

Healthcare Access and Delivery

The American healthcare system, responsible for meeting the needs of over 307 million Americans, consumes nearly one-sixth of the U.S. economy (Census, 2010 and DH&HS, 2010). This chapter will examine the current U.S. healthcare system in terms of some of its most pressing issues and challenges, including increasing cost, the weak economy, rising number of people without health insurance, variable quality of care and outcome disparities. The final section of this chapter will briefly discuss how the healthcare reform, as legislated by the Patient Protection and Affordable Care Act, will address each of these issues.

Recent studies by the Organization for Economic Cooperation and Development (OECD) have evaluated the U.S. healthcare system against various systems in other countries and found that it has not compared well on issues related to cost, access and health outcomes (OECD, 2009).

“Although national health spending is significantly higher than the average rate of other industrialized countries, the U.S. is the only industrialized country that fails to guarantee universal health insurance and coverage is deteriorating, leaving millions without affordable access to preventive and essential health care. Quality of care is highly variable and delivered by a system that is too often poorly coordinated, driving up costs, and putting patients at risk. With rising costs straining family, business, and public budgets, access deteriorating and variable quality, improving health care performance is a matter of national urgency.”

Why Not the Best? *Results from a National Scorecard on U.S. Health System Performance* The Commonwealth Fund Commission on a High Performance Health System. September 2006

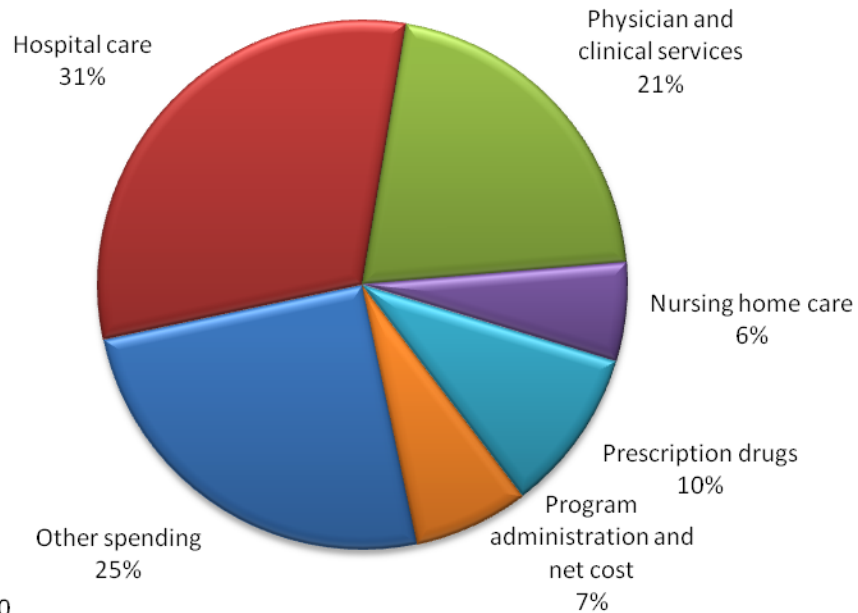
Cost of Care

American citizens spend more of their gross domestic product (GDP) on healthcare than any other developed country (OECD, 2009). Currently, it is estimated that one-sixth (projected to be 17.6 % in 2009) of the U.S. GDP is used to pay for healthcare (DH&HS, 2010). According to a recent OECD report, the average for OECD countries is 8.9%.

The Centers for Medicare and Medicaid Services (CMS) estimated that Americans spent over \$2.5 trillion on healthcare in 2009. This equates to \$8,160 per U.S. resident (KFF, 2009). CMS projects that by 2018, healthcare spending in the U.S. could reach over \$4.3 trillion or \$13,100 per resident, and account for 20.3% of GDP.

Overall, healthcare spending in 2008 was fairly evenly split between private and public sources. Private insurance, out-of-pocket and other private sources accounted for 52%, while government programs, including Medicare, Medicaid, SCHIP and other public sources, accounted for 48% (CMS, 2010).

