ORIGINAL CONTRIBUTION

Will Universal Health Insurance Assure Universal Access to Ongoing Primary Care for Adults?

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Objective: To assess the impact of current public insurance status (Medicare and Medicaid) and hypothetical payment levels of a new insurance program on physician acceptance of adult primary care patients desiring continuing care.

Method: Survey of 175 primary care physicians in a medium-sized city and six surrounding counties in North Carolina.

Main Outcome Measure: Likelihood of accepting new continuing care patients covered by Medicare, Medicaid, or a hypothetical health insurance system mandated to cover the uninsured.

Results: The response rate was 80%; 86% of the respondents were accepting new patients with private insurance. Of the remaining physicians, 72% were not accepting new continuing care patients covered by Medicaid and 55% were not accepting patients who paid via Medicare assignment alone. Seventy-nine percent of respondents were unlikely to accept new continuing care patients insured by a hypothetical public plan that reimbursed physicians at 60% of reimbursement levels provided by privately insured patients, compared with only 25% who were unlikely to accept patients if the reimbursement was 80% of the private level.

Conclusions: Medicaid and Medicare do not assure access to continuing primary care. Also, physician reimbursement is an important determinant in any new health care system designed to provide universal and consistent access to regular primary care services.

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CONSENSUS NOW exists that health care reform is badly needed within the United States. One of the most salient concerns is that access to ongoing primary care is unavailable especially to patients who are underinsured or uninsured. The US Census Bureau estimates that 35 million Americans were uninsured in 1990 (14.1% of the population); only 7% of this group were unemployed, with the remainder being those who were employed without insurance (40%), children (33%), or those not currently in the labor force, defined as students or homemakers (20%).[1] Given the rising numbers of uninsured patients, it is not surprising that there is public support for devising a plan that would provide insurance for this group.[2,3] Some proposals include expanding the role of public insurance in hopes of also expanding access to care. However, there is evidence that people currently insured by public programs, especially Medicaid, have problems related to access.[4-9]

Barriers to physician acceptance of patients on public insurance plans include level of reimbursement relative to that of privately insured patients,[4-6,8,9] paperwork load and associated staffing requirements,[4-6,8,9] and retroactive payment denials.[6] Other factors cited include physician supply and demand in particular service areas[4-6] and practice overheads.[5]

Presently, it is unclear that providing public insurance to the uninsured will guarantee access to primary continuing care, especially if public reimbursement rates are lower than private rates. No studies have documented the effect of reimbursement levels on access to such primary care. Therefore, this study describes current access to ongoing primary care by private practitioners

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MATERIALS AND METHODS

METHODS

Surveys were mailed in November 1992 to 175 general internists and family practitioners in a southern city of 180 000 inhabitants and six surrounding counties, who spend the majority of their time in private, office-based, primary care practice. A second mailing was done in December for nonresponders. Physicians who were accepting new patients were asked about their policies of acceptance of new continuing care patients covered by Medicaid, Medicare assignment alone, and Medicare supplemented by payments from balance billing. Responses were framed as a choice between unlikely, likely, and very likely acceptance of these patients based on the insurance categories. This approach was believed to have a higher probability of eliciting more forthright answers than a simple yes/no option. Physicians were then asked about accepting new continuing care patients who were insured by either a publicly funded capitation style health maintenance organization or a fee-for-service program with reimbursement rates of 60%, 80%, and 100% of private insurance rates. The same likelihood of acceptance response options were used. Finally, physicians were asked to determine the minimal rate of reimbursement relative to private rates that would guarantee continuing care to their patients insured through this public insurance system.

STATISTICAL ANALYSIS

Although the term *likely* represented weaker patient acceptance than *very likely*, both responses were considered affirmative answers. All statistical comparisons of categorical responses with demographic variables and practice characteristics were made using Pearson's χ^2 test. All *P* values were calculated as two-tailed.

in a medium-sized southern city and its surrounding counties based on patient coverage by Medicaid and Medicare, and assesses access based on variable reimbursement levels of a hypothetical public insurance program in an environment in which multitiered reimbursement still exists.

RESULTS

Of 175 physicians surveyed, 140 (80%) responded; 87 were family practitioners and 53 primary care internists. Fifty-one were considered rural physicians defined as practicing in communities with populations less than 30 000. Forty-two percent of the survey participants were in solo practice, 44% in a single specialty group, and 14% in a multispecialty group. The average length of their experience was 16 years, with a median of 14 years. The majority received their doctor of medicine degrees in the 1970s and 1980s.

Of the 140 responding physicians, 120 were actively accepting new patients. Data on acceptance rates based on Medicaid and Medicare are summarized in **Table 1**. Including those physicians not accepting new continuing care patients at all, 76% of responding physicians were not accepting Medicaid patients for continuing primary care, 61% were not accepting those paying by Medicare assignment alone, and 34% were not accepting even patients with Medicare supplemented by balance billing payments.

Physicians were also asked about the likelihood of accepting new continuing care patients covered under a hypothetical public insurance program for the currently uninsured, paying at variable levels relative to private insurance (**Table 2**). The number of physicians accepting publicly insured patients increased more than threefold (21% to 75%) in a comparison between the 60% and the 80% reimbursement levels; at the 100% payment level, only 7% were unlikely to accept publicly insured patients, which is a lower percentage than those currently not accepting new patients at all (14%). This suggests that if public program reimbursement levels per patient were compared with reimbursement levels of privately insured patients, fewer primary care practices would be closed to new continuing care patients.

