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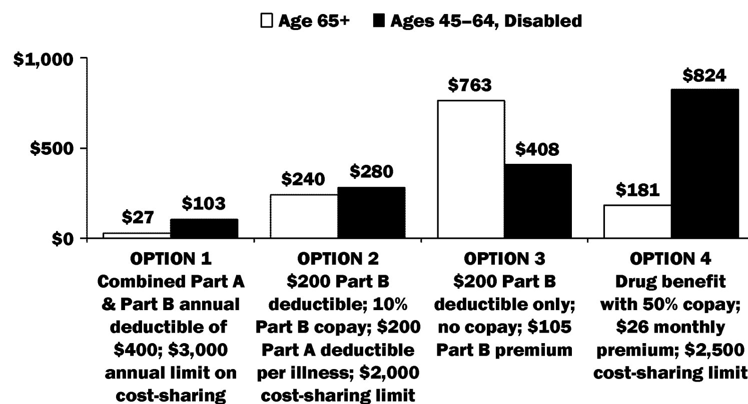
Study Finds Medicare Benefits Can Be Improved, Cost Burdens Reduced

A range of options exists for modernizing Medicare that would reverse spiraling out-of-pocket costs for beneficiaries and reduce or eliminate the need for private supplemental insurance, according to a new Commonwealth Fund report. Three options analyzed would restructure Medicare deductible and premium shares to reduce costs to beneficiaries, especially those with large expenses. A fourth option that would add a prescription drug benefit to Medicare could be combined with any of the other options.

Findings from the study, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures,* by Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard of the Urban Institute, were highlighted by Commonwealth Fund president Karen Davis at a House Ways and Means Health Subcommittee hearing on May 9.

On average, Medicare beneficiaries now spend more than a fifth of their income—22 percent—on health care. Many vulnerable groups spend far more: for poor women age 85 or older, insurance and medical bills can devour over 50 percent of their resources. Davis

Medicare Beneficiaries' Savings in Out-of-Pocket Spending Under Four Reform Options, 2000



Note: Medicare's Part A deductible is for inpatient hospital stays, nursing home care, and home health care. Part B's deductible is for doctors' services and outpatient care.

Source: Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures,* The Commonwealth Fund, May 2001.

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Medicare beneficiaries now spend more than a fifth of their income—22 percent—on health care.

noted that two of three Medicare beneficiaries are sick or poor and one-third have serious physical or cognitive impairments, accounting for 62 percent of Medicare outlays.

One of the options discussed in the report would lower the share of income that elderly Medicare beneficiaries would spend out-of-pocket for their health care from 21.7 percent to 16.4 percent. It would eliminate all deductibles and coinsurance, except a $200 Medicare Part B deductible (for doctors' services and outpatient hospital care). By having additional Medicare premiums substitute for the costly premiums charged by Medigap supplemental policies, this option would offer beneficiaries the greatest average decline in out-of-pocket spending—and do so without raising overall program costs.

Prescription drug benefit coverage could be added to any of the three benefit restructuring options, although at additional cost to Medicare. The Urban Institute drug option features 50 percent coinsurance, a $2,500 limit on beneficiary cost-sharing, and a $26 monthly premium. Such a drug benefit would increase Medicare spending by about 6 percent.

Under all the options that were analyzed, beneficiaries who are older, have low incomes, and are in poor health would experience the greatest savings.

The authors point out that the current Medicare benefit is clearly inadequate. About 90 percent of beneficiaries have additional coverage to make up for gaps, but these sources are becoming unstable and more expensive. Employer-sponsored supplemental insurance is declining for current retirees, and many employers plan to eliminate coverage for future retirees. Medigap policies, meanwhile, offer poor insurance value for increasingly high premiums. The availability of Medicare+Choice, a managed care program providing more comprehensive benefits, is also diminishing.

