



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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Medicare Outperforms Private Coverage, Study Shows

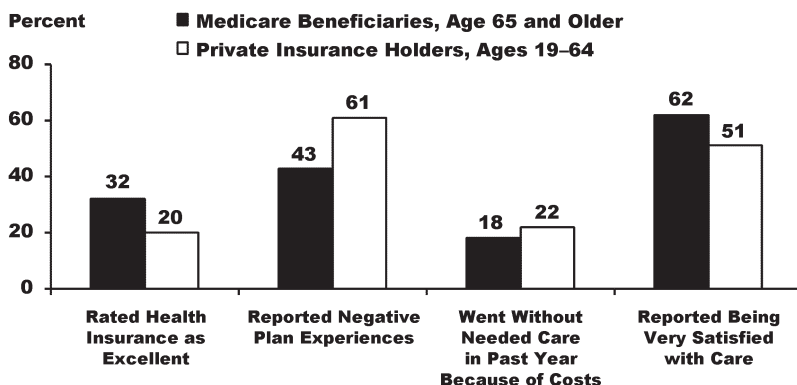
While some in Congress debate ways to restructure the Medicare program to operate more like private insurance, new analysis of a U.S. health insurance survey indicates Medicare actually outperforms private sector health coverage on many measures, including people's satisfaction with their insurance coverage and their ability to obtain health care when needed. The findings suggest that Medicare reformers should think twice before refashioning the 37-year-old program after private coverage.

The study, which was based on results of the Commonwealth Fund 2001 Health Insurance Survey, were reported in a *Health Affairs* Web Exclusive, "Medicare Versus Private Insurance: Rhetoric and Reality," by the Fund's Karen Davis, Cathy Schoen, Michelle Doty, and Katie Tenney. The survey included telephone interviews with 3,457 adults age 19 and older.

According to the study, elderly Medicare beneficiaries were more likely than working-age adults (those 19 to 64) covered by employer-sponsored plans to rate their health insurance as "excellent"

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Medicare Enrollees Report Better Experiences with Their Health Insurance Than Enrollees in Private Coverage



Source: Karen Davis, Cathy Schoen, Michelle Doty, and Katie Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, October 9, 2002.

Grantee Spotlight

Sandro Galea, M.D.

Wanting to do something to help New Yorkers in the wake of last year's attack on the World Trade Center,

Sandro Galea, M.D., M.P.H., and colleagues at the New York Academy of Medicine's Center for Urban Epidemiologic Studies realized that reliable estimates of the disaster's psychological effects would be useful to city planners in forming a response. Just one month after September 11, the first survey to assess the mental health effects on New Yorkers was fielded by a team led by Dr. Galea and David Vlahov, Ph.D., the Center's director. The Commonwealth Fund provided funding for a mental health needs assessment four months later, and an additional survey was conducted six to nine months after the attack. We asked Dr. Galea what he learned from the studies.

A substantial number of people who were not directly affected by the 9/11 attack experienced symptoms of post-traumatic stress disorder or depression, or both. How did the effects of the attack ripple throughout the city?

Sandro Galea: In three ways, I think. First, while the attacks were happening, it was unclear what their scope was; many people felt that their own lives were endangered even if they were not at the World Trade Center site. Second, the number of people able to see the towers collapse was almost certainly large—about a quarter of New Yorkers by our estimates. Third, the effects of the attacks on the city included disruptions to transportation, communication, and a substantial economic downturn—all of which affected hundreds of thousands of New Yorkers. What we learned is that large-scale disasters in densely populated urban environments can have public health implications well beyond the people directly affected by the attacks.

Now that you have data from one to two months, four to five months, and six to nine months after the attacks, what

have you found about the progression and persistence of 9/11-related psychological effects?

Galea: Our early analysis of these data is showing relatively rapid resolution of most of the probable full-blown post-traumatic stress disorder that developed after September 11. However, our most recent data suggest that a large number of people continue to have psychological symptoms. This is the first time we've been able to follow the course of traumatic stress symptoms in the general population after a disaster, and what we learn could be critical in guiding public mental health response in the future.

How did New York use the survey data?

Galea: Our preliminary and subsequent data contributed to the state's effort to obtain FEMA [Federal Emergency Management Agency] funding for mental health interventions. Also, the State Office of Mental Health has implemented Project Liberty, which provides services for those who've demonstrated symptoms of psychological illnesses as well as outreach to the general population through education and counseling.

In the event of another terrorist attack, how do you think the public health research community might play a role in the response?

