People with Disabilities: Access to Health Care and Related Benefits

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Having health care coverage, whether through private insurance or through public programs, is a major determinant in obtaining health care. Whether one has access to specific services often will depend on the source of one's coverage—generally an employer or a public program, such as Medicare or Medicaid. For people with existing medical, physical, or cognitive conditions who need ongoing, specialized, or medically related services, obtaining coverage is uncertain. They are less likely to be able to obtain private insurance and may not meet the specific rules for public programs. Even when obtained, the scope and depth of that coverage are likely to be restricted, with respect to a particular individual's health care needs.

The linkages between employment-based coverage and public programs often create negative incentives. Some people may be trapped in a job for fear of losing health care insurance. Others face real and perceived disincentives for leaving public programs and seeking employment, since having a job may mean losing needed coverage. This disincentive arises because the employer might not offer any health insurance or because the coverage is different. For example, private insurance is less likely to provide for chronic, long-term, or health-related needs.

Health care reform proposals, such as those debated by President Clinton and Congress in 1994, would have eliminated many, but not all, impediments in the labor market related to health coverage. For most people with disabilities, these changes would have meant considerable improvement. In the absence of comprehensive health care reform, the efforts of public and private payers to contain their health care expenditures will dominate the situation. Private insurers will con-
People with Disabilities continue to avoid those at higher risk of using services and will seek ways to reduce coverage.

This paper undertakes two tasks. First, it provides an overview of the health care needs of people with disabilities and outlines sources of and gaps in their health care coverage. Second, it addresses the challenges from resorting to incremental steps rather than comprehensive reform to close these gaps.

The Connection between Disability and Health Care

On average, people with disabilities tend to use more health care services than people without disabilities, but many of the health care needs of persons with disabilities are shared with the general population. Individuals with disabilities are not necessarily in poor health. An analysis of data from the National Health Interview Survey found that nearly half of all persons with a limitation in activity due to a chronic condition reported that they were in fair or poor health (Ries 1991, p.2). Nonetheless, even when in good to excellent health, people with disabilities reported more than twice as many physician contacts and more than five times as many hospital days as others in good health. The small portion (6.1 percent) of the population that reported limitations in activity and fair or poor health accounted for nearly 20 percent of all physician contacts and 41 percent of all hospital days in the United States.

Physical Impairments

Approximately 40.2 million individuals had a condition (not including mental or emotional disorders) that caused a physical limitation, a limitation in activities of daily living (ADLs), or a limitation in instrumental activities of daily living (IADLs), based on data from the 1991-92 Survey of Income and Program Participation (U.S. Chamber of Commerce 1993, p. 16). Less than half of all disabilities identified in the Survey of Income and Program Participation (SIPP), however, were classified as severe.
Generally, people with chronic conditions require physician and hospital care, as would others, but they also may need very specialized attention from providers or multidisciplinary teams. Health care utilization varies considerably, depending on the type and severity of the disabling condition. Persons with multiple conditions (e.g., mental illness and chronic physical health conditions) must have providers who understand these interactions. Some people may have a greater need for prescription drugs, long-term occupational, physical, or speech therapy, or home care services. Others may require assistance with activities of daily living (e.g., personal care such as bathing or eating), adaptive equipment, interpreter services, transportation, adapted clothing, or even institutional care. Additional needs may include help with instrumental activities of daily living (e.g., shopping or managing money) or employment. Families and caregivers may also need support groups, stress management, training and counseling, time off, or help in coordinating and managing services.

People with severe chronic illnesses or disabling conditions also are at risk for secondary health problems like pressure sores or nutritional problems (U.S. Department of Health and Human Services [HHS] 1991, p. 39). Limited physical activity or immobility can increase the risk of circulatory, respiratory, and musculoskeletal problems. In order to reduce the chance of secondary problems, people with disabilities may need special equipment, rehabilitation or habilitation (i.e., maintenance) therapies, including audiology, occupational therapy, physical therapy, psychosocial services, respiratory therapy, speech-language pathology services, cognitive, vision, and behavioral therapies, or therapeutic recreation (National Council on Disability 1994, p. 27). Thus, for persons with disabilities, prevention takes on a broader meaning.

Among people with disabilities, some may be economically disadvantaged, elderly, homeless, or severely mentally ill, and, therefore, may need other types of services. For example, they might need case management, care coordination, assistance with obtaining housing or disability benefits, supervision of daily activities, community living supports, transportation, or psychosocial rehabilitation (Schlesinger and Mechanic 1993, p.125). Others may need oversight because their disability makes them vulnerable to neglect or abuse.
The National Institute of Mental Health estimates that there are between 4 and 5 million adults with “serious mental illness” (not including substance abuse disorders or mental retardation) who are either living in institutions or in the community (Barker, et al. 1992, p. 1). Based on the 1989 National Health Interview Survey, approximately 1.4 million adults between the ages of 18 and 69 were unable to work or were limited in their work because of mental illness. Over 82 percent of these individuals had had this work limitation for a year or longer. Furthermore, approximately 48 percent of adults with severe mental illness indicated that they were in fair or poor health, compared to 12 percent for the adult household population overall.

Persons with severe mental illness have many health and health-related needs. The nature of this condition is such that it requires periodic, intensive use of services and varying levels of ongoing support. Persons with severe mental illness may require hospitalization, outpatient care, institutional care, prescription drugs, crisis intervention, care in group homes, or home-based services. At various times, they may also need assistance with daily activities, such as personal hygiene, self-care, learning, social transactions, and relationships. In fact, 36 percent of adults aged 18 to 69 with severe mental illness reported not having a work limitation. However, 58 percent of these adults had other limitations such as coping with day-to-day stress (53 percent); social functioning, i.e., forming and keeping friendships (27 percent); concentrating long enough to complete tasks (21 percent); or instrumental activities of daily living, i.e., managing money, household chores, shopping, or getting around outside the home (5 percent). In addition, family members may need assistance to enhance their coping skills.

