

Access to Health Care

American College of Physicians*

Executive Summary

The American College of Physicians believes that there is an increasingly urgent need to address a growing national problem, that of many Americans lacking access to health care. Spiraling increases in health care costs are reducing access to health services, especially for those without health insurance protection or the financial means to pay. Cost containment actions are increasingly undermining the basic infrastructure on which delivery of services depends—facilities and personnel. Further, many of these cost containment actions are eroding the ability of physicians to provide optimum care for their patients.

Problems Faced by Patients and Physicians in the Present System

Problem: Inadequate Access to Health Care

Lack of an adequate financing system to assure access to needed health care and lack of facilities and personnel contribute to the medical complications, unjustifiable pain and suffering, and expense that can result from failure to obtain timely diagnosis and treatment. Lack of an adequate financing system jeopardizes the nation's health care delivery system, as the cost burden of uncompensated care increases.

Problem: Inadequate Health Insurance Protection

"Health insurance," as used in this paper, is defined broadly to include private health insurance, public health benefit programs, and "insurance" protection through self-insured plans provided by many large employers and prepaid health plans, including health maintenance organizations. More than 205 million Americans, 86% of the civilian population, have some form of health insurance (1). Approximately 181 million persons

have private health insurance, and approximately 136 million of them obtain their insurance coverage through employment-related plans. More than 33 million persons are covered by Medicare, and about 24 million are covered by Medicaid (2). Other public health benefit programs, including those administered by the Department of Veterans Affairs (VA), the Public Health Service, and the Department of Defense, provide access to health care services for specific qualifying groups. However, health insurance coverage is neither uniform nor equitable.

Whereas many persons have overlapping and duplicative coverage, others have insufficient coverage or no protection at all. There are roughly 31 to 37 million Americans without any form of public or private health insurance. Another 50 million Americans are underinsured; that is, they have inadequate insurance protection for major hospital and medical expenses (3).

Problem: Costs Continue To Rise

Total national health care expenditures have risen from \$75 billion in 1970 to approximately \$600 billion in 1989 (4). Health care costs increased at an average annual rate of 17% from 1970 to 1988; at the same time, all items of the consumer price index increased at an average annual rate of 11% (5). These dramatic increases in health care costs have generated ever greater pressures for cost containment. Efforts by employers, the government, and third-party payers to control rising costs are increasingly intruding on clinical decision making and are undermining physician-patient relationships.

Administrative costs (that is, the costs of recording, billing, reviewing, processing, auditing, and justifying medical charges) are among the fastest rising components of health care costs. Included in these expenses are the costs of insurance marketing, the profits and reserves of government and private insurance carriers, and other overhead expenses necessitated by our current health care payment mechanisms. The total costs of health care administration in the United States are estimated to be approximately 22% of all personal health care spending (6), amounting to \$110 billion in 1989. Substantial additional costs are generated by the medical liability system and efforts by physicians to minimize the exposure to claims of professional malpractice. The number of professional liability cases, the size of malpractice awards, and the costs of malpractice insurance continue to rise.

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Problem: A Burdensome System for Patients, Their Families, and Physicians

Current health care payment mechanisms, involving multiple public and private insurers and third-party payers, are complex, confusing, costly, wasteful, and intrusive. Health insurance coverage under private insurance plans as well as under public programs, such as Medicare and Medicaid, is generally difficult to understand and requires complex mechanisms for recording, billing, auditing, reviewing, and processing claims. Patients, their families, and physicians must complete a multitude of forms, often for several carriers, involving significant time and expense. Patients and their families are burdened with this paperwork when they are most vulnerable—worried and sick.

Physicians must also respond to demands for documentation and justification from insurance carriers and quality review organizations. These frustrating layers of review, which involve demands to justify clinical decisions, requirements for prior approval, and denials of payment, undercut provision of high-quality care for all patients by inappropriately second-guessing professional judgments and intruding into physician-patient relationships. The time and expense required to deal with these administrative burdens further limit the ability of physicians to care for patients.

Criteria for a Better System

To evaluate proposals for achieving a better health care system, we identified and used the following criteria. These criteria are not intended to be all inclusive and are listed categorically rather than in order of priority.

Benefits

1. There should be a mechanism for determining the scope of benefits.
2. There should be a uniform minimum package of benefits for all.
3. Coverage decisions should be based on clinical effectiveness.
4. Coverage and benefits should be continuous and independent of place of residence or employment.

Financing

5. Financing should be adequate to eliminate financial barriers to obtaining needed care.
6. There should be mechanisms for controlling costs.
7. Administrative expenses and procedures should be minimized.
8. Professional liability costs should be minimized.
9. Existing sources of revenue should be incorporated into any new financing system.

Organization and Delivery

10. There should be an adequate infrastructure in terms of facilities and manpower to deliver optimum health care services efficiently and effectively.
11. There should be mechanisms to assure quality.

12. Innovation and improvement should be fostered.
13. The system should be flexible.
14. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care, and pursue health promotion activities.

Satisfaction

15. Patients should be satisfied.
16. Physicians and other health care professionals should be satisfied.

Alternative Proposals for Extending Health Insurance Protection

Addressing the problems of inadequate access, cost control, and excessive administrative burdens are not competing objectives. These problems can be addressed simultaneously, and solutions should not be seen as being mutually exclusive. Six major types of proposals for improving access to health care are described and evaluated against the above criteria. The proposals and our conclusions concerning their advantages and disadvantages are summarized as follows:

Proposal 1: Encourage Individuals and Employers to Purchase Private Insurance

Private insurance has been a successful financing mechanism for most Americans. However, efforts to encourage individuals to purchase insurance would not be effective in assuring protection for those lacking insurance who are unemployed, have low incomes, or have been denied coverage. Tax credits and other means of subsidizing private insurance premiums are expensive and inefficient in expanding financial access to health care.

Proposal 2: Mandate Employer Coverage

Requiring all employers to provide a package of health insurance benefits could extend insurance coverage to approximately two thirds of the uninsured population and could improve coverage for many who are underinsured. However, this approach would provide only a partial solution and would need to be coupled with other remedies. It could contribute to increased unemployment, and it would leave unaddressed the inefficiencies and inequities of current insurance mechanisms, including high overhead costs and multiple and conflicting administrative burdens for health care providers and patients. However, because of its ability to expand coverage rapidly for a significant portion of the uninsured population, this mechanism warrants consideration as a partial, short-term solution.

Proposal 3: Create Health Insurance Risk Pools

Creation of health insurance risk pools, similar to automobile insurance risk pools, would spread insurance risks for those who are in small groups or denied coverage. However, unless substantial subsidies are provided, the premiums of risk-pool members could be

much higher than those of persons with comparable group insurance and would be largely unaffordable. Creation of risk pools for "uninsurable" persons could encourage greater selectivity among insurance companies, resulting in more persons being denied individual, private policies and being shifted into a risk pool.

Proposal 4: Extend Medicaid Eligibility

Expanding Medicaid eligibility might be a desirable, short-term means for improving financial access of health care services for those who are poor or nearly poor but do not qualify for public assistance. Establishing uniform, minimum eligibility standards could reduce some of the present inequities in coverage and benefits among the states. These improvements would require substantially greater amounts of federal and state funding, amounts that would be difficult to achieve at a time of budgetary constraints. Overall, this approach could serve as an interim means for improving access for low-income groups, particularly for those below the poverty level who qualify for Medicaid in some states but not in others. However, because of the social-welfare nature of the program and the low payment rates that restrict access to care, we do not advocate this approach as the primary, long-term means for increasing access to health care for all Americans.

Proposal 5: Expand Charity Care

All physicians and other health care providers should voluntarily provide care on a charitable basis to patients who are in need and lack the resources to pay customary charges. However, there are inherent risks to patients and society in a system that relies solely on benevolence for the provision of health care services. History has shown that under such a system, health care services are not equally available to all, and poor persons typically either do not receive needed care or receive services of lesser quality. Therefore, expansion of charity care does not constitute an appropriate response to the access problem.

Proposal 6: Establish a Universal Access to Health Insurance Program

Universal health insurance programs utilize an insurance mechanism to protect all eligible participants from the costs of health care services. A universal access program could be provided through either the public or private sectors or by some combination of both. The key feature would be that a uniform insurance mechanism would spread the risks of health care costs equitably on a nationwide basis.

The primary advantages of a universal access program are that everyone is covered and that coverage is continuous, regardless of changes in place of residence or employment. All participants are covered for specific health insurance benefits and have financial access to mainstream health care. Nationally administered programs in other countries have administrative costs that are much lower than those now borne in the United States, primarily because there is less administrative

overhead involved in the billing, processing, and collection of claims. Disadvantages include the potential for greater governmental intervention in the practice of medicine and in clinical decision making, loss of physicians' ability to set fees, more intense pressure for cost containment, and more overt rationing of health care services.

Conclusions and Recommendations

Having reviewed the major, alternative types of proposals for financing access to health care services for all Americans, the College concludes as follows:

A nationwide program is needed to assure access to health care for all Americans, and we recommend that such a program be adopted as a policy goal for the nation. The College believes that health insurance coverage for all persons is needed to minimize financial barriers and assure access to appropriate health care services.

Assuring access also involves issues of cost and quality. The medical profession bears responsibility to ensure that acceptable, appropriate, and cost-effective care is delivered.

Although several of the proposals that we reviewed may provide necessary short-term solutions to aspects of the access problem, it is our position that a longer-term view is necessary:

A comprehensive and coordinated program to assure access on a nationwide basis is essential. In the near term, given the urgency of the need, it should build on the strengths of existing health care financing mechanisms. In the longer term, careful consideration of new and innovative alternatives, including some form of a nationwide financing mechanism, will be necessary.

Expansion of Medicaid and mandated employer health insurance require immediate consideration for bringing prompt relief to a large segment of the population presently without adequate access to health care. Although these short-term approaches have serious negative implications for achieving long-term reform, they would bring an immediate amelioration of intolerable conditions.

The entire structure of the American health care delivery system must be carefully examined. Alternative approaches for achieving greater access to health care services must be carefully considered, including the possibility of a unified insurance mechanism. The staggering administrative burden of the present system, both in the obvious expense of its administration and in the rising bureaucracy and paperwork that it engenders, drives us towards this conclusion.

Therefore, we urge extreme caution in merely building on the present structure. Although this approach has appeal for various political and practical reasons, we will continue to argue that some proposed solutions should be considered short-term remedies and that the time has come for a thoughtful re-examination of all aspects of the present health care system.

