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CORRECTION

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After publication of this article, additional information was provided by the insurance company that may affect interpretation of some of the study results. Specifically, the method of identifying "those who are new to a health plan" resulted in a substantial number of false-positives. We identified new subscribers by determining whether their unique identification number had appeared in previous years. We have discovered, however, that an individual may also acquire a new unique identification number under the following circumstances: changing to a spouse's coverage, some changes in marital status, change from parent's to self- coverage, and changing to a different health plan with the same insurer. This last change may have occurred during the time period of the study as a new, more restrictive, lower cost plan was being marketed. Although the contribution of each of these situations is unknown, the audited disenrollment rate of the plan, as reported to NCQA during the study time period, averaged 12.0%. This disenrollment rate does not include any of the situations noted above.

Thus, the average disenrollment rate cited in the article of 19.6% overstates the audited rate by about 50%. Some of these false-positives reflect circumstances that probably would not result in changes in health care; others might result in changes in health care as enrollees make adjustments to new situations and new coverage. Even so, the reported effects on utilization (lower mammography rates, greater risk for avoidable hospitalization, and higher costs among "new" enrollees compared with those who have not changed their plan) must reflect effects averaged across both those who are truly new and those who changed their identification number but not their plan (false-positives). The observed differences therefore suggest greater differences among those who are truly new diluted by the effects of those who are not new (but false-positives).

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