Persons with less severe mental illness or those suffering significant upsets in their everyday lives may need assistance from a range of mental health providers, such as family or marriage counselors, social workers, psychologists, or primary care physicians. Concern about the potential overuse of such services when people have third party coverage is part of the reason that provision for mental illness is so limited in many proposals. It has been difficult to design broad coverage targeted to just the most severely mentally ill.
Two groups are not included in the preceding national data: persons with substance abuse disorders and persons with mental retardation. The 1991-92 SIPP indicated that 300,000 people, aged 15 and older, had an alcohol or drug problem disorder that caused a physical, ADL, or IADL limitation (U.S. Department of Commerce 1993, p. 71). In addition to the needs that have been listed, individuals with these problems may require care in residential treatment or detoxification centers. Of the approximately 500,000 working-age people with mental retardation, 75 percent had a work limitation, 53 percent were unable to work, and 37 percent needed assistance with ADLs or IADLs (National Institute on Disability and Rehabilitation Research [NIDRR] 1991, p. 27).* Depending on the cause of the mental retardation, for example, fetal alcohol syndrome, traumatic brain injury, or Down's syndrome, individuals may require a wide range of medical services or assistance with basic life activities (HHS 1991, p. 455). Other related needs might include prevocational training or supported employment.

Children and Disability

Children need comprehensive primary and preventive health care. All children must have their physical and mental development monitored, be immunized, and receive dental and vision care. As children reach adolescence, they increasingly need psychosocial support, mental health services, education, family planning, and health guidance. Thus, a large proportion of care for children is provided on an outpatient basis.

Developmental, learning, and emotional problems are among the most common chronic conditions for both children and adolescents, yet children are less likely to be chronically ill or disabled than adults. Approximately 5 percent of children under age 15 experience a limitation in activity caused by chronic conditions, as compared to 9 percent for people aged 15-44 and 22 percent for those aged 45-64 (National Center for Health Statistics [NCHS] 1992). Other studies indicate that, while approximately 5 percent of children have special needs, about 1 to 2 percent have severe impairments (Taylor, Epstein, and Crocker 1990, p. 28). Still, the array of conditions among this relatively small number of children is vast. In contrast, adults generally have a more limited and predictable range of disorders (Durch 1994, p. 5). Thus,
children with these rare conditions require specialized care that may be
difficult to access. In addition, any chronic condition in children has
broader implications for overall development and schooling. Children
who are chronically ill, independent of how severe, are at risk for
behavioral or psychiatric problems and, therefore, may need special
pediatric counseling and support services (Perrin, Guyer, and
Lawrence 1992, p. 71). Special services may be necessary to compen-
sate for frequent absences from school. Moreover, family members,
foster care parents, and siblings may need special training, guidance,
and time off.

Coverage Today

Today’s health care system has many gaps. Some people do not have
coverage. Among those who do, coverage is not uniform. Private insur-
ance and Medicare tend to have restricted scope and depth of protec-
tion, whereas Medicaid and veterans’ coverage is broader but is fraught
with other limitations.

Of the approximately 8 million adults aged 18 to 64 who were
unable to work because of a disability in 1989, 17.3 percent had neither
private nor public coverage, 34.3 percent had private insurance, 34.3
percent had public coverage, and 13.2 percent had both private and
public coverage (NIDRR 1993, p.18).3 Individuals without work limi-
tations had much higher rates of private health insurance coverage (78
percent), lower rates of public coverage (4 percent), and somewhat
lower uninsured rates. National data also show clearly that not having
health coverage means not getting timely or continuous care. Disabled
or not, people who do not have health coverage have fewer physician
contacts and hospitalizations than people who do (NIDRR 1993, p.
37).

Gaps in health care coverage lead to perverse work incentives.
Because private insurance is largely linked to employment, this protec-
tion can be jeopardized with each job change.4 Public coverage is usu-
ally linked to receipt of public cash benefits. Some cash benefit
programs are not available to those who are able to work or to those
who have too much income, thus creating disincentives for beneficia-
ries to resume employment. As a result, the need for health coverage, or coverage of a certain type, may influence decisions concerning whether or not to work and where to work.

**Private Health Care Coverage**

Private insurance varies considerably, depending on the employer, the location, and the plan chosen. Persons with limitations, whether in work or in basic life activities, are less likely than persons without limitations to have private coverage. The extent of this coverage varies with the ability to work as well as with the need for assistance (see table 1). In 1989, of individuals unable to work, 48 percent had private coverage through a former employer or a spouse’s employer or had purchased it individually. However, among those unable to work and needing assistance with basic life activities (activities of daily living or instrumental activities of daily living), a smaller proportion relied solely on private coverage because this group had high rates of public coverage also.

Employer-provided coverage is the most common form of private insurance for disabled and nondisabled people. However, it is not evenly accessible across industries or size of firm (Employee Benefit Research Institute [EBRI] 1994, p. 10). Differences also exist across educational levels. Thirty-one percent of high school graduates have direct employer coverage, as compared to 39 percent of people with a college level education or more. Overall, disabled workers who have low labor market skills are disadvantaged in terms of employment opportunities (National Academy of Social Insurance 1994, p. 10) and in gaining access to private health coverage.

Even when private health insurance is available, several features make it difficult for persons with disabilities. Often the definition of covered services is too narrow, providing too little protection outside of acute episodes of hospital and physician care. Additionally, there may be restrictions on a given service (i.e., the amount, duration, or scope), limits on total coverage or “lifetime caps,” and high out-of-pocket costs (e.g., copayments or deductibles). As a consequence, families that include a member with chronic care needs are exposed to tremendous costs.
Table 1. Type of Health Coverage among Adults Aged 18-64, by Disability, 1989

