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A Policy Analysis of Access to Health Care Inclusive of Cost, Quality, and Scope of Services

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A policy analysis of access to health care was undertaken using a review of current studies and proposals for health care reform in order to uncover the issues of cost, quality, and scope of services that would be required to realize health care coverage for the 38.7 million Americans who remain uncovered. This national issue was explored at the state level, and it was also explored at the individual level by a description of those affected by age, race, ethnicity, health status, and gender. Finally, the author looks at health care reform as one of many other issues affecting the American citizen as choices are made about how to utilize limited resources.

Access to health care through insurance is unrealized for one sixth of the U.S. population (Glied, 2001). This is a complex problem because the 38.7 million Americans without coverage (U.S. Bureau of the Census, 2001) are not a homogeneous group, and policy recommendations to address increasing access to health care offer solutions that are diverse and difficult to implement.

The March 2000 Current Population Survey (Mills, 2000) revealed that there are 10 million uninsured children and that 32.4% of the poor (10.4 million) are uninsured. Hispanics (66.6%) were less likely than White non-Hispanics (89%) to be covered by health insurance. Blacks, Asians, and Pacific Islanders had coverage rates that approximated 79%. Among poor people, just over one half (52.5%) of workers were insured, and 59.2% of nonworkers were insured. Young adults (18-24) were less likely than other groups to have health insurance coverage (71% as compared with 82.9% for those ages 25-64). It is not surprising that the likelihood of having health insurance rises with income. Households with annual incomes under $25,000 had a 75.9% insurance coverage rate. Those households with incomes of $75,000 or more had a 91.7% coverage rate.

Zelenak (2000) proposes a health insurance tax credit for uninsured working adults taking into

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account age, gender, and an index number that reflects the average cost of nongroup health insurance for all adults. This credit would be designed to cover the entire cost of a basic insurance package for those at 200% of the federal poverty level (FPL). This credit is reduced by $150 for every $1,000 by which the person's income exceeds 200% of FPL. At the $30,000 income level for a single person the credit is eliminated. This plan is aimed at working poor adults, because children of low-income working parents would be eligible for the Children's Health Insurance Program (CHIP). The credit would be advanced to the individual with reconciliation of payment (related to increase in salary or excessive advanced payments) at the end of the year.

Glied (2001) identifies the weakness and the strength of Zelenak's (2000) proposal. If credits do not account for health status, those in poor health who are rated by insurers will not be able to meet the costs of insurance. Ratings set by national averages would fall short of premiums in high-cost New England states, which have premiums that are 35% higher than Mountain states. The strength of Zelenak's proposal is the use of the Internal Revenue System, an existing bureaucratic structure, to advance tax credit payments. However, if advanced payments are made to individuals and payments are excessive, then a system of reconciliation would require the person to repay the additional monies. The problem here would be the cost of collecting these payments and that the fear of repayments may very well deter the use of this system. Glied also identifies a potential for fraud if repayment is not completed.

Weil (2000) builds on Zelenak's (2000) idea of tax credits for low-income people. He recognizes that tax credits do not guarantee availability of reasonably priced insurance coverage. Many poor workers do not have a group plan from their employers from which to purchase insurance. Nongroup plans are expensive and less comprehensive. Weil proposes to allow tax credit recipients to buy into the state CHIP (SCHIP) or Medicaid. The children in these families are eligible for CHIP, and making their parents eligible for this coverage simplifies enrollment and care seeking. Furthermore, if Medicaid families go on to employment they will be able to retain their insurance, preserving continuity of care and keeping them in a system they know. Like Zelanak, Weil proposes to use existing bureaucratic structures to administer his plan. He calls on states to design the buy-in program, with eligibility and implementation mechanisms, under the approval of the U.S. Department of Health and Human Services. In Weil's plan, the Treasury Department would administer the tax credit to the states, eliminating a dependence on the individual to deal with repayments at year's end.