Serious consideration of any form of a universal access to health insurance program would be likely to generate considerable controversy and could be divisive for the medical profession. Adoption of such a program would involve a substantial restructuring of the entire U.S. health care system and, therefore, should be approached thoughtfully and with caution. Experience with the Medicare and Medicaid programs has given many, if not all, physicians cause to be leery of further governmental involvement in health care and skeptical that significant administrative savings would be achieved under yet another national program. Nevertheless, we believe that there is much that can be done to improve the accessibility, quality, and efficiency of our health care system. Some type of coordinated, comprehensive program is required on a nationwide basis.

The College does not pretend to have the answer to how the nation can best achieve universal access to health care. We do, however, wish to highlight the

urgency of the need to address this issue. Maintenance of the basic infrastructure for the provision of health care is a national priority; reliance solely on private charity or the efforts of individual states to meet this national need will be insufficient. This paper concludes with an appeal for open and thorough consideration of all options for improving access to health care, including consideration of proposals for universal health insurance mechanisms.

This paper is intended to facilitate further discussion by helping our members to understand the factual underpinning of the present problem, setting forth initial criteria for evaluating proposals, and clarifying our philosophical commitment to developing both short-term solutions and achieving longer-term reform. This document raises many questions while highlighting our concerns about the present system and our commitment to developing a better system for meeting the needs of all Americans.

Position Paper

Introduction

Since its founding in 1915, the American College of Physicians (ACP) has espoused a commitment to "enlighten and direct public opinion with regard to the great problems of health and medicine" and to ensure "the enactment of just medical laws." It is fully consonant with this mandate that the College comment on issues related to assuring that needed health services are available in this nation.

The present state of our health care system lends a new urgency to the task of addressing and resolving problems facing the system. In particular, we are deeply troubled by the large numbers of Americans without adequate access to health care services; inordinate increases in health care costs, including the costs of marketing, health insurance, and malpractice insurance; cost containment actions that undermine the basic infrastructure, including facilities and personnel, on which delivery of services depends; and growing administrative burdens and increasing intrusion into the practice of medicine by government and other third-party payers.

Growing pressures from government and business to contain health care costs have resulted in restrictions on the provision of health care services and have eroded physicians' ability to determine and provide patient care. Medicine is suffering from the paradox of being clinically able, but financially unable, to fulfill its mission of caring for those in need. Not only are these factors a source of frustration and demoralization to physicians, they threaten our self-definition as a caring and humane society. It is overwhelmingly clear that more vigorous efforts must be made to address these and related problems.

During the past 2 years, the College has attempted to

develop an objective response to the problem of access. This process has involved the policy committees of the ACP, the Board of Governors, the Board of Regents, members attending presentations at the Annual Scientific Session, and members attending ACP regional meetings. Advice and recommendations have been received from many persons. Deciding on and achieving needed changes will require the commitment and participation of many more of our members. This paper constitutes one element of an ongoing effort to disseminate information about the difficult and complex health care access problem, to outline possible approaches for resolving this problem, and to urge participation of all concerned—physicians and laymen alike—in developing and implementing solutions.

Some aspects of this problem have been addressed in position statements previously endorsed by the College. In this paper, the principal focus is on financing health care services as a means of assuring access. The decision to focus these comments on health care financing, more specifically on expanded insurance protection, has been subject to substantial discussion. "Insurance," as used in this paper, is defined generically to include all public and private programs for the payment or reimbursement of health care expenses, including self-insurance plans and prepaid programs such as health maintenance organizations. The conclusion has been reached that although other mechanisms can be designed to provide health services (for example, systems of free clinics), health insurance dramatically enhances the patient's ability to select the site and provider of care. This ability to "vote with your feet" is an important check on the system and is a vital means of ensuring sufficient competition to foster a commitment to quality, respond to patient needs, and assure that facilities are adequately maintained.

Obviously, in addition to financing care, cost and quality are critical elements of the challenge. We do not

attempt to duplicate in this document our previous recommendations on these essential issues. All health care providers, especially physicians, have a professional responsibility to ensure that optimal, appropriate, and cost-effective care is delivered.

That which follows constitutes the College's initial analysis of issues that are critical to understanding and responding to the problem of financial access to care and the burdensome aspects of the current situation. It states our fundamental position on the need to assure access to health care and indicates the direction for further discussion, analysis, and action. We are pleased to note the wealth of new ideas that has been advanced recently. It is particularly heartening to see that many individuals and organizations have turned their attention to this pressing national problem. Recent articles in major journals and reports of prestigious study groups and commissions will receive our future analysis. We expect that this document will provide a policy framework for our own ongoing analysis as well as for those of other concerned parties.

The Present System: Problems Faced by Patients and Physicians

Problem: Inadequate Access to Health Care

To be without adequate health insurance protection for the costs of medical and surgical services, hospital care, prescription drugs, and outpatient services means that the patient and his or her family must rely on personal financial resources, obtain care on a charitable or uncompensated basis, or forego care. Consequently, proper care is often delayed until problems become serious, and conditions that could be effectively and economically treated on an outpatient basis often remain untreated until hospitalization is required. A 1986 survey by the Robert Wood Johnson Foundation (7) indicated that as many as 38.8 million persons needed health care during the previous year but had difficulty obtaining it. Approximately 45 million persons with chronic or serious illnesses had not been seen by a physician in the previous 12 months.

In addition to the medical complications and the unjustifiable pain, suffering, and expense that can result from failure to obtain timely diagnosis and treatment, lack of an adequate financing mechanism to assure access to needed health care services results in funding shortfalls that jeopardize the entire infrastructure of the nation's health care delivery system. The amount of uncompensated care provided by hospitals increased from 5.1% of total expenses in 1980 to 6.3% (approximately \$7.5 billion) in 1988 (8) and is expected to continue to rise as the number of uninsured persons continues to increase (9). However, the burden of providing uncompensated care is not shared equally among the nation's hospitals, and more than one fourth of the care provided by public hospitals is uncompensated (10).

Financial limitations and an increasingly competitive health care environment have forced many hospitals—both for-profit and not-for-profit—to seek to curtail the amount of uncompensated care they provide and to shift uninsured patients to public hospitals. More than

1 million Americans are turned away from hospitals each year, because they lack insurance or other means to pay for care, and many of the uninsured persons who require emergency care are transferred to public hospitals (10). As public hospitals then raise prices for their privately paying patients in attempts to recover uncompensated costs, they become less able to compete successfully for privately paying patients.

In 1984, bad debts and charity care cost hospitals \$5.7 billion, or 4.6% of their total costs (8). Over 50 public hospitals were sold to private, for-profit chains between 1981 and 1984. Many public hospitals are now in financial distress. If this trend continues, access to health care for uninsured persons will be further diminished as private hospitals accept fewer uninsured patients and more public hospitals are forced to close. Without a financial base of insured or privately paying patients, public hospitals are finding it increasingly difficult to provide care that is equal in quality to that provided in private hospitals. Unless they are reimbursed adequately for uncompensated services, they will be forced to close or curtail their services.

Problem: Inadequate Health Insurance Protection

Insurance Coverage Is Uneven

Health insurance comes in various forms designed to meet different health care needs. Major forms of insurance include coverage for hospital expenses, physician services, major medical expenses, disability (both short- and long-term), dental care, and vision services. Coverage for mental health care services, long-term health care, and home health care is also available but to a much more limited extent. Private sector insurance is provided by both commercial insurance companies and not-for-profit organizations such as Blue Cross and Blue Shield and employee benefit funds. About 66% of all persons with private health insurance and 75% of all covered workers obtain their insurance through employer-sponsored group benefit plans. Approximately 147 million Americans have health insurance coverage through an employer-sponsored plan (1).

Individuals as well as groups may have overlapping and duplicative coverage; consequently, it is difficult to determine precisely how many persons are insured. The Health Insurance Association of America (HIAA) estimates that more than 181 million Americans (76% of the civilian noninstitutional population) have one or more forms of private insurance protection. Approximately 160 million persons under 65 years of age and 21 million persons 65 years of age and over have private health insurance (1).

Public-sector health benefit programs include Medicare, Medicaid, and Workers' Compensation. Health care services also are provided either directly or under contract to eligible beneficiaries by the Department of Veterans Affairs (VA), the Public Health Service (including the Indian Health Service), the Department of Defense (including the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]), public hospitals and community health centers, and state and local public health programs.

Almost 30 million persons 65 years of age and over and approximately 3 million disabled persons have

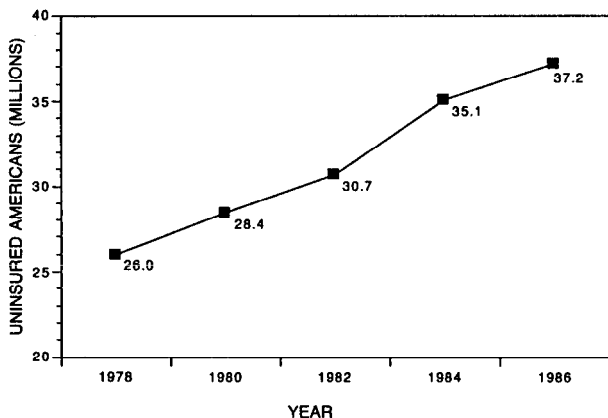


Figure 1. Uninsured persons in the United States by year.

Medicare Hospital Insurance (Part A), and more than 98% of these persons have also elected Medicare Supplemental Coverage (Part B) (2). Approximately 23 million persons are covered by Medicaid; of these persons, more than 3 million are elderly. To qualify for Medicaid, applicants must meet specified income and assets criteria and must be elderly, blind, disabled, or part of a qualifying family with dependent children. Income and asset eligibility standards vary widely among the 50 states (see Appendix 1). In 1989, the average income threshold for a family of three to qualify for Medicaid was \$4942, approximately 49% of the federal poverty level of \$10 080 (11). Coverage and benefits under Medicaid are very restricted. Payment rates are also very low, and access is limited to health care providers who accept the Medicaid payment as payment-in-full. The Department of Veterans Affairs provides health care to those who qualify among the nation's 27.5 million veterans, and the Indian Health Service provides health care for approximately 1 million Native Americans.

Millions Are Uninsured

Estimates of the number of persons without any form of health insurance coverage range from 31 to 37 million (3, 12). The figure of 37 million has been generally accepted, but recent data from the U.S. Bureau of the Census (12) suggest that the number may be as low as 31.1 million. The lower estimate is based on data from the Bureau of the Census' March 1988 population survey which included more comprehensive questions on health insurance than it had in the past. Some policy analysts have disputed the validity of the revised estimates.

Nevertheless, the latest available, detailed analyses of national population data are based on the earlier estimate of 37 million uninsured persons (13). These data show that the number of uninsured persons rose by over 1 million each year between 1978 and 1986 (Figure 1). It indicates that approximately 55% of uninsured persons are employed adults; 32%, children; and 13%, unemployed adults. More than half of uninsured non-agricultural workers are employed in the retail or service industries. However, even in the professional and related service industries, in which many workers are highly skilled, almost 10% of workers are uninsured. One quarter of the nation's nearly 12 million self-em-

ployed workers are uninsured, representing approximately 16% of all uninsured workers (13).

