Section 2. Insurance and the Uninsured

How many Americans are without health insurance? Where do they live and work? How old are they? This section of the chartbook describes the economic and demographic characteristics of the uninsured. It also describes two aspects of the health sector in the United States: the sources of coverage among the 220 million Americans who are insured and how that coverage is changing.

In addition to providing basic information on the pattern of health insurance coverage, this section concentrates on children without health insurance. In particular, a number of figures describe how the percentage of uninsured children has effectively remained unchanged over the last 7 years despite substantial increases in the number of children covered by Medicaid.

Different data sources provide different answers to the question; how many Americans are without health insurance? The estimates contained in this section of the report are based on an analysis of the March 1996 income supplement of the Current Population Survey (CPS) prepared by the Census Bureau. This survey asks a series of questions on the health insurance coverage of individuals and families for the prior calendar year (1995). The estimates contained in this section follow the methods used by the Census Bureau in their calculation of the number of uninsured.

In addition to providing information on the characteristics of Americans with and without health insurance, this section provides background information on the use of managed care options by those with insurance. Managed care can take a variety of forms including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). This section concludes with a series of figures portraying the use of the different types of HMOs, health service utilization of HMO members, and PPO enrollment and ownership.

Figure 2.1.
Health Insurance Coverage by Type of Insurance, 1995

Figure 2.1 provides a breakdown of health insurance coverage by type of insurance. It should be noted in viewing the figure that individuals may have more than one source of health insurance. Based on the annual demographic supplement to the Current Population Survey, conducted by the Bureau of the Census:

- 62% of the U.S. population relied on employment-based health insurance coverage (group health insurance through an employer or union);
- 24% of the U.S. population relied on Medicare or Medicaid as a source of health insurance; and
- 9% of the U.S. population relied on private nongroup coverage to meet their health insurance needs.

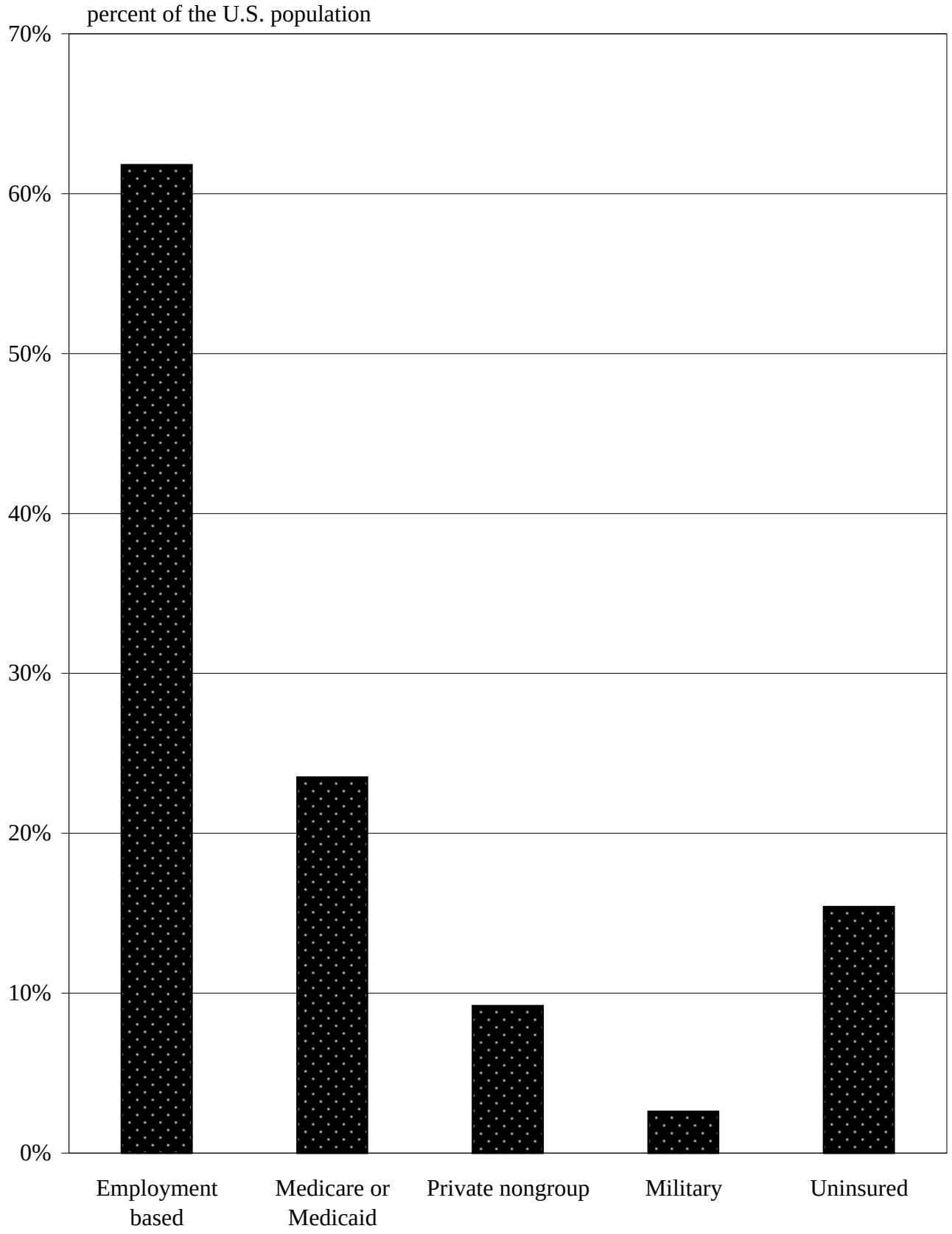
In 1995, approximately 41 million people in the United States (15.4%) were without any form of health insurance coverage throughout the year. The uninsured were often young and poor, but many of them did have some ties to the labor force, frequently in small firms. By contrast, less than 1% of the elderly (age 65 and over) were uninsured. Most people with health insurance had employment-based coverage, while others were covered under government-sponsored plans such as Medicare and Medicaid or nongroup privately purchased health insurance.

TABLE 2.1.
Health Insurance Coverage by Type of Insurance, 1995

Type of Health Insurance	Percent of U.S. Population
Employment based	61.8
Medicare or Medicaid	23.5
Private nongroup	9.2
Military	2.6
Uninsured	15.4
Total population (in millions)	264.3

NOTE: Table prepared by CRS. It should be noted in viewing the figure that individuals may have more than one source of health insurance.

Figure 2.1. Health Insurance Coverage by Type of Insurance, 1995

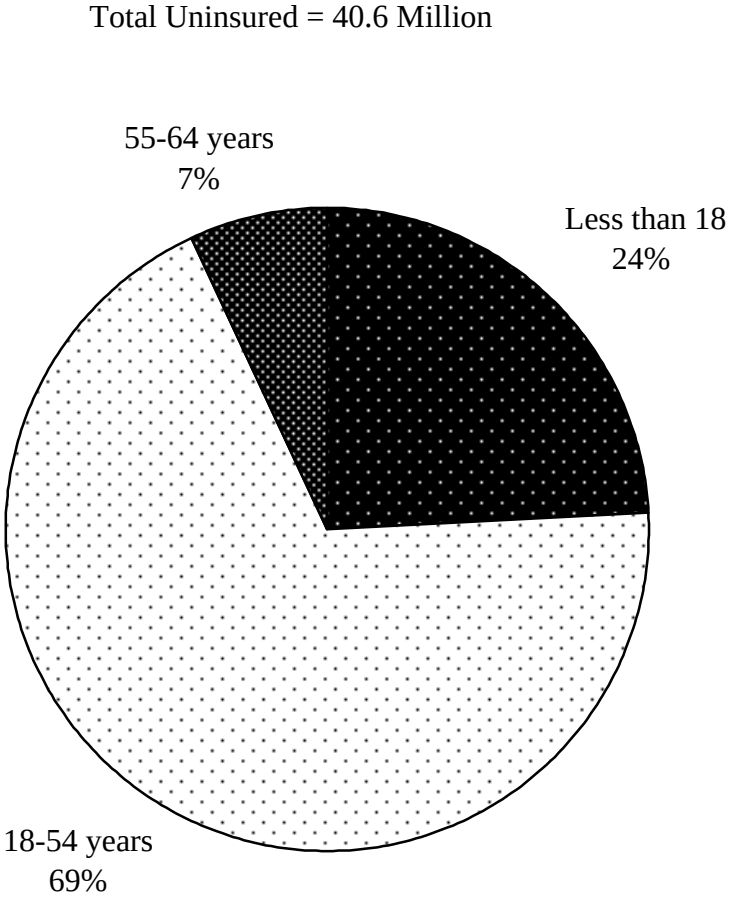


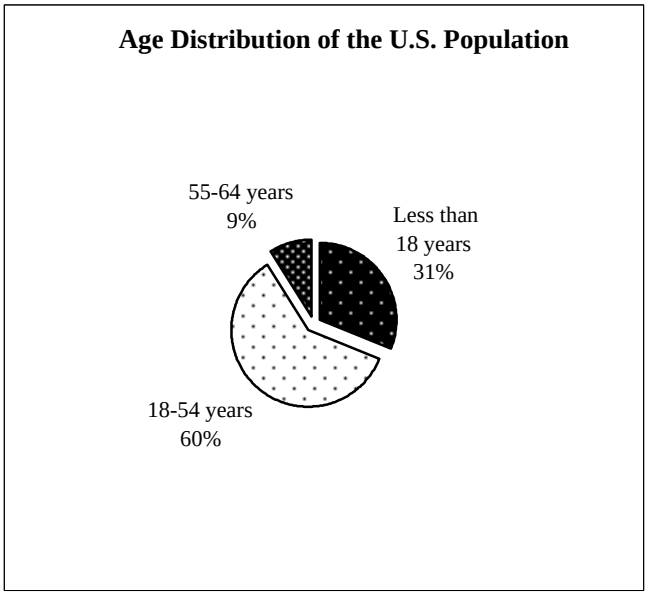
Source: CRS analysis of data from the March 1996 Current Population Survey (CPS).

Figure 2.2. Uninsured by Age, 1995

Persons aged 18-54 comprise 69% of all the uninsured population, whereas they constitute 60% of the nonelderly population. In contrast, children under age 18 make up 24% of those without health insurance, but 31% of the nonelderly population. Similarly, persons 55-64 years make up 7% of the uninsured, whereas they comprise 9% of all nonelderly people.

Figure 2.2. Uninsured by Age, 1995



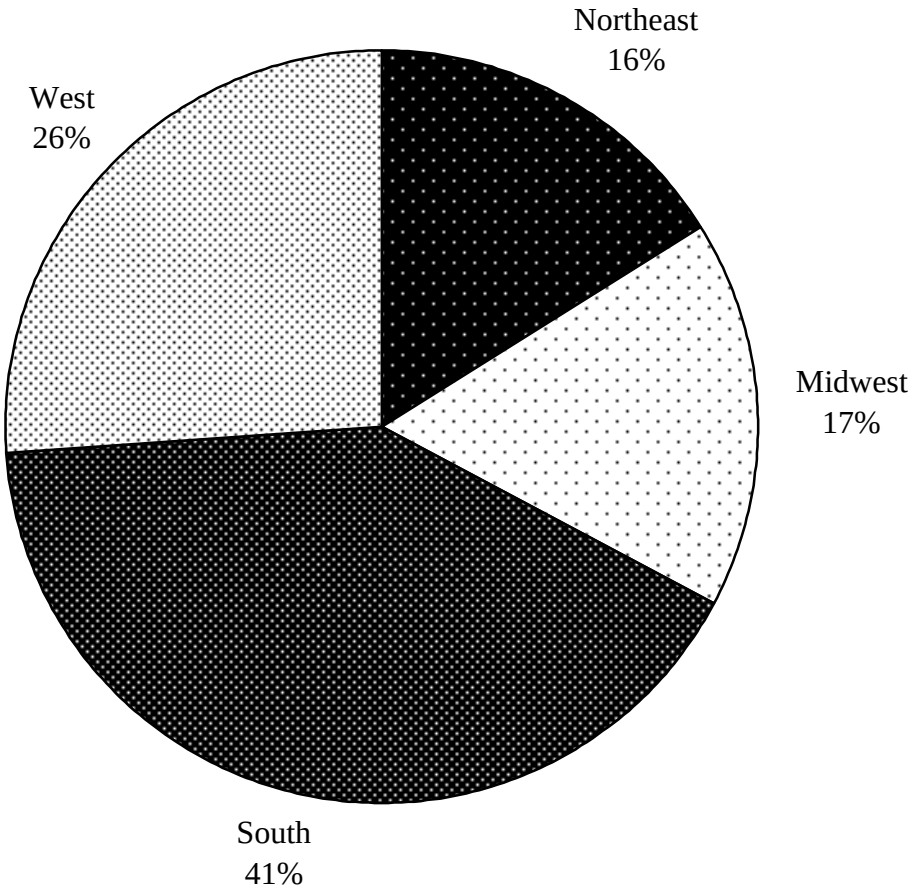


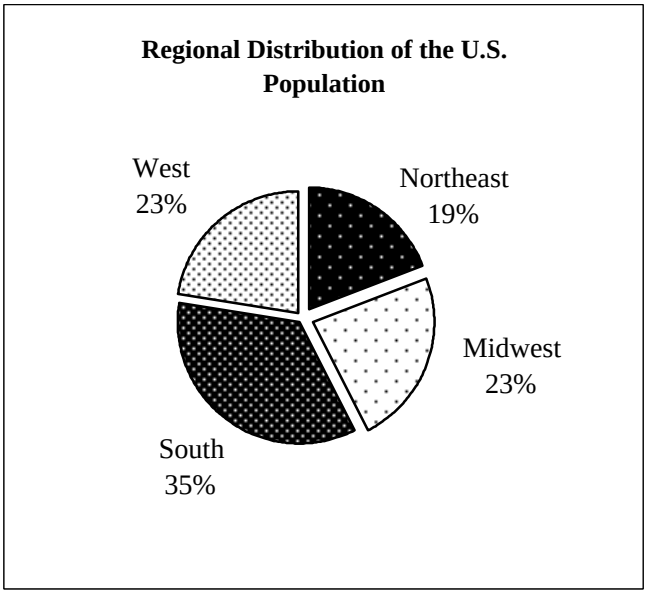
Source: Chart prepared by CRS based on analysis of the Current Population Survey, March 1996.

