HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Access to Care

The issue

Health insurance is necessary but not sufficient to assure that low-income Americans obtain access to needed health care. A widely accepted view of access suggests that access depends not only on insurance, but also on characteristics of the individual, health care system variables, and other factors that can facilitate or impede the process of getting care. This conception of access highlights considerations separate from health insurance that need to be addressed in structuring health care for the low-income population.

The evidence

Many in the low-income population cycle on and off health insurance over the course of a year, obtaining coverage for themselves and/or their children, but losing eligibility some months later due to administrative requirements for recertification, a change in their income, non-payment of premiums, or other reasons. Researchers examining the impact of this dynamic on access to care have found that the gains in access that are associated with being insured do not materialize when coverage is unstable.

Access to care in Medicaid is linked to the supply of providers willing to accept the program's low-income beneficiaries, and provider participation in Medicaid is chronically inadequate. In provider surveys, low Medicaid payment rates and burdensome administrative requirements emerge as leading barriers to provider acceptance of Medicaid. Other studies have produced mixed findings concerning an association between Medicaid fee levels and provider participation, and the literature suggests that numerous factors affect Medicaid physician supply.

Access may be influenced also by the organization of health care delivery. Findings from research on the impact of managed care and disease management in Medicaid are varied and indicate that these arrangements can improve the coordination of care for low-income individuals, but can also impede access. This mixed evidence points to a need for more study of the mechanisms that affect access to care for low-income people under these arrangements.

The adequacy of the delivery system to address access barriers that are associated with low socioeconomic status is also an important variable. For the low-income population, transportation and arranging time off from work may present barriers to obtaining care. Individuals' ability to understand and navigate the health care system effectively also influences their access; in the low-income population, lower health status, lower health literacy, and language and cultural barriers may present particular challenges in this regard. Disparities in access to care that persist even within the insured low-income population suggest that the factors underlying access are not fully understood.

A further goal of access to care is the receipt of high-quality care. As the science of quality measurement and improvement evolves and new uses of quality information emerge, research is highlighting distinctive issues that arise in the context of the low-income population.

Stable, continuous health coverage is essential to improved access to care and ultimately, to improved health. Much evidence indicates that Medicaid's historically low payment levels have dampened provider participation, limiting access, particularly to specialty services. Provider payment levels that are adequate to secure provider participation, effective coordination of care, and measures to address an array of both financial and non-financial barriers to access are needed to convert the potential of health coverage into actual access to care for low-income Americans.

Key Evidence

Cycling on and off public coverage is problematic because instability in health coverage reduces individuals' access to care.

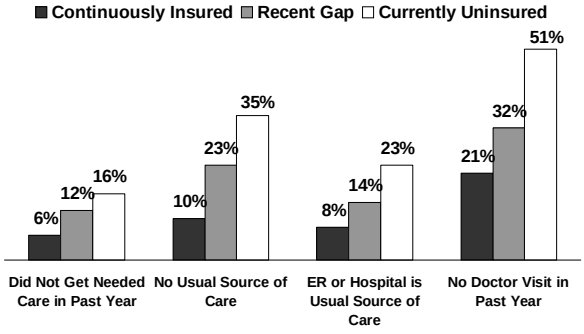
- Studies show that many low-income individuals and families cycle on and off the Medicaid and State Children's Health Insurance Program (SCHIP) rolls and experience spells without insurance. Burdensome application requirements, premiums, short eligibility periods, low provider reimbursement, and lack of provider contact have been linked to this instability in public coverage.[1] [2] [3] [4] [5]

- Relative to stable coverage, cycling on and off coverage has been found to lead to poorer access to and use of care, poorer management of chronic conditions, increased hospitalizations, and, ultimately, poorer health outcomes. Data from three different surveys analyzed in one study indicate higher rates of access problems, less connection with regular sources of care, and more medical cost problems among adults who had recent lapses in coverage relative to adults with continuous insurance. The insured adults with a recent lapse in insurance reported these problems at rates approaching the levels found among currently uninsured adults (Fig. 37).[6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16]

Figure 37

Access and Care Experiences, by Continuity of Insurance

Working-Age Adults



SOURCE: Schoen and DesRoches, "*Uninsured and Unstably Insured: The Importance of Continuous Coverage,"* Health Services Research, April 2000.