More than half of uninsured persons live in families of full-time workers who are steadily employed. The remainder live in families headed by workers who are sometimes unemployed, seasonal workers, part-time workers, or nonworkers. Although most uninsured persons were in families headed by someone who was fully employed, the wages of these workers were generally low (13). Three quarters of the uninsured workers earned less than \$10 000 and nearly 93% earned less than \$20 000 in 1985. Overall, one third of all full-time, fully employed workers who earned less than \$10 000 in 1985 were uninsured (13).

Low-income workers and those in seasonal or part-time sectors of the work force often are caught in a gray zone; they are not covered by employment-based insurance but not eligible for Medicaid. Such persons must "spend-down" their income and deplete any savings or other assets they might have to levels of destitution before they qualify for Medicaid. In 1985, there were 14.2 million persons considered to be poor (family income below the poverty line) or nearly poor (family income below 125% of the poverty line) who did not qualify for Medicaid and lacked any other form of public or private insurance coverage (13). Between 1975 and 1987, the proportion of poor and nearly poor Americans covered by Medicaid fell from 63% to 53%; however, the number of persons with family incomes of less than 125% of the poverty line grew from 37.2 million to 43.5 million, an increase of 17% (12).

Others Are Underinsured

In addition to those without any insurance protection are those with discontinuous coverage (due to breaks in employment or other disruptions of coverage) and those with limitations in coverage such that, despite having commercial insurance, Blue Cross and Blue Shield, Medicare, or Medicaid, they face significant out-of-pocket charges when they seek medical care. On paper, Medicaid coverage may appear adequate but, in reality, many who are eligible for Medicaid have difficulty obtaining care, because Medicaid's low reimbursement rates frequently limit access to mainstream medicine.

Definitions of underinsurance are typically linked to the adequacy of coverage for catastrophic health care expenses. "Catastrophic" can be defined either based on fixed dollar amounts of out-of-pocket costs, such as \$1000 or \$2000, or as a percentage of family income, typically 10% or 15%. A 1984 study (14) that based its definition on the out-of-pocket expenditures that a nationally representative sample of persons were at risk for paying in 1977 (after taking their health insurance into account) found that from 8% to 26% of the privately insured population under 65 years of age was underinsured; the intermediate estimate was 13%. The proportion of uninsured persons depends on the degree to which protection against the small possibility of having large uninsured expenses from an unusually costly illness is emphasized in the definition. Three definitions for being underinsured were used:

1. Persons with a 5% probability of out-of-pocket expenses exceeding 10% of family income.
2. Persons with a 1% probability of out-of-pocket expenses exceeding 10% of family income.
3. Persons with or without hospital insurance with inadequate protection for out-of-pocket hospital expenditures.

Using these three different definitions, the study found that the total number of persons with inadequate health insurance coverage ranged from 2.5 to 4 times the number of persons who were always uninsured or 24% to 37% of the U.S. population in 1977. The study concluded that approximately 27% of the population, 50.7 million persons in 1977, had inadequate or no insurance coverage (14).

Implementation of provisions expanding coverage under the Medicaid program (provided in the Catastrophic Health Insurance Act of 1988 and retained when that legislation was repealed in 1989) will affect the number of persons who are underinsured. These provisions extend Medicaid coverage to qualifying, pregnant women and children who meet statutorily specified levels of poverty. They also require state Medicaid programs to pay Medicare premiums and cost-sharing amounts for Medicare beneficiaries with incomes below the federal poverty line. These provisions should reduce, but certainly not eliminate, the number of persons who are underinsured.

Problem: Costs Continue To Rise

Total health care expenditures in the United States increased steadily from \$75.0 billion in 1970, to \$248.1 billion in 1980, and to an estimated \$647 billion in 1990. Health care spending rose from 7.4% of the gross national product (GNP) in 1970, to 9.1% in 1980, and to approximately 12% in 1990. Approximately 41.6% of these expenditures came from public sources (30.2% federal, 11.4% state and local); the remainder were private expenditures (2).

The United States leads all other industrialized countries in the share of total domestic expenditures devoted to health care. In 1987, total domestic health expenditures among the 24 countries comprising the Organization for Economic Cooperation and Development (OECD) ranged from 3.5% of the gross domestic product (GDP) in Turkey to 11.2% in the United States; the mean was 7.3%. Average total health expenditures as a percentage of GDP for OECD countries have remained relatively stable since 1980, fluctuating only from 7.0% to 7.4% (15).

Canadian health care costs, which during the 1960s were similar in proportion to those of the United States (approximately 6% of the GDP), remained relatively constant at approximately 8.5% of the GDP during the 1980s (15). The difference between the growing level of U.S. health care expenditures and the stable level of Canadian health care expenditures is generally attributed to the enactment of national health insurance legislation in Canada and the adoption of Medicare and Medicaid in the United States, both of which occurred in the mid-1960s.

Personal consumption expenditures in the United

States for medical care (for example, private spending for direct health and medical services to individuals and spending by Medicare and Workers' Compensation and Temporary Disability Insurance) amounted to \$400.8 billion in 1987. This figure represented 12.5% of Americans' disposable income in 1987, up from 9.7% in 1980 and 7.7% in 1970 (16). Meanwhile, the proportion of disposable income devoted to housing and transportation remained relatively stable, and the share of disposable income spent on food and clothing actually declined (17).

Public health care expenditures in the United States have increased even more dramatically, but constitute a lower proportion of the GDP than in other developed nations. In 1987, public health expenditures amounted to 4.6% of the GDP in the United States, but averaged 5.8% of the GDP in all OECD countries excluding Turkey (15).

The levels of federal spending under Medicare in the United States increased fivefold from 1970 to 1980, rising from \$7.1 billion to \$35.7 billion. By 1987, Medicare spending had increased to \$81.2 billion, more than ten times the 1970 level. Federal spending under the Medicaid program increased at similar rates, rising from \$5.2 billion in 1970 to \$49.4 billion in 1987 (18). There are many reasons for these increases: greater numbers of elderly persons are living longer and receiving Medicare benefits, inflation accounted for slightly more than half of the increase in medical care costs, and changes in medical science and technology resulted in improvements in medical care so that age-specific mortality rates have declined. Nevertheless, the rapid rates of increase in both public and private health care spending are generally seen as being out of control, particularly in light of increasing federal budget constraints and corporate cost consciousness in a competitive environment.

The largest components of national health care expenditures are hospital care (39%) and physician services (21%) (4). Consequently, efforts to control health care costs have focused largely on these two groups. Spending for hospital services increased almost 7-fold from 1970 to 1987, and spending for physician services increased by a factor of 7.2. However, spending for some other categories within the national health care expenditures accounts increased by even greater multiples during the same period: 7-fold for dental services, 8.6-fold for nursing home expenditures, and 10-fold for other professional services. The costs of program administration (including the net cost of insurance) increased by a factor of 9.3, and the cost of government, public health activities (including spending by the Public Health Service, the Department of Defense, and the Department of Veterans Affairs increased by a factor of 10.5 (4).

Total health administrative costs, including the costs incurred by physicians, hospitals, and nursing homes as well as by third-party payers, have been estimated to be approximately 22% of all health care spending in the United States (6). Developing accurate estimates of administrative costs is a complex task. Because the best available data raise one of the most serious challenges

to the present system, it is important that these data continue to be refined and scrutinized.

Commercial insurers have average administrative costs of 10.5%. Employers who resort to self-insurance for their employees' health care incur similar administrative expenses. Insurance policies that are sold as supplements to Medicare coverage—"Medigap" policies—have some of the highest overhead costs. Premiums for individual Medigap policies marketed by Blue Cross and Blue Shield in 1984 included 81% for claims payments and 19% for overhead. For commercial insurers, only 60% represented claims payments and 40% represented overhead (19). Stated another way, for every dollar paid in premiums, 19 cents under the Blue Cross and Blue Shield plans and 40 cents under commercial Medigap plans went for administrative costs, marketing, and profits or reserves. Subsequent data for 1985 showed some improvement, with benefits payments amounting to 88.6% of premiums for Blue Cross and Blue Shield and 65.8% for commercial policies (19). However, these overhead costs were still far above the rates for Medicare, Medicaid, and the Canadian Health Care System, each of which was less than 3% (6, 20).

Hospital administrative costs amounted to \$26.9 billion in 1983 or 18.3% of the \$147.2 billion spent for hospital care. Nursing home administrative costs account for about 14.4% of nursing home expenditures, adding another \$4.1 billion to the identified national health care expenditures not spent for health care in 1983 (6).

Physicians' overhead represented the single largest segment of the health care dollar not devoted to patient care. A 1986 study by Himmelstein and Woolhandler (6) indicated that approximately 45% of physicians' gross income can be attributed to professional expenses, amounting to \$31.1 billion nationwide in 1983. These expenses include the cost of clerical staff, malpractice insurance, billing, and other office overhead necessary to complete forms, determine the proper coding for each procedure or service, maintain records, respond to utilization reviews, and comply with regulations and requirements of government and other third-party payers.

One of the fastest growing components of physician practice costs has been professional liability insurance. Average premiums for self-employed physicians have increased at an average annual rate of 21.9%, rising from \$5800 in 1982 to \$12 800 in 1986. During this period, average liability insurance premiums in internal medicine increased from \$3700 to \$7100. In obstetrics and gynecology, premiums increased from \$10 800 to \$29 300. The high premiums are attributable to increased incidence of malpractice claims and rising levels of jury awards (20).

Professional liability claims rose from 3.2 claims per 100 physicians before 1981 to 9.2 claims per 100 physicians in 1986. More than one third of all physicians had been sued at least once in their careers as of 1986; 29% of physicians in medical specialties and 51.9% in surgical specialties had been sued (20). Initial jury awards for both economic and non-economic damages averaged \$1 760 632 in 1987; the median award was \$825 000. As recently as 1980, awards had averaged \$404 726, and

the median had been \$150 000 (21). The resulting increases in professional liability premiums have accounted for an increasing share of physician practice revenues. With adjustments for inflation, nearly one sixth of the average increase in revenues of self-employed physicians were devoted to liability insurance premium expenses.

Problem: A Burdensome System for Patients, Their Families, and Physicians

Patients frequently have difficulty understanding their insurance coverage and can be deterred from filing claim forms that are complex, time-consuming, and confusing. Physicians are equally dissatisfied with the amount of paperwork that is often required by a multitude of public and private third-party payers, each with its own rules and requirements for obtaining payment. The amount of paperwork involved in recording, billing, reviewing, auditing, justifying, and explaining medical charges is tremendous, and intrudes on physicians' time for patient care. Although some administrative activities will always be necessary, most physicians believe that current administrative demands have reached an unreasonable level.

