the health insurance industry and health care providers. Although employers have not generally taken an active role in creating the pools, they have offered de facto support, as long as the enabling legislation does not require them to bear the cost of running the pool. In fact, in Illinois, where a pool has just been created and is to be funded from state general revenues, the local Chamber of Commerce and the local chapter of the National Federation of Independent Business have strongly endorsed the effort.

Table 1 shows the growth of risk pools, from the first two created in the mid-1970s to the 15 in existence today, in various stages of implementation. Risk pool bills were also introduced in 12 additional states last year and, at the federal level, legislation to encourage the creation of state risk pools is being developed.

TABLE 1. GROWTH OF STATE RISK POOLS

Operational	Under Implementation	Proposed in 1987
Connecticut	Illinois	Alaska
Florida	Iowa	California
Indiana	Maine	Georgia
Minnesota	Montana	Mississippi
Nebraska	New Mexico	Missouri
North Dakota	Oregon	New York
Wisconsin	Tennessee	Ohio
	Washington	South Carolina
		South Dakota
		Texas
		Vermont
		West Virginia

Basic Design

Though there are some important distinctions among the various risk pools, they are characterized more by their similarities than by their differences. Basically, the state forms an association, by mandating participation by all companies authorized to sell health insurance within its boundaries. Self-insured firms are exempt under the Employee Retirement Income Security Act (ERISA).

The association is governed by a board, typically dominated by representatives of the insurance industry, and develops a standard health insurance policy pursuant to guidelines established in the law regarding benefits, premiums, deductibles, coverage, etc. "All health insurance companies in the state are required to offer eligible customers a 'qualified plan,' namely, one that provides benefits at or above the levels of the association's plan. Alternatively, insurance companies may refer eligible companies to a statewide "lead carrier" that sells policies and administers under contract with the board. In practice, virtually all insurers refer to the central pool."[6]

Eligibility

All states with risk pools have eligibility requirements for individuals wishing to apply for pool coverage. Table 2 summarizes these criteria and profiles the existing pools' key administrative features.

TABLE 2. ADMINISTRATIVE FEATURES

State	Who's Eligible	Maximum Benefits	Number of Enrollees	Growth in Enrollment	Enrollee Profile[1]
Connecticut (1976)	- All residents ineligible for Medicare	$1 million	1984: 3,579 1985: 3,388 1986: 2,312	1984: NA 1985: -1% 1986: 132%	NA
Florida (1983)	- Residents ineligible for Medicaid plus - Rejected by two insurers - Received notice benefit reduction or - Premium increase exceeded pool rate	$500,000	1984: 382 1985: 818 1986: 1,058	1984: NA 1985: +114% 1986: +29%	534 M; 550 F from 0-19:135 20-29:130 30-39:150 40-49:217 50-59:297 60-64:144 65-74: 10 >75:1
Illinois (1987)	- Residents ineligible for Medicaid plus - Rejected by one insurer - Premium increase exceeded pool rate or - Certain conditions covered automatically - Also groups of 10 or less if one or more meet above criteria	$500,000	NA	NA	NA
Indiana (1982)	- Residents ineligible for Medicare plus - Rejected by two insurers - Received notice benefit reduction - Premium increase exceed pool rate or - Certain condiditions covered automatically	No limit	1984: 3,510 1985: 3,276 1986: 2,998	1984: NA 1985: -1% 1986: -1%	1,516 F 1,328 M from 0-19:303 20-29:255 30-39:287 40-49:378 50-59:731 60-64:856 65-74: 19 >75:15
Iowa (1987)	- Residents ineligible for Medicaid plus - Rejected by one insurer or - Premium exceeded pool rate	$250,000	NA	NA	NA

State	Who's Eligible	Maximum Benefits	Number of Enrollees	Growth in Enrollment	Enrollee Profile[1]
Maine (1987)	- Residents ineligible for Medicare or Medicaid plus - Premium exceeded pool rate	$500,000	NA	NA	NA
Minnesota (1976)	- Rejected by one insurer - Restrictive rider limits coverage or - Certain conditions covered automatically	$250,000	1984: 9,158 1985: 10,139 1986: 11,784	1984: NA 1985: +11% 1986: +16%	NA
Montana (1987)	- Rejected by two insurers or - Restrictive rider limits coverage	$250,000	NA	NA	NA
Nebraska (1986)	- Residents ineligible for Medicare or Medicaid plus - Rejected by one insurer - Restrictive rider limits coverage or - Premium exceeded pool rate	$500,000	1984: NA 1985: NA 1986: 67	NA	NA
New Mexico (1/1/88)	- Residents ineligible for Medicare or Medicaid plus - Rejected by one insurer - Restrictive rider limits coverage or - Premium exceeded pool rate	No limit	NA	NA	NA
North Dakota (1982)	- Rejected by one insurer or - Restrictive rider limits coverage	$250,000	1984: 615 1985: 1,017 1986: 1,279	1984: NA 1985: +65% 1986: +26%	from 0-17:103 18-39:339 40-54:265 55-64:299 >65:161

State	Who's Eligible	Maximum Benefits	Number of Enrollees	Growth in Enrollment	Enrollee Profile[1]
Oregon (4/1/88)	- Residents ineligible for Medicare or Medicaid plus - Rejected by one insurer - Premium exceeded pool rate or - Certain conditions covered automatically	NA	NA	NA	NA
Tennessee (1987)	- Residents ineligible for Medicaid plus - Rejected by one insurer	$500,000	NA	NA	NA
Washington (1987)	- Residents ineligible for Medicaid plus - Rejected by one insurer or - Restrictive rider limits coverage	$500,000	NA	NA	NA
Wisconsin (1981)	- Residents ineligible for for Medicaid - Received notice of benefit reduction or - Premium exceeded pool rate	$500,000 (as of 1/1/88)	1984: 1,918 1985: 1,919 1986: 2,075	1984: NA 1985: 0 1986: +8%	639 F; 462 M from 0-30:121 31-40:132 41-50:154 51-60:374 61-65:319 61% unemployed household income: <$12,000 - 40% >$12,000 <$25,000 - 42% >$25,000 - 18%

1 Data for Florida as of 2/28/87; Indiana, 4/30/87; North Dakota, 5/31/86; and Wisconsin, 9/30/86.

Source: Telephone survey of state insurance commissioners and lead carriers, May-July 1987.