Uses of U.S. Healthcare Funds – 2008



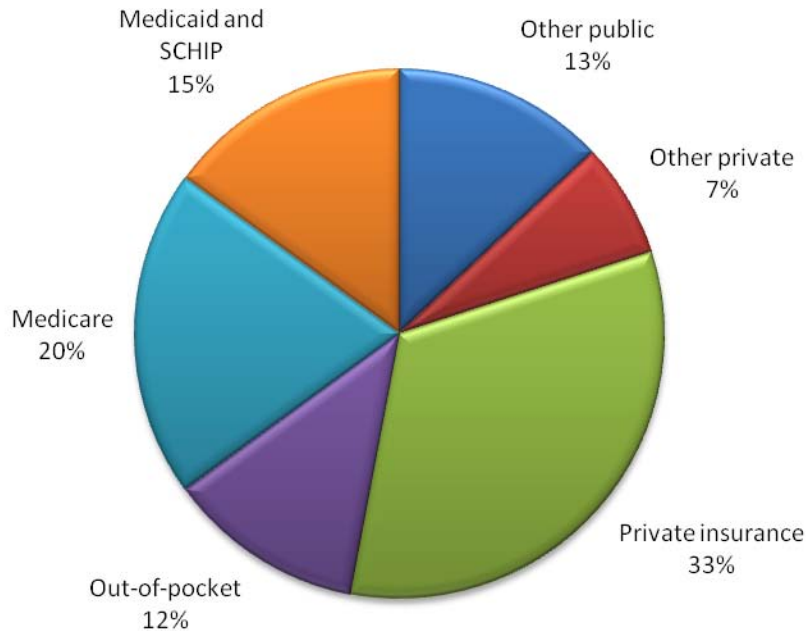
Source: CMS, 2010

CMS projects public spending will increase during the next 10 years as baby boomers become eligible for Medicare.

In 2008, Americans spent 31% of their healthcare dollars on hospital care and 21% on physician and clinical services. Other spending included dentist services, other professional services, home health, durable medical products, over-the-counter medicines, sundries, public health, other personal health care, research and structures, and equipment.



Source of Funding for U.S. Healthcare – 2008



Source: CMS, 2010

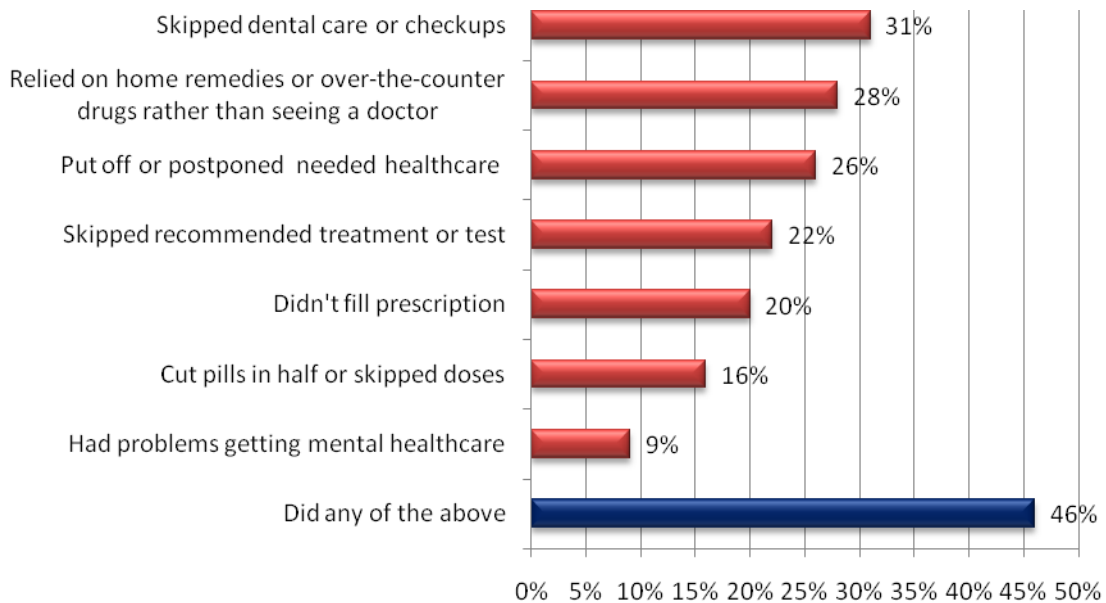
While most of the costs associated with healthcare are paid by either private insurance or government programs, individuals still must pay out-of-pocket costs for healthcare, including health insurance premiums, deductibles and copayments.

