

MARKET WATCH

Care For The Uninsured In General Internists' Private Offices

Internists are a crucial source of care for uninsured patients—many of whom were their patients before they lost coverage.

by Gerry Fairbrother, Michael K. Gusmano, Heidi L. Park, and Roberta Scheinmann

ABSTRACT: This paper examines the care of uninsured patients in general internists' private practices. More than two-thirds of internists provide at least some charity care, usually to their existing patients who have become uninsured. They appear to be filling a need for people who are moving between coverage, by helping bridge coverage intervals. Approximately two-thirds of all internists accommodate uninsured patients by reducing the charge or creating a payment plan, with internists who are practice owners much more likely to do so. This care to the uninsured is important, especially with growing unemployment rates, because the safety net would not be able to absorb these patients.

THE PRIVATE SECTOR accounts for the vast majority of ambulatory care for uninsured Americans. In 1994 more than twenty-seven million of the uninsured's thirty-three million primary care visits occurred in physicians' offices (82 percent), in contrast to 3.3 million (10 percent) in community health centers (CHCs) and 2.6 million (8 percent) in hospital outpatient departments.¹ CHCs and hospital outpatient departments serve a higher proportion of uninsured patients, but because the number of these institutions is small relative to private practitioners, their overall share of uninsured patients is lower. In contrast, uninsured patients represent on average only 9 percent of private office-based providers' visit load, but because there are many private practitioners,

the aggregate number of visits for uninsured patients is commensurately large. Thus, private practitioners are a large and vital component of the safety net.

Despite this fact, most studies of the uninsured have focused on care in safety-net facilities, including our own work exploring the limits of care for the uninsured in CHCs.² However, because private practitioners are responsible for such a large share of the care to uninsured patients, understanding the nature of their care is important. In this paper we extend our earlier work by examining the level of care given to uninsured patients by one important group of private primary care physicians: internists.

Together with office-based family practitioners, internists account for approximately 83

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percent of all primary care visits to office-based practices, with internists responsible for almost 40 percent of this.³ Despite their important role in the system, there have been few studies of internists' practices with respect to the uninsured. One of the few studies found that almost all internists would see uninsured patients, although fewer reduced charges or otherwise adjusted policies to make the visit affordable.⁴ The study raised troubling issues, but it was limited because it surveyed internists in one location only and did not provide details about the level of care or the characteristics of the uninsured patients they treat. In this study we surveyed internists nationwide to determine the level of charity care they provide, the office policies they adopt to accommodate their uninsured patients, the characteristics of those patients, and their views on their ability to provide adequate care to their uninsured patients.

Data And Methods

We conducted a mail survey (with four follow-up contacts) of primary care internists in private practice between July and October 2002.⁵ Internists in our sample were drawn randomly proportionate to four regions from a universe of 29,413 internists included in the master list of members maintained by the American College of Physicians/American Society of Internal Medicine (ACP-ASIM) that excluded internists who are hospital-based, at medical schools, at government-owned facilities, or in non-patient care settings or who indicated that they primarily practice a subspecialty. We received 607 completed surveys, for a response rate of 41 percent. This rate is consistent with that obtained for mail surveys of physicians.⁶ There were no statistically significant differences between responders and nonresponders in age, sex, practice type, or geographical region.

The survey asked internists whether they provided charity care and, if so, how many hours per month they provided and where they provided those hours. To define *charity care* in the survey, we used the definition in the Community Tracking Study: "Charity care is

defined as charging no fee or a reduced fee to patients with financial need. Charity care does not include services you provided expecting to be paid but were not."⁷ We also asked about policies for self-pay/uninsured patients and their ability to secure additional services needed at reduced or no cost. We used the term "self-pay/uninsured" rather than "charity care" because we wanted to understand policies for patients who could pay for a primary care visit but not for any subsequent care.

We weighted our data to correct for response differences between regions, and we present descriptive information from weighted results. Chi-square tests were used to determine statistical significance of differences in proportions.

