The Cost of Lack of Health Insurance

American College of Physicians

A White Paper

2004

The Cost of Lack of Health Insurance

A White Paper of the
American College of Physicians

This paper written by Rachel Groman, MPH, was developed for the Health and Public Policy Committee of the American College of Physicians: Lynne M. Kirk, MD, C*hair;* J. Fred Ralston, MD, *Vice Chair;* Patricia P. Barry, MD; Yul D. Ejnes, MD; Joe E. Files, MD; Joel S. Levine, MD; Mark E. Mayer, MD; Thomas McGinn, MD; Robert M. McLean, MD; Carla Nester, MD; and Laurence D. Wellikson, MD.

THE COST OF LACK OF HEALTH INSURANCE

White Paper of the
American College of Physicians

Introduction

As stated in the College's 2000 *No Health Insurance? It's Enough to Make You Sick*, the benefits of American medicine are available only to those who can access the health care system. Yet, the number of Americans without health insurance continues to grow despite the fact that the US spends twice as much per capita on health care than other industrialized nations. (1) According to Karen Davis, president of the Commonwealth Fund, in our complex, pluralistic system of health insurance, far more energy goes into shifting costs—from one employer to another, employers to workers, federal government to state governments and back, and to safety-net hospitals serving the uninsured—than into enhancing efficiency or quality of care. (1)

Tough economic times and soaring health care costs have further compromised access to the health system. As unemployment rises, states cut back on the number of people eligible for public insurance programs. At the same time, employers reduce benefits, shifting a larger share of health care costs to employees, or simply discontinue health insurance coverage. After increasing by roughly a million Americans each year throughout most of the 1990s, (2) the number of uninsured now exceeds 43 million persons, representing more than 15 percent of the U.S. population. (3) This 2002 figure represents an increase of 2.4 million people over 2001. (3)

The American College of Physicians has developed a comprehensive proposal for expanding health insurance coverage to all Americans. (4) One common response of skeptics is that the cost of such a plan would be enormous and unaffordable. What is often ignored is the fact that the United States already spends an enormous amount on health care for the uninsured, both in terms of the actual direct costs of services provided and in terms of the indirect costs to society of having individuals forego or delay receipt of needed health care services. These expenditures will only grow as the number of uninsured continues to climb.

This paper seeks to quantify, as much as is possible, the cost of maintaining a considerable uninsured population. To fulfill this objective, a review of existing literature was conducted. Most studies were found to offer only a glimpse of some of the costs involved. This paper therefore attempts to identify and summarize in one document the extent of what is known about the aggregate economic costs to the United States of not having universal health insurance coverage.

What Does it Mean to Be Uninsured?

In 2000, ACP conducted a literature review of over 1,000 documents published in the last ten years linking health insurance coverage with the utilization of health care services and individual health outcomes. The College's findings, presented in the paper, *No Health Insurance? It's Enough to Make You Sick*, verified, with scientific evidence,

that the uninsured experience reduced access to health care. Uninsured Americans are less likely to have a regular source of care, to have had a recent physician visit, and to use preventive services. They are more likely to delay seeking care and to report not receiving needed care.

More specifically, uninsured working-age adults are more likely to go without care that meets professionally recommended standards for managing chronic diseases, such as timely eye exams to prevent blindness in persons with diabetes, and they oftentimes lack regular access to medications needed to manage conditions like hypertension or HIV. The uninsured are also more likely to receive less frequent or no cancer screening, resulting in delayed diagnosis, delayed treatment, and premature mortality. For uninsured Americans, particularly those with chronic conditions, lack of access to needed care results in more medical crises and emergency hospitalizations. (4)

In the end, failing to extend health care coverage to the uninsured compromises access to care, results in the inefficient use of medical services, and ultimately carries multiple economic consequences. On the one hand, there are direct costs borne by the health care system for treating the uninsured, which must be absorbed by providers as free care, passed on to the insured via cost shifting and higher health insurance premiums, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs. (4) But there are also indirect costs to individuals and families, in terms of financial security and well-being; to businesses, realized through employee health, attendance, and productivity; and to society at large, in terms of public health and general productivity. (5) These costs are discussed in more detail below.