<table>
<thead>
<tr>
<th>Source of health insurance coverage (percentage)</th>
<th>Private</th>
<th>Private only</th>
<th>Medicare</th>
<th>Medicare only</th>
<th>Medicaid</th>
<th>Medicaid only</th>
<th>Military</th>
<th>Not insured</th>
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<tbody>
<tr>
<td><strong>Type of disability</strong></td>
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<td>(work activity and self-care)</td>
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<td>Unable to work</td>
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</tr>
<tr>
<td>Needs assistance, ADL</td>
<td>47.5</td>
<td>34.3</td>
<td>23.9</td>
<td>7.3</td>
<td>26.8</td>
<td>17.3</td>
<td>6.2</td>
<td>17.3</td>
</tr>
<tr>
<td>Needs assistance, IADL</td>
<td>44.8</td>
<td>18.4</td>
<td>38.7</td>
<td>10.3</td>
<td>38.1</td>
<td>20.4</td>
<td>5.8</td>
<td>12.4</td>
</tr>
<tr>
<td>Does not need assistance</td>
<td>48.6</td>
<td>37.8</td>
<td>20.2</td>
<td>6.4</td>
<td>23.2</td>
<td>16.0</td>
<td>6.4</td>
<td>19.1</td>
</tr>
<tr>
<td>Limited in amount or kind of work</td>
<td>71.2</td>
<td>66.3</td>
<td>2.8</td>
<td>0.8</td>
<td>6.7</td>
<td>4.8</td>
<td>5.0</td>
<td>19.8</td>
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<tr>
<td>Needs assistance, ADL</td>
<td>57.3</td>
<td>40.3a</td>
<td>15.8a</td>
<td>b</td>
<td>28.3a</td>
<td>21.8a</td>
<td>4.5a</td>
<td>10.6</td>
</tr>
<tr>
<td>Needs assistance, IADL</td>
<td>65.5</td>
<td>57.8</td>
<td>10.1</td>
<td>4.6a</td>
<td>17.3</td>
<td>11.3</td>
<td>3.6a</td>
<td>15.4</td>
</tr>
<tr>
<td>Does not need assistance</td>
<td>72.2</td>
<td>67.0</td>
<td>2.3a</td>
<td>0.6</td>
<td>5.9</td>
<td>4.3</td>
<td>5.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Limited in nonwork activity only</td>
<td>75.5</td>
<td>71.5</td>
<td>3.2</td>
<td>1.2</td>
<td>6.6</td>
<td>5.1</td>
<td>3.8</td>
<td>15.8</td>
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<tr>
<td>Needs assistance, ADL</td>
<td>45.1</td>
<td>36.6a</td>
<td>18.2a</td>
<td>9.7a</td>
<td>30.1a</td>
<td>25.1a</td>
<td>5.4a</td>
<td>9.5a</td>
</tr>
<tr>
<td>Needs assistance, IADL</td>
<td>60.8</td>
<td>52.2</td>
<td>10.7a</td>
<td>7.2a</td>
<td>24.1</td>
<td>17.9</td>
<td>2.1a</td>
<td>11.1a</td>
</tr>
<tr>
<td>Does not need assistance</td>
<td>76.3</td>
<td>72.6</td>
<td>2.7</td>
<td>0.9</td>
<td>5.7</td>
<td>4.3</td>
<td>3.8</td>
<td>16.0</td>
</tr>
<tr>
<td>No work limitation</td>
<td>79.3</td>
<td>77.7</td>
<td>0.4</td>
<td>0.1</td>
<td>2.8</td>
<td>2.5</td>
<td>2.1</td>
<td>16.6</td>
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<tr>
<td>Needs assistance, ADL</td>
<td>b</td>
<td>b</td>
<td>b</td>
<td>b</td>
<td>b</td>
<td>b</td>
<td>b</td>
<td>b</td>
</tr>
<tr>
<td>Needs assistance, IADL</td>
<td>24.5&lt;sup&gt;a&lt;/sup&gt;</td>
<td>24.5&lt;sup&gt;a&lt;/sup&gt;</td>
<td>31.9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>10.6&lt;sup&gt;a&lt;/sup&gt;</td>
<td>39.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>18.5&lt;sup&gt;a&lt;/sup&gt;</td>
<td>b</td>
<td>25.2&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Does not need assistance</td>
<td>79.3</td>
<td>77.7</td>
<td>0.4</td>
<td>0.1</td>
<td>2.8</td>
<td>2.5</td>
<td>2.1</td>
<td>16.6</td>
</tr>
</tbody>
</table>

**SOURCE:** 1989 National Health Interview Survey data published in NIDRR 1993

**NOTE** The percentages reflect the proportion of individuals in each disability category who have various types of insurance coverage. For example, 48.6 percent of individuals who are unable to work and do not need assistance have private coverage.

1 Low statistical reliability

b. Standard error indeterminate, estimate=0.
Large versus Small Groups

Competition in the employer market has moved private insurance from pooling risk across groups to managing the risk exposure for specific, smaller groups. Not all employer groups can get health insurance, even if they want it, and not all insurance policies are the same. Most private insurance covers small groups. The same coverage is more expensive for small than for large groups, primarily because of relatively higher administrative costs, additional risk premiums, and the cost of medical underwriting. In the small group health insurance market, insurers compete based on their ability to sell to low-risk groups and to avoid relatively high-risk groups. In smaller groups, employers are encouraged to switch policies as a means of saving money. During such changes, employees lose coverage for “preexisting” conditions. Consequently, people with disabilities are more likely to be denied full insurance, especially if they are covered through a relatively small firm.

In larger groups (firms with more than 200 employees), the possibility is greater that employers will self-fund the cost of workers’ health care. In other words, these employers take on the risk directly and avoid state taxes on health insurance premiums. Even if the large group is not self-funded, the cost of its health insurance is basically the expected cost of that group. Large firms usually pay less than small firms for the same amount of coverage. Large firms traditionally offer more choices of health plans, have more comprehensive benefits, and generally pay a larger portion of the cost of family coverage.

The Americans with Disabilities Act and Health Care

The Americans with Disabilities Act (ADA) applies to employer-provided health insurance, whether it is self-funded or purchased from an insurance company (U.S. Equal Employment Opportunity Commission [EEOC] 1993, p.1). Under the ADA, employees with disabilities must be accorded equal access to whatever health insurance the employer provides to employees without disabilities. Furthermore, specific insurance terms or conditions, covered treatments, or procedures may not single out a particular disability or group of disabilities.

However, not all health-related distinctions of such plans would violate the ADA; thus, the impact of the ADA on employer-provided
health coverage is limited. The EEOC gives examples of permissible distinctions: benefits provided for the treatment of physical conditions may be different from those provided for the treatment of mental or nervous conditions. Although this approach has a differential impact for people with mental illness, the plan conditions must apply equally to people with and without disabilities. Employers may have preexisting condition clauses or dollar caps, or they may place limits for all enrollees, such as on the number of covered blood transfusions or x-rays, without violating the ADA. Plans may not, however, exclude coverage of specific conditions, like deafness, schizophrenia, or kidney diseases.

Private Long-Term Care Coverage

Today, virtually no one has private insurance for long-term care services. Although most health insurance plans now provide for nursing home and home health care, this coverage is usually defined as an alternative to hospital care or for post-acute recuperation. It is not available for chronic, long-term situations. Separate private long-term care insurance is available, but relatively few people—at most 5 percent of the elderly and a negligible percentage of the nonelderly—have purchased it (Wiener, Illston, and Hanley 1994). Private long-term care insurance is primarily sold to seniors and is not marketed to people with disabilities or to children. Most of this insurance does not cover specific services. Instead, it pays a fixed dollar amount if the beneficiary qualifies for services. However, the cash amount may not be sufficient to cover the cost of care. Private insurers claim that sales are low because of uncertainty surrounding taxation; unlike health insurance, long-term care is not explicitly addressed in the tax code. Thus, it is not clear, for example, whether premiums can be paid on a pretax basis through employer flexible benefit plans.

