

The ESRD Uninsured Matter

Mark E. Williams

Health-care insurance is the key to health-care access, yet the number of uninsured in the United States grows by a million persons per year and consists, in large part, of those who are financially unable to obtain medical coverage. Their unpaid medical bills add significantly to the cost of health insurance for those who do pay. Those without insurance receive care on a sporadic basis, and the risk of poor health-care outcomes is well established. The end-stage renal disease (ESRD) uninsured face unique problems related to chronicity of care and the system of chronic dialysis-care delivery. This article addresses the growing challenge of the ESRD uninsured in the United States and describes how the current system copes with the ESRD uninsured. More broadly, it discusses who the uninsured are (including undocumented immigrants), the health-care consequences of being without coverage, and how their care is currently financed. It also presents a health-care reform measure in Massachusetts designed to provide affordable insurance to those without coverage.

© 2007 by the National Kidney Foundation, Inc.

Index Words: Uninsured; ESRD; Dialysis; Immigration; Insurance

The matter of caring for the uninsured in America is no longer a fringe issue of interest to a few health-care analysts. The number of persons in the United States without health insurance has grown to 46 million (Fig 1). Three contributing factors are (1) fewer working persons have employer-sponsored insurance, either because employers fail to offer it or because workers turn down their insurance benefit; (2) public coverage in many areas has become more restricted; and (3) the influx of undocumented immigrants has increased the numbers of uninsured. Yet, health-care insurance is the key to general health-care access, and the same is true for chronic kidney disease and end-stage renal disease care. Years of health-care research have made a convincing case that having health insurance would improve health-care outcomes of the uninsured.¹

Poor access to care for the uninsured has a ripple effect on the larger insured population that increases cost and threatens quality.² The health-insurance issue puts a spotlight on several public-policy challenges in a health-care system in crisis: personal responsibility for individual health, coordination of health care, national spending, the plight of undocumented immigrants, and health-care reform. This article addresses the growing challenge of the uninsured in the United States in general and the unique problems facing the uninsured patients with ESRD. Who are the uninsured? What are the health consequences of being without insurance? How is their care currently funded? How does the system of

ESRD care cope with the uninsured? What reform measures may provide solutions?

Case Report

A 58-year-old female was admitted with a failing kidney allograft. She had a history of ESRD secondary to nephritis 22 years earlier and had received a cadaveric kidney transplant in 1986. Recently, she had developed nausea, vomiting, and generalized weakness. On admission, key laboratory values included serum creatinine 18.7 mg/dL, hematocrit 23.7%, potassium 6.7 mEq/L, platelets 140,000, BUN 130 mg/dL, serum phosphorus 9.9 g/dL, serum lactate dehydrogenase 315 IU/dL, and serum haptoglobin less than 20 mg/dL. Chest x-ray indicated mild pulmonary edema. Her urinary protein-creatinine ratio was 1.4. Coombs test and antibody to heparin were negative. A kidney-transplant biopsy revealed acute and chronic rejection. Cyclosporine level was undetectable.

The patient reported that she had been unable to obtain health insurance in recent years. She was employed at a local coffee house and was forced to choose between pur-

From the Joslin Diabetes Center, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA.

Address correspondence to Mark E. Williams, MD, Renal Unit, Joslin Diabetes Center, 1 Joslin Place, Boston, MA 02215. E-mail: mark.williams@joslin.harvard.edu

© 2007 by the National Kidney Foundation, Inc.

1548-5595/07/1401-0010\$32.00/0

doi:10.1053/j.ackd.2006.10.013

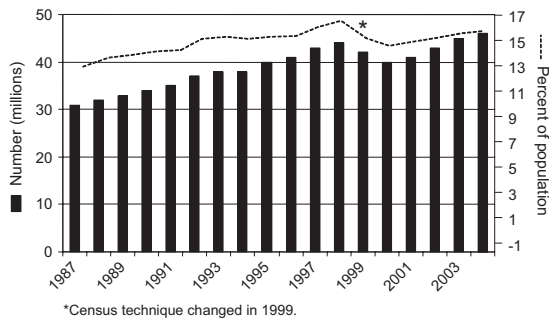


Figure 1. Americans without health insurance. Note that census technique changed in 1999. Source: Census Bureau, Wall Street Journal Research.³⁹