<u>Cost Borne by the Health Care System</u>

According to the study, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" total medical care received by the uninsured in 2001, including both the full-year and part-year uninsured, was $98.9 billion. Of this total, about $35 billion was considered uncompensated care, or care that was not paid for out-of-pocket or by a public or private source. The authors of the report note that "free" care-- the primary source of care provided to the uninsured in 2001--is not necessarily a substitute for lack of coverage, nor does it offset the effects of being uninsured on access to and use of care. In 2001, the total dollar value of care received by an uninsured individual was still only about half that received on average by privately insured individuals. (6)

Hospitals

Hospitals are the largest source of uncompensated care, delivering about $24 billion in uncompensated care to the uninsured in 2001. (6) The uninsured, who often lack preventive care and have more serious conditions, rely heavily on hospital services because of limited access to other sources of primary care. According to one study, the uninsured have a substantially higher proportion of admissions to hospitals for ambulatory care sensitive conditions (ACSCs), a slightly longer than average length of stay as an inpatient, and a substantially higher cost per case (12.3 percent higher or $651) than privately insured individuals. (7) A separate study revealed that the uninsured are 30-50% more likely to be hospitalized for an avoidable condition, with the average cost of an avoidable hospital stay in 2002 estimated to be about $3,300. (8) The cost borne by

hospitals for caring for the uninsured is also an internal medicine issue, since the majority of hospital care received by the uninsured is provided by internists.

Another recent study by the Center for Studying Health System Change points to the increasing use of hospital emergency departments by the uninsured. Between 1996-97 and 2000-01, emergency department visits by uninsured patients increased by about 10 percent, despite little change in the number of uninsured. (9) Moreover, between 1999 and 2000, over 31 percent of emergency department visits by uninsured persons were considered non-urgent. (9) The increasing reliance of the uninsured on the emergency department, especially for non-urgent care, has serious economic implications, since the cost of treating patients is higher in the emergency department than in other outpatient clinics and medical practices. (9) Additionally, hospital emergency rooms are inefficient for treating routine health problems and do not offer a continuum of care for an uninsured patient once discharged. (10)

Current literature suggests that coordinated preventive and outpatient care could result in substantial economic savings. Appropriate management of diabetes outside the hospital, for example, could avoid up to 23,000 admissions for diabetes and could save up to $84 million in direct hospital costs. (7)

Clinics and Community Health Centers

Clinics and community health care centers, including the Veteran's Administration and Indian Health Service hospitals, provided about $7.1 billion in uncompensated care received by the uninsured in 2001. (6)

Physicians

Physicians, not including those employed by hospitals or clinics, provided about $5.1 billion in uncompensated care to the uninsured in 2001, which includes donated time and forgone profits. While this figure seems much lower than the value of uncompensated care provided by hospitals, hospitals, unlike physicians, receive a substantial amount of public assistance for caring for the uninsured. Physicians, on the other hand, account for more than half of the private subsidies that underwrite the cost of uncompensated care. (6)

A study by researchers at the New York Academy of Medicine (NYAM), supported by the ACP Foundation and released in November 2003, found that over two-thirds of internists treat uninsured patients who are unable to pay the physician's usual fee, charging them a reduced or no fee and/or creating a payment plan. (11) Approximately 60 percent of 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 10 hours monthly.

Analysts warn that charitable physicians and the safety net, despite their valued role to the uninsured, are not substitutes for health insurance. (12) According to the NYAM study, internists expressed concern that they were unable to provide uninsured patients the same quality of and continuity of care that insured patients received. (11) Furthermore, changes in the structure and financing of the health care system have constrained physicians' ability to cross-subsidize free care to uninsured patients. As a result, there has been a decline in the supply of physicians who are able to offer charity

care -- from 76.3 percent in 1997 to 71.5 percent in 2001—while those who continue to offer such care are spending less time doing so. (10)

As the number of physicians able to provide free care declines, access to care for the uninsured is further curtailed. The percentage of uninsured persons with a usual source of care—which is already far lower than for any insured group—dropped to 64.2 percent in 2001, down from 68.6 percent in 1997, while the proportion of uninsured persons seeing a physician dropped to 46.6 percent in 2001, from 51.5 percent in 1997. (10)

