Why Are People Uninsured?

Nancy J. Johnson

Lisa and Gary are responsible parents and follow the advice of their pediatrician in raising their two young children. They do not have access to employer group insurance in that Gary is self-employed as a music production supervisor and Lisa is at home with the children. However, as careful healthcare consumers, they purchased individual premiums for each of them as well as each of the children. Then last spring, they received a rejection notice from their insurance company for the youngest child. The reason was a congenital hip misalignment of their 18- month daughter, which the pediatrician had determined 'minor' and most likely 'temporary'. However, the insurance company determined the baby 'uninsurable' due to the need for monitoring and radiology services. Since then, they have not *been able to replace the insurance coverage for their young daughter and she is ineligible for government-funded health programs due to the family's income.*

Introduction

In the late 1990s, there was a brief period of time in which the number of Americans without health insurance was *not* increasing annually. Since 2001, the number increased from about 42 million to approximately 46.5 million in 2005 (US Census Bureau 2006). However, the number of uninsured Americans under age 65 fell by 1.5 million between 2006 and 2007 (US Census Bureau 2008). The primary reason for this decline was the growth in public health insurance coverage from Medicaid and Medicare, as well as the growth in military programs such as the Veterans Administration and the TRICARE military insurance plan. This represents the first decline in the number of uninsured in over a decade. However, 45 million is still a large number of uninsured individuals in the United States, representing the gaps

N.J. Johnson
El Rio Community Health Center, Tucson, AZ, USA
e-mail: NancyJ@elrio.org

N.J. Johnson and L.P. Johnson (eds.), *The Care of the Uninsured in America*,
DOI 10.1007/978-0-387-78309-3_2,

between private and public health insurance coverage. Over 80% of the uninsured under age 65 are members of working families (Institute of Medicine 2003).

So, why are so many Americans uninsured at any point in time? This chapter will explore many of the causes for people in the United States (US) being medically uninsured, the forces that allow this situation to continue, and preview some of the options and alternatives that may change this situation.

Medical Insurance in the US

Many believe that the challenges faced from the increased cost of health insurance as well as the number of Americans without insurance is primarily due to *how* insurance is acquired in the US. The government currently, actually, pays for health insurance for over 50% of Americans. Medicare provides public insurance for all those over age 65 and the disabled in the US. The government provides Medicaid for the very poor and low-income pregnant women as well as the state children's health insurance programs (SCHIPS) for low-income children. Medicare is funded through payroll taxes, federal general revenues and beneficiary premiums; while Medicaid is funded through federal and state taxes. Veterans may receive much of their healthcare through the Veterans Health Administration.

The growth of these three programs was the primary reason for a decline in the uninsured in the most recent reported data from 2007. However, this description of sources for healthcare insurance does not address the issues of the various governmental programs or the the amount of money utilized to identify who is eligible and who is not eligible, as well as to enforce the benefit limits to which individuals are entitled. There are also many uninsured who may qualify for these programs, but are *not* enrolled as well. Other groups of Americans who receive their health insurance through private insurance usually do so through employers, but that also presents the challenges of benefit limits, pre-existing conditions, non-covered services, and waiting periods. This can lead to starts and stops in coverage, disruption in treatment, and continually influences the numbers of uninsured at any point in time.

Employer health coverage is also subsidized through the federal tax system because workers do not need to pay taxes on compensation received as employer provided healthcare benefits, and premiums paid by employers that are part of an employee's compensation are exempt from payroll tax, as well as income taxes. Finally, there is also the working poor, a group which doesn't have access to employer-offered insurance, or cannot afford their portion of the employer premium, and have too much income to qualify for governmental health insurance programs. Investigation of the American structure of options for healthcare coverage illustrates the complexity, both financially and programmatically, and provides some indications as to why so many people are uninsured (Fig. 1).