Medicaid

Medicaid is a federal- and state-funded program, which provides coverage for medical care and related services for some, but not all, low-income persons. Covered groups, defined by federal requirements with a great deal of state discretion, include pregnant women, children, and elderly or disabled people with very low incomes and few assets.
Some people are eligible for Medicaid because they receive cash assistance; this would be the case for either low income, single-parent families receiving Aid to Families with Dependent Children (AFDC) or for low-income aged, blind, or disabled individuals receiving Supplemental Security Income (SSI). At age 18, adolescents with physical disabilities can apply for SSI (and, therefore, become eligible for Medicaid), even if they are living at home. In addition, noncash assistance groups, such as all young children with family income below the federal poverty level, also qualify.

States can provide Medicaid coverage to individuals receiving state supplement payments (SSP), or they can include people with larger incomes whose medical expenses relative to income are extremely high ("medically needy"). In 1991, 34 states extended Medicaid to SSP recipients, and 36 states had medically needy programs for the disabled. Through medically needy programs, states cover many elderly and disabled people requiring nursing facility or home care. A state may offer a more limited package of services to its medically needy population than to its categorically needy population (Congressional Research Service [CRS] 1993, p. 249).

Eligibility for Medicaid is narrow, but the array of covered services in many states is broad. Unlike private medical insurance or Medicare, Medicaid covers preventive care, case management, extensive rehabilitation and day treatment, home health services, medical devices, personal care services, care in nursing homes, and transportation. However, many states have relatively low provider reimbursement and have restrictive licensing policies, thus limiting beneficiaries' access to services.

In addition to care in a nursing facility, states may, under a waiver program, provide home- and community-based services for persons who would otherwise require institutional care. In contrast to the home care benefit, which involves skilled medical attention, waiver services can include a wide variety of nonmedical, social, and supportive services. These waivers are frequently used to serve populations such as the frail elderly—but also people with mental retardation, developmental disabilities, chronic mental illness, or AIDS (CRS 1993, p. 384).

Special work incentive rules are built into the SSI and Medicaid programs for blind and disabled individuals who already are receiving SSI benefits and return to work. Under Section 1619 (a), SSI recipients
may continue to have Medicaid benefits, although their cash benefits are gradually reduced as their earnings increase. Once the individuals' earnings rise to the point where they lose SSI cash benefits altogether, they may continue Medicaid coverage, as long as the disabling condition does not improve.12

People who lose their jobs and, therefore, their health coverage may find that they are eligible to have Medicaid pay their former employer's premium to continue coverage. The individual must have income below 100 percent of the poverty level and assets below 200 percent of the SSI limit and may not otherwise be eligible for Medicaid. In such cases, the state may opt to pay the premium for continuation coverage. This provision has several restrictions: federally mandated continuation applies only to employers with 20 or more employees, is time-limited, and does not apply to employers that did not offer coverage originally. Finally, coverage is that defined by the private plan, which is unlikely to cover many health-related services needed by persons with disabilities.

Current Medicaid policy addresses some of the employment disincentives for individuals leaving SSI rolls and returning to work. It does not, however, address the motivation to go on Medicaid in the first place. This incentive arises because employer-based coverage is unavailable or inadequate and because Medicaid's income test effectively requires that one stop working to become eligible.

**Medicaid and Mental Illness**

According to the 1989 National Health Interview Survey, 43.5 percent of adults aged 18 and over with serious mental illness received SSI (Barker et al. 1992, p. 7). As a result, in most states these individuals would be eligible for Medicaid. Medicaid financing for mental health historically has been skewed toward institutional care. However, at state option, outpatient services may be included, such as clinics, hospital outpatient departments, partial hospitalization, psychiatric day care, and care from psychiatrists, psychologists, social workers, or psychiatric nurses. Furthermore, states may provide targeted case management, prescription drugs, psychosocial rehabilitation services, and "clinic" services, such as day treatment, family therapy, medication management, psychological testing, and group therapy. The extent of coverage varies considerably by state.
Under Medicaid, states may offer coverage in institutions for mental diseases (IMDs) for persons aged 65 and over and in inpatient psychiatric hospitals for children under age 21. Individuals between the ages of 21 and 65 may receive services for mental illness in hospitals or in nursing facilities, as long as these facilities are neither IMDs nor psychiatric hospitals. Because individuals between the ages of 21 and 65 are not eligible for institutional care under Medicaid, they are precluded from receiving home- and community-based services under a waiver.

**Medicaid and Children**

The Medicaid program treats coverage for children differently from coverage for adults. The distinctions arise from the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program for children, which was enacted in 1967 as part of the Medicaid initiative to identify and treat children's health problems early. Under the EPSDT program, children may receive services that other groups do not. These services include physical examinations, immunizations, laboratory tests, health education, vision, dental, and hearing care. The greatest change in EPSDT came in 1989 when the law required that any physical or mental illness identified during the screens must be referred for treatment; furthermore, the treatment must be covered by Medicaid, even if it is not normally covered under the state's Medicaid list of benefits. Subsequent referrals to health, developmental, or educational professionals must also be reimbursed.

The 1989 change effectively eliminated restrictions on amount, duration, or scope of covered services (as long as the services are medically necessary) and required every state to offer all mandatory and optional Medicaid benefits to children. These expansions particularly opened up many new services for mentally ill and developmentally disabled children. Furthermore, numerous states have been able to shift financing of some public and school health services to Medicaid. Thus, many services in school-based early intervention programs can be reimbursed through Medicaid funds.
Medicare

Medicare primarily serves individuals who were in social security-covered employment but are now either disabled or age 65 or older. Ninety-six percent of the population over age 65 is covered by Medicare (EBRI 1994, p. 5). Medicare is also available for nonelderly people who have been on the Disability Insurance (DI) benefit rolls of the Social Security Administration (SSA) for two years. Overall, 24 percent of working-age individuals who are unable to work and 3 percent of those who are limited in the amount and kind of work they can do are covered through Medicare (see table 1).

In most cases, Medicare coverage is not as broad as that of Medicaid. Medicare has two components: Part A, which covers primarily hospitalization, inpatient care, and home health, and Part B, which primarily covers outpatient and physician services. Medicare does not cover most prescription drugs taken at home. However, Medicare does cover home health services for people requiring skilled nursing and provides for broader mental health services than do most private plans. Generally, Medicare beneficiaries do not pay a premium for Part A, but they do pay a premium for Part B.