Most states do not allow people who are eligible for Medicaid to apply for pool coverage, and a few also prohibit Medicare beneficiaries from participating. Several others, such as Florida and Wisconsin, offer a special Medicare supplement plan to encourage Title XVIII beneficiaries to join.

Anyone applying for pool coverage must be a state resident. In addition, they must meet at least one of the following requirements, which vary slightly from state to state:

- Have been rejected for standard coverage by at least one private insurance carrier (Florida, Indiana and Montana require two rejections);
- Have received a notice of benefit reduction;
- Have had a premium increase exceeding the rate for pool coverage;
- Have a restrictive rider on their policy which serves to limit coverage because of a pre-existing condition; or
- Suffer from certain chronic health conditions, e.g., cancer, which automatically qualifies them for pool coverage without satisfying other requirements (Illinois, Indiana, Minnesota, Oregon).

The Connecticut Health Reinsurance Association is an exception to this list. Connecticut's pool is unique in that it does not require that an individual first be rejected by a private carrier before applying for the pool. The only eligibility requirements are that an applicant be a resident of the state and be ineligible for Medicare. Therefore, in addition to individuals with high-risk medical conditions, the Connecticut pool also has many "good risks," e.g., people in-between jobs, students just graduated and not yet employed and individuals converting from group policies.

Specific eligibility criteria aside, concrete examples of how an individual becomes eligible for risk pool coverage may be helpful. In the first scenario, a man is enrolled in a group health insurance policy at his place of employment that does not cover a particular medical procedure or device that he requires. Is he eligible for the state pool? The answer is yes, if he drops the group policy and can demonstrate that he was rejected for an individual policy that contained the desired coverage. If the individual resides in a state that offers the same coverage as the group plan, he would not be accepted in the pool, nor would membership in it solve his problem. In the second scenario, a woman has an individual health insurance policy that contains a restrictive rider. (A "restrictive rider" is an exclusion which applies to a particular person for a medical condition disclosed on the initial insurance application. If the same condition develops later, the rider cannot be applied after the fact.) Is she eligible for the state pool? Yes, if she can show that the restrictive rider in her existing policy prevents her from getting medically necessary treatment.

Covered Benefits

Most of the enabling legislation has specified minimum benefits that risk pools must provide. Coverage is comprehensive, major medical-style coverage and typically includes the following services:

- inpatient hospital
- physician
- prescription drugs
- diagnostic X-rays and laboratory tests
- oxygen/anesthetics
- skilled nursing facility care
- home health care

- limited mental health care
- durable medical equipment (other than eyeglasses/hearing aids)
- physical therapy.

The maximum lifetime benefit per covered person for eligible servi ranges from $250,000 to $1 million. Indiana and New Mexico place no limit the value of pool benefits that may be received.

Nearly all of the pools exclude coverage for a pre-existing condition f which medical advice or treatment was recommended or received within specified period of time (generally six months) before the effective date enrollment. In Connecticut and Montana, the waiting period is 12 months. few of the pools allow the waiting period to be waived if the individual h recently satisfied the pre-existing condition exclusion under previous insuran coverage. The rationale behind the waiting periods is the same as it is f private policies: to guard against adverse selection, whereby an individual wh anticipates needing medical treatment joins just before the treatment is begu

Pool Participation

As Table 2 illustrates, the seven risk pools that are fully operational hav collectively experienced a steady, moderate growth in total enrollment over th last three years. As of the end of 1986, total pool enrollment reached 21,573 an increase of 5 percent over 1985 which, in turn, was an increase of percent over the 1984 level.

The largest risk pool by far is the Minnesota Comprehensive Health Asso ciation with 11,784 enrollees as of December 31, 1986 -- just over half of th total nationally. Each of the remaining active pools had 1986 enrollments equal to less than a third of Minnesota's. Taken individually, state health risk pools have been growing at an uneven rate. Since 1984, pools in Florida and North Dakota have been growing very rapidly, while those in Minnesota and Wisconsin have had more modest increases. In Connecticut and Indiana, enrollment has stabilized or begun to drop.

In a few states, it is possible to point to specific factors that probably contributed to the change in enrollment. In Florida, for instance, enrollment has climbed since January 1, 1987, when the waiting period for pre-existing conditions was reduced from 12 to 6 months and after the state waged a public media campaign. In Indiana, pool participation has been declining at a rate of 1 percent over the last two and one-half years. An official of the Mutual of Omaha Insurance Company, which administers the pool for the state, attributes the decline in enrollment to the large premium increases imposed each year since 1984. Similarly, a recent sharp decline in Connecticut's enrollment is probably linked to higher cost-sharing requirements. State insurance officials and representatives of lead insurance carriers in other states could not point to specific factors operating to increase or decrease the number of enrollees.

Enrollee Profile

Only three states (Florida, Indiana and North Dakota) are able to provide even limited demographic information on pool enrollees, while a fourth (Wisconsin) has very detailed information (see Table 2).

According to the data supplied by the four state respondents, females constitute a majority (54 percent) of pool enrollees. Not surprisingly, pools also favor older individuals who would be more likely to have chronic medical conditions. Only 32 percent of participants were under age 40. Participation

tends to increase with age, although the figures do not present evidence of an uninterrupted climb from age bracket to age bracket. People in their 50s and early 60s constitute the single most frequently occurring age group.

