



# The Commonwealth Fund Quarterly

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A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

## What's Inside:

- 2 *Health Insurance Tax Credits Inadequate for Older Adults, Study Says*
- 3 *Employer Policies Can Limit Health Plan Participation*
- 4 *Changes in Labor Market Leaving Many Low-Wage Workers Without Coverage*
- 5 *High-Risk Pools Unaffordable for Many Who Are Denied Health Coverage*
- 6 *Ill Medicare Beneficiaries Need Extra Protection from Costs, Report Finds*
- 7 *Public Programs: Missed Opportunities for Early Health Care*
- 8 *Study of Healthy Steps Program Shows Promising Results*
- 9 *New Initiative Weighs "Business Case" for Quality*
- 10 *Workshop Focuses on Quality Measures for Minority Health Care*
- 11 *Ian Axford Fellows in Public Policy Selected*
- 11 *Fidelity Vice Chair Appointed to Fund's Board*

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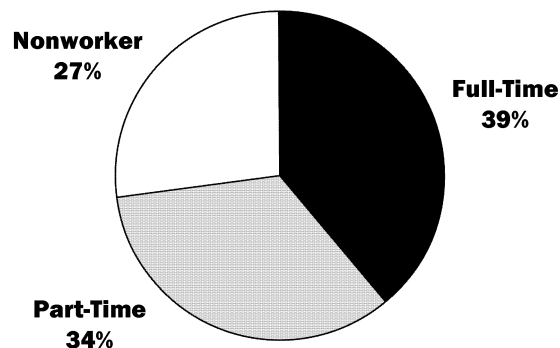
## Health Insurance Is a "Family Affair," Study Finds

**P**olicymakers searching for promising ways to expand health insurance coverage to the more than 6.2 million low-income uninsured parents in the United States may be able to find a solution that is close to home. According to a new study released by The Commonwealth Fund Task Force on the Future of Health Insurance, states that extend health insurance coverage to parents through the public programs that cover their children significantly reduce the number of uninsured parents and children.

The study was conducted by Jeanne M. Lambrew, an associate professor of health policy at George Washington University who was a key health adviser to President Clinton in his second term.

The maximum amount of income that parents can earn and still qualify for Medicaid or the Children's Health Insurance Program (CHIP) coverage is shockingly low in many states. According to the report, a number of states set the limit at less than 50 percent of the federal poverty level. In Alabama, Arkansas, and Louisiana, income eligibility standards for public health coverage as of February 2001

## Nearly Three of Four Low-Income, Uninsured Parents Work



Source: Jeanne M. Lambrew, *Health Insurance: A Family Affair*, The Commonwealth Fund, May 2001.

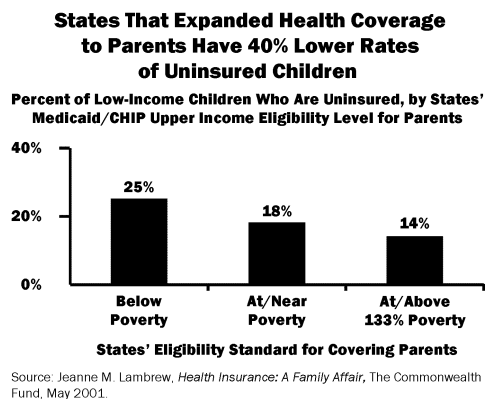
Continued on page 2

*Uninsured rates for children in states that have extended coverage eligibility to parents above the poverty line are nearly half those of states that restrict eligibility to parents below the poverty line.*

were each less than 25 percent of the poverty level. Many low-income, working parents consequently have too much income to qualify for state coverage but too little to afford private insurance. Nearly three-quarters of these parents are employed, either full-time or part-time.

“The failure of states to insure entire families at least partly explains the slow growth of insurance coverage for children in some states and the persistence of high uninsured rates,” said Cathy Schoen, executive director of the Task Force. “This report suggests that proposals to encourage states to expand health insurance to low-income parents could benefit not only these parents but their children, too.”

