



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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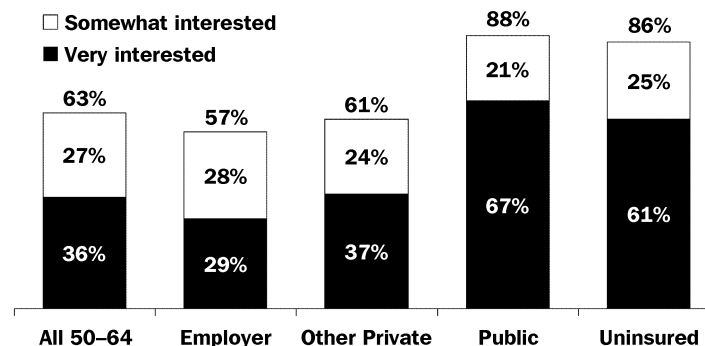
Older Adults Keen on Medicare, But Lack of Drug Benefits Causes Concern

Americans ages 50 to 70—those nearing the age of Medicare eligibility as well as those who recently enrolled in the program—place a high value on Medicare, according to a study recently released by The Commonwealth Fund. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare does not cover. Medicare's benefit package was designed when the program was established in 1965 and has not changed significantly since then, despite the fact that drugs play an increasingly crucial role in modern medicine.

Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70 reveals that adults not yet eligible for Medicare are eager to join the program. In fact, nearly two-thirds of adults age 50 or older, but still too young for Medicare, said they would be interested in participating early, before age 65. And when respondents were asked who they would trust most to insure people their age, Medicare received the highest rating, outranking employer-sponsored coverage and direct purchase of insurance.

How interested would you be in getting Medicare before turning 65?

Percent of adults ages 50–64* interested in coming in early, by their current insurance source



* Not currently on Medicare.

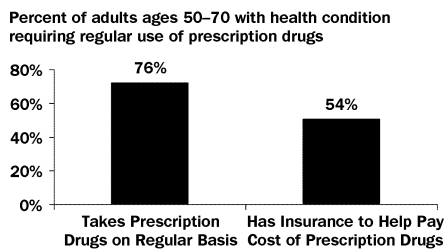
Source: *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.*

Four of five Americans ages 50 to 70 require prescription medicines, yet only 54 percent have a drug benefit.

The report, authored by the Fund’s Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis, also finds that Medicare beneficiaries ages 65 to 70 are more likely than adults ages 50 to 64 to be very confident in their ability to obtain high-quality medical care when needed and to be satisfied with that care. Sixty-eight percent of these recently eligible Medicare beneficiaries said it was “very important” for them to become covered by Medicare, and most gave their health insurance a positive rating.

The absence of comprehensive prescription drug coverage is, however, a major concern for the 50 million people ages 50 to 70. Although nearly four of five adults in this group suffer from a health condition requiring regular use of prescription drugs, only half (54%) reported having a drug benefit.

Many Adults Who Need Prescription Drugs Do Not Have Coverage

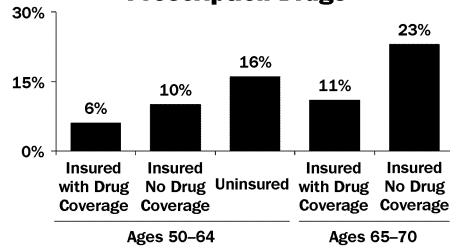


Source: The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.

Whether they are currently in Medicare or nearing eligibility, respondents lacking a drug benefit—even if they have other insurance—report high out-of-pocket expenses, difficulty affording care prescribed by a doctor, and struggles paying medical bills. One of 10 (9%) adults ages 50 to 64 and nearly one of six (16%) ages 65 to 70 reported that they typically spend more than \$100 per month out-of-pocket for prescription medications. For one of five Medicare beneficiaries ages 65 to 70, drug spending alone accounts for

approximately 5 percent of personal income.

Percent of Adults Paying More than \$100 per Month Out-of-Pocket for Prescription Drugs



Source: The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.

Adults who lack prescription drug coverage also go without necessary care at alarmingly high rates. Otherwise insured adults ages 50 to 70 without drug coverage are three times as likely as those with coverage to have not filled a prescription because of the cost.