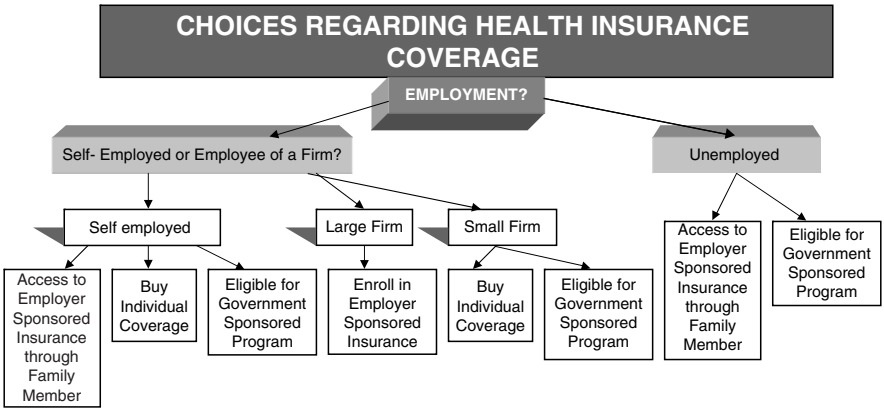

Fig. 1 Choices regarding health insurance coverage

Causes of Being Uninsured

Medical Insurance Is Not Affordable

The most commonly cited reason for being uninsured is the cost of health insurance. This is heard from employers as well as from employees and individuals who choose not to enroll. Employers continue to see increasing costs in offering insurance to their employees and consequently, employees do not enroll when it is offered, due to their share of the cost. The Robert Wood Johnson Foundation (2005) reported that the average health insurance premium for single coverage in 2004 was $308 per month and family coverage was $829 per month. On average historically (St. Luke's Health Initiative 2007), the employee has paid approximately 16% of single coverage premium, whereas, the average percent paid for family coverage was 28%. In 2008, the average percentage paid by the employee for their portion of family coverage has risen to 40% in some markets (HealthNet of Arizona 2008).

For industries that tend to pay lower wages, the cost for health insurance is greater for the employee. In addition, the out-of-pocket costs such as co-payments and deductibles have continued to rise significantly since 2001 (RWJ 2005). Lastly, in the past 25 years, except for a short period of time in the mid-1990s, the rise in health insurance costs has been substantially greater than increases in worker wages. If these rates of increases continue, health insurance will cost a family upwards of $36,000 per year by the year 2014. In 2004 (St. Luke's Health Initiative 2007), Out-of-pocket expenses were estimated at 17% and currently, they are greater than 35% with some health insurance plans. A glance at the recent data supports this with an annual increase in Medicaid enrollment of 5.8% in 2003 while the employer plans decreased by 4.8% (Kaiser Family Foundation 2006). However,

60% of the population continues to access health insurance through their employer and, for the first time in a decade, the data from 2007 did not show a decline in employer-offered health insurance coverage (Holahan and Cook 2008). National employer surveys in 2007 did indicate the lowest rate of health insurance premium growth in 4 years. However, this growth of 6.1%, still significantly outpaced the growth in workers' wages which was 3.7% and overall inflation of 2.6% (St. Luke's Initiatives 2007). The continuance of the trend would depend upon the economy and efforts for healthcare reform in the future.

Employers continue to work with strategies designed to control costs such as disease management programs, closed provider networks and higher employee deductibles and co-payments. A survey of employers (EBRI 2007) identified various perceptions as to why healthcare insurance premiums continue to rise. These included: higher insurance company profits, higher spending for hospital care, higher spending for physician services, higher spending for prescription drugs and an aging population.

A comprehensive study by Cunningham (2007) investigating the problem of paying medical bills for American families documenting that about 57 million individuals were in families with problems paying medical bills in 2007. This represents an increase of about 14 million since 2003 (Cunningham 2007). Although the uninsured had more challenges in affording healthcare, most people with medical debt (42.5 million) had insurance coverage.

