



Cathy A. Schoen
Vice President

2003 Annual Report

IMPROVING HEALTH INSURANCE COVERAGE AND ACCESS TO CARE



Over the past year, the New York City Mayor's Office, with support from the Fund, has piloted and implemented the redesign of enrollment processes at Medicaid community offices, like this one in Jamaica, Queens. The modernized offices and new procedures have helped to reduce waiting times dramatically; at the same time, they have raised morale and job satisfaction among eligibility workers and clients.

Adequate, secure, and accessible health insurance is essential to the future of the United States health care system. Without it, the doors to high-quality medical and preventive care will remain closed to many American families, and catastrophic medical bills will continue to threaten their economic security.

Despite recent efforts to expand health coverage incrementally, the number of uninsured Americans has continued to grow, reaching 43.6 million in 2002, an increase of 2.4 million in a single year. Millions more face erosion in their coverage, higher deductibles, and periods without health insurance.

Comprehensive reform is once again vying for the attention of national and state policymakers. As in the early 1990s, when strategies to achieve comprehensive coverage were last debated, economic forces are chipping away employer-sponsored coverage, squeezing state budgets, and threatening to push even more Americans into the ranks of the uninsured and the under-insured. Gateway cities like New York face the additional challenges of meeting the needs of an

increasingly diverse population and investing in the health of an immigrant workforce.

Restructuring the nation's health insurance system to meet the needs of the 21st century is central to the mission of The Commonwealth Fund. Three programs focus on improving coverage and access to care:

- The Program on Medicare's Future works to preserve and strengthen the current and future ability of Medicare to guarantee access to health care for elderly and disabled beneficiaries.
- The Task Force on the Future of Health Insurance seeks ways to expand rates of coverage and improve the quality and stability of coverage for the under-65 working-age population.
- The Health Care in New York City Program strives to reduce the high rate of uninsured among city residents and improve access to care for low-income and other vulnerable groups.

Program on Medicare's Future

Since 1995, the Program on Medicare's Future has been dedicated to preserving the role of Medicare—one of the most popular and effective federal programs—in guaranteeing access to health services for the nation's elderly and disabled. Over the past year, as Congress considered proposals to reshape the structure and benefits of Medicare, the Fund provided critical information and analysis on the impact such changes would have on beneficiaries.

Much of the program's work has focused on the negative financial and health consequences of lack of prescription drug coverage. Fund-supported studies have demonstrated that even seniors who have drug benefits may not have coverage



Barbara S. Cooper
Senior Program Director

adequate to their needs, or that their coverage may not extend through the entire year. Plus, existing levels of coverage seem to be slipping downward. A recent report¹ by Bruce Stuart and colleagues at the University of Maryland documented a significant drop in the share of Medicare beneficiaries ages 65-69 with supplemental employer-sponsored health insurance, from 46 percent to just over 39 percent, between 1996 and 2000. Since employer coverage is the most reliable source of supplemental drug benefits, new retirees may increasingly face the prospect of having no viable source of drug coverage as employers continue to cut back.

The prescription drug needs of an especially vulnerable and often “forgotten” segment of the Medicare population—people under age 65 with disabilities—were examined by Becky Briesacher and colleagues at the University of Maryland School of Pharmacy and Pennsylvania State University. Their report² showed that disabled beneficiaries face a daunting combination of burdens—low income, high medication bills, and heavy use of medications that are typically different from those used by the elderly—yet have been largely neglected in the debate over a Medicare prescription drug benefit, with most discussion focusing on the elderly.

Disabled beneficiaries were also the focus of a recent report³ by Dale and Verdier on the impact of Medicare’s two-year waiting period. Over 1.2 million seriously disabled Americans under age 65 are waiting for their Medicare coverage to begin, of whom as many as a third have no current health insurance. The authors found that eliminating the waiting period would give people suffering from a broad range of debilitating diseases access to appropriate medical care to manage their conditions.

