injury that was deeper. In the children with strictures who were treated with steroids, there was a trend toward less frequent need for esophageal replacement (4 of 10 in the steroid group vs. 7 of 11 in the control group). The number of patients was too small, however, for the difference to be statistically significant. Thus, the value of steroids in the treatment of esophageal injury is unproved.

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SPECIAL ARTICLE

UNIVERSAL NEW YORK HEALTH CARE

A Single-Payer Strategy Linking Cost Control and Universal Access

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Abstract Now that universal access to health care is back on the governmental agenda, elected officials are faced with the dilemma of expanding our present pluralistic system of numerous private and public payers, with its built-in administrative inefficiencies and inflationary pressures, or scrapping the present system of financing and moving to a tax-based scheme like the Canadian Medicare program, an option fraught with political difficulties.

There is, however, a third option. The New York State Department of Health has developed a proposal for universal access — Universal New York Health Care, or UNY-Care — that would retain the existing payers, including employer-based insurance coverage, but combine them in a one-payer framework. Providers would no longer have to interact with the many public and private payers, each with its own rules, criteria, and levels of payment. The single payer would serve as the only payer for most health care services and would also negotiate reimbursement rates.

The single-payer framework should bring savings in administrative and billing costs and should move government closer to the goal of buying health care services — getting good value for payment rendered — rather than simply paying bills as they are submitted. Although the single-payer strategy could be implemented at either the state or the federal level, it seems ideal as the principal responsibility of the states in a national plan for universal coverage. (N Engl J Med 1990; 323:640-4.)

AFTER disappearing for a decade, universal health insurance has returned to state and federal agendas. Massachusetts, despite budgetary and political obstacles, struggles on in its attempt to implement the first state universal-coverage plan.[1] Hawaii recently enacted a health insurance program for those who are not working, to complement its existing legislation on mandated employer-based health insurance.[2] Many other states are developing proposals. At the federal level, Senator Edward Kennedy (D-Mass.) and Representative Henry Waxman (D-Calif.) have introduced a plan for expanding employer-based insurance and Medicaid coverage.[3] The proposal of the Pepper Commission would require that all employers with

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100 employees or more provide health insurance, would make important changes to private insurance, and would convert Medicaid into a new public insurance program conforming to the Medicare reimbursement schedule.[4]

Most recent proposals and legislation continue to ignore cost control, despite the fact that the problems of medical inflation and lack of insurance are closely linked. Two major proposals that consider both universal coverage and cost constraint have been offered: Enthoven and Kronick's sponsor-based competitive model,[5] and the proposal of the Physicians for a National Health Program recommending a variation on the Canadian plan.[6] Enthoven and Kronick's proposal would expand employment-based insurance and provide subsidized insurance for those not in the labor force. Managed competition is its central cost-control strategy, which relies on the creation of public and private sponsors to subsidize health care for people with low incomes and to work for the efficient provision of health care.[5,7] The proposal of the Physicians for a National Health Program recommends eliminating private insurance in health care and shifting to a tax-based system led by the federal government.[6] Since the government would negotiate directly with the representatives of health care providers, a "bilateral monopoly"[8] between government and providers is the proposal's central cost-control strategy.

Joining Universal Coverage and Cost Control

The New York State Department of Health, under the leadership of Dr. David Axelrod, has developed a proposal for universal health insurance — Universal New York Health Care or UNY-Care[9] — that would retain our system of private and public insurance, like most recent proposals. But like the Canadian system, UNY-Care would interpose a one-payer structure and one-card system of membership between providers and payers, making the government the sole buyer of health care. Private insurance would be restructured to aid in the fight against medical inflation, to reduce paperwork costs, and to make the health care benefits that all New Yorkers would receive more uniform.

By expanding and standardizing insurance, issuing all New Yorkers a single card, and creating a single system with a public authority deputized to control costs, UNY-Care would strive to transform our pluralistic system into a universal one. UNY-Care has three goals, all essential to linking cost control and expanded access. The first is to reform fundamentally the current system of private insurance and expand it to cover those who are not now insured. The second is to reform the system of billing and payment, creating a single statewide electronic system for all payers. The third is to have the single-payer system create a single system to reimburse for health care, to control the flow of revenue better.

All residents would be issued a UNY-Care card, which would give them access to services and activate the new billing and payment system. Patients would no longer file claims. Providers would bill — and be paid by — a single payer.

The central new idea behind UNY-Care involves overcoming the biggest source of red tape and waste in our health care system — the paperwork and delays associated with the myriad public and private payers — while at the same time controlling and speeding up the flow of revenue to hospitals, nursing homes, and physicians.