Medicare also has work incentive provisions. In the case of a disabled beneficiary who has returned to work and is engaging in substantial gainful employment (beyond a nine-month trial work period), Medicare will continue to provide coverage for three years even after Disability Insurance cash benefits have been discontinued. After three years of coverage, the disabled individual may elect to purchase Medicare Part A and Part B protection. The individual must pay a premium rate equal to the average monthly cost for beneficiaries aged 65 and over. In January 1994, 78,000 beneficiaries were eligible for the buy-in benefit because they were working and their paid Medicare coverage had lapsed; only 450 chose this buy-in option (Department of Health and Human Services 1994). For Medicare beneficiaries with income below 200 percent of the federal poverty line, state Medicaid programs must pay the Part A premium.
Veterans Affairs

The Department of Veterans Affairs (VA) medical care system is the largest in the United States. It encompasses over 150 veteran medical centers and offers a full range of services. However, eligibility rules are complex, and resources are not sufficient to care for all eligible veterans. Wide disparities often result in the levels of care at different centers received by veterans with similar conditions or incomes.

The VA has programs such as hospitalization, blind rehabilitation, care for spinal cord injuries, rehabilitation, prescription services, prosthetic appliances, alcohol and drug dependence rehabilitation, domiciliary care, nursing home care, community residential care programs, hospice units, adult day care centers, hospital-based home care programs, and community outreach clinics. It also has a large outpatient care component that spans examinations, treatment, home health services, podiatric, optometric, dental, and surgical services for eligible veterans. The Veterans Health Administration is noted for its work in geriatrics, spinal cord injury, and substance abuse. In addition, in 1993 the VA cared for approximately 6 percent of the nation's AIDS cases and provided one-third of the nation's care for the chronically mentally ill (Paralyzed Veterans Association [PVA] 1994).

Eligibility rules for veterans' health benefits are confusing. Eligibility requirements for inpatient and outpatient care are different, although, in general, priority is given first to those who need treatment for service-connected disabilities and to those who have disabilities that are 50 percent or more service-connected and who require care for any condition. Some categories are "mandatory" and must be provided services, while others only are served if resources or space are available. Veterans whose incomes are above a specific threshold who do not have service-related needs may be excluded from care. In 1991, three million veterans used VA services, i.e., 12.5 percent of the total veteran population (DVA 1992, p. 66). Ninety-eight percent of these patients had service-connected disabilities or were indigent, and did not have service-connected disabilities. In fact, 25 percent of veteran patients have no other health insurance (DVA 1991, p. 5).
Health Care Reform Proposals

In 1994, Congress debated a number of proposals to reform the financing of health care. Many plans would have substantially reduced the number of people without health insurance or with substantial gaps in health insurance. Access to health care would have been dramatically easier for individuals with chronic care needs, even under those proposals that fell short of universal coverage. As a result, work disincentives and fragmentation of health services would have been substantially alleviated for people with disabilities.

In the absence of major reform, discussions are likely to revolve around incremental changes in existing programs, modifications to the tax code, or small-scale block grants to states. In today’s environment, proposals to expand coverage marginally under existing public programs are likely to compete with new demands to reduce the size of the federal government. In addition, closing coverage gaps in a piecemeal fashion for persons with disabilities could perpetuate work disincentives, lead to significant inequities across populations, produce further unraveling of private insurance, or involve substantial public costs.

The array of potential incremental reforms is practically infinite. First, as a society, we should decide how much we are willing to spend, through public and private funds, to improve access to health care. Then we must sort out philosophical differences regarding program structure and priority populations. In this section, possible options for incremental reform and their impact for disabled persons are enumerated, in very general terms. Acute care coverage is addressed, including insurance market reforms and changes to Medicaid, Medicare, and veterans coverage. Issues relating to long-term care are also discussed, including insurance reforms, tax code changes, and new block grant programs.

Access to Acute Care

Acute care coverage could be expanded through private insurance, Medicaid, or Medicare. It is difficult to design a change that only affects those who currently have no public or private coverage. Because private health insurance is voluntary and because different sources of coverage overlap, any incremental modification is likely to
have a number of unintended consequences. For example, changes that make private insurance easier to obtain are likely to make it more expensive and, ultimately, will lead to fewer covered individuals. Modest expansions in Medicaid could unintentionally encourage employers to drop coverage and could lead to more employees becoming eligible for Medicaid.

Expanding Access to Private Insurance

Improving access to private insurance means addressing affordability and availability. Individual or small group coverage is frequently not available for people with chronic health conditions; even where it is obtainable, health insurance is often not affordable for moderate-to-low income persons. The insurance reflects the expenses of health care. Therefore, unless these expenses are significantly altered, increasing the voluntary purchase of health insurance requires that the cost be subsidized. Subsidies can be general or targeted through tax deductions, tax credits, vouchers, or premium discounts. It is very difficult to direct subsidies to only those who, without such assistance, would not have health insurance. As a proxy, most proposals restrict subsidies for private insurance to low income populations.

In 1989, for example, the Pepper Commission examined, but rejected, a proposal that would have enrolled everyone with family income below the poverty level into Medicaid, modified the insurance market towards community rating, and provided a sliding-scale subsidy for the voluntary purchase of private coverage (starting at 99 percent of the cost for families with incomes just above the poverty level and declining to zero for those with family incomes above 200 percent of the poverty level). In 1990, such a proposal would have cost approximately $32 billion in new public expenditures and would have reduced the number of uninsured with incomes below 200 percent of the poverty level by nearly 74 percent, assuming 14.4 million individuals enrolled in Medicaid and/or private insurance. Other recent proposals would give individuals the option to enroll in the Federal Employee Health Benefit Program or in Medicare, while providing subsidies toward the purchase of that coverage.

Subsidizing the cost of health insurance is not efficient. People who already have coverage and those willing to buy coverage without a subsidy end up receiving one. Some people eligible for a subsidy will
receive coverage from more than one source. Moreover, because of the elasticity of demand among those without coverage, it takes a sizable subsidy to encourage the voluntary purchase of health insurance. In the Pepper Commission example, a subsidy of 50 percent of the cost of health insurance (on average) was assumed to motivate only half of the eligible families to buy insurance (Pepper Commission 1990, appendixes B and D). Assuming that 7.7 million individuals were to enroll, just subsidizing private insurance, could cost $8 billion. A less generous subsidy would lower this figure, but would be less effective at expanding coverage and more likely to apply only to those who would have obtained coverage in the absence of the subsidy.