One explanation for the trust that many 50-to-64-year-olds place in Medicare may be that so many of them are either uninsured or have unstable health coverage. About 5.6 million of the 39 million men and women in this age group are uninsured. Those who lose their health coverage tend to go without needed medical care and remain uninsured for long stretches of time—despite the increased risk of chronic, acute, or disabling health conditions for older adults. ❖

Medicare+Choice Hits Bumps in the Road

Three new studies supported by The Commonwealth Fund have found that the Medicare+Choice program, created by the Balanced Budget Act of 1997, has hit bumps in the road. Beneficiaries are facing rising premiums, reduced benefits, and considerable out-of-pocket costs. Not only have few new plans entered the Medicare+Choice market, but frequent

plan withdrawals are creating concerns about the program's future.

Are Enrollees Getting Less for More?

Amanda Cassidy and Marsha Gold of Mathematica Policy Research, Inc., take an in-depth look at changes in the benefits offered by Medicare+Choice plans and find some worrisome trends. In *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?*, Cassidy and Gold report that, based on the Health Care Financing Administration's Medicare Compare database, the proportion of managed care organizations offering a plan with no premium is down by a third, from 62 percent in 1999 to 42 percent today. At the same time, the percentage of plans offering prescription drugs—a major reason why Medicare beneficiaries are attracted to Medicare+Choice in the first place—has declined from 73 to 68 percent. The average generosity of the benefit has also fallen somewhat, while cost-sharing required of enrollees has increased.

The authors find as well that benefit and premium levels vary widely across the country, with some of the sharpest disparities occurring between urban and rural areas. "Plan withdrawals from certain markets mean that in 2000, fewer Medicare beneficiaries live in counties with a Medicare+Choice contract," says Gold. Today, 68 percent of beneficiaries are in counties that have a managed care option, compared with 72 percent in 1999. When they do have an option, beneficiaries are less likely to have a choice of at least one plan that includes a prescription drug benefit, or one that is offered with a zero premium.

The authors say that benefit reductions from 1999 to 2000 likely reflect the managed care industry's

response to changes in reimbursement made in the Balanced Budget Act of 1997 (BBA). However, the reductions also suggest that plans have had difficulty negotiating competitive rates from health care providers.

Does It Really Pay to Play?

As more Medicare+Choice plans attempt to restructure benefits and impose additional cost-sharing on enrollees, understanding the impact on beneficiary out-of-pocket spending becomes especially important. *What Do Medicare HMO Enrollees Spend Out-of-Pocket?*, another Fund-supported analysis, is among the first to tackle this issue. In examining Medicare Part B premiums, health plan premiums, and individuals' payment for health services in 1995, authors Jessica Kasten, Marilyn Moon, and Misha Segal of the Urban Institute find that managed care coverage does not necessarily protect enrollees from high out-of-pocket spending. The burden is particularly steep for more vulnerable beneficiaries and for certain categories of services.

Noninstitutionalized Medicare+Choice enrollees, who account for 97 percent of the enrollee population, spent \$1,406, or 11 percent of their income, out-of-pocket. Beneficiaries in fair or poor health, however, spent substantially more—\$1,771, or 18 percent of their income. HMO enrollment, the study finds, does not equalize the financial burden between sicker and healthier beneficiaries.

Dental services accounted for the largest share of direct spending on health care (31%). Medical provider services (28%), including physician care, and prescription drugs (25%) were the next two largest categories of out-of-pocket spending. While Medicare+

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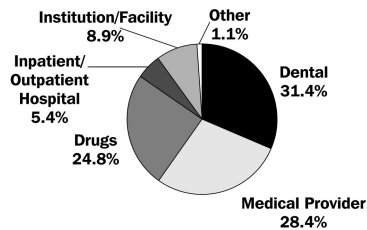
a prescription drug

benefit or zero

premium.

Choice HMOs presumably furnish comprehensive coverage for medical provider services, 15 percent of enrolled patients paid for 50 percent or more of this care themselves. Similarly, 31 percent of users spent 50 percent or more of the cost of their medications out-of-pocket.

Medicare HMO Enrollees' Out-of-Pocket Spending for Health Services, 1995



Note: "Other" includes home health and hospice spending.
Source: Jessica Kastan, Marilyn Moon, and Misha Segal, *What Do Medicare HMO Enrollees Spend Out-of-Pocket?*, The Commonwealth Fund, August 2000.

"Despite the better health of enrollees in Medicare HMOs than the Medicare population in general, roughly the same proportion of both groups reported difficulty paying medical bills in 1997," says Marilyn Moon. "And insurance really doesn't fully protect people in poor health in either group. That many beneficiaries are paying for half of their medical and prescription drug expenses out of their own pockets suggests HMO coverage is not as comprehensive in this area as some believe."