Feder, Levitt, O'Brien, & Rowland (2001) agree with Zelenak (2000) and Weil (2000) that the 25 million low-income, uninsured people should be targeted for insurance coverage. These authors are in agreement with Weil that expansion of Medicaid and SCHIP make the most sense. They note that research demonstrates that those with low and modest incomes are unlikely to take advantage of subsidies that fall short of the cost of insurance, and they are unlikely to use care if they face large out-of-pocket costs. They argue for public program expansion to extend protections now available to some low-income persons to all low-income persons. They propose that the full and comprehensive coverage of Medicaid should be made available to all persons with incomes below 150% of poverty. Those between 150% and 200% of the poverty rate should be eligible for SCHIP, which offers somewhat less generous benefits with modest premiums and cost sharing (presently, almost 30% of this income group is without health insurance). Payment for Medicaid is a federal entitlement; everyone who satisfies eligibility is guaranteed coverage, and federal and state funding follows the individual and cannot be capped. SCHIP provides capped federal funds to states and allows states to choose whether to create an individual entitlement. This means that states may cap enrollment in SCHIP.

Although we have looked at some proposals to expand access to health care, it is important to note that disparities in health insurance coverage and access to care vary across U.S. cities. Brown, Wyn, and Teleki (2000) found that there is a strong relationship between a city's rate of employer-sponsored health coverage and its overall rate of health coverage and access to care. Those who live in cities with high uninsured populations have a harder time getting the health care they require as compared to cities with low uninsured rates.

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Cities vary greatly as to employer-based coverage from a high of 84% in Milwaukee, Wisconsin to a low of 49% in El Paso, Texas. The variation in the rate of those who are uninsured ranges from a high of 37% in El Paso, Texas to a low of 7% in Akron, Ohio and Harrisburg, Pennsylvania. And further reinforcing what we know, those with lower incomes were at the highest risk. Of those with incomes less that 250% of the poverty level in Honolulu, 11% were uninsured. In El Paso, 50% of those with incomes less than 250% of the poverty level were uninsured. What has been demonstrated here are the extremes in the spectrum of access to care among U.S. cities.

Cunningham and Kemper (1998) found that 14% of the uninsured reported that they did not get needed medical care in the past 12 months, and 29% postponed seeking medical care. Using data from the 1996-1997 Community Tracking Study Household Survey, they found the rate of access problems for the uninsured is about twice as high as the privately insured and those with Medicaid and about three times as high as the Medicare population.

In a proposal for expanding health care coverage for the uninsured, Kahn and Pollack (2001) evaluated past failures in the area as being the result of one or more large health interests opposing legislation to expand coverage and a willingness to spend both financial and political capital to mobilize the public and Congress to their side. Furthermore, pro-reform groups were unwilling to compromise. Kahn and Pollock suggest that health coverage expansion will require broad-based support that goes beyond ideological interest group and party lines.

Davis, Schoen, and Schoenbaum (2000) note that we will have a federal budget surplus of $4.6 trillion over the next 10 years. They suggest that these resources can be made available to include coverage for the remaining 14% (U.S. Bureau of the Census, 2001) of the U.S. population without health care. They note that 8 million of the 10 million uninsured children are actually eligible for Medicaid or CHIP but parents are unaware of these programs, do not believe they are eligible, or find the enrollment process insurmountable or humiliating. Medicaid and CHIP could be expanded to automatically cover all individuals and families with incomes below 100% of poverty. These authors propose an automatic enrollment system for employer-based health coverage that would also cover part-time, temporary, and new employees as well as allowing former employees and their dependents to be covered for 18 months. All young adults would be covered to age 23 under their parents' policies. These proposals would cover a total of 6,350,000 persons. The 350,000 are young adults still dependent on their parents but presently not covered by the family health insurance policy. Employees in small firms without health coverage would be allowed to participate in the Federal Employees Health Benefits Plan. They propose to extend Medicare by allowing the disabled, those age 55 and over, any dependent of a Medicare beneficiary, anyone denied private health insurance for health reasons, anyone with serious health problems such as cancer or hospitalized for a serious illness, and anyone who had health care expenses over $30,000 in the last 5 years to buy into Medicare early.