"Costs to beneficiaries are often left out of the equation when Medicare budgets are analyzed," said Stephanie Maxwell, lead author of the report. "But it's critical to have a clear picture of how proposed changes in Medicare will affect beneficiaries—especially those who already have barely enough to get by."❖

Medicare Buy-In Option Important for Many Older Adults, Studies Find

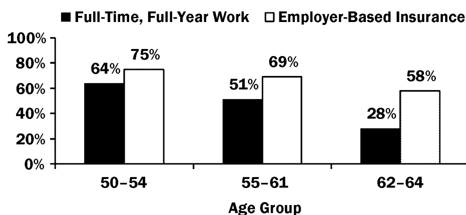
One approach for reducing the number of uninsured is to allow those under age 65 to "buy into" Medicare by paying monthly premiums. Two new studies say that to maximize coverage, any future Medicare buy-in should be made available to as many low-income, older adults as possible.

Older men and women without insurance face particularly acute financial and health risks. Among Americans ages 62 to 64, more than 860,000 are without health coverage; of these, more than half (52%) live on incomes below 150 percent of the federal poverty level. The uninsured "near elderly," moreover, are disproportionately in poor health—about a third (32%) describe their health status as only fair or poor. Lack of health coverage is also a major problem, however, for those ages 55 to 61, about 2 million of whom are uninsured. Because of their poorer health status, older adults without employer or other group coverage typically face high premiums in the individual insurance market—a cost that renders these policies unaffordable for those with low incomes.

In a recent *Health Affairs* article and report published by The Commonwealth Fund, Pennsylvania State University researchers Pamela Farley Short, Dennis G. Shea, and M. Paige Powell conclude that targeting a Medicare buy-in to those who have just lost their employer insurance would reach relatively few people in the short run. The loss of job-based coverage as people approach retirement age is a steady but slow process, they say—few currently uninsured or individually insured people have recently disenrolled from an employer health plan. A more logical basis for a Medicare expansion, the researchers argue, is the declining average health status—and consequently higher medical expenses—of those nearing age 65.

The Decline in Employer-Sponsored Health Coverage Is a Slow and Steady Process

Percentage of adults ages 50–64 with full-time, full-year work or employer-based insurance



Source: Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* The Commonwealth Fund, June 2001.

In another study, *Medicare Buy-Ins: Estimating Coverage and Costs,* analysts at the Lewin Group found that substantial subsidies would be required for a Medicare buy-in to achieve a sizable reduction in the number of older uninsured adults, many of whom live on low incomes and cannot afford typical health insurance premiums. If the Clinton Administration's Medicare buy-in proposal for 62-to-64-year-olds, which included a 25 percent tax credit, had been enacted, it would have resulted in enrollment of approximately 550,000 people, say John Sheils and Ying-Jun Chen, the report's authors. However, only about 47,000 (8.5%) enrollees would have otherwise been uninsured—the rest of those buying in would have previously had health coverage. Even with the tax credit, premiums under the buy-in plan would still represent a large share of family income—and few of the uninsured would be able to afford them.

The Lewin Group analysts say that enrollment could be greatly expanded by limiting the premium to an amount that does not exceed 5 percent of income. Enrollment in the plan would then increase to about 1 million adults, of whom 330,000—one-third—would otherwise have been uninsured.❖

Substantial subsidies will be required for a Medicare buy-in to achieve a sizable reduction in the number of older uninsured adults.

Managing Expectations a Key for Home Visiting Programs

Whether convinced by mounting scientific evidence or prodded by political pressure, policymakers throughout the country have been placing special emphasis on early child development in recent years. In many states, this new focus has led to the establishment of home visiting programs, where trained nurses and other pediatric professionals are sent into families' homes to help new parents learn how to provide their young child with a stimulating and safe home environment.

A new study of these programs finds that although states and local communities vary in their approach to home visiting, they share many of the same challenges—trying to set realistic program expectations, coordinating the efforts of multiple agencies, and assuring that the services provided are of sound quality. The study, *No Place Like Home: State Home Visiting Policies and Programs,*

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was based on a survey of states with child home visiting programs that target primarily low-income families. The Commonwealth Fund published the report in May.

A number of trends have converged to create an environment conducive to the expansion of state-based home visiting efforts, says Kay Johnson, the study's author and a research professor in pediatrics at Dartmouth Medical School. These include growing public awareness of research into infant and brain development, a new focus on early education and school readiness, recognition of the importance of family support, and expansions of child health insurance coverage.

