

HEALTH POLICY

Will Insured Citizens Give Up Benefit Coverage to Include the Uninsured?

Susan Dorr Goold, MD, MHSA, MA, Stephen A. Green, MD, MA, Andrea K. Biddle, PhD, MPH, Ellen Benavides, MHA, Marion Danis, MD

OBJECTIVE: To describe the willingness of insured citizens to trade off their own health benefits to cover the uninsured.

DESIGN: Descriptive study of individual and group decisions and decision making using quantitative and qualitative methods.

SETTING AND PARTICIPANTS: Twenty-nine groups of citizens ($N = 282$) residing throughout Minnesota.

INTERVENTIONS: Groups participated in Choosing Health-plans All Together (CHAT), a simulation exercise in which participants choose whether and how extensively to cover health services in a hypothetical health plan constrained by limited resources. We describe individual and group decisions, and group dialogue concerning whether to allocate 2% of their premium to cover uninsured children in Minnesota, or 4% of their premium to cover uninsured children and adults.

MEASUREMENTS AND MAIN RESULTS: While discussing coverage for the uninsured, groups presented arguments about personal responsibility, community benefit, caring for the vulnerable, social impact, and perceptions of personal risk. All groups chose to insure children; 22 of 29 groups also insured adults. More individuals chose to cover the uninsured at the end of the exercise, after group deliberation, than before (66% vs 54%; $P < .001$). Individual selections differed from group selections more often for the uninsured category than any other. Nevertheless, 89% of participants were willing to abide by the health plan developed by their group.

CONCLUSION: In the context of tradeoffs with their own health insurance benefits, groups of Minnesotans presented value-based arguments about covering the uninsured. All 29 groups and two thirds of individuals chose to contribute a portion of their premium to insure all children and most groups chose also to insure uninsured adults.

KEY WORDS: public opinion; consumer participation; medically uninsured; health priorities; resource allocation.

J GEN INTERN MED 2004;19:868–874.

The contentious public and political discussions about health care during the last decade made little difference for those Americans, over 43 million, lacking health insurance. The high proportion of Americans without insurance and rising health care costs contribute to poor access to care in the United States.¹ One fifth of Americans report difficulty paying medical bills, and about one quarter forgo needed care or medication because of cost. More than 18,000 excess deaths in 2000 can be attributed to a lack of insurance.² Besides individual hardship for the uninsured, society as a whole suffers.³ Foregoing or delaying care ultimately results in more expensive care,⁴ the cost of which is borne by the general public.

Given the widespread impact of uninsurance, it is not surprising that public support for governmental intervention has steadily increased. In 1992, a majority of voters were not willing to pay more to achieve expanded access.⁵ In 1998, 61% of voters believed that a top legislative priority for Congress was helping the uninsured obtain health care,^{6,7} but were divided concerning their willingness to pay (46%) or not pay (49%) more in premiums or taxes to expand coverage.⁶ Although misinformed about *who* is uninsured (most did not know that the majority are employed), the public surveyed in *Health Coverage 2000* overwhelmingly supported covering the uninsured.⁸ Seventy percent were willing to pay as much as \$50 more per year in taxes to assure all Americans had health insurance, and 91% said passing laws to help the uninsured receive health care coverage should be a legislative priority. In April 2002, 23% of likely voters listed “affordable health care” as a first or second choice when asked what would be most important to them in deciding how to vote for a member of Congress, behind only the economy and jobs (35%) and Social Security and Medicare (25%).⁹

It appears Americans are conflicted about the uninsured: they want to expand coverage, but are uncertain as to what policy best achieves that goal and are hesitant to

Received from the Department of Internal Medicine (SDG), University of Michigan Medical School, Ann Arbor, Mich; Section on Ethics and Health Policy (MD), Department of Clinical Bioethics (SAG), National Institutes of Health, Bethesda, Md; Department of Health Policy and Administration (AKB), University of North Carolina at Chapel Hill, Chapel Hill, NC; and (EB), Minneapolis, Minn.