Uninsured rates for children in states that have extended coverage eligibility to parents above the poverty line are nearly half those of states that restrict eligibility to parents below the poverty line.



Other studies have shown that insuring parents is also good for children's health. Insured parents with a regular health care provider are more likely to ensure that their children receive regular preventive care.

“States have already made great strides in expanding coverage to children,” noted Jeanne Lambrew, the report's author. “Adding parents to existing state programs for children is

not only administratively easy and efficient, it is effective at further reducing the number of uninsured kids. Clearly, it is the next logical step.” The report finds that covering all parents up to 200 percent of the federal poverty level under Medicaid or CHIP would extend coverage to 6.2 million uninsured low-income parents. ❖

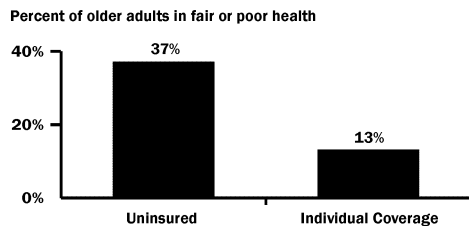
## Health Insurance Tax Credits Inadequate for Older Adults, Study Says

The modest tax credits proposed by the Bush Administration and members of Congress to help adults purchase individual health coverage will likely be of little benefit to older men and women, researchers say. A recent study examining the individual health insurance market for Americans ages 50 to 64 finds that it often fails to offer affordable, comprehensive coverage to those who have lost their connection to employer-based insurance because of involuntary retirement, illness, or loss of job. High annual premiums and deductibles that together can consume as much as one-half of personal income make individual insurance—where it is available at all—prohibitively expensive for many adults in their midlife years. Even with the President's proposed tax credit, individual insurance would still be out of reach for many of these Americans, researchers say.

The study, which appeared in the July/August issue of the journal *Health Affairs*, was based on analysis of a Commonwealth Fund survey of more than 1,500 people ages 50 to 64 conducted from August to November 1999. The authors, former Fund senior research analyst Elisabeth Simantov and current

Fund staff Cathy Schoen and Stephanie Bruegman, also examined premium and benefit data from the nongroup health insurance market in 15 cities.

**Older Adults Who Are Uninsured Are More Likely to Be in Fair or Poor Health Than Those with Individual Coverage**

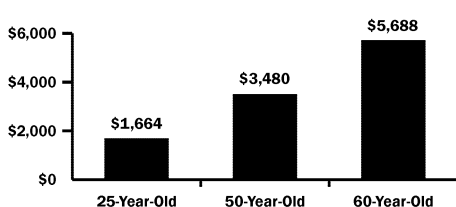


Source: Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139-49.

Men and women in their 50s and 60s are at an age when health problems are of increasing concern. At the same time, their ties to group health coverage through the workplace grow increasingly tenuous. Still too young for Medicare, those who can no longer work because of an illness or disability, or because they have lost a job late in their career, must purchase individual health coverage directly on the open market.

"Steep insurance premiums charged to older adults make nongroup coverage generally unaffordable, even with large tax credits," says Schoen, the Fund's vice president for health policy, research, and evaluation. Based on Internet data for 15 cities, median premium costs quoted a 60-year-old for a \$250-deductible policy are nearly \$5,700 per year.

**Median Premiums Quoted for \$250-Deductible Policy in 15 Major Cities, by Age**



Source: Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139-49.

As a result of such steep costs, older adults who purchase individual insurance may forgo coverage such as prescription drugs or face a high deductible. The survey finds that premiums plus other out-of-pocket costs amounted to \$3,500 or more annually for nearly half of those with individual insurance.

President Bush has proposed offering a tax credit of \$1,000 for people purchasing individual insurance. The study shows, however, that a \$1,000 credit would pick up at most one-third of premium costs. Furthermore, very few states guarantee access to health coverage for older adults in poor health.