- The National Committee on Quality Assurance has a one-year standard for quality monitoring of health plans. The reasoning is that health plans need at least a year to affect performance, and thus should not be held accountable for levels of services to those enrolled for less than a year. Research examining the business case for provider investments in quality improvements has pointed out the challenges in aligning financial incentives properly in a fragmented health system in which the patient moves among different providers, employers, and payers.[17] [18] [19]

Inadequate participation of providers and plans can hinder appropriate access to care. Acceptable payment rates appear necessary but perhaps not sufficient to garner adequate provider participation.

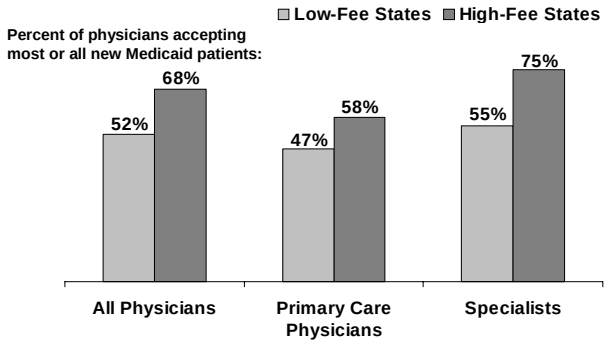
- High Medicaid acceptance rates by physicians in a community have been shown to be an important factor affecting access to care for Medicaid enrollees. An analysis that modeled the impact of the supply of physicians accepting Medicaid on beneficiary access to care found a significant association between higher predicted participation rates and a higher probability of having a usual source of care, a lower probability of having unmet medical needs, and a higher probability of being satisfied with the choice of specialists. Another study related the low use of oral health services in the low-income population to the

inadequate supply of dentists willing to treat them. Other research found that increased Medicaid reimbursement led to significantly less drop-out of eligible children from Medicaid, ostensibly due to wider access to care for enrollees and more incentive for providers to keep patients enrolled.[20] [21]

- Provider surveys point to low payment and excessive paperwork and administrative burdens as leading reasons for provider unwillingness to serve Medicaid patients. The evidence from other research is mixed on the question of whether higher Medicaid payment levels lead to higher provider participation rates and beneficiary access (Fig. 38). Several studies suggest that other provider practice, health system, and community characteristics also affect provider participation.[22] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] [33] [34] [35] [36] [37]

Figure 38

Physicians' Acceptance of Medicaid Patients in High-Fee vs. Low-Fee States, 2001



Note: Differences are significant at p<.05.
SOURCE: Zuckerman et al, "*Trends: Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation,"* Health Affairs, Web Exclusive, June 23, 2004.

- Provider participation in Medicaid is particularly limited among dentists and in some specialties. Physicians report more difficulty making specialty referrals for their Medicaid patients than for their patients with private insurance or Medicare.[38] [39] [40]

- A recent study evaluated the impact that reforms to South Carolina's Medicaid Dental program had on the number of children receiving dental services through the program. In 2000, the state increased reimbursement rates for dentists, streamlined Medicaid billing procedures, and worked with community partners to recruit dentists to the program and encourage compliance among patients with appointments and treatments. As a result of the reforms, there was a statistically significant increase in the monthly number of children receiving dental services through Medicaid.[41]

- Although EPSDT requirements entitle children to the full range of Medicaid benefits permitted under federal law, research indicates that low provider payment rates, provider shortages, inadequate screening of children, poor data reporting, patient care-seeking behavior, and other factors have kept EPSDT from accomplishing its full potential to secure access to care for low-income children.[42] [43] [44] [45]

- Numerous studies on the use of emergency departments (EDs) suggest that, independent of insurance coverage, inadequate access to primary care is associated with higher rates of ED use overall and for non-urgent care. Findings from a site visit study in 12 nationally representative communities in 2005 are illustrative. Respondents reported that the use of EDs for primary care has intensified recently, a fact many attributed to inadequate access to primary care, especially for Medicaid enrollees and the uninsured. They cited increasing unwillingness among primary care physicians to accept more patients, and some respondents reported that primary care physicians routinely refer Medicaid and uninsured patients to EDs for non-urgent care. Frustrated with trying to secure specialty care for low-income patients,

some primary care physicians refer patients to the ED in the hope that they will gain access to specialty care.[46 47 48 49 50 51 52]

Managed care and other organized care delivery systems have had mixed results in improving access and coordination of care for low-income populations. Approaches designed for the general population may need to be refined for the low-income population.