Hospitals, nursing homes, physicians, and employers must maintain a growing work force of health care administrators. Between 1970 and 1982, the number of health care administrators increased by 171%, while the number of physicians and total health care personnel increased by 48% and 57%, respectively (6). Hospitals spend vast amounts of money and manpower for tasks such as billing, marketing, cost accounting, and institutional planning. Hospital administrative costs are difficult to quantify, because many health care workers have administrative functions but are classified as clinical personnel for accounting purposes.

A study by the American Medical Association (22) found that physician office staff spend an average of 46.7 hours per month processing Medicare claims and 32.6 hours per month processing Blue Shield claims. Additional time is required to complete forms for commercial insurers. Physicians estimated that it takes nearly 1 hour of staff time for each claim submitted to Medicare or Blue Shield. In addition, the typical physician personally must spend 4.6 hours per month on administrative work related to Medicare claims and 2.4 hours per month on similar work on Blue Shield claims. Surprisingly, when calculated on a per claim basis, the administrative burden was about the same, 0.1 physician-hours per claim. Nearly 14% of the 3000 patient care physicians responding to the study reported that they had resorted to using outside billing services to file claims or help meet reporting requirements and regulations. The average cost to the physician per claim processed by a billing service was \$8.50 for Medicare and \$7.80 for Blue Shield (22).

Denials of payment, demands to justify clinical judgments, and requirements for prior approval undermine professional decision making and physician-patient relationships. Physicians could better use the time and money they spend responding to demands for documentation and justification by insurance carriers and quality

review organizations in improving patient care, providing care to indigent persons, or enhancing their medical knowledge and skills. Consequently, there is growing frustration among physicians with the increasingly burdensome aspects of medical practice.

Criteria for a Better System

We have highlighted some of the major weaknesses of the current, patchwork, health care situation in the United States, including inadequate financial access, absent or insufficient insurance protection, continually rising costs, and a system that is burdensome for patients, their families, and physicians. This section seeks to identify the characteristics of a more ideal system. In it, we will analyze proposals for increasing access to health care in light of these criteria. The criteria below are not intended to be all inclusive and are listed categorically rather than in order of priority.

Benefits

1. *There should be a mechanism for determining scope of benefits.*

An effective health care system should have a rational basis for determining the scope of benefits that are covered and for prioritizing these benefits. The system may not be able to accommodate financially the clinical capacity to provide all possible services.

Our policy committees have struggled in an effort to develop a definition of an appropriate package of benefits, including whether such benefits should be defined as "basic" or "essential" health services. Despite these efforts and the efforts of those of our members who responded to our surveys, there is little that does not seem to be, in some way or under some circumstances, either basic or essential. The central challenge, therefore, is how best to select and prioritize the vast array of services which could be made available. We need clearly defined roles for both clinical recommendations and priority setting and a separate process to determine what is financially and practically feasible.

The medical profession must be actively involved in determining clinical appropriateness and effectiveness. However, the process for clinically based recommendations on services should be kept separate from but be fully informed by the necessarily societal and political determination of what is feasible. In this way, all citizens can be more fully involved in this debate, thereby raising public awareness of the complex problem of appropriate allocation of societal resources. Any decisions to curtail or limit coverage based on costs or budgetary considerations should be made with full representation of all concerned parties, including patients and physicians.

2. *There should be uniform, minimum benefits.*

There should be a uniform, minimum package of health care benefits for all. These minimum benefits should be "universal," that is, available to everyone. Coverage must not vary geographically as it does presently among both public and private insurance plans

because of different judgments among carriers as to what is and is not appropriate. For example, coverage now varies widely among private plans for such services as cosmetic surgery, home health care, psychiatric services, and preventive health care.

Even under the Medicare program, although uniform guidelines and criteria for making coverage determinations are provided to all contractors, each of the 48 carriers, 57 intermediaries, and 54 professional review organizations (PROs) has discretion in making its own coverage decisions (23). If a national coverage policy decision has been issued concerning a particular item or service, all Medicare contractors are bound by it. If there is no national policy, each contractor makes its own determination. The inequities of this highly decentralized process become most apparent to beneficiaries who, on moving from one state to another, find that the services that had been reimbursable through their previous Medicare contractor are not covered by their new carrier.

Physicians dealing with more than one Medicare contractor and with multiple insurance companies are faced with conflicting coverage policies. These conflicts add to their administrative burdens and necessitate additional documentation and paperwork to process claims that may be denied or subjected to various review processes. Lack of a uniform minimum coverage policy is perplexing to both patients and physicians and results in inequitable access to some health care services.

3. *Coverage decisions should be based on clinical effectiveness.*

An ideal health care system would provide insurance coverage and payment for appropriate and efficacious health care services but would not cover services that are inappropriate, ineffective, or unnecessary. Currently, there is a lack of clinical data on the effectiveness of many medical tests and procedures and a lack of scientific knowledge of what constitutes appropriate care for specific patient conditions or problems. Much research has been done to evaluate new medical practices and technologies. Examples include the ACP Clinical Efficacy Assessment Project, the Patient Outcome Assessment projects supported by the National Center for Health Services Research and Health Care Technology Assessment, the randomized controlled clinical trials sponsored by the National Institutes of Health, and research by the Office of Technology Assessment and the Health Care Financing Administration. However, the total amount of this research, generally known as health services research, has been minuscule in relation to national health care expenditures. Scientific knowledge on effectiveness and appropriateness is still very limited. Consequently, public and private health insurance plans make coverage decisions based on limited scientific data, determinations of existing norms of care, patient demand, and political and economic considerations.

Ideally, all new—as well as existing—medical tests, procedures, and technologies should be evaluated scientifically to determine their clinical efficacy and appropriate conditions of usage. Procedures that are determined to be ineffective or inappropriate should not be

covered. Research priorities will need to be set and coverage decisions reviewed as scientifically sound data become available. The Institute of Medicine (24), the National Leadership Commission on Health Care (3), and the Physician Payment Review Commission (25) have indicated that several hundred million dollars in additional federal funding will be needed each year to expand clinical effectiveness research. The College has strongly supported legislative efforts to increase the level of health service research funding.

4. *Coverage and benefits should be continuous and independent of place of residence or employment.*

Participants should continue to have access to covered health care services regardless of place of residence or employment status. Coverage should be "portable"; persons changing jobs or moving from one state to another should not lose their health care benefits.

Financing

5. *Financing should be adequate to eliminate financial barriers to obtaining needed care.*

The financial burden for the program should be shared progressively. Any premiums, copayments, deductibles, or taxes used to finance it should be based on ability to pay.

6. *There should be mechanisms for controlling costs.*

Cost containment measures are essential to any health care financing system. Payments should be made only for necessary and appropriate care. There should be incentives for patients to obtain and for health care providers to deliver health care services in a cost-effective manner. Charges and payments for health care services should be based on objective determinations of reasonableness.

7. *Administrative expenses and procedures should be minimized.*

Administrative burdens on patients, physicians, hospitals, and other health care providers should be kept to a minimum. Requirements for billing and completion and processing of forms and other paperwork should not deter health care professionals from working within the system. Providers of health care should not be subjected to complicated and differing rules and requirements from a multitude of insurers and other third-party payers. Likewise, the cost of administering the program, including program costs as well as the administrative overhead of insurance carriers and fiscal intermediaries, should be minimized so that a high proportion of program outlays are devoted to delivery of health care services. Finally, the system should promote efficiency, with insurance agencies sharing information and providing coordinated coverage and benefits.

8. *Professional liability costs should be minimized.*

The direct costs of medical malpractice insurance as well as the indirect costs of added tests and procedures

done to reduce the risk for malpractice litigation add significantly to overall health care costs. These costs have continued to rise due to many factors, including the increasing proclivity of patients to sue, legal fees that are contingency-based, excessive jury awards for pain and suffering, and the tendency of insurance companies to agree to out-of-court settlements. Restructuring of the professional liability system, including necessary elements of tort reform, should be an integral part of health care reform.

9. *Existing sources of revenue should be incorporated into any new financing system.*

For a new system to be financially viable, it must, when possible, continue to capture those resources currently financing health care services. Some savings, of course, may ultimately result under a more efficient system and should be shared among contributors. It is critical, however, that resources now available to the system not be lost, although they may assume a different form. For example, resources from employers presently providing coverage and governmental programs, such as Medicare, Medicaid, CHAMPUS, and VA programs, should be incorporated.

Organization and Delivery

10. *There should be a sufficient infrastructure in terms of both facilities and manpower to deliver health care services efficiently and effectively.*

Health care facilities—hospitals, outpatient clinics, skilled nursing homes, home health agencies, and hospices—should be available to meet the full continuum of health care needs. Likewise, the supply of physicians, nurses, and other health care professionals should be adequate to meet requirements for professional services. A new health care financing system must be analyzed in terms of its impact on public hospitals to ensure that the necessary infrastructure for delivery of services is sufficient to meet patient needs. Health planning will be needed to ensure that resources are allocated to meet needs best and to avoid unnecessary duplication, waste, and inefficiency. National policies on manpower will need to ensure that sufficient numbers of the right kinds of physicians and other health care professionals are educated and trained to provide patient care services as well as to meet national needs for teaching, research, and administration.

11. *There should be mechanisms to assure quality.*

Quality assurance and utilization review should be provided through accepted mechanisms: accreditation and certification standards for institutions, and peer review and other quality assurance mechanisms for health care providers. Patients must be able to express their satisfaction or dissatisfaction with the quality of services they receive by choosing among providers.

12. *Innovation and improvement should be fostered.*

Sufficient resources must be devoted to research and development to achieve continued advances in medical science. The system must be responsive to scientific

advances, improvements in technology, and changes in medical practice. Issues of maintenance of the health care infrastructure have to be addressed. It is critical that capital resources be available on a continuous basis to enable new construction, restoration and maintenance of existing facilities, and purchase of new equipment and other capital improvements.

13. *The system should be flexible.*

The financing system should be responsive to variations in patient care needs and preferences concerning how services are organized and delivered. It should recognize the pluralistic nature of our society, accommodating differences in population, culture, and location. The system should permit various organizational models for delivery of health care services, including private practice, group practice arrangements, health maintenance organizations, and preferred provider organizations.

14. *Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care, and pursue health promotion activities.*

Health promotion and preventive health care are effective means for improving the nation's health and reducing health care expenditures. The health care system should, therefore, encourage prenatal care, maternity care, well-child care, immunizations, physical exercise, good nutrition, healthful life styles, and similar activities that contribute to good health. The system should also encourage Americans to cease unhealthful activities such as smoking, alcohol abuse, and drug use.