Figure 2.3. Uninsured by Region of Residence, 1995

People living in the Northeast and Midwest are less likely to be uninsured than those in the West and South. While residents of the Northeast and Midwest make up 19% and 23%, respectively, of the U.S. population, they constitute only 16% and 17% of persons without health insurance. In contrast, while the South contains 35% of the U.S. population, 41% of all people without health insurance reside in the South. Likewise, while 23% of U.S. residents live in the West, 26% of all people without health insurance live in Western states.

Figure 2.3. Uninsured by Region of Residence, 1995





Source: Chart prepared by CRS based on analysis of Current Population Survey, March 1996.

Figure 2.4.
Source of Children's Health Insurance, 1988 and 1995

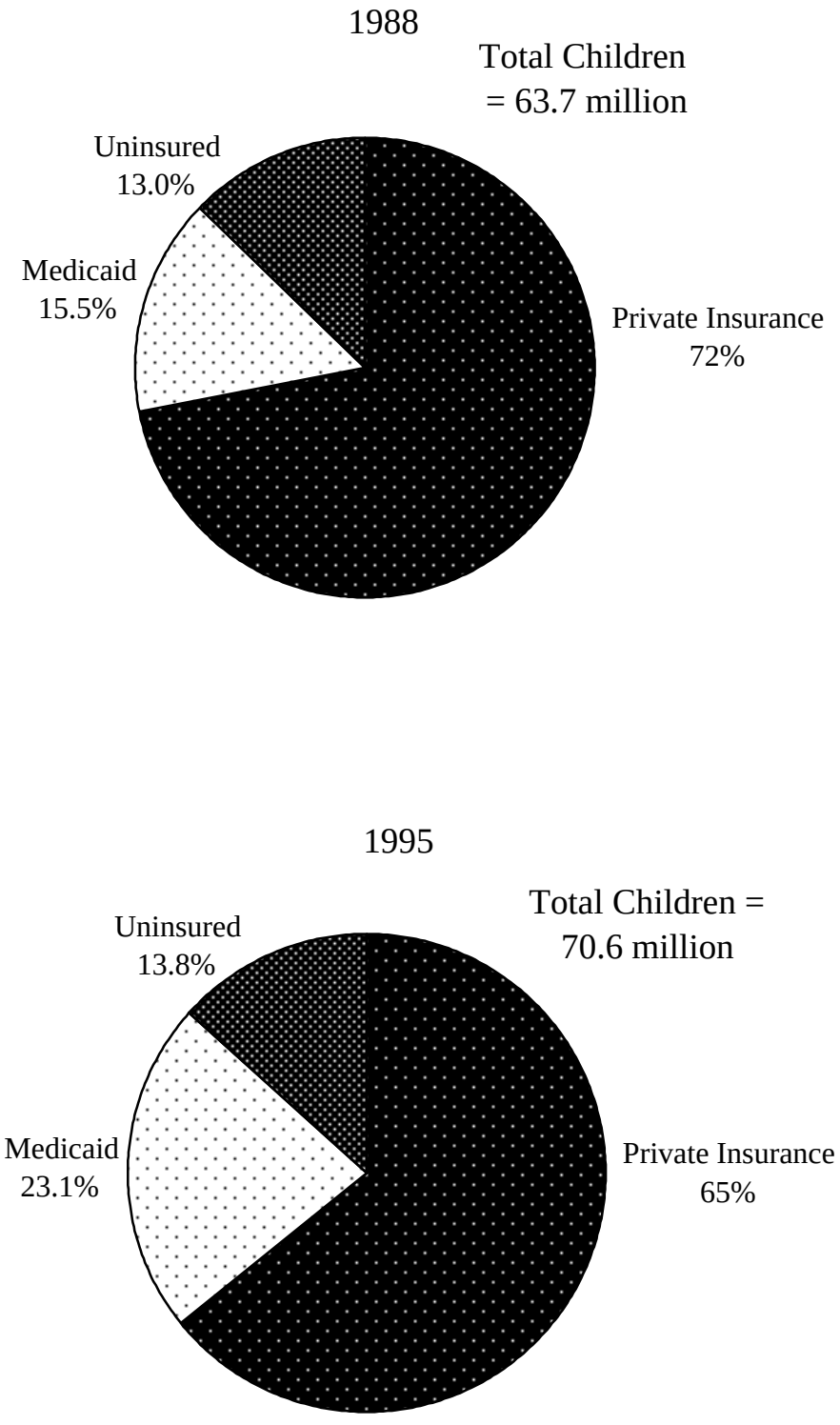
Figure 2.4 shows the percentage of children covered by private insurance and Medicaid, or who were uninsured in 1988 and 1995, according to data collected in the Current Population Survey (CPS). Care should be exercised in interpreting these data because changes to the survey instrument and data collection methods in the intervening years may have affected the estimates of insurance coverage derived from the CPS. Nevertheless, while the precise size of the changes in insurance coverage from year to year may be uncertain, the **trends** are not in doubt. The percentage of children with private health insurance -- employer-group coverage or individually purchased policies -- declined significantly from 1988 to 1995. Simultaneously, the percentage of children covered by Medicaid increased by approximately the same number of percentage points as the decline in private coverage. Consequently, the proportion of children with no health insurance changed very little over the period from 1988 to 1995, but number increased by 18%.

TABLE 2.4.
Source of Children's Health Insurance
1988 and 1995

(Number of Children)	1988	1995
Private Insurance	46,900,000	46,900,000
Medicaid	9,900,000	16,300,000
Uninsured	8,300,000	9,800,000
Total	63,750,000	70,566,000

NOTE: Table prepared by CRS. Some individuals are covered by more than one type of insurance.

Figure 2.4. Source of Children's Health Insurance, 1988 and 1995



Source: Figure prepared by CRS based on CRS analysis of the Current Population Survey, March 1989 and March 1996.

Figure 2.5.
Uninsured Children by Age, 1995

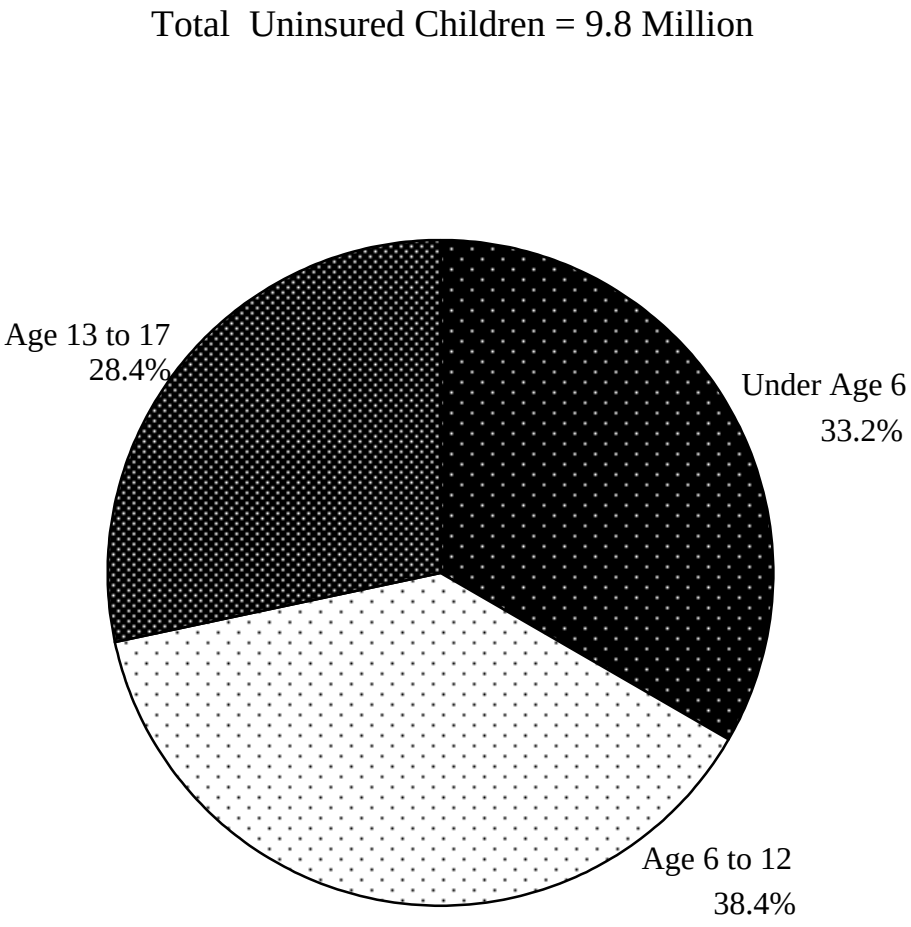
Figure 2.5 shows the distribution by age of uninsured children under age 18. The 9.8 million children without health insurance in 1995 comprised 13.8% of all children under age 18. Of this number, 33% were under age 6, 38% were ages 6 to 12, and 28% were ages 13 to 17. Among the three age groups, the highest proportion of uninsured children was among those 13 to 17 years old, 14.4% of whom were uninsured. The lowest rate of uninsured children was among those under age 6, 13.4% of whom were without health insurance in 1995.

TABLE 2.5.
Uninsured Children by Age, 1995

	Number	Percent
Under age 6	3,250,000	33.2
Ages 6-12	3,760,000	38.4
Ages 13-17	2,780,000	28.4
Total	9,790,000	100.0

NOTE: Table prepared by CRS.

Figure 2.5. Uninsured Children by Age, 1995



Source: Figure prepared by CRS based on CRS analysis of the Current Population Survey, March 1996.