- Research on the relationship between managed care arrangements and health care access in the low-income population and in Medicaid has produced mixed evidence. Some studies find improved access to and use of preventive and primary care, higher satisfaction, lower unmet need, lower emergency department use, and reduced preventable hospitalizations associated with managed care. However, others indicate increased unmet need and reduced utilization and still others show no consistent effect of managed care on access.[53 54 55 56 57 58 59 60 61 62 63 64 65 66]

- Studies have provided evidence that disease management initiatives can improve chronic disease management among low-income people and improve health outcomes. Researchers found that Virginia Medicaid patients whose doctors received instruction on recommended asthma care and drugs, training in patient communication, and lists identifying patients needing follow-up had reduced emergency visits and better use of some asthma drugs. Community-level gains occurred as well, relative to communities where the training was not offered. Other research found that outcomes improved for a largely low-income diabetic population served by health centers participating in a diabetes management program.[67 68]

- Studies of Medicaid disease management programs in several states indicate that these programs have promise but have yet to be rigorously evaluated. Unique characteristics of the Medicaid population and program appear to pose special challenges. In particular, instability in Medicaid enrollment and provider turnover mitigate the potential impact of the initiatives. In addition, limited medical history data and data lags in Medicaid hinder timely identification of high-risk beneficiaries. Regarding management of chronic mental health and substance abuse disorders, the difficulty of coordinating between the Medicaid agency and multiple other state and community agencies with different priorities, constituencies, and funding has been noted. Provider resistance and concerns that disease management may reduce Medicaid beneficiaries' access to providers have also been cited.[69 70 71 72]

A constellation of issues distinct from health insurance coverage, including transportation, child care, and time off from work, as well as minority race/ethnicity, health literacy, and cultural competence of health care providers, may present obstacles to health care access for low-income Americans. Addressing these barriers can improve access for this population.

- Medicaid enrollees have cited convenience of location and waiting time for both routine and urgent care as important considerations in their choice of health plans. While they indicate strong feelings about other aspects of care, they often report their choice of plans being constrained by their transportation needs. In a survey on access to prenatal care among low-income and uninsured women who deliver at safety-net hospitals, transportation and lack of insurance were the most commonly cited obstacles to timely and adequate prenatal care.[73 74]

- A study comparing the impact of three different health insurance models on improving health care access for low-income children found that one of several key factors associated with the most successful model was the availability of after-hours care in settings other than the emergency room.[75]

- In a model controlling for Medicaid status and numerous other factors, children living below or near the poverty level were at significantly greater risk of going without needed services than those with more income, a research finding that may suggest the presence of non-financial barriers, such as transportation barriers and limited control over work hours. Other research has documented the role of waiting time for appointments, lack of transportation, lack of childcare for siblings, low levels of parental education, lack of parental knowledge about prevention and health care needs, and other non-financial barriers in impeding access to care.[76] [77] [78] [79] [80]

- The Institute of Medicine has found that understanding and use of health information are lower among certain populations, including the elderly, those with less education, the poor, minorities, and groups with limited English proficiency such as recent immigrants. Adults with limited health literacy have less knowledge of disease management and of health-promoting behaviors, report poorer health status, and are less likely to use preventive services.[81]

- Ethnic minorities, especially Hispanics and Asians, report less satisfaction with their care, more difficulty getting appointments, less satisfaction with their physicians' listening skills and explanations, and less trust in their doctors. Language has been documented as an additional barrier.[82] [83] [84] [85] [86]