All of the proposals that we have looked at have sought to build on and expand systems that are already in place. All of these proposals will be costly. If consensus is to take place for expanding health coverage, public attitudes must be known. The Kaiser Family Foundation/Harvard School of Public Health Post-Election Survey: The Public and the Health Care Agenda for the New Administration and Congress (2001) found that only 21% of voters polled said that one of their top two priorities for using the present budget surpluses is to provide health insurance to people who are currently uninsured. Thirty-three percent of those polled wished to provide prescription coverage for the elderly or make Medicare more financially sound. If the solutions we looked at to improve coverage are complex and fragmented, so are the public's opinions about these issues. In the same survey, although only 21% wish to use the budget surplus to pay for expanding health care coverage to the uninsured, 30% said they would most like to see legislation passed to provide such insurance. Forty-one percent of those voters polled feel the government should make a limited effort to provide health insurance to some of the uninsured, which would use part of the federal budget surplus. Fifty-two percent of the voters polled said that if Congress could not guarantee health

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insurance for everyone, people between the ages of 55 and 64 who have no health insurance but who are ineligible for Medicare should be next to get health insurance coverage. Voters were equally divided between offering the uninsured income tax deductions, tax credits, or other financial assistance to help them purchase private health insurance on their own and expanding state government programs such as Medicaid and CHIP to provide low-income people with health insurance. Fifty percent of these same voters would not be willing to pay more either in higher taxes or higher insurance premiums to help the uninsured, whereas 46% of these voters would be willing.

When given several proposals to improve access to care for the uninsured, only 32% of the voters polled wanted a national health plan financed by taxpayers and covering all Americans. Three quarters or more of these same voters favored increasing government funding to expand community health clinics for the poor, expanding Medicaid and CHIP to provide coverage for low-income people without health insurance, and offering the uninsured American income tax deductions, tax credits, or other financial assistance to help them purchase private insurance on their own.

In a policy perspective, Budetti (1997) argued that managed care would be the venue for numerous proposals designed to address consumer and quality issues. In an attempt to improve access to quality care at reasonable rates with access to primary and preventive services, Medicaid and CHIP patients have been enrolled, like many privately insured patients, in health maintenance organizations (HMOs).

Sparer and Brown (2000) note that commercial health plans such as Oxford and Aetna U.S. Healthcare have left the Medicaid market due to inadequate reimbursement and excessive government regulation. Safety net providers such as public hospitals and community health centers (CHCs) are affiliating in order to create Medicaid-managed care plans. Affiliation is necessary in order to raise capital, increase the pool of enrollees, and benefit from efficiencies related to organizational size. Problems with these Medicaid-managed care organizations threaten their potential success. Board members are affiliated with sponsoring organizations that try to maintain control of the managed care plan. In efforts to protect their own product lines, such as higher payments for care to Medicaid patients in their emergency rooms (ERs), board members do not allow the managed care plan to recruit patients in the ER into the managed care plan. Sponsors of managed care also find themselves competing for plan resources as well as Medicaid patients. Intraorganizational factors such as the experience of Medicaid managed care chief executive officers to mediate conflicts among board members, maintain a good knowledge base about the rules and regulations that govern the state's Medicaid program, and political ability to lobby legislators are advantages that can help Medicaid-managed plans to prosper.

States themselves have much power to set and implement policy designed to effect program eligibility, benefits, and reimbursement policy. Some states like Colorado and Massachusetts are proactive in keeping safety-net plans afloat by giving them assistance with enrollment and marketing. Often this is done to protect Medicaid beneficiaries from the commercial plans, which may end a product line that is not commercially viable (Sparer & Brown, 2000).