Subsidizing voluntary coverage also does not resolve today's work disincentive issues. Only proposals mandating that everyone obtain coverage present the opportunity to "delink" employment and health coverage, thereby lessening the motivation to obtain public health care protection by leaving work. However, if private benefits are very limited as compared to public ones, the incentive, particularly for chronically ill populations, would continue.

Reforming Insurance Market Rules

Some policymakers favor changing insurance market rules as a means of expanding coverage without increasing public expenditures. Most of their proposals address the sale of insurance, and some plans deal with the determination of premiums. Health insurance premiums are based on the cost of health care and are affected by the rules associated with the sale of insurance. As long as insurers can deny coverage to those most likely to use health services, the price of insurance will reflect the average cost among those with insurance plus a portion of the cost for the uninsured. Therefore, if people can no longer be denied or excluded from coverage, the overall price of insurance for individuals and small groups is likely to increase.

If new rules address only the sale of insurance, and not the rates, then insurers can selectively price their coverage in order to encourage or discourage specific groups. If premiums are regulated to remain within certain limits, prices for the relatively young and healthy are more likely to increase. Coverage for the sick may expand, but some young and healthy people may drop their coverage due to higher premiums.
New rules regarding the pricing and selling practices of insurers would require a considerable amount of regulation in a voluntary system. Most state insurance departments are not well prepared to undertake this task. The incentive for insurers to avoid high-risk individuals is so strong that merely banning certain practices is unlikely to prevent insurers from seeking other ways, for example, through location, provider choice, or marketing efforts, to avoid high-risk populations. Individuals also have strong reasons to minimize their risk in a voluntary system. Without some limits on eligibility, individuals can wait to buy policies until the moment they need health care, thereby undermining the ability of the private market to sell insurance that pools the cost of health care risks. Consequently, insurance market reforms alone—in the absence of mandatory health care coverage—will not necessarily expand access to insurance and could decrease coverage.

*Mandating Private Benefits*

In addition to regulating the sale and pricing of health insurance, one could mandate coverage of certain benefits. Mandating broader coverage would lead to higher premiums. For example, most private plans have various restrictions on inpatient and outpatient mental health care in order to limit costs. If the number of days of inpatient psychiatric care were required to be 365, instead of the more typical 30 days, then premiums would increase by 2.6 percent, on average (Congressional Research Service 1988). If reimbursement of outpatient mental health care were raised from the more typical 50 percent of provider charges to 80 percent of charges, premiums would increase by 0.7 percent, on average. Overall, covering mental health care in a manner similar to other health care services would raise private premiums by about 3.1 percent.

*Changing Medicaid*

Beginning in the late 1980s, there was a series of expansions to Medicaid eligibility and covered services. Benefits added during the 1980s, for example, included home and community-based waivers, case management, and supported employment. In addition, modifications were made to eligibility, income, or asset criteria. New eligibility rules for pregnant women and children, based on family income rather
than on receipt of cash benefits, heralded a change in the fundamental principles of the program.

A similar expansion might be considered to provide for the disabled of working age and with family incomes of less than the poverty threshold. Thus, coverage could be extended to 2.8 million people, but with nearly $9 billion in new public costs. Of course, more restrictive eligibility criteria or more limited benefits could lower the cost of this proposal.

Some suggestions are to eliminate the Medicaid program and to enroll beneficiaries in private plans for acute care coverage. This would remove the Medicaid stigma and improve access to private providers. However, many individuals would lose benefits now available under Medicaid but not typically allowed under private plans. Even if Medicaid long-term care coverage does not change, access to many extended services (rehabilitation, assistive devices, social, and supportive services) would be lost in the shift to private plans. While access to such “wrap-around” services could be maintained explicitly through a separate program, in all likelihood such fragmented financing would result in less coordinated care.

Other proposals involve expanding current Medicaid work incentive provisions, by raising the earnings threshold at which Medicaid is discontinued. While these changes would increase the motivation to leave the cash benefit rolls, one must first become eligible for cash benefits, by stopping work, for example, in order to get health and health-related coverage. This increases the pull to obtain cash benefits in the first place. Ultimately, such changes also raise the policy question of why individuals in similar situations, i.e., disabled but working, are treated differently: those who once received cash benefits have health and health-related coverage, but those who never received cash benefits do not.

Changing Medicare

One possible change to the Medicare program would involve eliminating the existing 24-month waiting period for individuals who are receiving DI cash benefits. This would add nearly 628,000 DI beneficiaries to Medicare at an estimated cost of $2.6 billion. Eliminating the waiting period would provide relief for those individuals who have left their jobs without retaining health coverage because their employer did
not offer it, because they could not afford the continuation premium, or because the continuation period expired. However, this approach also increases the incentive for disabled individuals to obtain cash benefits in order to get health coverage. Thus, a coverage gap would be filled, but the link between cash benefits and health care would be strengthened. This incentive is weaker if the services the individuals need most are extended or long-term care benefits, which are generally not provided by Medicare.

Access to Health-Related and Long-Term Care Services

Expanding coverage for health-related or long-term care services also can be accomplished by adding new programs or by modifying private insurance, public programs, or the tax code.

New Home- and Community-Based Care Programs

Several proposals have attempted to improve access to home- and community-based, long-term care services by creating a new, federally funded program. In most cases, the programs are capped at a specific federal dollar amount and require state contributions. They typically are designed to give states and individuals a great deal of flexibility, and, ultimately, would replace current Medicaid waiver programs.

The president's proposal, for example, included a significant new public program to cover home- and community-based care for individuals with disabilities. Other bills had similar provisions. The president's program would have been state-administered using federal funds and required state contributions. States were allocated a fixed budget, with total budgeted federal spending starting at $4.5 billion in 1996 and increasing to $38.3 billion by 2003. Ultimately, such a program could cover approximately 3 million severely disabled individuals, of whom about 710,000 would be of working age.

Eligibility for the program was based on the need for assistance with three or more ADLs, on severe cognitive or mental impairment, and on special criteria for young children. Under the plan, states had a great deal of flexibility in designing service systems. States had to provide needs assessments and individual care plans. However, not all services identified in the individual care plan had to be offered by the state; in fact, only personal assistance services were required. All other services
were at the discretion of the state (for example, case management, home modifications, homemaker and chore assistance, respite services, assistive devices, vocational rehabilitation, supported employment, or mental health) as were limits on amount, duration, and scope of any services offered. Care was offered in the home, in community residential settings, or outside the home. The plan did not provide complete coverage for these services to eligible persons. All services were subject to coinsurance (ranging from less than 10 percent to 25 percent of costs) depending on income, and there was no out-of-pocket limit on an individual’s contribution.