- Some health services research uses "preventable hospitalization" – hospitalization for a condition that can be managed effectively on an outpatient basis – as a proxy measure for inadequate access to primary care. Studies showing that racial/ethnic and socioeconomic disparities in preventable hospitalization rates persist even when insurance differences are controlled suggest that the mechanisms of access have not been fully explained.[87] [88] [89]

- Inadequate health literacy, language barriers, and poor cultural competence are strongly correlated with poorer knowledge and self-care among people with various chronic diseases. Research on disease management, which often emphasizes improved self-care, suggests that patient education materials need to address lower health literacy, language barriers, and racial and ethnic diversity in the Medicaid population.[90] [91] [92] [93] [94] [95]

- A study of strategies to improve asthma care for children in Medicaid managed care found that patients of the practice sites with the highest cultural competence scores were more likely to use preventive asthma medications, had better control of their asthma at follow-up, and had better parent ratings of care. Asthma patients in practice sites that had policies to promote access and continuity of care (e.g., 24/7 telephone advice, promoted preventive asthma visits, better follow-up care) also had better outcomes than patients in other sites.[96]

Those with worse health status are at higher risk of having access problems.

- People who report fair or poor health are almost three times as likely not to get needed care as people who report their health as good or excellent – 13% versus 4.6% in 2001. People with health problems are also more likely to delay care than healthier people. Greater difficulty getting care among those in worse health reflects, in large part, their greater need for care and more frequent opportunities to encounter problems with the health care system.[97]

Efforts to improve quality and market strategies that rely on quality information may face distinctive challenges with respect to the low-income population.

- Efforts to improve quality in Medicaid managed care face an array of challenges not present in the private insurance sector. These include turnover in health plans and enrollment, the high prevalence of special health care needs, gaps in knowledge about which activities and structures improve the health of beneficiaries, and the need for a commitment of sufficient public dollars for quality monitoring and improvement.[98]

- There is some evidence that public reporting of health care quality information has a positive impact on quality improvement, but public reporting has also prompted concerns related to disadvantaged populations. For example, a study that found low comprehension of quality indicators across privately insured, Medicaid-covered, and uninsured consumers nonetheless found that the privately insured had a significant advantage in their grasp of concepts key to using quality information for decision-making. Also, some have cautioned that public reporting of quality information that does not adjust well for health differences might lead providers to avoid higher-risk patients, many of whom are concentrated in the low-income population.[99] [100] [101]

Endnotes

[1] Perry M et al, *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*, Kaiser Commission on Medicaid and the Uninsured, January 2000.

[2] Wooldridge J et al, *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program*, U.S. Department of Health and Human Services, 2003.

[3] Cohen Ross D and L Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

[4] *SCHIP Disenrollment and State Policies*, Children's Health Insurance Research Initiative (CHIRI) Issue Brief No. 1, June 2002.

[5] Sommers B, "*From Medicaid to Uninsured: Drop-out Among Children in Public Insurance Programs*," Health Services Research, 40(1), February 2005.

[6] Sudano J and D Baker, "*Intermittent Lack of Health Insurance Coverage and Use of Preventive Services*," American Journal of Public Health, 93(1), January 2003.

[7] Fairbrother G and A Haidery, *How Would Stable Insurance Coverage Increase the Quality of Care?* New York Academy of Medicine, report prepared for New America Foundation, October 2004.

[8] Schoen C and C DesRoches,"*Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage*," Health Services Research, 35(1), Part II, April 2000.

[9] Burstin H et al, "*The Effect of Change of Health Insurance on Access to Care*," Inquiry, Winter 1998/99.

[10] Kogan M et al, "*The Effect of Gaps in Health Coverage on Continuity of a Regular Source of Care Among Preschool-Aged Children in the United States*," Journal of the American Medical Association, 274(18), November 1995.

[11] Hoffman C et al, "*Gaps in Health Coverage Among Working-Age Americans and the Consequences*," Journal of Health Care for the Poor and Underserved, 12(3), August 2001.

[12] Duchon L et al, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk*, Commonwealth Fund, December 2001.

[13] Short P and D Graefe, "*Battery-Powered Health Insurance? Stability in the Coverage of the Uninsured*," Health Affairs, November/December 2003.