Thus far we have looked at several proposals to target the poor, working, uninsured who have incomes up to 200% of the poverty level. Viable solutions seem to be in the direction of expanding existing programs such as Medicaid and SCHIP. Furthermore, these programs are using HMO structures to keep costs down and offer primary and preventive care. We have seen that commercial entities are often not attracted to this market share and that safety-net providers must struggle to put together Medicaid-managed care plans that are fraught with intraorganizational competition, leadership problems, and state Medicaid programs that can be helpful and supportive or not. We have also looked at a survey of voters and found that strong support for covering all of the uninsured in this country is not evident. In this policy climate it becomes important to understand how managed care penetration and the uninsured rate in an area affect access to care for low-income, uninsured persons.

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Cunningham (1999) found that access to care for a low-income, uninsured person is lower in states with high Medicaid managed care penetration as compared to uninsured persons in states with low managed care penetration. Access to care is also lower in areas with high uninsurance rates. Cunningham suggests that lower revenues under Medicaid managed care may limit the ability of safety-net providers to use Medicaid revenues to subsidize care for the uninsured, and that the competition for the Medicaid managed care business draws Medicaid patients away from safety-net providers, resulting in a loss of an important funding stream. This may be a critical finding in policy discussions about how to fund care for the uninsured in a political climate in which voters are unwilling to provide health insurance for all its citizens.

POLICY ANALYSIS: COST OF HEALTH CARE

Policy analysis is a systematic methodology which takes into account the issues pertaining to a problem and the barriers to problem resolution, and then seeks to arrive at viable, implementable solutions, within the complex social fabric of a society, that will be acceptable to its citizens. Thus far this analysis has looked at who is affected by lack of access to health care and some proposed solutions for improving access. We will undertake a look at the issues of quality and cost of health care in order to see how these factors must be accounted for in any proposal of improvement in access to health care in the United States.

According to Ginzberg and Minogiannis (2000), the estimated national health expenditure for 1999 was approximately $1.2 trillion, an increase of about $250 billion in the last 20 years. Health care spending increased by almost 7% to $1.3 trillion in 2000 (Levit, Smith, Cowan, Lazenby, & Martin, 2002). Furthermore, 50% of all health care is state and federally funded, inclusive of more than $100 billion in tax subsidy for group health insurance coverage. Thirty four percent of payments for the U.S. health care sector in 1999 came from employer group health insurance policies. Finally, consumers paid out of pocket for 16% of health care costs. Unaccounted for in the above estimates are 1% to 2% in annual charity donations and cost shifting in hospitals that are meant to subsidize care of the poor and near poor. Federal actuaries estimate that by 2008 the national health expenditure will be over $2 trillion annually.

Hogan, Ginsburg, and Gabel (2000) project a continued rise in spending for covered medical services related to a managed care backlash in which consumers are choosing preferred provider organizations because they are less restrictive, expensive pharmaceuticals, and continued provider consolidation. They project that substantial premium increases would mean a decrease in consumer spending on other goods and services, lower wage increases, and lower profits. Additionally, increased outlays for Medicare and Medicaid would be necessary. Increases in insurance premiums could lead to an increase in the number of uninsured persons related to an inability of the working poor to pay for their portion of employer-sponsored health coverage.

Underinsurance, a problem often lost in the dialogue about the uninsured, accounts for access problems for the lowest income quartile studied by Donelan, DesRoches, and Schoen (2000). These insured adults reported that they did not have enough money to pay for medical bills, prescription drugs, or other health care costs. Adults with annual incomes below $20,000 were more likely to have these problems. These findings indicate that those with annual incomes below the national average, as well as the uninsured poor, need comprehensive coverage.

Wielawski (2000), a health journalist, notes that the comprehensively insured are not only financially protected; the insurance companies have negotiated deeply discounted fees from hospitals and providers for the care of their clients. Not only are the uninsured without financial protection from health insurance, they have no one with whom to negotiate discounted fees. If, say, a hernia repair were required, they would pay full costs. Furthermore, a substantial part of that payment would be required in advance. It is important to note that one in six Americans are without health insurance, and this dual pricing system adds great inequity to the health care system.