When asked to speculate about the proportion of private insurance rates that a new public program would probably pay, the mean (±SE) response rate was 64.3%±1.3% and the median was 63%. When each physician was asked at what private insurance reimbursement level he or she would readily accept a new continuing care patient in a new public insurance program, the mean (±SE) rate of acceptance was 85.1%±1.1% and the median was 85%.

Family practitioners and general internists were equally unlikely to accept new continuing care Medicaid patients. Other significant findings include: (1) rural physicians were four times more likely to accept new Medicaid patients for primary continuing care than were nonrural physicians (53% vs 13%, $P<.0001$); and (2) rural physicians were more likely to accept new continuing care patients covered by a public capitation system than were nonrural physicians (56% vs 32%, $P=.006$).

Two other similar, though statistically insignificant, trends in the data were that (1) 56% of rural physicians were likely to accept continuing care patients who paid by Medicare assignment alone compared with 39% of nonrural physicians ($P=.06$); and (2) rural physicians were only half as unlikely as nonrural physicians to accept new continuing care patients covered by a new public program with reimbursement based on 80% of private rates (30% vs 16%, $P=.07$).

COMMENT

This study shows that patients insured under current public health insurance programs, especially Medicaid, are not guaranteed access to continuing primary care. Other published data do not describe such severe limitations to access. Perloff et al[4] showed that 35% of surveyed pediatricians "limited their

Table 1. Likelihood of Acceptance by Physicians of New Continuing Care Patients Based on Insurance/Reimbursement Categories

Insurance	No. (%) of Physicians		
	Not Likely	Likely	Very Likely
Medicaid	86 (72)	15 (12)	19 (16)
Medicare assignment only	66 (55)	32 (26)	23 (19)
Medicare and balance billing	27 (23)	26 (22)	67 (56)

Table 2. Likelihood of Acceptance of Physicians of New Continuing Care Patients Based on Theoretical Payment Levels of a New Public Program

Reimbursement Level Compared With Private Insurance, %	No. (%) of Physicians		
	Not Likely	Likely	Very Likely
60	110 (79)	25 (18)	5 (3)
80	34 (25)	72 (52)	33 (23)
100	10 (7)	25 (18)	105 (75)
Reimbursement by HMO-style capitation*	81 (60)	41 (30)	14 (10)

**HMO indicates health maintenance organization.*

participation in Medicaid." Mitchell[5] documented that 83.5% of internists "accepted Medicaid." A 1990 report[7] indicates that 79% of physicians who "treat Medicare patients" are accepting all new Medicare patients. The same study concludes that 42% of primary care physicians "fully participate in Medicaid." Several explanations for discrepancies between this and past studies are apparent. First, the entire spectrum of studies show declining participation rates over time as public insurance programs have tightened fee restrictions and increased regulations. Second, Mitchell[5] studied "participation" and not physicians' acceptance of new patients. More important, none of these surveys asked specifically about accepting new continuing care patients. Physician practices might accept patients for acute, isolated problems regardless of insurance status. Such short-term, episodic care does not promote prevention or the timely, reliable health maintenance inherent to ongoing primary care. These high "rates of participation" are therefore meaningless. The data presented herein are a much more accurate and relevant reflection of the attitudes that must be overcome by a new public insurance program.

Based on our data, it is clear that any new public insurance program that would reimburse physicians at less than 80% of current private insurance rates would not open access to continuing care in the majority of primary care practices. Another salient finding is that rural physicians seem to have more liberal patient acceptance policies than nonrural physicians possibly because of the following: more rural patients are poor and uninsured,[10] making any insurance system more attractive to these practices; rural physicians face more social pressure to "take all comers"; there are fewer rural emergency departments to handle primary care overflow; or rural physicians have different training or characteristics that influence them to accept more of these patients.

Our data suggest several possible solutions that would open up access to adult continuing care through universal health insurance. A simple approach would be to raise Medicaid and Medicare reimbursement levels to 80% of the private sector rate and fund any new public insurance program at that level. However, given the stagnation of primary care physician incomes, increasing practice overhead costs, and burgeoning medical student debt, there would still be pressure to select the "100% continuing care patient" over the "80% patient." We believe a more rational approach would be to standardize physician fees for both the private and public insurance systems to remove much of the discrimination engendered in a two-tiered system. This change would also eliminate the practice of cost shifting, making private insurance plans more affordable.

The major limitation of this study is its narrow geographic scope. The medical "market" depicted in this survey is in a medium-sized city in North Carolina. A large preferred provider organization is a factor in the local insurance mix. No closed model health maintenance organizations operate in the study area and physician participation in capitation payment plans is rare. Other cities of similar size in different regions of the country may have greater health maintenance organization and preferred provider organization penetration. Physicians in these markets may accept more publicly insured patients.

If a physician can only work a limited number of hours, has high overhead costs, and personal, practice-, and medical school–related debt, then low reimbursement levels will remain a formidable barrier to access. Health care reform legislation should, in the short term, standardize reimbursement to make access to care more uniform and, in the long term, contain provisions to train and retain enough primary care physicians to ensure that universal health insurance is equivalent to universal access to continuing primary care.

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