A June 2010 study by the Kaiser Family Foundation found 21 percent of Americans have had trouble paying their medical bills during the past year (KFF, 2010). Among those without medical insurance, the rate was significantly higher, with 53% reporting problems. Problems associated with medical bills include being contacted by a collection agency, using savings, not paying other bills, borrowing money and not being able to pay for basic necessities.

Other indicators of difficulties in paying for medical expenses are the actions people are taking to reduce their out-of-pocket costs associated with health care. The 2010 Kaiser survey reported that nearly half of Americans (45%) have taken some action during the past 12 months to reduce their healthcare costs.

Putting Off Care Because of Cost

Percent who say in the past 12 months, they or another family member in their household has done each because of the cost



Source: KFF, 2010

Among those without health insurance, almost three-fourths reported they had delayed or skipped care in the past year. Putting off needed care, relying on home remedies or over-the-counter drugs and skipping dental care were the most frequently mentioned, 62%, 58% and 57%, respectively.

While the costs associated with healthcare continue to increase, there does not seem to be an increase in the quality of healthcare received. A 2008 study by the Agency for Healthcare Research and Quality (AHRQ) found that between 2001 and 2005, total annual healthcare expenditures increased at a rate of 4.6 times the rate of the increase in the summary measure of quality of care. During this period, the annual total healthcare expenditures rose 6.5%, while the quality increased at a rate of 1.4% (NHQR, 2008).

Economic Recession (Impact on coverage, type of coverage and utilization)

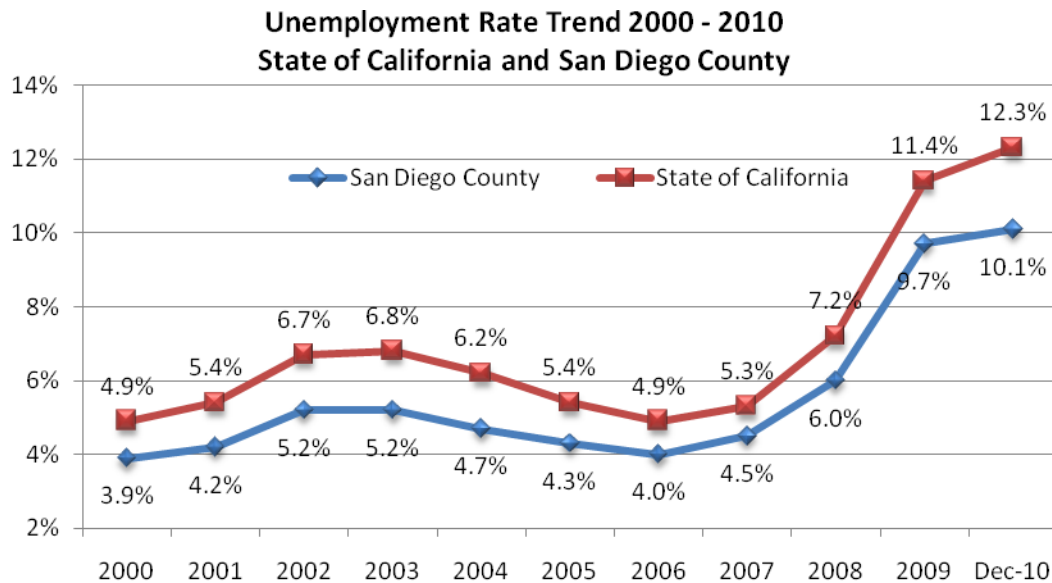
The economic recession that began in December 2007 has been more severe than any economic downturn since the Great Depression.

The National Bureau of Economic Research defines an economic recession as significant decline in the economy which usually lasts for months. The economic downturn is measured in consumer spending, employment, industrial production, real income and wholesale trade. A key indicator of this is two consecutive quarters of negative growth, which is measured by the gross domestic product.