chasing food, paying rent, and buying medications. Recently, her self-care had deteriorated; she was facing potential eviction and had not been taking her medications (cyclosporine, prednisone, and azathioprine) consistently. Her depression had worsened. Hospital treatment included correction of hyperkalemia and empiric steroids. A transplant ultrasound revealed no transplant hydronephrosis and a resistive index of 0.76. A hematology consultant recommended an ADAMST 13 level and felt that hypertension, not thrombotic thrombocytopenic purpura, was present. Her transplant medications were resumed. She was started on dialysis. She was provided with a Web site listing to obtain drug assistance, and an advisory letter was sent to her landlord. She completed her Medicaid disability application. She was maintained on hemodialysis. Lacking insurance, she was unable to be placed in a free-standing dialysis facility and continued dialysis as an outpatient at her hospital's inpatient hemodialysis facility, awaiting Medicaid approval.

Health Consequences for the Uninsured

The medical care that millions of uninsured patients receive has been called by the Institute of Medicine, "too little, too late."³ The Emergency Medical Treatment Labor Act (EMTLA), commonly known as the "anti-dumping law," was created in 1986 to prevent hospitals from refusing to provide emergency care to the uninsured, regardless of their immigration status. Nonetheless, in some areas

of the country, this open-door policy has become more restrictive, with only life-threatening conditions being treated in nonresidents and other conditions being referred out for care in clinics.⁴ Because the uninsured typically receive care on a sporadic basis in emergency settings, the full health consequences of uninsurance is difficult to ascertain. However, the uninsured are generally acknowledged to be at risk for poor health outcomes for fundamental reasons⁵ (Table 1): lack of continuity in health coverage, less preventive care, less therapeutic care, and fewer medical services used with poorer coordination of care.⁶ The uninsured are admitted to the hospital less often and have fewer emergency room visits than do the insured.⁷ Lack of health insurance is felt to be a factor in the poor health of lower-income Americans, who are often uninsured.⁸ The uninsured in general are in worse health, diagnosed at a more advanced state, receive inferior care, and face greater morbidity and mortality risk than do those with health coverage. They are more likely to fail to fill a prescription and more likely to visit an emergency room than are those with insurance. They are less likely to receive services for major health conditions such as traumatic injuries, heart attacks, pregnancy, and cancer.⁹ They are more likely to become disabled and die early. Uninsured cancer patients are twice as likely to die as those with insurance.¹

Uninsured CKD patients are less likely to receive pre-ESRD care and typically present more severely ill and in need of ESRD treatment. Their average glomerular filtration rate at initiation of dialysis is lower.¹⁰ They are more likely to be dialyzed without adequate support services from nutritionists and social workers. For a wide range of procedures, the

Table 1. Health Consequences of Being Uninsured

Delayed medical care
Fewer diagnostic and therapeutic medical services
Present more severely ill
No pre-ESRD care
Longer hospital length of stay
Greater cost for dialysis initiation
Poorer health outcomes
Higher mortality

uninsured receive only 60% as much care as the insured.⁷ What emerges is a two-tiered health-care system. Ironically, the uninsured have medical-debt problems, nonetheless, and pay more than twice as much as insured individuals out of pocket for the care they do receive.⁷ However, the consequences to the individual and society go well beyond the health consequences to the uninsured individual or even the cost they receive,¹ to the demands placed on the health-care system and to broader effects on the society itself.

The Cost of Dialysis

Medicare spending for ESRD in 2003 totaled more than \$18 billion, predominantly from Medicare A and B paid claims, a 7% increase from the previous year.¹¹ The ESRD program now accounts for 6.7% of the entire Medicare budget. ESRD costs per patient average \$55,000 or more annually. However, the uninsured are often pariahs to the current United States dialysis system, as demonstrated by the case report, with care consisting of outpatient treatments in an inpatient unit, benefiting little from the acute surroundings, while losing the support services of a chronic-care facility. Although one solution is for the hospital to enter into a “single-payor agreement” with a dialysis vendor, paying for treatments of the uninsured patient in the chronic setting, hospitals may be reluctant to do so. Hospitals and dialysis chains also seem unwilling to cooperate in an effort to share the uninsured ESRD burden equitably.

Who Are the Uninsured?