Figure 2.6.
Uninsured Children by Family's Income Relative to Poverty Thresholds, 1995

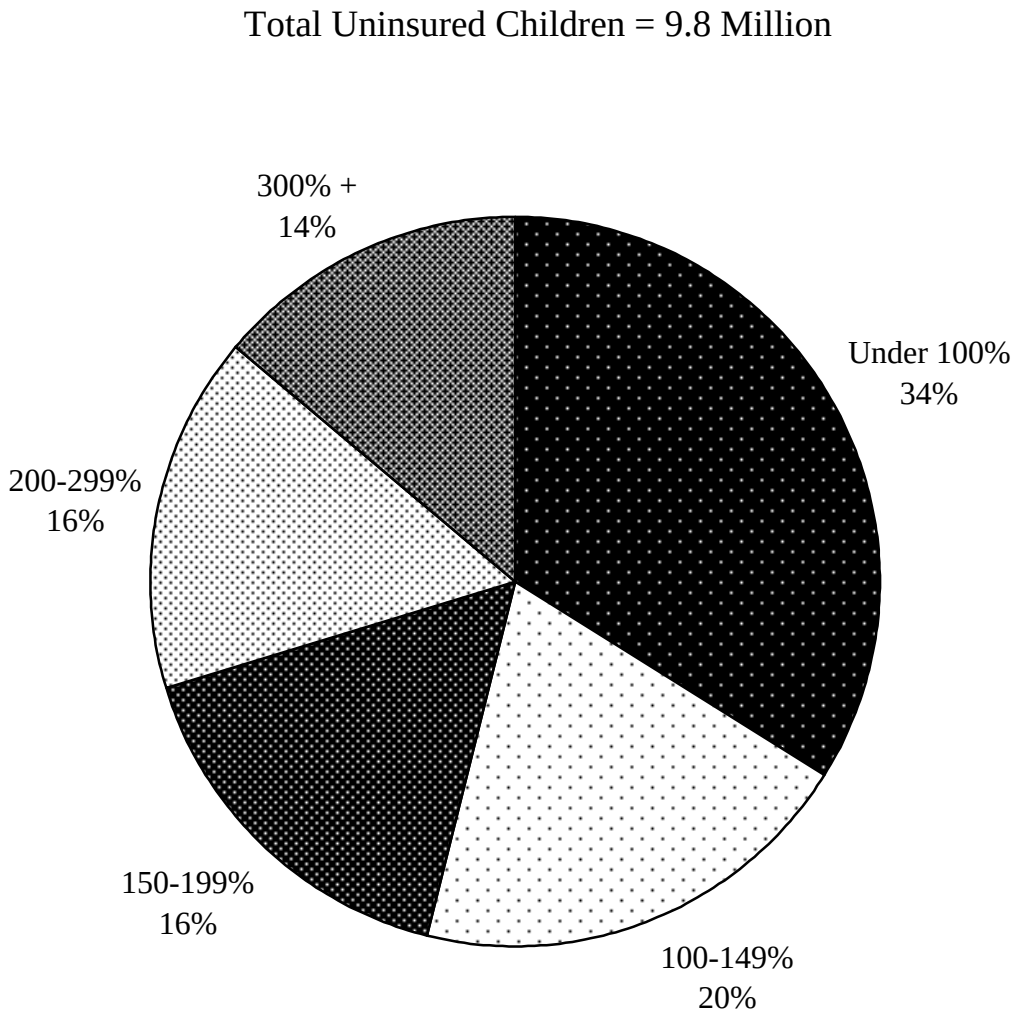
Figure 2.6 displays the distribution of uninsured children by family income relative to poverty thresholds (adjusted for size of family). One-third of uninsured children were in families with income below the poverty line in 1995. Slightly more than one-third of children without health insurance were in families with incomes between 100% and 200% of the poverty level. About 14% were in families with incomes three times the poverty level or higher.

TABLE 2.6.
Uninsured Children by Family's Income Relative to Poverty Thresholds
1995

	Number	Percent
Under 100%	3,325,000	34
100%-149%	1,952,000	20
150%-199%	1,604,000	16
200%-299%	1,559,000	16
300%+	1,356,000	14
Total	9,795,000	100

NOTE: Table prepared by CRS.

Figure 2.6. Uninsured Children by Family's Income Relative to Poverty Thresholds, 1995



Source: Figure prepared by CRS based on CRS analysis of the Current Population Survey, March 1996.

Figure 2.7.
Uninsured Children by Parents' Insurance Status, 1995

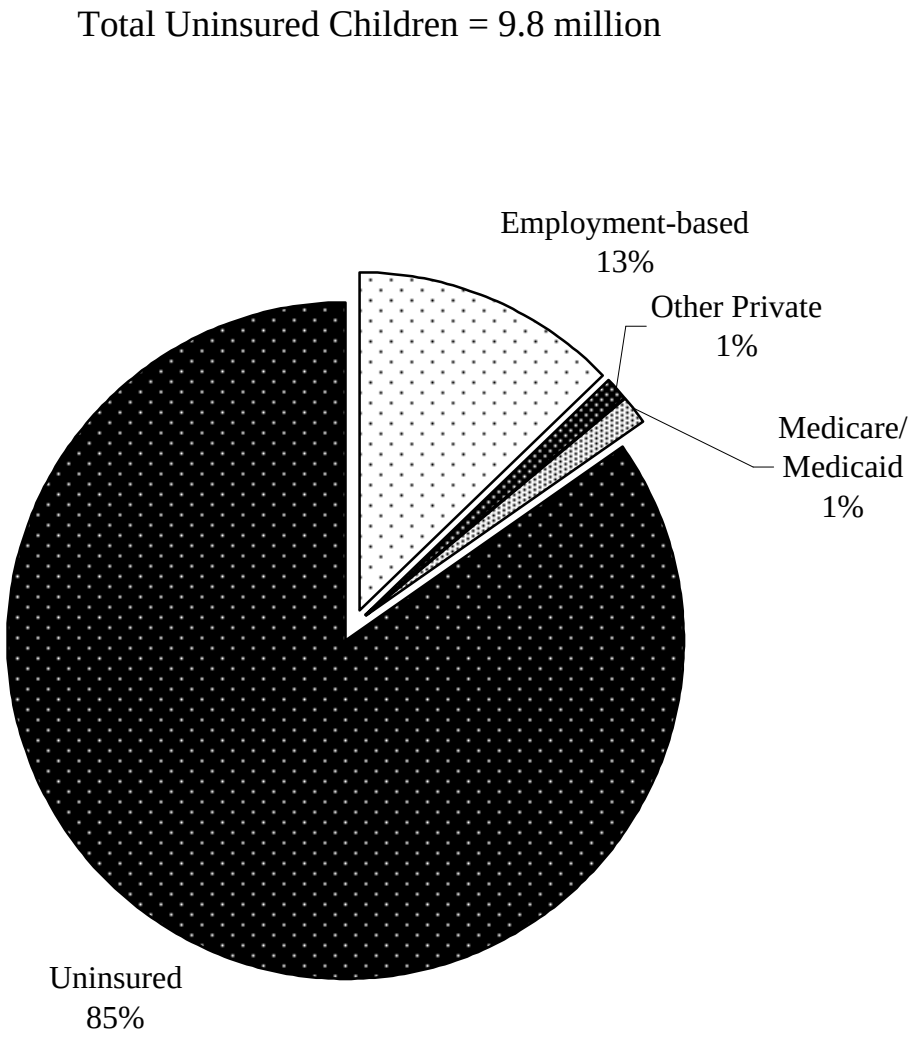
Figure 2.7 reports the health insurance status of the head of the family in which there was a child without health insurance throughout 1995. Only 13% of these parents had employment-based group coverage. Most uninsured children -- 85% -- were members of families in which the parents were uninsured also.

TABLE 2.7.
Uninsured Children by Parents' Insurance Status, 1995

	Number	Percent
Employment	1,253,000	13
Other private	111,000	1
Medicare or Medicaid	119,000	1
Uninsured	8,312,000	85
Total	9,795,000	100

NOTE: Table prepared by CRS.

Figure 2.7. Uninsured Children by Parents' Insurance Status, 1995



Source: Figure prepared by CRS based on CRS analysis of Health Interview Survey, 1993.

Figure 2.8.
Uninsured Children by Parents' Employment Status, 1995

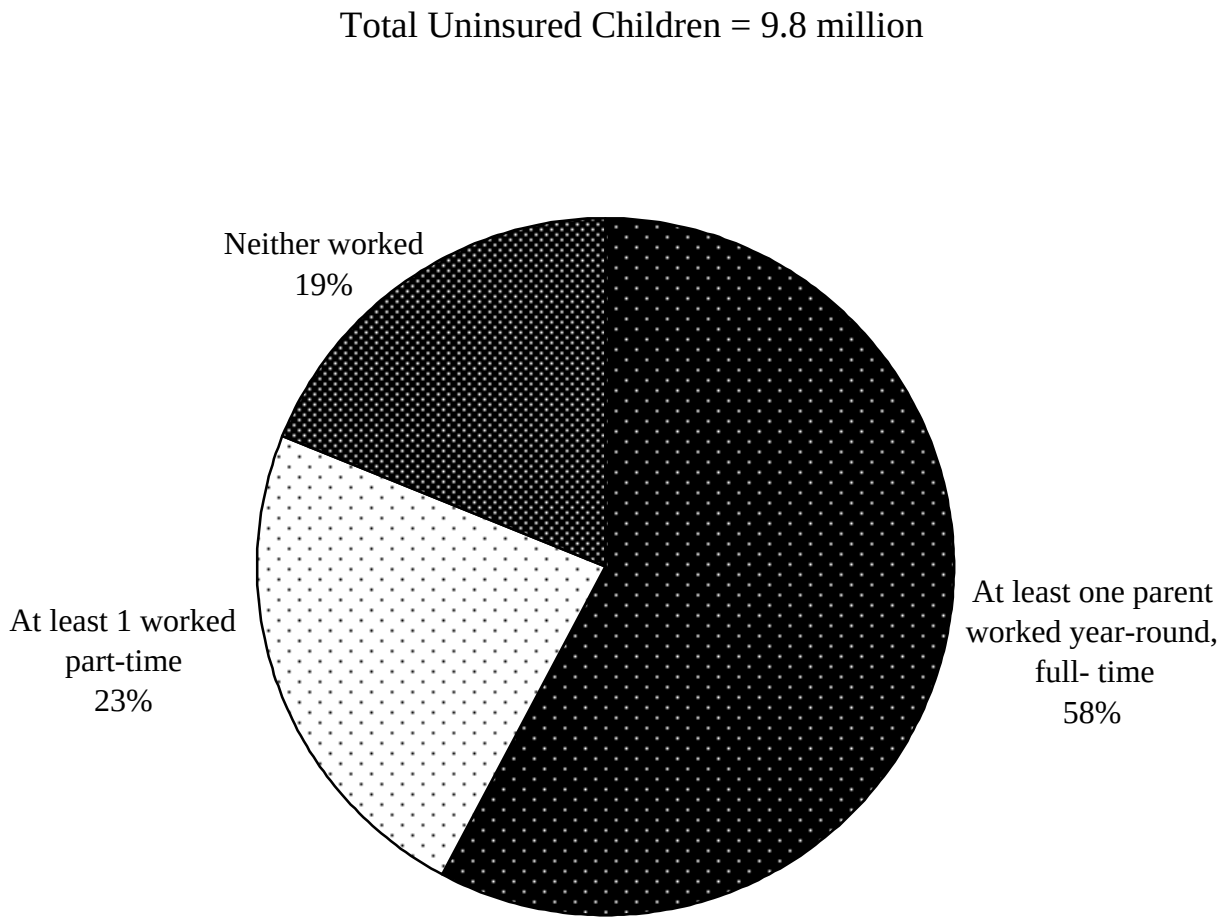
Figure 2.8 describes the employment status of the parent(s) of uninsured children. In 1995, almost 58% of uninsured children had at least one parent who worked full-time for the full year. Only 19% of children without health insurance were in families in which there was not at least one working parent.

TABLE 2.8.
Uninsured Children by Parents' Employment Status
1995

	Number	Percent
At least one parent worked full-time for the full year	5,656,000	58
At least one parent worked part-time	2,290,000	23
Neither parent worked	1,848,000	19
Total	9,794,000	100

NOTE: Table prepared by CRS.

Figure 2.8. Uninsured Children by Parents' Employment Status, 1995



Source: Figure prepared by CRS based on CRS analysis of Health Interview Survey, 1993.

Figure 2.9.
Uninsured Children by Size of Parent's Employer, 1993

Figure 2.9 shows the number of workers at the firm that employed the head of the family that included both an uninsured child and a working parent.[1] Almost 50% of these family heads worked for firms with fewer than 25 employees, and 37% worked in very small firms (those with fewer than 10 employees). Only 18% of uninsured children with a working parent were in families where the head-of-family was employed in a firm with 1,000 or more workers.