Costs Borne by the Uninsured

In the recently released IOM report, *Hidden Costs, Value Lost*, analysts applied the concept of health capital to calculate the health risk of being uninsured. Similar to strategies used by the government to evaluate alternative public policies by comparing the value of averted risk, this approach involved estimating the value of diminished health and longevity within the U.S. population as a result of uninsurance. (13) The IOM estimated that the economic value of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance ranges from $1,600 to $3,300 for each additional year spent without coverage. (13) For the entire uninsured population of roughly 41 million Americans in 2002, the aggregate, annualized cost of diminished health and shorter life span was estimated to be between $65 billion and $130 billion for each year of health insurance forgone. (13)

Stated otherwise, these values represent the personal economic value that would be added if the entire U.S. population had health insurance coverage. (13) An investment in health, according to the IOM report, yields returns in productivity, lifetime earnings, enjoyment of life, and developmental potential, to name a few. (13) While the IOM estimates account for losses in productivity experienced by uninsured individuals themselves, it does not include spillover loses to society as a whole resulting from the poorer health of the uninsured population. (13)

A similar analysis found in the IOM report compared the cost of universal coverage in terms of Quality Adjusted Life Year (QALY) saved to various other public health interventions. According to the analysis, the cost of universal coverage is lower than many other commonly used public health interventions.

TABLE 1 Cost-Effectiveness Ratios for Selected Life-Saving Measures

Intervention	Comparator	Target Population	Cost per Quality Adjusted Life Year (QALY) Saved[a]
Annual colorectal screening	No screening	People 50-75	$22,000
Dual passenger airbags	Driver side only	Front right passenger	$75,000
Coronary angioplasty	No revascularization	Patients w/ mild angina & one-vessel disease	$136,000
Universal coverage	**16.5% uninsured population < age 65**	**Currently uninsured**	**$50,000-$180,000**
Annual mammography	Annual clinical breast exam	Women ages 40-50	$297,000

Screening patients to prevent HIV transmission	Universal precautions	Health care workers in acute care setting	$606,000
Annual Pap smear	Pap smear every 2 years	Women ages 20-75	$2,000,000
Lap/shoulder belts (9% use)	No restraints	Rear-center seats of cars	$3,000,000

[a] All dollars have been adjusted to 2001 dollars by the medical care price index.
SOURCES: Graham, 1999; IOM (from: Hidden Costs, Value Lost, IOM (2003))

Overall Health Status and Productivity

It has been estimated that lack of health insurance leads to the death of 18,000 adults ages 25 to 64 each year—making it the sixth-leading cause of death in this age group, ahead of HIV/AIDS or diabetes. (1) Furthermore, uninsured people with chronic conditions report worse health and more functional limitations and are three times more likely not to get needed medical care compared to those who are privately insured. The vast majority delay or forgo needed care because of the cost. (14)

The uninsured also use far less medical technology than insured patients do. In a study published in the summer of 2003, researchers concluded that more than $1.1 billion is lost annually from excess morbidity and mortality among the uninsured because of lack of access to new technologies for the treatment of heart attacks, cataracts, and depression. According to the authors, "substantial welfare is lost every year because the benefits of technology are not reaching the uninsured." (15)

Functional limitations brought on by poor health can adversely affect workforce productivity and carry large economic costs. The report, *Sicker and Poorer: The Consequences of Being Uninsured*, commissioned by the Kaiser Commission on Medicaid and the Uninsured, notes that the combination of less ability to work and lower productivity resulting from poor health has been estimated to reduce earnings by between 10-28%, depending on race and gender, over a ten-year period. (8)

Financial Security and Stability

The cost of uninsurance also includes the financial burden experienced by uninsured individuals and families. The IOM estimates that the increased financial risk and uncertainty borne by the uninsured and their families costs between $1.6 billion and $3.2 billion. This figure represents the value of the financial protections provided by health insurance to those now lacking coverage and is in addition to the estimate value of forgone health cited above. (13)

Without the protections afforded by health insurance, a simple medical condition can constitute a substantial financial liability. According to the Commonwealth Fund, more than one-quarter of families in which one or more members were uninsured had to "change their way of life significantly" to pay medical bills. This figure rose to 40 percent when all family members were uninsured. (16) In a separate finding, half of those surveyed who were uninsured and had medical bills reported that they struggled to pay for expenses such as food and rent, while the vast majority (70 percent) said they were forced to deplete their savings to pay medical bills. (16)