Galea: Well, first we need mechanisms in place for rapid, reliable assessments of the scope of need in the general population. I think it's fair to say that we were unprepared for an attack that would have mental health consequences both for people who were directly affected and for the general population. Rapid assessments would help us establish estimates of the scope of the problem and of the public health resources that should be implemented after a disaster. Second, we need to think about creative efforts that have a reasonable chance of minimizing the incidence of post-traumatic stress disorder and other psychological distress. We're now working on a project to evaluate the potential benefit of an early educational intervention. It's plausible that efforts like this can be implemented quickly after a disaster and have a tremendous positive effect.



Sandro Galea's surveys of New Yorkers post-September 11 could help guide future public mental health efforts.

(photo: Martin Dixon)

(32% vs. 20%). Seniors on Medicare were also a third less likely than private plan enrollees to have had a negative experience with their coverage (43% vs. 61%)—such as finding out that their plan did not pay for a medical service, that it paid for only part of a medical bill, or that the limit of what the plan would pay for a specific illness or injury had been reached.

Furthermore, 50 percent of elderly Medicare beneficiaries surveyed said they were “very confident” in their ability to get needed medical care in the future, compared with only 37 percent of working-age adults in private plans. Medicare enrollees were also more likely to report being very satisfied with their care and more likely to rate their doctor as excellent.

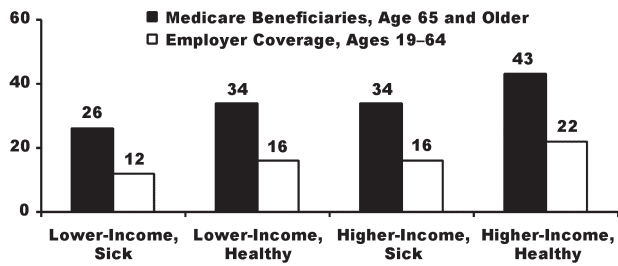
“Apart from lacking a prescription drug benefit, Medicare seems to be working better for its beneficiaries than the employer-group coverage available to most people under age 65,” said Davis, the Fund’s president and the lead author of the study. “It’s also notable that Medicare enrollees report fewer problems accessing health care and greater confidence that they can get care when needed—given that they’re disproportionately sicker and poorer than the privately insured.”

Medicare also seems to provide better protection against financial hardship than employer-sponsored health coverage—one of the primary functions of insurance. According to the study, elderly Medicare beneficiaries were one-fourth as likely as those with employer coverage to report a problem with medical bills, such as not being able to pay or being contacted by a collection agency, after accounting for income and health status.

The absence of a Medicare prescription drug benefit, however,

Predicted Rating of Health Insurance Coverage, by Health, Poverty, and Insurance Status, 2001

Percent rating coverage as “excellent”



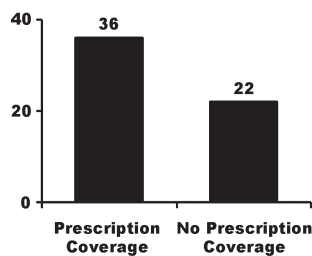
Notes: “Sick” denotes persons in good/fair/poor health status with an average number of chronic conditions for this group. “Healthy” denotes excellent/very good health status with an average number of chronic conditions for this group. “Lower-income” denotes income of 200 percent of the federal poverty level or lower, “higher-income,” more than 200 percent.

Source: Karen Davis, Cathy Schoen, Michelle Doty, and Katie Tenney, “Medicare Versus Private Insurance: Rhetoric and Reality,” *Health Affairs* Web Exclusive, October 9, 2002.

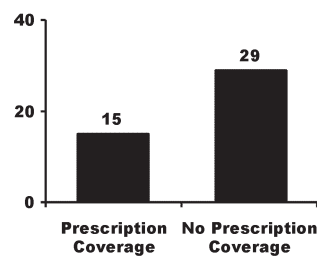
contributed to the higher out-of-pocket costs, as a percentage of income, that were reported by beneficiaries in the survey. Medicare beneficiaries who have prescription drug coverage were 50 percent more likely than those without it to rate their insurance as excellent and half as likely to report medical bill problems.

Medicare Beneficiaries with Prescription Coverage Rated Their Insurance Higher and Reported Fewer Medical Bill Problems Than Those Without Coverage

Percentage of enrollees age 65+ who rated insurance as excellent



Percentage of enrollees age 65+ who reported any medical bill problem



Source: The Commonwealth Fund 2001 Health Insurance Survey.