■ **Characteristics of the practices in our sample.** Almost three-quarters of the internists in our sample were practice owners, either full (42 percent) or in part (31 percent), while the remaining 27 percent were employees. Half of the practices consisted of three or fewer physicians, and the remaining half were evenly divided between practices of four to eight physicians (24 percent) and nine or more physicians (25 percent). Internists' patients generally had private insurance (46 percent) or Medicare (44 percent), but 8 percent had Medicaid. Most of the revenue was from fee-for-service payments (69 percent), capitated managed care payments (21 percent), or other third-party sources (3 percent). However, 7 percent of the average practice revenue was from uninsured, self-pay patients.

Study Results

■ **Office policies regarding the uninsured.** The average charge for a routine office visit is \$64, with 75 percent of internists charging between \$45 and \$85 (data not shown). Uninsured patients might have trouble affording a visit if they are facing financial difficulties.⁸ In fact, most internists have charging and collection policies that accommodate uninsured patients (Exhibit 1). In almost all offices the insurance status of the patient is determined before the medical service is delivered, either at the time of the schedul-

**EXHIBIT 1
Office Policies Of Internists Regarding Self-Pay/Uninsured Patients, 2002**

	All internists (%)	Ownership (%)		p value
		Full or part owner	Employee or other	
When does your office usually determine the insurance status of a patient?				
During scheduling phone call	63	67	49	***
Upon arrival for appointment	35	29	48	
Following patient's visit	3	4	3	
What is your practice's usual policy for a self-pay/uninsured patient who has difficulty paying the full charge?				
Charge customary amount	35	31	46	***
Charge reduced or no fee	65	69	55	
When does your practice usually collect payment for this patient?				
Full payment at time of visit	25	27	20	
Partial payment at time of visit	30	29	36	
Billed after visit, if at all	45	45	44	
If the patient does not pay as anticipated, what is your collection policy? ^a				
Create a payment plan	68	71	61	**
Continue to bill	28	28	29	
Write off	39	41	35	
Use collection agency	27	26	29	
Will you accept new patients ^a				
With Medicare	84	84	82	
With Medicaid	45	41	57	***
With private insurance	90	91	86	
Who are self-pay/uninsured	80	80	78	

SOURCE: Authors' analysis of survey of general internists, 2002.

NOTES: N = 607. Full or part ownership, n = 440; employee or other, n = 167. Estimates were calculated using sampling weights to adjust for differential nonresponse rates by geographical region.

^a These categories are not mutually exclusive; hence, the percentages add to more than 100 percent, and chi-square values were calculated for each row.

p < .05 *p < .01

ing telephone call or upon arrival at the office.

If the patient is uninsured and has trouble paying for the visit, 65 percent of internists reduce the customary fee or charge nothing, while 35 percent do not make any accommodations. Furthermore, most internists will accept partial payment at the time of the visit or bill later. Only 25 percent ask for full payment at the time of a visit.

Most internists also have collection policies to assist uninsured patients in making their payments. More than two-thirds of internists will create a payment plan, but approximately one-quarter will continue to bill. Ultimately, if the bill is not paid, more than a third of internists will write off the charge. However, 27 percent will use a collection agency. Thus, it is not surprising that in surveys approximately

half of uninsured adults report problems paying for medical expenses and one-third report being contacted by a collection agency in the past year.⁹ Often, a bill from a collection agency, and the serious financial consequences of bankruptcy and devastated credit reports, can deter them from making another visit to the same provider or seeking care in the future.¹⁰ As might be expected, the internists who have charging policies that accommodate uninsured patients also have accommodating collection policies. Specifically, internists who reduce fees or charge nothing are less likely to use a collection agency than internists who do not modify their customary charge (22 and 35 percent, respectively; $p < .01$, data not shown).

Internists who are full or part owners are more likely to have policies that accommodate patients who have trouble paying than internists who are employees or in another category. Specifically, internists who are owners are more likely than nonowners to charge a reduced fee and are more likely to create a payment plan (Exhibit 1). This result is consistent with previous studies that found that physicians who own their practice are also more likely to provide charity care.¹¹ Owners have the discretion to set office policies, whereas employees do not; it appears that internist-owners accommodate the needs of their patients who are uninsured and need help paying for a visit.

■ Who are these uninsured patients?