Satisfaction

15. *Patients should be satisfied.*

The health care system should be satisfactory to patients in terms of meeting their health care needs and providing services. Patients should be able to choose their own physicians and the type of setting from which they obtain health care services. Patients who are dissatisfied with the services they receive should not be unduly restricted from changing physicians or providers. The freedom of patients to choose their own physicians is an important safeguard for assuring quality of care.

Patients should also be able to understand easily how to obtain and pay for care. The financing system should not be so complex that patients cannot readily obtain the care they need. Any use of insurance or claims should be fairly simple, so that patients can pay for the services they receive and obtain appropriate reimbursement.

16. *Physicians and other health care professionals should be satisfied.*

The health care system should foster an environment in which physicians can work effectively and be reasonably satisfied. Such an environment would provide appropriate compensation for physician services and

would allow physicians to practice without undue outside interference in clinical decision making or burdensome administrative and paperwork requirements.

Appropriate professional judgment should not be impeded. Making clinical diagnoses and decisions regarding the management and treatment of disease are challenges that are hallmarks of the medical profession. Inappropriate infringements on this activity may discourage the most promising candidates from seeking or remaining in medical careers. Therefore, the financing system should not unduly influence clinical decision making, except to the extent that payments should not be provided for inappropriate and ineffective services. Physicians and other health care professionals must be able to determine the most appropriate course of treatment, within the necessary limitations of their scope of expertise, the circumstances of specific patient situations, scientific knowledge, and clinical standards. This is one of the major challenges that attracts students to enter careers in medicine. Unreasonable infringement on professional judgment in patient care decision making limits physicians' ability to care best for their patients and is a major source of frustration for those in practice.

Proposals for Extending Health Insurance Protection

The following section briefly summarizes and analyzes, in light of the above criteria, six major types of proposals that use insurance mechanisms for expanding access. As previously noted, other mechanisms can be designed to deliver health care services; however, we believe that an insurance mechanism would be preferable because it enhances the ability of each individual to select both the site and provider. Each of the generic categories of proposals discussed below could be fulfilled by many variously structured plans for improving access to health care. For example, the generic proposal to mandate employer health insurance could be addressed by federal legislation, as proposed by Senator Kennedy and Congressman Waxman, or by the state program now in effect in Hawaii.

Proposal 1. Encourage Individuals and Employers To Purchase Private Insurance

Various incentives could be used to encourage individuals to obtain health insurance. Public education efforts could be made to inform Americans of the risks and costs of health care and the value of insurance. Federal and state tax policy could also be used to encourage individuals and employer groups to purchase private insurance. For example, the Internal Revenue Code could be revised to permit self-employed persons to deduct fully the cost of their health insurance premiums, and personal income tax rules could be revised to allow more favorable treatment of health insurance premiums as an itemized deduction. Vouchers for the purchase of insurance could also be given to qualifying, uninsured individuals. However, private health insurance, whether paid by individuals, employers, or government, is expensive, and premiums are rising rapidly.

Advantages of the Voluntary, Private-Insurance Approach

1. This approach would rely primarily on a private-sector insurance mechanism and, therefore, would not be disruptive to existing financing mechanisms.

2. Individuals and employer groups would still have freedom to choose among private health insurance plans and to determine what, if any, benefits they wish to purchase.

3. This approach might appeal most to the approximately one third of uninsured persons under 65 years of age who have family incomes greater than 200% of the poverty level (about 13 million persons). Extension of a 100% tax deduction for health benefits might appeal particularly to the 2.1 million uninsured self-employed persons included in this group (16% of uninsured persons).

Disadvantages of the Voluntary, Private-Insurance Approach

1. This approach would probably not benefit the approximately two thirds of uninsured persons who have family incomes at or below 200% of the poverty line; for these persons, insurance could still be too expensive unless subsidies were provided.

2. Many uninsured persons may be fully aware of the value of health insurance, but may give higher priority to other needs.

3. Individual, private insurance is generally the most expensive form of insurance coverage. Costs are high because of the marketing, premium collection, and processing costs involved, and because insurance risks cannot be spread as well as in group insurance. Premiums also must provide a margin for profits and reserves.

4. Building on existing, private-insurance mechanisms would further increase administrative costs and would not alleviate current paperwork and administrative burdens that cause dissatisfaction for physicians and patients.

Conclusions: Encouraging Individuals and Employers To Purchase Private Insurance

Private insurance has been a successful financing mechanism for assuring access to health care for most Americans. However, most private insurance is provided through the employment setting, and efforts, such as public information campaigns or tax incentives, to encourage purchase of individual insurance, which generally costs much more than group insurance, would not be expected to benefit those with low family incomes, those who are unemployed, or those who are denied coverage. Although most existing, private insurance is provided through the workplace, voluntary expansion of insurance coverage by employers does not appear to be an effective remedy for low-income workers or those who are employed on a part-time or seasonal basis. Tax subsidies or credits for the payment of private insurance premiums, which include administrative expenses for marketing, profits, and reserves, would be an expensive and inefficient method of expanding financial access to health care.

Although a voluntary, private-sector approach might

be politically preferable to solutions that could involve government programs, this approach would not reduce the high administrative costs or burdens generated by the current system. Instead, it would perpetuate many current inefficiencies and problems. Indeed, this approach might increase insurance costs as greater efforts would be required to coordinate benefits and market individual policies. Paperwork and administrative requirements would not be reduced, but could increase as the number of insurance carriers and policies proliferates.

Proposal 2: Mandate Employer Coverage

Another option would be to require all employers to provide a package of health insurance benefits to eligible employees and their dependents. This approach recognizes that most Americans (136 million) obtain health insurance through their or a family member's employment, and about two thirds of those who are currently uninsured live in households headed by an employed person (26). Requiring all employers to provide health insurance coverage for workers and their dependents is also seen as an equitable and effective way to extend health insurance protection.

A version of this approach was adopted by the state of Hawaii in 1974. Under state law, employers are required to cover all employees who work 20 or more hours per week for at least 4 consecutive weeks. Employers must pay at least 50% of premium costs, and employee premiums are limited to 1.5% of annual wages. The state subsidizes premiums paid by firms with fewer than eight employees.

Legislation enacted in Massachusetts in 1988 would require employer-paid health insurance for all employees. Other state residents would be able to purchase insurance coverage from a state program, with premiums based on their income and family size. A payroll tax to be paid by employers would help fund health insurance for unemployed persons. However, lack of adequate funding at the state level threatens to delay implementation of this program, which was originally scheduled to begin in 1992.

Legislation to mandate employer coverage has also been considered at the national level. Bills have been introduced but not passed by Congress that would establish minimum levels of health insurance benefits to be provided by all employers. Under several proposed bills, coverage would be required for all full-time employees working a certain number of hours per week and for their dependents. Employers would be mandated either to purchase a package of minimum benefits or provide comparable benefits. The Congressional Budget Office (CBO) estimated that one legislative proposal (S.1265, 100th Congress) would have affected 51 million Americans, including 23 million previously without any coverage and 28 million whose existing coverage did not meet the bill's proposed minimum benefits requirements. The CBO estimated that this legislation would cost employers an additional \$22 billion per year (about \$900 per employee) and would cost employees \$3 billion each year (26).

Advantages of Mandated Employer Coverage

1. Health insurance coverage could be extended to approximately two thirds of those who are currently uninsured.

2. Net costs to the federal government would be negligible, with reductions in Medicare and Medicaid costs offsetting losses in federal revenues from reductions in income and payroll taxes due to elimination of jobs or decreases in wages.

3. Cost to enrollees would be relatively small, and enrollees would benefit from low group rates.

4. Workers would be assured of minimum health insurance protection, because all employers would be required to provide at least the minimum level of benefits.

5. Cost shifting among employers would be reduced. Employers who provide benefits for their employees and dependents would no longer be subsidizing (through higher insurance premiums) the uncompensated costs of caring for employees and dependents of others.

6. The problem of inadequate insurance for those covered could be addressed if all benefits packages were required to meet minimum standards.

7. Socially desirable goals, such as providing prenatal care, child care, and mental health services and prohibiting denial of coverage for pre-existing conditions, could be achieved if they were required as part of a mandatory benefits package.

8. Employers already providing benefits equal to or greater than the minimum would be unaffected.

9. Exemptions could be made for small employers or certain industries to protect them from unreasonable cost increases. Federal or state subsidization or tax credits could also be used to reduce the danger that some employers would go out of business and to protect jobs.

10. Public hospitals and other public programs would obtain some relief from demands for uncompensated care, as fewer patients would be without insurance coverage.

Disadvantages of Mandated Employer Coverage

1. Costs to employers would increase substantially when there is growing resistance to such increases.

2. Small employers of low-wage workers would be most affected. The added cost of insurance could cause some employers to go out of business, resulting in the loss of jobs. In some areas, such as inner cities with high unemployment and substantial populations without health insurance, adding to the burden of employers could exacerbate existing problems.

3. Part-time and temporary workers who do not work the requisite number of hours or weeks for an employer to be required to provide coverage would remain without access to health care.

4. Employment opportunities would be reduced for low-wage, part-time, and seasonal workers as employers seek to avoid incurring additional health insurance costs.

5. Reductions in jobs and wages would result in lower state and federal payroll and income taxes, so that the program would not be truly budget-neutral and would contribute to state and federal deficits.

6. Mandating benefits would undermine the collective

bargaining process. Health insurance benefits are a negotiable item for which wage increases or other benefits are often traded. Requiring all employers to provide specific, minimum health insurance benefits would limit the ability of employers and workers to determine which employment-related benefits are of highest priority.

7. A state-by-state approach of mandating benefits could cause substantial administrative problems for large employers operating in more than one state. Minimum benefits could be different in each state, and states without mandatory health insurance requirements might be able to lure jobs away from those with requirements.

8. Higher labor costs could make it more difficult for U.S. companies to compete in world markets and might contribute to the nation's worsening balance-of-trade problems.

9. Unnecessary and expensive insurance costs could be incurred from duplication of coverage for families with more than one wage earner.

10. Laid-off and unemployed workers could be uncovered or unable to pay insurance premiums.

11. Inadequate financing, particularly likely when state or other government funding is involved, would make the program financially unstable.

Conclusions: Mandating Employer Health Insurance

Mandated employer health insurance could immediately extend insurance coverage to two thirds of uninsured persons and would improve coverage for many underinsured persons. Uniform, national, employer coverage requirements would provide insurance protection to working poor persons who are now covered by Medicaid in some states but not in others. This approach would alleviate the financial burden on Medicaid in some states. However, this approach alone, especially if adopted on a state-by-state basis, would provide only a partial and less-than-optimal interim solution that would still leave many persons uncovered. It would perpetuate inefficiencies and inequities of current insurance mechanisms, including high overhead costs and administrative burdens for health care providers and patients. Systematic means of cost control or quality assurance are not intrinsic features of such an approach and would need to be addressed.