“Medicare beneficiaries’ more positive experiences compared with the privately insured may be due to the fact that most Medicare beneficiaries enjoy stable coverage under the traditional fee-for-service program,” said Davis. “As a result, they generally have a wider choice of physicians and face fewer restrictions on coverage.” ❖

Prescription Drug Debate Neglecting Medicare's Disabled

Although they represent the fastest-growing segment of the Medicare population, disabled Medicare beneficiaries are often forgotten in the debate over a Medicare prescription drug benefit, a new study concludes. Five million disabled Medicare beneficiaries under age 65 face a daunting combination of low income, poor health status, heavy prescription drug use, and high medication bills. Yet with the exception of Medicaid, these enrollees have few options for obtaining stable and comprehensive prescription drug coverage.

The study, *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits*, by Becky Briesacher, Bruce Stuart, Jalpa Doshi, and Sachin Kamal-Bahl of the University of Maryland, and Dennis Shea of Pennsylvania State University, was sponsored by The Commonwealth Fund and the Henry J. Kaiser Family Foundation.

Approximately 5 million U.S. adults are under age 65 but qualify for Medicare because they are totally and

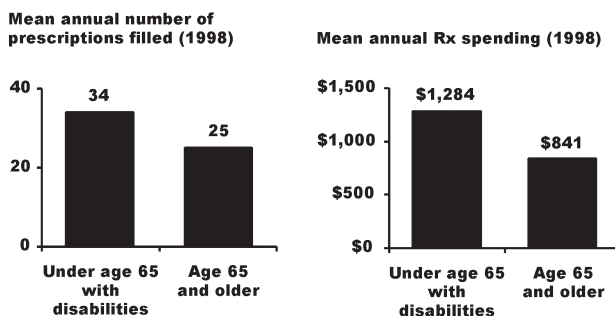
permanently disabled. Using 1998 data, the authors found that disabled beneficiaries are more than twice as likely as the elderly to live under the federal poverty level (45% vs. 20%) and to report being in only fair or poor health (59% vs. 23%). The disabled also fill more prescriptions than the elderly and spend more on them.

This combination of poorer health, lower income, and greater need entails severe financial burdens for Medicare's disabled. In 1998, disabled beneficiaries spent an average of \$1,284 on prescription drugs (\$388 out-of-pocket), compared with \$841 spent by the elderly (\$379 out-of-pocket), and paid more out-of-pocket for prescriptions as a percentage of income. Moreover, the disabled rely heavily on public programs for their drug coverage, particularly Medicaid. The authors warn that state budgetary constraints may threaten funding for this key source of drug coverage for the disabled.

Even though disabled beneficiaries' need for a Medicare drug benefit is especially acute given their low income and relatively worse health, a number of policy proposals would actually provide greater financial protection to the elderly because they fail to target the sickest and poorest beneficiaries. ❖

In 1998, disabled Medicare beneficiaries spent an average of \$1,284 on prescription drugs, compared with \$841 spent by the elderly.

Disabled Medicare Beneficiaries Fill More Prescriptions and Spend More Annually on Them



Source: Betsy Briesacher, Bruce Stuart, Jalpa Doshi, Sachin Kamal-Bahl, and Dennis Shea, *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits*, The Commonwealth Fund, September 2002.

Asset Tests Squeezing Many Low-Income Medicare Beneficiaries

A number of Medicare beneficiaries across the country have discovered that “assets trump income” is the rule when applying for government programs that provide help with premiums and out-of-pocket medical costs. When the so-called Medicare Savings Programs were created

by Congress beginning in 1988, income and asset limits were set to ensure that financial assistance would be given to those beneficiaries with the greatest need. But according to a new Commonwealth Fund report, less than half (48%) of those who meet the income requirements also meet the asset limits—meaning a substantial proportion of low-income individuals are unable to get help from the programs.

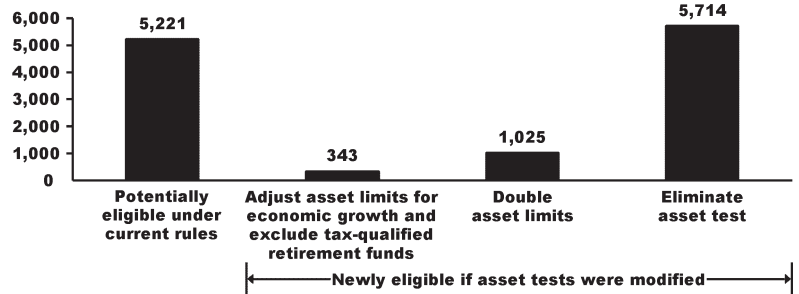
In *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs*, Georgetown University researchers Laura Summer and Robert Friedland review various modifications to the asset test that could extend help to more low-income beneficiaries who apply for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals (QI) programs. These programs, intended to assist low-income beneficiaries who do not qualify for full Medicaid, are open to people with income below 175 percent of the federal poverty level and assets up to \$4,000 per individual or \$6,000 per couple.