With the new Medicare prescription drug benefit's reliance on private health plans, the Fund continues to track Medicare's experience with managed care. A recent update⁴ by

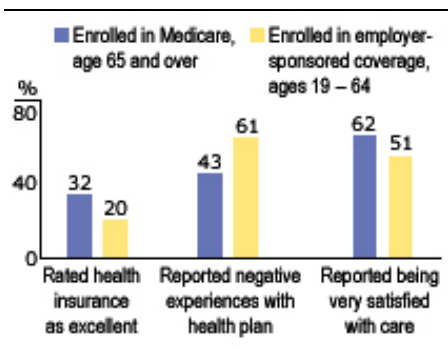
Marsha Gold and Lori Achman of Mathematica Policy Research showed that beneficiaries' benefits have continued to decline while out-of-pocket costs have grown under the Medicare+Choice program. Average out-of-pocket expenses for all enrollees in Medicare+Choice plans went up by 24 percent in 2002, with those in poorest health projected to spend an average of \$4,783—three times the amount spent by enrollees in good health.



Geraldine Dallek
Health Policy Consultant

Another report,⁵ by Geraldine Dallek and Brian Biles, M.D., of George Washington University, delineated persistent problems in the Medicare+Choice program: lack of health plan participation in some areas, wide variability in premiums and benefits, unstable participation by plans and providers, a confusing benefits structure, signs of deliberate efforts to discourage high-risk beneficiaries from enrolling, and—the bottom line—failure to achieve savings. The findings suggest the need for caution in adopting competition-based approaches for Medicare's future.

Patient satisfaction with Medicare and employer-sponsored coverage



Davis et al., "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002), based on data from The Commonwealth Fund 2001 Health Insurance Survey

Two investigations comparing the performance of the Medicare program with that of private insurance further challenged the notion that privatization would be better for Medicare beneficiaries. According to survey findings reported in a *Health Affairs* article⁶ by Commonwealth Fund president Karen Davis and colleagues, Medicare outperforms private sector plans in terms of patients' satisfaction with quality of care, access to care, and overall insurance ratings. Elderly Medicare beneficiaries rated their health insurance as excellent 2.7 times more often than did enrollees in employer-sponsored plans; they were also less likely to report negative experiences with their insurance plans. In a subsequent article,⁷ also published in *Health Affairs*, Marilyn Moon and colleagues at the Urban Institute analyzed cost trends over a 30-year period, revealing that Medicare's long-term ability to control costs equaled or surpassed that of insurers in the private sector.

Medicare's health care spending for a comparable set of benefits grew at an average of 9.6 per year from 1970 to 2000, slower than the 11.1 percent average annual growth found for private health insurers. Moon noted that Medicare's track record as a purchaser able to contain costs is partly a result of its structured payment systems and regulatory controls.

Despite these successes, Medicare's track record does not compare favorably with most modern insurance packages when it comes to its cost-sharing arrangements, which are not designed to help those who need help most—the sickest beneficiaries. Stephanie Maxwell and Urban Institute colleagues Marilyn Moon and Matthew Storeygard identified possible measures to modernize cost-sharing, then simulated their impact on beneficiaries' out-of-pocket spending and overall program expenditures. Their report⁸ outlined a range of modest policy options that would reduce financial burdens on the sickest beneficiaries while offering a sounder insurance package. Some measures could be implemented at little or no additional cost to Medicare.

Medicaid and other publicly supported programs currently do offer additional cost-sharing and other benefits to low-income Medicare beneficiaries, but participation by eligible seniors is low. Medicare savings programs, for example, enroll only about 60 percent of eligible beneficiaries. The Fund has supported work to identify and enroll the millions of seniors who fail to receive these much-needed benefits. In one project, the National Council on the Aging used Fund support to launch Benefits CheckUp, an Internet service that allows seniors to screen their eligibility for nearly 1,000 federal and state benefits programs and get information on how to apply. Demonstration projects in eight communities have alerted hundreds of thousands of seniors of their likely eligibility for Food Stamps, Medicaid, and other benefits. A report by Laura Summer and Robert Friedland of Georgetown

University's Center on an Aging Society reviewed various modifications to the asset test that could extend help to more low-income beneficiaries.⁹