Proposal 3: Create Health Insurance Risk Pools

Health insurance risk pools, like automobile insurance risk pools, are a mechanism for assuring that insurance is available to high-risk persons who otherwise would be considered uninsurable. Risk pools can provide insurance protection for persons with pre-existing medical conditions or other problems, such as testing positive for human immunodeficiency virus, for which they might otherwise be denied health insurance coverage. Costs can be borne entirely by those in the risk pool or can be subsidized by government or by premiums of nonrisk-pool policies. State and federal organizations can help to reduce premiums by providing insurance for losses beyond a certain level.

Fifteen states have enacted laws establishing health

insurance risk pools (27). (As of February 1988, health insurance risk pools were operational in Connecticut, Florida, Indiana, Minnesota, Nebraska, North Dakota, and Wisconsin. Risk pools were being implemented in Illinois, Iowa, Maine, Montana, New Mexico, Oregon, Tennessee, and Washington.) In these states, private insurers generally must accept a proportionate share of risk-pool policies either through direct applications or by reinsurance. Federal legislation to encourage states to set up risk pools has been considered recently. Under one proposal, federal assistance would be provided for states either to establish risk pools or, for those with existing pools, to improve access to affordable insurance. Another proposal would mandate participation by all employers doing business in a state with an established risk pool.

Advantages of Risk Pools

1. By spreading risks among a large population, insurance losses are more predictable and insurance companies can provide coverage at lower group rates. Although premiums are generally higher than for non-risk-pool enrollees, they are not so high as might be required for individual coverage if it were available.

2. Some nonpoor uninsured persons (including those with pre-existing illnesses) and some small employers might be able to obtain health insurance protection that is otherwise unavailable or unaffordable.

3. Risk pools provide a joint public- and private-sector solution to the problem of uninsurability with minimal government involvement.

4. States could take the initiative for establishing risk pools. A federal reinsurance system could be established for states that do not create their own risk pools.

Disadvantages of Risk Pools

1. Premiums for risk pools are high, ranging from 125% to 150% of those for standard risk policies, even though most states with risk pools have established caps on premiums (28). Consequently, enrollment must be voluntary, and substantial public subsidies may be required.

2. Enrollment in existing state health insurance risk pools has been low. Most states with risk pools limit coverage to those who are "uninsurable" (about 1% of the population), but only a small fraction of those who are eligible actually enroll (about 20 000 of approximately 230 000 persons eligible in five states in 1985) (28). This low enrollment may be due to the relative newness of risk pools, lack of public awareness of the risk pools, or the high premiums.

3. State funding of the magnitude necessary to subsidize risk pools adequately would be difficult, given the current fiscal climate and past levels of state support.

4. The existence of risk pools may encourage insurers to become more selective in issuing individual insurance policies, forcing those who are less healthy into risk pools to obtain insurance coverage.

5. Risk pools would not reduce administrative burdens for physicians and could create additional paperwork and delays for receiving payment.

6. Risk pools could increase costs, as insurance carriers add additional administrative staff to determine eligibility and process claims.

Conclusions: Creating Health Insurance Risk Pools

Risk pools for uninsured and unemployed persons could improve access for those who are now denied coverage or are unable to purchase lower-cost group insurance. However, unless substantial subsidies are provided, premiums for risk-pool members could be much higher than premiums for comparable group insurance and would be largely unaffordable. The creation of health insurance risk pools for "uninsurable" persons could encourage greater selectivity among insurance companies, resulting in greater emphasis on marketing to those who are the most healthy and have the lowest risk. Those with previous illnesses or health histories indicating higher risk would be referred to a risk pool. Broader sharing of costs across society would be more equitable, and other devices would be preferable.

Proposal 4: Extend Medicaid Eligibility

Medicaid is a joint state and federal program to provide health care to poor persons. Coverage and eligibility standards vary widely among the states (*see* Appendix 1). Thirty states set the maximum income eligibility standard at less than half of the federal poverty level of \$10 060 for a family of three (11). In 1989, to qualify in Alabama, a family of three could not earn more than \$1416; in California, a family of the same size could qualify with annual earnings of up to \$8328. Families with incomes and assets above state eligibility levels must spend-down their own resources before qualifying for Medicaid coverage. Thirty-six states also provide coverage for the "medically needy." Under these programs, Medicaid coverage is available to those who incur large medical expenses and meet the categorical eligibility standards, except that they may have earnings that are up to 33% above the income eligibility standard. The average income eligibility level for medically needy programs was \$6165 in 1989, 61% of the poverty level (11).

All states must provide coverage for certain services, such as inpatient and outpatient hospital services, physician services, skilled nursing facility care, laboratory, and x-ray services. State Medicaid programs differ, however, in their coverage of "optional" services, such as physical and occupational therapy, prescription drugs, inpatient psychiatric services, diagnostic and screening services, and preventive and rehabilitative services. Payment rates for physician services are generally much below customary charges, and physicians accepting Medicaid patients are required to accept the Medicaid rate as payment-in-full. Physician participation rates are low, and access for Medicaid recipients is consequently impeded.

Expansion of Medicaid eligibility would be another means of improving financial access to health care services for those who are poor or nearly poor but who do not qualify for public assistance. Under the Omnibus Budget Reconciliation Acts of 1986 and 1987, states were given the option of expanding Medicaid coverage to include pregnant women, children under 5 years of age, and elderly and disabled persons with incomes of up to 185% of the federal poverty level.

Provisions retained despite repeal of the Catastrophic Health Insurance Act of 1988 have required states, since 1 July 1989, to extend Medicaid coverage to pregnant women and infants with incomes at or below 75% of the poverty line. Effective 1 July 1990, Medicaid coverage must be provided for qualifying women and infants with incomes below 100% of the poverty line. Medicaid programs must also begin paying Medicare premiums for low-income elderly and disabled persons. This coverage will be phased in over 4 years. Since 1 January 1989, states have been required to pay the premiums for qualified persons with incomes below 85% of the poverty line; by 1 January 1992, coverage will be required for those with incomes below 100% of the federal poverty line.

Other action to expand coverage could be accomplished at the state level by extending coverage to additional optional groups, adopting or expanding "medically needy" programs, or raising eligibility levels for the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. In Oregon, the state legislature has authorized the state Medicaid program to contract with managed care systems to provide care for medically indigent persons. Under this plan, which requires a waiver of federal regulations, coverage would be extended to all state residents with incomes below the poverty level. A commission would determine and rank priorities for specific health care services based on their cost and effectiveness. Political decisions would then be made as to which services would be covered and the level of funds to be appropriated.

Although designed primarily to address the needs of poor families, state Medicaid programs now spend disproportionate amounts on care for elderly persons, particularly for nursing home and home health care. Elderly, blind, and disabled persons comprise 28% of Medicaid recipients but account for 74% of Medicaid expenditures. Only 12% of Medicaid funds are spent for care of dependent children, and 13% for care of adults in families of dependent children (29).

Advantages of Extending Medicaid Eligibility

1. Medicaid provides an existing mechanism for extending health insurance protection to uninsured persons based on determinations of their categoric qualifications, income, and resources.

2. Extension of health insurance protection could be targeted toward those who are not now eligible for Medicaid, but who have incomes that are below or near the poverty line.

3. Creation of national eligibility levels could reduce the disparities currently existing among states.

4. Extending Medicaid coverage to those with family incomes of up to 200% of the poverty level would provide protection for approximately 30% of those now uninsured.

5. Allowing some groups, such as those who have been denied private insurance because of pre-existing conditions, to buy Medicaid coverage would enable "uninsurable" persons to obtain insurance protection. Premiums could be set at average Medicaid cost or otherwise subsidized to provide low-cost coverage.

Disadvantages of Extending Medicaid Eligibility

1. State Medicaid budgets are already overburdened and could not absorb the additional costs of expanded coverage or improvements in benefits and payment rates without massive and sustained additional federal funding or other sources of revenue. Budget constraints also appear to preclude the level of federal financial assistance that the states would require.

2. Providing states with additional options for coverage would further increase disparities in eligibility and benefits among states. States with the highest proportions of unemployed or low-wage workers might be least able to expand Medicaid coverage.

3. Medicaid is often stigmatized as being a social-welfare program for the poor. Some low-income workers and their families would not apply for Medicaid even if they qualified for assistance.

4. Medicaid payment rates are low, and physicians accepting Medicaid payment are required to accept the Medicaid rate as payment-in-full. Physician participation rates are consequently low, and access is impeded.

5. Raising income eligibility levels without corresponding increases in physician participation will not necessarily assure that patients receive needed medical care. If payment rates and the number of physicians accepting Medicaid remain constant, expansion of coverage may mean that some patients have to wait longer to receive services.

Conclusions: Extending Medicaid Eligibility

Medicaid provides an existing mechanism through which coverage could be extended to some qualifying groups who now lack insurance protection. Current disparities in coverage and benefits among states could be reduced by federal legislation setting eligibility levels and mandating coverage. Disadvantages include substantially increased requirements for federal funding, the danger that potential beneficiaries will perceive services obtained through a social-welfare program as being inferior, and low Medicaid payment rates and requirements for mandatory assignment that result in low physician participation rates. In addition, expanding coverage as budgetary constraints increase could further diminish Medicaid's limited resources available for the care of poor women and children. Nevertheless, this approach could serve as an interim means for improving access for low-income groups, particularly those whose incomes are below the poverty level and who qualify for Medicaid in some states but not in others. Because of the social-welfare nature of the program and the low payment rates that restrict access to care, we do not advocate this approach as the primary means for increasing access to health care for all Americans.

Proposal 5: Expand Charity Care

Some argue that very few Americans actually are denied care when they need it. Data from the 1988 American Hospital Association annual survey (8) show that hospitals in the United States provided unreimbursed care valued at \$14.2 billion, 6.3% of their gross patient revenues in 1988. Approximately 32% of this uncompensated care was charity care and 68% was bad

debt. However, the extent of bad debt and charity care provided varied widely by type of hospital, with the highest proportions provided by public (13.3%), major teaching (10.3%), and large (685 or more beds) urban (8.8%) hospitals. Unreimbursed care as a percentage of gross patient revenues was lowest at investor- and religious organization-owned hospitals, and most of the unreimbursed care at investor-owned hospitals was bad debt. Another study (9) estimated the true cost of charity care to be only 1.2% for voluntary hospitals and 0.1% for for-profit hospitals.