Reforming and Expanding Private Insurance

There are roughly 1.9 million New York residents who have no health insurance — 11 percent of the state's residents, evenly distributed between New York City and the rest of the state. The number of uninsured people in New York is slightly lower than the national average of 13 percent, primarily because of New York's relatively more comprehensive Medicaid program and broader base of private insurance.

To close the recurring gaps in coverage permanently, UNY-Care would make job-based insurance more uniform and simpler, and would expand it to cover the two thirds of the uninsured (about 1.2 million people) who are employed persons or their dependents. UNY-Care would also arrange for the purchase of publicly subsidized private insurance for unemployed people and those not in the labor force. (Although it is conceivable that the state itself could insure this group, it is far more likely that the state would merely make certain that private insurance was available.) Finally, roughly 1.2 million people who are currently employed and insured but whose income falls below 200 percent of the federal poverty level would have their current out-of-pocket expenses subsidized according to a sliding scale. All told, 3.1 million people would receive insurance or subsidies for insurance under UNY-Care. Millions more would receive stronger catastrophic coverage.

To ensure job-based coverage, all employers would either pay a payroll tax equivalent to about 13 percent of the first $14,000 of wages per employee, or offer insurance that met UNY-Care's standards. Employers providing roughly $25,000 of inpatient hospital coverage and $25,000 of out-of-hospital coverage each year would avoid the tax. Moderate deductibles and copayments would be permitted. Most employers offering coverage for the first time would be eligible for substantial subsidies to help them meet premium costs for the first four years. Employers could avoid providing coverage for part-time employees by paying the payroll tax.

Insurance reform is at the heart of UNY-Care. Medical underwriting and preexisting-conditions clauses would be eliminated. More uniformity in controls on use would be sought. Although we have deliberately avoided making specific the final details of the standard package of benefits, our intention is to set a standard of generous coverage. Routine visits to a physician, physical and occupational therapy, labora-

tory and diagnostic services, and inpatient care would be included. In estimating costs, we assumed premiums of $1,400 per year for individual coverage and $3,200 for family coverage. (Catastrophic coverage and its costs are addressed in a separate program.) These premiums would provide coverage comparable to that of a good Blue Cross or health maintenance organization plan offered by a major employer, such as the state government, in 1990. We believe these amounts would cover most services that Americans and their health professionals define as covered health care.

In addition, unemployed residents not covered under Medicaid and those whose incomes are under 200 percent of the poverty level would receive subsidized, publicly sponsored private insurance. Also, people with low incomes, whether employed or unemployed, would receive subsidies for additional medical expenses, including copayments, deductibles, and nonreimbursable medical expenses. These subsidies would ensure that a low-income person's out-of-pocket liability, including insurance costs, would be zero at 100 percent of the federal poverty level and $1,000 at 200 percent of the poverty level.

Health coverage would be changed in other ways. The UNY-Care proposal recommends that all insurers be granted a stop-loss limit of roughly $25,000 per patient per year for inpatient hospital services, and $25,000 per patient per year for out-of-hospital services. UNY-Care would cover the cost of catastrophic care, to be financed primarily through a surcharge on the premiums of health insurance plans. Such an approach should offer genuine catastrophic coverage to all residents, while at the same time further standardizing insurance coverage.

People will be permitted to carry insurance for coverage beyond the standard UNY-Care package of benefits, although covered services under UNY-Care should be ample enough to limit the extent of this extra coverage.

Reforming the Billing and Payment System

The second goal of UNY-Care is to reform the billing and payment system, creating a single, statewide electronic system to process claims rapidly and ensure timely payment to providers. Achieving this goal will not only avoid administrative waste, but also counter the tendency for payment to slow down in the face of the cost-control strategies discussed below.

Many agents currently pay for medical care in the United States, which, as numerous authors[8,10-12] have argued, adds delay, costs (estimates range from 6 to 20 percent[8,12]), and confusion for doctors, hospitals, institutions for long-term care, and patients. Creating a public authority to serve as the health care system's single payer is a way to reduce these problems for providers, patients, and insurers. The authority would probably be an independent public-benefit corporation with a board of governors appointed jointly by the governor of New York and the legislature.

Himmelstein and Woolhandler[11] have identified three principal sources of administrative inefficiency in our present system: the need for hospitals to attribute costs to individual patients; the need to maintain expensive and duplicative billing operations to serve myriad payers; and the administrative costs, including marketing, associated with private insurance. Initially, at least, UNY-Care would improve efficiency in two of these areas. Shifting to a single payer would produce the greatest savings, allowing hospitals and doctors to simplify and standardize their accounts-receivable operations. Insurance companies, because their policies would be made uniform and their claims processing simplified, should be able to cut their administrative and marketing costs sharply.