Many states have already made a substantial commitment to home visiting programs. Of the 42 states that responded to the survey, 37 reported state-based home visiting programs. An additional three states provide support for a range of locally based home visiting programs.

One of the major pitfalls for state home visiting programs is overpromising on the results that can be achieved.

One of the major pitfalls for home visiting programs, the report says, is overpromising on the results that can be achieved. Child advocates and maternal and child health agency staff eager to develop home visiting programs in their states often use all evidence at their disposal in their efforts to sell the concept to the governor and state legislature. In the process, however, they frequently overstate what the program can realistically accomplish. Where state laws mandate program evaluations and lay out specific outcome measures, the challenges can be particularly great.

In some cases, coordination among multiple home visiting programs is the most difficult issue facing state agencies. Political and turf battles, the study finds, are often unavoidable, and states must contend with integrating the services provided by different programs. Moreover, available funding often drives state policy and program decisions. Programs that rely, for example, on Medicaid dollars for their home visiting efforts must deal with the limited scope of services for which Medicaid provides reimbursement.

The report recommends that states establish a continuum of early childhood services that can address a wide range of family needs, from pregnancy planning and prenatal services to infant developmental assessments and parent education. At the same time, they should narrow program objectives and outcome measures, emphasize quality, and establish mechanisms for interagency coordination. ❖

Task Force Says Changes Needed to Finance Indigent Care

Asserting that the nation's teaching hospitals cannot continue to provide an ever-increasing amount of free medical care under the current system, a group of leading health policy experts recommends revamping the way health care for the poor and uninsured is financed in the United States. The group's proposals range from expanding health coverage for the uninsured to revising Medicare and Medicaid payment policies for teaching hospitals.

Academic health centers (AHCs) provide a number of benefits to society—educating and training doctors, conducting research, supplying specialized medical services, as well as giving free health care for those who have no resources or insurance. A new report from The Commonwealth Fund's Task Force on Academic Health Centers, *A Shared Responsibility: Academic Health*

Centers and the Provision of Care to the Poor and Uninsured, says that the amount of charity care provided by these institutions is increasing faster than the amount provided by other types of hospitals.

From 1991 to 1996, the amount spent by AHCs on charity cases increased by more than 40 percent as a percentage of gross patient revenues. During this period, public AHCs provided the highest levels of charity care among all hospitals, while private AHCs provided twice as much free care as other private hospitals.

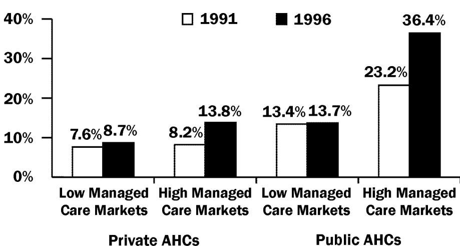
Historically, academic health centers have financed the cost of charity care through higher charges to insured patients, according to David Blumenthal, M.D., director of the Institute for Health Policy at Massachusetts General Hospital and executive director of the Task Force. As competition has increased, however, hospitals have been less able to make these "cross-subsidies" available. "Hospitals that already provide a significant amount of charity care are serving a growing proportion of indigent cases," says Dr. Blumenthal. "At the same time, the amount of free care provided by other hospitals is going down."

Academic health centers in markets with high managed care penetration are experiencing even greater financial strain. The proportion of charity care provided by both public and private AHCs in these markets increased during the 1991–96 period, while the share provided by markets with low rates of managed care remained constant.

As a first policy priority, the Task Force recommends expanding the availability of health insurance coverage through incremental reforms. States and the federal government could also find ways to maximize enrollment of eligible individuals in existing public insurance programs. The Task Force further suggests that Medicare and Medicaid disproportionate share hospital (DSH) payment policies be adjusted so that hospitals with the largest number of indigent patients are more adequately compensated for the cost of treating them. Medicare could exclude the cost of treating indigent patients from its payments to managed care plans; instead, Medicare could direct these funds to hospitals serving a disproportionate share of low-income and uninsured patients.❖

From 1991 to 1996, public academic health centers provided the highest levels of charity care among all hospitals.