Early Implementation: A Tale of Four Cities

In a study of the Medicare+Choice experience in four large urban areas, Geraldine Dallek and Donald Jones of Georgetown University report that Medicare managed care is neither living up to the promise foreseen by its proponents nor plagued by the problems anticipated by its detractors.

Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa-St. Petersburg examines enrollment patterns in the four cities, paying particular attention to changes related to

consumer education and disenrollment. Based on their evidence, Dallek and Jones find that Medicare+Choice is resulting in less competition, not more.

Congress originally expected that new provider-sponsored organizations (PSOs) would compete with HMOs and traditional Medicare for beneficiaries. But one year after implementation began, no new types of managed care organizations had entered any of the four markets. The authors report that hospital and physician groups have been reluctant to take on the financial risk of contracting directly with Medicare and are wary of competing with HMOs for beneficiaries. "Provider groups fear that HMOs could respond to any encroachment on their business by refusing to contract with them to care for privately insured enrollees," says Dallek, the study's lead author. As a result, the bulk of Medicare enrollment in each city is concentrated in just two or three large plans.

Although Dallek and Jones found that few health plans had pulled out of the four cities studied during this period, plan withdrawals did have a significant impact on the counties surrounding Cleveland, New York, and Tampa-St. Petersburg. Interviews with plan representatives indicate that the pullouts stemmed as much from their organizations' failure to obtain favorable contracts from local hospitals and physicians as from reductions in Medicare's reimbursement levels.

The study's authors also find that Medicare+Choice's new "lock-in" provision, which will be phased in starting in 2002, may create significant problems. Current rules allow Medicare beneficiaries to disenroll from their Medicare+Choice plans at any time and, in fact, many do. For example, in Tampa-St. Petersburg, six of the seven

Hospital and physician groups fear that if they compete with HMOs for their Medicare business, HMOs might respond by refusing to contract with them for care of privately insured enrollees.

plans reporting had voluntary disenrollment rates of 20 percent or greater in 1999. In three of the four cities, the rate of *rapid* disenrollment (within three months) in 1999 was up substantially from 1998—a possible indication that marketing agents are providing inadequate information about enrollment or the plan itself. Starting in 2002, Medicare+Choice will require beneficiaries to stay with their plan for one year. ❖

Quality of Health Coverage Essential to Access, Security

The most essential notion of health insurance is that it guarantees access to affordable health care when we are sick. Yet a recent Fund-supported study shows that a substantial number of adults with health coverage continue to go without needed care because of high costs—a prime indication that these men and women are “underinsured.”

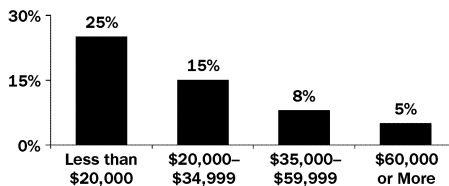
“Inadequate Health Insurance: Costs and Consequences,” published in the Internet journal *Medscape General Medicine* on August 11, the health care news and information website, reports that nearly one of five insured adults experienced a time in the past year when he or she did not have enough money to pay for medical bills, prescription drugs, or other health care costs. The study, by Karen Donelan and Catherine M. DesRoches of the Harvard School of Public Health and Cathy Schoen of The Commonwealth Fund, was based on analysis of *The Commonwealth Fund 1999 National Survey of Workers’ Health Insurance*, which interviewed more than 5,000 adults ages 18 to 64.

According to the authors, approximately one of 10 insured adults

did not see a doctor when sick, fill a prescription, or follow up on a recommended treatment or diagnostic test because of the cost. Those with lower incomes were most at risk: one-quarter of insured adults with annual income less than \$20,000 reported a time when they did not visit a doctor when they were ill. A similar proportion of low-income, insured adults did not fill a prescription because of the cost or because getting care when needed was “extremely,” “very,” or “somewhat” difficult.

Health Care Access Concerns Indicate Inadequate Insurance for Low- and Moderate-Income Adults

Percent of insured adults who had a medical problem but did not see a doctor due to costs

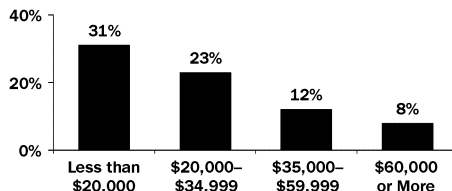


Source: Karen Donelan, Catherine DesRoches, and Cathy Schoen, “Inadequate Health Insurance: Costs and Consequences,” *Medscape General Medicine*, August 11, 2000.