In 1990 the most common health insurance coverage was an indemnity plan with a $250

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deductible and 20% coinsurance after the patient exceeded the deductible. By 1997 the most common health plan was an HMO or point-of-service plan with no deductible and a $10 copayment when using in-network providers. In a study of trends in out-of-pocket spending by insured American workers, high-income households saw the greatest reduction in their out-of-pocket spending for medical care (Gabel, Ginsburg, Pickreign, & Reschovsky, 2001). However, it is this same group that is subjected to the cost management techniques of network providers, primary care, gatekeepers, and drug formularies. A backlash against these cost-limiting designs has caused managed care plans to reduce these techniques while increasing the size of their provider network. Ironically, HMO premiums rose 8.3% from spring 1999 to spring 2000, the highest increase in 7 years. Workers are not being asked to cost-share widely to absorb this new increase because the general economy is fairing well. The health policy concern here will be how to control costs as premiums are rising and employees are facing few out-of-pocket expenses when using services.

In summary, funding for the health care of the uninsured suffers in states with high Medicaid managed care penetration and high uninsurance rates. Cost shifting and charity donations no longer are substantial funding streams for care for the uninsured. In this strong economic period the uninsured number 38.7 million; if there is an economic downturn it is not unreasonable to project that this number will rise. A consumer backlash against restrictive managed care designs, increasingly costly drug prices, and provider consolidation may have set the stage for the recent rise in HMO premiums. Rising premiums hurt the lowest income quartile the most. Some of these workers will no longer be able to afford coverage; others will go without care. Workers who can no longer afford coverage are more vulnerable to a system that will charge them undiscounted costs for care if they are unfortunate enough to need care. The safety net is strained. The Balanced Budget Act of 1997 reduced the federal monies allocated to the hospitals that cared for the uninsured and began phasing out requirements that CHCs get cost-based reimbursement. Congress also repealed the Boren Amendment, which allowed hospitals to sue challenging the adequacy of Medicaid reimbursement (Sparer & Brown, 2000). One public policy advocated in a report by the University of California, Los Angeles Center for Health Policy Research (Rice, Pourat, Levan, Silbert, & Richard, 1998) was direct subsidies to help low-income workers to purchase health insurance.

POLICY ANALYSIS: QUALITY OF HEALTH CARE

The three broad approaches to quality in health care are professional accountability, which relies on self-regulation based on ethical and professional norms; market accountability, which depends on informed choices by employers and consumers; and regulatory accountability, which rests on government action to correct professional and market inability or unwillingness to ensure quality (Fraser, McNamara, Lehman, Isaacson, and Moler, 1999).

Few would argue that at this time we are using the market accountability model. Most of the U.S. workforce is not offered a choice of health plans and so, by default, employers and business coalitions who make these purchasing choices will need to use their economic power to ensure quality care (Fraser et al., 1999).

Using the 1998 National Business Coalition on Health Survey and a separate telephone interview of 9 of the 75 coalition members who participated in the survey, quality initiatives were identified by the researchers (Fraser, McNamara, Lehman, Issacson, & Moler, 1999). Half of the coalition respondents used the Health Plan Employer Data and Information Set (HEDIS). HEDIS provides health-plan-level data. The other half of the respondents used consumer satisfaction surveys in an effort to find out about quality of care at the provider level. Furthermore, the report indicated that hospital discharge data, Health Care Financing Administration (HCFA) 1,500 physician data, and medical chart data were used to identify quality of care. Some coalition leaders also collect qualitative data on the quality management systems in place at various plans, information on the patient appeals systems, and copies of patient complaints filed with state insurance departments. Furthermore, they request information

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on National Committee for Quality Assurance (NCQA) accreditation status and litigation history.