The number of uninsured people in the United States is rising.^{12,13} In 2004, 45.8 million people, nearly 16% of the entire population, were without health insurance coverage, an increase of nearly 1 million in a year, according to the United States Census Bureau. Sources of health-care coverage of nonelderly Americans for 2005 are shown in Figure 2.¹⁴ The percentage of workers holding insurance is falling.¹⁵ Millions more are uninsured temporarily during the year. Documented immigrants are about half as likely to have employer-based insurance. Recent studies indicate that

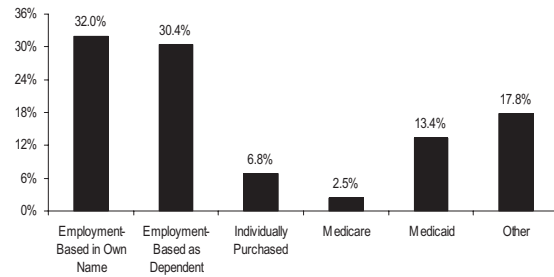


Figure 2. Sources of health-insurance coverage of nonelderly Americans. Source: Employee Benefit Research Institute.²³

up to 20% of patients seen in emergency rooms are uninsured.¹⁶ In Massachusetts, almost 12% lack coverage, with estimates varying from 450,000 to more than 650,000 residents without insurance, a jump of 10% in the past year.¹⁷ Nationally, the increase in the number of uninsured has been predominantly among native-born United States citizens.

Health-insurance coverage varies by age, work status, income, race, and citizenship. A quarter to a third of those younger than 34 years are uninsured. Nearly all who do not have insurance in the United States are younger than 65 years, because most elderly are covered by Medicare; however, in 2000, approximately 350,000 older Americans had no health insurance,¹⁸ mostly the poor and non-United States citizens. Furthermore, at least a quarter of older adults will be uninsured in the year preceding their Medicare eligibility.¹⁹ Nearly 1 in 5 Americans younger than age 65 is uninsured.⁷ About 15% of young adults are uninsured, especially non-students.²⁰ Recent surveys indicate that 1 in 8 children has no insurance.^{7,21} Nearly 2 million United States veterans have no health insurance, even though most are employed.²² Paying the entire premium for an individual plan is prohibitively expensive, especially for the unemployed. However, having a full-time job also no longer guarantees insurance coverage and access to health care. In fact, more than half of all uninsured working adults are employed full time throughout the year.²³

The increase in uninsured Americans over the past decade has been associated with declining employer-sponsored insurance not offset by increases in public coverage. Most uninsured individuals report that the main

reason they lack insurance is that they are not eligible for health-care benefits at their job or that coverage is too expensive.⁹ Workers account for well over half of the uninsured, and this group is disproportionately employed in blue-collar jobs. Employers may cut back coverage for workers or their families, offer coverage that is too expensive to purchase, or hire more part-time employees.²⁴ Uninsured rates among workers generally decline as the firm size increases.¹⁴ Of note, although most of the growth in the uninsured has occurred among poverty-level and low-income families, uninsured rates for moderate-income and middle-income families are also rising. People may transition between being insured and lacking coverage on the basis employment.¹⁹ Compared with lower numbers of Caucasians, a third of Hispanics and a fifth of Blacks are uninsured related to economic and social factors.³

Recent recognition has been given to the effect of citizenship and immigration status on health insurance. Although the majority of uninsured (79%) are United States citizens, legal immigrants (noncitizens) are more likely to be uninsured than are citizens. Even though most immigrant families have a full-time worker in the family,¹⁴ as few as a third have employer-based coverage.¹⁶ Uninsured rates for immigrants decreases with increased length of residency in the United States.²⁵ Uninsured noncitizens, however, are not the major reason for growth in the uninsured population in the United States¹⁹ Although their uninsurance rates are high and the number of uninsured legal immigrants has been increasing, new immigrants make up only 10% of the uninsured population and only 3% of the total United States population.

Sources of Compensation

The cost of health care for the uninsured ultimately gets passed on to other programs under the current system. Recent data indicate that unpaid hospital bills, largely from the uninsured, cost about \$45 billion nationally a year and add about 8.5% to the cost of health insurance for those who do pay.²⁶ At the same time, private payers have to make up for Medicare and Medicaid underpayments in

many states. As a result of the rise in health-insurance premiums caused by cost shifting, the numbers of uninsured continues to grow.

The Medicare budget that provides ESRD coverage has increased by more than 40% over the past decade. If otherwise eligible for Medicare, all ESRD patients are entitled to medical-care coverage through Medicare, regardless of age or income. Eligibility for Medicare is determined by the number of "work credits" a person has accrued under Social Security; to qualify for Medicare under the ESRD program, 2 years is sufficient time.