Men and women with higher incomes—from \$20,000 to \$35,000—also lack ready access to health care because their health plans provide inadequate coverage or protection from medical costs. About one of four in this income group had been contacted by collection agencies in the year prior to the survey about medical bills that were past due.

Low- and Moderate-Income Adults Often Have Insurance with Inadequate Financial Protection

Percent of insured adults who were contacted by a collection agency about medical bills



Source: Karen Donelan, Catherine DesRoches, and Cathy Schoen, “Inadequate Health Insurance: Costs and Consequences,” *Medscape General Medicine*, August 11, 2000.

One of 10 adults with health insurance did not see a doctor when sick, fill a prescription, or follow up on recommended treatment because of the cost.

The experiences of these Americans indicate that their health insurance places limits on benefits or includes onerous patient cost-sharing provisions. In other words, they are underinsured. For those already living on budgets stretched to meet basic living expenses, lack of adequate insurance can lead to severe financial difficulties or health problems if medical needs are not met. “If we are to expand access to insurance for people living on low or modest incomes, we would do well to consider the comprehensiveness, affordability, and quality of insurance available,” conclude the study’s authors. ❖

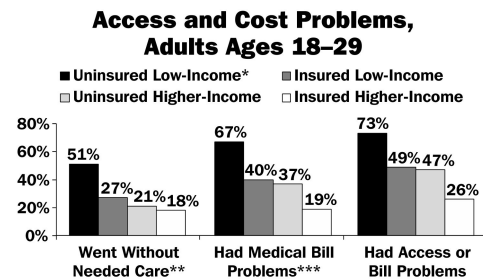
Gen-Xers Uninsured at Double the Rate

Casting a shadow on the popular image of young adults in their 20s enjoying unlimited opportunity in a booming economy, a recent report from The Commonwealth Fund Task Force on the Future of Health Insurance reveals that 12 million are vulnerable to the catastrophic expense of serious illness or injury because they lack health insurance. Men and women ages 19 to 29 are twice as likely to be uninsured as children or older adults.

On Their Own: Young Adults Living Without Health Insurance, by Kevin Quinn and Louisa Buatti of Abt Associates, Inc., and the Fund’s Cathy Schoen, finds that lack of insurance is jeopardizing the health of young adults, especially those living on low incomes. Despite tight labor markets over the past decade, the proportion of young adults without health coverage has risen from 22 to 30 percent. Today, adults ages 19 to 29 are uninsured at twice the rate of 30-to-64-year-olds and account for more than a quarter of the nation’s 44 million uninsured.

Despite tight labor markets over the past decade, the proportion of uninsured Americans ages 19 to 29 has risen from 22 percent to 30 percent.

The study finds that family income and ability to attend school full-time are crucial factors for college-age adults ages 19 to 23. Those who can afford to attend school full-time typically remain covered under their parents’ health plan—an opportunity that mainly benefits the sons and daughters of higher-income families. Among 19-to-23-year-olds from families with incomes in the top 20 percent, two-thirds are in school full-time and have health insurance, while only 7 percent are uninsured. In stark contrast, more than half of college-age adults with family incomes in the bottom 20 percent are uninsured; only 10 percent are insured and attending school full-time.



* Low-income is less than 200% of poverty.

** Did not see a doctor when sick, fill a prescription, or get recommended test or treatment in past year.

*** Time could not pay medical bill or contacted by collection agency for medical bills in past year.

Source: Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On Their Own: Young Adults Living Without Health Insurance*, The Commonwealth Fund Task Force on the Future of Health Insurance, May 2000.

Low-income 19-to-29-year-olds with no health insurance are at especially great risk. Three-quarters of the 12 million without coverage have incomes below 200 percent of the poverty level—roughly \$17,000 for a single person. At these incomes, there is often little cash available to spend on health care after meeting basic living expenses.

The authors point out that failure to invest in the country’s future by leaving young adults out of the health insurance system creates a long-term cost to personal health and, ultimately, to the health of the nation’s economy. ❖

Urban Health Insurance Rates Vary Widely Across U.S.

Where you live can sometimes influence your access to health coverage and health care. A new analysis of urban areas in the United States finds that residents of urban communities along the southern U.S. border are the most likely to be uninsured.