The NCQA is an independent, nonprofit organization whose mission it is to evaluate and report on the quality of the nation's managed care organizations. Its goal is to make standardized plan-specific performance information available to groups and individuals in the health care marketplace. This plan-specific comparative data allow public and private purchasers to compare data across plans and also across regions for measures related to clinical performance, procedure utilization, and patient's satisfaction with care. Quality Compass, NCQA's database of managed health care information, uses standardized, independently audited information from NCQA's HEDIS. This database allows NCQA to produce national, regional, and state averages as well as benchmarks on specific clinical indicators and service. NCQA also has an accreditation process, and health care plans that desire this accreditation must report their results on a subset of clinical HEDIS measures and on an Agency for Healthcare Research and Quality Consumer Assessment of Health Plans survey (NCQA, 2000; Thompson, Bost, Ahmed, Ingalls, & Sennett, 1998).

Evaluation of quality of care implicitly assumes access to care. However, a discussion of quality belongs in this article because as we seek to find cost-effective ways to give more people health care, we will also want to get an adequate return for these outlays. If health care policy takes place in political arenas, decisions should be based on credible, objective data. An example of how NCQA data may be used by private insurers and public insurers follows. According to NCQA (2000), the Center for Disease Control (CDC) reported that almost 1 in 15 Americans suffer with diabetes, with a treatment cost of $98 billion annually. Diabetics in accredited plans have a greater likelihood of receiving retinal exams (49.4% vs. 39.92%) and of having their lipid levels checked (71.4% vs. 66.1%) and controlled (39.1% vs. 33.4%) than in nonaccredited plans (NCQA, 2000).

The government pays for 50% of all health care through state and federal coffers (Ginzberg & Minogiannis, 2000). In an effort to assure quality care for those citizens that the HCFA provides coverage for, they are requiring that managed care organizations that contract with them to provide primary care for Medicare beneficiaries must provide information on patients' functional status so these patients may be compared with those patients whose care is fee for service. This will be accomplished with the Short Form 36 and other questions. Secondly, patient satisfaction will be measured for comparison among plans. Lastly, the participating managed care organizations will be measured by HEDIS benchmarks (Buppert, 2001).

HCFA makes summary plan-level performance measures available to the public through its beneficiary-oriented handbook and the Medicare Health Plan Compare Web site (www.medicare.gov/mphCompare/home.asp). Furthermore, disenrollment rates are available from a toll-free line (Operational Policy Letter #131, 2001). The government is empowering citizens to "vote with their feet" by provision of information on health plans in the managed care sector, thereby ensuring a climate of competition in which quality is recognized as a fiscal asset.

POLICY ANALYSIS: THE SCOPE OF HEALTH CARE SERVICES

Using data from the Behavioral Risk Factor Surveillance System from 1997 and 1998 to assess the unmet health needs of 33 million U.S. adults aged 18 to 64, there are some marked differences between uninsured and insured adults (Ayanian, Weissman, Schneider, Ginsburg, & Zaslavsky, 2000). Almost two fifths of the long-term uninsured, those uninsured for equal to or more than 1 year, and one third of the short-term uninsured, those uninsured for less than 1 year, reported that they could not see a physician when needed in the past year due to cost as compared to 1 in 14 insured adults. Cost barriers to physician care were worst for women, Blacks, unemployed, and those with low incomes.

Who are the uninsured? The proportions of uninsured individuals were higher among young adults, men, Blacks, Hispanics, residents of the South and West, those less educated and with lower incomes, the self-employed, unemployed, and those not in the labor force. This group

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contained more smokers, obese persons, and binge drinkers than the insured group. Persons who identified themselves as hypertensive, diabetic, and hypercholesterolemic were less likely to be uninsured than adults without these health problems. However, uninsured individuals who had these conditions were much less likely than their insured counterparts to have received routine checkups to monitor these conditions. Furthermore, the uninsured group was less likely to report that they received preventive screening for cancer or cardiovascular disease. The long-term uninsured had fewer mammograms and less cholesterol screening than the uninsured. Long-term uninsured adults with diabetes were less likely than insured diabetics to have eye and foot exams, cholesterol screening, and influenza vaccinations. Lower rates of cancer screening among uninsured adults may be the reason why they are diagnosed at later and less curable stages of breast and colorectal cancer (Ayanian et al, 2000).