TABLE 2.9.
Uninsured Children by Size of Parent's Employer, 1993

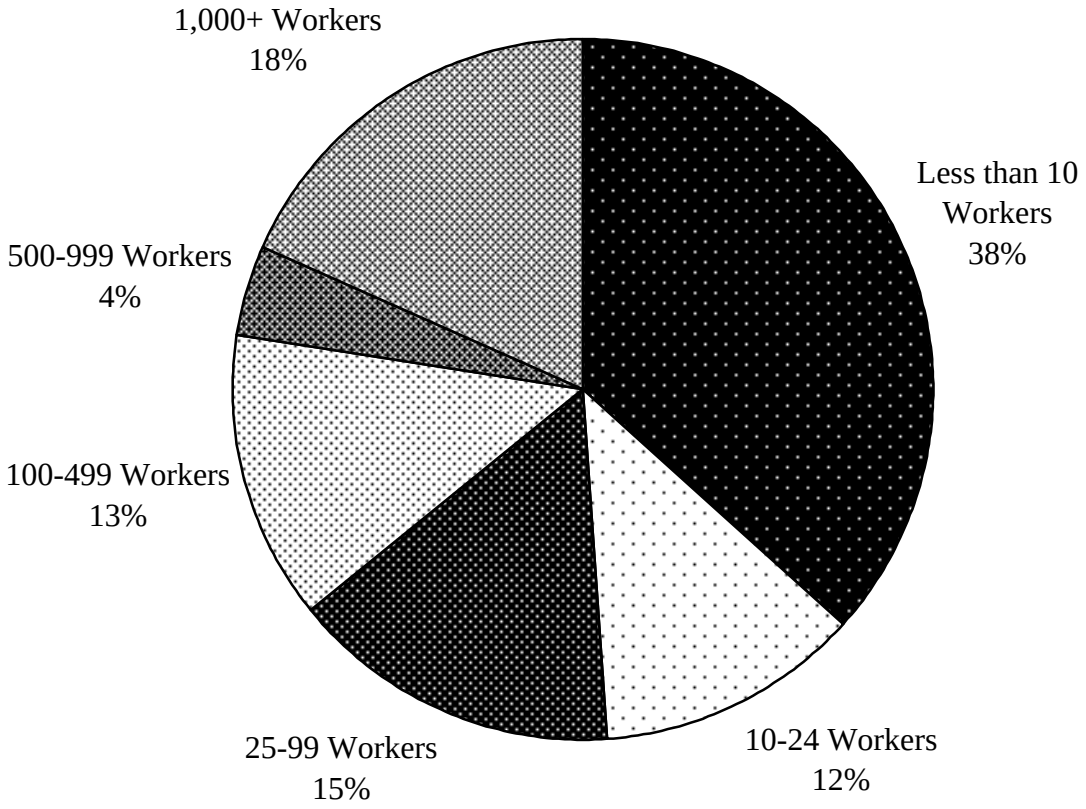
	Number	Percent
<10 Workers	2,932,000	38
10-24 Workers	972,000	12
25-99 Workers	1,218,000	15
100-499 Workers	1,049,000	13
500-999 Workers	347,000	4
1,000+ Workers	1,451,000	18
Total	7,969,000	100

NOTE: Table prepared by CRS.

[1] The firm comprises all locations at which the employer does business including, but not limited to, the establishment where the head of the family participating in this survey went to work each day.

Figure 2.9. Uninsured Children by Size of Parent's Employer, 1993

Total Uninsured Children With a Working Parent = 8.0 million



Source: Figure prepared by CRS based on CRS analysis of the Current Population Survey, March 1996.

Figure 2.10.
Length of Time Since Child Was Last Insured, 1993

Figure 2.10 displays the length of time since uninsured children were last insured, according to data collected in the 1993 National Health Interview Survey. Of the 8.8 million children who were uninsured in an average month in 1993, 8.6% had been insured sometime within the last 6 months. Another 6.0% were last insured between 6 months and 1 year ago. Sixteen percent last had health insurance coverage between 1 year and 3 years ago and about 18% last had health insurance coverage more than 3 years ago. More than half of all uninsured children had either never been insured or their parent or parents were unable or unwilling to say when the child was last covered by health insurance.

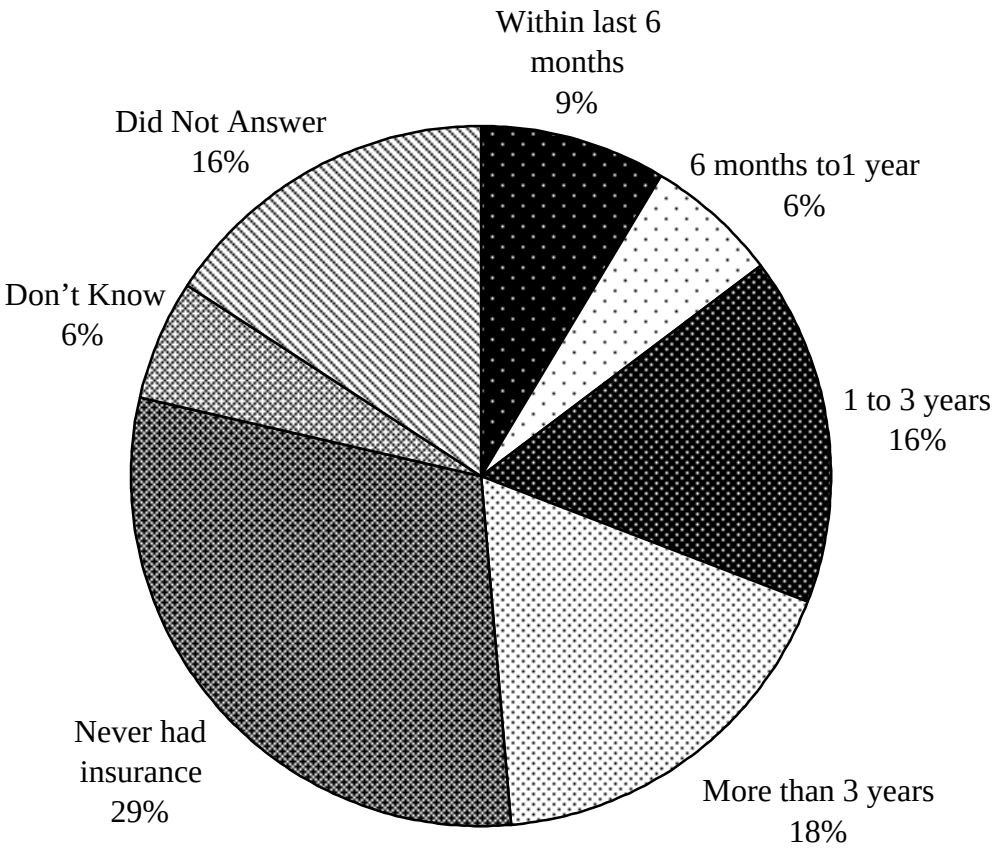
TABLE 2.10.
Length of Time Since Child Was Last Insured, 1993

	Number	Percent
6 months or less	759,000	9
6 months to 1 year	530,000	6
1 to 3 years	1,423,000	16
More than 3 years	1,556,000	18
Never insured	2,648,000	30
Do not know	502,000	6
Did not answer	1,383,000	16
Total	8,801,000	100

NOTE: Table prepared by CRS.

Figure 2.10. Length of Time Since Child Was Last Insured, 1993

Total Unisured Children (in 1993) = 8.8 million



Source: Figure prepared by CRS based on CRS analysis of Health Interview Survey, 1993.

Figure 2.11.
Percent of Children Seeing a Physician in a Two-Week Period 1993

Figure 2.11 shows the difference in the probability of a physician contact in any 2-week period in 1993 among privately insured children, children covered by Medicaid, and uninsured children, all with two or more medical conditions.[1] Among children with two or more medical conditions, 54% of those covered by private health insurance had at least one physician contact during a 2-week period, compared with only 35.5% of uninsured children, a difference in probabilities of 18.5 percentage points. Thus, the probability that a privately insured child with two or more medical conditions had contact with a physician in the previous 2 weeks was 52% greater than the probability that an uninsured child had a physician contact during that time (.539/.355 = 1.52). In contrast, the probability of a physician contact among children covered by Medicaid who had two or more medical conditions was similar to that of privately insured children. Among this group, the probability of a physician visit among privately insured children exceeded that for Medicaid-covered children, but by only 1.4 percentage points, 53.9% for privately insured children to 52.5% for those covered by Medicaid, or a 2.7% greater probability (.539/.525 = 1.027).

TABLE 2.11.
Percent of Children Seeing a Physician in a Two-Week Period, 1993

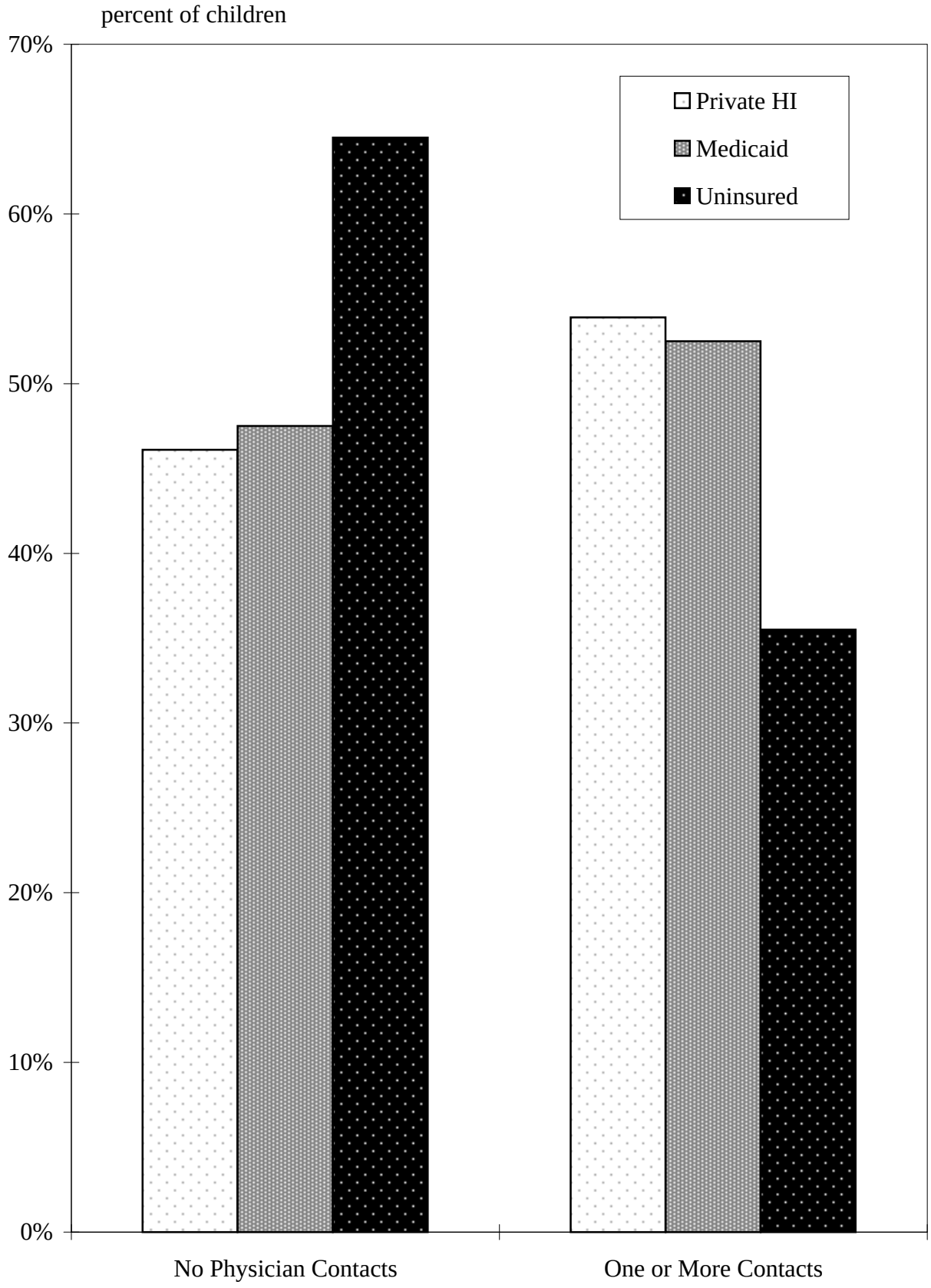
	Private HI	Medicaid	Uninsured
No contacts	46	47	65
One or more contacts	54	53	35

NOTE: Table prepared by CRS.

[1] A physician contact is defined as consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. The contact may have occurred in a physician office, a clinic, hospital outpatient department or emergency room, or in another setting. Contacts with physicians while a hospital inpatient are not included.

Medical conditions include illness, injury, or impairment, and may be either *chronic* (lasting or expected to last more than 3 months) or *acute* (lasting or expected to last less than 3 months). All conditions except impairments are coded in the HIS according to the ninth edition of the *International Classification of Diseases*. Special codes developed by the National Center for Health Statistics are used to code impairments.

Figure 2.11. Percent of Children Seeing a Physician in a Two-Week Period, 1993



Source: Figure prepared by CRS based on CRS analysis of the Health Interview Survey, 1993.

Figure 2.12.
Enrollment in Employment-Based Health Plans, by Plan Type, 1992-1996

Health plan enrollments shifted dramatically from 1992 to 1996. Among employees of private and public employers with more than 200 workers, enrollment in conventional fee-for-service (FFS) plans declined from 45% of the total to 26%. Enrollees shifted from FFS plans to health maintenance organizations (HMOs) and point-of-service (POS) plans. (POS plans resemble an HMO for in-network services, and a FFS plan for out-of-network care.) The proportion of enrollment in PPO plans remained relatively stable at about 25% of the total.