The authors note that to reflect market realities, tax credits would need to be greatly increased as well as adjusted by such factors as age, health status, and geographic region. "Given the complexity of doing this through the tax code and the uncertainty and inadequacy of individual insurance, other alternatives—such as the ability to purchase Medicare coverage before age 65—should be considered," Schoen urged. ❖

**Employer Policies Can Limit Health Plan Participation**

A new study finds that a surprising number of working Americans cannot get health insurance—even though they work for companies that offer health benefits. Employer policies such as waiting periods for new employees, exclusions for part-time employees, and high employee premium contributions prohibit or deter low-income workers from signing up for health coverage. Removing barriers to participation, the

*Steep insurance premiums charged to older adults make nongroup coverage generally unaffordable, even with large tax credits.*

study finds, could significantly increase coverage rates for working families.

“Looking beyond offer rates, employer eligibility policies play an important role in coverage,” said lead author Jon R. Gabel, vice president for health systems studies at the Health Research and Educational Trust, which conducted the study with support from The Commonwealth Fund. “Nearly one of four employees working for firms that offer benefits is ineligible.” The study, based on a 1999 national survey of more than 1,900 employers, appears in the July/August issue of the journal *Health Affairs*.

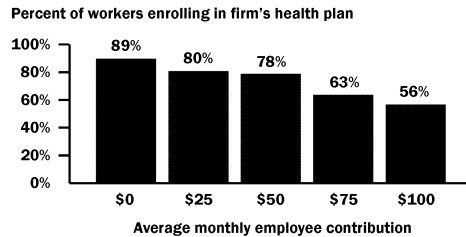
Most new employees face a waiting time before they become eligible for their workplace health plan, according to the study. Only one of three workers (31%) has coverage that starts immediately. Eleven percent of employees at companies offering health plans face waiting times of four months or more. Those working for small or midsize firms and low-wage businesses are the most likely to experience such lengthy waiting times, the authors noted.

Restrictions on eligibility for part-time workers also limit health plan participation. Only two of five (41%) part-time employees are eligible to join a plan that is available to their full-time coworkers. Firms with fewer than 1,000 workers are the least likely to cover part-time workers: about one of four part-timers in small and medium-size firms is eligible for health benefits, compared with over half of part-time workers in large firms.

The study finds that requiring large employee contributions for premiums discourages participation, particularly in low-wage firms. Coverage take-up rates fall sharply as employee premium shares increase, with

the steepest drop-off occurring in firms with the highest concentration of low-wage employees.

**Health Insurance Take-Up Rates by Plan with the Lowest Monthly Contribution for Single Coverage Employees in Firms with Many Low-Income Workers\***



\* 35% or more of employees have earnings less than \$20,000.

Jon R. Gabel, Jeremy D. Pickreign, Heidi H. Whitmore, and Cathy Schoen, "Embraceable You: How Employers Influence Health Plan Enrollment," *Health Affairs* 20 (July/August 2001): 196–208.

The authors say that employers can improve employee coverage rates by eliminating or shortening waiting periods for new workers; allowing part-time workers to participate in health plans or reducing the number of hours worked that are required for eligibility; and reducing the premium contribution borne by employees, especially those earning low wages. ❖

## Changes in Labor Market Leaving Many Low-Wage Workers Without Coverage

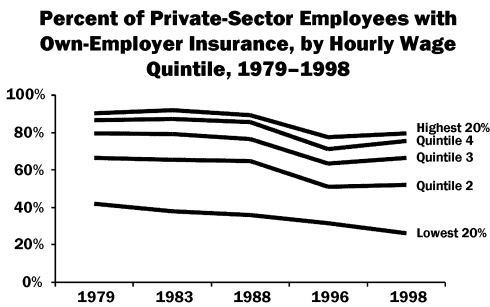
**C**hanges in the U.S. economy and labor market in the last two decades have contributed to a decline in health insurance coverage through workers' own jobs. While two-thirds of private employees had health coverage through their own firm in 1979, just over half did by 1998.

Researchers at the Center for National Policy say that while percentages of workers who obtain health coverage through their own job have stabilized and improved slightly since 1996—largely due to a high-employment

*Nearly one of four employees working for firms that offer health benefits is ineligible to participate.*

economy and the continuing trend toward two-worker families—the longer-term loss of own-employer coverage is troubling.