Most internists report that their uninsured patients are mostly established patients who lost their insurance (52 percent of internists reported serving mostly this type of patient; data not shown) or a mixture of new and established patients (10 percent). Another two percent of internists report seeing primarily uninsured patients referred by colleagues or uninsured relatives of existing patients. Only 33 percent of the internists reported that their patient population consisted mostly of new patients. Three percent reported seeing no un-

insured patients. Providing care to uninsured patients who are not medically indigent but rather, because of job loss or other circumstance, have lost their health insurance is an important service, especially with rising unemployment rates. However, it is not the usual image of the uninsured or charity-care patient. Reinforcing the notion that it is not the medically indigent receiving care in private offices is the finding that internists would be more likely to take on a new self-pay/uninsured pa-

“Internists have doubts about their ability to provide the quality of care that they would like to provide to uninsured patients.”

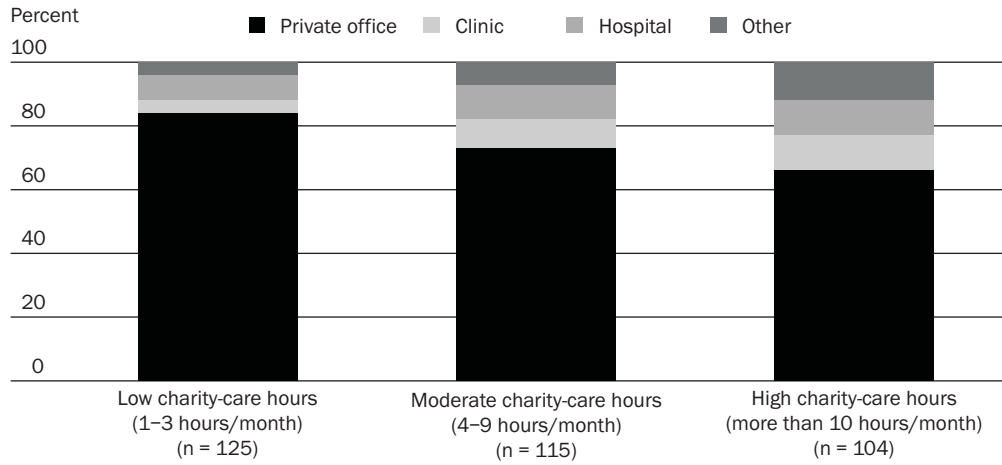
tient than to accept a Medicaid patient and almost as likely to accept a new self-pay/uninsured patient as to accept a new patient with private insurance (Exhibit 1). These surprising findings suggest that the self-pay/uninsured patients our physicians have in mind are not charity-care patients but

rather patients who are temporarily uninsured or have the ability to pay. It could be sound business practice to see these patients, who might become insured again in the future.

■ **Charity care given by internists.** More than two-thirds (68 percent) of all internists provided at least some charity care each month. The amount varied considerably, but approximately 60 percent of the internists who provided any charity care provided between a quarter of an hour and five hours per month, while another 15 percent provided six to ten hours monthly (median, four hours per month). A few internists provided considerably more hours, bringing the mean number of hours per month to eleven.

However, as hours of charity care increased, it was increasingly likely that at least some of these hours were provided outside the private office (Exhibit 2). Internists who provided more than ten hours of charity care per month provided 34 percent of these hours in clinics, hospital settings, or other locations. We do not know whether internists volunteer time in safety-net sites or whether they are possibly salaried by sites that might or might not be safety-net institutions. Our findings on the

EXHIBIT 2
Proportion Of Charity-Care Hours Provided In Internists' Private Offices And Other Settings, By Amount Of Charity Care Provided, 2002