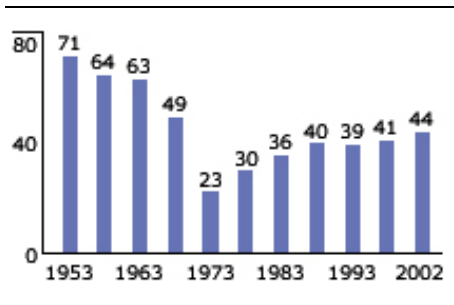
The Fund is currently supporting work by the National Academy of Social Insurance to investigate alternative strategies to assure that low-income beneficiaries receive the additional Medicaid benefits to which they are entitled. The Fund is also supporting work to develop a Medicare high option, which would include lower cost sharing and prescription drug coverage.

Task Force on the Future of Health Insurance

The Commonwealth Fund Task Force on the Future of Health Insurance is an independent, nonpartisan forum for exploring strategies to expand and improve health insurance coverage for the under-65 population, especially American workers and their families. Drawing its members from business, labor, government, and policy research, the Task Force works to develop policy options, assess promising models for insurance expansion, and anticipate the effects of market and policy changes on the stability, quality, and affordability of health insurance. The Task Force is chaired by James J. Mongan, M.D., president and CEO of Partners HealthCare System, Inc.¹⁰

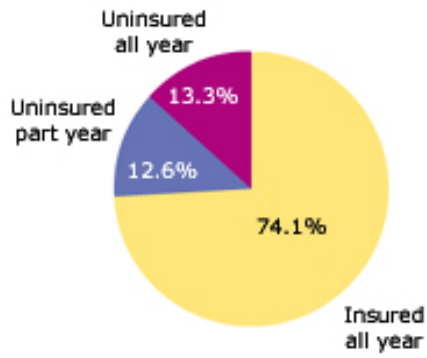
A weak labor market and the continuing erosion of health insurance have sparked new calls for comprehensive health insurance reform during the past year. The Task Force contributed to the momentum by developing a proposed framework for a more automatic, affordable health insurance system for Americans under age 65 that would build on existing forms of public and private coverage. The framework was presented in an article¹¹ in *Health Affairs*, "Creating Consensus on Coverage Choices," in which Fund coauthors Karen Davis and Cathy Schoen laid out a comprehensive blueprint for near-universal coverage. The framework allows

Number of uninsured Americans, in millions



National Health Interview Survey, 1953-1976; EBRI, 1980; Current Population Survey, 1990-2003

Insurance status of Americans under age 65, 2000



Medical Expenditure Panel Survey, 2000

for incremental insurance expansions, phased in over time. Key elements have subsequently appeared in the position papers of several presidential candidates.¹²

With millions losing coverage due to job loss and intense pressure on public budgets, policy leaders also continue to look for strategies to expand insurance one step at time. A report¹³ by Jeanne Lambrew and Arthur Garson, Jr., M.D., outlined a dozen policy options that, for roughly \$1 billion each, would provide sub-groups of uninsured and underinsured Americans with access to private or public health coverage. Although not a substitute for comprehensive reform, the policies would provide badly needed insurance to workers changing jobs, small business employees, and others at relatively modest cost.

One step forward would be to help uninsured young adults. An analysis by Sara Collins and Fund colleagues found that nearly two in five college graduates and half of high school graduates not attending college were uninsured at some point during the first year after finishing school.¹⁴ Extending parents' policies to young adults through age 23, letting low-income young adults stay on CHIP or Medicaid past age 19, and mandating college-based insurance would sharply reduce the number of uninsured young adults and enhance insurance continuity during the transition from dependence to independence. The report helped spark interest among members of Congress and state lawmakers in legislation to close coverage gaps affecting low-income adults.