In July 1986, the Board of Governors of the Wisconsin Health Insurance Risk-Sharing Plan authorized a survey to gather demographic data about their policyholders. The 1,101 replies formed the basis for the following findings:

- Most participants are married (63%);
- Total household income is less than $12,000 annually for 40% of the sample; another 42% have total incomes between $12,000 - $25,000; and 18% are above $25,000;
- Only 39% of the sample was employed; the primary reasons for being unemployed were disability (42%) and duties as housewife (30%);
- The primary health conditions that prevented respondents from obtaining standard health insurance coverage were: heart condition (22%), diabetes (14%), high blood pressure (11%) and cancer (9%);
- 27% have been enrolled less than one year, 28% from one to two years, and 45% for more than two years;
- Although there appears to be a small, stable base of long-time subscribers, there has been a great deal of fluctuation in the system, with a high rate of turnover; and
- Previous survey results indicate that the majority of individuals who left the pool did so because they could no longer afford the premiums and/or deductibles.[7]

A word of caution is in order before making an attempt to generalize the Wisconsin findings to pool enrollees nationwide. First, the survey sample represents only about 5 percent of total pool enrollment in 1986 and thus may not present a representative profile. Also, since 40 percent of the respondents to the survey received a premium subsidy unique to that state's pool, the findings regarding income of participants are probably not universal.

Cost of Insurance

Premium rates for pool coverage are capped by state law and range from 125 percent to 400 percent of the average premium rates for individual standard risks in the state for comparable coverage. In all but two states, however, the actual premium caps in effect are 150 percent or less. Only Connecticut bases premiums on the average group premium rate offered by other insurers. Were they not limited by law, risk pool premiums would almost certainly rise to higher levels, perhaps three or four times as great as individual standard policies. Even capped at 150 percent, pools are expensive, as might be expected for comprehensive insurance designed to cover high users of medical services.

In addition to the premium, participants must meet high deductibles. The pools generally offer a choice of deductibles ranging from $200 to $2,000 per person (see Table 3). The higher the deductible, the lower the premium. A co-insurance rate of 20 percent of covered expenses in excess of the deductible is also required, although in a few states the co-insurance rate is set at 10 percent.

The maximum out of pocket payment is between $1,000 to $5,000 per individual ($2,000 to $7,000 for a family), depending on which deductible plan is chosen. Clearly, risk pools are designed for only those high-risk individuals who can afford to incur significant medical bills before coverage under the pool kicks in.

TABLE 3. FINANCING FEATURES

State	Premium Cap [1]	Deductibles[2]	Cost-Sharing Limits	Pool Funding	Pool Losses[3]	Growth in Losses
Connecticut (1976)	125%-150%	$ 400 $1,000 $1,500	$2,000/ind. $4,000/fam.	insurers assessed-no tax credit	1984: -$1,296,756 1985: -$1,570,078 1986: -$ 917,048	1984: NA 1985: +21% 1986: -42%
Florida (1983)	200%	$1,000 $1,500 $2,000	$2,500-3,500/ind. $5,000-7,000/fam. 100%	insurers assessed-tax credit offsets 100%	1984: -$316,285 1985: -$464,707 1986: -$100,913	1984: NA 1985: +47% 1986: -78%
Illinois (1987)	135%	$ 250/ind. $ 500 $1,000 $ 500/fam. $1,000 $1,500	$1,500/ind. $3,000/fam. $ 500 Medicare beneficiary	general revenues	NA	NA
Indiana (1982)	150%	$ 200 $ 500 $1,000	$1,000-2,000/ind. $2,000-4,000/fam.	insurers assessed-tax credit offsets 100%	1984: -$ 743,158 1985: -$2,267,140 1986: -$5,127,762	1984: NA 1985: +205% 1986: +126%
Iowa (1987)	150%	$ 500 $1,000	$1,500-2,000/ind. $3,000-4,000/fam.	insurers assessed-tax credit offsets 100%	NA	NA
Maine (1987)	150%	$500-$1,000	$1,500/ind. $3,000/fam.	new tax on hospital gross patient services revenue	NA	NA
Minnesota (1976)	125%	$ 500 $1,000	$3,000/ind.	insurers assessed-no tax credit	1984: -$4,013,106 1985: -$4,817,068 1986: -$9,046,311	1984: NA 1985: +20% 1986: +88%
Montana (1987)	150-400%	$1,000 maximum	$5,000/ind.	insurers assessed-tax credit offsets 100%	NA	NA

State	Premium Cap [1]	Deductibles[2]	Cost-Sharing Limits	Pool Funding	Pool Losses[3]	Growth in Losses
Nebraska (1986)	135-165%	$ 250 $ 500 $1,000	$5,000/ind.	insurers assessed-tax credit offsets 100%	NA	NA
New Mexico (1/1/88)	150%	$ 500 $1,000	$1,500-2,000/ind. $2,500-3,000/fam.	insurers assessed-partial tax credit offset	NA	NA
North Dakota (1982)	135%	$ 150 $ 500 $1,000	$3,000/ind.	insurers assessed-tax credit offsets 100%	1984: -$ 638,724 1985: -$ 867,045 1986: -$1,650,470	1984: NA 1985: +36% 1986: +90%
Oregon (4/1/88)	150%	NA	NA	NA	NA	NA
Tennessee (1987)	135%	$ 500 $2,000	$1,500-2,500/ind. $2,500-3,500/fam.	insurers assessed-tax credit offsets 100%	NA	NA
Washington (1987)	150%	$ 500 $1,000	$1,500-2,500/ind. $3,000-5,000/fam. $1,000 Medicare beneficiary	insurers assessed-tax credit offsets 100%	NA	NA
Wisconsin (1981)	150%	$1,000	$2,000/ind. $4,000/family $ 500 Medicare beneficiary	insurers assessed-no tax credit (eff. 1/1/88 $200,000 in tax relief from general revenues)	1984: -$1,220,946 1985: -$ 875,552 1986: -$ 764,301	1984: 1985: -28% 1986: -13%

1 These percentages represent the maximum allowable levels state health risk pool premiums may reach in relation to the average premium rates for individual standard health risks in the state for comparable coverage.

