The State of the U.S. Health Care Sector

A REVIEW OF DATA ON THE HEALTH SECTOR OF THE UNITED STATES

Ida Hellander

This report provides data on the state of U.S. health care at the start of the new century. It reveals increasing numbers of uninsured and underinsured Americans; increasing costs for health insurance, health care services, and medicines; and increasing inequalities in health and in access to health care. The author also provides data on the current state of the pharmaceutical and health service industries, including Medicaid and Medicare HMOs. The results of some opinion polls on health care, conducted among physicians and the general public, are also summarized.

UNINSURED AND UNDERINSURED

• A recent article, "No Health Insurance? It's Enough to Make You Sick," reviews research linking lack of health coverage to poor health, and includes abstracts of about 124 articles. The article is available on-line at the American College of Physicians–American Society of Internal Medicine (Web site: www.acponline.org/uninsured/lack-contents.htm).

• The number of uninsured Americans is predicted to climb from 44.3 million in 1998 to 55 million by 2008, 22 percent of the non-elderly population, according to a study by the insurance industry. Falling Medicaid enrollment (due to welfare cuts) has contributed to an increase in the number of uninsured Americans with incomes below 200 percent of poverty to 24 million. However, the percentage of the uninsured above 200 percent of poverty is increasing faster. This group accounted for 40 percent of the uninsured in 1994 (16 million people) and 46 percent (20 million people) in 1998 (Health Insurance Association of America, December 8, 1999).

• One in four adults aged 18 to 64 (about 40 million) reported going without needed medical care due to costs, and a similar proportion (23 percent) said they

International Journal of Health Services, Volume 30, Number 3, Pages 641–653, 2000

cannot afford to pay their medical bills. Adults with incomes below $35,000 have greater problems; they are more likely to be uninsured (32 percent), to be in fair or poor health (25 percent), to go without needed care because of costs (37 percent), and to not have enough money to pay medical bills (41 percent) (Commonwealth Fund, September 1999).

- A study by the Urban Institute of 1,004 women who left welfare between 1995 and mid-1997 found many lost health coverage. Forty-one percent were uninsured one year after leaving welfare, 36 percent had retained Medicaid, and 4 percent had other public coverage. Less than one-quarter (23 percent) had private or employer-sponsored coverage. Of 1,662 children studied, 23 percent were uninsured at one year, 50 percent had Medicaid, and 2 percent had other public coverage. Just over one-quarter (27 percent) of the children had private coverage (*Health Affairs,* January/February 2000).
- In 1997, about one-fifth of employers offered their employees a choice of at least two health plans, according to RAND economists. Only about 10 percent of firms with fewer than 50 employees offered their employees a choice of plans, while 35 percent of large firms offered workers at least two options (Marquis and Long, *Health Affairs,* November/December 1999).
- About 70 million Americans—about 1 in 4—have no prescription drug coverage ("Affordable Medications for Americans," Sager and Socolar, July 27, 1999).
- The proportion of firms offering retiree health insurance benefits fell 9 percent between 1991 and 1998. A study of 498 companies with over 1,000 employees found that 78 percent provided retiree coverage in 1998, down from 87 percent in 1991. In 1998, many employers also required retiree contributions to the cost of the plan (96 percent), capped benefits (40 percent), or offered Medicare managed care programs (40 percent) to reduce costs. Retirement health coverage declines as company size decreases (Kaiser Family Foundation, October 1999).
- One in seven Californians aged 45 to 64 is uninsured, according to a recent survey. Health problems often appear when people reach their mid-40s, and 46 percent of those who retire before age 50 do so because of health problems. The uninsured in this age group "often delay medical visits until they are old enough to qualify for Medicare at age 65." In addition, the survey found that more than 50 percent of those earning less than $20,000 annually complained of fair or poor health, compared with only 8 percent of those earning more than $80,000 annually (Field Institute and the University of California, Dorothy Rice et al., September 1999).
- About 28 percent of adults aged 18 to 64 in New York City are uninsured, twice the national average. Only 44 percent of New Yorkers have employer-provided coverage, compared with 63 percent nationally, and minorities are 50 percent more likely to be uninsured than whites (Commonwealth Fund, September 1999).