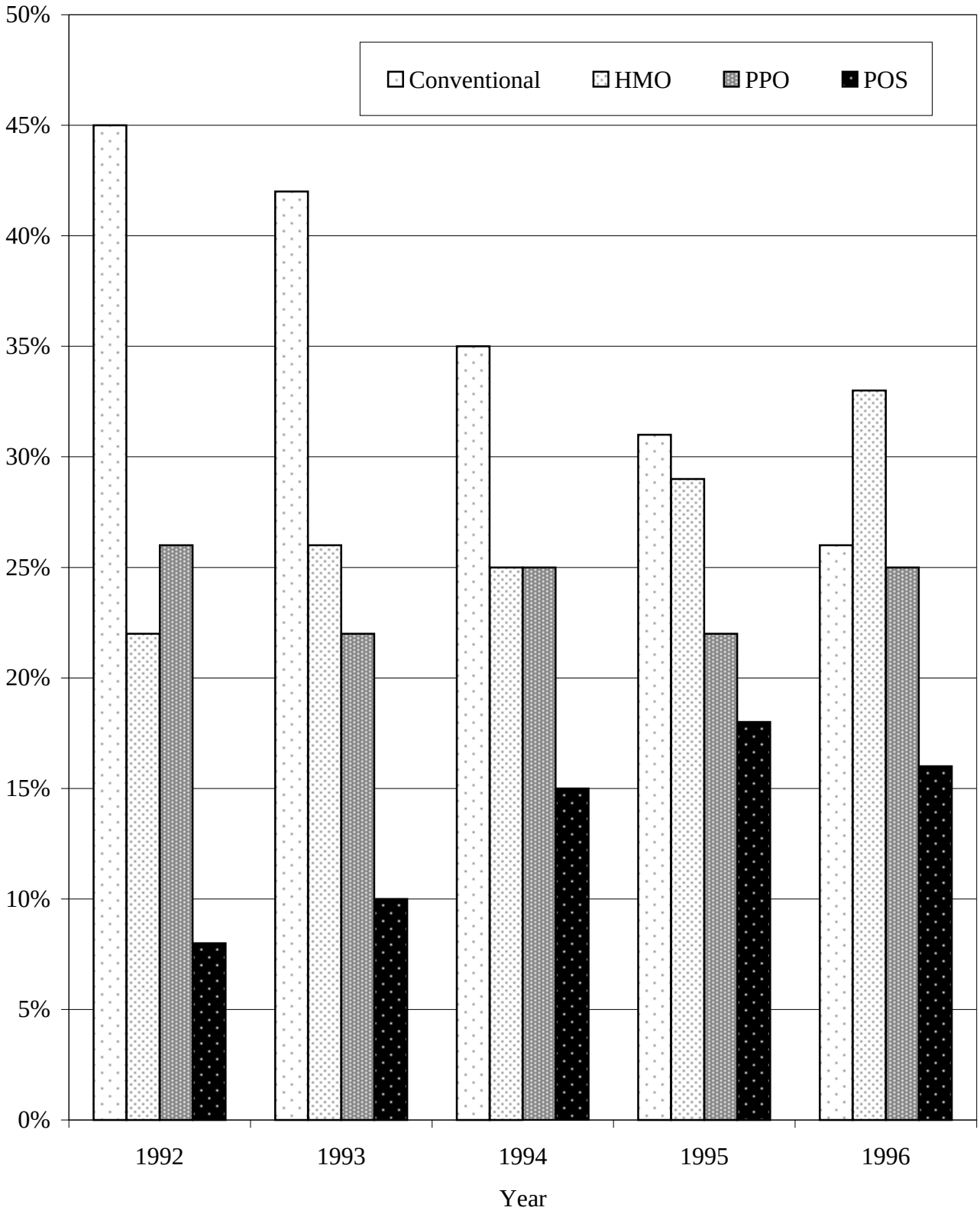
The shift to managed care was rapid. In 1992, slightly less than half (45%) of enrollees were in conventional FFS plans, and the remaining 55% were in some form of managed care, either an HMO, PPO, or POS plan. By 1996, almost 75% of enrollees were in managed care plans.

TABLE 2.12.
Enrollment in Employment-Based Health Plans, by Plan Type, 1992-1996
(in percent)

	Type of Plan			
Year	Conventional	HMO	PPO	POS
1992	45	22	26	8
1993	42	26	22	10
1994	35	25	25	15
1995	31	29	22	18
1996	26	33	25	16

NOTE: Table prepared by CRS.
Source: KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits, 1992-1996.

Figure 2.12. Enrollment in Employment-Based Health Plans, by Plan Type 1992-1996



Source: Chart prepared by CRS based on KPMG Peat Marwick Survey of Employer Sponsored Health Benefits, 1992-1996.

Figure 2.13.
Change in Employment-Based Health Insurance Premiums 1992-1995

While health insurance premiums increased every year from 1992 to 1995, the annual rate of change in premiums was smaller each year than the previous year among all plans combined, according to surveys of employers by Hay-Huggins and KPMG Peat Marwick. The rate of growth declined from about 11%-12% in 1992 to about 1%-2% in 1995. This pattern of rate change was shown among fee-for-service (FFS), health maintenance organizations (HMOs), and generally among preferred provider organizations (PPOs). Point-of-service (POS) plans showed a different pattern, and the pattern differed by survey. KPMG reported that POS plans saw rates of change in premiums increase from 1993 to 1994 over the previous period, before declining again from 1994 to 1995. Hay reported that rates of POS plan premium growth dropped in 1994 before rising again in 1995.

POS plans saw the lowest premium growth over the entire period, growing about 3%-4%. Premiums in HMOs and PPOs grew about 5%, while FFS plan premiums grew between 5% and 6%. The higher growth in FFS plan premiums may help explain the decline in FFS enrollment over this period; similarly, the lower premium growth in POS plans probably encouraged greater enrollment in these types of plans.

TABLE 2.13.
Change in Employment-Based Health Insurance Premiums, 1992-1995
(in percent)

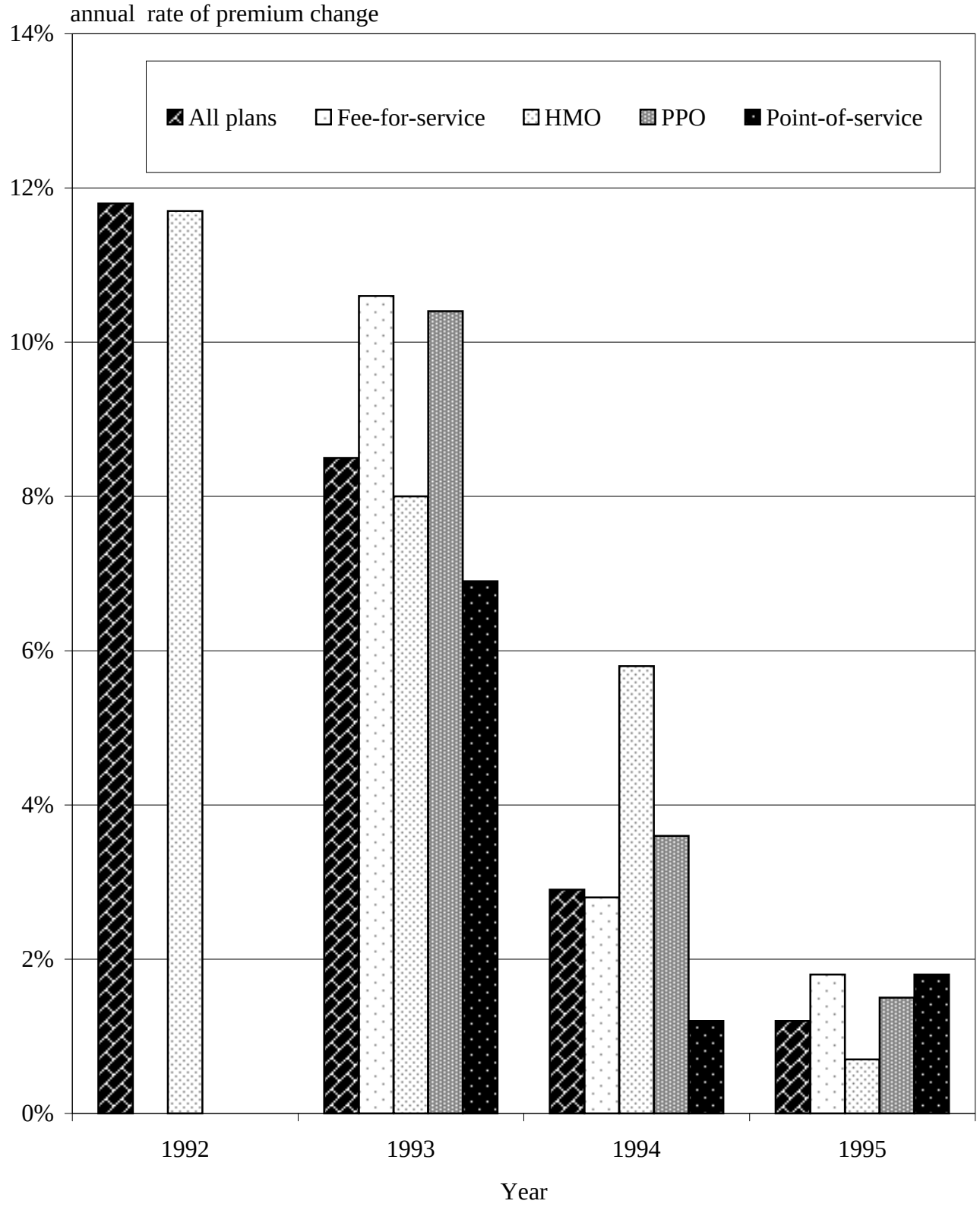
Year	All Plans[a]	FFS	HMO	PPO	POS
Hay-Huggins Survey					
1992	11.8	-- [b]	11.7	-- [b]	-- [b]
1993	8.5	10.6	8.0	10.4	6.9
1994	2.9	2.8	5.8	3.6	1.2
1995	1.2	1.8	0.7	1.5	1.8
1992-1995	4.2	5.0	4.8	5.1	3.3
KPMG Peat Marwick Survey					
1992	10.8	11.0	10.0	11.0	-- [b]
1993	8.1	9.0	8.0	8.0	4.9
1994	4.8	5.1	5.3	3.2	5.9
1995	2.2	2.7	0.4	3.5	2.4
1992-1995	5.0	5.6	4.5	4.9	4.4

[a]Calculated as average of premium charges for four plan types and employee-only and family coverage; weighted by enrollment. Includes both employer and employee share.
[b] Not available.

NOTES: Table prepared by CRS. HMO = health maintenance organization; PPO = preferred provider organization.

Sources: Hay-Huggins Benefits Report (calculations for 1994 and 1995 by Paul B. Ginsburg and Jeremy D. Pickreign; data for 1992 and 1993 from published Hay-Huggins reports to clients); and KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits (calculations by KPMG staff as specified by Ginsburg and Pickreign). Table from: Ginsburg, Paul B., and Jeremy D. Pickreign. Tracking Health Care Costs. *Health Affairs*, fall 1996. p. 146.

Figure 2.13. Change in Employment-Based Health Insurance Premiums, 1992-1995



NOTE: 1992 fee-for service, PPO, and point-of-service data are not available.
Source: Figure prepared by CRS based on data obtained from Hay/Huggins, Inc.

Figure 2.14.
Comparison of Medicare Growth with Private Health Insurance, 1970-1994

Over the past 15 years, *aggregate* growth in *total* personal health expenditures has averaged 13.7% annually under Medicare and 13.0% annually under private health insurance. After a period of lower or identical growth rates for Medicare from 1985 to 1991, Medicare's growth rate exceeded that of private health insurance from 1992 to 1994 (top panel of figure 2.14).

The recent differences in growth rates may suggest that private health insurance has become more successful in controlling costs than Medicare. However, several analysts argue that comparisons of growth in total spending under Medicare and private health insurance mask differences which have little to do with the success of private insurers in controlling costs.[1] Three critical distinctions between Medicare and private health insurance have been cited:

- Differential rates of growth in populations covered;
- Differences in the mixture of services covered, and differential growth in costs for these services; and
- Changes in covered benefits over time.

Examining expenditures per enrollee eliminates differential rates of growth in populations covered as a factor causing growth. When this is done, Medicare growth still exceeds that of private health insurance after 1991, but the differences are narrowed (middle panel in figure 2.14). When growth in personal health expenditures is examined only for services which are covered by both Medicare and private health insurance, Medicare expenditures grew more slowly than private health insurance expenditures every year over the past 10 years except 1994 (bottom panel in figure 2.14). The gap in growth in 1994 narrows to 5.1 percentage points -- 8.7% under Medicare and 3.6% under private health insurance.