Address correspondence and requests for reprints to Dr. Goold: Department of Internal Medicine, University of Michigan Medical School, 300 N.I.B., Room 7C27, Ann Arbor, MI 48109-0429 (e-mail: sgoold@umich.edu).

pay the full price. What tradeoff is the public willing to make to benefit the uninsured? Our study used Choosing Healthplans All Together (CHAT), a simulation exercise in which participants choose health service benefits for themselves and for their community, constrained by limited resources.¹⁰ A community-based health reform study conducted in Minnesota in 2000 observed how insured persons, as individuals and as groups, weighed the needs of the uninsured against their own, and examined what, if anything, insured persons would be willing to give up to provide insurance to those without any.

METHODS

Instruments

This study used a structured small group simulation exercise, CHAT, designed to allow groups of laypersons to construct health plans within the constraint of limited resources.^{10,11}

In the first step of the exercise, participants use a game board (Fig. 1) to select benefits by distributing pegs among the holes on the board. Resources can be allocated among a variety of benefit categories, including some not typically included in health insurance such as long-term care, dental services, and coverage for the uninsured. Participants select from up to 4 options for each benefit category or can forgo a category altogether. A manual describes options in simple language.

Participants have 50 pegs to allocate; each peg represents approximately 2% of a weighted average (including singles and families) insurance premium (\$5,000 per annum). Players could choose not to use all of their pegs and instead “keep the money” as taxable income.

After making benefit selections, participants spin a roulette wheel and receive health event cards for the category on which the ball lands. Each health event describes an illness scenario and the associated consequences of coverage choices including out-of-pocket payment responsibilities, access, and choice of provider or treatment. In one uninsured “health event,” an uninsured neighbor has broken his leg; another describes a coffee can collection at the local service station.

During the game, participants make choices and face consequences 1) alone, 2) in groups of three, 3) as an entire group, and 4) once again alone (Fig. 1). This progression promotes group decision making and allows comparison of individual and group choices. Further information about the exercise is available upon request.

Players were informed that coverage would remain in place as chosen for 5 years, that 6% of Minnesotans were uninsured, and there would be no other way to insure health services (e.g., no Medicaid program). In the uninsured category, individual participants and groups had three options: 1) allocate no pegs to cover the uninsured; 2) allocate two pegs (4% of their total available premium) so that all children in Minnesota would have insurance; or

3) allocate four pegs (8% of their total available premium) so that all children and all adults in Minnesota would have insurance.

Volunteers completed self-administered, pregame written questionnaires about demographics, type and source of health insurance, health status, health care utilization, and out-of-pocket costs. Questions also asked about the importance of relative health insurance features including choice of doctors, access to specialists without referral, good mental health coverage, prevention or wellness programs, out-of-pocket expenses, and wait times for doctor appointments.¹² Postgame questionnaires asked participants to rate the informativeness of the CHAT exercise, and their perceptions of the group process and outcome of decision making using items from published work,^{11,13–15} some of which were adapted from existing instruments.^{16–19} Other 4-point Likert items asked whether participants would be willing to abide by the group’s choice of health plan, whether health insurance should balance community and individual needs, and whether health insurance should include a bonus program to reward healthy behaviors.

Data Collection

CHAT was administered to 31 groups of 8 to 15 members ($N = 322$) recruited through area employers and community organizations. Twenty-two of the 31 group sessions were convened in the 7-county metropolitan area; 9 were in rural Minnesota. Participants were recruited using word-of-mouth, community bulletin boards, and/or (for the 19 employer-based groups) a designated liaison. Participants were compensated with \$50 or time off work to participate.

Choices made by individuals at the start of the game (cycle 1) and after group discussion (cycle 4) were recorded, as well as choices made by each group as a whole (cycle 3).