Sara R. Collins
Senior Program Officer

Low-wage workers are at particular risk of being uninsured or under-insured. An issue brief¹⁵ by Task Force staff revealed that workers earning less than \$10 per hour in both large and small firms are notably less likely to have access to job-based coverage and often face barriers to participation even when coverage is offered. A recent analysis¹⁶ of state coverage patterns by Randall Bovbjerg and Jack Hadley further found that Medicaid provides minimal support for low-income

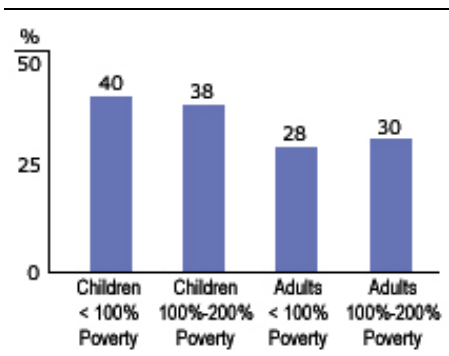
working adults, and that public programs for working adults vary widely by state. Noting the cyclical nature of enrollment, the authors recommend greater counter-cyclical subsidies to states in times of economic downturn.

With states under acute fiscal pressure because of falling revenues, policy efforts have also focused on finding ways to maintain Medicaid coverage and prior public program expansions. Medicare's failure, until recently, to include coverage of prescription drugs, as well as its imposition of a long waiting period before disabled adults can gain coverage, has contributed to fiscal pressures on states. Two reports^{17, 18} on the interaction between Medicare and Medicaid by Stacy Berg Dale and James M. Verdier estimate that expanding Medicare to include drugs and eliminating the two-year waiting period would reduce state Medicaid costs by \$6.8 billion and \$1.8 billion, respectively. Applied to the Medicaid program, the savings could help maintain coverage for millions of low-income adults and families. Elimination of the waiting period would also expand coverage to an estimated 400,000 disabled people who are currently uninsured and provide new insurance security for all 1.2 million now in the waiting period.

Task Force-sponsored work also documented the potential of helping people remain enrolled in their existing coverage. In a recent Fund report,¹⁹ Leighton Ku and Donna Cohen Ross of the Center on Budget and Policy Priorities calculated that the numbers of low-income children and adults without health insurance would decline significantly—by roughly 40 percent for children and 25 percent for adults—if everyone with insurance coverage at the beginning of a year could retain it over the next 12 months. The authors argue that improving insurance retention is cost-effective and could be accomplished through rule changes in Medicaid and CHIP.

National surveys that track insurance over time reveal that one of four Americans under age 65—more than 60

Percent reduction in number uninsured if everyone with coverage retained it during the year



Ku and Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, The Commonwealth Fund, December 2002

million people -- have been uninsured during all or part of the previous year. To draw attention to the problem of insurance instability, the Task Force sponsored a panel of grantees to present recent work at the annual meeting of AcademyHealth. In addition to the previously mentioned findings, the panel featured a case study²⁰ by Deborah Bachrach on the negative effects of insurance instability, or “churning,” for low-income beneficiaries in New York and new analysis²¹ by Pamela Farley Short on the dynamics of insurance over a four-year period.

Insurance instability and churning impose high costs on the nation’s health care system and the people it serves. In invited testimony²² before the Senate Special Committee on Aging, Fund president Karen Davis highlighted problems associated with complexity, gaps in coverage, and churning—including barriers to participation in public insurance programs—and outlined the potential benefits of simplification and insurance expansions. Underscoring the need for simplification and more automatic enrollment, an article²³ by Dahlia Remler and Sherry Glied, both at the Mailman School of Public Health at Columbia University, pointed out that participation is much greater—sometimes twice as high—in programs using automatic enrollment mechanisms than in programs requiring several steps, including documentation, to enroll.

A slow economy and escalating premiums have triggered a search for more affordable insurance policies, especially among small firms seeking cut rates. A new Fund report²⁴ by Mila Kofman of Georgetown University spotlighted what appears to be a new wave of insurance scams and fraudulent insurance products. Striking a responsive chord in markets across the country, the report was covered by the *Wall Street Journal*, CNN, NPR, and dozens of local outlets. The report described the efforts of state attorneys general to protect families and employers.