COSTS

- Total U.S. health spending increased to $4,094 per person, or $1.1 trillion, in 1998. Total spending increased 5.6 percent in 1998, compared with a 4.7 percent increase in 1997. Spending on prescription drugs grew the most: 15.4 percent in 1998, to $90.6 billion. Private health insurance costs grew rapidly, by 8.2 percent in 1998, double the rate of the previous three years (*Health Affairs* release, January 10, 2000).
- Low-income workers pay more to get health coverage on the job than their higher-income counterparts. Employees at firms paying an average of $7 per hour faced premiums of about $130 a month, while workers at firms paying an average of $15 per hour paid $84 a month for coverage. As a result, 87 percent of employees at higher-wage firms participate in company plans, compared with 78 percent of workers in lower-wage firms. According to researchers, about 20 percent of the uninsured, or 7.3 million people, are offered but "do not accept" health coverage, mostly "because they can't afford the premiums" (*Wall Street Journal,* October 13, 1999; Center for Studying Health System Change, October 1999).
- Medicare's spending growth in 1998—just 2.5 percent—was the lowest in 35 years, and preliminary reports show that Medicare spending for 1999 actually fell by 1 percent. Medicare spending grew 6 percent in 1997. The Health Care Financing Administration cites a combination of factors for the slow growth, including the impact of its efforts to reduce fraud, spending cuts, and a low general inflation rate. While Medicare spending flattened, total private health care spending increased by 6.9 percent in 1998, after a 4.8 percent increase in 1997. Private spending on hospitals rose 3.9 percent in 1997 and 6.1 percent in 1998. Medicare spending on hospitals rose 5.6 percent in 1997 and just 0.9 percent in 1998 (*Health Affairs,* January/February 2000; *New York Times,* January 11, 2000).
- Health insurance premiums are expected to rise an average of 8 percent to 10 percent in 2000, on top of increases of 7 percent to 9 percent in 1999. The California Public Employees Retirement System (CalPERS) has agreed to average increases of 9.7 percent for 2000, the biggest jump since the early 1990s. The increase marks the third major hike in three years—following increases of 7.2 percent in 1998 and 9.5 percent in 1999 (*Washington Post,* September 19 and December 14, 1999).
- The Xerox Corporation has announced a plan to abandon buying health insurance for its workers and may instead give employees between $5,000 and $6,000 a year to purchase their own coverage. It's unclear if employees would have access to group coverage. Xerox claims the new plan would give employees more choice and even cash, if they buy cheaper plans. However, critics note that the plan could have a devastating impact on less healthy, disabled, or older workers with preexisting conditions and reduce risk sharing between

healthy (and wealthy) and less healthy enrollees (*Los Angeles Times,* December 5, 1999).

• Health care costs have risen sharply in Rochester, New York, since competition has overtaken collaboration in the region. In 1993, a report by the General Accounting Office found that health insurance costs were 33 percent below the national average in Rochester; today that advantage has eroded to just 6 percent. Since the mid-1990s, insurers have moved away from community rating and into HMOs (managed care penetration in Rochester is currently 70 percent) (*Modern Healthcare,* October 25, 1999).

• Tax deductions for health insurance and medical expenditures cost the government $111.2 billion in lost revenue for 1998. A study by researchers at the Lewin Group found that the tax benefit is regressively distributed. It varied from $2,357 per family among those with annual incomes of $100,000 or more, to $71 per family among those with annual incomes under $15,000. As a result, the wealthiest 10 percent of the population received 23.6 percent of the tax benefit ("Cost of Tax-Exempt Health Benefits in 1998," Sheils and Hogan, *Health Affairs,* March/April 1999).

MEDICAL AND SOCIOECONOMIC INEQUALITY

• Only 59 black and Hispanic students are enrolled in University of California medical schools this year, down from 103 in 1993. There are 569 first-year students at the state's five medical schools (*Los Angeles Times,* October 7, 1999). The University of North Carolina, once a national leader in minority recruitment, also reports a 50 percent drop in entering minority students (*Charlotte Observer,* October 23, 1999).