Charity Care Provided by Academic Health Centers as a Percent of Gross Revenues Is Increasing



Source: Task Force on Academic Health Centers, *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured,* The Commonwealth Fund, April 2001.

Davis Makes Case for Expanding Programs to Cover Uninsured

In her invited testimony before the U.S. Senate Finance Committee on March 15, Commonwealth Fund president Karen Davis outlined a plan for working with existing public health insurance programs to provide coverage for the most vulnerable among the nation's 43 million uninsured. Davis stressed the importance of expanding Medicaid and the State Children's Health Insurance Program (CHIP), in particular, to cover parents of enrolled children.

Davis said in her testimony that Medicare and Medicaid are ideally

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At least $1 trillion of the 10-year budget surplus was generated by savings in Medicare and Medicaid in the late 1990s.

suited to covering those uninsured Americans with low incomes, unstable jobs, and serious health problems. She noted that the two programs, which together cover one of four Americans, have been providing health care coverage to the sickest and poorest for more than 35 years. While funded by the government, both programs purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents.

When discussing the use of tax credits as a way to help the uninsured afford health coverage, Davis sounded a note of caution. "The provision of tax credits for the purchase of nongroup insurance is particularly problematic," she said. "A $1,000 tax credit toward a $6,000 premium for a 60-year-old woman earning less than $35,000 a year is hardly sufficient to make such coverage affordable. It's difficult to adjust tax credits to take account of variations in individual health insurance premiums by age, geographic location, and health status."

Different strategies should be employed to cover different groups, Davis said. She offered a number of options for expanding existing programs, including:

- covering 2.2 million uninsured parents with incomes below 200 percent of the federal poverty level under Medicaid or CHIP
- providing premium assistance through Medicare to 3.4 million uninsured adults age 55 and older
- expanding Medicare coverage for 3.7 million uninsured adults under age 55 who are sick and disabled by eliminating the two-year waiting period and broadening eligibility to those able to work
- improving the link between public programs and employer coverage through premium assistance and other methods, providing health coverage to another 5 million to 13 million
- increasing participation of low-wage workers in company health plans through employer-administered premium assistance, covering 6 million uninsured workers and family members.

"At least $1 trillion of the 10-year federal budget surplus was generated by savings in Medicare and Medicaid in the late 1990s," Davis reminded committee members. "It is an ideal time to reinvest a significant share of those savings in improved health care for those left behind."❖

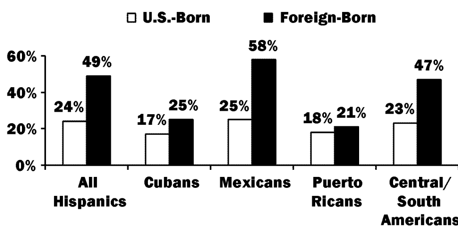
Hispanics' High Uninsured Rates Linked to Jobs, Immigrant Status

The alarmingly low rates of health care coverage within the nation's Hispanic population have been well documented. While much of the problem can be attributed to a lack of access to employer-based health insurance, a new study reveals that immigrant status appears to play a key role as well.

In 1997, Hispanics under age 65 were more than twice as likely as non-Hispanic whites to be uninsured and only 60 percent as likely to have coverage through an employer, according to *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured*. The study, written by Claudia Schur and Jacob Feldman of the Project HOPE Center for Health Affairs, draws from analysis of the National Health Interview Survey, the Survey of Income and Program Participation, and the Current Population Survey.

Schur and Feldman found that the highest uninsured rates within the Hispanic population in 1997 were for people of Mexican origin (38%) and immigrants from Central and South America (39%). The lowest uninsured rates were for Cubans (22%) and Puerto Ricans (19%). Half of Hispanics born outside the United States were uninsured in 1997, compared with one-quarter of U.S.-born Hispanics.

Percentage of Nonelderly Hispanics Who Are Uninsured, by Immigrant Status and Country of Origin, 1997



Note: The NHIS classifies persons born in Puerto Rico as foreign-born.
Source: Claudia L. Schur and Jacob Feldman, *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured,* The Commonwealth Fund, May 2001.