“While Medicare Savings Programs provide important protections for some low-income elderly beneficiaries,” says Summer, the report’s lead author, “a smaller proportion of people with low incomes qualifies for assistance today than when the programs were first established. It’s largely because asset limits haven’t been adjusted for economic growth.” As a result, low-income beneficiaries—many of whom are single, older women in fair or poor health—sometimes liquidate their assets in an attempt to become eligible for subsidies.

Although the federal rules for asset tests have not been changed since 1988, some states have modified the tests or otherwise tried to ease enroll-

People Age 65 and Older Who Would Be Eligible for Medicare Savings Program* Benefits, Based on Income and Assets

Number of people (in thousands)



* Includes: Qualified Medicare Beneficiary program (income at or below 100% of the federal poverty level, or FPL); Specified Low-Income Medicare Beneficiary program (income between 100% and 120% of FPL); Qualifying Individuals I program (income between 120% and 135% of FPL); and Qualifying Individuals II program (income between 135% and 175% of FPL). Source: Laura Summer and Robert Friedland, *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs*, The Commonwealth Fund, October 2002.

ment for low-income beneficiaries. Minnesota, for example, does not count toward the asset limit the first \$10,000 in assets for individuals and \$18,000 for couples. Meanwhile, four states—Alabama, Arizona, Delaware, and Mississippi—have eliminated the asset test altogether. Other reforms examined by the researchers include adjusting asset limits for growth in the economy, exempting tax-qualified retirement funds, and doubling asset limits.

Raising asset limits to reflect growth in the economy from 1988 to 1998, the authors say, would add 230,000 people to the 5.2 million who are currently eligible for the Medicare Savings Programs. The additional cost in 2002 of providing benefits to people newly eligible under this modification would be \$172 million. ❖

Five Years Along, Medicare+Choice Not Living Up to Goals

Despite its early promise, the Medicare+Choice program has a troubled recent history. While the Congressional Budget Office had originally forecast that more than a third of Medicare beneficiaries would join the program by 2005, enrollment

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Medicare+Choice enrollees in good health saw their out-of-pocket costs rise 20 percent in 2002, to \$1,430; enrollees in poor health saw them rise 34 percent, to \$4,783.

now stands at just 13 percent—less than in 1997, the year the program was launched. Moreover, the number of Medicare+Choice contracts that Medicare holds with private health plans dropped by more than half from 1998 to 2002, with plan withdrawals affecting more than 2.2 million beneficiaries. The program has also failed to generate Medicare savings. Three recent studies from The Commonwealth Fund detail the program's difficulties and their causes and make recommendations for Medicare reform.

In *Medicare+Choice After Five Years: Lessons for Medicare's Future*, Brian Biles, Geraldine Dallek, and Andrew Dennington of George Washington University's Center for Health Services Research and Policy assess Medicare+Choice in seven metropolitan areas. In all the markets, the program is failing because it has become unattractive to all parties involved—health plans, health care providers, and beneficiaries.

Medicare's payments to plans have not kept pace with overall health care inflation, the report finds, at the same time that providers are increasingly demanding higher compensation. As a result, managed care organizations are exiting the Medicare market.

Beneficiaries, meanwhile, are left scram-

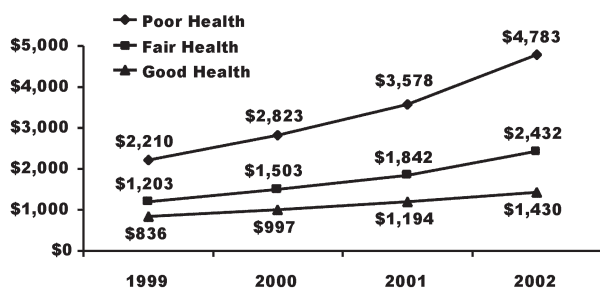
bling to find a new plan following the withdrawal of their HMO. Physician turnover, benefit reductions, and premium increases are creating further hardship for beneficiaries.