This gap may be narrowed further if Medicare expenditures for treatment of end-stage renal disease (ESRD) and hospice care are removed (because Medicare largely funds these services), along with the effects of policy changes in Medicare. Levit, et al. report that taking differences in enrollment growth, services covered, and policy changes into account, Medicare growth from 1993 to 1994 was about 5.6% per beneficiary and private health insurance was about 3.6% per covered person, for a gap of 2.0 percentage points using this adjusted basis. Note that differences in the severity of illness between Medicare beneficiaries and the nonelderly may account for some of the remaining difference in growth rates.

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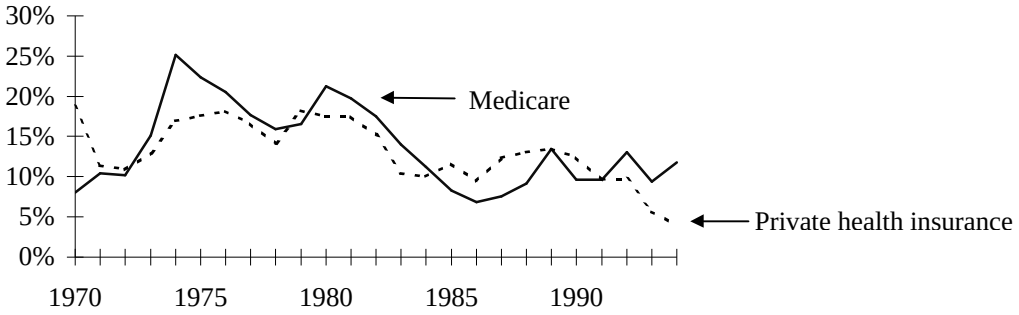
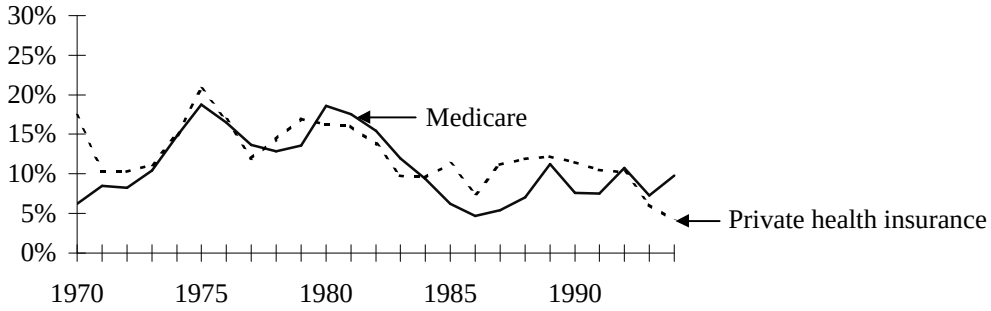
[1] See Levit, Katharine R., et al. National Health Expenditures, 1994. *Health Care Financing Review*, spring, 1996; Moon, Marilyn and Stephen Zuckerman. *Are Private Insurers Really Controlling Spending Better Than Medicare?* Prepared for the Henry J. Kaiser Family Foundation, Urban Institute, July 1995.

Figure 2.14. Comparison of Medicare Growth with Private Health Insurance, 1970-1994

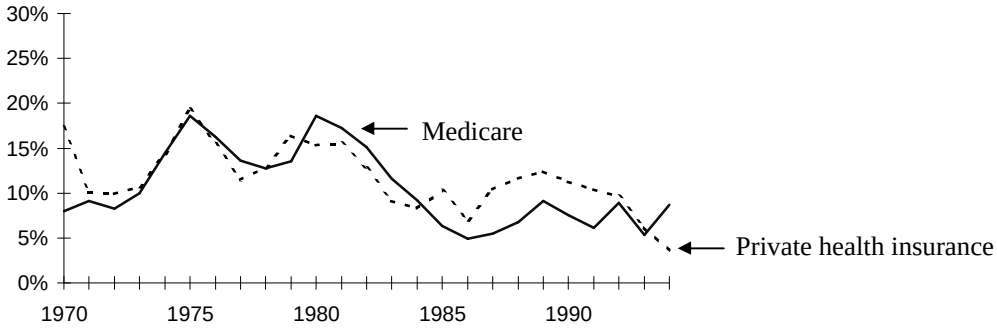
Aggregate Growth Rate



Growth Rate Per Enrollee



Similar Services Growth Rate Per Enrollee



Source: Prepared by CRS based on National Health Expenditure data from HCFA, Office of the Actuary.

Figure 2.15.
Distribution of HMOs by Number of Enrollees, 1994

Data on health plan enrollment presented in previous figures are from surveys of employer plans. Increasing numbers of employees and their families are enrolling in managed care plans, including HMOs, PPOs, and other types of managed care delivery system arrangements. The data presented in this and following figures are for HMOs, derived from surveys of HMOs by the Group Health Association of America (GHAA), now the American Association of Health Plans (AAHPs).

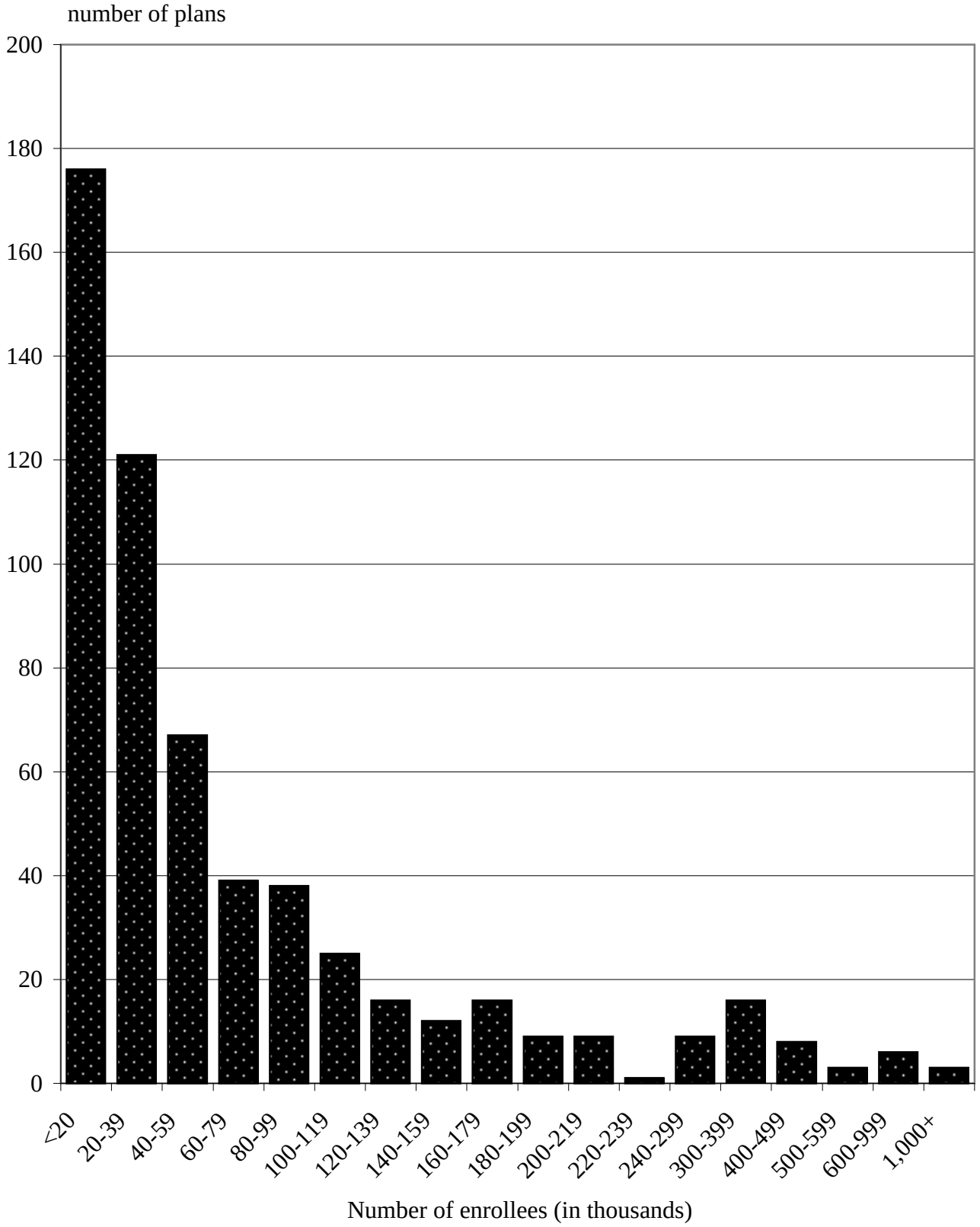
In 1994, most HMOs surveyed by GHAA had fewer than 100,000 enrollees, and about 50% had fewer than 44,000 enrollees. Not shown in the figure is that, on average, 85% of HMO members enrolled through group contracts (mostly with employers), 1% through individual contracts, 3% through Medicare risk contracts, 1% through other Medicare contracts, and 6% through Medicaid programs. These proportions varied widely across HMOs.

TABLE 2.15.
Distribution of Plans by Number of Enrollees at Year-End, 1994

Number of Enrollees	Number of Plans
<20,000	176
20,000-39,000	121
40,000-59,000	67
60,000-79,000	39
80,000-99,000	38
100,000-119,000	25
120,000-139,000	16
140,000-159,000	12
160,000-179,000	16
180,000-199,000	9
200,000-219,000	9
220,000-239,000	1
240,000-299,000	9
300,000-399,000	16
400,000-499,000	8
500,000-599,000	3
600,000-999,000	6
1,000,000+	3

NOTE: Table prepared by CRS.

Figure 2.15. Distribution of Plans by Number of Members, 1994



Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO PPO Industry Profile*, Exhibit 3-2.

Figure 2.16.
Increasing Diversification in the HMO Industry, 1990-1994

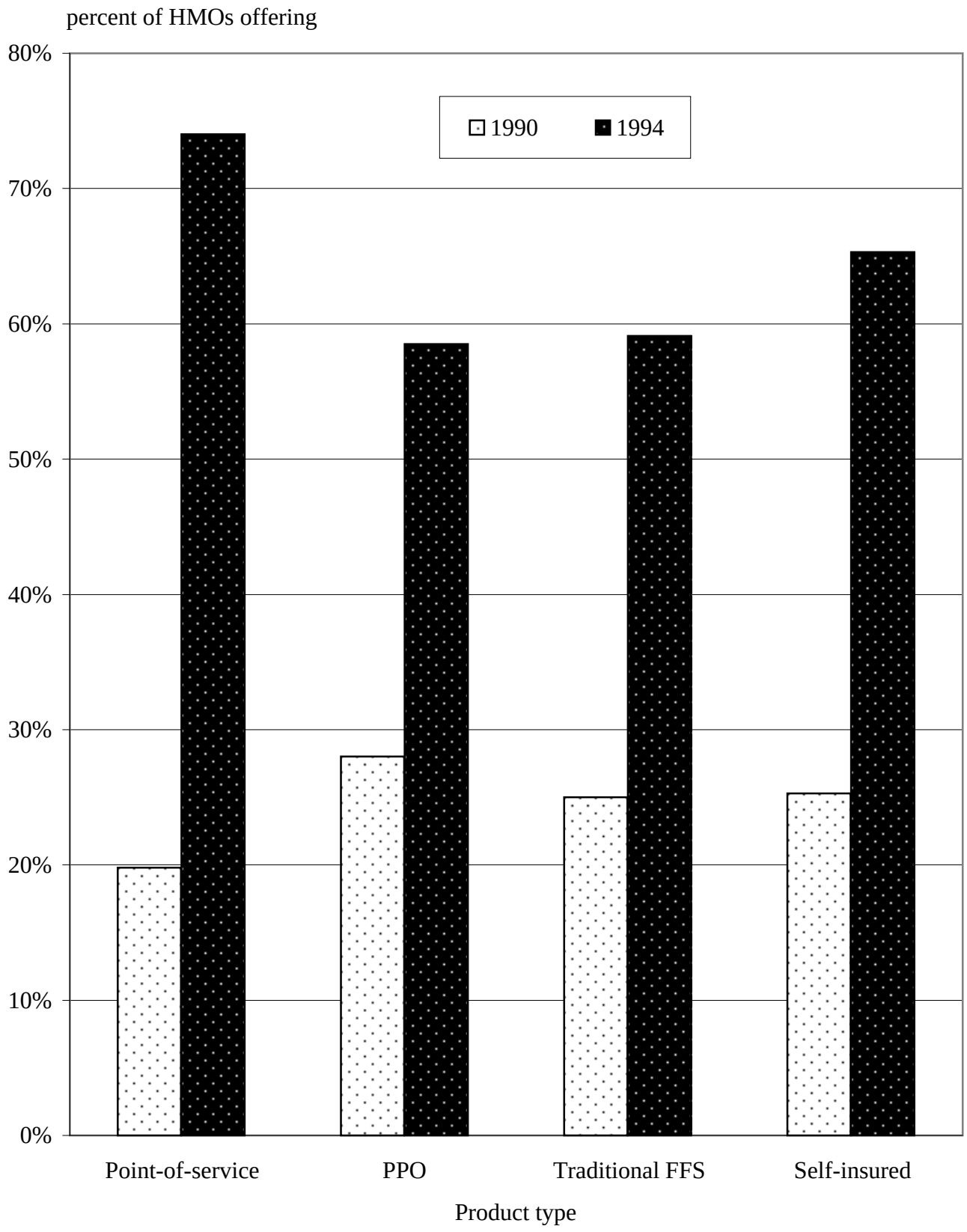
Managed care was once largely dominated by closed-network HMOs, in which enrollees are generally restricted to the HMO's group of providers. Today, HMOs are themselves diversifying. They are offering their members an increasing array of health plan options that go beyond traditional HMO arrangements. An HMO may contract with an employer to provide a fee-for-service (FFS, or indemnity) option as well as a traditional HMO option. Many HMOs are also selling utilization management and claims processing services to self-insured employers. This diversification is shown in the figure. The percentage of HMOs offering point-of-service options, which enable enrollees to obtain services from non-network providers (usually at an additional cost) has grown from just under 20% in 1990 to 74% in 1994. Preferred provider organization (PPO) products were being offered by 59% of HMOs in 1994, up from 28% in 1990. More HMOs were offering FFS products, increasing from 25% in 1990 to 59% in 1994. Also, in 1994, an HMO was much more likely to be offering a self-insured third party administrator product than it was in 1990.