Financial insecurity sustained by the uninsured can be attributed to several factors. A third of the poor (income below 100% FPL or $14,128 for a family of three in 2001) (12) and more than a quarter of the near poor (income below 200% FPL) lack

health insurance, making those without coverage often the very individuals least able to manage a financial emergency. (12) Additionally, the uninsured-- unlike the insured--are often required to pay in advance and out of pocket for their medical care. In 2003, uninsured families averaged $772 in out-of-pocket spending on health care. (17) While this amount is often lower than that of an insured family, uninsured families pay for a higher proportion of their total health care costs out-of-pocket and are more likely to have high medical expenses relative to their income. (13) Out-of-pocket costs make up about a quarter of the total care received by the uninsured, suggesting that in spite of charity care and government programs, uninsured Americans still pay for a significant portion of the care they receive. (6)

Other studies suggest that the uninsured are charged more for care than their counterparts. The Chicago-based Hospital Accountability Project reported that Cook County patients without health insurance pay more than double what those with coverage pay for hospital medical care. (18) The author attributed this price disparity to the fact that the uninsured lack the leverage of a large health insurer to negotiate their medical bills. Regardless of the cause, the finding adds evidence to the fact that the uninsured face serious financial barriers that limit their access to care and are often burdened with debts as a result of obtaining care.

Further compounding the problem is the fact that an increasing number of safety-net facilities are instituting cost-sharing plans as a result of recent financial pressures. According to the National Association of Public Hospitals and Health Systems, more than 80 percent of public hospitals surveyed in 2000 had implemented cost-sharing plans, including pharmacy co-payments ranging from $2 to $10 per prescription. (19) A separate survey on the use of the safety net by the uninsured found that three out of five respondents needed help paying their medical bills. Nearly half of all respondents reported having unpaid bills or being in debt to the facility where they received care, while those who used a hospital emergency room (ER) or outpatient department were even more likely to report being in debt to the facility. Among those prescribed medications, 56 percent reported needing help paying for them, and 13 percent reported obtaining none or only some of their medications because of the cost. (20) Since the safety net is most often the only point of access for the uninsured and relied on as a source of complimentary or inexpensive care, these findings suggest that the financial hardships faced by the uninsured may be more severe than previously estimated.

<u>Costs Borne by the Government</u>

Governments finance the bulk of the uncompensated care received by the uninsured, spending about $30 billion in 2001 on payments and programs largely justified to serve the uninsured. This figure includes grants, direct care programs, tax appropriations, and Medicare and Medicaid payment add-ons. Compared to other government expenditures, total government spending in the name of the uninsured is considerably less than spending on Medicare ($247 billion), Medicaid ($226 billion), and tax subsidies for private insurance ($138 billion), according to the authors of "How Much Medical Care Do the Uninsured Use, and Who Pays For It?." (6)

Federal Government

The federal government provided about two-thirds of total government spending on the uninsured, or about $19.9 billion, primarily through Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), and Indirect Medical Education (IME) payments to hospitals through Medicare and Medicaid, and through the Veteran's Administration (VA). (6)

State and Local Governments

State and local governments spent $10.7 billion on payments and programs to serve the uninsured, directed primarily to hospitals through tax appropriations and indigent care programs. (6)

As the cost of health care in general rises, local governments often have to take resources out of other programs to provide medical care for the uninsured. Facing a $6.9 million shortfall in a program to serve the medical needs of the uninsured, Hillsborough County, Florida, had to reallocate tax funds that had been planned for highway construction. Other cities have closed health facilities or converted them from public to for-profit largely because of the burden of providing uncompensated care. These changes affect not only the uninsured, but also the insured. (21)

Table 2, taken from the article, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" indicates that total available funding for uncompensated care may exceed the estimated $35 billion in uncompensated care received by the uninsured in 2001: (6)

TABLE 2

Sources of Funding Available for Uncompensated Care of the Uninsured, In Billions of 2001 Dollars

Provider and funding source	Private sources	Government spending			Total available for uncompensated care
		Federal	State/local	Total	
Hospitals	$2.3-4.6	$14.2	$9.4	$23.6	$25.9-28.2
Clinics	0.13	5.69	1.29	6.98	7.11
Physicians	5.10	--[a]	--[a]	--[a]	5.10
Total	7.5-9.8	19.9	10.7	30.6	38.1-40.4

SOURCE: Hadley J, Holahan J. How Much Medical Care Do the Uninsured Use, and Who Pays For It? Health Affairs Web Exclusive. 12 February 2003. Accessed at www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm on 5 December 2003.