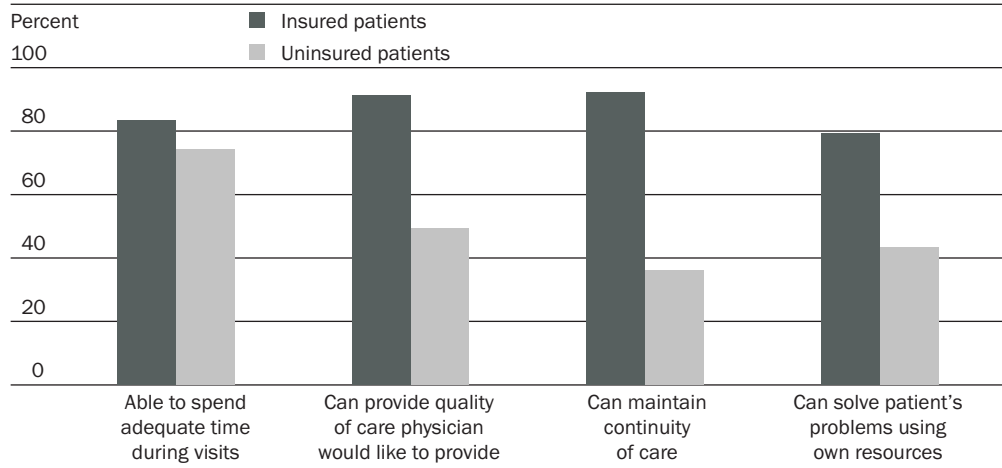
SOURCE: Authors' analysis of survey of general internists, 2002.

percentage of physicians providing charity care and mean number of hours provided are consistent with other studies.¹² However, the fact that some of the hours might be provided in sites other than the private practice has not previously been reported.

■ **Quality of care.** Internists have doubts about their ability to provide the quality and

continuity of care that they would like to provide to uninsured patients (Exhibit 3). While internists report that they are generally able to spend adequate time during the office visit for both insured (83 percent) and uninsured (74 percent) patients, they report that they are far less likely to be able to provide the quality of care they would like to provide for uninsured

EXHIBIT 3
Internists' Ability To Care For Insured Versus Uninsured Patients, 2002



SOURCE: Authors' analysis of survey of general internists, 2002.

NOTE: Percentage of internists who responded that they are "almost always" or "always" able to do each of the activities noted.

than for insured patients (91 versus 49 percent), maintain continuity of care (92 versus 36 percent), and solve patients' medical problems using the resources at hand in their offices (79 versus 43 percent).

■ **Laboratory tests, drugs, and diagnostic procedures.** Patients generally need services beyond the office visit, such as laboratory tests to confirm the diagnosis, medications to treat the illness, and sometimes diagnostic procedures or advice from a specialist. Internists reported that their uninsured patients have difficulty getting this additional medical care when needed (Exhibit 4). It is particularly difficult for uninsured patients to secure laboratory tests and diagnostic procedures (only 9 and 5 percent, respectively, said that patients could secure these "most of the time or often"). Less than one-quarter of internists reported that they could provide medications to their uninsured patients or refer them to specialists "most of the time or often." Not surprisingly, then, almost half of internists reported that their uninsured patients failed to follow advice about receiving these services because of cost "most of the time or often" (47 percent). Only 3 percent reported that this happened "rarely or never" (data not shown).

Study Limitations

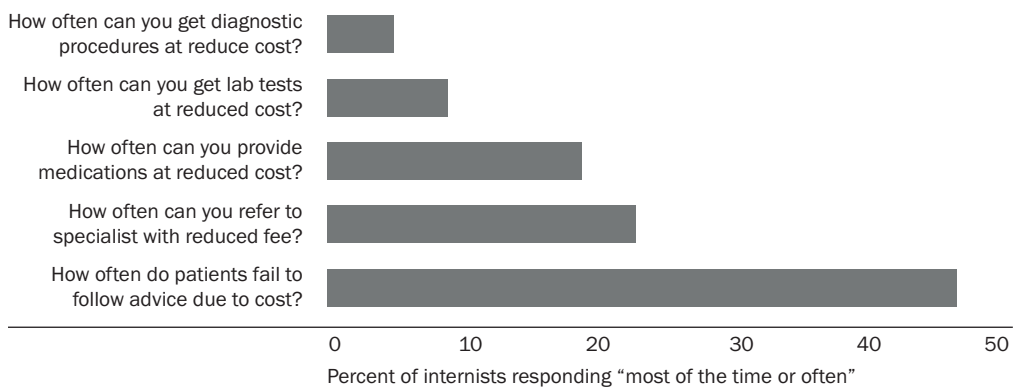
One limitation of this study is the 41 percent response rate. Although this is not an un-