TABLE 2.16.
Increasing Diversification in the HMO Industry, 1990-1994
(percentage of HMOs offering)

Product Type	1990	1994
Point-of-service	19.8	74.0
PPO	28.0	58.5
Traditional FFS	25.0	59.1
Self-insured	25.3	65.3

NOTE: Table prepared by the CRS.

Figure 2.16. Increasing Diversification in the HMO Industry, 1990-1994



Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO 1PO Industry Profile,* Exhibit 2-1.

Figure 2.17.
Trends in Inpatient Utilization Rates:
HMO Enrollees and the U.S. Population, 1988-1993

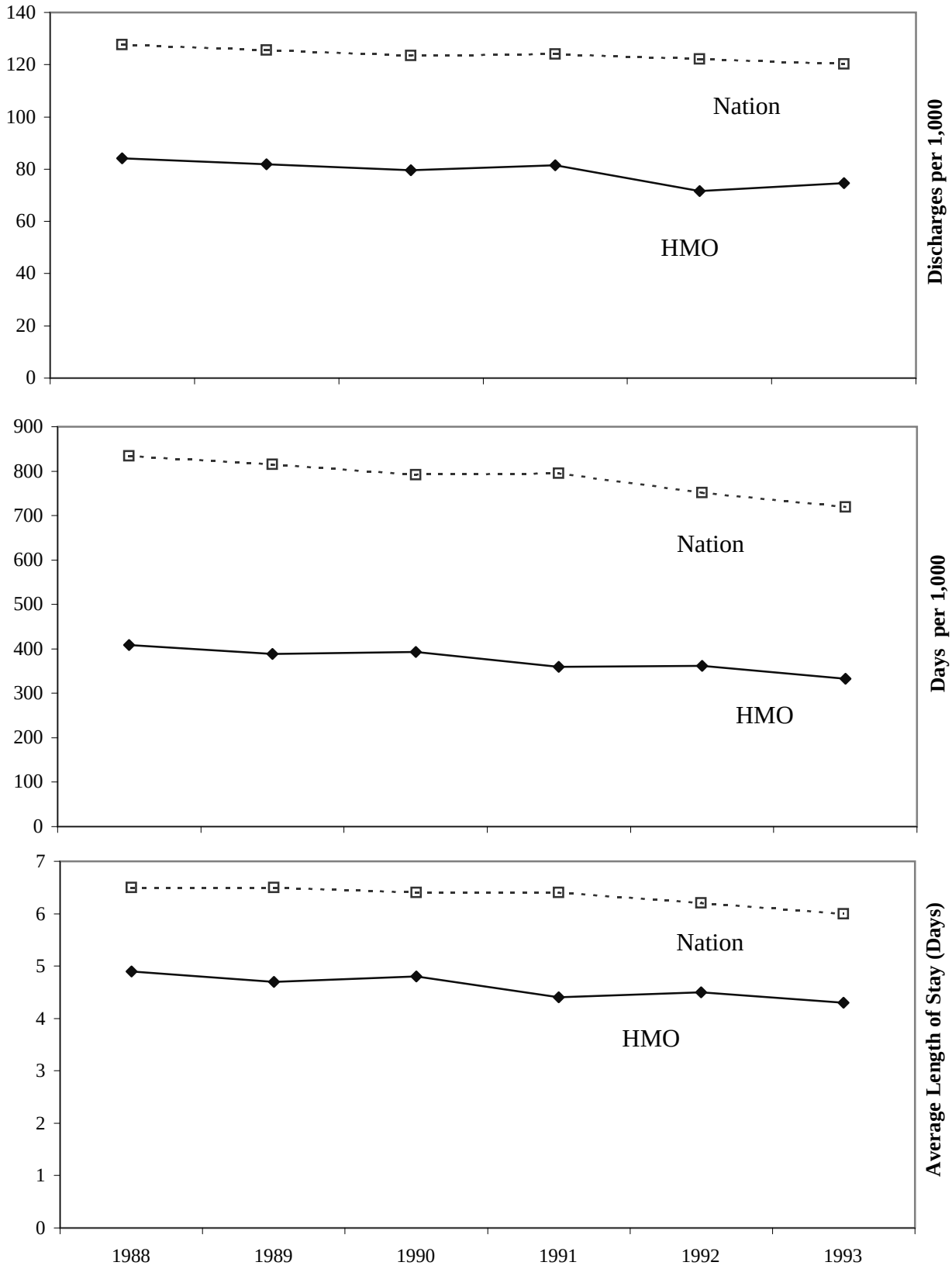
The most costly health care event is hospitalization. Most studies of HMOs have found that HMOs are able to provide medical care for less than fee-for-service (FFS) insurance partly by reducing hospital admissions and by providing for shorter lengths of hospital stays. The relative success of HMOs in reducing the utilization of inpatient care is shown in the figure. Total inpatient HMO utilization rates declined between 1988 and 1993. Overall, HMO members were hospitalized about two-thirds as often as the population as a whole in 1993. On average, they spent about half as many days in the hospital. Nationally, total utilization rates have also declined since 1988. Because the national figures include HMO members, the national decline is *partly* explained by increased HMO membership as well as the growth in other kinds of managed care, such as preferred provider organizations (PPOs) and the increasing use of utilization review by FFS (indemnity) insurers.

TABLE 2.17.
Trends in Inpatient Utilization Rates:
HMO Enrollees and the U.S. Population, 1988-1993

	1988	1989	1990	1991	1992	1993
Discharges per 1,000						
HMO	84.2	81.8	79.6	81.4	71.6	74.6
Nation	127.6	125.5	123.5	124.1	122.1	120.2
Days per 1,000						
HMO	409	389	393	360	362	333
Nation	834	815	792	795	751	719
Average length of stay						
HMO	4.9	4.7	4.8	4.4	4.5	4.3
Nation	6.5	6.5	6.4	6.4	6.2	6

NOTE: Table prepared by CRS.

Figure 2.17. Trends in Inpatient Utilization Rates: HMO Enrollees and the U.S. Population, 1988-1993



Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO and PPO Industry Profile*, Exhibit 3-3.

Figure 2.18.
Selected Procedures Per 100,000 Among HMO Enrollees and the Overall Population, 1993

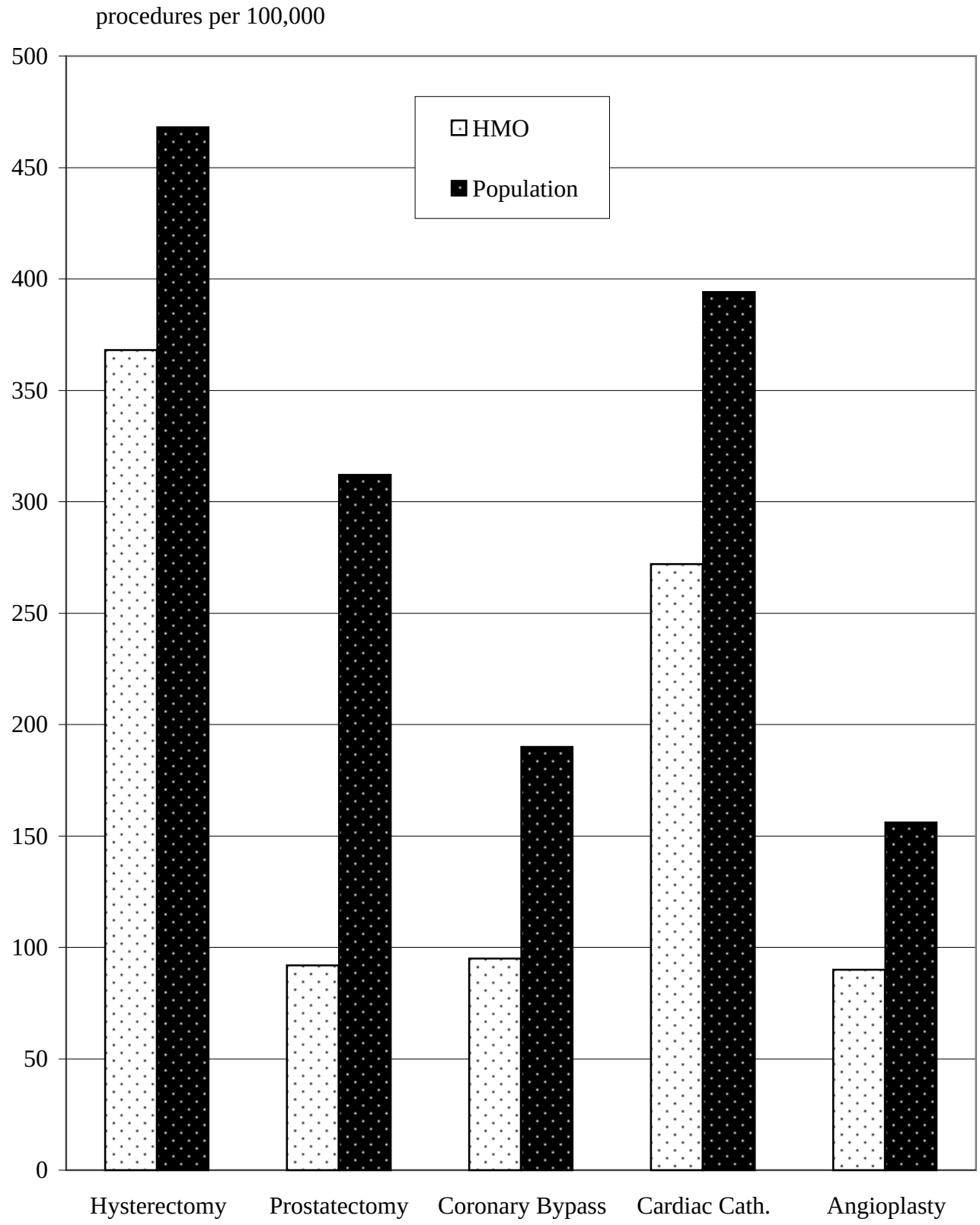
The five medical procedures included in the figure are high in cost, high in volume, and often show wide regional variation in the rates at which the procedures are performed. In 1993, all five procedures were performed less frequently on HMO enrollees than for the population of the nation as a whole. For example, the hysterectomy rate for women nationally was 468 per 100,000 or 27% higher than the HMO rate of 368 per 100,000. Coronary bypass procedures were done almost twice as often for the nation as a whole as are done for HMO enrollees.

TABLE 2.18.
Selected Procedures Per 100,000 Among HMO Enrollees and the Overall Population, 1993

	HMO	Population
Hysterectomy	368	468
Prostatectomy	92	312
Coronary bypass	95	190
Cardiac catheterization	272	394
Angioplasty	90	156

NOTE: Table prepared by CRS.

Figure 2.18. Selected Procedures per 100,000 Among HMO Members and the Overall Population, 1993



Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO PPO Industry Profile*, Exhibit 3-6.