The Business Cycle Dating Committee of the National Bureau of Economic Research indicated the most current recession began in December 2007 and ended in June of 2009. This recession lasted 18 months, which makes it the longest of any recession since World War II. Previously the longest postwar recessions were those of 1973-75 and 1981-82, both of which lasted 16 months (NBER, 2010).

On an individual basis, if impacted by the recession, the most frequent symptom is a decline in income precipitated by a loss of employment or curtailment of hours worked. Depending on the length of unemployment and the individual's financial reserves, the consequences of a recession can range from fiscal belt tightening to financial devastation.

During the past 10 years, the unemployment rate in San Diego County has varied from 3.9% in 2000 to 10.6% in September 2010.



Source: EDD, 2011

There are many health consequences of losing a job; some of these include:

Changes in Health Insurance Coverage – Losing a job often means people lose their health insurance. In 2009, more than one in five adults under age 65 (22%) were uninsured, which puts their health and financial security at risk. While some people can use the health insurance benefits available under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows them to continue paying their

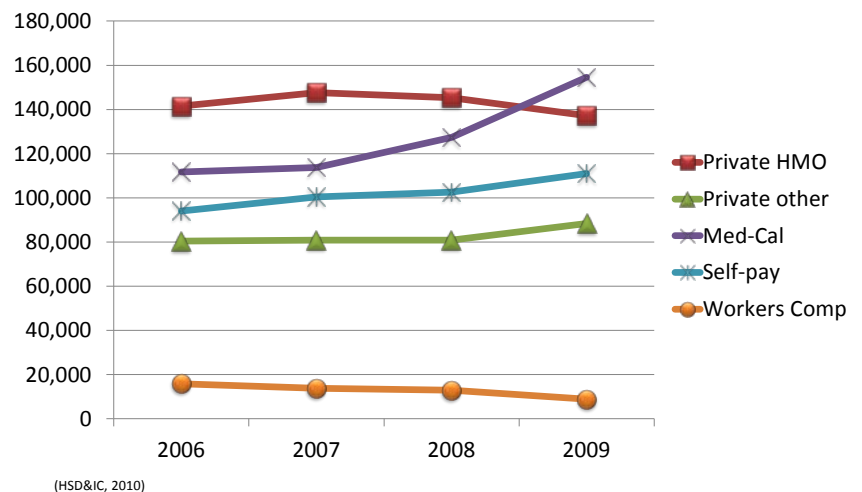
own premiums for up to 18 months after job loss, the cost is often prohibitive for someone who has just lost his or her income.

Current insurance estimates provided by the UCLA Center for Health Policy Research indicate that 22.9% of those under age 64 living in San Diego County are currently uninsured. Statewide, the uninsured rate was 24.3% (LA Times, 2010). This data was derived from 2007 California Health Interview Survey (CHIS), county unemployment and household income data, and county-level Medi-Cal and Healthy Families public health insurance enrollment data from 2007 to 2009. Additional information about insurance coverage from the 2009 CHIS is expected to be released in February 2011.

Changes in Healthcare Utilization – Providers’ reluctance to treat uninsured patients frequently results in many uninsured adults not having a usual source of healthcare. A recent study by Kaiser Family Foundation indicated that over half of uninsured adults have no regular source of healthcare. Moreover, because of concerns about high medical bills, they are more than twice as likely to delay or forgo needed care (KFF, 2010).

Higher Emergency Department Utilization – Rising rates of the uninsured may be reflected in higher use of emergency departments, which by law must provide at least stabilizing care to all patients regardless of ability to pay. Review of San Diego County ED discharges by source of payment between 2006 and 2009 found the demand for ED services increased by 11.9%, from 582,129 to 651,595 visits. (Note: discharges with missing payor information have been excluded from this analysis.) In addition, several shifts in payor sources were noted, including a decline in private HMO and Worker Compensation ED discharges and increases in both self-pay and Medi-Cal ED discharges. The decline in private HMO coverage was offset by a slight increase in other private insurance. The increase in self-pay and Medi-Cal discharges suggests more patients are relying on ED care due to lack of insurance coverage.