Fewer Employers Offer Medical Insurance

There are various characteristics of employers that indicate the likelihood of health insurance that will be offered in the future. These include the size of the business, the number of part-time employees employed, the nature or type of business, and whether the business is unionized or not. Regardless of these characteristics, there has been a decline in the number of employers that offer health insurance to their employees as mentioned above. Small employers comprise most of the decline. Currently, less than 43% of employers with less than 50 employees offer health insurance benefits (RWJ 2005). The greater the number of part-time employees and the greater number of low-wage positions existing in the business results in a greater likelihood that insurance benefits will not be offered. Industries which tend to offer lower or no health benefits or none at all include service, wholesale/retail, construction, agriculture, and the forestry service.

The RWJ Foundation (2005) reports that nearly 50% of low-wage workers are not offered any type of health insurance benefit currently. The Kaiser/HRET (2006) survey of small employers with size ranging from 3 to 199 employees indicated that 79% of small employers cited cost as the major issue to not offering a health insurance benefit, found that benefits were variable each year in terms of cost and covered services (e.g., mental health, cost for families). Some employers simply pass on market premium increases directly to the employee that impacts re-enrollment

by the employee and their dependents. For the past decade, there has been an average of a 10% annual increase in healthcare premiums (Kaiser Foundation 2008).

Insurance Plans Offer Different and Confusing Benefits and Costs

In addition to the challenges for employers to provide affordable health insurance plans for their employees and their families, various designs of insurance plans are confusing for many employees. The differing features of plan designs and the restrictions have many unknowns that can lead to insured individuals and their families avoiding access to the healthcare system and not receiving regular preventive care. Surprises of co-payments for outpatient screening procedures such as colonoscopies and emergency room visits as well as the varying co-payments for differing tiers of pharmaceuticals can incent insured individuals to avoid utilization of needed services and decrease adherence to recommended treatment plans. Providers of healthcare are frequently just as uncertain as to what various insurance plans may or may not cover. This places the providers such as hospitals, clinics, and physicians in an uncomfortable position in terms of managing care and service delivery. There is a notable *absence* of tools or lists of desirable characteristics for health insurance policies that would enable health care consumers to make wise choices about options for healthcare insurance.

Workers Are Not Eligible to Enroll, or Choose Not to Enroll

Although employers may offer insurance, some workers are not insured due to being part-time workers or having a waiting period before eligibility begins. However, for workers who are eligible, approximately 13% choose not to enroll (Kaiser Foundation 2006). There is a relationship with declining income and choosing not to enroll in employer-offered health insurance as well. As health insurance premiums increase, some choose to take the risk of *not* having health care coverage. Some insured families lose coverage due to the worker changing jobs or getting laid off in poor economic times. Divorce and death can also cause families to lose insurance coverage.

Individuals Are Not Able to Find a Medical Insurance Plan Due to Cost or Pre-Existing Medical Conditions

Individuals and families who do not have access to employer health insurance benefits, or who do not work, or who are self-employed, may try to purchase health

insurance in the individual market. Some states offer small group coverage for the self-employed and nationally; this is about 6% of the non-elderly Americans (RWJ 2005). As a result, most self-employed Americans or small businesses find their health insurance premiums determined primarily on age and health status. Insurance companies in some states must insure all individuals who apply for coverage, yet can charge whatever premiums they choose for those they expect to have high medical utilization and costs.

Individuals who have been employed full time and insured by an employer with greater than 20 employees, they may be eligible to continue coverage through the Consolidated Omnibus Reconciliation Act (COBRA) after employment has been terminated. However, this is also a much more expensive option that can only be used for up to 36 months post-employment.

Another barrier to being insured is the existence of previous medical conditions, commonly called "pre-existing conditions," which can result in expensive premiums. Some states, *allow* insurance companies to simply deny coverage for an individual perceived as being high risk. Individuals with pre-existing medical conditions, at times, cannot purchase any sort of insurance for any amount of money in the marketplace. The best strategy for these individuals is to affiliate themselves with an employer who offers insurance in order to gain medical insurance since no one can be selected out or denied in the group insured model.