The study also revealed that nearly three-quarters of Hispanics who have lived in the United States less than five years are uninsured. Even after 15 years in the United States, one-third of foreign-born Hispanics remain uninsured, compared with only 14 percent of foreign-born non-Hispanics.

Among the study's other findings:

- Less than 70 percent of full-time Hispanic workers were offered health coverage by their employers in 1999, compared with almost 90 percent of non-Hispanic whites.
- Hispanic immigrants who have come to the United States since 1994 and who work full-time have earned less than half as much as their non-Hispanic white immigrant counterparts ($13,000 annually vs. $27,000).
- Married Hispanics are younger than married whites, more likely to have young children at home, and more likely to be part of a family with only one worker—factors that all limit the avenues through which health insurance can be obtained.❖

Nearly three-quarters of Hispanics who have lived in the United States less than five years are uninsured.

Early Signs Are Good for New York Long-Term Care Program

A New York State demonstration program that offers managed care to low-income adults requiring long-term care appears to be enrolling more patients than previous programs while providing an expanded range of services, according to initial findings of a study by the Urban Institute. If the early success of the initiative—the Evaluated Medicaid Long-Term Care Capitation Program—can be sustained, it may provide a model for other states searching for ways to coordinate the care provided to these patients.

Study results are described in *Integrating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York,* a new report from The Commonwealth Fund, which provided start-up support for the demonstration program.

Many elderly or disabled low-income adults qualify for both Medicare and Medicaid benefits. States are currently pursuing one of two strategies to integrate long-term and acute care services provided to these patients, increase flexibility in delivering benefits, and improve incentives for the appropriate use of health care services. The first strategy combines Medicare and Medicaid payments into a single capitated payment and makes one plan responsible for providing all long-term and acute care services. The second strategy coordinates—rather than integrates—

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Medicare- and Medicaid-financed health care, with capitated payments for Medicaid services.

New York's demonstration program for "dually eligible" patients uses the coordinated care model. It differs from integrated acute and long-term care programs in capitating only long-term care payments. In addition, the New York program is required to coordinate with Medicare acute care rather than fully integrating the financing of all patient care needs.

"Although complete integration of financing and service delivery may be simpler administratively, the relatively high enrollment in health plans participating in the New York State program attests to coordination's appeal," says Korbin Liu, an Urban Institute analyst and the study's lead author. "A drawback of fully integrated programs is that enrollees are asked to give up their primary physician in favor of the program's staff doctor. This is not a requirement at New York program sites."

Capitated Medicaid long-term care appears to be an improvement over standard public home and community-based care in New York.

Capitated Medicaid long-term care also appears to be an improvement over standard public home and community-based care in New York, according to Liu. The participating plans' ability to offer extensive transportation services, normally uncovered social services, and case management is an expansion of the generous levels of care provided under the state's Medicaid program.

The plans discussed in the report are VNS Choice, a subsidiary of the Visiting Nurse Service of New York, the largest home health agency in the country; Co-op Care, operated by a subacute skilled nursing facility in the Bronx; and Senior Network Health, part of an integrated acute care system in semirural Oneida County. ❖

Minority Health Policy Fellows Selected

In July, the sixth cohort of Commonwealth Fund/Harvard University Fellows in Minority Health Policy will begin work toward master's degrees in public health or public administration. The program, established in 1995, prepares U.S. physicians, particularly those from minority groups, for leadership positions in minority health and public policy. Fellowships provide for a one-year, enriched course of study at the Harvard School of Public Health or the John F. Kennedy School of Government. The new fellows and their areas of interest are:

- **Laura Gerald-Rogers, M.D.,** pediatrician and administrative director, Lumberton Children's Clinic. *Developing public health policies for underserved communities, particularly children and adolescents.*
- **Octavio Martinez, M.D.,** chief resident in psychiatry, University of Texas Health Science Center at San Antonio. *Improving mental health of minority Americans.*
- **David Nunez, M.D.,** senior physician, Kaiser Permanente Medical Group. *Improving care for minority children in low-income communities.*
- **Shairi Turner, M.D.,** clinician, Chelsea Urgent Care Center of Massachusetts General Hospital; medical clinic codirector, Temporary Home for Women & Children. *Promoting health and disease prevention within minority populations.*
- **Donald Warne, M.D.,** staff clinician, Phoenix Epidemiology and Clinical Research Branch of National Institute of Diabetes and Digestive

and Kidney Diseases. *Eliminating health disparities, particularly to reduce rates of diabetes, in Native American communities.*

- **D'Nyce Williams, M.D.,** assistant professor and clinical instructor of obstetrics and gynecology, Morehouse School of Medicine. *Creating a health policy division at a predominantly minority academic institution.*❖

Health System Comparisons Reveal Many Similarities

Cross-national comparisons of health care systems often reveal that the challenges confronting the United States are faced by nearly all countries—the need for improvements in quality, increased demand in the face of finite resources, and the difficulty of balancing advances in medical research and technology with their high cost. In the most recent issue of *Health Affairs* (May/June 2001), leading health policy analysts compared and contrasted nations' experiences, providing needed international perspective on health system performance.

A controversial study issued last year by the World Health Organization (WHO) shows how comparing health care systems can in itself pose a major challenge. The WHO study, which undertook the daunting task of rating the health systems of 191 countries, drew extensive media attention when it ranked highest some health systems that had not previously been thought of as successful national models. At the same time, more highly regarded systems were ranked much lower.

In an article critical of the WHO report, Robert J. Blendon and colleagues at Harvard University maintain that there is often little relationship between the rankings and the public's views in these countries. The authors compared the WHO results for 17 countries with rankings of citizens' satisfaction with their own health care systems. When looking at overall system performance, Blendon found striking differences between the two evaluations. In Italy, the country ranked second by WHO on this measure, just 20 percent of citizens reported they are satisfied with their health care system. At the other extreme is Denmark: although it is ranked 16th in overall performance, 91 percent of Danes said they are satisfied. The authors assert that the study's shortcomings stem from its reliance on public health experts—many of whom did not reside in the countries they were rating—to the exclusion of the views of people actually experiencing the health care systems.

The special *Health Affairs* issue, which is sponsored by The Commonwealth Fund, also features comparisons of health system components across nations. A study led by Linda H. Aiken of the University of Pennsylvania, for example, shows that the United States is not alone in having a nursing shortage, high levels of job dissatisfaction among nurses, and reports of uneven quality of hospital care. For the study, the authors examined reports from 43,000 hospital nurses across Canada, England, Germany, Scotland, and the United States. High proportions of registered nurses in all countries except Germany were found to be dissatisfied with their jobs, including more than 40 percent of nurses in the United States. Only 30 to 40 percent of nurses in all the countries reported there are enough registered nurses to provide high-quality care.

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More than 40 percent of registered nurses in the United States were found to be dissatisfied with their jobs.

Minimizing medical errors was the focal point of a five-point strategy for improving health care quality outlined in the issue and presented last October at The Commonwealth Fund's International Symposium on Health Care Policy in Washington, D.C. Authors Elise C. Becher and Mark R. Chassin of the Mount Sinai School of Medicine in New York say that the first step is to increase public demand for higher quality health care. Public and private employers could initiate educational efforts, they suggest, to help employees understand that "quality problems imperil their health." The federal government could also invest far more in creating tools and systems to measure and improve quality. In addition, the authors' plan calls for health care purchasers to develop new financial incentives to reward excellence in care; tougher sanctions against poorly performing physicians and other health professionals; and more visible leadership by health care providers to establish evidence-based measures for reducing errors and improving quality.❖

Hundreds of thousands of New Yorkers have lost Medicaid coverage despite their continued eligibility for benefits.

Ads Tell Working New Yorkers They May Still Qualify for Medicaid

Leaving welfare behind does not have to mean leaving your health coverage behind, too. This is the message of new subway and radio ads now appearing in New York City subway cars and airing on area radio stations. Sponsored by The Commonwealth Fund, the public outreach effort is designed to alert New Yorkers who have left—or are about to leave—welfare rolls for the workforce that they and their families can still get health care coverage through Medicaid. Hundreds of thousands in the city have lost Medicaid coverage because of confusion over their continued eligibility in the wake of welfare reform.