Data Analysis

Descriptive statistics were employed for participant demographics and attitudes. Comparisons used χ^2 statistics and Fisher’s exact test for categorical variables and Student t tests²⁰ for continuous variables. The Mantel-Haenszel χ^2 statistic was used to examine linear relationships between pairs of ordinal variables.²¹ McNemar’s χ^2 test was employed to assess the degree of agreement between individual health care coverage choices made during the first and fourth cycles of the game.²² Because the final cycle was conducted after group discussion, we corrected those responses for intraclass correlation.

Verbatim transcripts of audiotaped group discussions were electronically and manually searched for any mention of the uninsured or the uninsured options. A typology of arguments was created by one author (SDG), reviewed by two others (MD, SAG), and presented for review to experts in health services research in two venues.

This project was exempted from institutional review board (IRB) review by the Office of Human Subjects

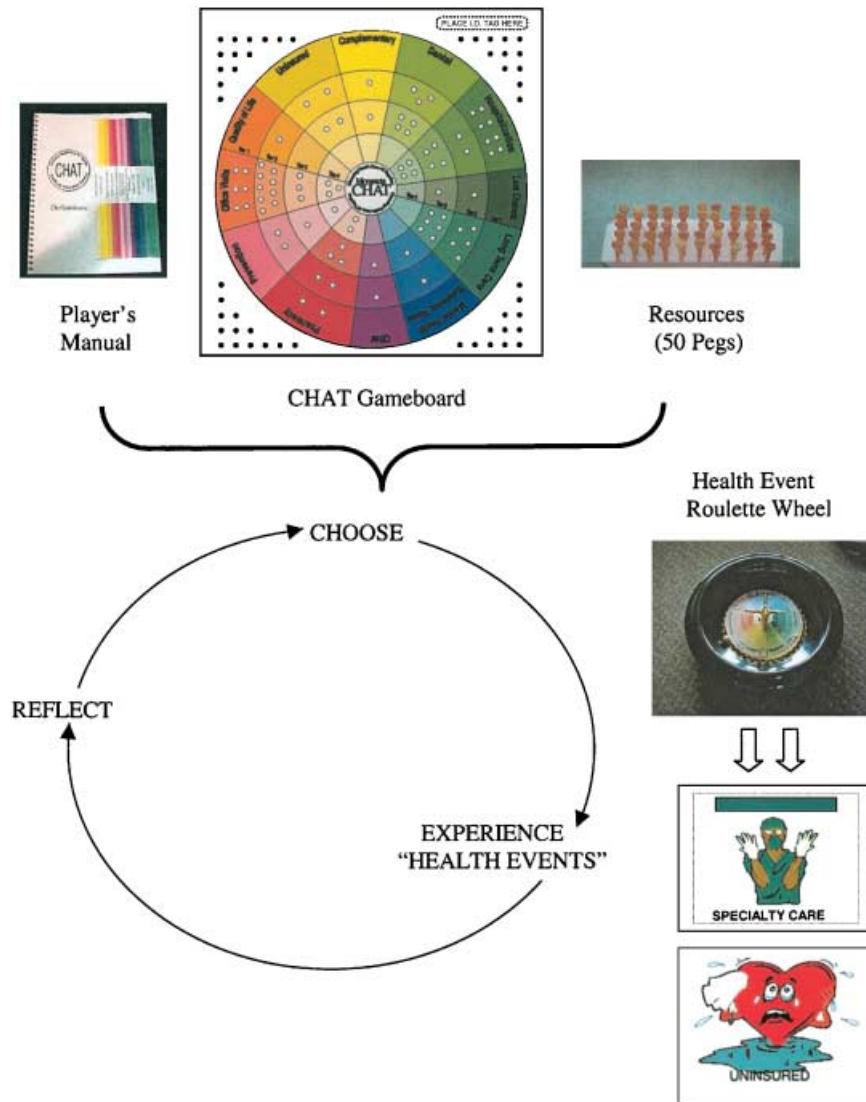


FIGURE 1. Basic steps in the CHAT exercise. These steps are repeated in 4 rounds—individual, small group, entire group, and individual.