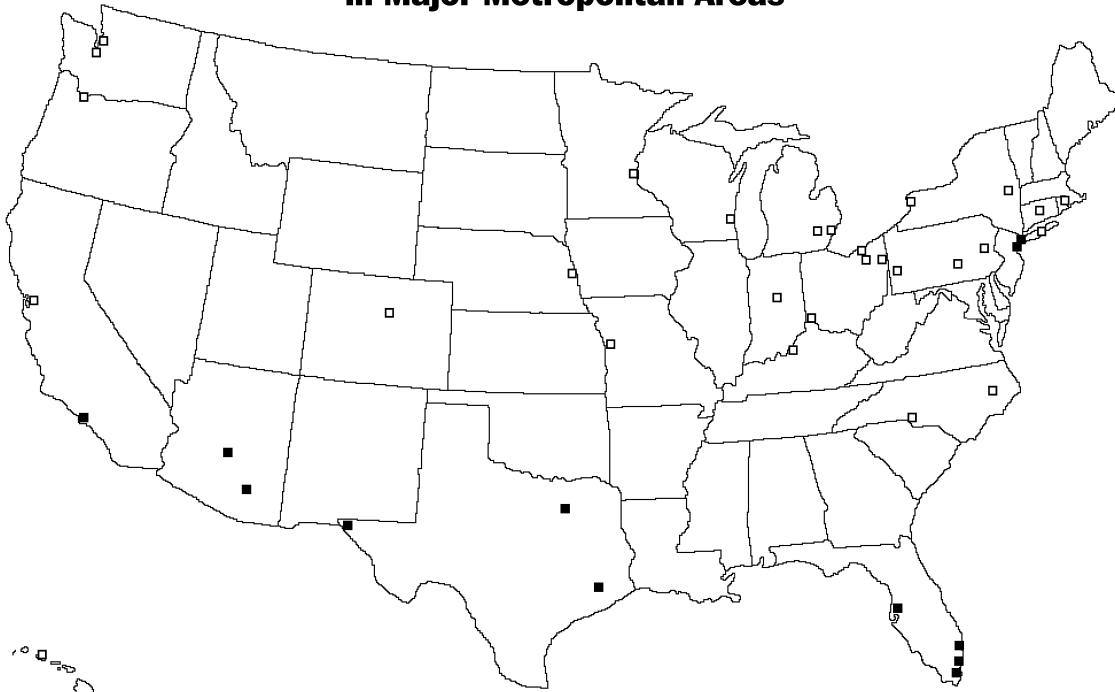
In the Fund-sponsored study, *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities*, E. Richard Brown, Roberta Wyn, and Stephanie Teleki of the UCLA Center for Health Policy Research examined health insurance coverage of nonelderly

residents in 85 metropolitan areas. The average uninsured rate for all the communities was found to be 19 percent, with a high of 37 percent in El Paso, Texas, and a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania.

Although the uninsured overall have poor access to health care services, those in urban areas with low health coverage rates have an even harder time gaining access to care than their counterparts in high-coverage communities. One possible reason the report cites is that public hospitals and community health centers—the safety net—are overwhelmed by uninsured residents in cities that have disproportionately large uninsured populations.

Urban residents along the southern U.S. border are generally more likely to be uninsured.

High and Low Uninsured Rates in Major Metropolitan Areas



■ High Uninsured Rate (25% or greater)

- Dallas, TX
- El Paso, TX
- Fort Lauderdale, FL
- Houston, TX
- Jersey City, NJ
- Los Angeles, CA
- Miami, FL
- New York, NY
- Phoenix-Mesa, AZ
- Tampa, FL
- Tucson, AZ
- West Palm Beach, FL

□ Low Uninsured Rate (less than 15%)

- Akron, OH
- Albany, NY
- Allentown, PA
- Ann Arbor, MI
- Buffalo-Niagara, NY
- Charlotte, NC-SC
- Cincinnati, OH-KY-IN
- Cleveland, OH
- Denver, CO
- Detroit, MI
- Harrisburg, PA
- Hartford, CT
- Honolulu, HI
- Indianapolis, IN
- Kansas City, MO-KS
- Louisville, KY-IN
- Milwaukee, WI
- Minneapolis, MN-WI
- Nassau-Suffolk, NY
- Norfolk, VA
- Oakland, CA
- Omaha, NE-IA
- Pittsburgh, PA
- Portland, OR-WA
- Providence, RI-MA
- Seattle, WA
- Tacoma, WA
- Youngstown, OH

Source: E. Richard Brown, Roberta Wyn, and Stephanie Teleki, UCLA Center for Health Policy Research, *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities*, The Commonwealth Fund, August 2000.