Emergency Department Discharges by Payor Source
San Diego County, 2006 – 2009



Higher Primary Care Clinic Utilization – Community clinics in San Diego County have experienced rising rates of primary care clinic utilization. Review of the California Office of Statewide Health Planning and

Development Annual Utilization Report of Primary Care Clinics between 2005 and 2009 found that the number of persons utilizing the clinics has increased by 32.7%. Between 2008 and 2009, utilization increased by 14.4% (OSHPD, 2010)

Competing Demands for the Family Budget – The loss of income, jobs and assets associated with a recession forces families in distress to make choices about how they will use their limited resources. For many, that means deciding among competing demands for food, housing and healthcare (Ku, 2009).

Impact on Hospitals – A special report issued by the California Hospital Association in July 2009, highlighted some of the serious negative impacts the economic recession is having on California hospitals (CHA, 2009). These include:

- Decreases in total operating margins – 45% of hospitals reported decreases in operating margins.
- Declining reimbursement rates – During the first quarter of 2009, 51% of hospitals reported an increase in patients covered by Medi-Cal.
- Increases in bad debt and charity care costs – 60% of hospitals reported an increase in bad debt and charity care provided.
- Increases in non-payment of hospital bills – During 2009, bad-debt expenses rose 14% due to patients' inability to cover their cost of care, even if they had health coverage.
- Declines in the number of elective procedures – 58% of hospitals reported a decrease in elective procedures and 51% reported an overall decrease in admissions.



Health Insurance Coverage

The U.S. Census Bureau reported recently that the number of people with health insurance in the United States has dropped for the first time in 23 years. According to the latest data available, there were 253.6 million people with health insurance in 2009, down from 255.1 million in 2008. This marks the first time that a decline was noted in the number of people with health insurance since the government started collecting insurance coverage data in 1987 (Census, 2010).

The U.S. Census Bureau's *Current Population Report Income, Poverty and Health Insurance Coverage in the United States: 2009*, reported the following.

IOM Findings on the Consequences of Uninsurance

The clinical literature overwhelmingly shows that uninsured people, children as well as adults, suffer worse health and die sooner than those with insurance. Families with even one member who is uninsured lose peace of mind and can become burdened with enormous medical bills. Uninsurance at the community level is associated with financial instability of healthcare providers and institutions, reduced hospital services and capacity, and significant cuts in public health programs, which may diminish access to certain types of care for all residents, even those who have coverage. The economic vitality of the nation is limited by the productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

America's Uninsured Crisis (IOM, 2009)