Many physicians reduce charges, provide free care, or do not attempt to collect their bills for patients they know lack insurance or cannot afford to pay. The amount of uncompensated care provided by physicians is considerable but difficult to document. One recent study (30) of physicians in San Francisco reported that \$51 000 per physician practice was written off in 1985 as being uncompensated care or services that were not billed. Charity patients accounted for 7% of all physician patients, and physicians provided, on average, \$19 000 per year in services to these patients; the remaining \$32 000 was for care that was billed but not paid (30).

Physicians who treat patients covered by Medicaid and, thereby, agree to accept the low Medicaid fees as full payment are, in effect, providing charity care. The same might be said for accepting patients covered by Medicare on assignment when Medicare-approved charges are substantially lower than physicians' customary charges.

If charity care were available to those who truly need help, other public or private action might not be necessary. Some state and county medical societies have organized programs for physicians to provide free care to indigent persons. Ways to increase charity care include providing organized mechanisms for donating services (for example, establishing free clinics and community service programs), revising the tax code to permit deductions for the professional value of charitable care, and direct appeals to physicians and others to serve the poor.

Advantages of Expanding Charity Care

1. Physicians and hospitals could directly address the problem of access for uninsured persons. This approach would appeal to the innate altruism of physicians and institutions.
2. Those most in need might get help without expansion of government programs or mandates for provision of health insurance.
3. Direct costs to government and employers would not increase.

Disadvantages of Relying on Charity Care

1. Charity care would not provide equal access to health care for all Americans.
2. Many persons feel that requesting charity care is demeaning and will not seek help except in an emergency situation.
3. Data on utilization of health care services of poor persons, before and after adoption of Medicaid in 1965, show that charity care was ineffective in meeting the

health care needs of poor persons. Dramatic increases in use of health care services and improvements in indices of health status after 1965 reflected improvements in access to health care services.

4. Tax deductions for charity care could be easily abused and fraudulent claims would be difficult to detect.

5. Charity care is generally viewed as being of lesser quality than other health care.

Conclusions: Expanding Charity Care

The medical profession has a responsibility to continue to provide a certain degree of charity care. The American College of Physicians urges all physicians to provide care voluntarily on a charitable basis to patients who are in need and lack the resources to pay physicians' customary charges. However, there are inherent risks to patients and society in a system that relies solely on benevolence for the provision of health care services. History has shown that under such a system, health care services are not equally available to all, and poor persons typically either do not receive needed care or receive services of lesser quality.

Proposal 6: Establish a Universal Access to Health Insurance Program

Several proposals have been made that would use an insurance mechanism to spread the cost of health care services equitably on a nationwide basis among all eligible participants. Programs to establish universal access to health insurance do not require a system in which hospitals and other health facilities are owned by the national government or in which physicians and other health care workers are employed by the government.

Practically all industrialized countries except the United States have national health care programs to assure universal access. These programs take many different forms, but they share the common feature of being government programs designed to enable all citizens to obtain health care services without financial barriers. Coverage is generally universal (everyone is eligible regardless of health status) and uniform (everyone is entitled to the same benefits). Costs can be paid entirely from tax revenues or by some combination of individual and employer premiums and government subsidization.

One format is to have a single, uniform program administered at the national level, as in Sweden and France. Another format sets minimum benefits at the national level but allows programs to differ as they are administered at the provincial or state level (as in Canada and Switzerland). Another variation is to permit qualifying, nongovernment programs to operate at the local level (for example, through nonprofit sick funds and medical associations as in the Federal Republic of Germany). Still another arrangement is to have a national program administered through local councils (as in Belgium and the Netherlands). National health insurance programs can be operated solely by the government or can be structured to incorporate private health insurance.

The overall cost of a universal access program would depend on how the program were structured, the benefits provided, the extent of optional or exempted coverage, mechanisms to assure appropriate use of services, and various other considerations. The public or government share would depend on how private insurance were incorporated into the plan and the amount, if any, paid by employers and individuals.

Given the various ways in which a health insurance program could be structured, it is difficult to provide more specific analysis without an actual proposal. Physicians need not assume that payment rates under a universal access plan would be inadequate, although experience with Medicaid and Medicare gives cause for concern. There is also reason to be apprehensive that a universal access program could result in greater intervention in the practice of medicine by government or other payers, thus further diminishing physician autonomy.

A universal access plan could achieve substantial savings by reducing the amount of administrative expenses currently borne by physicians, hospitals, nursing homes, and others providing and paying for health care services. Aggregate savings could be achieved by reducing the paperwork and expenses involved in coding for services, billing and collecting payments from patients, and submitting and documenting claims to multiple insurance carriers—each with its own forms, coverage provisions, copayments and deductibles, and review and compliance requirements. Further savings could be achieved by eliminating much of the administrative overhead that health insurance carriers incur for administration, marketing, reserves, and profits.

Recent proposals (31, 32) suggest that a universal-access program would shift the mix between public and private expenditures and that total expenditures would not increase at as great a rate as has been sustained in recent years. At current levels of national health care spending, each reduction of 1% in the amount of total spending for administrative costs would save \$5.5 billion annually. Potential savings from reduction of administrative overhead under a national health insurance program have been estimated to be about 10% of current health care spending. Those savings might conceivably offset the costs involved in expanding access to health care (31).

Establishment of a universal access program implies that there would be some centralized planning to assure that sufficient resources are allocated to meet the nation's health care needs. Planning and financing decisions would be needed to provide appropriate health care facilities where they are most needed, to foster technologic innovation and scientific advances, and to ensure that there are sufficient numbers of appropriately trained health care professionals. Substantial investments in health services research would be required to enable the program to deliver health care services as effectively and efficiently as possible and to improve the quality of health care. Investments would also be required for research and development to permit continued achievement of advances in medical science and technology.

Financing for a universal access program could be

obtained from general tax revenues, a surcharge on income taxes, payroll taxes, or income-related premiums or by various other means, including using the savings obtained by converting from the present system. Although coverage would apply equally to all, contributions could vary according to income. Contributions could also be adjusted or waived for targeted groups, such as unemployed and poor persons, children, and pregnant women. A universal health insurance program could replace the need for Medicaid and most charity care. Additional issues, such as whether to permit the purchase of coverage beyond that provided under the program and voluntary exemptions from enrollment, would require careful analysis.

Advantages of a Universal Access to Health Insurance Program

1. All persons would have access to specific health insurance benefits covering at least essential health care services. Coverage could serve as a safety net and be supplemented by private insurance.

2. Access to mainstream health care could be provided.

3. Equity would be achieved among the states, as all persons would be eligible for national insurance coverage.

4. Lower premium rates per dollar of coverage could be obtained for a uniform package of benefits than is possible under a multiplicity of plans with varying benefits and coverage.

5. Administrative overhead would be far lower than under most private-sector plans due to savings from economies of scale. Additional savings could be obtained from the reduction or elimination of costs for billing, processing claims, marketing, reserves, and profits.

6. A minimum-benefits package could be designed to include prenatal, well-child, and other primary and preventive care that could improve our nation's health status. Increased access to these and other health care services could result in better health and reduced costs for preventable illnesses.

7. Coverage could be optional for those with other insurance that is at least equivalent, and supplemental private insurance could still be purchased by those seeking additional protection.

8. The cost of expanding health insurance to uninsured persons could be broadly and equitably shared.

9. Costs would be offset to some extent by savings from increased worker productivity and resultant higher earnings and tax revenues (although such savings are difficult to measure); reduced payments for much more expensive sequelae and complications of neglected illness; elimination of expenditures for Medicaid and other programs; and diminished costs of so-called "uncompensated care" which is now ultimately shifted to private insurers, the public treasuries, and charities.

10. Health care providers would be assured of payment, thus reducing or eliminating bad debts and uncompensated care.

11. Planning and financing on a national scale could better assure that resources are allocated to provide the health care facilities and the manpower needed to de-

liver health care services most effectively. Adequate resources could be provided for research and development, health services research, and the education and training of needed health care professionals.

12. Administrative burdens on physicians could be reduced.

Disadvantages of a Universal Access to Health Insurance Program

1. Substantial change would be required, entailing a restructuring of health care financing mechanisms and programs.

2. Universal coverage and expansion of benefits could result in greater health care costs, thereby generating further pressures for cost containment.

3. Greater government involvement in the practice of medicine, with increasing controls on volume, utilization, costs, and quality reviews, could result in further losses of physician autonomy.

4. Governmental decisions to ration or not to pay for some procedures (for example, organ transplants) would more directly limit medical decision making and the availability of these services.

5. Centralized planning and uniform determinations of coverage and benefits could prevent development of local variations that might better meet local needs.

6. There would be a loss of clerical, administrative, and accounting jobs now required for hospitals, physicians' offices, and other health care facilities to complete and process bills and other paperwork. Employment in the insurance industry might also suffer as jobs in marketing and claims processing are lost.

7. The role of private insurance companies might be diminished and their profits reduced.

Conclusions: Establishing a Universal Access to Health Insurance Program

The primary advantage of a universal access program would be that all Americans would have specific health insurance benefits and financial access to mainstream health care. In addition to universality and portability, such a program would offer equity in benefits among the states. Substantial cost savings could be achieved compared with current aggregate health insurance costs. A single health insurance program could also alleviate much of the frustration faced by individual practitioners who must now deal with multiple insurance plans and carriers.

A universal access program could include coverage for prenatal, well-child, and other primary and preventive care that could improve the nation's health. Improvements in health could achieve additional savings from increased worker productivity and reduced payments for expenses that now arise from complications of neglected illnesses. A universal access program could alleviate the financial stress on many public hospitals that results from the provision of care to poor and indigent patients for which little or no compensation is now received.

Government administration of Medicare and Medicaid has not been a model of efficiency, nor has it given physicians, hospitals, or other health care providers reason to assume that administrative burdens would be

reduced or that there would be less government interference under an expanded national program. Mechanisms would be needed to assure that the potential administrative savings from adoption of a national insurance mechanism would be allocated to improve or expand health care services.

Conclusions and Recommendations

A National Program Is Needed To Assure Access

All Americans should be able to obtain appropriate health care services, irrespective of age, race, sex, financial status, or place of residence. We believe that assuring access to health care services would achieve improvements in health status, decrease incidence of morbidity and mortality, and, possibly, contribute to increased life expectancy among those groups with the least access to care and the highest, age-adjusted, disease-specific mortality rates.

A multitude of existing programs and mechanisms enables most persons to obtain the health care services that they need. Still, many persons do not have adequate health insurance protection. In addition, rising costs and increasing bureaucratic and administrative burdens of the present system require re-examination. The existing system is inefficient and expensive, and a new approach is required.

We have focused on mechanisms to increase health insurance coverage as a means of improving access to health care services. Six types of broad policy proposals have been identified; the advantages and disadvantages of each have been presented. In view of these criteria, we conclude the following:

A nationwide program is needed to assure access to health care for all Americans, and we recommend that developing such a program be adopted as a policy goal for the nation. The College believes that health insurance coverage for all persons is needed to minimize financial barriers and assure access to appropriate health care services.