Research at the Clinical Center of the National Institutes of Health, and approved by IRBs at the University of Michigan, the University of North Carolina at Chapel Hill, and Duke University. During the game, participants were given an alias to preserve anonymity.

RESULTS

Participants were predominantly white, socioeconomically advantaged, and insured (see Table 1). During cycle 1, about half of individuals choosing “for themselves and their family” allocated some of their limited resources to include the uninsured (see Fig. 2). Forty-six percent of individuals allocated no pegs to the uninsured category, 32% allocated two pegs (insuring all children in Minnesota), and 22% allocated four pegs (insuring all children and adults in Minnesota).

During cycle 3, when each group designated coverage options for the community as a whole, all groups chose to

allocate some pegs to include the uninsured; 75% (22/29) of the groups provided adults and children with insurance, while 25% (7/29) of the groups provided insurance to children.

During cycle 4, when individuals again chose for themselves and their families, 34% did not provide coverage for the uninsured, 35% only insured children, and 31% chose to insure both adults and children. Thus, while 54% of individuals chose to extend any coverage to the uninsured

Table 1. Participants (N = 322)

Mean age, y (SD)	42.4 (11.6)
Women, %	67
White, %	94
Income <\$35,000, %	18
Insured, %	97
Employer-provided insurance, %	82
Fair/poor health status, %	5
Hospitalized last year (household), %	9
Chronic illness (household), %	28

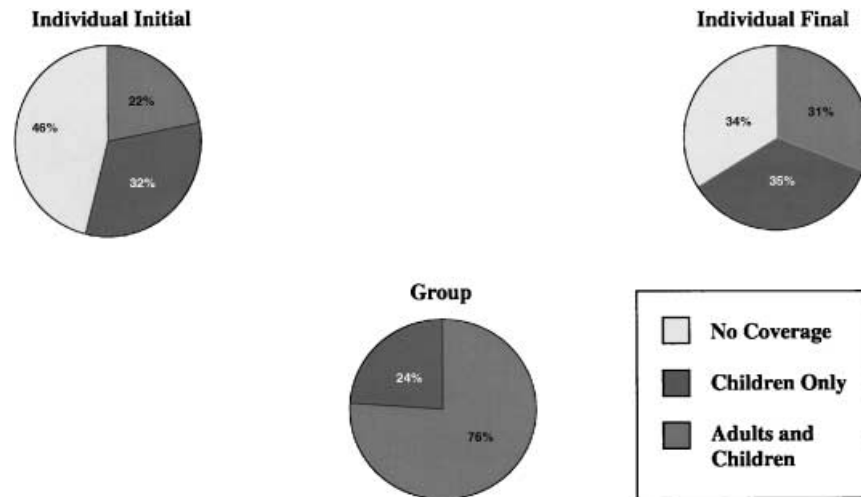


FIGURE 2. Allocations to the uninsured by: Individual Initial: individuals before group discussion; Individual Final: individuals after group discussion; Groups.

initially, 66% of individuals chose to include any coverage to the uninsured at the end of the exercise, after group deliberations ($P < .001$). There were few demographic or attitudinal differences between individuals who did and did not allocate pegs to the uninsured in either cycle 1 or 4. Those who chose not to allocate resources to the uninsured in either cycle were more likely to report greater than \$2,000 per year out-of-pocket health care costs, more likely to agree that the health care system is “broken,” and less likely to agree that mental health coverage is important. Benefit selections differed between those who did and did not select coverage for the uninsured. Compared to those who did not elect to cover the uninsured in their final selections, those who covered the uninsured were more likely to select coverage for long-term care (71% vs 52%; $P = .0012$) and mental health (87% vs 59%; $P < .0001$). Individuals who opted to provide health coverage for the uninsured in their final selections opted for less intensive coverage of hospitalization ($P = .0001$), pharmacy ($P = .0026$), office visit coverage ($P = .0043$), and dental coverage ($P = .0009$) for themselves and their families. Those who initially did not allocate pegs to the uninsured but did so in the final round ($n = 56$; that is, they changed from none to any coverage for the uninsured), tended to do so by decreasing, but not dropping, coverage in other categories.