Hospitals and doctors would still bill insurers directly for services not covered under UNY-Care; this would create another incentive to keep the level of services covered under the program high. The electronic system of claims processing that would constitute the heart of the UNY-Care single-payer system should permit rapid answers to queries from providers to third-party payers about the extent of this extra coverage.

UNY-Care would greatly simplify billing operations for hospitals and physicians. The current billing system is complex and costly. Because of its many payers with many rules, our present system breeds billing errors, requires a separate subsystem to correct those errors, and involves duplicate systems by which the provider and payer record essentially the same information. Communicating information about control of use and coordination of benefits is also extremely inefficient. The current system encourages payers to withhold payment until they are absolutely satisfied that claims are correct. Our ultimate goal is to arrange rapid advance payment to all providers by separating the flow of money from the adjudication of individual claims.

We believe that something like a single-payer system is in the cards for U.S. health care. If the future lies in regulating the levels of reimbursement for hospitals and outpatient and long-term care services, as well as services by physicians — and the history of Medicare suggests that this is the case — then the states and the federal government will not only be responsible for limiting the aggregate payments to all these providers, but will also be forced to ensure that those payments are adequate and timely.

A System of Cost Control

Bringing the rate of medical inflation to an acceptable level is a central task of UNY-Care, which will be not only the single payer, but also the single buyer of health care, using its purchasing power to stem rising costs.

In UNY-Care's early years, the current system of case payment would probably be retained for hospitals, with negotiated rates eventually replacing rates based on formulas. The transition to buying health care will mean more than controlling hospital costs; it

will mean expanding limits on reimbursement to all providers, including physicians.

Under UNY-Care, physicians would be required to accept fee limits and assignment. In view of Medicare's new approaches to physician reimbursement, changes are likely to occur whether universal coverage is enacted or not. The new schedules should increase the income of the state's 14,000 practicing primary care physicians, who make up about 40 percent of the total.

Controlling costs means more than setting rates for all providers; it also means budgeting health care. UNY-Care would be a powerful tool for building a statewide health budget that identified priorities and the revenues required, and permitted the allocation of resources within the system to encourage efficiency and address areas of greatest need. The mechanism for unified buying of health care would allow the state to project annual cost increases and expected revenues from all sources — including Medicare, Medicaid, other federal sources, insurance premiums, and state taxes — accurately. Such projections would also allow UNY-Care administrators and elected officials to plan for growth for all providers, making recommendations for the necessary adjustments in taxes, premiums, and levels of reimbursement.

The current system of making public policy is badly disjointed, because each payer has its own priorities and ways to achieve them, thereby furthering the "paradox of excess and deprivation" to which Enthoven and Kronick referred.[5] The procedure for setting hospital rates differs sharply from that by which the level of Medicaid and other state spending for primary care is now set. The system of hospital reimbursement includes an annual trend factor based on the analysis of a panel of economists, whereas Medicaid expenditures outside hospitals — specifically, expenditures for primary care services — are more sensitive to the state's political and fiscal situation.

In New York City, for example, there is much evidence of a rise in "social morbidity"[13] that has rendered primary care and drug-treatment facilities, the number of psychiatric beds, and housing inadequate; hospitals (especially emergency rooms) are therefore chronically overcrowded. The solution is not simply more money for hospitals. The solution lies in shifting resources toward primary care in locations of greatest need. As a hypothetical example, increases in the rates of hospital reimbursement could include "withholds" earmarked for primary care services, or to create new ambulatory care centers in underserved areas.

Although not explicitly addressed in the UNY-Care proposal, the public budgeting process would of necessity treat operating and capital expenditures separately. As Canada has discovered, keeping these streams of revenue separate is critical to any strategy for cost control and balanced growth.

Feasibility and Other Questions

At the heart of the question of feasibility is whether any level of government can say no to excessive and unaffordable medical inflation and yes to adequate sources of revenue in the form of increased taxes and premiums.

Granting the state the power to regulate reimbursement for all providers, including doctors, is not an enormous step in New York, given the scope of the regulations now in force. New York already sets rates for hospitals, nursing homes, and Medicaid in settings of outpatient care. Outside Medicaid, physicians' fees remain uncontrolled. The more difficult issue is whether the state can keep the system adequately funded when increased taxes or premiums are needed.

Coupling strong cost-control measures with mandated participation by employers should appeal to most large businesses. Increasingly, they are voicing their frustration with current failures in cost control and the inequity of supporting the minority of employers who provide no coverage.