Although Medicare is the ultimate primary payer for most dialysis recipients, including many who are employed but uninsured, some patients will remain ineligible. To the extent that they qualify for Medicaid, it becomes the primary payer for ESRD services. Medicaid is a joint federal/state health-care program for the poor, created by Congress in 1965. Medicaid pays for a range of public-health services, including hospital care, prescription drugs, specialty care, and long-term care. Most of the funding for Medicare is federal, with the amount paid by states as their share of costs under the existing matching program ranging from 20% to 40%. Eligibility requirements for Medicaid vary from state to state and are determined by a variety of factors, primarily involving financial status, such as poverty-level income and minimal assets. Other criteria include state residency and immigration status.²⁷ (New federal laws that require individuals to provide verification of citizenship to qualify for federal Medicaid money may result in more uninsured people.)

Medicaid is now the largest government health-care program, surpassing the costs of Medicare with \$256 billion in expenditures in 2002.²⁸ Medicaid is the largest individual category for spending by states, exceeding education and transportation. About one-seventh of Medicare beneficiaries have dual coverage with Medicaid, which covers coinsurance and deductible payments. Many states are now experiencing serious financial constraints because of the combination of increased state expenditures (such as Medicaid) and shortfalls in state revenues. State revenues have been unable to keep pace with increases in health-care costs in general and a growing

number of dependents. As Medicaid spending has grown, states have resorted to cost cutting, with many enacting restructuring of Medicaid eligibility, reducing payments to hospitals, and reducing prescription-drug contracts. Medicaid is the major insurer for ESRD patients who are ineligible for Medicare coverage and covers maintenance-dialysis treatments when administered at a hospital-based, Medicaid-enrolled dialysis facility or a licensed free-standing ESRD center. ESRD Medicaid expenditures in many states have continued to rise, even though reimbursement rates to providers have not increased. Flat rates have led to a petition filed by Florida residents with the state legislature to increase Medicaid coverage for dialysis patients. For Medicaid primary patients, Medicaid covers only about 55% of the costs of providing ESRD care.

For the uninsured, a large portion of federal, state, and local spending is channeled through Medicaid, with matching federal support. States such as Massachusetts spend large amounts to provide medical care for the uninsured. Many of the employed uninsured are also enrolled in the publicly funded Medicaid program. Medicaid makes substantial payments to hospitals to cover programs for the uninsured. For uncompensated care, increases in Medicaid are vitally important at times when the number of uninsured increase because of a decline in employer-sponsored programs. Some people with medical problems who are uninsured but looking for an individual policy may seek out health-maintenance organization (HMO) plans, which may be less restrictive in accepting pre-existing conditions than are indemnity-insurance plans.^{27,29} However, HMOs will not generally accept patients who have ESRD at the time of application.

In Massachusetts, the Medicaid program is the underpinning of the health-care safety net.³⁰ Approximately 1 in 7 residents in the Commonwealth is covered by the state Medicaid program. A quarter of the total state budget is spent on the health-care program, with the Federal government reimbursing approximately half of every dollar. Expansion in MassHealth has actually reduced the number of uninsured in the state, until recent years. However, the program only covers 80% to

90% of the cost of providing Medicaid services.

Illegal Immigrants

A legal immigrant is a foreign national who has been granted permanent-resident status through an immigration petition. Millions of legal immigrants make up a significant portion of the U.S. labor force and are integrated into society in this country. In Massachusetts, more than 300,000 legal immigrants reside as permanent residents, eligible to become U.S. citizens and able to apply for Massachusetts Medicaid. The patterns of immigration have changed since the Immigration Act of 1965, and many more now come from Latin America and Asia than expected in quotas previously set on the basis of the nation of origin.³¹

Most immigrants (74%) to the United States are legal, but many others (26%) reside here illegally—without sponsorship (Fig 3). More than 5 million undocumented (illegal) aliens (immigrants) are estimated to live in the United States.^{28,32,33} Immigration issues have been increasingly debated within the federal government the past year. A rise in anti-immigration sentiment has occurred in the United States in 2006, with federal Homeland Security agents raiding worksites in half of the states.³⁴

Medical costs associated with treating undocumented immigrants are difficult to recover. Although a process does exist for undocumented immigrants to become citizens and, thus, be accepted onto Medicaid roles, the 1996 Welfare Law states that even documented immigrants cannot apply for Medic-