[14] America's Children: Health Insurance and Access to Care, Institute of Medicine and National Research Council, 1998.

[15] Olson L et al, "*Children in the United States with Discontinuous Health Insurance Coverage*," New England Journal of Medicine, 353(4), July 28, 2005.

[16] Harman J et al, "*Association between Interruptions in Medicaid Coverage and Use of Inpatient Psychiatric Services*," Psychiatric Services, 54(7), July 2003.

[17] Fairbrother and Haidery, 2004.

[18] *HEDIS 2003 Volume 2 Technical Specifications*, National Committee for Quality Assurance.

[19] Leatherman S et al, "*The Business Case for Quality: Case Studies and an Analysis*," Health Affairs, March/April 2003.

[20] Cunningham P and L Nichols, "*The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*," Medical Care Research and Review, 62(6), December 2005.

[21] *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, U.S. General Accountability Office, September 2002.

[22] Schoenman J and J Feldman, *Results of the Medicare Payment Advisory Commission's 2002 Survey of Physicians*, Medicare Payment Advisory Commission, March 2003.

[23] *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, U.S. General Accountability Office, September 2001.

[24] Yudkowsky B et al, *Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000*, October 2000.

[25] Cunningham P and J May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Center for Studying Health System Change, August 2006.

[26] Gold M et al, "*Participation of Plans and Providers in Medicaid and SCHIP Managed Care*," Health Affairs, January/February 2003.

[27] Wang E et al, "*Inequality of Access to Surgical Specialty Health Care: Why Children with Government-Funded Insurance Have Less Access Than Those with Private Insurance in Southern California,"* Pediatrics, 114(5), November 2004.

[28] Zuckerman S et al, "*Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation*," Health Affairs, Web Exclusive, June 23, 2004.

[29] Cunningham and Nichols, 2005.

[30] Adams E, "*Factors Affecting Physician Provision of Preventive Care to Medicaid Children*," Health Care Financing Review, 22 (4), Summer 2001.

[31] Fox M et al, "*Effect of Medicaid Payment Levels on Access to Obstetrical Care*," Health Affairs, Winter 1992.

[32] Asplin B et al, "*Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments*," Journal of the American Medical Association, 294(10), September 14, 2005.

[33] Berman S et al, "*Factors that Influence the Willingness of the Private Primary Care Pediatricians to Accept More Medicaid Patients*," Pediatrics, 10(2), August 2002.

[34] Perloff J et al, "*Which Physicians Limit Their Medicaid Participation, and Why*," Health Services Research, 30(1), April 1995.

[35] Hughes R et al, "*Dentists' Participation and Children's Use of Services in the Indiana Dental Medicaid Program and SCHIP*," Journal of the American Dental Association, April 2005.

[36] Coburn A et al, "*Effects of Changing Medicaid Fees on Physician Participation and Enrollee Access*," Inquiry, Fall 1999.

[37] Shen Y and S Zuckerman, "*The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries*," Health Services Research, 40(3), June 2005.

[38] Skaggs D et al, "*Access to Orthopedic Care for Children with Medicaid versus Private insurance in California*," Pediatrics, 2001.

[39] Resneck J et al, "*Medicare, Medicaid, and Access to Dermatologists: The Effect of Patient Insurance on Appointment Access and Wait Times,"* Journal of the American Academy of Dermatology, 50(1), January 2004.

[40] Schoenman and Feldman, 2003.

[41] Neitert P et al, "*The Impact of an Innovative Reform to the South Carolina Dental Medicaid System*," Health Services Research, 40(4), August 2005.

[42] *Medicaid: Elevated Blood Lead Levels in Children*, U.S. General Accountability Office, February 1998.

[43] *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children*, U.S. General Accountability Office, January 1999.

[44] "*The Use of EPSDT and Other Health Care Services by Children Enrolled in Medicaid: The Impact of OBRA '89,"* The Milbank Quarterly, 76(2), 1998.

[45] *Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, U.S. General Accountability Office, July 2001.

