

Introduction to Special Theme Issue on Health Insurance in the United States

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Health insurance matters. It affects the experiences, behaviors, and outcomes of patients, clinicians, family members and health care institutions. For economists, employers, and governmental policy makers, health insurance also has broad and far reaching impacts, extending into such far-flung arenas as immigration policy, bankruptcy law, and even domestic partner/gay marriage issues.¹⁻⁴ Perhaps it shouldn't. That is the haunting question that weaves together the collection of articles in this special theme issue of *Medical Care*, sponsored by the Medical Care Section of the American Public Health Association (APHA) as a collaborative effort of the journal and the professional association that it represents.

Consider this recent true story of a close personal friend, for whom insurance mattered. She is a 50-year-old physician working in a public clinic for the uninsured in Chicago, Illinois. She discovered a breast lump, and immediately went to her own physician. Her physician referred her for an ultrasound-guided biopsy. However because her health insurance was in transition, she delayed getting the biopsy for 5 full months, a biopsy that ultimately returned as positive for adenocarcinoma. In transition? Waited 5 months? Why would a physician not have known better than to delay her biopsy nearly half a year?

Although the story is complex (I will spare the reader the full details), such complexities and delays are not unusual in the complex and frustrating world of health insurance in the United States. My friend with breast cancer was originally working part-time for a clinic where she did not receive health insurance. For many years she was covered under her husband's plan. When a new practice opportunity opened at the hospital where her husband worked, she changed jobs, joining him in working there. One of the benefits of the new job was that part-time workers (she was 55% time) received health insurance. So far so good. But this also meant she could no longer remain on her husband's plan (at that workplace, such family coverage was forbidden if both spouses work there); and because her insurance costs would be "pro-rated," requiring her to pay 45% of the premiums out of pocket, she realized that this "benefit" was actually a financial detriment. She decided she would be better off reducing her time in her new job to less than 50% so she would no longer have "benefits," and did so. It was at that moment when she discovered the lump in her breast.

Untangling the disenrollment-re-enrollment paperwork dragged on for the next 5 months. Each time she thought the matter resolved, another bureaucratic hurdle had to be surmounted. Looming large over the whole process was the question of whether, in the unlikely event a cancer was found, it would be considered a "pre-existing condition." When finally straightened out and she went for biopsy, her worse fears were realized.

While each of us has a personal experience that we could also relate about ourselves, family members, or friends, the purpose of this special theme issue is to take a look at the bigger picture of how health insurance is and is not working. In my own case, written as a personal essay several years back, I concluded by confessing that while I considered myself something of an expert on health policy, I was clueless about the fact that I would

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not have Medicare coverage when I turn 65.⁵ Imagine a frail senior trying to understand the subtle and complex Medicare insurance coverage rules and choices and you will find, as was recently documented in this Journal, that they are also often clueless about even the difference between managed care and fee for service, despite being required to choose between them under our current Medicare program.⁶

COMMENTARIES ON FUNDAMENTAL ISSUES

Much more serious, however, is a more fundamental misunderstanding of what health insurance is, what is its purpose, and how it should be designed. When we asked Bruce Vladeck (former head of the HHS, the Health Care Financing Administration of the US Department of Health and Human Services who oversaw the Medicare and Medicaid programs during the 1990s) to comment on the articles in this theme issue, he used the opportunity to dissect “the logic of health insurance,” elaborating on how health insurance is fundamentally different from automobile or homeowners insurance.⁷ He worries that we risk “solving” the health insurance problem without adequately understanding the problems health insurance was invented to address.

Robert Evans reviews an important contribution by James Naessens and colleagues from Mayo Clinic.⁸ Employees working at Mayo were offered a choice of a high premium/more comprehensive plan versus a less expensive plan with skimpier (more out-of-pocket costs) coverage. Uniquely, the authors had access to health records both before and after choice decisions, and were able to link their health status to their insurance plan choices. They found as predicted (by both the authors and, as Evans points out, by classic health economic theory) evidence of “self-selection.”⁹ High deductible plans worked to sort out the sicker from healthier enrollees. Evans then asks whether we truly believe insurance should be designed to place the greatest financial burden on the chronically ill, and raises uncomfortable questions about the implications, ethics, and consequences of such an approach.⁸

Barbara Starfield, internationally recognized primary care authority, discusses Jennifer DeVoe’s study exploring the relationships and dynamics between health insurance and “access” in children.¹⁰ DeVoe finds significant impact of having both health insurance and a usual source of care. By dissecting their differential impact she concludes that they have different yet synergistic roles, and suggests that it is important to simultaneously strengthen both, rather than trade off efforts and resources devoted to each independently.¹¹ Starfield, who has written eloquently about these dynamics elsewhere,¹² here argues that we need universal health insurance like other industrialized countries to “release our energies” to deal with more formidable challenges in health services organization and delivery in general, and in particular use those energies to make primary care more available, comprehensive, and effective in ways it is elsewhere in the world.