[a] Not applicable.

These figures suggest that a substantial portion of the current cost of covering the uninsured is potentially available from existing sources to transfer to new government efforts to extend coverage to the uninsured and create a more efficient health care system. (6) According to Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured, "[This report demonstrates that] we are already paying a substantial amount to care for a large uninsured population without a guarantee of coverage. The implication is that we pay for care in the least efficient way possible—after people get sick and need emergency or hospital care." (22)

Cost Borne by Employers

Employers bear the cost of the uninsured through lost employee productivity, employee turnover, and employee absenteeism due to health reasons. According to the Commonwealth Fund's 2001 Health Insurance Survey, 16 percent of the uninsured were absent from work during the year because of a dental problem, compared with 8 percent of those with health insurance. (5) A more recent study found that common ailments--headaches, back pain, arthritis and other muscle and joint pain--cost the nation's employers $61.2 billion annually in lost workplace productivity and absenteeism. (23) Although the study did not specifically look at health insurance status, it is a good indicator of how much employers could save by keeping their workers healthy.

Healthier workers are generally more productive, earn higher wages, and are less likely to be absent from work because of illness, according to a 2001 study by the National Bureau of Economic Research. The authors noted that increased expenditures on improving health might be justified purely on the grounds of their impact on labor productivity after finding that a one-year improvement in a country's life expectancy translates into a four percent improvement in gross domestic product (GDP). (24)

Employers also bear the cost of the uninsured through taxes and the expense of providing employee health insurance. As reported in *The New York Times*, employers contribute federal taxes that help pay for programs that cover the greatest share of hospital costs for the uninsured. Furthermore, employers and managed care companies paid $1.5 billion to $3 billion through higher rates to cover part of the $24 billion hospitals spent caring for patients who could not pay their bills in 2001. (25) According to Kate Sullivan, director of health care policy at the United States Chamber of Commerce, "Employers are now subsidizing the uninsured and low-paying government programs like Medicare and Medicaid, to the detriment of their own employees. When the government programs pay 65 or 80 cents for a dollar of hospital care, employers end up paying $1.15 or $1.25 for that care." (25)

Cost Borne by the General Public

Public programs, including Medicare, Social Security Disability Insurance, and the social justice system almost certainly have higher budgetary costs than they would if the U.S. population in its entirety had health insurance up to the age of 65, according to the IOM's, *Hidden Costs, Value Lost*. (13) Although it is nearly impossible to estimate the extent to which costs are inflated, the impact of uninsurance on the budget of public programs can easily be conceptualized. For example, individuals with diabetes or poorly controlled hypertension due to irregular or no medical attention enter the Medicare program with more comorbidities and worse health status than those whose conditions have been treated over time, making them a larger burden to the Medicare program. (13)

Public Health Hazards

According to IOM's *Hidden Costs, Value Lost*, population-based resources are likely to be undermined by the competing demands for public dollars for personal health services for the uninsured. (13) When critical public health interventions are compromised, the insured are no better off than the uninsured. For example, a large rubella outbreak in New York in 1997, originated in a Hispanic immigrant community where most inhabitants had never received a rubella vaccination because of lack of health

insurance. Consequently, the immigrant community infected surrounding communities, including people who had health insurance. (26)

Similarly, population-level disease surveillance is reduced in communities with large uninsured populations since the uninsured are less likely than those with coverage to have a regular health care provider. (13) As a result, providers have less exposure to the earliest signs of an outbreak, which hinders both detection and containment efforts. This could be especially serious in the case of a bioterrorist attack, and equally threatening to the insured and uninsured. (27)

Reductions in Educational Attainment

According to the report *Sicker and Poorer: The Consequences of Being Uninsured*, children in poor health miss more school days and have lower cognitive development than their healthy counterparts. Lower educational attainment due to poor childhood health contributes to lower wages and lower labor force participation, which increases the likelihood of not being insured as an adult, thereby increasing one's odds of continued poor health as an adult. (8) A cycle is created which results in increased costs to the individual, the health system, and society as a whole.

Summary and Conclusion

The value of extending health insurance coverage to all Americans requires an understanding of the alternative—the cost of leaving over 15 percent of the population uninsured for all or part of the year. As this paper illustrates, the most integral cost estimate of the uninsured takes into account multiple factors, some more quantifiable than others.