Figure 2.19.
Preferred Provider Organization (PPO) Enrollment
1992-1994

A PPO is a health plan arrangement in which providers contract to provide services to enrollees for discounted amounts, usually paid on a fee-for-service (FFS) basis. Enrollees in the PPO may use other non-preferred providers, usually with higher coinsurance requirements. One way the typical PPO differs from HMOs is that visits to specialists generally do not require referral by an enrollee's primary care provider.

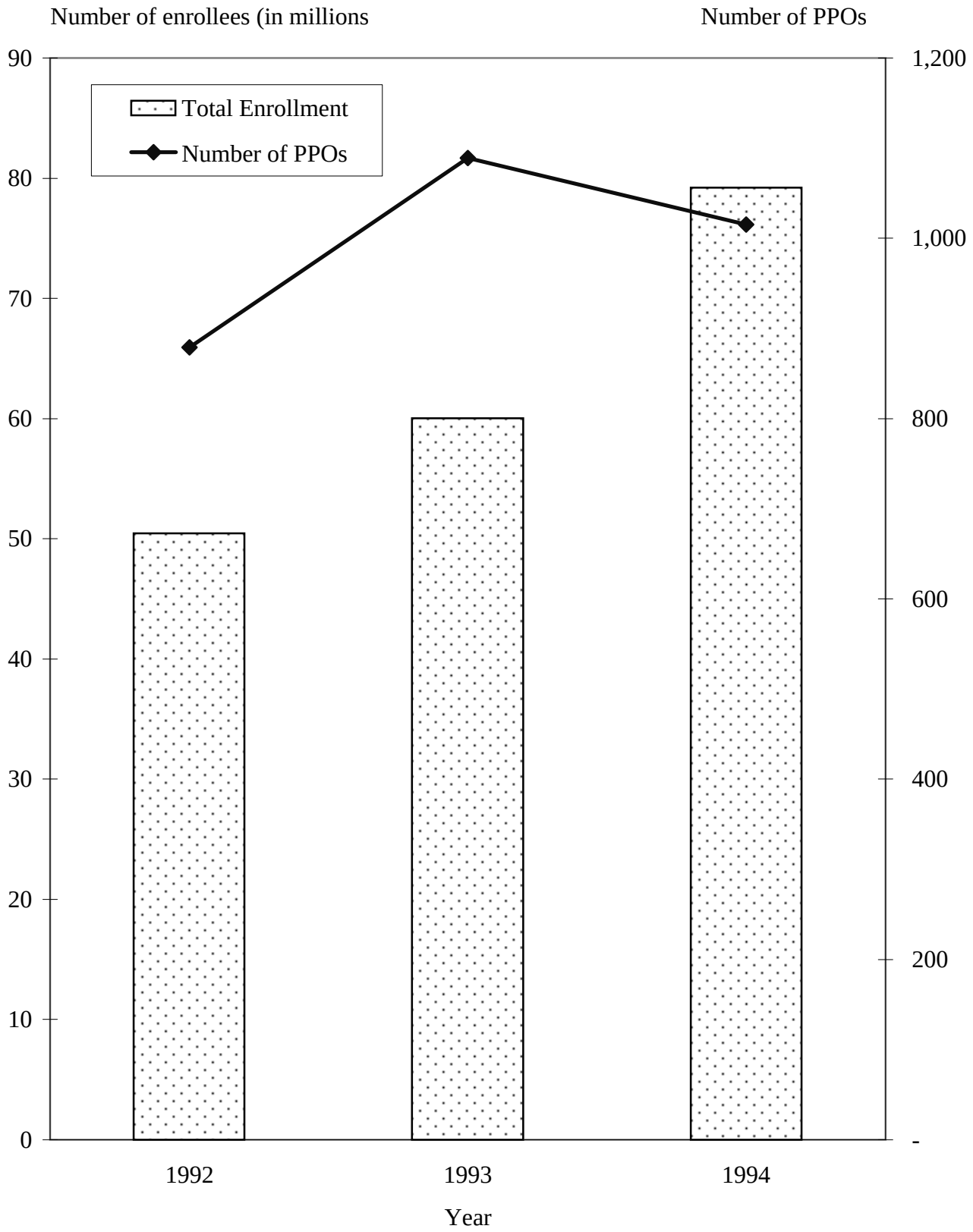
Enrollment in PPOs has been rising, increasing about 57% between 1992 and 1994. The number of PPOs increased during that period from 879 to 1,015, or by 15%.

TABLE 2.19.
PPO Enrollment, 1992-1994

Year	Total Enrollment	Number of PPOs
1992	50,447,748	879
1993	60,037,800	1,089
1994	79,210,981	1,015

NOTE: Table prepared by CRS.

Figure 2.19. Preferred Provider Organization (PPO) Enrollment, 1992-1994



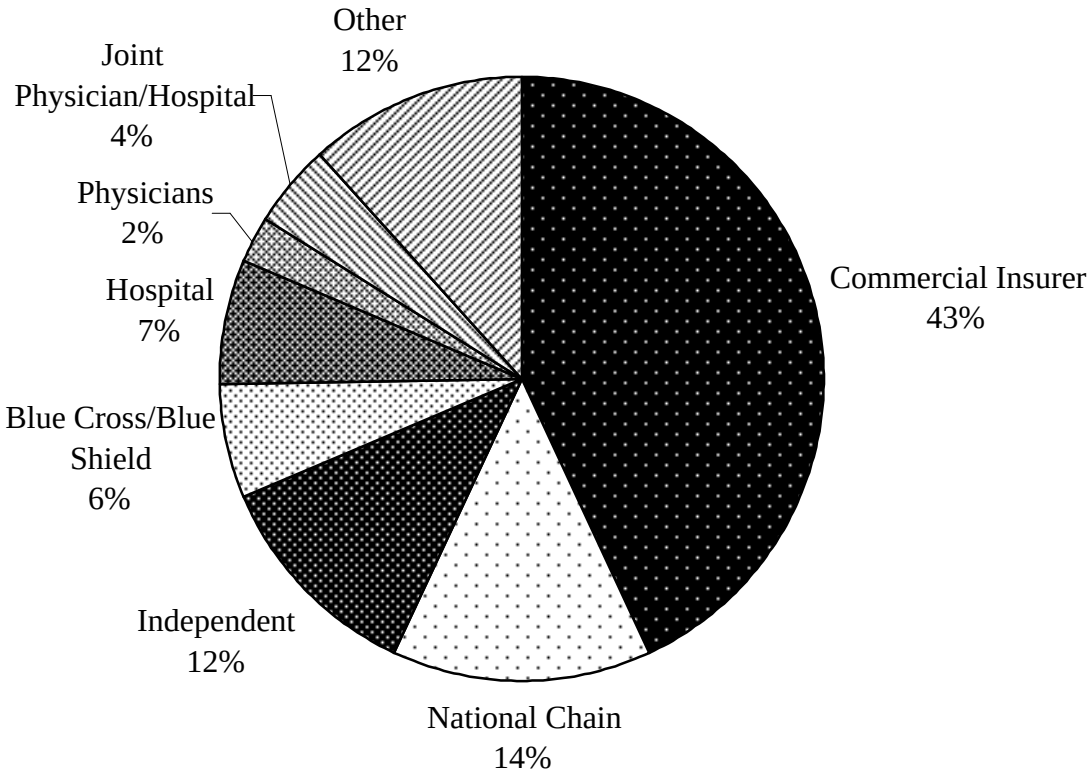
Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO PPO Industry Profile*, Exhibit 7-2

Figure 2.20.
PPO Ownership, 1995

Preferred Provider Organizations (PPOs) are owned by a wide range of organizations. As shown in figure 5.10, 43% are owned by commercial insurers or by national managed care chains (14%). However, some are owned by providers, such as hospitals (7%), and joint hospital/physician organizations (4%).

Figure 2.20. Preferred Provider Organization (PPO) Ownership, 1995

Total Number of PPOs = 1,026
Total PPO Enrollment = 79.2 Million



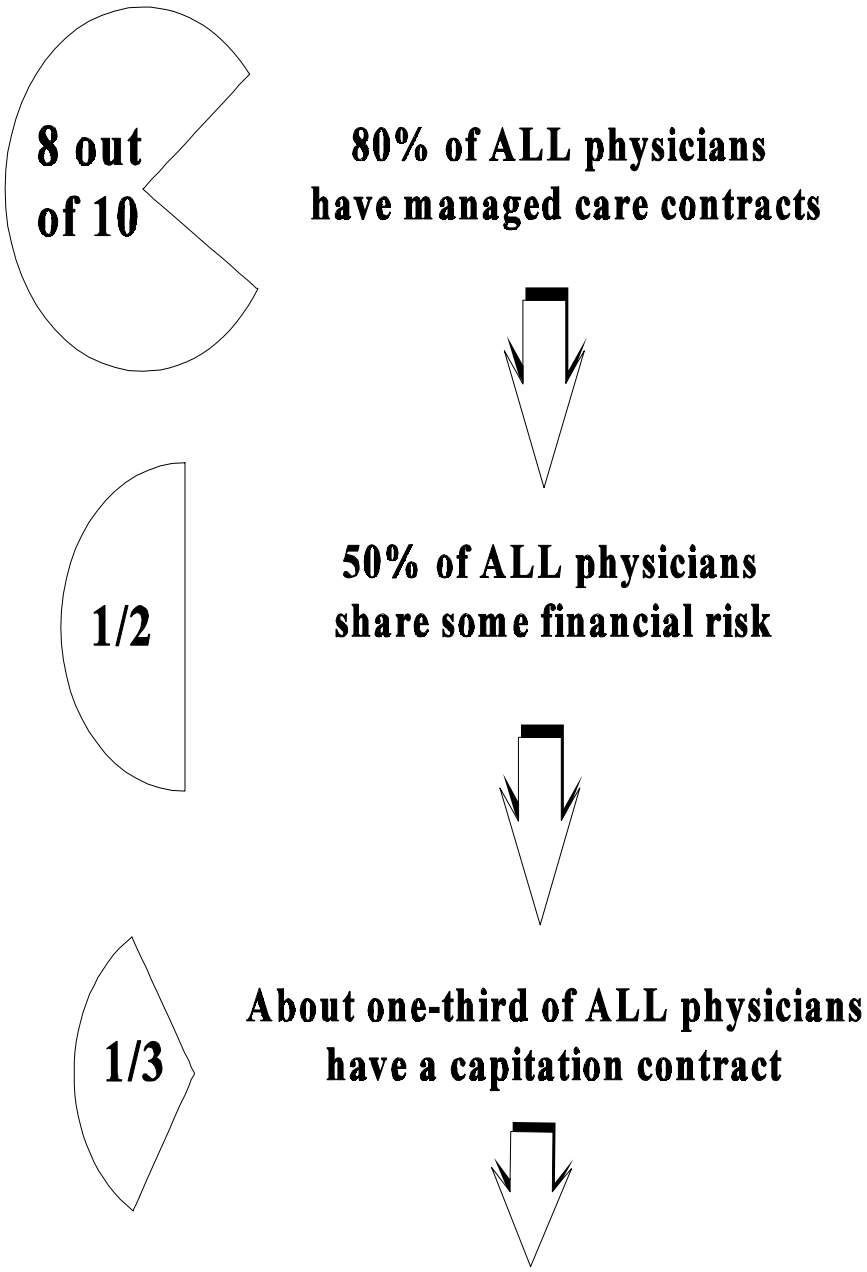
Source: Figure prepared by CRS based on AAHP, *1995-1996 HMO PPO Industry Profile* , Exhibit 7-1.

Figure 2.21.
Extent of Physician Affiliation with Capitation Contracts
1994-1995

Managed care has a broad and growing presence in the U.S. healthcare system. Managed care organizations use a variety of means (or *physician incentive plans*) to compensate physicians, some of which share financial risk with the providers of health care services. About 80% of all physicians participated in at least one managed care contract in 1994-1995; however, only about 50% shared some financial risk. This is because many physicians participate preferred provider organizations (PPOs), in which compensation is based on reduced fee-for-service (FFS) reimbursement rather than on shared financial risk.

The primary ways managed care organizations share financial risk with physicians involve some combination of capitation prepayment, bonuses, and FFS withholds. *Capitation* entails the payment of a fixed-fee per member per month for all covered services regardless of the level of service utilization. Money *bonuses* may be paid to individual physicians or physician-groups on the basis of performance relative to determined standards. Managed care organizations may also *withhold* a percentage of FFS payment to form pools of money from which reimbursement for speciality services are drawn, and surplus funds may be returned to individual physicians. In the mid-1990s, only about one-third of all physicians had a capitation contract. Moreover, of these physicians, 19% of revenue was at risk, on average.

Figure 2.21. Extent of Physician Affiliation with Capitation Contracts, 1994-1995



Source: Figure prepared by CRS based on data from the American Medical Association and Proje HOPE/Gallup surveys.