The uninsured category had the highest level of disagreement between individuals and groups (Table 2). Despite this disagreement, nearly all (89%) participants were willing to abide by the decision made by their group. Furthermore, nearly all participants agreed “The way in which the group reached its decision was fair” (98.6%) and that their views were considered and taken into account (97.8%).

Reasons Given for Covering the Uninsured

Analysis of group dialogue suggested that participants opted to provide coverage for the uninsured for a variety

of reasons. Sometimes, they could identify with the circumstance. This could be on the basis of speculation (e.g., “It could happen to me or someone I know”; “...I mean if I got fired from here or something, I’d want to know that I have coverage”), or they might appeal to their own experience:

- A: “I have never had health insurance in my entire life. Nobody in my family [did].”
- B: “But that’s your choice.”
- A: “But it’s not a choice, and I’ll tell you from personal experience that it is not a choice.”

Choosing coverage for the uninsured was, in a way, insuring themselves against the possibility of becoming uninsured. Other participants voiced concern about friends or family members who either were uninsured or vulnerable to becoming uninsured. One woman “was thinking not just of, not necessarily about myself, but my sister who has two kids and it’s like, well, if she did lose her job...I would

Table 2. Proportion of Individuals (N = 322) Whose Choices in Cycle 4, “for You and Your Family,” Were Identical to the Choice Made by the Group in Cycle 3 “for Your Community”

	%
Uninsured	41
Hospitalization	42
Office visits	52
Pharmacy	53
Complementary medicine	57
Mental health and substance abuse	60
Long-term care	62
Prevention	63
Dental	67
Last chance	68
Other	69
Quality of life	77

want them covered somehow." Participants also expressed concern for the less fortunate, expressing the belief that everyone should have health insurance, whether or not it was guaranteed by employment. "The bottom line is some people just can't afford it...they can't do it." "...the single mom and the kid...she is working two jobs...she doesn't have a health plan." A desire to care for vulnerable populations, such as children and the elderly, was particularly evident. Participants argued to "at least cover the children of the uninsured," occasionally arguing to cover adults to protect children: "When the mother or father of at least four children gets sick, they don't have access...." Similar arguments arose about the elderly:

A: "There are so many of the elderly who cannot afford any kind of insurance."

B: "That's a good point."

C: "Okay, I'll go for it."

Third, participants recognized that coverage for the uninsured promoted the common good. Communities would be safer because "...children are well taken care of...and healthy, not abused, not as addicted, we have less violence...my world would be safer." There was also a perceived financial benefit to society ("if we don't insure these people, they're going to end up on welfare"), coupled with recognition of the cost shifting that occurs in the current system:

A: "They get [hospital] bills...and they can't pay. Who pays for that bill?"

B: "The hospital."

A: "No, we do. It's the people who are insured."

Comments about other benefit categories also appealed to community need or the common good. Participants recognized that mental illness and substance abuse, for example, can impose harm on relatives, friends, and co-workers, as well as on individual patients ("Even [coverage for] substance abuse, if it can keep our families together, if it can keep people productive on the job, I think we're saving a lot right there. I think it's important, even for that reason alone").

Reasons Given Against Covering the Uninsured

The most prominent argument against covering the uninsured population was the belief that health insurance was a personal responsibility, and not obtaining it, a personal choice. One participant said he would have difficulty justifying to the community using limited resources for the uninsured. He could understand if "Joe Blow needs insurance [and] can't afford it," but not "the John Doe who doesn't want to pay...and would rather buy the new car...." Adults have a responsibility to obtain insurance through employment, even a single parent who "decides to stay home and care for her children, when she is very capable of working at a job..." There was also the view that insurance is "not an entitlement," "and if it is, then I should have life insurance and...long-term disability and short-term disability and everything else."