It is important to note that states vary widely by the number of their citizens who have adequate health coverage, with Hawaii leading the list with 87.9% of its population having adequate health coverage. Adequate health insurance was lower in southern, southwestern, and western states. Among those who were employed, estimates of either underinsurance or being uninsured range from 7.9% in Hawaii to 28% in Louisiana (*Morbidity and Mortality Weekly Report*, 1998). Currently one in five women is uninsured, and those who are young, low income, Latina, or African American are at higher risk (Salganicoff & Beckerman, 2000). The Commonwealth Fund 1998 Survey of Women's Health (Collins et al., 1999) found that lower income and less educated women are less likely to receive regular preventive services and counseling choices of hormone replacement therapy. Poor women also had higher smoking rates. Across all socioeconomic strata two in five women reported violence or abuse in their lifetime, resulting in worse physical and mental health. Although mammography rates for women age 50 and older increased from 55% to 61%, there was no improvement for breast and cervical cancer clinical preventive services between 1993 and 1998. In 1998 rates for clinical breast exams (66%), Pap tests (64%), blood cholesterol tests (55%), and physical exams (61%) remained unchanged since 1993. Those women who fared worst were Asian Americans. Hispanic women fared worse than White and African American women. Only 25% of women over 50 had been screened for colon cancer in the past year, and of that group 53% had not been screened in the past 5 years. Thirty percent of uninsured women did not receive preventive health care in the past year as compared to one in seven insured women. Overall, from a sociodemographic and health perspective, poor women have worse health status and fewer opportunities for job-based coverage related to these women's lower employment rates, lower educational attainment, and lower marriage rates (Wyn, Solls, Ojeda, & Pourat, 2001).

In a study looking at access to care for symptomatic conditions, Baker, Shapiro, and Schur (2000) found that uninsured adults are far less likely to receive medical care when they develop new symptoms that could represent serious medical conditions or have major adverse affects on quality of life. In this study the most common reason cited by the underinsured for not receiving necessary care was the inability to pay. In summary, the quality of health care rests on employers, business coalitions, consumers, and government (Fraser et al., 1999). Using an evaluation process is critical for the assurance of health care that is comprehensive and has targeted endpoints that are measurable and reflect the minimization of disease risk factors (NCQA, 2000; Thompson et al., 1998). We have also seen that particular state citizenship, female gender, poverty, low educational attainment, minority status, joblessness, and low marriage rates are determinants of lack of access to health care (Ayanian et al., 2000).

Policy initiatives to cover the uninsured are piecemeal at best. Perhaps a better understanding of how present health care expenditures are allocated might help policy makers to make wise choices. In Berk and Monheit's (2001) study, they noted that the top 1% of the population accounts for 27% of total health care expenditures, according to 1996 Medical Expenditure Panel Survey (MEPS) data, and the top 10% of spenders accounts for more than 66% of health spending. Inpatient hospital services account for a large portion of care provided to the top spenders, even at the discounted rates that were negotiated by health plans in recent years. However, there was

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extreme stability over time in the amount of resources used by the bottom 50% of the population, which used about 3% of the total health care resources. Although the recent growth of managed care may account for increases in preventive services, the 1996 MEPS data show that the bottom 50% had average annual expenditures of $122 in medical costs, whereas the top 1% spent $56,459 per person annually. In an analysis of this top 1% of the spenders, 46.3% were elderly, and those in fair or poor health made up 48.6% of these high users. The exact health care needs and prognosis of this group were not identified in this study. Cost containment and equitable distribution of health care services may require health policy decisions about the level of care provided to those with the greatest need. In Lamm's (2000) discussion of Oregon's decision to add 100,000 people to Medicaid, prioritization of health care led policy makers to decide not to cover organ transplants under Medicaid. Lamm argues that "the American public has come to feel entitled to what no nation can financially deliver—all the health care that is or may be beneficial to its health."

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