[46] Oster A and A Bindman, "*Emergency Department Visits for Ambulatory Care Sensitive Conditions: Insights into Preventable Hospitalizations*," Medical Care, 41(2), February 2003.

[47] Lowe R et al, "*Association Between Primary Care Practice Characteristics and Emergency Department Use in a Medicaid Managed Care Organization*," Medical Care, 43(8), August 2005.

[48] Billings J et al, *Emergency Department Use in New York City: A Substitute for Primary Care?* Commonwealth Fund, November 2000.

[49] Larkin G et al, "*Trends in U.S. Emergency Department Visits for Mental Health Conditions*," Psychiatric Services, 56(6), June 2005.

[50] Johnson W and M Rimsza, "*The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization*," Pediatrics, 113(3), March 2004.

[51] Halfon N et al, "*Routine Emergency Department Use for Sick Care by Children in the United States,"* Pediatrics, 98(1), July 1996.

[52] O'Malley A et al, *Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System*, Center for Studying Health System Change, November 2005.

[53] Bindman A et al, "*The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions*," Health Services Research, 40(1), February 2005.

[54] Sisk J et al, "*Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use*," Journal of the American Medical Association, 276(1), July 3, 1996.

[55] Gadomski A et al, "*Impact of a Medicaid Primary Care Provider and Preventive Care on Pediatric Hospitalization*," Pediatrics, 101(3), March 1998.

[56] Zuckerman S et al, "*Has Medicaid Managed Care Affected Beneficiary Access and Use?*" Inquiry, Fall 2002.

[57] Lillie-Blanton M and B Lyons, "*Managed Care and Low-Income Populations: Recent State Experiences*," Health Affairs, May/June 1998.

[58] Garrett B et al, "*Effects of Medicaid Managed Care Programs on Health Services Access and Use*," Health Services Research, 28(2), April 2003.

[59] Basu J et al, "*Managed Care and Preventable Hospitalization Among Medicaid Adults,*" Health Services Research, 39(3), June 2004.

[60] Piehl M et al, "*Narrowing the Gap: Decreasing Emergency Department Use by Children Enrolled in the Medicaid Program by Improving Access to Primary Care*," Archives of Pediatric and Adolescent Medicine, August 2000.

[61] Long S and T Coughlin, "*Impacts of Medicaid Managed Care on Children*," Health Services Research, 36(1), April 2001.

[62] Garrett B and S Zuckerman, "*National Estimates of the Effects of Mandatory Medicaid Managed Care Programs on Health Care Access and Use, 1997-1999*," Medical Care, 43(7), July 2005.

[63] Mitchell J et al, "*Impact of the Oregon Health Plan on Children with Special Health Care Needs*," Pediatrics, 107(4), April 2001.

[64] Schoenman J et al, "*Primary Care Case Management for Medicaid Recipients: Evaluation of the Maryland Access to Care Program*," Inquiry, Summer 1997.

[65] Phillips K et al, "*Barriers to Care among Racial/Ethnic Groups under Managed Care*," Health Affairs, July/August 2000.

[66] Ware J et al, "*Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*," Journal of the American Medical Association, 276(13), October 1996.

[67] Felt-Lisk S et al, *Evaluation of HRSA's Clinical Pharmacy Demonstration Projects, Final Report,* U.S. Department of Health and Human Services, November 30, 2004.

[68] Rossiter L et al, "*The Impact of Disease Management on Outcomes and Cost of Care: A Study of Low-Income Asthma Patients*," Inquiry, Summer 2000.

[69] White C et al, *State Medicaid Disease Management: Lessons Learned from Florida*, Duke University, March 2005.

[70] Williams C, *Medicaid Disease Management: Issues and Promises*, Kaiser Commission on Medicaid and the Uninsured, September 2004.

[71] Gelber S and R Dougherty, *Disease Management for Chronic Behavioral Health and Substance Abuse Disorders,* Center for Health Care Strategies, February 2005.

[72] *An Analysis of the Literature on Disease Management Programs*, Congressional Budget Office, October 2004.

[73] Gibbs D et al, "*Consumer Perspectives on Information Needs for Health Plan Choice*," Health Care Financing Review, 18(1), Fall 1996.