Lori Achman and Marsha Gold of Mathematica Policy Research, Inc., have been tracking the Medicare+Choice program for The Commonwealth Fund since 1999. In their latest analysis, *Trends in Medicare+Choice Benefits and Premiums, 1999–2002*, Achman and Gold show that average monthly Medicare+Choice plan premiums in 2002 increased by nearly one-third—from \$25 in 2001 to \$32 in 2002. Cost-sharing also increased dramatically: the percentage of Medicare+Choice enrollees who were required to pay a share of hospitalization costs more than doubled, from 33 percent in 2001 to 78 percent in 2002. There were also notable decreases in coverage of brand-name or off-formulary drugs.

In the companion issue brief, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002*, Gold and Achman demonstrate how cost-sharing burdens fall most heavily on the sickest beneficiaries. The authors say that while out-of-pocket costs for an enrollee in good health rose by 20 percent in 2002, to \$1,430, costs for an enrollee in poor health rose by 34 percent, to \$4,783.

According to Brian Biles, the George Washington University analyst who coauthored the earlier report, the nation's experience with Medicare+Choice argues against large-scale reforms that would expand the role of private health insurance in the Medicare program. He maintains that a stable, modest managed care program—together with a strong fee-for-service program with a prescription drug benefit—may be the most realistic way to attain policymakers' goals. ❖

Estimated Total Annual Out-of-Pocket Spending for Medicare+Choice Enrollees, by Health Status, 1999–2002



Source: Lori Achman and Marsha Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999–2002*, The Commonwealth Fund, November 2002.

Most Workers Could Not Afford COBRA If They Lost Their Job

A survey of U.S. workers finds that only one of four would be very likely to continue his or her health insurance coverage through COBRA if he or she lost a job, and cost appears to be the main reason. According to an analysis of the Commonwealth Fund 2002 Workplace Health Insurance Survey, the percentage of workers who would choose to retain their health coverage would more than double if a subsidy were available to help pay part of the COBRA premium—an option that has been considered by Congress for some groups of displaced workers. For those who lacked health insurance in 2001, job loss was the primary reason.

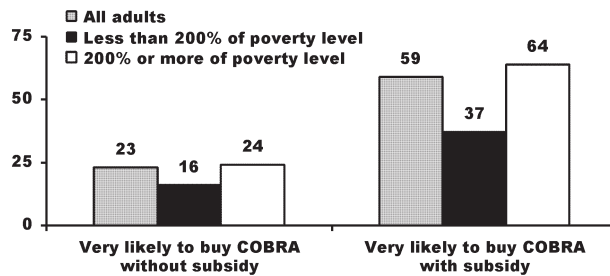
As reported in *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care*, an issue brief by the Fund's Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, just 23 percent of workers with employer health insurance would be very likely to continue their coverage through COBRA, which allows workers who have lost their job to temporarily remain on their former employer's plan. Among low-income workers surveyed, just one of six—16 percent—said they would continue their coverage.

Those percentages double, however, when workers were asked if they would take COBRA coverage if provided with a premium subsidy: three of five (59%) workers would be very likely to enroll in COBRA with a subsidy that would reduce their premium share to \$50 a month for individuals and \$150 a month for families, an amount roughly equivalent to a

75 percent subsidy for the average group employer rate. “A relatively small subsidy can make a big difference in helping unemployed workers retain their health insurance coverage,” noted Fund analyst Jennifer Edwards, the brief's lead author.

More Workers Would Retain Health Coverage Through COBRA If a Subsidy Were Available

Percent of nonelderly adults with employer insurance who would buy COBRA coverage



Source: Jennifer Edwards, Michelle Doty, and Cathy Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care*, The Commonwealth Fund, August 2002.

Two of five workers experienced increases in their health insurance premiums or cost-sharing, or both, during the year, the analysis shows. Although public support for the nation's employer-based health insurance system appears to remain strong, many workers are not confident that companies will continue to offer coverage to them in the future. Workers are even less certain about their ability to get good health care down the road.

“The survey signals a warning for job-based health coverage, especially as both unemployment and health care costs are rising,” said Karen Davis, president of The Commonwealth Fund. “Americans prefer this system of coverage, but they have concerns about whether health insurance will be there for them in the future.” ❖

“A relatively small subsidy can make a big difference in helping unemployed workers retain their health insurance coverage.”