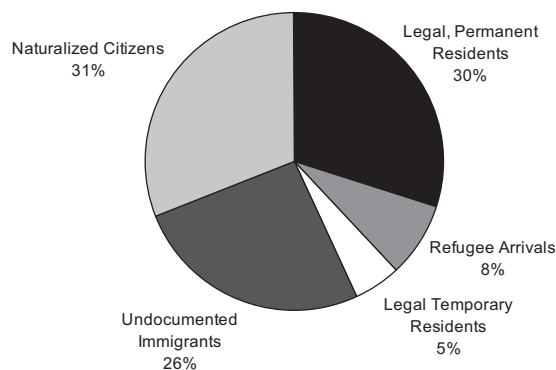


Figure 3. Legal status of the immigrant population, 2002. Source: Urban Institute.

aid during their first 5 years in the United States, in many cases. Undocumented immigrants are allowed emergency health care only. By the Emergency Medicaid Act of 1986, the federal government helps pay for health care of undocumented immigrants. However, Washington has relegated much of the funding of health care of uninsured undocumented persons to states, local governments, hospitals, and clinics.³³

ESRD care of undocumented immigrants falls to public hospitals. Many such patients would not receive dialysis care in their native country,³² and they commonly have low levels of formal education, little awareness of their kidney problem, and little predialysis care. Inability to be placed in free-standing dialysis units leads to a cycle of preventable hospital admissions, for dialysis itself or related complications. Medicaid's Disproportionate Share Hospital Program, designed to compensate hospitals that serve large numbers of uninsured patients, does not include payment of medical care for uninsured immigrants.³⁵ More restrictive policies for hospital admissions are likely to emerge in the future, with fewer safety-net hospitals willing to serve uninsured, undocumented persons for nonemergency care.

Uncompensated-Care Pool

Uncompensated care is health care received by uninsured individuals and not paid for out of pocket by the care recipient. Hospitals in the United States provide roughly \$25 billion annually in uncompensated care.^{7,36} The Congressional Budget Office estimates that the uninsured pay less than a third of the cost of their health care each year.³⁷ Public-health programs are estimated to compensate only about one-third of the overall cost of uncompensated care.⁷ Uncompensated care for the uninsured constitutes about 3% of the annual U.S. health-care bill. The bulk of uncompensated care is provided by major teaching hospitals and public hospitals. However, as spending on the uninsured has escalated, hospitals have become less able to absorb the financial burden, which had led to allocation of health services and aggressive billing practices. Cost shifting is a fundamental feature of

the current system of compensation, through measures such as taxes and private charities. Uncompensated-care pools have been created in many states over the past quarter century by use of state and local resources. Also called the "free-care pool," the pool pays for medically necessary services provided to uninsured people by acute-care hospitals and community health centers. In addition, the pool reimburses hospitals for emergency bad-debt charges; that is, emergency services for uninsured individuals who do not provide payment. Free-care pools do not reimburse physicians or pay laboratory fees. The vast majority of pool expenditures are for the uninsured, and approximately 90% of inpatient services covered are for emergent or urgent care, mostly the former. Flow of funds in and out of the pool is complex, with revenues roughly divided between federal financial participation and state/local sources. Nonfederal revenue comes from sources such as mandatory state assessments on hospitals and health plans. Much of the free-care funding goes to hospitals designated as safety-net institutions, in the form of regular payments to qualifying hospitals. In addition to safety-net institutions, care pools may provide mechanisms for hospitals with better patient-payer mixes and greater financial stability to receive payment transfers from the pool for care of the uninsured. In Massachusetts, the cost of uncompensated care is more than \$1 billion annually, more than two-thirds of which is for care provided by hospitals. As a result, claims submitted to the pool for primary care are being restricted, especially if the care can be provided outside the hospital.

Massachusetts Health Reform

The groundbreaking health-reform legislation signed by the Massachusetts governor in April 2006 is the nation's first law to require all state residents to have health insurance. It will result in near-universal coverage for the uninsured (excluding undocumented immigrants) and is inspiring other states to reduce their numbers of uninsured.³⁸ Since 2000, Massachusetts has experienced growth in the enrollment of the state Medicaid program and in the number of uninsured, currently esti-

mated to be 500,000. Care for the uninsured is funded through a mix of federal, state, hospital, and insurers' assessments combined with local government funds. Massachusetts spends up to \$2 billion annually for programs directed at coverage for the uninsured.^{1,39} The new complex, bipartisan, health-care plan is a patchwork of employer-based insurance and public-health subsidies and reflects compromises between the business community and health-care advocates. It requires all residents to obtain health insurance by mid-2007, with a state income tax penalty for those who can afford coverage but do not purchase it. *Pari passu*, the reform is designed to markedly reduce uncompensated care in the state.