“The decline in own-employer health coverage has been sharpest for those Americans earning the least,” says James L. Medoff, a Harvard University economics professor who is the lead author of the study, *How the New Labor Market Is Squeezing Workforce Health Benefits*. Among workers in the bottom fifth of the wage scale—those earning less than \$7 per hour—the rate of own-employer coverage fell from 42 percent in 1979 to 26 percent in 1998. During this period, the proportion of blue-collar and service employees receiving health coverage through their own jobs declined from 63 to 46 percent. The decrease for white-collar workers was much smaller, from 69 to 60 percent.

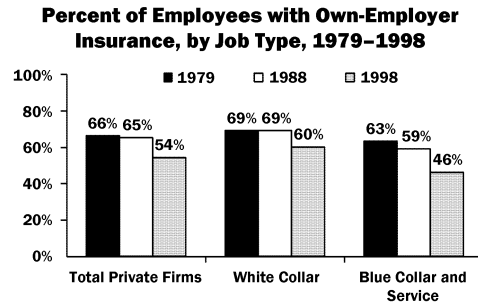


Note: In 1998, the lowest 20% earned less than \$7.00 per hour and the highest 20% earned more than \$21.00 per hour.  
Source: James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, *How the New Labor Market Is Squeezing Workforce Health Benefits*, The Commonwealth Fund, June 2001.

Private-sector employees also were far more likely to pay a share of their health insurance premiums in 1998 than they were in 1979. The average value of employer-paid benefits fell by 17 percent, after adjusting for health care inflation.

Again, the decline was most severe for low-wage workers, with the gap widening in the past 19 years. Employers paid twice as much per hour

in health benefits for the top third of wage earners as they did for the bottom third.



Source: James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, *How the New Labor Market Is Squeezing Workforce Health Benefits*, The Commonwealth Fund, June 2001.

The decline in affordable coverage through work has translated into high uninsured rates among low-wage workers, according to the report. At the end of the 1979–98 study period, 39 percent of private-sector employees in the bottom fifth of the wage distribution were uninsured.

“One side effect of these trends is likely to be more pressure on family health benefits,” noted Maureen S. Steinbruner, president of the Center for National Policy. “The big question will be how to share the costs of premiums for the spouses and children of workers, especially those at the low end of the wage scale.” ♦

## High-Risk Pools Unaffordable for Many Who Are Denied Health Coverage

Results from an analysis of high-risk insurance pools for people denied private health coverage indicate that high premiums, deductibles, and copayments severely limit the impact of high-risk pools in making insurance available and affordable for

*The decline in own-employer health coverage has been sharpest for those Americans earning the least.*

those who are otherwise uninsurable. Premiums average \$3,083, and range as high as \$4,900 a year per individual, while deductibles are set at \$10,000 in some states.

For many people who have no employer-sponsored health insurance but do have extensive health care needs and medical expenses, obtaining coverage in the individual insurance market is not a viable option. Insurers can turn down “high risks” because of an existing or previous illness. Partly to help insure those denied private health coverage, more than half the states operate high-risk insurance pools. However, enrollment is very limited. These pools cover about 110,000 people. Minnesota has the largest program with 25,892 enrollees in 1999.

The study, conducted by Lori Achman and Deborah Chollet of Mathematica Policy Research, Inc., with support from The Commonwealth Fund, finds, however, that state risk pools often charge premiums that are high relative to incomes and typically include sizeable deductibles and copayments. Even though they are designed for people with serious or chronic illnesses, risk pools also often require waiting periods for those with preexisting conditions.

In their study, Achman and Chollet found that:

- Premium prices range from an average of \$1,832 per year in Washington, or about 4 percent of median household income, to \$4,920 per year in Missouri, or 12 percent of income.
- Only six states operate income-related subsidy programs for low-income residents to help with premiums or cost-sharing requirements.