In terms of direct costs to the health system (in 2001 dollars), the uninsured receive as much as $98 billion in medical care, $35 billion of which is considered uncompensated. (6) Total government spending on the uninsured is about $30 billion a year, representing the bulk of the cost of uncompensated care. Hospitals provide about $24 billion worth of uncompensated care, while physicians spend about $5.1 billion a year caring for patients who cannot pay their bills. (6) Meanwhile, employers and managed care companies spend between $1.5 billion and $3 billion through higher rates to cover part of the $24 billion hospitals spend caring for the uninsured. (6)

Although the indirect costs associated with lack of insurance are more difficult to calculate, this paper would not be complete without their consideration. Inadequate preventive care and delayed treatment among the uninsured yields substantial societal costs in terms of reduced life expectancy, lower workforce productivity, diminished educational attainment, imperiled public health, and the financial burden shouldered by uninsured individuals and communities.

The IOM report**,** *Hidden Costs, Value Lost*, estimates the aggregate, annualized cost of diminished health and shorter life span to be between $65 billion and $130 billion for each year of health insurance forgone. (13) This figure does not include the increased financial risk and uncertainty borne by the uninsured and their families, which is estimated to cost between $1.6 billion and $3.2 billion, nor does it account for the wide range of societal costs to which a price tag cannot be assigned.

Critics of universal coverage are quick to point out the high cost of the additional medical care that would be used by newly insured Americans if coverage were expanded. However, a report published in *Health Affairs* in June 2003, found that this amount may

not be as high as critics claim. The authors estimated that the uninsured would use about $34-$69 billion (in 2001 dollars) in additional medical care if they were fully insured, accounting for about 3-6 percent of total health care spending. While this amount may seem large in absolute dollars, an increase in medical spending of this range would increase health care's share of gross domestic product (GDP) by less than one percentage point. (28)

Given our discussion of the positive effects health insurance has on life expectancy, public health, educational attainment, production, and the economy in general, it appears that the benefits of covering the uninsured are greater than the costs of not insuring them. In a related analysis, the IOM found the estimated value of health gained when an uninsured child or adult is given an additional year of coverage ($1,645 to $3,280) to be higher than the estimated annual cost of the additional health care that the uninsured would use if insured ($1,004 to $1,866), resulting in a benefits-cost ratio of at least one for most values within each range. (13)

Health insurance has enormous health, social, and economic benefits that can be expressed in a plethora of ways. It is critical that in the debate of how to extend coverage to the uninsured both short and long-term benefits are fully considered since the latter may offset what many critics fear are the direct costs associated with such an expansion.