• The U.S. infant mortality rate was 7.2 per 1,000 live births in 1998, according to researchers at Johns Hopkins. The U.S. has the highest infant mortality of any developed nation, double that of Sweden. New Hampshire had the lowest rate of any state, at 4.3 deaths per 1,000, while the District of Columbia had the highest rate, at 13.2 (*Washington Times,* December 7, 1999).

• Blacks with lung cancer are 12.7 percent less likely to have surgery for early-stage disease than whites (64 percent vs. 76.7 percent), according to a study of 11,000 Medicare patients by researchers at Sloan-Kettering Cancer Center. In addition, blacks without surgery are less likely than whites without surgery to be alive five years after diagnosis (26.4 percent vs. 34.1 percent) (*New England Journal of Medicine,* October 14, 1999).

• A Centers for Disease Control (CDC) study of maternal deaths nationwide between 1979 and 1992 found that Hispanic women are nearly twice as likely to die from pregnancy-related complications as whites (10 deaths per 100,000 vs. 6 deaths per 100,000). A CDC study earlier this year [1999] found that black women have the highest rate of maternal mortality (25 deaths per 100,000), over four times the rate for whites (*Obstetrics and Gynecology,* October 31, 1999).

• Thirty years ago, the income gap between the richest one-fifth of the world's people and the poorest stood at 30 to 1. Today it is 74 to 1. The combined wealth of the world's three richest families is greater than the annual income of 600 million people in the developing countries, and 1.3 billion people live on less than a dollar a day. "Global inequalities in income and living standards have reached grotesque proportions," according to the U.N. annual Human Development Report (*San Francisco Examiner,* July 12, 1999).

PHARMACEUTICALS, INC.

• Glaxo Wellcome is merging with SmithKline Beecham in an $80 billion deal. The new firm will have combined annual sales in excess of $25 billion (*New York Times,* January 17, 2000).

• The Monsanto Company, owner of pharmaceutical giant G. D. Searle, is merging with Pharmacia and Upjohn in a $27 billion deal. The new firm will have estimated sales of $17 billion yearly (*New York Times,* December 20, 1999).

• Warner-Lambert and Pfizer are in merger negotiations (*Los Angeles Times,* November 5, 1999).

• Drug companies pay significantly less in taxes than any other U.S. industrial sector, according to a study by the Congressional Research Service. Between 1993 and 1996, drug makers' tax rate averaged 16.2 percent, compared with an average of 27.3 percent for all other large industries. Meanwhile, after-tax profits averaged 17 percent of sales for drug companies between 1994 and 1998, compared with 5 percent for all other industries. Pharmaceutical companies received tax credits totaling $3.8 billion in 1996, reducing their tax bill by 50 percent on $24.8 billion in taxable income.

• Between 1998 and 1999, prices of the 50 most commonly prescribed drugs for older Americans increased an average of four times faster than the rate of inflation (6.6 percent vs. 1.6 percent). Prices of some common medications for seniors have skyrocketed since 1994, including lorazepam (up 385 percent), Imdur (111 percent), Lanoxin (87 percent), Atrovent (37 percent), and Propulsid (30 percent) (Families USA, November 1999).

• The U.S. could save $16.2 billion a year if medications were purchased at Canadian prices, according to researchers at the Boston University School of Public Health ("Affordable Medications for Americans," Sager and Socolar, July 27, 1999).

• Melvin Goodes, CEO of Warner-Lambert, was the highest paid health executive in 1998, with total compensation (excluding stock options) of $16.5 million. Three other pharmaceutical executives are among the ten highest paid health executives for that year: Pfizer CEO William Steere ($4.4 million), American Home Products' John Stafford ($4 million), and Johnson and Johnson's Ralph Larsen ($4 million) (*Jenks Healthcare Business Report,* September 24, 1999).