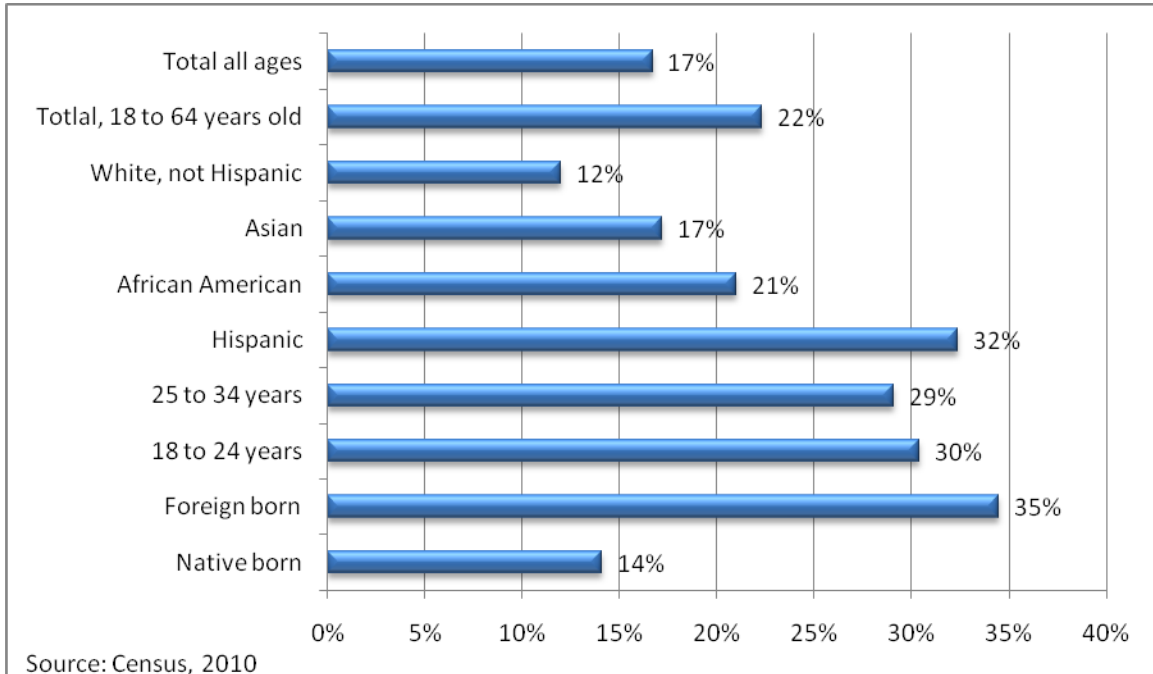
Status	2006	2007	2008	2009
Number uninsured (in millions)	47.0	45.7	46.3	50.7
Uninsured percent	15.8%	15.3%	15.4%	16.7%
Number covered by private health insurance (in millions)	201.7	202.0	201.0	194.5
Number covered by government health insurance (in millions)	80.3	83.0	87.4	93.2
Percent covered by employment-based health insurance	59.7%	59.3%	58.5%	55.8%

Nearly every demographic group experienced a significant rise in the uninsured rate between 2008 and 2009, with the exception of children, who remained stable at about 10%. Review of the 2009 uninsured



rates across different demographic groups found a number of disparities, as shown in the following chart.

People in the U.S. without Health Insurance Coverage by Select Characteristics – 2009



Race and Ethnicity

In 2009, the uninsured rate and number of uninsured among non-Hispanic whites, African Americans and Hispanics increased from 2008 levels. The uninsured rate for Asians in 2009 was not statistically different from 2008.

Age

The uninsured rate for those under 65 increased in 2009 to 18.8% from 17.3% in 2008. Only the rate among children without health insurance under 18 (10.0%) did not change significantly from 2008.

Nativity

The uninsured rate of both the native-born population and foreign-born population increased to 14.1% and 34.5%, respectively. Among foreign-born non-citizens the uninsured rate in 2009 was 46.0%.



Economic Status

Among the four household income categories, the uninsured rate in 2009 was significantly higher than in 2008 for three categories: less than \$25,000, \$50,000 to \$74,999 and \$75,000 or more, 26.6%, 16.0% and 9.1%, respectively.

Region

Between 2008 and 2009, the uninsured rate increased in all four regions – 11.6% to 12.4% in the Northeast; 11.6% to 12.4% in the Midwest; 17.4% to 18.3% in the West and 18.2% to 19.7% in the South. All of these increases were significant.

Healthcare Quality

Defining healthcare quality is complex and can have many dimensions. The definitions used by the Institute of Medicine and the U.S. Agency for Healthcare Research and Quality provide a good starting point for a discussion of healthcare quality.

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (IOM, 2001)

“Quality health care means doing the right thing at the right time in the right way for the right person and having the best results possible.” (AHRQ, 1998)

Since 2003, the AHRQ has led the effort to develop The National Health Care Quality Report as a conceptual framework for measuring the performance improvement of the U.S. health system in its provision of high-quality care. The framework addresses two main dimensions: health care quality and consumer perspectives on health care needs. Components of the health care quality dimension include:

- Safety – Avoiding injuries to patients from the care that is intended to help them.
- Effectiveness – Providing healthcare services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- Patient-centeredness – Providing healthcare that is in partnership with practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care.
- Timeliness – Providing healthcare without delay after a need is recognized. Measures of timeliness include time spent waiting in doctors’ offices and emergency departments and the interval between identifying a need for specific tests and treatments and actually receiving those services.