Diabetes, for example, is a chronic disease in which individuals struggle to acquire and keep healthcare coverage. The American Diabetes Association has identified the inability for many Americans with diabetes to find healthcare coverage to be a primary issue for advocacy (http://www.diabetes.org, 2008). Nearly, 21 million American children and adults have diabetes and many are uninsured and unable to access the necessary supplies, medications and education needed to self-manage their disease and prevent expensive and life-threatening complications such as heart disease, retinopathy, kidney failure, and vascular disease. Health insurance problems make it harder for people to manage their diabetes, and uninsured adults with diabetes are less likely to receive needed care and effectively manage their disease. Even those with insurance struggle to obtain needed care when the insurance is inadequate. People with diabetes need health insurance that is available, affordable, and adequate to provide care for their chronic illness (http://www.diabetes.org, 2008)

In 2004, a team of researchers at Georgetown University Health Policy Institute (2005), studied the experiences of 851 individuals who had diabetes and the role of health insurance. These individuals were all under 65 years of age and either were uninsured, about to lose their insurance, or insured with problems. They echoed the problems that many face who have a chronic health condition. Despite having some sort of insurance, they struggled with medical debt, trying to find less expensive test strips and medications on E-Bay, or from Canada, and some had serious expensive complications from lack of management of their diabetes. Essentially, when people have a chronic health condition and their insurance coverage breaks down, they frequently lose their jobs and struggle with financial resources as well as healthcare status.

Another scenario illustrates a family in which one parent suffered from asthma and the other from hypertension. Based upon the continued increases in their

employer-based health insurance and out-of-pocket costs, they both sought employment for less compensation but improved healthcare benefit plans.

There Are Limited Medical Insurance Programs for Low-Income Adults Without Children

Although Medicaid helps provide health insurance coverage for low-income individuals, the financial eligibility requirements are very limited and differ from state to state depending on the local economy, the number of families who are low-income, and the design of the state's Medicaid program. Most State guidelines for childless adults are very restrictive and even the poorest are often not eligible. In addition, the process of enrolling and staying enrolled is challenging for this low-income population. Convenience of enrolling in Medicaid programs is seen as one of the most effective methods to improve enrollment for those eligible for Medicaid (RWJ 2005). For other subgroups of Americans, such as immigrants and refugee populations, this assistance with enrollment is an essential strategy. Flores et al. (2005) found that the barriers to insuring eligible children in Latino families included lack of knowledge about the application process, language barriers, family mobility, and system problems such as lost paperwork and excessive waits.

Another recent study released by the National Institute for Health Care Management (2008) reported that one in four are eligible for Medicaid and the State Children's Health Insurance Program (SCHIP) but are not enrolled. The study cited reasons that included not being aware of the programs, not knowing how to enroll, fear of being linked to a publicly financed program and the challenge of staying enrolled.

Most of the 12 million eligible in the US are low-income families which include 6.1 million children (64% of the uninsured children in the US). The study was based upon the 2006 data from the 2007 Current Population Study and also reported that of the 10 million uninsured non-US citizens, 5.6 million are undocumented immigrants, and 4.4 million are legal residents (NIHCM Foundation 2008). These numbers illustrate that an additional 25% of the uninsured would be insured if outreach programs addressing some of the barriers to eligibility completion were addressed. Fortunately, governmental health insurance programs tend to include children; however, children frequently lose eligibility around age 19, creating a gap in coverage. Young adults frequently face challenges in finding employment, which provides health insurance benefits**.**

Changes in Income or Eligibility; Job Change, Move, Layoff, Marital Status

Approximately, *two million Americans* lose their health insurance each month. Health insurance transitions can happen when there is a job change, layoffs, a move,

change in marital status, or a change in income status. Individuals purchasing coverage from the marketplace or their employers could potentially be uninsured at any point in time. For example, a large stable employer in the southwest experienced an employee strike which lasted for approximately 2½ months. After 30 days, as prescribed in the employee medical insurance benefit, the striking employees and their families did not have health insurance. Suddenly, these seemingly stable families were struggling with paying out-of-pocket for health and medical care. Regularly taken prescription medications were the key stumbling point for individuals who suddenly discovered that the cost of purchasing their regular medications for chronic illnesses totaled over $800–$1,000 per month. Needless to say, anyone could become uninsured or experience a transition in insurance coverage and be at risk for a period of time.