• Two pharmaceutical giants will pay $725 million in criminal fines to avoid U.S. prosecution for running a global cartel that fixed prices on vitamins. According to the Justice Department, Roche Holdings AG (Switzerland), BASF AG (Germany), and potentially a dozen other firms met over a nine-year period to determine how they would set prices and spread sales among the cartel. The supplements included vitamins and nutrients used to enrich cereals and processed food. Rhône-Poulenc (France) will not be held criminally liable for its participation in the cartel because the firm divulged information that helped solve the case. Roche, BASF, and Rhône-Poulenc are the three largest companies in the $3 billion nutritional supplement market. Roche also paid a $14 million fine in 1997 when it was found guilty of fixing prices for citric acid (*Lancet,* May 29, 1999).

• New England lawmakers are exploring the idea of combining their states' populations into a giant drug-purchasing group to gain discounts on prescription drugs. The six New England states have 13.5 million people and spend $5.4 billion annually on prescription drugs. Legislators are also considering passing price controls at the state level with 20 percent to 40 percent discounts. The Massachusetts legislature recently passed a provision to create a drug-purchasing pool with 25 percent of the state's population, 1.6 million people (state employees, Medicaid and Medicare beneficiaries, and those without prescription drug coverage). The state estimates that it will save taxpayers and patients about $170 million a year. Merck and other drug companies are lobbying Governor Paul Cellucci to veto the bill. Former Governor William Weld has come out in favor of the proposal, arguing the provision will cut drug bills 30 percent (*Boston Globe,* December 12, 1999; *Wall Street Journal,* December 13, 1999).

• The Federal Trade Commission and 32 state attorneys general are suing Mylan Laboratories for $120 million. Mylan raised the price of clorazepate by 3,200 percent after cornering the market on a key ingredient. Eli Lilly, American Home Products, Abbott Laboratories, and Hoechst AG are also under investigation for "unreasonable restraint of trade" and price-fixing. The firms allegedly paid manufacturers directly not to make generics or formed exclusive contracts with suppliers of key ingredients (*Dallas Morning News,* December 9, 1999).

CORPORATE MONEY AND CARE

• Knoll Pharmaceuticals, manufacturer of Synthroid, has offered to pay $135 million to settle a class-action lawsuit by consumers. Knoll suppressed research by U.C.–San Francisco scientist Betty Dong showing that a less costly, generic version was bioequivalent to Synthroid and threatened to sue the Journal of the American Medical Association if it published her work (CBS's "60 Minutes," December 19, 1999).

• A study of over 3,600 patients with end-stage renal disease (ESRD) found that for-profit ownership of dialysis facilities is associated with 30 percent higher

mortality and 26 percent lower rates of placement on a renal transplant waiting list. More than 200,000 patients with ESRD undergo dialysis in the U.S. each year, about two-thirds (68 percent) in for-profit centers. The care of ESRD patients is a $15.6 billion industry (Garg et al., *New England Journal of Medicine,* 341(22): 1653–1660, 1999).

- The ten highest paid HMO executives received a total of $22.9 million in compensation in 1998, a year HMOs complained of sagging profits. Cigna's Wilson Taylor was the highest paid HMO executive in 1998, with $5 million in total compensation. Norman Payson (Oxford) was second, at $3.2 million, followed by three HMO executives who topped $2 million in annual pay—Alan Hoops at PacifiCare ($2.7 million), Richard Huber at Aetna ($2.2 million), and Leonard Schaeffer at Wellpoint Health Networks ($2.2 million). Total compensation includes salary, bonus, and other benefits with a case value, but excludes valuable stock options (*Jenks Healthcare Business Report,* September 24, 1999).
- Patients with sickle-cell anemia often receive substandard care from HMOs, according to specialists in the field. Dr. Elliott Vichinsky, a sickle-cell specialist at Children's Hospital in Oakland, often sees patients who have been "brutalized by the health care system. Two out of three deaths in my adult population are preventable. . . . These are really the orphans of managed care." A chronically ill patient with a genetic disease is "the nightmare of the insurance industry," according to attorney Beth Sufian, who frequently defends people with debilitating diseases (Salon.com, Allen, December 15, 1999; *American Health Line,* November 11, December 17, 1999).
- A group of lawyers filed class-action lawsuits in federal court in November 1999 against five of the nation's largest HMOs, charging systematic violations of federal anti-racketeering laws. The attorneys, led by Richard Scruggs, a key player in tobacco lawsuits, accused the insurers of providing financial incentives for physicians and reviewers to limit treatment; imposing "gag" clauses; making decisions of medical necessity based on financial considerations; and limiting patients' access to specialists. The HMOs named in the suits are Cigna, Foundation Health, Humana, PacifiCare, and Prudential (*Los Angeles Times,* November 24, 1999).
- A Massachusetts Independent Practice Association (IPA) sought to fine physicians $250 for each day of a patient's hospital stay deemed medically unnecessary. The plan was criticized by the IPA's member-physicians in the Boston media. There are 350 physicians in the Mount Auburn Cambridge Independent Practice Association, including several Physicians for a National Health Program members who gave media interviews calling the plan "immoral." The policy was withdrawn the following day (*Boston Globe,* October 14, 1999).
- Many of the 44 companies that contract with Medicare to process claims are under investigation for fraud by the Department of Health and Human Services (HHS). Eight such companies have paid more than $275 million in fines for activities like falsifying records, billing Medicare for costs that should be paid by