2 In addition, a coinsurance is required (generally at a level of 20%).

3 Net pool losses are defined as the difference between premium income and claims paid, plus administrative expenses.

Source: Telephone survey of state insurance commissioners and lead carriers, May - July 1987.

Thus, while existing pools guarantee the availability of coverage, none attempts to address fully the issue of affordability. Only Wisconsin extends a measure of relief to low-income policyholders or potential applicants. A fund was set up effective July 1, 1985 to help low income policyholders pay their premiums. Eligibility for a premium reduction is based on an income level below $16,500. A sliding scale of percentage reductions ranges from 6 to 30 percent; effective January 1, 1988, this formula will be made more generous, from 17 to 33 percent. In the first year the premium subsidy was in effect, 603 individuals, or roughly a third of pool enrollees, applied and were found eligible.[8] Wisconsin has also created a deductible subsidy based on a sliding scale, to take effect next year. (The pool in Maine, which was implemented in October 1987, will also provide a premium subsidy.)

Paying for the Pool

Although premium rates have been set high, they have tended to be insufficient to cover claims expenses. As a result, all existing risk pools operate at a loss. In order to cover the losses, all of the pools except two assess member carriers in proportion to their share of the state insurance market. The laws allow abatement of the assessment if paying it would endanger the ability of member firms to meet their contractual obligations. In addition, because of ERISA, self-insurers are not required to joing the pool and therefore are not assessed any of the cost.

The Illinois Comprehensive Health Insurance Plan has a different method for recouping deficits. Any future costs will be paid out of state general revenues, not through an assessment of member insurance companies. The Illinois pool, which took effect on July 1, 1987, must make coverage available to residents no later than January 1, 1988. In Maine, the new pool is scheduled to be financed by a tax on hospitals' gross patient services revenue. (In Oregon, the method of funding future pool deficits has not yet been determined.)

The fact that 12 out of 15 risk states assess member insurers to cover losses gives an incomplete picture of how the pools are actually financed, however. Nine of the 12 have made pool deficits a public burden by granting insurers a dollar-for-dollar tax credit to offset the assessment. This credit is usually applied against the state's tax on health insurance premiums sold although in a few cases, insurers can instead offset pool liabilities against the state's corporate income tax.

Only Connecticut, Maine, Minnesota and Wisconsin fail to provide a tax subsidy to participating insurers. Of these, Minnesota only recently ended its long-standing tax credit, effective January 1, 1987; Wisconsin will use general revenues to pay a portion of its pool's assessment beginning January 1988.

Turning to the precise nature of operating losses, Table 3 illustrates the dollar difference between premium income and claims paid, plus administrative expenses, for each state from 1984 to 1986. In three states (Indiana, Minnesota and North Dakota), pool losses have been growing at a significant rate over the last three years. In contrast, losses in three others (Connecticut, Florida and Wisconsin) have begun to decline or, at the very least, to stabilize.

In summary, risk pools are not self-financing. They remain afloat financially in large measure because of hidden state tax subsidies. The relative magnitude and importance of the deficits is examined in detail in a following section.

How Successful Are the Pools?

In assessing the degree of effectiveness that state health risk pools have enjoyed, three factors come into play:

(1) the longevity of the pools and their popularity;
(2) the growth in enrollment, both in absolute and relative terms; and
(3) the degree of financial health.

In terms of the first criterion, it is safe to say that the risk pool concept has met the test. Not only have all of the pools in operation over the past ten years remained in business, their number will more than double in 1987 and 1988, when eight new ones come on line.

Measuring success by enrollment is somewhat difficult. On one hand, total enrollment has grown at a steady pace year in and year out and should top 23,000 by the end of 1987. In most instances, however, actual pool growth falls significantly short of the target populations.

On a microeconomic level, several states initially estimated the size of the under-65 population that was unable to purchase adequate health insurance because of medical conditions and would therefore be eligible to join the pool. For instance, in Wisconsin, officials estimated that an enrollment of 3,000-5,000 individuals would not be unrealistic. In point of fact, some 2,112 residents were enrolled as of April of this year, making the projections appear to be feasible. Similarly, officials in Nebraska anticipated that 100-200 people would join during their pool's first year of operation; after six months in business, there are 234 enrollees. On the other hand, North Dakota estimated that its pool would serve 5,000 individuals but after five years, enrollment has only reached roughly 30 percent of the target.

On a macroeconomic level, although there are no solid figures upon which everyone agrees, some experts have estimated that one to two million non-elderly individuals are considered to be medically uninsurable and could afford to join a risk pool.[9] This figure roughly corresponds to the frequently cited target of 1 percent of the under 65 population as "uninsurable." According to an analyst who has calculated the size of the 1 percent target group in selected states, Wisconsin would need to enroll 42,000 people in order to reach its potential.[10]

Several factors could affect the ability of these estimates to predict actual pool enrollment: benefit levels, the length of the waiting period for pre-existing conditions, the nature of the eligibility criteria, premium rates and cost-sharing requirements, and marketing/education efforts, to name a few. The simple fact is that: "Data identifying individuals with chronic medical conditions by income levels do not exist, so it is difficult to know whether those with chronic medical conditions could afford the coverage."[11]

Attempts to measure the success of risk pools on the basis of their financial health produce mixed results. It is true that in spite of rapid premium increases, all of the pools have lost money (see Table 3). The largest deficits in absolute terms are in Indiana (losses of $5.1 million in 1986) and Minnesota (losses of $9 million in 1986). But these sums should be put in perspective before any conclusions are drawn about the overall soundness of the pools.