Federal policymakers have expressed growing interest in state-level demonstrations of health insurance expansions. Karen Davis and Task Force member Arthur Garson, Jr., M.D., dean of the University of Virginia School of Medicine, contributed to a special report²⁵ by the Institute of Medicine, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, in which they recommend that the federal government fund demonstrations of between three and five coverage expansion models. The Task Force followed up with a June 2003 forum, sponsored by the Alliance for Health Care Reform, which brought together state and federal leaders and senior policy analysts to advance the concept of federally funded state expansion pilots.

During 2003, several states began to move forward with new policies to improve insurance coverage, even as they grappled with fiscal crises. Maine made national news by enacting legislation to address health care access, cost, and quality. With expert support from several Task Force grantees, the Maine effort resulted in a new public-private initiative known as Dirigo (after the state motto, “I lead”), which would pool coverage for small-business employees, self-employed workers, and low-income working adults and sponsor efforts to improve quality of care.

Other Task Force initiatives emphasized the potential of state strategies to cover the uninsured and improve the quality of care. Case studies²⁶ of ten states that have had early success in expanding coverage, developed by Sharon Silow-Carroll and colleagues of the Economic and Social Research Institute, highlighted a range of valuable strategies. An in-depth case study²⁷ of Minnesota by Deborah Chollet and Lori Achman of Mathematica Policy Research suggests that well-coordinated incremental efforts can be highly effective. Evidence from Rhode Island, described in a report²⁸ by Silow-Carroll, indicates that strategic quality improvement efforts have

reduced public program costs and provided measurable health improvements for beneficiaries.

The Task Force built on past efforts to address the particularly acute problems of lack of health insurance and barriers to care among Hispanics. An audience of community leaders, providers, and advocates heard a keynote speech by Surgeon General Richard Carmona, M.D., and a presentation by Congresswoman Hilda Solis, chairwoman of the Congressional Hispanic Caucus Health Care Task Force, at a February 2003 conference, "Lack of Insurance and Quality of Care: A Health Care Crisis for Hispanics," sponsored by the National Hispanic Medical Association with support from the Fund. Analysis by the Fund's Michelle Doty found formidable barriers to health care for people who are uninsured and speak Spanish: two-thirds of uninsured, Spanish-speaking adults have no regular doctor, and almost half report communication problems with their physicians.²⁹ The findings underscored the need to address language and insurance concerns to improve access and quality of care.

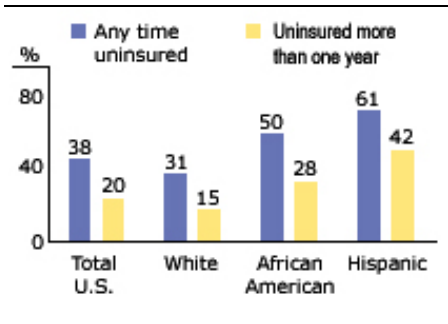


Richard Carmona, M.D.
U.S. Surgeon General

An array of Task Force projects documented the negative consequences of being uninsured or inadequately insured. A study³⁰ by Michael Gusmano, of the International Longevity Center-USA, and Gerry Fairbrother and Heidi Park, both at the New York Academy of Medicine, found that it is often difficult or impossible for community health centers to refer uninsured patients for needed diagnostic, behavioral, or specialty care. A paper³¹ by Emory University researchers Kenneth E. Thorpe and David Howard found systematic evidence that uninsured cancer patients receive less care yet incur much higher out-of-pocket expenses than comparable patients with health insurance.

A study³² by Carol Pryor and colleagues offered evidence that federal rules may inadvertently encourage aggressive debt collection efforts by hospitals against impoverished patients.

Percent of nonelderly population that lacked health insurance during 1996-2000



The Commonwealth Fund and Penn State analysis of the 1996-2000 Panel of the Survey of Income and Program Participation

After the publication was released, the House Energy and Commerce Committee began to investigate the problem and seek legislative solutions.