private insurance, destroying claims, filing false claims, and obstructing audits. In 1998, Illinois Blue Cross and Blue Shield pled guilty to fraud and paid $144 million in criminal and civil fines, the largest such settlement. Colorado Blue Cross and Blue Shield paid $6.1 million in fines, and New Mexico Blue Cross and Blue Shield agreed to pay $5.1 million by 2001 to settle fraud charges. Blue Cross and Blue Shield plans handle two-thirds of all Medicare claims. Anthem Blue Cross and Blue Shield of Connecticut was fined $74 million in December for falsifying cost reports to Medicare from 1989 to 1991. Anthem Blue Cross is a subsidiary of the Indianapolis-based Anthem Inc., which has purchased several former Blues plans in other parts of the country when they converted to for-profit status (*Hartford Courant,* December 9, 1999; *New York Times,* December 20, 1999).

- Beverly Enterprises, the nation's largest nursing home chain with 536 facilities, will pay the government $200 million to settle charges of Medicare fraud in its operations between 1990 and 1997. The fine is the largest ever paid by a nursing home company for defrauding Medicare. The Vencor chain is also under investigation for Medicare fraud (*Wall Street Journal,* August 23, 1999; *St. Petersburg Times,* August 3, 1999).
- Medical groups in California, Denver, and Texas are in financial crisis. The California Medical Association says that nearly a third of the state's 350 medical networks have shut down or entered bankruptcy proceedings in the past three years. It estimates that two networks alone owe the state's doctors about $100 million. In the past year, five Denver physicians' groups have gone bankrupt, and five more are on the brink of insolvency. Dallas's giant 960-member Genesis Physicians' Practice Association filed for bankruptcy this year (*Wall Street Journal,* November 15, 1999; *Dallas Morning News,* October 31, 1999; *Orange County Register,* October 21, 1999).
- The University of Pennsylvania Health System is laying off an additional 1,700 people, on top of layoffs of 1,100 workers last year, for a total loss of 20 percent of its workforce. The University lost $198 million on revenues of $1.9 billion in fiscal 1999 (*Philadelphia Inquirer,* October 22, 1999).
- Harvard Pilgrim's HMO in Rhode Island collapsed after the Massachusetts-based not-for-profit withdrew its support. The Rhode Island HMO was taken over by the state, which will transfer most of its 155,000 subscribers to other health insurers (*Providence Journal,* December 11, 1999).
- HMOs are in trouble in Massachusetts as well. Harvard Pilgrim lost $170 million and was placed in receivership by the state's attorney general in January. Harvard Pilgrim (formerly Harvard Community Health Plan) has 1.1 million members. Fallon HMO recently hired a new CEO to stem two years of financial losses, and Tufts is anticipating a $45 million loss this year, leading to its pull-out from New Hampshire, Maine, and Rhode Island. The three plans were ranked among the "top five HMOs in the nation" by *Newsweek* (*Boston Globe,* December 3, 1999; *Newsweek,* November 1999).