Assuring access also involves issues of cost and quality. The medical profession bears responsibility to ensure that acceptable, appropriate, and cost-effective care is delivered.

A nationwide program would establish a coordinated financing mechanism that would assure access to appropriate care for all of our citizens. Public policymakers are urged to initiate action now to accomplish this goal. A national commitment to assure access to health care is essential, because the current situation is resulting in the denial of adequate care to an inordinate number of persons, cost-cutting incentives are beginning to replace medical decision making in determining use and availability of health care services, our current system has excessive administrative costs, and the infrastructure of our health care system is in jeopardy.

The Issue of Administrative Costs and Burdens Must Be Addressed

It appears that substantial savings could be obtained by reducing administrative costs, improving efficiency,

and eliminating wasteful duplication of coverage. Current payment and reimbursement mechanisms in the United States necessitate large bureaucracies and enormous administrative expenses to ensure that each and every service provided by institutions, physicians, and other health care providers is attributed to a specific patient. These expenses occur in commercial and not-for-profit private insurance plans as well as in public programs. There are tremendous costs involved in identifying, billing, collecting, and reviewing payments for services. Private, competitive programs also incur costs for advertising, marketing, profits, and reserves. These administrative costs are borne not only by the insurers and public programs but also by hospitals, physicians, and others.

In contrast to private insurance costs, publicly funded programs do not include costs for profits, marketing, or premium collection. The overhead for the universal public insurance system in Canada currently averages 2.5% of program costs. Overhead costs of Medicare and Medicaid amounted to less than 3% in 1983. Today, with increased Medicare and Medicaid total outlays, these costs are closer to 2%. This figure includes costs for contractor administration, research and demonstration projects, surveys and certifications of facilities, as well as salaries for program administration (2). Additional administrative savings could be achieved under a nationwide insurance program, because there would be no need to determine income or categorical eligibility, as presently required under Medicaid.

With a gross national product (GNP) approaching \$6 trillion, the amounts of money that could be saved by at least stabilizing the rate of growth in U.S. health care spending could be staggering and may indeed be enough to pay fully for the cost of a universal access to health insurance program. Each one-percentage-point reduction in the proportion of GNP now attributed to health care (which includes administrative overhead as well as other costs due to inefficiencies inherent in the system) would yield savings of almost \$60 billion per year.

Criteria Must Be Used To Evaluate Proposals for Reform

The issues concerning problems of access to health care are complex. Any new program to address them on a nationwide basis will have to include consideration of the ramifications of such changes. Caution must be exercised to preserve the strengths of the existing system, such as its ability to foster innovation and achieve advances in medical science, while correcting for its deficiencies. The time has come for a re-examination of the present system and a full examination of possible new approaches. This paper is an attempt to begin that process.

We have discussed development of a comprehensive financing program as one option for assuring access to health care for all Americans. Although we recognize that consideration of this option could be controversial and divisive for the medical profession, we believe that it merits serious examination. We further recognize that there are many major policy issues that would need to be resolved before a nationwide, health insurance fi-

ancing mechanism could be developed for the United States. One central task would be to define clearly the services that would be covered.

We have indicated that a new process for determining the scope of benefits would be required. Such a process must distinguish the clinical role of advising on the appropriateness of specific services from the societal role of determining the feasibility of providing such services. The structure of the program, particularly of the financing mechanism, would be equally important. It must be designed in conformance with agreed upon criteria for a better system. We have offered criteria that might be used.

Payment rates for health care services would need to be sufficient to assure that adequate numbers are attracted to health professions careers. Likewise, sufficient financial resources would need to be devoted to supporting appropriate educational and training programs.

Planning and financing would be required to assure that facilities are kept up-to-date and are available where needed. Investments in research and development would need to be sufficient to enhance scientific knowledge and to achieve further technologic advances. Funding for health services research would be even more critical as greater emphasis would be given to improving the effectiveness and efficiency of the delivery of health care services.

Cost containment and controls to avoid excessive use of services would be necessary under a nationwide health insurance program, as under any health insurance plan. However, such efforts could be based primarily on scientifically valid determinations of medical necessity and appropriateness.

Finally, we re-emphasize the need to minimize costs and dramatically ease administrative burdens for patients, families, and physicians and other health care providers. Restructuring and reforming the professional liability system are necessary to reduce the cost of medical practice and to encourage appropriate utilization of medical services.

Complex Policy Questions Must Be Discussed and Debated

Unresolved questions to be addressed include how to assure that the manpower, facilities, and services are, in fact, available and how to integrate a new universal-access program with existing public health programs, such as Medicare and Department of Veterans Affairs, community health, and National Health Service Corps programs. How would a nationwide health insurance program affect the availability of private health insurance? A comprehensive and coordinated nationwide program would highlight the need to address many pending questions concerning standards of quality and mechanisms for quality assurance. What controls on utilization would be required? These and other questions will need to be considered.

Issues of Timing, Cost, and Feasibility Require Sound Analysis and Discussion

Much confusion exists concerning the issue of costs of an expanded system. Some have argued that incre-

Appendix 1. Annualized Medicaid Eligibility Thresholds—July 1989

State	AFDC (Family of Three)	Percent of Poverty Level	Medically Needy	Percent of Poverty Level	OBRA 1986-1987 Pregnant Women (Family of Three)	Percent of Poverty Level
	\$	%	\$	%	\$	%
Alabama	\$1,416	14.1%			\$10,060	100.0%
Alaska	9,708	77.2			12,580	100.0
Arizona	3,516	35.0			10,060	100.0
Arkansas	2,448	24.3	\$3,300	32.8%	10,060	100.0
California	8,328	82.8	10,704	106.4	18,611	185.0
Colorado	5,052	50.2			7,545	75.0*
Connecticut	6,660	66.2	8,857	88.0	18,611	185.0
Delaware	3,996	39.7			10,060	100.0
D.C.	4,716	46.9	6,288	62.5	10,060	100.0
Florida	3,444	34.2	4,596	45.7	15,090	150.0
Georgia	4,968	49.4	4,404	43.8	10,060	100.0
Hawaii	7,224	62.4	7,224	62.4	21,405	185.0
Idaho	3,780	37.6			7,545	75.0*
Illinois	4,104	40.8	5,496	54.6	10,060	100.0
Indiana	3,456	34.4			10,060	100.0
Iowa	4,920	48.9	6,600	65.6	18,611	185.0
Kansas	4,920	48.9	5,760	57.3	15,090	150.0
Kentucky	6,312	62.7	3,696	36.7	12,575	125.0
Louisiana	2,280	22.7	3,096	30.8	10,060	100.0
Maine	7,584	75.4	7,092	70.5	18,611	185.0
Maryland	4,752	47.2	5,508	54.8	18,611	185.0
Massachusetts	6,948	69.1	9,300	92.4	18,611	185.0
Michigan	6,900	68.6	6,660	66.2	18,611	185.0
Minnesota	6,384	63.5	8,508	84.6	18,611	185.0
Mississippi	4,416	43.9			18,611	185.0
Missouri	3,420	34.0			10,060	100.0
Montana	4,308	42.8	4,896	48.7	10,060	100.0
Nebraska	4,368	43.4	5,904	58.7	10,060	100.0
Nevada	3,960	39.4			7,545	75.0*
New Hampshire	6,072	60.4	6,900	68.6	7,545	75.0*
New Jersey	5,088	50.6	6,792	67.5	10,060	100.0
New Mexico	3,168	31.5			10,060	100.0
New York	6,468	64.3	8,508	84.6	18,611	185.0
North Carolina	3,192	31.7	4,298	42.7	10,060	100.0
North Dakota	4,632	46.0	5,220	51.9	7,545	75.0*
Ohio	3,852	38.3			10,060	100.0
Oklahoma	5,652	56.2	5,196	51.7	10,060	100.0
Oregon	5,184	51.5	6,900	68.6	8,591	85.4
Pennsylvania	4,608	45.8	5,400	53.7	10,060	100.0
Rhode Island	6,516	64.8	8,700	86.5	18,611	185.0
South Carolina	5,028	50.0			18,611	185.0
South Dakota	4,524	45.0			10,060	100.0
Tennessee	4,644	46.2	3,000	29.8	10,060	100.0
Texas	2,208	21.9	3,204	31.8	13,078	130.0
Utah	6,192	61.6	6,192	61.6	10,060	100.0
Vermont	7,812	77.7	10,500	104.4	18,611	185.0
Virginia	3,492	34.7	4,298	42.7	10,060	100.0
Washington	5,904	58.7	7,188	71.5	18,611	185.0
West Virginia	2,988	29.7	3,480	34.6	15,090	150.0
Wisconsin	6,204	61.7	8,268	82.2		
Wyoming	4,320	42.9			10,060	100.0
Average state	\$4,942	48.6%	\$6,165	61.0%	\$14,617	144.1%

* Complying with federal mandate. AFDC = Aid to Families with Dependent Children; OBRA = Omnibus Budget Reconciliation Act. Source: National Governors' Association, July 1989.

mental steps are necessary because of cost concerns. Others argue that the efficiencies of a universal system would offset the costs of expanded services. These analyses will need to be examined in greater detail, particularly because they are highly dependent on specific elements in the design of either approach.

Cost and budgetary considerations may necessitate taking an incremental approach to accomplishing the goal of extending health insurance protection to all Americans. One interim step that has already been taken has been to expand Medicaid coverage for some segments of the population and to establish uniform eligibility levels based on percentages of the poverty level. Further improvements could be achieved by establishing uniform Medicaid eligibility levels that would extend coverage to all persons with incomes at or below a predetermined level. Coverage for employed workers and their families could be expanded by requiring employer-based health insurance. However, these should be viewed as interim measures as we continue to explore the need for other changes in the health care delivery system.

A comprehensive and coordinated program to assure access on a nationwide basis is essential. In the near term, given the urgency of the need, it should build on the strengths of existing health care financing mechanisms. In the longer term, careful consideration of new and innovative alternatives, including some form of a nationwide financing mechanism, will be necessary.

The American College of Physicians believes that it is time to confront the issue of access to health care. Piecemeal solutions to a national problem of this magnitude will not suffice. Maintenance of the basic infrastructure for the provision of care in this country is a national priority and must be addressed accordingly. Hence, the problem of access to care must be addressed not only because of the need to assure that services are available to those who are presently uninsured or underinsured, but also as a means of creating a more efficient system for delivering services to all Americans. Reliance solely on private charity or the efforts of individual states—with their differing and variable resources—to assure that the national need is met is a fundamental abrogation of this overarching responsibility. The College is committed to working with its members and others to meet this challenge.

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