The key parts of the plan (Table 2) are the individual requirement and the company contribution. By several methods, the legislation makes possible the purchase of affordable individual insurance. The plan converts large subsidies in the form of federal Medicaid money paid to hospitals for treatment of the uninsured into assistance for low-income individuals to purchase their own health insurance. (In turn, the uncompensated free-care pool used to pay hospitals for treating uninsured residents would be expected to decrease.) Massachusetts residents will also be able to satisfy the coverage requirement by purchasing alternative catastrophic health-care insurance. Importantly, the reform makes individual health care accessible through the creation of an innovative state-chartered marketplace called "the connector." This marketplace maximizes coverage choice by serving as a clearinghouse for health insurance, matching the individual with the best available plan. Individual coverage can be purchased through the connector, which makes a broad choice of plans available. With regard to companies, the reform plan imposes a fee on businesses with more than 10 employees

that do not provide health coverage for their employees. This per-worker contribution does not directly pay for employee insurance, but goes to the state's uncompensated-care pool.

Questions remain about the financing of the plan beyond its initial implementation, particularly with rising health-care costs. How much more the coverage of the uninsured will cost is being debated and is estimated to be a third more.⁴⁰ The law takes \$1 billion from the state's free-care pool to subsidize insurance for those who cannot afford it. Additional funding will come from Medicaid and new state revenues. Furthermore, the plan is unlikely to serve as a model for other states or nationally, given the relative small number of uninsured and the liberal political context of Massachusetts. Nonetheless, the reform legislation promotes empowerment of previously uninsured persons, while preserving the employer group-coverage mechanism. As a result, the ESRD uninsured patient population in Massachusetts will also benefit.

Conclusion

Millions of Americans lack health insurance. As one of the principle issues of health-care reform under discussion nationally, care of the uninsured is a divisive issue: Should government expand health care to include more of the uninsured or take less responsibility for providing health care? In a nation with little constitutional right to health care, the current system is failing those who lack coverage. The ESRD uninsured are a sign of the problems faced by uninsured with other medical conditions and a symptom of larger health-care questions about cost and allocation of services facing the country. Provision of care to the ESRD uninsured is determined by the individual nephrologist, government programs, the policies of individual dialysis chains, and hospitals. The demands being placed on the health-care system will only worsen if the solution continues to be to pay hospitals for deferred care of the uninsured. The benefits of expanding coverage for ESRD should be similar to those for other patients. Providing health insurance for the uninsured is the basis for a reform measure being modeled in Massachusetts. It may provide one

Table 2. Massachusetts Health-Insurance Law

Requires all recipients to obtain health insurance by mid-2007
Offers sliding-scale subsidies to the poor
Imposes fee on businesses that do not provide insurance (more than 10 employees)
Expands state Medicaid program to more low-income adults and children

solution to the problem of the uninsured, including those with ESRD.