Consumer perspectives on health care needs and reasons for seeking care are:

- Staying healthy (preventive care) – Caring for healthy people is an important component of health care. Educating people about healthy behaviors can help postpone or avoid illness and disease. Additionally, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and expenditures.
- Getting better (treatment for acute illness) – When acute care is needed, delivering optimal treatments for acute illness can help reduce the consequences of illness and promote the best recovery possible.
- Living with illness or disability (chronic disease management) – Chronic diseases such as diabetes must be managed across a lifetime and often involve lifestyle changes and regular contact with a provider to monitor the status of the disease. Effective management of a chronic disease can mean the difference between normal, healthy living and frequent medical problems.
- Coping with the end of life.

Utilizing process and outcome measures, healthcare quality is evaluated in several ways, including:

- Clinical performance measures of how well providers deliver specific services needed by specific patients, such as whether children get the immunizations they need.
- Assessments by patients of how well providers meet health care needs from the patient's perspective, such as whether providers communicate clearly.
- Outcome measures, such as death rates from cancers preventable by screening, that may be affected by the quality of healthcare received.

The following briefly highlights some of the key findings from the 2009 National Healthcare Quality Report published by AHRQ (NHQR, 2009). These include:

- Healthcare quality in America is suboptimal.
- There is a substantial gap between best possible care and that which is routinely delivered.
- The quality of healthcare delivered varies widely. For example, caregivers reported that 95% of hospice patients received the right amount of pain medication, but only 8% of patients needing care for alcohol problems received such treatment at a specialty facility.
- Across the core NHQR report measures tracked, the median level of receipt of needed services was 58%.
- Despite efforts to improve the effectiveness of preventive and chronic illness care in the U.S. health care system, it continues to perform better when delivering diagnostic and therapeutic care in response to acute medical problems. The U.S. healthcare system achieves higher performance on hospital measures, such as acute treatment for heart attacks, than on outpatient measures, such as cancer screening and diabetes management. In fact, all 10 of the worst-performing process measures tracked in the 2009 NHQR are measures of outpatient care, and six are related to preventive services.

- There are significant disparities in care for individuals without health insurance. In fact, the quality of care for those without health insurance is getting worse. Uninsured people are less likely to get recommended care for disease prevention and management. Large differences were observed between individuals with private insurance and those with no insurance for measures related to:
 - Preventive services, including cancer screening, dental care, counseling about diet and exercise, and flu vaccination.
 - Diabetes management.
- The analysis of trends for 2009 NHQR finds that quality improvements are and continue to be unevenly spread across the settings of care. Some areas have shown increasing rates of improvement, while improvements in other areas have slowed. For example, care delivered in hospitals improved at an annual rate of change of almost 6%, which continues to be the highest rate of quality improvement among the major health care delivery settings. In contrast, care in outpatient settings improved at a rate that only slightly exceeded 1%.
 - Measures of hospital care improve more quickly than measures of outpatient care.
 - Measures of acute treatment improve more quickly than measures of preventive care and chronic disease management.

Healthcare Disparities

Healthcare disparities are the differences or gaps in care experienced by one population compared with another. The National Healthcare Disparities Report (NHDR) shows that some Americans receive worse care than other Americans. Within the scope of healthcare delivery, these disparities may be due to differences in access to care, provider biases, poor provider-patient communication, poor health literacy, or other factors (NHDR, 2009).

Review of the 2009 NHDR found three major themes:

- Disparities are common and uninsurance is an important contributor. Disparities related to uninsurance were found in almost all aspects of healthcare, including:
 - All dimensions of health care quality — effectiveness, patient safety, timeliness and patient centeredness
 - All dimensions of access to care
 - In many types of care — preventive care, treatment of acute conditions and management of chronic diseases
 - For many clinical conditions — cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases
 - In many care settings — primary care, home health care, hospice care, emergency departments, hospitals and nursing homes.



- Within many subpopulations — women, children, older adults, residents of rural areas and individuals with disabilities and other special health care needs.
- Many disparities are not decreasing. In fact, quality of care and access to care measures during the past five years show that disparities persist for all populations.