• Columbia/HCA senior executive Robert Whiteside was sentenced to two years in prison, fined $7,500, and ordered to pay restitution of $576,000 for his role in defrauding Medicare at the giant hospital chain (*Orlando Sentinel,* December 3, 1999).

• The percent of HMO members enrolled in not-for-profit plans decreased from 88 percent in 1981 to 36 percent in 1999 (*USA Today,* October 20, 1999).

• PacifiCare is buying Harris Methodist Health Plan, Dallas's largest HMO with 314,000 subscribers, for more than $100 million. PacifiCare has 3.7 million enrollees, including more than 1 million in its Secure Horizons Medicare HMO. Aetna also picked up more than 1 million Texas enrollees in its purchase of Prudential's health plan (*Dallas Morning News,* October 30, 1999).

• Wellpoint Health Networks is buying Chicago-based Rush-Prudential Health Plans, for $200 million. Wellpoint is the nation's fifth largest HMO, with more than 7.2 million enrollees. Rush-Prudential has 400,000 enrolless (*Chicago Tribune,* December 10, 1999).

• The University of California, San Francisco, and Stanford Medical Center are dissolving their merger after losing $43 million in two years. The system's two CEOs resigned in August 1999, and the board brought in the Hunter Group to manage, and now disentangle, the merger (*Modern Healthcare,* November 1, 1999).

MEDICAID HMOs

• Oregon officials are cutting services and enrollment in order to trim spending from the Oregon Health Plan. Governor John Kitzhaber is backing a plan that calls for state agencies to halt enrollment and in some cases to return grant funds targeted for outreach programs for uninsured children and homeless youths. The plan also calls for eliminating coverage for 10 medical services on the prioritized list (*Portland Oregonian,* November 30, 1999).

• In Tennessee, the sickest patients disproportionately enroll for care at academic medical centers (AMCs) participating in TennCare. Although academic MCOs enrolled only 4.5 percent of the TennCare population in 1995, they cared for 38 percent of the patients with AIDS, 31 percent of those with coagulation defects, 10 percent of those with cystic fibrosis, 14 percent of those who were pregnant, 26 percent of those receiving transplants, 28.4 percent of those with sickle-cell disease, and 27.7 percent of the profoundly mentally retarded. Since the study, one of three AMCs participating in the program has become financially insolvent (*JAMA,* September 15, 1999).

More than half of the pregnant women in TennCare's Medicaid managed care plan failed to receive timely (53.2 percent) or adequate (51.3 percent) prenatal care, according to a study of 506 TennCare enrollees. Women who enroll in TennCare after pregnancy is diagnosed are 2.4 times more likely to begin prenatal care late than previously enrolled women (*Obstetrics and Gynecology,* August 1999; *Reuters Health,* August 8, 1999).

Infants born to women in one TennCare Medicaid HMO were nearly three times more likely to die during their first 60 days of life than infants born to women in the Blue Cross and Blue Shield TennCare plan. In addition to the higher infant mortality (16 of 2,269 infants died before age two months), researchers say the plan—which was not identified—was more likely to deliver extremely low-birthweight babies in hospitals ill-equipped to handle such emergencies. "[F]ailure to provide appropriate facilities for high risk pregnancies could have contributed to poorer outcomes" (*Pediatrics,* September 1999; *Tennessean,* September 8, 1999).