usual rate for mail surveys to physicians, the nonresponse could introduce bias. The bias is likely to result in an overestimation of the proportion of physicians who provide charity care and have office policies that accommodate uninsured patients. Because this is socially desirable behavior, potential responders who do not act accordingly might be less likely to return the survey. However, we did not find a statistically significant difference between responders and nonresponders along several demographic variables. In addition, our results on provision of charity care were consistent with the findings from the Community Tracking Study (CTS), which had a 65 percent response rate among physicians.¹³ Further, although response bias is possible, the results nevertheless were dramatic enough to indicate the limitations of the safety net as it operates in private practitioners' offices.

Another limitation is that we relied on physicians' self-reports. This limitation could lead to overreporting hours of charity care provided for those physicians who reported at least some charity care. Other questions about office policies and what patients they would see are more factual and less subject to reporting biases.

The third limitation is that we surveyed only general internists and not other primary care physicians; thus, our results generalize

**EXHIBIT 4
Internists' Ability To Get Additional Services For Their Uninsured Patients, 2002**



SOURCE: Authors' analysis of survey of general internists, 2002.

only to general internists. However, our study does capture an important group of primary care providers who provide about 40 percent of primary care visits nationwide.¹⁴ We plan to follow this study with one examining the same issues for family practitioners and other primary care providers.

Discussion And Policy Implications

Although internists collectively provide many charity-care hours for uninsured patients every year, by their own reckoning they are not able to provide the same quality and continuity of care for uninsured patients that they provide for their insured patients, within their own offices. They are even less able to secure external services, such as medications, laboratory tests, or specialist consultations, if these are needed. Furthermore, a substantial proportion of internists' charity care goes to their existing, formerly insured patients who become uninsured. These internists are providing a service to an important segment of the population, especially given growing unemployment rates. They are filling a need for people who are probably moving between coverage and no coverage. However, they apparently are not reaching deeply into the medically indigent population.

Still, the care provided by office-based internists in private practice, as well as other private practitioners, is substantial and important. Based on our data, we estimate that the 29,413 internists of the ACP-ASIM membership in private office-based practice provide approximately 2.6 million hours of care—or 10.2 million visits—to uninsured patients per year, using 15.6 minutes as the average time for an office visit.¹⁵ It would be disastrous for the health care system if this source of care were to erode. There is simply not enough capacity in safety-net institutions to absorb large numbers of these patients.¹⁶

However, current forces at play—market pressures from insurance companies, managed

care plans, employers, and government payers—are likely to reduce physicians' willingness to see uninsured patients in at least three ways.¹⁷ First, as money becomes tighter, private practitioners are less able to fund care for uninsured patients from existing revenues. Furthermore, managed care plans are less likely to contract with physicians with high percentages of uninsured patients.¹⁸ Second, these market pressures have made it financially advantageous for physicians to consolidate or sell

“If market forces cause private practitioners to reduce their care for uninsured patients, there will be nowhere for them to go.”

their private practices, which in turn results in fewer physicians who are owners of their practices.¹⁹ Our findings show that practice owners are far more likely than physician-employees are to adopt charging and collection policies that accommodate their uninsured patients. Practice mergers and consolidations

take the decisions about charging and collection out of the hands of physicians, who may be responding to a sense of social responsibility to care for uninsured patients, and put them in the hands of managers, who are likely to have the financial health of the practice as their top priority. Third, practice managers, or physicians themselves, are more likely use aggressive tactics to collect payment as money becomes tighter. More than a quarter of physicians surveyed report that a collection agency is used in their practice setting if a patient does not pay.

These trends are cause for alarm, because if market forces and policy consequences cause internists and other private practitioners to reduce their care for uninsured patients, there will be nowhere for them to go. Private practitioners provide five times as many visits for the uninsured as safety-net institutions provide.²⁰ The safety net is simply not large enough to absorb the uninsured now being seen by internists and other private practitioners.

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