*State risk pools often charge premiums that are high relative to incomes and typically include sizeable deductibles and copayments.*

- Deductibles are typically \$500 to \$1,000 but can be as high as \$10,000 (Alaska, Arkansas, and Florida).
- In addition to deductibles, most risk pools require coinsurance that amounts to 20 percent of covered expenses above the deductible.
- Most states cap patient out-of-pocket expenses at \$2,000 to \$2,500 per year, but a few cap them at \$10,000 while others have no limits at all.
- Waiting periods for obtaining care for a preexisting condition after coverage begins are typically six months, but extend to 12 months in eight states.

The report notes that only limited revenues are available through state premium taxes, since the Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from paying them. To help keep costs down for risk pool enrollees, the authors suggest that Congress consider lifting this exemption for the limited purpose of high-risk pool financing. ❖

### **III Medicare Beneficiaries Need Extra Protection from Costs, Report Finds**

**A** leading expert on Medicare says that policymakers contemplating changes to the entitlement program for the elderly and disabled must take steps to protect the most vulnerable beneficiaries—those with chronic or acute ailments—from incurring out-of-pocket expenses that are even higher than what they currently bear.

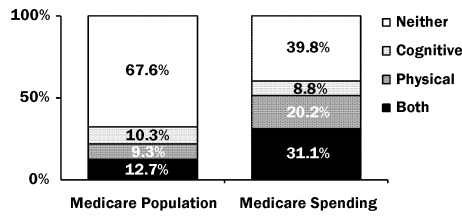
In the forthcoming report, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*,

Marilyn Moon, a senior fellow at the Urban Institute, says that understanding the needs of Medicare beneficiaries with physical ailments and cognitive problems is crucial to ensuring that the health insurance coverage for this population is not undermined, whether through the expansion of Medicare managed care or through other program changes. “HMOs and other plans serving the Medicare population have strong incentives to limit enrollment of elderly and disabled individuals with cognitive or physical problems because it costs more to serve these beneficiaries,” says Moon. “Since these people are the least attractive customers for private insurance carriers, they’re the ones Medicare reforms and protections should be targeting.”

In 1996, 33 percent of Medicare beneficiaries suffered from either a cognitive or a physical ailment, and nearly 13 percent had both cognitive and physical problems. Sixty percent of all Medicare outlays are incurred by beneficiaries with such health problems. Beneficiaries living below the poverty level, the authors found, were more than twice as likely to have cognitive and physical difficulties than those with incomes that are more than four times the poverty level (13% vs. 5%). The report also finds that beneficiaries with health problems are burdened with high out-of-pocket expenses. In 1996, total out-of-pocket spending for cognitively and physically disabled beneficiaries was \$3,989, while beneficiaries with neither condition spent \$2,744.

In general, health maintenance organizations (HMOs) that serve the Medicare population attract healthier individuals than does traditional Medicare. Furthermore, beneficiaries with health problems are often unwilling to join a plan that may restrict their choice of physician. Even

**Medicare Beneficiaries with Health Conditions, as a Percentage of Beneficiary Population and Total Medicare Expenditures, 1997**



Note: All figures exclude ESRD beneficiaries and the Medicare expenditures also exclude HMO beneficiaries.  
 Source: Marilyn Moon and Matthew Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*, The Commonwealth Fund, forthcoming.

65-to-69-year-olds, a key enrollment target of Medicare HMO plans, choose traditional Medicare when they have health problems. In 1993, 4.8 percent of the Medicare HMO population in this age group had both cognitive and physical impairments; by 1996, the proportion was only 1.5 percent. Meanwhile, the proportion of vulnerable beneficiaries in the 65-to-69 group with traditional fee-for-service Medicare rose from 4.2 percent to 4.6 percent.

The authors emphasize that if Congress chooses to rely increasingly on private-sector solutions for restructuring Medicare, it will be crucial to implement “risk adjustment” mechanisms to assure that private plans are reasonably compensated for enrolling people with health problems—and not overpaid for enrolling those who are healthy. Fee-for-service options to serve those with multiple problems are likely to be needed indefinitely as well. ❖

*Medicare beneficiaries with health problems are burdened with high out-of-pocket expenses.*

### **Public Programs: Missed Opportunities for Early Health Care**

**P**ublic health services and government-sponsored insurance programs are missing important opportunities to provide

low-income children with comprehensive health care services that could make a significant difference in their overall growth and development, researchers say.