Another concern articulated about including the uninsured was a concern about free riders. Participants worried that people might drop any current insurance to receive this plan for free ("How do we slow that uninsured group from becoming half the population?"). A related argument raised concerns about the potential for broader impact on the state, as people might move to Minnesota to get insurance:

"And let's talk about another reality. If we're going to cover the adults, we are opening the door to people from states right now that have no coverage whatsoever. And that will be a drain...just like what's happening with welfare."

These comments did not occur in isolated discussion about the uninsured, but rather while considering other benefit categories, in the context of choosing benefits with limited health care resources.

DISCUSSION

This study of largely middle class, commercially insured individuals demonstrates the development of greater support for covering the uninsured during the course of group deliberation and provides insights into those deliberations. All groups elected to contribute a portion of their limited health premium dollars to cover children and most supported the additional use of limited resources to expand coverage to uninsured adults. More individuals chose to cover the uninsured following the discussion than initially. Nearly all participants were willing to abide by the group's decisions, despite substantial individual-group disagreement about this issue. While other studies^{6,9} indicate that U.S. citizens support the general idea of "universal" health insurance, or have documented, like this one, a "willingness to pay" for universal insurance, such responses may reflect a lack of context, or the inherently abstract nature of the question. In this study, insured Minnesotans faced a more concrete (albeit still hypothetical) tradeoff, as they were asked to select health benefits as if they were doing so for themselves, their families, and their communities. Through the use of health event role playing, participants in this study perceived the consequences of limiting their benefits, making the tradeoffs even more explicit, so it is all the more impressive that they traded off their *own* health benefits to insure all children (and, for most groups and some individuals, all adults).

The results reported here should be interpreted with caution. The study asked participants to make tradeoffs in a hypothetical context. A combination of quantitative and qualitative methods and the use of group-based data collection (conceptually fitting given the focus on shared resources) precludes sampling that would permit conclusions about the prevalence of a population's opinions and preferences. The geographic and demographic make-up of our sample also limits such conclusions, because it reflects a single state. Perhaps Minnesotans are more communally minded than residents of other states, or are responding

to the lower cost of expanding coverage because the percentage of the population without insurance is lower than in other states.²³ The disproportionate number of middle class women is also not representative of the employed population as a whole, and it is possible that having a majority of women or fewer low-income respondents influenced our results. Nonetheless, our findings are consonant with findings reported by others^{6,9} as well as results we have observed in North Carolina, where coverage for the uninsured by individuals increased after group deliberations.^{11,15}

Our findings add to the literature on public opinions and values regarding the uninsured in a number of unique ways. First, national surveys do not, with the exception of willingness to pay questions, involve the use of tradeoffs. Even willingness to pay questions are asked in a relatively abstract, general manner and thus the tradeoffs may not be “brought home” to respondents, whereas “health event” feedback and group discussion in our study made tradeoffs explicit and salient. Second, survey respondents are almost always individuals; our study looks both at individual and group choices and demonstrates an effect of the group process on individual opinions about the uninsured. Because insurance is a group product, a study of group decision making has conceptual appeal and adds information to what we know from individual-level data about public willingness to cover the uninsured. Finally, our study goes beyond other published reports in analyzing the reasoning used in the deliberative process. These findings provide important insights into public attitudes, opinions, and values about the vexing problem of the uninsured. They also illustrate what can be gained by group deliberation and discussion. Future research should seek to determine whether others share the opinions voiced by these participants, and whether they apply when groups have an opportunity to put them into actual practice.

Participants appealed to a variety of rationales in their arguments. Those advocating for coverage for the uninsured sometimes identified with their lot, either through their own experience, in imagining the possibility of being uninsured, or out of concern for known others who were uninsured or at risk. In an employment-based health insurance system like the one in the United States, including Minnesota, losing health insurance is one of many risks of those who become unemployed; a third of those with health insurance are worried about losing it.²⁴ Electing to cover the uninsured can be considered insuring against one’s own risk for that eventuality.