[74] Regenstein M et al, *Barriers to Prenatal Care: Survey of Low-Income and Uninsured Women Who Deliver at Safety Net Hospitals*, National Public Health and Hospitals Institute, October 2005.

[75] Rosenbach M et al, "*Access for Low-Income Children: Is Health Insurance Enough?*" Pediatrics, 103(6), June 1999.

[76] Dusing S et al, "*Unmet Need for Therapy Services, Assistive Devises, and Related Services: Data from the National Survey of Children with Special Health Care Needs*," Ambulatory Pediatrics, 4(5), September/October 2004.

[77] *Does Health Insurance Make a Difference?* Background Paper, Office of Technology Assessment, U.S. Congress, September 1992.

[78] *National Healthcare Disparities Report 2004*, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

[79] Sarver J et al, "*Usual Source of Care and Non-Urgent Emergency Department Use*," Academic Emergency Medicine, September 2002.

[80] America's Children: Health Insurance and Access to Care, 1998.

[81] Health Literacy: A Prescription to End Confusion, Institute of Medicine of the National Academies, 2004.

[82] Weech-Moldonado R et al, "*Race/Ethnicity, Language, and Patients' Assessment of Care in Medicaid Managed Care*," Health Services Research, 38(3), June 2003.

[83] Ngo-Metzger Q et al, "*Asian Americans' Reports of their Health Care Experiences: Results of a National Survey*," Journal of General Internal Medicine, 19(2), February 2004.

[84] Johnson R et al, "*Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care*," Journal of General Internal Medicine, 19(2), April 2004.

[85] Phillips et al, 2000.

[86] Baker D et al, "*Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients*," Medical Care, 36(10), October 1998.

[87] Pappas G et al, "*Potentially Avoidable Hospitalizations: Inequalities in Rates Between US Socioeconomic Groups*," American Journal of Public Health, 87(5), May 1997.

[88] Gaskin D and C Hoffman, "*Racial and Ethnic Differences in Preventable Hospitalizations Across 10 States*," Medical Care Research and Review, 57 Supplement 1, 2000.

[89] Blustein J et al, "*Preventable Hospitals and Socioeconomic Status*," Health Affairs, March/April 1998.

[90] Williams M et al, "*Inadequate Literacy is a Barrier to Asthma Knowledge and Self-Care*," Chest, 114(4), October 1998.

[91] Williams M et al, "*Relationship of Functional Health Literacy to Patients' Knowledge of Their Chronic Diseases: A Study of Patients with Hypertension and Diabetes*," Archives of Internal Medicine, January 1998.

[92] Chan K et al, "*How Do Ethnicity and Primary Language Spoken at Home Affect Management Practices and Outcomes in Children and Adolescents with Asthma?*" Archives of Pediatric and Adolescent Medicine, March 2005.

[93] Williams, 2004.

[94] White et al, 2005.

[95] Lieu T et al, "*Cultural Competence Policies and Other Predictors of Asthma Care Quality for Medicaid-Insured Children*," Pediatrics, 113(1), July 2004.

[96] Stanton M and D Dougherty, "*Chronic Care for Low-Income Children with Asthma: Strategies for Improvement*," Research in Action, Issue #18, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, June 2005.

[97] Strunk B and P Cunningham, *Treading Water: Americans' Access to Needed Medical Care, 1997-2001*, Center for Studying Health System Change, March 2002.

[98] Felt-Lisk, "*Monitoring Quality in Medicaid Managed Care: Accomplishments and Challenges at the Year 2000*," Journal of Urban Health: Bulletin of the New York Academy of Medicine, 77(4), December 2000.

[99] Hibbard J et al, "*Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?*" Health Affairs, March/April 2003.

[100] Jewett J and J Hibbard, "*Comprehension of Quality Care Indicators: Differences Among Privately Insured, Publicly Insured, and Uninsured*," Health Care Financing Review, 18(1), Fall 1996.

[101] Werner R and D Asch, "*The Unintended Consequences of Publicly Reporting Quality Information,*" Journal of the American Medical Association, 293(10), March 9, 2005.