The Health Insurance Association of America (HIAA) has testified that: "[Risk pools] do not represent a great financial burden on any one insurer if

financed by adequate premiums and if the losses are spread equitably over the entire insured population. For example, in 1985 the losses of the Minnesota state pool were approximately $5 million. If spread over all insured lives under age 65 in Minnesota, including all protected employees and their dependents, losses would be approximately $1.40 per person per year."[12]

Similarly, in congressional testimony, Communicating for Agriculture Inc., a risk pool advocacy group, deemphasized the importance of the deficits, stating that: "When one takes a close look at the total health and accident insurance premiums collected from all carriers in a given year in a state, you will find the total cost to operate a pool is somewhere around 1 percent of this figure. [We believe] this is a small price to pay to allow every citizen the right to purchase health insurance coverage."[13]

Another way to view the relative impact of operating deficits is to state the loss as a percentage of total pool expenses. If this is done, the 1986 deficit in Indiana equals 43 percent of expenses, while in Wisconsin it equals 24 percent. Also, deficits measured on a per policyholder basis result in losses of $1,710 per capita in Indiana, dropping to $768 in Minnesota and $368 in Wisconsin.

History has shown that state health risk pools have consistently experienced deficits and have had to assess their members to cover losses. The only exceptions have been Connecticut in the early stages of its pool and Florida, where losses have been minimal and covered by cash reserves. While serious, the mere existence of a deficit has not diminished any state's ability to attract enrollees, pay claims or maintain the support of the government.

Is it inevitable that risk pools will run losses? It may be. As the HIAA concludes, "The risk pools set a ceiling on the premiums charged which, when combined with the health status of the persons in the pool, can generally be expected to produce pool losses."[14] Another organization reached a somewhat different conclusion: "... while the cost to operate a state health pool will continue to rise throughout the first five or ten years, the cost (in real dollars) should eventually stabilize."[15] If the latter opinion is correct, that fact, coupled with the potential redesign of the pools as discussed below, could conceivably eliminate losses or reduce them considerably.

Pool Shortcomings

Basically, there are four factors, structural and legal, that limit the ability of state risk pools to provide access to health insurance for all of the uninsured:

1. Cost remains the biggest barrier. Last year, the annual premium ranged from $362 in Indiana for applicants under 19, to $7,650 in Florida for applicants 75 and over. Since then, only Wisconsin has lowered its premiums: the Board of Governors reduced rates by 10 percent for 1987.

The empirical information that exists on the relationship between the size of premiums and deductibles and the affordability of risk pools is limited but persuasive. Fifty-nine percent of respondents to the Wisconsin survey reported extreme dissatisfaction with premium costs; an even higher percentage (72 percent) felt that the deductible was too high.[16] Anecdotal information from Indiana, where pool premiums have been increasing at a more rapid rate than elsewhere, indicates that the rising cost of the pool has caused enrollment to decline consistently for the past two and one-half years.

Risk pools were not designed as a welfare program for the poor. Rather, the Medicaid program has generally been considered to be a better vehicle for meeting the health care needs of the poor. But with two-thirds of the uninsured in this country living in families with annual incomes of less than $20,350,[17] it is legitimate to question whether pool coverage costing one and one-half to two times standard individual rates can accomplish this goal. .

2. The second limiting factor is the ERISA preemption. Efforts to mandate participation by self-insurers in order to spread costs across a wider base have thus far failed. Legal challenges by self-insurers in three states (Connecticut, Minnesota and Wisconsin) have affirmed their position that ERISA exempts them from state insurance regulation and, therefore, from participation in risk pools. The net result of the preemption is that the costs of participating in risk pools fall to a significant degree on commercial insurers, who currently constitute about only 60 percent of the market.

As a result, insurers contend that they bear a disproportionate share of the load. The National Blue Cross and Blue Shield Association has testified that this inability to reach self-funded benefit plans and, in so doing, achieve more broad-based financing has been a primary consideration in a number of states that have not established risk pools.[18] (Legislation to remedy the immunity that self-insurers currently enjoy has been introduced Congress and is likely to be reintroduced this year.)

3. Another factor that has (or will have) an impact on pool balance sheets is the general absence of comprehensive cost containment techniques. "Starting these pools at the high end of health risk probably makes them infeasible as a vehicle for reaching other, less needy individuals who also lack insurance, at least long as the pools operate like conventional insurance and do not directly manage medical spending through controls on providers or other methods."[19]

Interviews with state insurance officials and/or executives from the lead carriers in each pool state reveal that few of the 15 pools have integrated even limited cost controls into ongoing administrative practices. "Cost controls" are defined as formal activities related to the control of health services costs through efforts such as improved efficiency, utilization review, or claims review. They include such specific techniques as Hospital Confinement Preauthorization; Hospital Preadmission Testing; and Mandatory Second Surgical Opinion.

The six states with partial cost containment (Indiana, Iowa, Minnesota, Montana, North Dakota and Wisconsin) generally require enrollees to have received preadmission certification for inpatient hospital care; administer concurrent review to determine whether medical services are still necessary; and require that a second surgical opinion be obtained. None of the mature pools have sought explicit authority to use such proven cost saving approaches as negotiated price discounts with individual providers or case management of an enrollee's care. Although pool managers in two states expressed doubt that these two particular options would be viable for their relatively small, scattered pool populations, there is no doubt that considerable room remains to improve each pool's performance in this area.

4. Finally, the policies offered by the pools have not been heavily marketed. Administrators in five of the seven states with mature pools say they have not aggressively marketed their policies (e.g., TV/radio spots, brochures in drivers' license renewals). By and large, promotional efforts have been based on the fact that every insurance company in the state is required

to notify anyone rejected for standard health coverage about the existence of the pool and assist them in applying. There is a small referral fee, ranging from $25-$75, for each enrollee signed up by a licensed insurance agent.

Curiously, examination of Table 2 reveals that the two states with self-defined "aggressive" marketing campaigns (North Dakota and Wisconsin) did not experience the fastest rates of growth last year. Although their membership increased, the pools in Florida and Minnesota grew faster. While better marketing may not be sufficient in and of itself to significantly increase pool membership in the face of the three shortcomings enumerated above, it should help to the degree that more people need access to such information.