Brown and his colleagues also found that the average rate of job-based health insurance for the 85 cities is 67 percent, ranging from 49 percent in El Paso to 84 percent in Milwaukee, Wisconsin.

People with low incomes are much less likely than more affluent individuals to have job-based coverage—no matter where they live. But the disparity is generally greater among the less advantaged living in low-coverage areas, particularly Hispanics, people with low to moderate incomes, those with less education, and noncitizens. ❖

CHIP Design Flaws Limit Enrollment

Since its creation three years ago as part of the Balanced Budget Act, the State Child Health Insurance Program (CHIP) has sparked widespread enthusiasm among states for expanding health coverage for children. A recent study sponsored by The Commonwealth Fund, however, has determined that a number of factors—from overly complex program designs to burdensome cost-sharing provisions and inadequate outreach efforts—have led to lower-than-expected enrollment levels and failure to maintain health coverage for children once they are enrolled.

According to *State Experiences with Access Issues Under Children’s Health Insurance Expansions*, one of two reports produced from the study, increases in children’s coverage through CHIP are often overshadowed by decreases in Medicaid enrollment. In many states, the loss of automatic Medicaid enrollment through welfare programs has caused a sharp decline in Medicaid applications and enrollees.

The analysis was based on literature reviews, interviews with national

experts, and close-up study of six states: California, Colorado, Florida, Massachusetts, New York, and Washington. The authors are Mary Jo O’Brien of Health Management Associates and Meghan Archdeacon, Midge Barrett, Sarah Crow, Sarah Janicki, David Rousseau, and Claudia Williams of the Lewin Group.

A number of states have chosen to build “stand-alone” CHIP programs—with an administration and infrastructure separate from Medicaid—to create a new identity for the program. While states have succeeded in making CHIP programs distinct from Medicaid, doing so has made coordination with the existing Medicaid program difficult and has led to confusion for families enrolled in both programs. Stand-alone CHIP programs often contract with a different mix of health plans and physician networks and cover different benefits. As a result, there is one set of provider network and health plan choices for CHIP enrollees, and another set for Medicaid enrollees. By maintaining separate public health insurance programs, states run the risk of losing children and families in the transition from one eligibility category to another.

Cost-sharing—in the form of copayments and premiums—is another prominent feature of many CHIP programs. In their companion paper, *State Experiences with Cost-Sharing Mechanisms in Children’s Health Insurance Expansions*, the authors report that although it was intended to control the use of health care services, foster the notion of personal responsibility, and generate revenue, cost-sharing has mainly introduced new complexity into program administration.

Premium-sharing, even at low levels, may also create a disincentive for families to enroll. States have found that

Overly complex program designs, burdensome cost-sharing, and inadequate outreach efforts have led to lower-than-expected enrollment levels in state CHIP programs.

low-income families without a checking account or credit card, or the ability to have premiums deducted from paychecks, face problems in arranging for payment of monthly premiums. ❖

Pediatric Care Specs Developed for Medicaid HMOs

With growing awareness that attention to young children's cognitive and social skills is of fundamental importance to their overall development, the next step is to ensure that health care providers offer families comprehensive pediatric care—and that purchasers' demands for developmental services are made explicit.

A recently completed project developed under The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) program provides state Medicaid agencies with options for incorporating specifications for child developmental services into managed care contracts. The model language, developed by Sara Rosenbaum and staff at George Washington University's Center for Health Services Research and Policy (CHSRP), covers the provision of developmental screenings, structured developmental assessments, parent education, and other pediatric services to young children in low-income families.

National experts on child health and development, including those working with the Fund's ABCD and Healthy Steps for Young Children programs, were consulted for the project, and Medicaid officials, health plans, pediatricians, and child advocates reviewed drafts of the specifications. The final report, *Optional Purchasing Specifications: Child Development Services*

in Medicaid Managed Care, along with purchasing specifications for other services such as dental care and lead poisoning prevention, is available through CHSRP's website at www.gwu.edu/~chsrp, and through the ABCD website at www.nashp.org/progs/pro0011.htm and the Fund's main site at www.cmwf.org. ❖

Availability of Specialty Care May Be in Jeopardy

A new report by the Commonwealth Fund Task Force on Academic Health Centers warns that specialty medical services, including burn and trauma care, transplants, inpatient AIDS treatment, and neonatal intensive care, will become less available in competitive health care markets where cost takes precedence over innovation.