Enormous potential exists to finance a wide range of preventive services that have been shown to foster not just physical health, but intellectual, behavioral, and emotional development as well. These interventions include preventive health care, guidance and support for parents, and activities that provide children with cognitive and sensory stimulation. Nearly one of four children under age 6—about 5.7 million children—is covered by Medicaid. In addition, 3.6 million infants are enrolled in state maternal and child health programs, while 1.3 million young children are served by publicly funded community health centers.

In a new series of reports from The Commonwealth Fund, health policy analyst Sara Rosenbaum and colleagues at George Washington University describe a multitude of ways in which public programs can improve the developmental services provided to economically and socially disadvantaged children. One report, *Room to Grow: Promoting Child Development Through Medicaid and CHIP*, examines the current and potential role of Medicaid and the Children's Health Insurance Program (CHIP) in delivering developmental services to low-income infants and toddlers. Some of the opportunities available to individual state Medicaid programs include:

- Establishing program eligibility rules and enrollment procedures that ensure prompt enrollment and access to care at the earliest possible time.
- Using Medicaid's Early and Periodic Screening, Diagnostic and Treatment

(EPSDT) program as a template for fashioning an early intervention benefit for all young children.

- Expanding the variety of health care settings in which families receive covered services.
- Expanding the range of health professionals who may participate in state Medicaid programs.
- Implementing quality-of-care measurement and improvement mechanisms that emphasize the provision of pediatric developmental services.

Another report in the series discusses the role of federally qualified community health centers, most of which offer at least one health education program for parents. Rosenbaum and her coauthors recommend that the Bureau for Primary Health Care (BPHC) offer incentive grants to individual health centers to encourage the adoption of standardized developmental screening, parent education groups, home visits, and other key services. The authors also call upon the federal Maternal and Child Health Bureau (MCHB) to place a priority on child development when providing money to states. ❖

## Study of Healthy Steps Program Shows Promising Results

**F**amilies participating in a major national child health care initiative report greater satisfaction with their infant or toddler's care, are more likely to follow certain recommended safety practices, and maintain stronger links to their pediatrician, according to early results from an ongoing evaluation of the

Enormous potential exists for public health services and government-sponsored insurance programs to finance a wide range of preventive services that foster intellectual, behavioral, and emotional development.

## Healthy Steps for Young Children Program.

The Healthy Steps program was launched in 1994 to help pediatric primary care practices provide mothers and fathers with the tools and information needed to nurture their young children's overall development. Since its inception, more than 8,000 families with children under age 3 have received Healthy Steps services.

While it is too soon to determine the effects of Healthy Steps on child health and development, the first year of the national evaluation has been able to assess parents' perceptions of care, parents' child-rearing practices, and children's receipt of developmental services. The multiyear study, which is being conducted at 15 Healthy Steps sites across the country by Bernard Guyer, M.D., and colleagues at the Johns Hopkins University Bloomberg School of Public Health, is based on questionnaires completed by parents at enrollment, telephone interviews with parents two to four months after the child's birth, and forms completed during office visits.

Preliminary findings published in the journal *Archives of Pediatrics and Adolescent Medicine* (April 2001) show that families enrolled in Healthy Steps are:

- more likely than families in the comparison group to discuss a broad range of child development issues with pediatric practices;
- more likely to receive home visits and other child development services, including office visits pertaining to baby's development, a brochure about infant development and a telephone number to call with questions, parent groups, and mailed reminders before well-baby visits;

- more likely to report that someone at their pediatrician's office went "out of their way for them," and less likely to be dissatisfied with help from the physician and/or nurse practitioner; and
- less likely to put their babies in the wrong sleeping position.