There are several existing models for more comprehensive financing and delivery programs in the United States, and 2 of the submitted commentaries usefully address their

accomplishments and challenges in the context of the discussion of the health insurance debate. Sid Socolar, himself a senior activist and advocate for Medicare, highlights recent changes in Medicare, a program many consider a model or foundation for a national health insurance. Socolar argues that, unbeknownst to most people, Medicare Part D, the Medicare Modernization Act of 2003, has introduced major changes that threaten both the direction and future of the program. He concludes with a 6-point program recently adopted by the APHA that he advocates as the best way to “preserve and strengthen” Medicare.¹³

Another public model is the US Veterans Administration system. Anne Sales, a nurse and PhD health services researcher who worked in the VA system for a decade, writes an essay describing the largest public integrated health care system in the United States. She outlines the contributions and lessons the VA experience can provide (beyond merely reforming the insurance and payment system) to the current discussion about health insurance.¹⁴

DATA AND LESSONS FOR POLICY CHANGE

The second part of this special theme issue features more quantitative looks at the impacts of health insurance and policies that affect program eligibility, design, and outcomes. Joseph Freeman et al present a systematic review of the recent literature on effects of health insurance on utilization and health outcomes in adults.¹⁵ To avoid selection biases typically introduced by cross-sectional studies showing that the insured are healthier (ie, are people healthier as a result of having health insurance, or were the healthy more advantaged to begin with, including being insured?) they narrowed their analysis to 14 studies using 1 of 3 more rigorous research designs—longitudinal cohort studies (4), quasi-experimental studies (5), and instrumental variable analyses (5). They compare their findings to those of the historic randomized-controlled trial, the RAND Health Insurance Experiment done 3 decades ago. Freeman finds that health insurance consistently increases utilization of physician services, preventive services, and improves self-reported health status and mortality—findings that confirm parts of the RAND experiment, while contradicting other RAND findings.

As mentioned above, the pieces by Naessen and DeVoe both add new dimensions to the usual one-dimensional looks at health insurance and health outcomes. Naessen et al enrich their examination by exploring factors in selection of health plan by linking selection decision-making with longitudinal Mayo Clinic clinical data. Their finding of clear evidence of “self selection,” while coming as no great surprise, raises fundamental questions about the design of health insurance programs.⁹ DeVoe went to a novel source to survey health insurance coverage and experiences of low income children—the Oregon food stamp program—to broaden our understanding of the relationships between usual source of care and health insurance coverage that Starfield discusses in her commentary. DeVoe finds that the combination of both no insurance and no usual source of care was the most harmful; however even if one was insured but lacked a usual source of care, there appeared problems in obtaining specialty care, and

those without insurance who nonetheless had a usual source had more problems obtaining prescriptions, dental care, and evidence of overall unmet medical needs.¹¹

The dynamics of gaining or losing health coverage or switching plans are explored in a number of studies we turn to next. Andrew Bindman and colleagues apply a validated tool measuring hospitalizations related to “ambulatory care sensitive” conditions to examine the effects of an enrollment policy change in California.¹⁶ When California Medicaid simplified its procedures by extending the period of coverage before “eligibility redetermination” from 3 to 12 months, the percentage of children with continuous coverage increased from 49% before the change, to 62% in the 2 years afterwards, with an accompanying decrease in preventable hospitalizations. One might wonder what the effect of universal coverage, with no such repeated eligibility “redeterminations” would be. Shana Alex Lavarreda and colleagues study the effects not of gaining or losing insurance, but of switching insurance plans.¹⁷ As opposed to those having continuous coverage, “switchers”—of whom there were 2.3 million in California alone in a single year—had increased odds of reporting care delays and other impaired basic care access measures.