Created by the award-winning firm Robbett Advocacy Media, the English- and Spanish-language ads publicize HealthStat—a telephone helpline operated by the city that provides callers with information about Medicaid and Child Health Plus, prescreens them for eligibility, and offers referrals for assistance in applying for and keeping coverage. The ads, which will run through the end of June on all subway lines, are also being aired on WSKQ-FM 97.9, WRKS-FM 98.7, WQHT-FM 97.1, and WINS-AM 1010.

"The goal of this public education campaign is to ensure that everyone moving from welfare to work keeps their connection to the health system and increases their chance for a successful transition," said Karen Davis, president of The Commonwealth Fund.

In theory, welfare and Medicaid eligibility were "delinked," so that individuals who lost eligibility for cash assistance could retain their health insurance and other essential supports, like food stamps. But in reality, the delinking of welfare and Medicaid has increased confusion over eligibility. Many New

Yorkers who work in low-wage jobs and remain eligible for Medicaid are now losing their coverage improperly.

"Enormous effort has been focused on opening the front door to the system to enroll more New Yorkers," said Fund senior program officer David Sandman, "but equal attention must be paid to closing the back door to keep eligible people insured."❖

Henney Joins Fund's Board

The Commonwealth Fund recently announced the election of Jane E. Henney, M.D., the first woman to head the Food and Drug Administration, to its board of directors. Dr. Henney, a prominent medical oncologist who served for two years as FDA commissioner, is a nationally recognized academic leader and public health administrator. She is currently a senior scholar at the Association of Academic Health Centers in Washington, D.C.

"Jane Henney brings to the Fund a unique and varied background as a physician, medical researcher, and public health leader who will prove to be an invaluable asset to the Fund's board," said Charles A. Sanders, M.D., chairman of the Fund's board of directors.

As FDA commissioner from November 1998 until January 2001, Dr. Henney won praise from industry groups and lawmakers for her efforts to implement reform legislation to streamline the approval process for new drugs and medical devices. She also served as the FDA's deputy commissioner for operations from 1992 to 1994.

Before taking the top job at the FDA, Dr. Henney served as vice president for health services at the University of New Mexico, where she is a tenured professor on leave of absence. Dr. Henney was elected last year to the Institute of Medicine of the National Academy of Sciences.❖

Fund Names Barry Communications Director

Paul K. Barry, director of corporate publications and public affairs for the College Board, is The Commonwealth Fund's new director of communications, the foundation announced in May. Barry is replacing Michael Vachon, who left the Fund in April to become director of public relations for Soros Fund Management in New York.

Barry comes to the Fund after 20 years with the College Board, the national, nonprofit association of schools, colleges, and universities that is perhaps best known for its college preparatory programs, including the SAT and PSAT exams and the Advanced Placement (AP) Program. Barry began his tenure there as associate editor of the *College Board Review* and *College Board News*. Earlier in his career, he was an assistant managing editor at Plenum Publishing in New York and an English instructor at Allegheny Community College in Pittsburgh.❖

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Copies of publications described in this *Quarterly* can be obtained by calling the Fund's toll-free number at **1-888-777-2744** or by visiting the Fund's website at **www.cmwf.org.**

Recent and Forthcoming Commonwealth Fund Publications, Spring 2001

Fund Reports

The Commonwealth Fund Task Force on Academic Health Centers, *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured,* April 2001

Marsha Gold and Lori Achman, Mathematica Policy Research, Inc., *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans,* April 2001

Kay A. Johnson, Johnson Group Consulting, Inc., *No Place Like Home: State Home Visiting Policies and Programs,* May 2001

Jeanne M. Lambrew, George Washington University, *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children,* May 2001

Korbin Liu, Sharon K. Long, Matthew Storeygard, and Amanda Lockshin, *Integrating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (forthcoming)

Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures,* May 2001

James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy, *How the New Labor Market Is Squeezing Workforce Health Benefits,* June 2001

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