Study Yields Lessons for States Seeking to Cover More Uninsured

What goes into effective health insurance expansions? Focusing on four states that have made significant progress in covering the uninsured, a team of researchers concludes that success requires, at a minimum, a clearly defined mission, expanding coverage under a single umbrella, and flexibility in response to changing economic conditions.

The researchers, Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, and Claudia Williams of the Economic and Social Research Institute, and Kimberley Fox and Joel C. Cantor of the Center for State Health Policy at Rutgers University, published their findings in *Assessing State Strategies for Health Coverage Expansion*, a new report from The Commonwealth Fund.

Over the past decade, states have pursued many approaches to reducing the number of uninsured. These include maximizing enrollment of individuals already eligible for public programs, covering additional low-income children through CHIP, expanding public program eligibility to include parents and childless adults, and shoring up employer-sponsored coverage. Frequently, states have implemented their initiatives in a piecemeal fashion. But several states, including Oregon, Rhode Island, New Jersey, and Georgia—the four that were the focus of the study—have developed comprehensive approaches that integrate, or at least coordinate, multiple policies and programs in order to reach the uninsured.

In interviews with these states’

program administrators, policymakers, and leaders in the consumer, business, and health care provider communities, the study authors were able to draw several lessons:

- **Strong political leadership and a clearly defined mission are critical.** Each of the states studied had a strong program champion, usually the governor, and established specific goals for coverage expansion or health promotion. Georgia, Rhode Island, and New Jersey have a strong commitment to expanding coverage for children; the latter two states have also extended coverage to parents. Oregon has chosen to provide more limited benefits to allow it to cover more people, regardless of age or family status.
- **Expanding coverage under one umbrella helps states insure entire families.** Housing various coverage efforts within a single program appears to help in garnering public and legislative support and minimizing administrative complexity. More important, it allows families to be covered together—which in turn encourages more appropriate use of health care services among enrollees.
- **Flexibility and creativity are needed to respond to economic conditions.** A robust economy and state budget surpluses made major health insurance access initiatives possible during the mid- to late-1990s. Looking ahead, states need to focus instead on sustaining past gains in the face of budget shortfalls. For example, to avoid major cutbacks in coverage or eligibility, Rhode Island has imposed modest premiums, while Oregon has proposed a leaner benefit

Housing various health insurance coverage efforts within a single program can help states garner public support and minimize administrative complexity.

package for non-mandatory Medicaid populations.

The researchers also stressed the importance of fostering input from consumer groups as well as the private sector, promoting equity in coverage, and, in states that are relying on managed care, working hard to attract and retain plan participation. ❖

Insurance Retention Key to Reducing Uninsured, Study Finds

Expanding eligibility for public and private health insurance is an obvious way to bring health coverage to more of the uninsured.

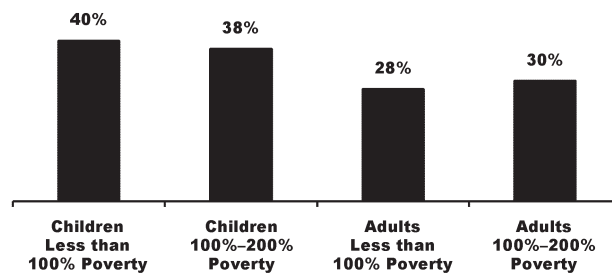
Now researchers say that helping those who already have insurance retain their coverage may be an equally important and cost-effective method not only for reducing the uninsured rate but for improving the continuity and quality of people's health care.

In *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, a new report published by The Commonwealth Fund, analysts Leighton Ku and Donna Cohen Ross of the Center on Budget and Policy Priorities examine why many low-income people lose their health coverage, what the effects of losing coverage are, and which strategies can help individuals retain insurance.

Low-income people are more vulnerable to loss of insurance than higher-income groups, the study finds, because they experience greater change, on average, in their job or life circumstances, which can alter their eligibility for coverage. Complicating matters are eligibility and procedural barriers to obtaining and retaining publicly funded coverage through Medicaid and the Children's Health Insurance Program

(CHIP). According to analysis of Census Bureau data for 1996–97, about one-fifth of low-income children and one-sixth of low-income adults who have Medicaid coverage at the beginning of a given year become uninsured by the end of that year. Many lose coverage despite remaining eligible for Medicaid because of complicated renewal proce-

Percent Reduction in Number of Uninsured If Everyone Insured at Start of Year Remained Covered Until End



Source: Leighton Ku and Donna Cohen Ross, *The Importance of Retaining Health Insurance for Low-Income Families*, The Commonwealth Fund, November 2002.

dures. In contrast, only about one-tenth of low-income individuals who begin the year with private health insurance become uninsured during the year.