MEDICARE HMOs: THE FINAL FRONTIER

- Medicare HMOs will receive a payment hike of $4.8 billion over the next five years, despite evidence from several studies that Medicare HMOs are already overpaid. A recently released HHS study found that Medicare HMOs will be overpaid $11 billion over the next five years and $34 billion over the next ten years, even without the additional payments (*Arizona Daily Star,* January 14, 1999).
- Older patients with an acute stroke are less likely to receive care by a neurologist if they are in an HMO. After adjusting for patient mix and other characteristics, the odds of receiving neurology care were half as great for patients in HMOs compared with patients not in HMOs. Lower use of neurology care was concentrated in older (over 55) patients in HMOs, while the probability of neurology care for patients not enrolled in HMOs did not change with age. Thirty-day mortality was similar for patients who did and did not receive neurology care, but among 30-day survivors, the 1-year mortality for patients who received neurology care was 29 percent lower than for those who did not receive neurology care. The study of 2,320 patients was done in the Twin Cities, "a mature HMO market" and "often viewed as a testing ground for examining the development and progression of managed care" ("The Minnesota Stroke Survey," Smith et al., *Medical Care,* 37(12): 1186–1198).
- A single question about health status is strongly predictive of future health expenditures in Medicare beneficiaries. Health plans can maximize profits by disproportionately enrolling beneficiaries who answer that their health is good or better, according to a study by researchers with the Agency for Health Care Policy and Research. In this study, 8,775 Medicare beneficiaries were asked, "In general, compared to other people your age, would you say your health is: excellent, very good, good, fair or poor." Eighteen percent rated their health as excellent, 56 percent as good or very good, 17 percent as fair, and 7 percent as poor. Health expenditures in the following year varied five-fold from $8,743 for beneficiaries rating their health as poor to $1,656 for beneficiaries who rated their health as excellent. Hospitalization rates varied dramatically as well, from 675 hospitalizations per 1,000 beneficiaries in poor health to 136 per 1,000 for those rating

their health as excellent (Bierman et al., *Effective Clinical Practice,* March/April 1999).

• Medicare HMOs are raising premiums and reducing coverage for medications. Average premiums will triple in 2000, from $64 to $190 a year, according to the Health Care Financing Administration. However, many seniors will face much larger increases of $500 to $1,000 a year. In Connecticut, Aetna is increasing the yearly premium on its Medicare HMO from $228 to $972, and capping medication coverage at $500 per year. Aetna is not alone; 32 percent of HMOs are limiting drug coverage to $500 a year or less, up from 21 percent in 1999, and over 70 percent of HMOs are raising drug co-pays. Foundation Health's Plan Beach HMO will no longer cover medicines at all. About 6.3 million of the 39 million Medicare beneficiaries are in HMOs; 750,000 seniors were dumped by HMOs in 1998–1999 (*New York Times,* July 2 and September 22, 1999; *Hartford Courant,* September 16, 1999; *Miami Herald,* September 16, 1999).

• A survey of 1,830 Medicare beneficiaries involuntarily disenrolled from Medicare HMOs found that the under-65 disabled, minorities, the poor and near-poor, and those reporting fair or poor health status experienced the greatest problems. Beneficiaries experienced higher premiums for supplemental benefits (39 percent) after being disenrolled, cuts in supplemental benefits, particularly drug coverage (35 percent), and some disruption of their medical care arrangements (22 percent). The proportion reporting monthly premiums of $75 or more increased from 3 percent to 21 percent of those surveyed. Forty-three percent of disenrollees said they were "more worried" about being able to pay their medical bills, and 5 percent (10 percent of those in fair/poor health) reported they couldn't get a prescription filled because they thought it cost too much or they couldn't afford it. The disabled were also more likely to have to change their primary doctors (27 percent) and specialists (31 percent), and to not fill a prescription because of cost (16 percent) ("How Medicare HMO Withdrawals Affect Beneficiary Benefits, Costs, and Continuity of Care," Kaiser Family Foundation, November 1999).

• Medicare home health payments dropped a dramatic 38 percent between 1997 and 1998 due to the cuts of the Balanced Budget Act of 1997. Per-patient utilization declined from $4,705 to $3,412 and from an average of 73 visits to 51 visits (Health Care Financing Administration, December 1999).

MEDICAL AND PUBLIC OPINION

• A survey of Oregon physicians by the Oregon Medical Association asked, "Should the Oregon Medical Association examine the merits of a single payer health plan?" Over two-thirds (70.6 percent, 551/781) of respondents said yes, while 29.4 percent (230/781) said no (*Business Journal of Portland,* October 18, 1999.

• Health care is at the top of the list of issues Americans are concerned about, according to a recent Harris Poll. About 19 percent of respondents rated health care as their top concern, tied with education and followed by crime (15 percent). About 12 percent said Social Security was the top concern, and 11 percent, taxes. Researchers noted that this was the first time since 1995 that health care was Americans' top concern (Harris Poll, November 5, 1999).