Arguments to protect vulnerable groups or benefit the least well off illustrate familiar notions of distributive justice,²⁵ while concerns about the common good reflect utilitarian concepts or, alternatively, enlightened self-interest.²⁶ Arguments against including the uninsured also used utilitarian principles, for instance in concerns about free riders. Finally, attitudes about personal responsibility and choice illustrate the value placed on free will (or self-determination).

The U.S. health care system is currently based on an economic model of accountability where it is assumed

that the “invisible hand” will allocate resources fairly.²⁷ In an economic model, efficiency concerns predominate and patients or health insurance enrollees purportedly exert influence in the system through the threat or exercise of “exit.”²⁸ However, a minority of insured Americans can choose between two or more insurance plans, and moral hazard and other intrinsic features of health insurance undermine the market’s ability to maximize efficiency. Moving toward a participatory, or deliberative democratic model of accountability requires providing insurance enrollees with meaningful voice as well as choice, affording them opportunities and mechanisms to develop and express shared interests and positions concerning their health care.^{29–33} A group exercise such as CHAT recognizes the group nature of insurance, with the necessity for interpersonal (not just intrapersonal) tradeoffs, and can facilitate discussion of citizens’ values and belief about health care, the cost of care, and potential harms and benefits inherent in tradeoff decisions. Unlike public opinion surveys, deliberative procedures are more consistent with normative models of an informed, thoughtful, and community-oriented public, emphasizing the use of reasons and arguments for and against different policies in an informed and cooperative process, rather than simply adding up individual private “preferences.” Participants are encouraged to reconsider their *ex ante* opinions in light of the interests, perspectives, and arguments of their fellow citizens.^{34,35} Perhaps more importantly, deliberative procedures go beyond what people decide to document *how* and *why* they decide—that is, the principles and reasoning used to generate both individual- and group-level decisions.

The results reported here offer encouraging preliminary evidence that through group deliberation, it may be possible for the public to gain a greater appreciation of the need to ration health care resources and share them with less fortunate members of the community.

This work was supported in part by the Allina Foundation. Dr. Goold and coauthors received the 2002 Mark S. Ehrenreich Prize for Research in Healthcare Ethics for the work reported in this paper. Dr. Goold was a Robert Wood Johnson Foundation Generalist Faculty Scholar during the research.

REFERENCES

1. Blendon RJ, Schoen C, DesRoches CM, Osborn R, Scoles KL, Zapert K. Inequities in health care: a five-country survey. *Health Aff.* 2002;21:182–91.
2. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. *Care Without Coverage: Too Little, Too Late.* Washington, DC: National Academies Press; 2002.
3. Editorial Staff. Back burner for insurance. *The Los Angeles Times.* August 29, 2001:812.
4. No health insurance? It’s enough to make you sick. Philadelphia, Pa: American College of Physicians-American Society of Internal Medicine; 2000.
5. Henry J. Kaiser Family Foundation/Harvard School of Public Health/Princeton Survey Research Associates Poll. Storrs, Conn: Roper Center for Public Opinion Research; November 4, 1998.