Those approaching the age of Medicare eligibility are particularly vulnerable to the consequences of being uninsured. In an article³³ on the use of medical technology for treatment of heart attack, cataracts, and depression among insured and uninsured patients ages 55-64, Sherry Glied and Sarah E. Little documented that underuse of technology results in higher morbidity and mortality in the uninsured. Gaining access to Medicare coverage dramatically improves previously uninsured older adults' use of a range of preventive services, including cholesterol testing, mammography, and prostate exams, according to Fund-supported research published in the *Journal of the American Medical Association*.³⁴ The findings suggest that if uninsured adults approaching age 65 were able to purchase Medicare coverage affordably, they would likely take advantage of potentially life-saving tests.

Other studies examined the content of insurance and possible expansion strategies for the uninsured, including tax credits. In her analysis of the value of insurance to low-income adults and families, Sherry Glied challenged the assertion that "something is better than nothing." Her findings, published as a book chapter,³⁵ indicate that insurance expansions will fail to meet the needs of people with very limited incomes if coverage depends on high front-end patient cost-sharing. A report³⁶ by Fund staff found that proposed tax credit plans are especially risky for women because they tend, at best, to be sufficient only for plans with high deductibles and that omit such important services as maternity care. In some states, the proposed tax credit is inadequate to buy any individual policy.

The design of employer-sponsored coverage is also of increasing concern. Task Force grantees have followed the progress of a new type of plan, known collectively as

“consumer-driven health care” or “defined contribution” plans. The plans take several forms, yet all raise the danger of splitting the risk pool and increasing costs and access barriers to low-income and sicker employees and their families. Employers’ participation in the new products has so far been marginal, with just 1.5 million people enrolled by the end of 2002, according to an analysis³⁷ by Jon Gabel, Anthony LoSasso, and Thomas Rice. Current fieldwork is examining the experiences of three employers that adopted the plan designs to gauge the effect on group coverage. A Task Force survey will assess the extent of erosion in private insurance markets.

To reach individual consumers and action groups, the Task Force has supported the enhancement of three insurance-related websites. Access to Health Insurance/Resources for Care³⁸ targets self-employed or part-time workers and provides information on public and private coverage options. In addition, the site alerts readers to important health policy news and provides links to state and national initiatives. The Fund also supported the launch of a new website, *healthcarecoach.com*,³⁹ by the National Health Law Program, which offers informative articles on insurance coverage for individuals and families. A grant to Georgetown University will enable the Health Policy Institute’s *healthinsuranceinfo.net*⁴⁰ to provide information on legal protections regarding insurance coverage. The Task Force is also supporting work by Karen Pollitz at Georgetown University to work with the American Diabetes Association in developing a manual to help its staff, and staff at other associations of chronically ill patients, respond to insurance concerns.



Jennifer N. Edwards
Director

Health Care in New York City Program

The Health Care in New York City Program seeks to reduce the number of uninsured city residents and improve access to needed health care services. By producing independent information and generating ideas on improving health coverage and delivery in its home city, the program helps local leaders make informed decisions in a rapidly changing health care environment and tests strategies that could be replicated nationally. In December 2002, The Commonwealth Fund received a certificate of appreciation from Mayor Michael Bloomberg in recognition of the Fund's contributions to the city's successful effort to enroll more than 106,000 New Yorkers in health insurance.

The dual impact of a weak economy and continued health care inflation has posed unique challenges in meeting the health coverage needs of New York City residents. More than a quarter of New Yorkers under age 65 were uninsured in 2001, well above state and national rates, and policy analysts predict further growth in uninsured rates in New York City. A Fund-sponsored survey of employers in the city and state found that most firms intend to cut back health benefits and pass on more costs to their workers in the future. If firms carry out those plans, three-fourths of New York employees with job-based benefits will see their insurance deteriorate and their health care costs increase.

The survey report,⁴¹ by Heidi Whitmore and colleagues at the Health Research and Educational Trust and the Fund, also emphasized that low-wage and small business workers in New York are especially likely to lack health insurance. Only two in five firms employing low-wage workers in New York State offer health insurance to their employees, compared with over half of comparable firms nationally. And when low-wage workers receive employer coverage, they are more likely to experience long waiting periods, pay higher premium costs,

and get less generous benefit packages than their counterparts in other businesses.