Small businesses would probably be the chief source of political opposition to the UNY-Care plan. It should be pointed out, however, that the majority of small businesses provide health insurance for their employees. The number of employees of small firms who would be affected by the UNY-Care proposal is small. Nationally, only 16 percent of all workers in businesses with 100 or fewer employees are uninsured.[14] In New York State this translates to just 8 percent of all employees (excluding government employees and those who are self-insured). Furthermore, UNY-Care would provide assistance for four years to businesses not currently providing coverage and for which the new requirement would constitute a substantial burden. Given the labor shortages predicted for the 1990s, employers who offer work without reasonable benefits will probably have difficulty in attracting qualified employees.

Insurance companies oppose many aspects of a single-payer strategy. Insurers fear that their activities of paying bills and processing claims will be made obsolete by UNY-Care. They also fear that standardizing insurance with a uniform benefits package, stop-loss provisions, and a policy of annual open enrollment would eliminate competition. Under UNY-Care, health insurers would compete on the basis of price and service, not product differentiation. Thus, UNY-Care would move health insurance closer to other industries that sell a standard product, such as retail gasoline. The industry's opposition should not obscure the real gains for insurers under UNY-Care, whose provisions call for writing new policies for as many as 1.9 million people.

UNY-Care would seek to integrate Medicare with the UNY-Care system. A federal waiver would be sought, permitting providers to bill the single payer for Medicare cardholders; indeed, Medicare cardholders could be issued UNY-Care cards. The state would seek permission to set rates for Medicare, as was granted in the mid-1980s. Finally, because extra billing would not be permitted for services covered under UNY-Care, it would not be permitted for Medicare patients. This proviso would markedly ease the bur-

den of paperwork for Medicare patients, many of whom must now pay the doctor upfront and then file all relevant paperwork with the Medicare intermediary. Also, low-income Medicare recipients would receive subsidies for Medicare's deductibles and copayments and for important services not offered by Medicare.

It is estimated that UNY-Care would cost between $1.2 billion and $1.9 billion in new state funds to finance the state's portion of expanded coverage.[9] The existing pool of municipal and state tax support for the bad-debt coverage and charity care provided by hospitals — $1.2 billion — could be reallocated entirely to UNY-Care. Also, if $500 million, or 10 percent of the annual inflationary increase of about $5 billion in health care costs were diverted to funding expanded coverage, UNY-Care could be financed without new tax revenues. Maintaining local tax support would require the agreement of New York City, because half the dollars used to cover bad debts and charity care come from municipal taxes. (Also, UNY-Care would not eliminate the need for some bad-debt and charity-care funds to cover the health care needs of indigent aliens and other nonresidents.) Nevertheless, the point stands: New York State, with a health care system costing roughly $45 billion to $50 billion annually, has enough resources in that system to finance universal health care without major new taxes.

Conclusion

We believe that in New York the issue of universal health care is here to stay. Governor Mario Cuomo recently signed legislation ensuring primary care coverage for all children under the age of 13. The Hospital Association of New York has responded to UNY-Care with a proposal for mandated health insurance and a private commission to set hospital rates. A key legislative committee is also likely to propose mandating employer-based insurance.

The big issue is whether the state should consider the organizationally more ambitious tasks associated with UNY-Care. We believe that a stable, effective universal health care system cannot be provided without creating a new organization to achieve it. The size of the single-payer authority would probably be relatively small, with fewer than 1000 employees. Many of these employees would come from existing state programs and agencies. In addition to receiving funds and setting insurance standards, the new agency would be charged with planning, developing information systems, conducting research, and reimbursing providers — tasks that would be key to overhauling our present fragmented, inflation-prone system.

The New York State Department of Health, perhaps in conjunction with a major foundation, is planning a regional demonstration of the feasibility of using this new organizational form to accelerate the pace of change in the current billing and payment system. Although the department is to sponsor this regional demonstration, it bears repeating that in the context of the statewide UNY-Care system, the single-payer organization would probably be a new agency, outside the Department of Health, with a separate system of governance.

To secure universal health care without abolishing private health insurance, we must create an organization capable of overcoming the many liabilities imposed by the existence of a number of payers. To secure universal entitlement without discrimination, we must organize a one-card system with a universal enrollment file that maintains up-to-date information on the insured status of all residents. To combat medical inflation, we must reorganize our current system of payment. If we want providers to accept more stringent controls over the expansion of health care services, we must offer them the offsetting advantages of a single organization to pay their bills, making that organization responsible for rapid payment. We must also redress the inequities inherent in our existing rates for primary care services. To build more public support for reasonable measures to stem medical inflation, we must ensure that all are covered, so that the burdens of saying no are fairly distributed; and we must also build a new institution around a one-card system, which has been the foundation of successful cost control and universal entitlement everywhere else in the developed world.

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