The Healthy Steps approach goes beyond pediatric services targeting physical health and development. It provides support to mothers and fathers in their role as nurturers of their child's emotional, behavioral, and intellectual growth. One of the program's most important elements is the addition of a child development specialist to the pediatric practice team, whose job is to give parents advice and guidance on promoting their child's healthy all-around development. The Commonwealth Fund is one of more than 80 national and local cofunders for Healthy Steps. ❖

## New Initiative Weighs "Business Case" for Quality

**D**espite marked gains in health care quality over the last decade, the evidence suggests that marketplace incentives and financing systems do not systematically and predictably reward the delivery of higher-quality care. A hospital that is able to reduce congestive heart disease admissions, for example, will suffer a dramatic decrease in inpatient care revenues under most payment arrangements. A physician who is paid well for specialized procedures may be paid nothing at all for delivering time-saving consultation services to patients through e-mail.

*Families enrolled in Healthy Steps are less likely to be dissatisfied with help from their child's physician or nurse practitioner.*

A new effort under way is examining the flow of resources within the U.S. health care system to highlight current barriers to, and incentives for, improvement in health care delivery. At the same time, the project is attempting to illustrate the systemwide benefits of providing superior patient care.

Working under a 15-month grant from The Commonwealth Fund, Donald M. Berwick, M.D., president of the Institute for Healthcare Improvement in Boston, and Sheila Leatherman, president of the Center for Health Care Policy and Evaluation in Minnetonka, Minnesota, are examining what they call the “business case” for improving quality of care. Berwick and Leatherman will conduct a set of real-world case studies over the next year to document the experiences of leading-edge health care organizations that are pursuing various quality improvement efforts.

“Our goal is to build a baseline of evidence that illustrates the relationship between business imperatives and quality improvement as it currently pertains to health care providers and health systems,” says Berwick. “We then plan to use that evidence to encourage policy changes that will enhance the ability of the U.S. health system to initiate and sustain quality improvement efforts.”

The seven case studies under development will explore quality improvement initiatives focused on: diabetes management, use of group office visits and e-mail consultations, smoking cessation, prevention of and management of care for acute myocardial infarction, improvement of cardiac surgery outcomes, appropriate use of pharmaceuticals, and implementation of automated clinician order entry systems.

A policy team of top health care leaders and health policy analysts will synthesize the project’s findings and develop recommendations for improving and expanding incentives for providing better care. ❖

## Workshop Focuses on Quality Measures for Minority Health Care

The National Quality Forum (NQF), a not-for-profit membership organization dedicated to improving the measurement and reporting of health care quality, held a workshop on June 28–29 focused on quality of health care for minority populations. Co-chaired by Kenneth Kizer, M.D., president and CEO of NQF, and Leo Morales, M.D., of the University of California, Los Angeles, the workshop convened national experts in quality measurement, quality reporting, and minority health. The Commonwealth Fund provided support for the meeting.

Three background papers prepared for the workshop helped stimulate discussion. A report by David Nerenz of Michigan State University focused on quality-of-care measures of special significance to minority populations. Kevin Fiscella of the University of Rochester summarized existing measures that could be used to monitor minority health care. The third paper, by Christine Molnar of the Community Service Society of New York, evaluated the issues and challenges associated with collecting and reporting minority health care data.

Workshop participants expressed full support for collecting racial and ethnic data and acknowledged the need to develop and adopt uniform standards

*Seven real-world case studies conducted over the next year will document the experiences of leading-edge health care organizations that are pursuing various quality improvement efforts.*

for their collection. The group also discussed a number of quality measures that could be used to specifically monitor health care delivered to minority populations. Some of the measures—such as the percentage of minority patients discharged on beta blocker medication following hospitalization for heart attacks—are neither new nor specific to minorities but do reflect considerable racial disparities in care. Others, such as those to monitor care of patients with sickle cell disease, would be specific to minority populations.