References

1. Hadley J: Sicker and poorer—the consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income. *Med Care Res Rev* 60:3S-75S, 2003 (suppl)
2. Radzwill M: The health insurance crisis in the United States: Lack of access and the ripple effect. *Manag Care Interface* 16:28-34, 2003
3. Institute of Medicine: *Coverage Matters: Insurance and Health Care*. Washington, DC, National Academy Press, 2001
4. Connolly C: Emergency care under strain: Hospitals filtering out nonurgent patients. *Washington Post*, July 3, 2004, p A1
5. Brown ME, Bindman AB, Lurie N: Monitoring the consequences of uninsurance: A review of methodologies. *Med Care Res Rev* 55:177-210, 1998
6. Collins SR, Davis K, Doty MM, et al: Gaps in health insurance: An all-American problem. *The Commonwealth Fund*, April 2005
7. Mahar M: *Money-Driven Medicine: The Real Reason Health Care Costs So Much*. New York, NY, Harper-Collins, 2006
8. Krugman P: Our sick society. *New York Times*, May 6, 2005, p C2
9. Kaiser Commission on Medicaid and the Uninsured: The cost of care for the uninsured: What do we spend, what would full coverage add to medical spending? May 10, 2004, p 3
10. Obrador GT, Arora P, Kausz AT, et al: Level of renal function at the initiation of dialysis in the U.S. end-stage renal disease population. *Kidney Int* 56:2227-2235, 1999
11. U.S. Renal Data System: *USRDS 2005 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*. Bethesda, MD, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2005
12. www.census.gov/hhes/www/hlthins/hlthin04/hlth04asc.html
13. Cortese DA, Smoldt RK: Healing America's ailing health care system. *Mayo Clin Proc* 81:492-496, 2006
14. Fronstin P: Sources of Health Insurance and Characteristics of the Uninsured: March 2005 Current Population Survey. December 2005 EBRI Issue Brief
15. Kilborn PT: Poor workers turning down employers' health benefits. *New York Times*, November 10, 1997, p A12
16. Weber EJ, Showstack JA, Hunt KA, et al: Does lack of a usual source of care or health insurance increase the likelihood of an emergency department visit? Results of a national population-based study. *Ann Emerg Med* 45:4-12, 2005
17. Altman SH, Doonan M: Can Massachusetts lead the way in health care reform? *N Engl J Med* 354:2093-2095, 2006
18. Mold JW, Fryer GE, Thomas CH: Who are the uninsured elderly in the United States? *J Am Geriatr Soc* 52:601-606, 2004
19. Baker DW, Sudano JJ: Health insurance coverage during the years preceding Medicare eligibility. *Arch Intern Med* 165:770-776, 2005
20. Callahan ST, Woods ER, Austin SB, et al: Young adults in Massachusetts: Who is at risk of being uninsured? *J Adolesc Health* 35:425-427, 2004
21. Wise PH: The transformation of child health in the United States. *Health Aff (Millwood)* 23:9-25, 2004
22. Sprague L: Veterans' health care: Balancing resources and responsibilities. Issue Brief, National Health Policy Forum, April 1, 2004, pp 1-20.
23. Employee Benefit Research Institute estimates. *Current Population*, March 2005 Supplement
24. Pear R: Health costs pose problems for millions, a study finds. *New York Times*, October 23, 1996, p C1
25. Holahan J: Why Did the Number of Uninsured Fall in 1999? Washington, DC, Kaiser Commission on Medicaid and the Uninsured, p. 81
26. Freudenheim M: Low payments by U.S. raise medical bills billions a year. *New York Times*, April 12, 2006, p A15
27. Schneider A, Elias R, Garfield R, et al: *The Medicaid Resource Book*. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, 2002
28. Testimony by the Honorable Thomas A. Scully before the Subcommittee on Health, House Energy and Commerce, October 8, 2003. Available at: URL: <http://energycommerce.house.gov/108/Hearings/10082003hearing1103/Scully1733print.htm>
29. McKinley M: Reimbursement for treatment of end-stage renal disease. Available at: URL: <http://www.eparent.com/healthcare/reimbursement.htm>
30. Seifert RW: The basics of MassHealth, the Medicaid program in Massachusetts. *Massachusetts Medicaid Policy Institute*. December, 2004
31. Barone M: The newest Americans. *Wall Street Journal*, April 11, 2006, p A14
32. Coritsidis GN, Khamash H, Ahmed SI, et al: The initiation of dialysis in undocumented aliens: The impact on a public hospital system. *Am J Kidney Dis* 43:424-432, 2004
33. Young J, Flores G, Berman S: Providing life-saving health care to undocumented children: Controversies and ethical issues. *Pediatrics* 114:1316-1320, 2004
34. Perez E: Illegal immigrants' new ally on Katrina pay: The government. *Wall Street Journal*, April 26, 2006, p B1
35. Coughlin T, Ku L, Kim J: Reforming the Medicaid disproportionate share hospital program. *Health Care Finance Rev* 22:127-157, 2000
36. Weissman JS: The trouble with uncompensated hospital care. *N Engl J Med* 352:1171-1173, 2005
37. National Center for Policy Analysis. Available at: URL: <http://www.ncpa.org>
38. Zhang J: States take a new look at health reform. *Wall Street Journal*, May 27 2006, p A4
39. Kowalczyk L: U.S. study finds rise in state's uninsured. *Boston Globe*, August 31, 2005, p A1
40. Holanan J, Bovbjerg R, Hadley J: Caring for the uninsured in Massachusetts. What does it cost, who pays and what would full coverage add to medical spending? Report for the Blue Cross Blue Shield of Massachusetts Foundation, 2004