Initiatives

In a recent survey, administrators of three of the seven fully operational risk pools indicated that they were in the process of or soon would be proposing significant policy initiatives to address perceived shortcomings. Both Connecticut and Indiana are considering taking stronger measures to contain costs. In particular, Indiana, out of concern for rapidly rising premiums and deficits and simultaneously falling enrollment, is looking to strengthen its existing utilization review program and to redesign benefits that may be too liberal.

Wisconsin proposed numerous revisions to its pool structure during the 1987 legislative session with the following results: (1) Eligibility criteria were revised, lowering from two to one the number of rejections required; (2) The lifetime benefit was increased from $250,000 to $500,000; (3) Cost controls were introduced; (4) Pool funding was revised to allow partial financing of deficits by general revenues; and (5) Amendments to liberalize the premium subsidy and institute a new deductible subsidy were adopted.

At present, there do not appear to be any discernible trends in risk pool management. Of the pools being implemented, only Maine provides funds to underwrite premiums for low-income residents. In California, a proposed risk pool bill has a contingency provision, stating that the measure will not take effect until Congress amends ERISA to change the tax status of self-insured firms.

Residual Effects of Risk Pools

Any analysis of the risk pool experience in this country would be incomplete without an appraisal of the residual or unintended consequences of risk pool policies. Accordingly, this section will examine the effects of pool operations on employer costs and staffing levels; on state Medicaid costs; and on health care provider costs.

1. Employer Costs/Staffing

At the national level, business organizations generally have not opposed the risk pool concept, except when losses would be financed by a tax on employers.

On June 26, 1986, the U.S. Senate Committee on Governmental Affairs held a hearing to receive testimony on the proposed "Access to Health Care Act of 1986" (S 2402, S 2403). Under the proposal, all states would have been required to form insurance pools for those who are not covered by job-based insurance and are unable to secure coverage for other reasons. Both group insured and self-insured employers who do not participate in the pools would

be subject to a 10 percent civil penalty levied on the amount that they spend on health insurance.

The National Association of Manufacturers testified in part that it could not support the legislation because: "The threat of a 10 percent penalty may cause employers to have lesser resources available for payment of basic wages, or might even force them to reduce the level of health benefits they do provide. Finally, since employers would have to pay for costs not covered by premiums -- and costs are likely to be enormously high -- the expense to the employer community will be great. It would be a further disincentive for employers to offer health insurance benefits."[20]

Also testifying at the hearing were the Chamber of Commerce of the United States and the National Federation of Independent Business. Both of these organizations declined to take a formal position on the proposed legislation. Again, they raised concerns that requiring employers who do offer insurance to finance any shortfall in the pools would be a disincentive to offer insurance.[21]

Currently, no existing risk pool is financed by a tax on employers, and none of the proposed pools would require one. Interviews with administrators disclosed that officials in three pool states believe that the existence of the pools has saved employers money and/or improved an individual's employment prospects; in three other states, officials believe that the pools have raised employer costs. The other administrators either had no opinion on the issue or felt their pools were too new to provide adequate information.

Officials in Wisconsin and Indiana said that many small businesses have had their costs lowered because they can shift a medically uninsurable employee in the state pool, thereby freeing them to obtain standard group health insurance for the rest of their employees. This option is potentially available to all employers who contribute towards an employee's pool premium expense. Wisconsin's survey discovered that 15 percent of pool enrollees had such a relationship with their employers.[22]

As to the impact of risk pools on employment, it can be argued that they help high-risk individuals find and hold jobs because they are no longer uninsured liabilities. At the very least, it seems reasonable to conclude that the existence of risk pools does nothing to hurt an individual's employment prospects because, with one exception, none of the pools mandate an employer responsibility to contribute. The exception is New Mexico, where employers are only required to contribute the same dollar amount to an employee's pool policy costs as they would for other employees with standard coverage.

Officials in Iowa and North Dakota, on the other hand, assert that risk pools have indirectly increased costs to some employers because their states have instituted a premium tax on all or some insurers to help pay for pool losses. They feel that the new premium tax could be expected to be passed on to an insurer's standard group health insurance line of business.

In the case of Minnesota, the state recently ended its ten-year policy of providing premium tax credits to insurers to offset the cost of their assessment for pool deficits. With the termination of the public subsidy, insurers such as Blue Cross must absorb all pool losses and will probably raise their premium rates to non-pool subscribers.

A countervailing argument can be made, however, that risk pools help keep health insurance premiums in the state at a more reasonable level. The

logic here is that the pools assure hospitals and other providers that the costs of treating pool enrollees will be reimbursed. If this is the case, then the bad debt/charity care incurred by providers should be lowered, with a concomitant decrease in the need to shift costs to patients who have purchased private insurance coverage.

2. State Medicaid Costs

There is no empirical evidence on which to assess whether risk pools increase or decrease state Medicaid expenditures. None of the 13 states has ever conducted a study of the fiscal relationship between their Medicaid and risk pool programs. Nine states expressly forbid residents who are eligible for Medicaid from enrolling in the pool.

An intuitive argument can be made that residents of states with risk pools would theoretically be spared the expense of "spending down" or depleting their resources to the point where they became eligible under the "medically needy" category of Medicaid. There is a certain appeal to this line of reasoning, and a few state pool administrators voiced the opinion their pools probably do save Medicaid money in this fashion.

There is no way to verify the accuracy of this position, however. In fact, it could also be argued that the existence of risk pools is irrelevant to a Medicaid because the prospective participants are so different and would not tend to overlap. Pool enrollees are nearly all under age 65 and are sufficiently well-off financially to be able to afford premiums that are on average one and one-half times as expensive as the standard individual rate. Medicaid recipients, on the other hand, are either impoverished and, thus, categorically eligible, or are aged, blind or disabled and have met the spend down requirements.