Healthcare Reform -- Patient Protection and Affordable Care Act (P.L. 111-148)

The healthcare reforms contained in the Patient Protection and Affordable Care Act (ACA) have the potential to dramatically change American healthcare. According to a recent analysis of ACA, the five key strategies contained in the law (TCF, 2010) include:

- Making health insurance coverage more available and affordable
- Creating incentives to improve quality and achieve savings
- Organizing care delivery systems to ensure accountable, accessible, patient-centered, coordinated care
- Creating standards and goals for better health outcomes, higher quality and greater efficiency
- Developing leadership and public–private collaboration to set and achieve national goals

During the first five years of ACA, many provisions will be phased in. The following briefly highlights some of the major provisions of ACA, by year of implementation, that address the issues of cost, access and quality improvement. Items presented in this table are based on an analysis of ACA by The Commonwealth Fund.

Year	Provision of the ACA	Cost	Access	Quality
2010				
	Coverage for young adults: Parents will be able to keep their children on their health policies until they turn 26		✓	
	Preexisting condition insurance plan: People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance.		✓	
	New insurance rules: Insurance companies will be banned from rescinding people's coverage when they get sick.		✓	
	Protection for children: Insurers can no longer deny health coverage to children with preexisting conditions or exclude their conditions for coverage.		✓	
	Preventive care: All new group and individual health plans will be required to provide free preventive care for recommended preventive services and immunizations.			✓
	Access to care: Additional funding for community health centers and the National Health Services Corps to serve more low-income and uninsured people.		✓	



Year	Provision of the ACA	Cost	Access	Quality
2011				
	Physician quality reporting: Medicare will provide information to beneficiaries allowing them to compare measures of physician quality and patient experience.			✓
	Limits on non-medical spending by health plans: Health plans will be required to offer rebates to enrollees if they spend less than a designated percent of their premiums on medical care (80% or 85% depending on the type of market).	✓		
	"Doughnut-hole" discounts: Medicare beneficiaries who hit the Part D prescription drug coverage gap will receive 50% discounts on all brand-name drugs.	✓		
2012				
	Hospital readmissions: Medicare will reduce payments to hospitals for potentially preventable readmission for select conditions.			✓
	Hospital value-based purchasing program: Medicare will reward hospitals that provide higher quality or better patient outcomes.			✓
	Accountable care: Medicare will launch a program that encourages providers to organize into accountable care organizations, which will share in savings generated by meeting quality targets and reducing costs.	✓		✓
2013				
	Preventive services in Medicaid: The current state Medicaid option to provide diagnostic, screening, preventive and rehabilitation services will be expanded to include more services.			✓
2014				
	Insurance industry fee: Insurers will pay an annual fee, based on market share, to help pay for reform.	✓		
	Insurance exchanges: New state-based marketplaces will offer small businesses and people without employer coverage a choice of affordable health plans that meet new, essential benefits standards.		✓	
	New rules for insurers: Insurers will be banned from restricting coverage or basing premiums on health status or gender.		✓	
	Premium subsidies: Premium and cost-sharing assistance on a sliding scale will make coverage affordable for families with annual incomes between \$30,000 and \$88,000 that buy plans through the exchanges.		✓	



Year	Provision of the ACA	Cost	Access	Quality
	Shared responsibility for coverage: Individuals will be required to carry health insurance or pay a penalty, with some exceptions, and employers with 50 or more workers will be required to offer health benefits or be subject to a fine of \$2,000 per employee (not counting the first 30 employees) if any worker receives federal premium subsidies for plans purchased through the insurance exchanges.		✓	
	Medicaid expansion: Medicaid eligibility will be expanded to all legal residents with incomes up to 133 percent of the federal poverty level.		✓	
	Medicare managed care plans: Four- and five-star Medicare private plans will receive 5% bonuses as a reward for providing better clinical quality and patient experiences.			✓

While under ACA, 32 million additional Americans will be able to obtain coverage by 2019, a major shortfall still exists: an estimated 23 million people uninsured, and many others who will still face financial barriers to obtaining needed care or face hardship in paying premiums or medical bills (TCF, 2010).

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