Some people transition directly from one health insurance plan to another, but many are uninsured for a month or longer. Research shows that people in poor health are twice as likely to encounter a lengthy spell without health insurance compared to people in good health (Kaiser Foundation 2006). About 80% of the diabetics studied in the Georgetown study had problems arise directly related to health insurance transitions (NIHCM Foundation 2008).

What Do These Causes for Being Medically Uninsured Tell Us?

With healthcare insurance being a "choice," rather than a mandate in the US, there is great variability in what research-identified barriers tell us about why people are uninsured. While some individuals may have many options for securing health insurance, it is still a *choice*. Some individuals simply choose to not purchase and/or participate in health insurance options, while others will pay whatever the cost to assure health insurance coverage. Some individuals choose not to enroll in public health insurance programs, even when the cost is zero, and will seek healthcare on an as-needed basis. These differences and the diversity in the population create a challenge in attempting to insure as many as possible in a complex "patchwork quilt" of methodologies by which to enroll or purchase health insurance.

Today, most of the uninsured are the "working poor." As discussed above, they usually make too much money to qualify for Medicaid, yet have too little income to be able to purchase private health insurance. For example, in 2008, a family of four at 200% of the federal poverty level would be earning $42,400 and therefore, not qualifying for Medicaid, but finding local prices for healthcare insurance ranging anywhere from $900 to $1,500 per month for family coverage. Purchasing health insurance for a family in this income range can exceed 10% of the family's income. Only 59% of persons with household incomes less than 150% of the federal poverty level are able to cover the entire family. As the household income increases to 200% of the federal poverty level, 90% of families have all household members insured (Institute of Medicine 2003).

Insurance Mandates and High Risk Pools

As mentioned previously, in many states, insurance companies can charge more because someone is sick or simply deny coverage. Individuals with chronic conditions such as diabetes may not be able to purchase insurance. Some states such as Illinois and Indiana, however, mandate that insurance be sold with comprehensive benefits to all residents regardless of health status. In addition, they may *not* charge these individuals more than they could charge healthy individuals in the community (http://www.naschip.org, 2008). Again, the Georgetown University study reports in that 395 people with diabetes needed to purchase individual health insurance and only 15 were successful (NIHCM Foundation 2008). The federal legislation of COBRA, mentioned earlier, allows certain people who would lose their insurance when their employment ends to purchase the existing employer-based plan for, anywhere from, 18 to 36 months. However, the individual must pay the entire premium and this is frequently cost prohibitive. When COBRA expires, another federal law passed in 2003, HIPAA (Health Information and Affordability Act) requires individuals to be offered non-group coverage. Again, there are no specific regulations for the type of insurance, so the actual insurance policy can be weak and expensive to purchase as well.

Thirty-three states in the United States have now created high-risk pools for individuals who have been turned down by private insurers and do not qualify for Medicaid assistance. The first of these high risk pools was established in 2002 and insures about 6% of its individually insured population. A few other states that focus on consumer outreach insure about 2–3% of the states' individually insured population (http://www.insure.com, 2008). These high risk pools for the uninsured are also expensive, require much paperwork, and have some caps on how much a benefit will pay for the individual. To begin with, a high-risk insurance pool is the last resort for those with pre-existing conditions, whose employers do not provide coverage and have individually been denied coverage because of their health status. The high risk pool coverage generally insures the middle class who do not qualify for Medicaid. Legislators created these pools as a safety net; each state operates differently depending on how much is funded by the state.

Essentially, the state government contracts with private insurers to administer the program, collect the premiums, and pay the claims. Although the benefits vary, most mirror basic health insurance coverage. However, these pools are allowed to charge up to 130–200% of the market cost for an individual premium. According to Families USA (2008), most states cap the premium at 150% of the market value and risk pools are ineligible for federal grants if they are not at 200% or below in pricing premiums. Those individuals in high risk pools have their choice of deductibles usually ranging from $500 to $10,000 depending on the state and choices offered. High risk pool policy holders can open tax-free Health Savings Accounts (HSAs) to save for deductibles, co-pays, and other out-of-pocket expenses.