The authors found that if everyone who had public or private coverage at the beginning of a year retained coverage throughout the year, the number of uninsured low-income children would decline by nearly two-fifths and the number of uninsured low-income adults would decline by more than one-quarter. “Even brief gaps in coverage can contribute to problems in accessing care, obtaining prescriptions, and paying medical bills,” says Ku, the report’s principal author. “Stable coverage helps patients maintain continuous relationships with doctors, which improves use of preventive and primary care.” He also notes that Medicaid average expenditures fall when people have coverage for longer periods.

About one-fifth of low-income children and one-sixth of low-income adults with Medicaid coverage at the start of a given year become uninsured by the end of the year.

The Medicaid and CHIP programs could keep more people enrolled, say the authors, by simplifying renewal procedures or reducing insurance premium requirements. The waiting periods and asset tests for these programs could be eased as well. ❖

NY Employer Coverage May Be Weakening

The tight labor markets and prosperity that marked the late 1990s made New York State employers more willing to shoulder the costs of health insurance to retain good workers. With the onset of a sluggish economy and continually rising medical costs, however, the future of employer-sponsored health insurance is far less certain, a new study finds.

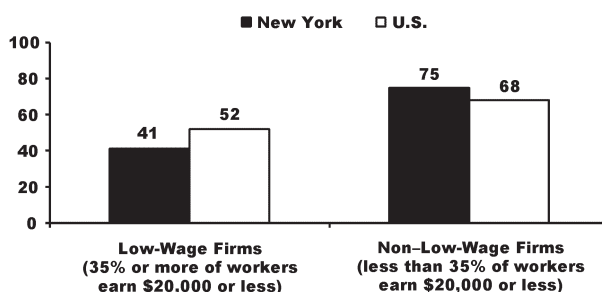
The study, *Employer Health Coverage in the Empire State: An Uncertain Future*, was based on results from the 2001 Commonwealth Fund/HRET Survey of Employer-Sponsored Health Benefits in New York and prepared by Heidi Whitmore, Kelley Dhont, Jeremy Pickreign, and Jon Gabel of the Health Research and Educational Trust and the Fund's David Sandman and Cathy Schoen. Its findings reveal that even when the economy was strong, the state lagged behind in coverage of low-wage workers.

Just two of five (41%) of New York's low-wage firms—defined as those with 35 percent or more of workers earning \$20,000 or less per year—offered health insurance to their employees in 2001, compared with the national average of 52 percent for such firms. About two-thirds (68%) of small firms in the state offered health benefits, compared with nearly all medium (93%) and large firms (99%). (Small firms were defined as having three to 49 workers, medium firms, 50 to 199 workers, and large firms, 200 or more workers.) Moreover, employees in small businesses across the state are more likely to face long waiting times, higher premium costs, and less generous benefit packages than their counterparts in larger firms.

“Even before September 11, there were serious indications that the employer-sponsored system was about to slip into a state of decline,” says Jon Gabel, the vice president for health system studies at the Health Research and Educational Trust.

Employers participating in the survey expressed strong interest in solutions involving public programs: three-quarters of employers were very or somewhat interested in assisting workers' participation in public health insurance programs (77%) or the state employee health plan (78%). Furthermore, leaders of businesses large and small said it is important for policy-makers to help small businesses provide health insurance benefits. ❖

Percentage of New York and U.S. Firms Offering Health Benefits in 2001



Source: Heidi Whitmore, Kelley Dhont, Jeremy Pickreign, Jon Gabel, David Sandman, and Cathy Schoen, *Employer Health Coverage in the Empire State: An Uncertain Future*, The Commonwealth Fund, September 2002.

Just two of five low-wage firms in New York offered insurance to their employees in 2001, versus a national average of 52 percent for such firms.

Report Provides Roadmap for Culturally Competent Health Care

A new study from The Commonwealth Fund spotlights a diverse group of health care organizations that are striving to

improve health care access and quality for the growing population of minority and immigrant Americans. In addition to highlighting model programs, the report also provides the first comprehensive framework for health care organizations seeking to study and address cultural barriers in health care delivery.

The report, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, was written by Joseph R. Betancourt, M.D., of Massachusetts General Hospital–Harvard Medical School, Alexander R. Green, M.D., and J. Emilio Carrillo, M.D., both of New York–Presbyterian Hospital—Weill Medical College of Cornell University. Its findings were disseminated at the Third National Conference on Quality Health Care for Culturally Diverse Populations, held in Chicago on October 2–4.