Kathleen Adams and colleagues look at a complex and varying set of insurance eligibility requirements and outcomes in 7 states before and after the 1997 extension of the State Children’s Health Insurance Program (SCHIP).¹⁸ Although there were multiple confounding events that affected the results from state to state (eg, changes in the economy, employment, teen pregnancy rates, welfare policies), their results point to the conclusion that expansion of the program led to significantly better pre-pregnancy coverage with all of the expected benefits from earlier access to preconception and prenatal care. In a similar vein, Tzy-Mey Kuo and colleagues examined timely initiation of teens’ prenatal care in the state of Florida to measure how this was affected by changes in the State’s Medicaid law.¹⁹ They found that, in general, the percentages of teens with late or no prenatal care decreased and a variety of racial disparities decreased, although these results depended on the specific categories of program and population studied.

Matthew Rutledge and Catherine McLaughlin examine 2 decades of data demonstrating growing disparities in health coverage between Hispanics and other groups in the United States.²⁰ They find this disparity rate is growing for both noncitizens and US born Hispanics, with the uninsurance rate for the former group going “from bad to worse” rising from 36.2% in 1984 to 56% in 2003. They explore various “observable” and unmeasurable factors that are likely contributors. They provocatively suggest that without these huge uninsurance rates for Hispanics, overall insurance rates would have held “fairly steady” from 1983 to 2003. Kathie Huang and Olveen Carrasquillo delve into the insurance characteristics of Asian Americans, the third largest and fastest growing minority group in the United States. Noting that overall the current system of employer coverage is not succeeding in covering Asian groups, they find the coverage gap is greatest for Koreans and Vietnamese who had unin-

surance rates of 29.8% and 21.5%, respectively.²¹ They speculate on the cultural, employment structure, as well as public versus private health insurance coverage implications of their findings.

Should families who must cope with the day-to-day care burden of having children with special needs also suffer a heavy financial burden? Dr. Hao Yu and colleagues examined trends in health costs between 2001 and 2004 to determine the extent to which health insurance protected such families against financial burden.²² Using data from the Medical Expenditure Panel Survey (MEPS), they uncovered 2 important findings. The first is demonstration of an upward trend in cost burden that parallel economy-wide increases in health care costs. Second, they found that families with public insurance were significantly better protected, although 15% of publicly-insured families still spent more than 10% of the family income (vs. 21% of privately-insured families). Unfortunately, these families with chronically ill children are not alone, as a recent study reported that there were 48.8 million people younger than age 65 living in families spending more than 10% of family income on health care in 2003, compared with 11.7 million in 1996.²³

The starting premise of the next paper may be surprising—that emergency department visits are *lower* for the uninsured (10% annual ED visit rate) than they are for patients insured by Medicaid (27% of Medicaid recipients visit ED annually). To better “decompose” the factors underlying these differences, Karoline Mortensen and Paula Song apply a novel statistical technique to the MEPS data and find that while the heavier prevalence of chronic illness explains a substantial portion of this higher utilization rate, there are additional “unmeasurable” factors that they suggest need to be better understood.²⁴

Medicare plans include both a traditional fee for service (FFS) and managed care (MC) plan options. Does one model deliver better cancer care? Although Gerald Riley et al were challenged by controversies in choosing gold standard criteria for best care (eg, see recent controversy regarding the optimal number of lymph nodes to be dissected in surgical resections for primary colorectal carcinoma²⁵), they assembled a list of quality indicators and found mixed results, with FFS and MC performing comparably on most measures and most cancers.²⁶ Although there were some differences favoring MC for conservative prostate surgery and earlier stage at detection of breast cancer, the authors were struck by the wide variability among MC and FFS plans, which far outweighed the average differences between these 2 approaches.

The final article in this section of our special issue analyzes “early returns” data on the Medicare Part D drug benefit insurance program. Pharmacist Marsha Raebel and her colleagues probe the controversial “donut hole” coverage gap, whereby once patients reach a threshold of \$2250 annual costs, the beneficiary must pay 100% of his or her drugs costs out of pocket (until they reach a second threshold of \$3600, when a “catastrophic” coverage benefit is activated).²⁷ Because of obvious concerns of adverse health and financial impacts for patients who reach such a drug benefit threshold,

TABLE 1. Coverage and Coverage Gaps in Health Insurance Articles in Special Theme Issue