Individuals must demonstrate proof of denial, as well as not being eligible for Medicaid or Cobra benefits. Lastly, there is generally a 6–12-month waiting period for individuals to have active coverage. High risk pools are continuing to expand as an option for uninsured individuals.

As mentioned above, high risk pools are quite expensive and are not feasible for the working poor who do not qualify for governmental healthcare programs. Cunningham (2007) investigated whether uninsured people paid full or reduced costs when they received healthcare services and if they were aware of providers in their communities who did charge less for uninsured individuals. Their research found that less than half of the uninsured in their sample population (47.5%) used or were aware of lower-priced providers. Promoting lower-priced providers in communities may also be another method for improving access to needed healthcare for the working poor.

What's Driving Risking Healthcare Costs?

All Americans recognize the continuing increases in medical insurance as well as the out-of-pocket expenditures. There are many factors driving these rising costs that include an aging population, increased utilization of healthcare services, new and more prescription medications available, cost-shifting from federal programs to state programs, new and better technology for diagnosis and treatment, corporate profits, medical liability, and the uncompensated care of the uninsured and underserved.

It is also evident that the healthcare system focuses on managing the care of those who are ill. In any given year, close to 50% of all healthcare spending pays for the care received by only 5% of the population (Kaiser Foundation 2006). In 2004, almost half the people in the US had a chronic condition that ranged from mild to serious. Healthcare for those with chronic conditions accounts for 75% of total healthcare costs (US DHHS 2002). As the population ages, healthcare spending begins to increase at around age 55 and healthcare costs for patients between the ages of 76 and 84 are nearly eight times as much as for the care of children ages 1–5 years of age (US DHHS 2002). The CDC Report on Aging and Health in America (2007) predicts that by 2030, 20% of the US population will be over 65 years of age and healthcare expenditures will increase by 25% without factoring in the cost of new technology and inflation. The majority of healthcare services are also utilized by the older population.

The uninsured and underserved traditionally receive little preventive and primary care, and frequently may not follow up on initial care; this can result in more acute episodes of illness. Community outreach and the current work to help the uninsured establish a low-cost medical home may help to minimize more expensive utilization of tertiary care services.

Results of No Health Insurance

The results of having no health insurance can lead not only to adverse health consequences, but also adverse financial consequences. For example, uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery. The uninsured are also less likely to receive care even when they have serious symptoms and uninsured children are 70% more likely to go without care for ear infections, asthma, and sore throats. Uninsured children are five times more likely not to have a needed prescription filled. Reviewing the potential financial consequences, 27% of families reported they struggled to pay for expenses, such as food, rent, and heat. Almost 44% reported they were forced to use most or all of their savings to pay medical bills and one out of five said they had run up a large credit card debt or had to take out a loan against their home to pay medical expenses (Commonwealth Fund 2004). In a 2007 Health Confidence Survey (EBRI 2007), 63% of the respondents reported an increase in the costs they are responsible for, and the negative impact of those increases on their financial health of their household. Fifty-two percent reported a decrease in their savings overall due to healthcare expenditures.

What Tradeoffs and Options Exist for the Medically Uninsured?

Most Americans are concerned about the continually rising cost of healthcare and what might happen to their coverage in the future as well as their ability to afford medical care. The challenge in determining what can be done revolves around three issues: cost, access, and quality. Many options are possible that stretch from expanding governmental coverage, offering Americans financial incentives or tax credits for health coverage, allowing the free market to set access and price, expanding primary prevention and primary care access, or developing clinical information systems to save money, along with other alternatives. However, due to the complex nature, potential consequences, and sheer size of the healthcare industry, local communities and states may do better to improve cost, access, and quality than the federal government.

Critical Thinking Case Studies

Sheila's husband works for a small restaurant chain that offers health benefits. However, the coverage is about $1,200 per month for the family and also requires an additional policy for prescription drugs. Sheila has diabetes and her children require asthma medications monthly which result in a monthly prescription bill of about $400. When money is tight, Sheila buys the children's medications, but foregoes her own.