The authors outlined promising practices on three levels—organizational, systemic, and clinical—to increase cultural competence. Organizational practices focus on hiring and promoting minorities in the health care workforce and involving representatives from the community in quality improvement efforts. Systemic practices include providing onsite interpreters to patients with limited English, while clinical practices include the integration of cultural competence into training for health care providers.

“Cultural competence is central to quality improvement, and should help health care systems and clinicians provide the best possible care to any patient they come in contact with, regardless of race, ethnicity, culture, class, or language proficiency,” Dr. Betancourt noted. “The models profiled in this report will, I hope, provide a roadmap for those interested in improving care and eliminating disparities.” ❖

Samuel O. Thier, M.D., Is New Chairman of Commonwealth Fund

Samuel O. Thier, M.D., a nationally recognized authority on health policy, medical education, and biomedical research, was chosen as The Commonwealth Fund’s new chairman at the most recent meeting of the foundation’s board of directors on November 12. Thier, a director of the Fund since 1997 and the current chairman of its Task Force on Academic Health Centers, replaces Charles A. Sanders, M.D., who headed the Fund’s board for 10 years.

Thier, who is also an expert in internal medicine and kidney disease, is president and chief executive officer of Partners HealthCare System, Inc., in Boston. He also teaches medicine and health care policy at Harvard Medical School.

“Dr. Thier is ideally suited to lead the Fund’s board at this challenging time for the U.S. health care system,” Sanders said of his successor. “His expertise and innovative thinking will help to further the Fund’s mission of expanding access to health care and improving quality of services.”

In a distinguished career, Thier has served as president of Massachusetts General Hospital, Brandeis University, and the Institute of Medicine, part of the National Academy of Sciences. He also chaired Yale School of Medicine’s Department of Internal Medicine for 11 years.

Born in Brooklyn, New York, in 1937, Thier attended Cornell University and received his medical degree from the State University of New York at Syracuse in 1960. He has since received 14 honorary degrees from universities around the country. Thier and his wife, Paula, live in Massachusetts and have three grown daughters. ❖

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“Cultural

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and should help

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clinicians provide

the best possible

care to any

patient they come

in contact with.”

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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, Fall 2002

Fund Reports

Lori Achman and Marsha Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999–2002*, November 2002

Gerard F. Anderson, Varduhi Petrosyan, and Peter S. Hussey, *Multinational Comparisons of Health Systems Data, 2002*, October 2002 (chartbook)

Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, October 2002

Brian Biles, Geraldine Dallek, and Andrew Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Major Cities*, September 2002

Becky Briesacher, Bruce Stuart, Jalpa Doshi, Sachin Kamal-Bahl, and Dennis Shea, *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits*, The Commonwealth Fund and The Henry J. Kaiser Family Foundation, September 2002

Geraldine Dallek, Andrew Dennington, and Brian Biles, *Geographic Inequity in Medicare+Choice Benefits—Findings from Seven Communities*, September 2002

Allen Dobson, Lane Koenig, Namrata Sen, Silver Ho, and Jawaria Gilani, *Financial Performance of Academic Health Center Hospitals, 1994–2000*, September 2002

Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care*, August 2002 (issue brief)

Marsha Gold and Lori Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002*, November 2002 (issue brief)

Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, November 2002

Jack A. Meyer and Larry S. Stepnick, *Portability of Coverage: HIPAA and COBRA*, November 2002 (issue brief)

Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration*, November 2002 (Web publication)

Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor, *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia*, November 2002

Laura Summer and Robert Friedland, *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs*, October 2002

Elliot K. Wicks, *Health Insurance Purchasing Cooperatives*, November 2002 (issue brief)

Heidi Whitmore, Kelley Dhont, Jeremy Pickreign, Jon Gabel, David Sandman, and Cathy Schoen, *Employer Health Coverage in the Empire State: An Uncertain Future*, September 2002

Journal Articles and Publications

Donald M. Berwick, *Escape Fire: Lessons for the Future of Health Care*, November 2002

Karen Davis, Cathy Schoen, Michelle Doty, and Katie Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002): W311–W324

Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring The Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* (November/December 2002): 188–94

Trudy Lieberman, "The Perils of Buying Your Own Policy," *Consumer Reports* (September 2002, Web exclusive); available in the Consumer Advice section of www.consumerreports.com

The Commonwealth Fund is a private foundation supporting independent research on health and social issues.