How does this proposal compare to Medicaid today? From the perspective of the individual, eligibility and cost-sharing requirements are different. (Eligibility requirements have more restrictive disability criteria but no means testing.) From the perspective of the state, there is more flexibility under the proposal to design services. While Medicaid is an individual entitlement, the proposed program would be an entitlement to states with an overall cap. States could phase out the Medicaid services and instead provide services under the new home- and community-based care program at a higher federal matching rate and with greater flexibility. Because state allocations under the new program would have been based in part on current Medicaid expenditures, inequities across states would have continued.

Changing Medicaid

In 1990, the Medicaid program spent nearly $28 billion (or 37 percent of total costs) covering institutional and community-based long-term care for 2.4 million elderly and nonelderly disabled beneficiaries (CRS 1993, pp.141, 146). This coverage included nursing home care, institutional services for the mentally retarded, care in institutions for mental diseases, home health services, and personal assistance. Short of creating an entirely new program, Medicaid rules could be modified by expanding eligibility through lower income and asset thresholds or through changes to spousal impoverishment rules. For example, one could mandate Medicaid coverage for personal care assistance in all states. If the income eligibility criterion were raised to 200 percent of the poverty level for this service and the asset test were removed, this expansion would cover approximately 10 million individuals with severe limitations (i.e., requiring assistance with three or more ADLs)
at a cost of approximately $13 billion. Small, incremental changes may bring relief to narrow segments of the population, but are unlikely to change problems with fragmented delivery across medical care, social services, long-term care, and vocational rehabilitation. Furthermore, only changes in federal mandates would narrow large disparities between states regarding spending levels, reimbursement, and covered services.

**Changing Coverage for Veterans**

Although many groups, such as the Commission on the Future Structure of Veterans Health Care, have advocated a change in VA eligibility and delivery of services, such initiatives were put on hold during the debate on health care reform. Proposals that provided universal coverage attempted to retain access to special VA benefits for some groups. Other proposals that mandated all individuals to obtain coverage included all VA eligibles as an already covered group that met the requirements of the mandate. Most plans, however, did not address the issue of veterans who are eligible for services (theoretically, all veterans) but who cannot obtain them due to limited resources in their area.

**Encouraging Private Long-Term Care Coverage**

Some recent proposals have focused on encouraging today’s nascent market for private long-term care insurance. The insurance industry has argued that the tax code should be clarified to permit deduction of insurance premiums for long-term care, just as for acute health care. Such a change would affect approximately 17 million individuals and would cost about $0.5 billion to $1.0 billion per year in lost revenues. Others have argued for a tax credit in order to signal the importance of long-term care insurance or to stimulate its purchase. This approach would affect fewer individuals, approximately 3 million, and could cost $0.5 billion to $0.8 billion, depending on the size of the credit. In addition, some have recommended national standards and consumer protection for long-term care policies. In a number of proposals, long-term care policies must meet these standards in order to qualify for preferred tax treatment. In others, policies that failed to meet standards would be prohibited or would face penalties.
Using the Tax Code

Deductions and credits have long been used to either encourage or discourage private actions or to modify inequalities that arise from existing definitions of costs and income. Deductions, generally, are best used to refine the definition of taxable income. They tend to favor taxpayers with higher incomes, who have greater tax rates. Tax credits tend to be more effective at encouraging a particular type of purchase. Most existing credits are not refundable, which means that the credit is limited by the amount of taxes owed. In contrast, a refundable tax credit benefits families regardless of their income, tax rate, or total tax liability. The Earned Income Tax Credit (EITC) is an example of a refundable tax credit.

Tax code modifications can be used to subsidize the cost of insurance premiums, either for health or long-term care. Alternatively, they can subsidize the cost of specific types of equipment or care, such as services currently not recognized in the medical care deduction. The tax code, however, is not a very effective tool for targeting financial assistance to those with few resources or with specific types or levels of disability. New tax forms would have to include measures of assets and types of disability to determine eligibility.

Several proposals in 1994 provided for tax code changes specifically to assist people with disabilities in the work force. One provision extended the existing medical expense deduction to include long-term care services for persons requiring assistance with two or more activities of daily living or with severe cognitive impairment. Such a provision could help the estimated 2.9 million persons needing assistance with ADLs or IADLs (based on the 1989 National Health Interview Survey), but only if they itemize their tax deductions.

The president’s plan included a proposal under which disabled, employed individuals could receive a tax credit up to $15,000 per year for 50 percent of the cost of personal assistance services. The credit would give individuals the flexibility to choose services and providers, without constraints that might arise in other programs because of utilization review or low provider reimbursement rates. However, the credit was limited to $15,000 per year and applied only to the cost of personal care services for employed individuals with physical and cognitive impairments, not mental illness. In 1989, approximately 60,000 indi-
individually needed assistance with ADLs and either worked or were limited in the amount or type of work they could perform. The tax credit would benefit such people regardless of earnings. Such a proposal also would help those currently unable to work because of the cost of personal assistance. In 1989, 2.3 million working-age individuals were unable to work and needed help with ADLs or IADLs; it is not clear how many of these people would have been employed if part of the cost of personal assistance had been subsidized. Somewhat more than 30 percent of these individuals currently are covered by Medicaid, the only existing program that might provide for such long-term care services. The potential employment effect of personal assistance subsidies for these individuals as well as for those currently without Medicaid is not clear. For many considering returning to work, the potential loss of acute care coverage is still a barrier.

Other Initiatives and State-Sponsored Changes

Several other steps could change the financing and delivery of health care. In the absence of federal health care reform, there has been an increased movement toward enrollment in managed-care plans. Managed care presents a number of open questions for populations with chronic conditions. In a fee-for-service plan, individuals can choose their providers and, to a large extent, their services. In managed-care systems, individuals often are limited to a panel of providers. The providers receive a set amount per enrollee. By controlling total payments, health plans may encourage providers to utilize health care resources more selectively and efficiently and may promote innovations in community-based delivery models. Safeguards may be necessary to ensure that needed services are not withheld. Furthermore, a smaller managed-care plan may not be able to support a wide range of specialty physicians, gatekeepers skilled in chronic care management, technicians, equipment, and testing for people with diverse chronic and disabling conditions. There is considerable concern about the ability of primary care gatekeepers to manage complex cases appropriately and to refer patients to the specialists and other types of services needed.