Notes

1. Davis, K. Time for Change: The Hidden Cost of a Fragmented Health Insurance System. Testimony given to U.S. Senate Special Committee on Aging. 10 March 2003. Accessed at www.cmwf.org/programs/insurance/davis_senatecommitteetestimony_execsumm_622.pdf on 5 December 2003.
2. Hoffman C, Wang M. Health Coverage in America: 2001 Data Update. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2003. Accessed at http://dev.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14309 on 5 December 2003.
3. U.S. Census Bureau. Health Insurance Coverage in the United States: 2002. September 2003.
4. American College of Physicians. No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health. White Paper. Philadelphia: American College of Physicians; 2000. Accessed at www.acponline.org/uninsured/lack-contents.htm on 5 December 2003.
5. Davis K. The Costs and Consequences of Being Uninsured. Med Care Res Rev. 2003; 60 (2): 89S-99S (Supplement to June 2003).
6. Hadley J, Holahan J. How Much Medical Care Do the Uninsured Use, and Who Pays For It? Health Affairs Web Exclusive. 12 February 2003. Accessed at www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm on 5 December 2003.
7. Siegrist, Jr. R, Kane N. Exploring the Relationship between Inpatient Hospital Costs and Quality of Care. Understanding the Inpatient Cost of Caring for the Uninsured. Am J Manag Care. 2003 Jun; 9 Spec No 1:SP43-9.
8. Hadley J. Sicker and Poorer: The Consequences of Being Uninsured The Cost of Not Covering the Uninsured Project. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; May 2002. Accessed at www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13970 on 5 December 2003.
9. Cunningham P, May J. Insured Americans Drive Surge in Emergency Department Visits. Issue Brief No. 70. Washington, DC: Center for Studying Health System Change; October 2003. Accessed at www.hschange.org/CONTENT/613/ on 5 December 2003.
10. Cunningham P. Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001. Tracking Report No. 6. Washington, DC: Center for Studying Health System Change; December 2002. Accessed at www.hschange.org/CONTENT/505/ on 5 December 2003.
11. Fairbrother G, Gusmano M, Park H, Scheinmann R. Care for the Uninsured in General Internists' Private Offices. Health Aff. 2003; 22(6):217-24.
12. Kaiser Commission on Medicaid and the Uninsured. Fact Sheet: The Uninsured and Their Access to Health Care. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; January 2003. Accessed at www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14185 on 5 December 2003.
13. Institute of Medicine. Hidden Costs, Value Lost. Consequences of Uninsurance Series, No. 5. Washington, DC: National Academies Press; 17 June 2003.
14. Reed M, Tu H. Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America. Issue Brief No. 49. Washington, DC: Center for Studying Health System Change; February 2002. Accessed at www.hschange.org/CONTENT/411/ on 5 December 2003.
15. Glied S, Little S. The Uninsured and the Benefits of Medical Progress. Health Aff. 2003; 22(4):210-19.
16. Duchon L, Schoen C, Doty M, Davis K, Strumpf E, Bruegman S. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. New York: The Commonwealth Fund; 2001. Accessed at www.cmwf.org/programs/insurance/duchon_securitymatters_512.pdf on 5 December 2003.
17. Freudenheim M. Workers Feel Pinch of Rising Health Costs. The New York Times. 22 October 2003. Accessed at www.nytimes.com/2003/10/22/business/22CARE.html on 5 December 2003.
18. Jaspen B. Uninsured Pay Twice As Much. The Chicago Tribune. 27 January 2003.

19. Singer I. Cost-Sharing and the Uninsured: Trends at Safety Net Institutions. Washington, DC: National Association of Public Hospitals and Health Systems; November 2000. Accessed at www.naph.org/Content/ContentGroups/Publications1/MON_2000_11_CostSharingandUninsured.pdf on 5 December 2003.
20. Andrulis D, Duchon L, Pryor C, Goodman N. Paying For Health Care When You're Uninsured: How Much Support Does the Safety Net Offer? Boston: The Access Project; January 2003. Accessed at www.accessproject.org/downloads/d_finexecsum.pdf on 5 December 2003.
21. Institute of Medicine. A Shared Destiny: Community Effects of Uninsurance. Consequences of Uninsurance Series, No. 4. Washington, DC: National Academies Press; 6 March 2003.
22. Health Affairs Press Release. U.S. Spent $35 Billion in 2001 to Care for the Uninsured with Government Picking Up Most of the Tab. 12 February 2003. Accessed at www.healthaffairs.org/press/janfeb0304.htm on 5 December 2003.
23. Stewart W, Ricci J, Chee E, Morganstein D, Lipton R. Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce. JAMA. 12 November 2003; 290(18):2443-2454.
24. Bloom D, Canning D, Sevilla J. The Effect of Health on Economic Growth: Theory and Evidence. Cambridge, MA: National Bureau of Economic Research; November 2001 (as quoted in: Advanced Medical Technology Association. Study Finds That Better Health Means a Better Economy. The New Health Economy. Washington, DC: AdvaMed). Accessed at www.advamed.org/publicdocs/newhealth-letter.html on 5 December 2003.
25. Freudenheim M. Businesses Begin to Consider the Cost for the Uninsured. The New York Times. 6 March 2003. Accessed at http://college3.nytimes.com/guests/articles/2003/03/06/1073863.xml on 5 December 2003.
26. Schlosberg C, Wiley D. The Impact of INS Public Determinations on Immigrant Access to Health Care. Washington, DC: National Health Law Program; 22 May 1998. Accessed at www.healthlaw.org/pubs/19980522publiccharge.html on 5 December 2003.
27. Alliance for Health Reform. Covering Health Issues: A Sourcebook for Journalists. Washington, DC: Alliance for Health Reform; 2003. Accessed at www.allhealth.org/sourcebook2002/ch1_4.html on 5 December 2003.
28. Hadley J, Holahan J. Covering the Uninsured: How Much Would It Cost? Health Affairs Web Exclusive. 4 June 2003. Accessed at http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.250v1/DC1 on 5 December 2003.