Call for Papers Topic	Submissions	Invited Commentaries
Effects of insurance on access, quality, cost, continuity of care	DeVoe—Insurance and Usual Source of Care Freeman—Systematic Review Insurance Effects Bindman—CA Medicaid Eligibility Reform Lavarreda—Effects Switching Insurance Plans Mortensen—ED Use Uninsured vs. Medicaid Multiple unpublished submissions	Starfield—Primary Care and Access
How insurance financing affects organization and delivery of care	Riley—Cancer Care Managed Care vs. FFS Unpublished submission	Vladeck—What is Health Insurance? Sales—VA System as a Model
Scope and consequences of underinsurance	Yu—Rising Family Costs Children Special Needs Raebel—Medicare Part D Pts Reaching Donut Hole	
Economic and public health implications and impacts of insurance/uninsurance/underinsurance		Evans—Self-Selection Separate and Unequal
Effects of insurance on health disparities access, and outcomes	Adams—SCHIP and Pre-pregnancy Teen Coverage Kuo—Florida Teen Insurance and Prenatal Care Rutledge—Rising Hispanic Disparity Huang—Uninsurance Asian-American Multiple unpublished submissions	
Impacts of newer health insurance models (high deductible HSA's, concierge medicine)		
Use/Role/Value insurance data population monitoring (quality, effectiveness, vulnerable populations)	Rutledge—Rising Hispanic Uninsurance	
Effects of specific policies and practices of insurance companies		
State or federal insurance policy regulatory actions and their consequences		Socolar—Medicare Program Changes/Reforms
Consumer understanding and behaviors related to insurance benefits and choices	Naessens—Mayo Employees Choice Health Plan	Yueng—A Vision of Health Care
Impacts of pre-existing conditions on coverage, consumer behaviors		Schiff—Introduction to Theme Issue
Insurance administrative costs, efficiencies		
International comparisons of insurance financing approaches		

Raebel compared utilization patterns for patients who exceeded this threshold both with those who did not, as well as with a group of beneficiaries in a Kaiser Medicare Advantage Plan that did not have a donut hole. As expected, beneficiaries who reached threshold had greater morbidity and used more prescription medications than those who did not. Of concern, medication adherence declined upon reaching the \$2250 donut hole. Although the authors were unable to detect health utilization outcome effects that have been demonstrated in other drug-cap studies,²⁸ they state that this preliminary study was hardly reassuring, given its short term design limiting its ability to detect longer term impacts.

THE BIGGER PICTURE

As important as what each of these studies individually show, there are larger themes that emerge. Also noteworthy is the ground that is *not* covered by this special issue. In part due to space constraints, but more likely due to a scarcity of research being funded and performed in the key areas we asked for in our call for papers, we were disappointed that we did not receive more submissions in a number of the topic

areas (Table 1). While there are thousands of “natural experiments” occurring on a micro and macro level related to our health insurance system, there is a paucity of efforts to study, learn, and act on lessons. Likewise, there seems to be a deaf ear on the part of policy-makers who should be the audience, but do not seem to be listening to lessons from the research that *is* being done.

MOVING FORWARD: TOWARD A DEPENDABLE AND DEPEND-LESS SYSTEM

What these articles tell us is that there are many gaps in insurance coverage (often gaping holes), and their expression depends on a multitude of factors and impacts in a variety of ways. As useful as each of these puzzle pieces is, there is a larger whole that emerges. Thus we need to step back and look at the bigger picture and think about the types of changes that will be needed to overcome the problems so painstakingly illustrated in these articles.

For example, what we see from several of these (and other) articles, is that whether a pregnant women ends up

getting insurance coverage, and what type of coverage she obtains for preconception, prenatal, and delivery care, depends on a variety of factors. It *depends* on what state she lives in, *depends* on her age, *depends* on her income, *depends* on her immigration/documentation status, *depends* on how many other children she already has, *depends* on where the baby's father or she herself works and what sort of insurance benefits that employer offers, *depends* on whether she is a prisoner (ironically prisoners have a constitutionally guaranteed right to health care under the eighth amendment prohibiting cruel and unusual punishment), *depends* on her truthfulness and accuracy in answering questions about her last menstrual period when signing up for private insurance (which in turn *depends* on how the insurer "polices" the application including how aggressively they pursue so-called "postclaims underwriting," whereby insurers attempt to uncover any "pre-existing conditions" such as pregnancy in order to rescind the policy for any under-reporting they uncover),^{29,30} and finally, as the data shows, it *depends, implicitly* on her race. And whether her child will be insured, and how, also *depends* on the mother's (or other family member's) ability to comply with repeated eligibility redetermination requirements—requirements that are often complicated, confusing, based on arbitrary thresholds, continually shifting, wasteful (to administer), and again varying from state to state. I think you get the idea.