States also have been active in changing health care systems, primarily by modifying Medicaid rules. Recently, six states were awarded large-scale Medicaid waivers (so-called "1115 waivers") to change eli-
gibility, benefits, and service delivery. Proposals by nine other states were pending as of September 1994 (Kaiser Commission on the Future of Medicaid 1994, p. 2). In most cases, the waivers mandate Medicaid coverage through managed-care plans. They also extend coverage to low-income populations who currently are not eligible for Medicaid, but cover them for fewer services than Medicaid beneficiaries have covered. Thus, the implied state preference is to cover more people for a smaller number of services. The impact on persons with disabilities, who frequently require a broad range of services, is not yet clear. Some waivers exclude the disabled, blind and aged from the waiver, others create special managed-care programs for the disabled or for populations with specific conditions, such as mental illness, substance abuse, or mental retardation.

Conclusion

The current health care system, a web of private and public coverage, leaves large gaps for people with disabilities. The most obvious breach is that 17 percent of those unable to work because of a disability and 12 percent of those needing assistance with activities of daily living have no coverage at all. Many others have coverage that excludes chronic, long-term, or health-related needs. These gaps create perverse incentives in employment patterns, particularly for people with chronic conditions who require a lot of care or nonacute care. Some individuals may be trapped in a job because of its health benefits, and others may not want to leave public programs. Employment does not convey coverage automatically; thus, leaving the cash benefit rolls carries the risk of losing one’s only opportunity for health care coverage. Furthermore, employment-based insurance frequently does not cover services needed by the disabled.

The opportunity to bring about fundamental change in access to acute care coverage “came and went” for now. Remaining options span a number of smaller, marginal revisions to either the public or private systems. These, however, must stand up to a budget-hostile environment. Furthermore, these incremental steps could exacerbate work disincentives, perpetuate inequities across different groups, or accelerate
the decline of private insurance. Recent efforts to overhaul state systems seem to center on spreading a thin public dollar even more thinly across more eligible people—with an as yet undetermined impact on individuals with disabilities. Ultimately, however, only if private and public coverage were seamless, covering most services that chronically ill populations need, would the barriers and employment disincentives completely be removed.

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*Data from the National Health Interview Survey, 1983-1986 (four-year average) Data are based on household surveys of the civilian, noninstitutionalized population.

1. In the SIPP, activities of daily living are defined as getting around inside the home, getting in or out of bed, taking a bath or shower, dressing, eating, or using the toilet. Instrumental activities of daily living include going outside the home, for example, shopping, keeping track of money and bills, preparing meals, doing light housework, or using the telephone.

2. Similarly, data from the National Health Interview Survey show that, although half of working-age persons have a chronic condition, only 15 percent have a limitation in activity and 10 percent are limited in work (National Institute on Disability and Rehabilitation Research 1991, p. 20).

3. Another 0.9 percent had coverage from undefined plans. Data from the 1989 National Health Interview Survey.

4. Firms with 20 or more employees must extend coverage to former employees for a fixed time period but may charge them the full premium plus 2 percent.

5. Insurers tempt the owners to drop their current policy by offering a lower price, but this price excludes the coverage of any “preexisting” medical conditions. As time elapses and these exclusions are no longer in place, the insurance price increases.

6. In the past, the tax code also was unclear about whether benefits would be treated as taxable income. Since 1989, it has been clarified that the earnings on long-term care insurance reserves can be treated in the same manner as earnings on life insurance reserves, i.e., these earnings are exempt from taxation for insurers and policyholders.

7. Twelve states, the so-called 209(b) states, use more restrictive eligibility standards than SSI policies, either regarding the definition of disability or regarding income and resource limits or definitions. States electing the 209(b) option must allow applicants to “spend down,” i.e., to deduct medical expenses from income in determining eligibility.

8. In such cases, parental income and resources are not counted, although the SSI benefit amount is reduced by one-third.

9. Effective April 1990, states have been required to cover all pregnant women and children under age 6 whose income is below 133 percent of the federal poverty level. In addition, Medicaid must expand coverage each year to children under age 19, so that, by October 2001, all children living below 100 percent of the federal poverty level will be covered.
10. In practice, to become medically needy, one must first deplete one’s assets to the eligibility standard (i.e., $2,000 for individuals and $3,000 for couples) and then continue to incur high medical expenses relative to one’s income.

11. Because the eligibility standard for medically needy applicants must be the same across all applicants (families, children, elderly, and disabled) and because it may not exceed 133 percent of the AFDC payment, very often the medically needy income standard is lower than the SSI benefit standard (CRS 1993, p. 211).

12. The individual’s earnings must be less than the combined equivalent of SSI, SSP, Medicaid, and publicly funded personal attendant care benefits.

13. Medicare also covers individuals with end-stage renal disease, regardless of whether or not they work.

14. Disabled beneficiaries include disabled workers under age 65, widows aged 50 to 64, and children aged 18 and over who were disabled before age 22.

15. In 1993, this voluntary premium was $245 per month for Medicare Part A. The premium rate for Part B was $36.60 per month. If the individual returns to the disability rolls within five years (seven years for widows and adult children), there is no two-year waiting period to be re-eligible for Medicare without paying a premium.

16. This estimate is based on the average cost of coverage for those now eligible because of a disability. In this sense, the cost per potential beneficiary is probably overstated. However, this estimate does not include the potential of more people claiming to be disabled than currently measured by random sample surveys. This estimate assumes that both the uninsured and those now covered by private insurance would seek Medicaid coverage.

17. The Internal Revenue Service has argued that legislation, not clarification, would be required.

18. Deductible expenses include the provision of assistance with “activities of daily living” (eating, dressing, bathing, toileting, transferring in and out of bed) or protection from threats to health and safety due to severe cognitive impairment. Services may not be provided by a relative and must be part of a plan of care prescribed by a licensed professional. All deductible medical expenses would be subject to the existing 7.5 percent floor.

19. The 50 percent is reduced by 10 percentage points for each $5,000 in adjusted gross income over $45,000. Services are defined broadly and include personal assistance to carry out “activities of daily living” (eating, dressing, bathing, toileting, transferring in and out of bed) in or outside of the home; homemaker/chore services (e.g., meal preparation or shopping); assistance with life skills (e.g., money management) for people with cognitive impairments; assistive technology services; or modifications to the home. To be eligible, individuals must prove that they have a “medically determinable physical impairment,” which has lasted or is expected to last at least 12 months. Furthermore, they must be unable to engage in substantial gainful activity without personal assistance services.
References