The Fund's New York City program is exploring ways to make private coverage more affordable and appealing to small firms. Stephen Rosenberg, M.D., has been evaluating a purchasing alliance called HealthPass that enables small firms in New York City and its suburbs to offer a choice of several health plans within a defined contribution model. His work⁴² indicates that the program's basic structure, management team, and interaction with the broker community have been key factors in its success. On track to achieve self sufficiency by 2005, HealthPass has great potential to move beyond the demonstration phase and serve as a useful model for programs elsewhere.

For New York's low-income seniors, Medicaid and EPIC, the state-funded pharmacy assistance program, play a crucial role in providing supplemental coverage for needed medications. Together, the two public programs reach a substantial share of the 2.4 million seniors in New York. Even so, a survey sponsored by the Fund and the Henry J. Kaiser Family Foundation found that nearly one-fifth of New York seniors had no coverage for medications in 2001. According to the survey report,⁴³ prepared by David Sandman and colleagues at the Fund and Dana Gelb Safran at Tufts-New England Medical Center, lack of prescription drug coverage places seniors' health and financial security in jeopardy. One-third of seniors without drug coverage reported that they skipped doses of their medications or did not fill a prescription due to cost concerns. Likewise, over one-third of seniors without drug coverage spent \$100 or more per month on their medications—twice the rate of those with coverage. The threat of rising drug costs could force more seniors to forgo potentially life-saving medications or deplete retirement savings.

As private coverage has eroded over the last decade and low-income residents have faced barriers to needed care, the state's publicly funded programs have become increasingly important sources of health coverage. Unfortunately, many individuals have not succeeded in enrolling in the programs, or retaining their coverage once enrolled. The Fund is studying the best approaches to connect eligible adults and children with public insurance programs and to ensure that they stay covered. Currently, a complex maze of rules means that people may not enroll in public programs for which they are eligible, or they may lose benefits for administrative reasons. Fund support has enabled the Children's Defense Fund to analyze the complexities families face and recommend policies that would simplify and coordinate coverage.

A project by Deborah Bachrach and colleagues sought to quantify how often administrative processes, rather than higher incomes or other eligibility changes, were causing children to lose coverage. They found that 93 percent of children who lost their Child Health Plus Part B coverage were actually still eligible but had failed to complete New York's recertification process. In a field report,⁴⁴ the authors propose strategies to make it easier for families to retain their children's coverage.

Another Fund-supported effort, the Model Office Project, has made great strides in streamlining enrollment in New York's Medicaid, Child Health Plus, and Family Health Plus programs. Over the past year, the New York City Mayor's Office of Health Insurance Access has piloted and implemented the redesign of Medicaid community offices, applications, and enrollment processes, resulting in dramatically shorter waiting times, an application process that can be completed in one visit rather than two, and greater satisfaction among clients and eligibility workers.



James R. Tallon, Jr.
President
United Hospital Fund

New York State's Medicaid managed care program was the subject of a comprehensive report prepared by Kathryn Haslanger of the United Hospital Fund (UHF).⁴⁵ For the past 12 years, the state has been attempting to transform Medicaid's fee-for-service delivery system to a managed care model, which policymakers believe has the potential to control costs and improve care. But the report, which was based on a seven-year UHF assessment supported in part by The Commonwealth Fund, concludes that Medicaid managed care has thus far not lived up to its promises. While Haslanger says the program has succeeded in some ways—for example, by improving patients' access to office-based specialists and reducing waiting times for care—frequent disruptions in enrollees' coverage "have rendered financial incentives for prevention and early detection fairly meaningless." Much of this turnover in enrollment, the report finds, results from administrative problems, not changes in individuals' eligibility status.

In March 2003, many New Yorkers came together as part of a national campaign to raise awareness about the problems of the uninsured. The Commonwealth Fund joined the Robert Wood Johnson Foundation, the United Hospital Fund, and others to cosponsor the events of New York City's Cover the Uninsured Week, which included town hall meetings, health fairs, and forums at hospitals, universities, and other locations throughout the city. Through its participation, the Fund sought to help consumers, payers, and providers find and enact real solutions to assist uninsured New Yorkers.

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