Women and children are supposed to be the groups where we have most expanded insurance coverage to ensure that they will be covered. Yet more than 9.1 million children are uninsured of whom 5.5 million are, in theory, eligible for either Medicaid (3.8 million) or SCHIP (1.7 million).³¹ And this *depends*, of course, on being a woman or a child.

Can we reform this situation on a piece-by-piece way, trying to patch all of the gaps, to pave over all the "depends" clauses that characterize our health insurance system? Dr Quentin Young (a past APHA president) has stated that incrementalism is not the solution but rather the cause of many of the problems in the health system. He has a point. In 1996, the Kennedy Kassebaum HIPAA legislation forbade health insurers from considering pregnancy to be a "pre-existing condition." However there are multiple loopholes in the law, such that it only applies to a woman changing jobs with existing coverage in a group plan, and only if that plan already includes maternity coverage. If obtaining insurance on an individual plan or a new insurance policy, a woman cannot be pregnant and still obtain coverage. And what about breast cancer or diabetes, for which there is no "pre-existing conditions" protective legislation?

Cost is the second thread that weaves many of these articles together and is certainly on the minds of both patients and policy-makers. Eighty-five percent of Americans are concerned about rising health costs (more of an issue than the Iraq war according to a recent Harris poll).³² The rise in the cost of health insurance continues to exceed the rate of inflation. From 2002 until 2007 health insurance costs increased by 78%, while the inflation rate increased by 17%.¹³ For many workers, wages are not even keeping pace with this general inflation rate. Yu wonders how families with children with special needs will suffer under the increased cost burden

they must shoulder.²² Raebel documents how some chronically ill seniors faced with expensive drug bills stop taking their medications.²⁷ Evans asks if we really are facing the implications of new forms of health insurance that shift costs from the healthy and well to the sick and poor.⁸

Our insurance system is indeed a costly one both for the individual and in the aggregate. Perhaps it is time to rethink why the United States is such an outlier internationally when it comes to cost. In addition to the enormous administrative waste inherent in the way we have chosen to organize our complex multipayer system, there are even more profound ways our system is failing compared with other nations in realms that are important for moderating cost. These include serious and growing shortcomings in primary care and prevention, underdevelopment of critical technology assessment (to critically review claims for new drugs, devices, and diagnostic technologies), and fragmented and poor implementation and penetration of information technology and electronic health records, to name 3 important areas. While superficially these problems may appear to be separate from that of health insurance, they in fact have everything to do with how we have chosen to structure our health financing systems, and in turn will have enormous impacts on affordability and design of health benefits and delivery.

The Medical Care Section of APHA has long favored a universal single payer national health insurance approach to bring us in step with the rest of the world, as well as to conform to the principles and practice of sound health care financing, organization, and delivery. More than 30 years ago one of our Section's well-known leaders, Avedis Donabedian, stated that, "There are 2 archetypal and opposing views about the nature of our problem, and the contribution of health insurance to its solution. On the one hand are those who believe that our medical care system is essentially sound; that it is in a process of healthy growth and evolution; and that the major role of health insurance is to provide protection against the unpredictable costs of illness. On the other hand are those who believe that our medical care system has failed to produce health services efficiently or to distribute them equitably; and who regard a national health insurance scheme not only as a means to achieve protection against the costs of illness, but also as a powerful force that should be used to reshape the medical care system itself."³³

Since these words were written, there is an emerging consensus. Health insurance matters, our system is failing, and there is an urgent need to head in a different direction—conclusions that the articles in this special theme issue reinforce. There is also growing support among clinicians and the general public that we need to move to a universal publicly-financed national health insurance system.¹³ A recent speech by Miriam Yeung captures this sentiment with her personalized vision for health care for all.³⁴ To paraphrase Kerr White (another historic Medical Care Section leader), "health insurance statistics represent people with the tears wiped off."³⁵ We hope the contributions in this special theme issue will help inspire further research and action to make that vision a reality and help wipe away the tears that many of these articles represent.

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