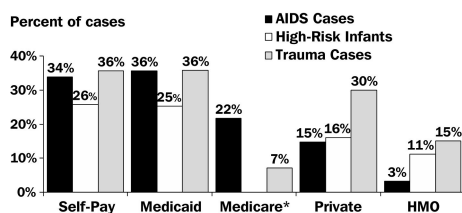
Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care states that unless insurers and policymakers take into account the expense of developing and providing these services—usually to a poorer, sicker population—many of the nation's academic health centers may be forced to reduce their current levels of access and innovation.

Academic health centers (AHCs) are at the forefront of the development and testing of new technologies and clinical processes for complex illnesses, as well as innovations in treatment of common conditions. While AHCs make up just 2 percent of all U.S. hospitals, they account for one-third of all level 1 trauma care units and one-fifth of all transplant programs and burn units. These institutions also provide a dispro-

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portionate share of certain specialized services to indigent and uninsured patients. The additional costs of caring for these patients, however, are not counted in insurers' reimbursement systems.

Share of AIDS Cases, High-Risk Infants, and Trauma Cases Treated by AHCs, by Type of Insurance



* Medicare data for high-risk infants are not available.

Source: *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care*, The Commonwealth Fund Task Force on Academic Health Centers, July 2000.

“Academic health centers should not be penalized for being leaders in developing new expertise in health care,” said David Blumenthal, M.D., executive director of the Task Force. “Not only do the uninsured and those with difficult medical problems depend disproportionately for their care on academic health centers, all Americans benefit from their innovations in patient care.”

The Fund’s Task Force recommends that the government step in where private markets fail to pay reasonable costs for specialty services. Furthermore, it recommends that payments be tied to AHCs’ ability to provide high-quality care and control costs.

“The challenge is to strike an appropriate balance between competitive forces and public policy affecting academic health centers,” said Dr. Blumenthal. “Academic health centers must be able to continue to assure efficiency, innovation, and equity in the availability of specialty services.” ❖

Media Coverage of New Drugs Found to Be Misleading

Newspaper and television reports on new medications often exaggerate benefits, ignore risks, and fail to disclose true costs, according to a collaborative study that appeared in the June 1 *New England Journal of Medicine*. The study, funded by The Commonwealth Fund and the Harvard Pilgrim Health Care Foundation, also found that only 40 percent of news stories citing experts with financial ties to the drug being studied disclosed this potential conflict of interest.

“Major scientific journals require study authors to disclose industry links, as evidence suggests that commercial funding of research may lead to more favorable research outcomes,” says Ray Moynihan, an award-winning medical journalist based in Sydney, Australia, who conducted the study while in the United States on a Commonwealth Fund Harkness Fellowship. “This standard might be adopted by the news media so the public can make more informed decisions on their health care.”

The study, which reviewed media stories from 1994 to 1998, also found that of the 207 articles randomly selected, 40 percent did not offer any numerical analysis of a drug’s benefits, leaving the public without any benchmark to judge the overall value of the drug to their health. Of the 124 stories that did, 83 percent reported only *relative* benefits—a practice that can be viewed as potentially misleading. For example, 1996 media reports on a new osteoporosis drug stated that it would reduce hip fractures by 50 percent, a relative figure that exaggerates the

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power of the drug. In terms of *absolute* benefit, however, the drug reduced the rate of hip fracture from 2 percent to 1 percent.

More than half (53%) of the stories, furthermore, failed to discuss the potential adverse effects of the three preventive medications included in the study: pravastatin (Pravachol), a cholesterol-lowering drug; alendronate (Fosamax), used for the treatment and prevention of osteoporosis; and aspirin, which has been shown to be effective in fighting cardiovascular disease.

“The media are a very important source of public health information,” says Dr. Stephen Soumerai, coauthor of the study and Moynihan’s Harkness mentor. “But stories on new drugs can be misleading when they fail to address potential conflicts of interest and don’t discuss both relative and absolute benefits, risks, and costs.”

