Financial Barriers and Outcomes After Acute MI

Rahimi and colleagues determined the prevalence of self-reported financial barriers to health care services or medications (“avoidance due to cost”) among 2498 participants in a prospective observational study of acute myocardial infarction (MI) and examined the association of these barriers with subsequent health outcomes. The authors report that 18.1% of patients reported having had financial barriers to health care services and 12.9% reported having had financial barriers to medication, even though 68.9% and 68.5%, respectively, were insured. Compared with patients without financial barriers, patients with financial barriers had a worse recovery, including higher rates of angina, poorer quality of life, and a higher risk of rehospitalization.

SEE PAGE 1063

Insurance, Care, and Status After a Health Shock

In an analysis of 1997-2004 data from a prospective, population-based survey, Hadley compared medical care use and short-term health changes among uninsured and insured nonelderly persons after a “health shock” (unintentional injury or onset of a chronic condition). After controlling for underlying medical conditions and baseline characteristics, the author found that uninsured persons who experienced a health shock received less medical care and had larger decreases in short-term health status than insured persons.

SEE PAGE 1073

Emergency Medicaid Expenditures for Immigrants

Undocumented or legal immigrants with less than 5 years of residence in the United States are excluded from Medicaid eligibility, with the exception of limited, emergency coverage (Emergency Medicaid). DuBard and Massing examined 2001-2004 Emergency Medicaid claims data for North Carolina, a state with a recent influx of immigrants. Among their findings were that 48,391 patients (99% undocumented) received services reimbursed under Emergency Medicaid. Childbirth and complications of pregnancy were the most common diagnoses; however, spending for patients who are elderly and disabled increased 98% and 82%, respectively, from 2001-2004.

SEE PAGE 1085

High-Deductible Health Insurance and ED Use

Wharam and colleagues assessed emergency department (ED) visits and subsequent hospitalizations before and after an employer-mandated switch from a traditional HMO plan to a high-deductible health plan. The authors found that among patients who switched to the high-deductible plan, ED visits and hospitalizations from the ED decreased from baseline compared with control patients who remained in the traditional health maintenance organization. In an editorial, Grudzen and Brook discuss issues to address before it can be concluded that efforts to control health care costs, such as high-deductible health plans, are safe.

SEE PAGE 1093 AND EDITORIAL ON PAGE 1126

Physicians Can Change the Future of Health Care

Starting with the premise that the purpose of the health care system is not to minimize costs, but rather to improve health and health care value for patients, Porter and Teisberg describe a strategy for health care reform that is market based and, importantly, physician led. Their proposal for reform emphasizes 3 principles: value for patients is the goal, care is organized around medical conditions (not specialties or procedures) and care cycles, and results—risk-adjusted outcomes and costs for each medical condition—are measured.

SEE PAGE 1103