The only thing that can be said with certainty is that should someone who is eligible for Medicaid succeed in joining a risk pool (as a few have in Minnesota), Medicaid costs would go up. This is because Medicaid would spend more on pool premiums for the individual than it would otherwise have spent under the program's stricter provider reimbursement limits.

3. Health Care Provider Costs

When asked whether risk pools have had any impact on the bad debt/charity care problem faced by hospitals and other providers, state officials similarly respond that they lack any data on which to judge. A few of them say, however, that the logical correlation of a relationship here is stronger than it is with the previous question concerning the potential impact on Medicaid. This is because individuals who could avail themselves of pool protection would no longer be forced into personal bankruptcy when they are faced with high medical bills.

As a Department of Health and Human Services study has concluded, some 65 to 75 percent of uncompensated care is associated with the problem of the uninsured. "This means that strategies directed toward the uninsured in the general population and bad debt recovery will reduce the uncompensated care problem substantially."[23]

Or, to frame the question in rhetorical terms: Who would have paid the approximately $45 million in total claims paid by the risk pools last year if they did not exist?

Conclusions

State risk pools have had moderate success in achieving what they were designed to do -- namely, making comprehensive health insurance available to a small segment of the uninsured population that is able to afford the cost of the premiums. However, they offer no assistance to uninsured individuals who cannot afford to enroll.

The pools enjoy broad-based support and appear to offer something for almost everyone, except for the poor. Individuals with unfavorable health histories or conditions are given the chance to buy comprehensive health insurance in the private market. State policymakers are able to satisfy a small sub-group of the population whom they see as deserving, without increasing state budget outlays. Insurers are able to pass along the worst insurance risks to the pools, and, for the most part, be absolved of any corporate tax liability for participating in the pool framework. Employers are able to insure high risk employees at no additional cost to themselves. Finally, hospitals and other health providers are probably relieved of at least some of their bad debt burden.

Risk pools will probably remain a small part of the solution to the general problem of the uninsured and underinsured. And in fact, a broad expansion of the concept may not be what is really needed. For the most part, states have declined to change the basic, limited nature of the pools, instead choosing to adopt a variety of strategies to respond to the increases in the uninsured population. For example, a majority of states now provide for the continuation of health insurance coverage and/or the right to convert to an individual insurance policy for workers who have been laid off.

Last year, ten legislatures also considered proposals to implement an entirely state-financed, state-administered health insurance program for indigent residents. The most popular approach to relieving medical indigency and improving access to health care, however, continues to be expansion of Medicaid eligibility.

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22. Galanter, op. cit.

23. HHS, op. cit., 60.

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Disability and Health Insurance in the United States

by

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Draft of a paper being prepared for the National Invitational Working Group Meeting, May 14-15, 1988, on public and private health insurance policies and practices affecting persons with disabilities sponsored by the National Institute on Disability and Rehabilitation Research (NIDRR).

Persons with disabilities due to chronic conditions are high utilizers of acute medical services. In the noninstitutionalized population, persons who have chronic conditions that prevent them from performing their major social roles have levels of utilization of hospital and physician services three to four times higher than persons with no activity limitations. Depending on the nature of the disability, persons with disabilities also have needs for continuing care of a nonacute nature. Such needs may include social services, home medical care, attendant care, and other services that are part of the long term care continuum.

However, both public and private health insurance in the United States provide coverage mainly for acute care services. Even so, there are basic imperfections in coverage for acute care services. Because private health insurance is financed largely as a benefit through employment, for many, loss of employment ultimately leads to loss of insurance coverage. Legislation enacted in 1986 (PL 99-272, Title X) may have moderated this problem by allowing most persons who were covered by group insurance and who leave employment to continue to pay for their insurance for up to 18 months at their former employer's group rates. Family members can also continue to pay for their coverage at groups rates in the case of separation from or the death of a worker.

The COBRA provision may help to fill some of the gap in insurance coverage for acute care of persons who can no longer work because of chronic conditions and who are not deemed eligible for federal SSDI or SSI Disability or State disability plans. However, the success of this policy depends on how affordable the group rate premiums are for persons with reduced income. 1984 data from SIPP (Griss, 1988) and the NHIS (Ries, 1987) show resoundingly that the reason that persons do not have health insurance coverage is because of its cost. Only a small share of private insurance is sold as individual policies primarily because of the high cost of premiums resulting from high

administrative costs and adverse selection.

The other source of health insurance is through public programs. Legislation extending Medicare coverage to workers with disabilities was undertaken to alleviate widespread lack of health insurance in this group. However, SSDI recipients are eligible for Medicare only after a two year waiting period elapses from the time they first began to receive cash benefits. Since there is a six month waiting period after the onset of disability before cash payments can be received, the effective waiting period after the onset of disability is two and one half years. As Lubitz and Pine (1986) indicate, many persons do not survive the waiting period. Prior to COBRA, about 35 percent of SSDI cash beneficiaries in the waiting period were without health insurance. [It may be possible to examine hi coverage using the NBS?].

In 1984, about 362 thousand new SSDI beneficiaries joined the roles, roughly 13.9 percent of the 2.6 million disabled workers enrolled (U.S. Social Security Administration, 1986). This means that a significant percentage--perhaps a quarter--of the 2.6 million workers with disabilities are awaiting Medicare coverage. What happens to these people is largely unknown, but some may be forced to spend their assets to cover high medical bills and ultimately end up impoverished and on Medicaid.

Another high risk group are persons unable to work but who are not eligible for SSDI or SSI. Rice and LaPlante (1988) estimate from the 1984 National Health Interview Survey and Social Security prgram data that of the 7.7 million persons in the United States who are unable to work, at least 3.3 million receive no benefits under SSDI or SSI and therefore are ineligible for Medicare and Medicaid.