She also tests her blood sugar only occasionally to save test strips. The last time she saw her physician, her blood sugar was *elevated.*

What assistance might be available for Sheila?

What options are there for her family?

Charlie lost his health insurance when he was laid off about a year ago. He was offered COBRA but could *not* afford it and was without insurance for 3 months paying for his high blood pressure and cholesterol medications on his credit card. He then was able to qualify for a new policy at $400 per month. However, his medications and physician visits were not covered. He elected to continue to use his credit card, but recently ended up in the hospital with chest pain. He has been discharged with a $16,000 hospital bill and no insurance. The hospital has coordinated a payment plan for him.

What might be the options for Charlie as his employer does not offer medical or dental benefits?

What would be the initial considerations in terms of his level of income and pre-existing conditions?

References

Center for Communicable Disease (2007) The state of aging and health in America. Center of Disease Control and Prevention, Atlanta, pp 1–46

Commonwealth Fund (2004) Affordability crisis in healthcare. Issue Brief

Cunningham PJ (2007) Identifying affordable sources of medical care among uninsured persons. Available at http://www.hschange.com/content/912/?topic=topic06. Accessed 29 Nov 2008

Employee Benefit Research Institute (2007) 2007 Health confidence survey: rising costs are changing the ways Americans use the healthcare system. Available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_11a-20071.pdf. Accessed 23 Nov 2008

Families USA (2008) Failing Grades: State Consumer Protection in the Individual Health Insurance Market. Families USA. Available at: http://www.familiesusa.org/assets/pdfs/failing-grades.pdf. Accessed 28 Sept 2009

Flores G, Abreu M, Brown V, Tomany-Korman SC (2005) How Medicaid and the State Children's Health Insurance Program can do a better job of insuring uninsured children: the perspectives of parents of uninsured Latino children. Ambul Pediatr 5(6):332–340

Georgetown University Health Policy Institute (2005) Falling through the cracks: Stories of how health insurance can fail people with diabetes, pp 1–48

HealthNet of Arizona (2008) Interview re: employer provided plans with Provider Network Representative, July 8, 2008

Holahan J, Cook A (2008) Changes in economic conditions and health insurance coverage, 2000–2004. *Health Affairs*, Available at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.498v1. Accessed 12 Oct 2008

Holahan J, Cook A (2008) The decline in the uninsured in 2007: why did it happen and can it last? Kaiser Family Foundation, Washington, DC, pp 1–19

http://www.covertheuninsured.org (2008) Accessed 1 April 2008

http://www.diabetes.org (2008) Accessed 12 April 2008

http://www.insure.com (2008) Accessed 28 Nov 2008

Institute of Medicine (2003) Uninsurance facts and figures: the uninsured are sicker and die sooner

Kaiser Family Foundation (2006) The uninsured: a primer key facts about Americans without health insurance. The Kaiser Commission on Medicaid and the Uninsured

Kaiser Family Foundation (2008) Few low-income uninsured buy non-group coverage. Available at http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANews. Accessed 12 Oct 2008

National Association for State Comprehensive Health Insurance Plans (2008) Available at http://www.naschip.org/. Accessed 30 Nov 2008

National Institute for Health Care Management Foundation (2008) Available at http://www.nihcm.org. Accessed 6 July 2008

Robert Wood Johnson Foundation (2005) Why are people uninsured? Available at http://www.statecoverage.net. Accesssed 16 Oct 2008

St. Luke's Health Initiatives (2007) Arizona health futures: employer-sponsored health insurance coverage, pp 1–7

US Census Bureau (2006) Health insurance statistics. Available at http://www.census.gov/hhes/www/hthins/hthin06.html. Accessed 15 Oct 2008

US Census Bureau (2008) Health insurance statistics. Available at http://www.census.gov/hhes/www/hthins/hthins07.html. Accessed 21 Nov 2008

US Department of Health and Human Services (2002) Medical expenditure panel survey. Available at http://www.hhs.gov. Accessed 17 March 2008