• Only 35 percent of Americans in HMOs are "satisfied" with their coverage, compared with 49 percent of enrollees in preferred provider organizations (PPOs) and 64 percent of people with fee-for-service coverage, according to a survey of 1,001 adults by the Employee Benefits Research Institute (*Atlanta Journal Constitution,* October 20, 1999).

• According to a recent Harris Poll, 82 percent of both the public and physicians now support "fundamental change or complete rebuilding of the entire health care system." For the public, that is up slightly from 79 percent in 1994, but for physicians, it is up substantially from 57 percent. Only 1 percent of physicians thought that managed care had been "very successful" at improving the quality of care, while 63 percent said it had been "not at all successful." Physicians who reported being satisfied with their practices fell from 78 percent in 1995 to 62 percent in 1999. There is a "convergence of the public and physicians in their desire to fundamentally change the health care system," said Harris Poll chairman Humphrey Taylor (*Reuters Health,* September 17, 1999).

• A statewide poll of Maryland residents shows broad public dissatisfaction with the current health care system and strong support for major change. The overwhelming majority of Marylanders (87 percent) believe the health system either is in crisis (29 percent) or has major problems (58 percent). The same percentage (87 percent) believe that every working resident should have health insurance coverage, and almost as many (78 percent) believe that every Maryland resident is entitled to health insurance coverage whether working or not. The poll also tested sentiment on a comprehensive government program (single payer) that would cover all Maryland residents. After hearing pros and cons of such a system (including arguments about new taxes, rationing, etc.), three-fourths (74 percent) of Marylanders supported such an approach (*Med Chi Physician,* September 1999).

• Seventy-nine percent of Americans believe that access to health care should be a right, according to a survey of 1,500 adults commissioned by the Kellogg Foundation. A similar percent believe that health care is ailing in this country, including one out of three people who believe that the system is either "critically" or "terminally" ill. Eighty-five percent agree that "much of the expense of health care in this country is created by insurance bureaucracy." Sixty percent say managed care programs have decreased the quality of health care (Kellogg Community Voices Press Release, October 6, 1999).

• A survey of 800 adults found that Americans feel as strongly about using the budget surplus to help the uninsured (55 percent) as they do about preserving

Social Security and Medicare (56 percent). Over two-thirds (69 percent) said they'd be willing to pay $50 more in taxes to help the uninsured. The survey was done by Democratic pollster Celinda Lake and Republican pollster Bill McInturff. A majority (54 percent) of people said they'd be more likely to vote for a presidential candidate who wants to extend health insurance to all (*Congress Daily,* October 12, 1999; *Philadelphia Inquirer,* October 18, 1999).

• Medical interns and residents are employees, not students, and have the right to form unions, according to a 3-2 decision by the National Labor Relations Board in November. The ruling overturns a 1976 decision against housestaff at Cedars-Sinai Medical Center in Los Angeles. This case was brought by the residents' union at Boston Medical Center, an affiliate of the Committee of Interns and Residents (CIR). Over 90,000 housestaff at private hospitals now have the right to form unions (*CIR News,* December 1999).

ARTICLES OF NOTE

• "Distribution of Variable vs. Fixed Costs of Hospital Care," Roberts et al., *JAMA,* February 17, 1999. The article finds that in a large urban teaching hospital, 84 percent of total hospital costs are fixed, and only 16 percent are variable. This suggests that, at least in overbedded hospital markets (which include most of the U.S.), moderate increases in hospital utilization, as might occur under national health insurance, could be accommodated at little additional cost.

• "Resolving the Gatekeeper Conundrum: What Patients Value in Primary Care and Referrals to Specialists," Grumbach et al., *JAMA,* July 21, 1999. A survey of nearly 8,000 patients in managed care in California revealed that "patients value the first-contact and coordinating role of primary care physicians. However, managed care policies that emphasize primary care physicians as gatekeepers impeding access to specialists undermine patients' trust and confidence in their primary care physicians."

Note — This article is modified from a report published by Physicians for a National Health Program, March 2000.

Direct reprint requests to:

Dr. Ida Hellander
Physicians for a National Health Program
332 South Michigan, Suite 500
Chicago, IL 60604