From the 1984 Survey of Income and Program Participation (SIPP) it is estimated that 8

million persons are unable to work due to chronic conditions (U.S. Bureau of the Census, 1986). Griss (1988) takes a slightly different view of this data. He estimates that 10.3 million persons with work disability do not work. This figure presumably combines persons who are limited in the kind or amount of work they can do but are not working with those who are unable to work. Included in this population of about 2 million persons are those who desire to work but cannot find jobs.

Griss shows that about 41.5 percent (4.3 million persons) of persons with work disabilities who are not employed are covered by Medicare or Medicaid. About 20.5 percent (2.1 million persons) have no insurance coverage. The remainder (4.0 million) are covered by private insurance. It should be pointed out that those who feel they could be working but cannot find jobs would be expected to be ineligible for SSDI or SSI cash payments and would thus not receive Medicare or Medicaid. Thus, the percentage of the target population that is insured would be higher than 41.5 percent. Because they are not working, they are at greater risk of not being insured.

Of the 5 million persons with work disabilities who are not working but are insured privately, 2.0 million are covered in someone else's name. Thus, about 3 million persons with work disabilities who do not work manage to retain private coverage in their own name. (Calculated from tables 18 and 19 from Griss--I assumed that a negligible number of persons are covered by reason that a family member receives public insurance).

Data from the National Health Interview Survey for 1984 show approximately 30 million persons were not covered by private or public insurance (Ries, 1987). Less than one percent were elderly since Medicare enrollment is almost universal among the elderly. The uninsured thus make up 14.6 percent of the nonelderly population. The reasons for noncoverage among the nonelderly are diverse. In some cases, people are not covered by

deliberate choice. Such persons are willing to gamble that they will not need health care and are unwilling to purchase coverage. Employers do not always offer health insurance and the cost of individual policies can be prohibitive. But the major risk of not being covered is not being employed. Persons who are unemployed are most likely not to be covered (38.3 percent) followed by persons in poverty (34.4 percent). Unemployment and poverty are of course strongly linked. It is clear that COBRA will not eliminate the risk of noncoverage among the unemployed since many will not be able to afford to pay premiums and many of the unemployed will have worked for employers that do not offer insurance (service jobs in particular). The fact that 42.6 percent of the uninsured are employed indicates that workplace remains a fundamental barrier to access. Of persons who are outside the labor force, 16.8 percent are not covered. This population is more likely to be covered through public sources either because of poverty or impairment or both.

The NHIS data on health insurance coverage by health status reveal several interesting patterns. For any health indicator we look at--self-assessed health, activity limitation, annual number of bed days--as we look down the scales to worse health, the percent covered by private health insurance declines while the percent covered by public insurance increases. Higher rates of public coverage as health status diminishes is observed for both Medicare and Medicaid. The net result is a substitution--though not a perfect one--of public for private coverage. The major processes operating here are that as the severity of a chronic illness or impairment progresses, persons find it more and more difficult to remain in the workforce and remain covered or are more likely to have irregular work histories or to never have worked. Persons with severe conditions may be eligible for SSDI if they have worked sufficiently long enough to secure insured status and subsequently covered by Medicare. For others with irregular work histories due to chronic conditions, employment loss may in itself impoverish those with low assets and

render them eligible for public assistance--a process that can be accelerated by high medical expenditures. Last, young persons with severe chronic conditions are most likely to experience problems with access to insurance. Among persons aged 18-24 years who are in poor health, 70.4 percent (base is 119,000) are not covered by private insurance. When all sources of insurance are considered, 34.1 percent in the above group are not covered. Persons ages 18-24 in fair or poor health are actually the most likely to not be covered by any source. Thus, although public coverage substitutes for private, it does so imperfectly. In fact, among working age persons over 24, the percent not covered tends to increase with poorer health. However, when we look at health care utilization another pattern emerges: the percent noncovered is highest for those with no physician visits in the year (and to a lesser extent for those with no hospitalizations). This is also the case when we examine coverage by private insurance. It probably reflects the fact that some persons who are healthy and apparently not risk averse choose not to purchase health insurance coverage.

Data from the National Mediacl Care Expenditures Study (NMCES) conducted in 1977 also show that people with activity limitations were less likely to have private health insurance coverage and more likely to have been beneficiaries of public insurance programs (Berk, Cafferata, and Hagan, 1984). They were no more likely to be uninsured than the rest of the population. Also, though they paid the same amount for insurance premiums as persons without limitaions, they were slightly more likely to pay for them out of pocket (35.4 versus 29.1 percent). The NMCES data also showed that persons with limitations had higher rates of medical care utilization, drug presecriptions, and medical equipment purchases. Furthermore, expenditures for persons with activity limitations were more than twice as high on the above items than for persons with no limitation.

Mean expenditures for persons of all ages with activity limitation was $1,502 compared

to $435 for persons with no limitation. For hospital care, the mean expense was $2,998 for persons with limitation versus $1,386 for those with no limitation. Of persons under 65 years of age, 23.8 percent of those with limitations had one or more hospital admissions during the year versus 9.6 percent of those with no limitations. Unfortunately, the expenditure data were not reported by age or by degree of limitation. However, Griss provides expenditure breakdowns by degree of limitation among persosn aged 19-64 years from unpublished tabulations.

Griss (1988) has put together a substantial quantity of data from the existing national surevys. This data provides information on the extent of health insurance coverage for acute care between persons with and without disabilities. The data does not indicate that persons with disabilities are more likely to be uninsured than persons with no disabilities. As Griss indicates, however, there is not much data available on the adequacy of acute care coverage or on long term care. I will add that of all persons who need the help of another person in ADL, 40 percent are nonelderly. This population may need improved access to long term care services.

I will comment more on data from the national data bases that are currently unpublished and about research needs for the future. I can only apologize to the readers that more progress has not been made on this review, but I will take the opportunity to revise the paper before the working group convenes.

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Figure 1 Advertisement from Foreign Affairs, October 1946.

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