Moynihan was a Harkness Fellow in Health Care Policy in the Department of Ambulatory Care and Prevention, a joint teaching and research department of Harvard Medical School and Harvard Pilgrim Health Care. ❖

U.S.–U.K. Meeting Focuses on Quality

The Fund and the London-based Nuffield Trust cosponsored a meeting, “Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action,” at Ditchley Park Conference Centre in Oxfordshire, England, on June 9–11. The meeting, which brought together 45 senior policymakers and leading quality experts from both countries, used coronary heart disease and cancer as models to compare U.S. and U.K. experiences in improving quality of

care, learn about what works and what does not, and develop opportunities for collaboration on quality issues. Keynote presentations were delivered by John Eisenberg, M.D., administrator of the U.S. Agency for Healthcare Research and Quality, Liam Donaldson, M.D., chief medical officer of the U.K. Department of Health, and Sheila Leatherman, senior advisor to The Nuffield Trust. ❖

2001 Ian Axford Fellows in Public Policy Selected

The Ian Axford Fellowships selection committee, chaired by Robert Reischauer, president of the Urban Institute and former director of the Congressional Budget Office, selected two 2001 Ian Axford Fellows in Public Policy in May.

The fellowships, established in 1995 by the New Zealand government in partnership with the private sector to reinforce links between New Zealand and the United States, enable outstanding U.S. public policy professionals in midcareer to take policy sabbaticals of six to nine months in New Zealand. The 2001 fellows and their projects are:

- Daniel Sarewitz, managing director and research scholar, Center for Science, Policy, and Outcomes, Columbia University: *The Development of Outcomes-Based Science Policy in New Zealand: Lessons for U.S. Policymakers.*
- Donald J. Schmid, assistant United States attorney, U.S. Department of Justice, South Bend, Indiana: *New Zealand Family Conferencing: A Model for U.S. Criminal Justice.* ❖

Forty percent
of the media
stories did not
offer any
numerical
analysis of a
drug’s benefits,
leaving the public
without any
benchmark to
judge the
overall value of
the drug to their
health.

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Recent and Forthcoming Commonwealth Fund Publications, Summer 2000

Fund Reports

Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities

E. Richard Brown, Roberta Wyn, and Stephanie Teleki, UCLA Center for Health Policy Research, August 2000

Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?

Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc., August 2000

Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care

The Commonwealth Fund Task Force on Academic Health Centers, July 2000

Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa—St. Petersburg

Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University, August 2000

What Do Medicare HMO Enrollees Spend Out-of-Pocket?

Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute, August 2000

The Roles of Medicare and Medicaid in Financing Health and Long-Term Care for Low-Income Seniors: A Chartbook on Medicare–Medicaid Enrollees in Four States

Harriet L. Komisar, Judith Feder, and Daniel Gilden, August 2000

Health Care Access and Coverage for Women: Changing Times, Changing Issues?

Deborah Lewis-Idema, Joan M. Leiman, and Karen Scott Collins, November 1999

State Experiences with Access Issues Under Children's Health Insurance Expansions

Mary Jo O'Brien, Meghan Archdeacon, Midge Barrett, Sarah Crow, Sarah Janicki, David Rousseau, and Claudia Williams, May 2000

State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions

Mary Jo O'Brien, Meghan Archdeacon, Midge Barrett, Sarah Crow, Sarah Janicki, David Rousseau, and Claudia Williams, May 2000

On Their Own: Young Adults Living Without Health Insurance

Kevin Quinn, Cathy Schoen, and Louisa Buatti, The Commonwealth Fund Task Force on the Future of Health Insurance, May 2000

Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70

Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis, July 2000

Journal Articles and Publications

Karen Donelan, Catherine M. DesRoches, and Cathy Schoen, "Inadequate Health Insurance: Costs and Consequences," *Medscape General Medicine*, August 11, 2000, available online at www.medscape.com/Medscape/GeneralMedicine/journal/public/mgm.journal.html

Marian E. Gornick, *Vulnerable Populations and Medicare Services: Why Do Disparities Exist?* The Century Foundation Press, 2000

Joel C. Cantor, Kathryn Haslanger, and Kathleen DeGuire, "Health Plan Responses to Medicaid Managed Care Policy in New York City," *Managed Care Quarterly* 8 (Spring 2000):39–47

Ray Moynihan et al., "Coverage by the News Media of the Benefits and Risks of Medications," *New England Journal of Medicine* 342 (June 1, 2000):1645–1650

Sara Rosenbaum et al., *Optional Purchasing Specifications: Child Development Services in Medicaid Managed Care*, Center for Health Services Research and Policy, George Washington University, forthcoming

Cathy Schoen and Catherine M. DesRoches, "Role of Insurance in Promoting Access to Care—Uninsured and Unstably Insured: The Importance of Continuous Coverage," *HSR: Health Services Research* 35 (April 2000, Part II):187–206

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