Workshop attendees emphasized the need for more research to prioritize measures and include them in quality measurement and reporting systems. ❖

## Ian Axford Fellows in Public Policy Selected

The Ian Axford Fellowships selection committee, chaired by Robert Reischauer, president of the Urban Institute, selected two Ian Axford Fellows in Public Policy in May. Established in 1995 by the New Zealand government in partnership with the private sector, the fellowship program enables outstanding U.S. professionals working in a broad range of public policy areas to take sabbaticals of six to nine months in New Zealand. The 2002 fellows and their projects are:

- **Maureen McLaughlin**, deputy assistant secretary for policy, planning, and innovation, U.S. Department of Education. *Reform Efforts in Tertiary Care Education in New Zealand.*
- **Paul Saucier**, senior policy analyst, Muskie School of Public Service, University of Southern Maine.

*Promoting a National Vision for People with Disabilities: Successful Policies and Enduring Barriers.* ❖

## Fidelity Vice Chair Appointed to Fund's Board

Robert C. Pozen, vice chairman of Fidelity Investments and former president of Fidelity Management and Research Company, has been appointed to The Commonwealth Fund's board of directors. Pozen has had a distinguished career in business, government, law, and academia. He will join the board when it next meets in November.

"With his vast financial and legal expertise and his experience in business, higher education, and the public sector, Bob Pozen is eminently well-suited to help us advance our goals of expanding health insurance coverage and improving health care access and quality," said Commonwealth Fund board chairman Charles A. Sanders, M.D.

Before being named president of Fidelity Management and Research Company, the nation's largest mutual fund firm, in 1997, Pozen served as its managing director and general counsel responsible for government relations, legislation, and litigation worldwide. He wrote the first textbook on comparative regulation of financial institutions in 1977, and recently published *The Mutual Fund Business*, a course book for business schools.

Mr. Pozen will remain at Fidelity through the end of the year. He will also devote his time to serving on President Bush's 16-member Commission on Social Security, which is charged with proposing ways to reform the federal entitlement program. ❖

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## Recent and Forthcoming Commonwealth Fund Publications, Summer 2001

### Fund Reports

Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc., *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*, August 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

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

Marilyn Moon and Matthew Storeygard, The Urban Institute, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*, forthcoming

Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University, *The Role of Medicaid and CHIP in Aiding Child Development Through Preventive Health Services*, July 2001

Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University, *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services for Children Ages 0 to 3*, forthcoming

Sara Rosenbaum, Michelle Proser, Peter Shin, Sara E. Wilensky, and Colleen Sonosky, George Washington University, *Child Development Programs in Community Health Center*, forthcoming

Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, George Washington University, *Health Policy and Early Child Development: An Overview*, July 2001

### Journal Articles and Publications

Jon R. Gabel, Jeremy D. Pickreign, Heidi H. Whitmore, and Cathy Schoen, "Embraceable You: How Employers Influence Health Plan Enrollment," *Health Affairs* 20 (July/August 2001): 196–208

Marsha Gold, "Medicare+Choice: An Interim Report Card," *Health Affairs* 20 (July/August 2001): 120–138

Marsha Gold and Lori Achman, *Raising Payment Rates: Initial Effects of BIPA 2000 (Fast Facts #6)*, Mathematica Policy Research, Inc., June 2000

Marsha Gold and Jessica Mittler, "'Second-Generation' Medicaid Managed Care: Can It Deliver?" *Health Care Financing Review* 22 (Winter 2000): 29–47

*Inquiry* 38 (Summer 2001)—articles based on the 10-report series *Strategies to Expand Health Insurance for Working Americans*, which was released by the Fund in December 2000 and is available at [www.cmwf.org](http://www.cmwf.org)

Cynthia S. Minkovitz et al., "Early Effects of the Healthy Steps for Young Children Program," *Archives of Pediatrics & Adolescent Medicine* 155 (April 2001): 470–479

Marilyn Moon, "Health Policy 2001: Medicare," *New England Journal of Medicine* 344 (March 22, 2001): 928–931

Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149

Stefan C. Weiss, Linda L. Emanuel, Diane L. Fairclough, and Ezekiel J. Emanuel, "Understanding the Experience of Pain in Terminally Ill Patients," *The Lancet* 357 (April 28, 2001): 1311–1315

*Women's Health Issues* 11 (May/June 2001)—entire journal issue devoted to new analysis of *The Commonwealth Fund 1998 Survey of Women's Health*

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