6. Blendon RJ, Benson JM, Brodie M, Altman DE, James M, Hugick L. Voters and health care in the 1998 election. *JAMA*. 1999;282:189–94.
7. Drazen J, Bush G, Gore A. The Republican and Democratic candidates speak on health care. *N Engl J Med*. 2000;3:1184–9.
8. Public Opinion Strategies and Lake Snell Perry Associates. Health Coverage 2000 Uninsured Survey, October 12, 1999, Available at: <http://www.rwjf.org/news/eventshc2000/summary.htm>. Accessed May 25, 2004.
9. Public Opinion Strategies and Greenberg Quinlan Rosner Research, April 28–30, 2002. Available at: <http://www.pos.org/latestnumbers/npr.asp>. Accessed May 25, 2004.
10. Goold SD, Biddle AK, Danis M. Choosing healthplans all together: a game to assess consumer values and preferences for health insurance. *J Gen Intern Med*. 2000;15:S68.
11. Danis M, Biddle AK, Goold SD. Insurance benefit preferences of the low-income uninsured. *J Gen Intern Med*. 2002;17:125–33.
12. Mechanic D, Ettl T, Davis D. Choosing among health insurance options: a study of new employees. *Inquiry*. 1990;27:14–23.
13. Danis M, Biddle AK, Henderson G, Garrett JM, DeVellis RF. Elderly Medicare enrollees' choices for insured services. *J Am Geriatr Soc*. 1997;45:688–94.
14. Biddle AK, DeVellis RF, Henderson G, Fasick SB, Danis M. The health insurance puzzle: a new approach to assessing patient coverage. *J Community Health*. 1998;23:181–94.
15. Danis M, Biddle AK, Goold SD. Enrollees choose priorities for Medicare. *Gerontologist*. 2004;44:58–67.
16. Tyler T. Psychological models of the justice motive: antecedents of distributive and procedural justice. *J Pers Soc Psychol*. 1994;67:850–63.
17. Tyler T, DeGoey P, Smith H. Understanding why the justice of group procedures matters: a test of the psychological dynamics of the group-value. *J Pers Soc Psychol*. 1996;70:913–30.
18. Lind EA, Tyler TR, Huo YJ. Procedural context and culture: variation in the antecedents of procedural justice judgments. *J Pers Soc Psychol*. 1997;73:767–80.
19. Lind EA, Kanfer R, Earley PC. Voice, control, and procedural justice: instrumental and non-instrumental concerns in fairness judgments. *J Pers Soc Psychol*. 1990;59:952–9.
20. Student. On the error of counting with a haemocytometer. *Biometrika* 1907;5:351.
21. Mantel N, Haenszel W. Statistical aspects of the analysis of data from retrospective studies of disease. *J Am Statist Assoc*. 1959;58:690–700.
22. McNemar Q. Note on the sampling error of the difference between correlated proportions or percentages. *Psychometrika*. 1947;12:153–7.
23. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academies Press; 2001.
24. Kaiser Family Foundation Health Poll Report survey, April 2004. Available at: <http://www.kff.org/healthpollreport/CurrentEdition/security/1.cfm>. Accessed May 25, 2004.
25. Rawls J. *A Theory of Justice*. Cambridge, Mass: Belknap Press; 1971.
26. Churchill LR. *Self-Interest and Universal Health Insurance: Why Well-insured Americans Should Support Coverage for Everyone*. Cambridge, Mass: Harvard University Press; 1994.
27. Peterson MA. Kenneth Arrow and the changing economics of health care. *J Health Polit Policy Law*. (Special Issue) 2001;26:823–8.
28. Hirschman A. *Exit, Voice, and Loyalty: Responses to Declines in Firms, Organizations, and States*. Cambridge, Mass: Harvard University Press; 1970.
29. Emanuel E. Justice and managed care: four principles for the just allocation of health care resources. *Hastings Cent Rep*. 2000;30:8–16.
30. Goold SD. Allocating health care resources: cost utility analysis, informed democratic decision making, or the veil of ignorance? *J Health Polit Policy Law*. 1996;21:69–98.
31. Eddy D. Connecting value and costs: whom do we ask, and what do we ask them? *JAMA*. 1990;264:1737–9.
32. Fleck L. Just health care rationing: a democratic decision-making approach. *Univ Penn Law Rev*. 1992;140:1597–636.
33. Fleck L. Just caring: Oregon, health care rationing, and informed democratic deliberation. *J Med Philos*. 1994;19:367–88.
34. Benhabib S. Toward a deliberative model of democratic legitimacy. In: Benhabib, S, ed. *Democracy and Difference: Contesting the Boundaries of the Political*. Princeton, NJ: Princeton University Press; 1996:67–94.
35. Gutmann A, Thompson D. *Democracy and Disagreement*. Cambridge, Mass: Belknap Press; 1996.