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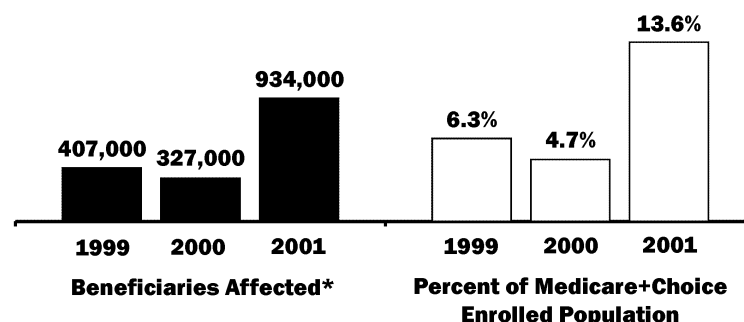
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Medicare+Choice Doesn't Add Up for Seniors

New research finds that tremendous turmoil within Medicare+Choice—Medicare's managed care program—is causing severe disruption, dislocation, and confusion for elderly Medicare beneficiaries and the hospitals and health care providers that care for them. Scores of managed care plan withdrawals from the Medicare market have sent hundreds of thousands of enrollees scrambling for new health coverage. High physician turnover within Medicare+Choice plans—which averages 30 percent or more in some states—has limited patients' access to their regular doctor or hospital.

Evidence suggests that the program's ills are not likely to be solved simply by raising Medicare payments to plans. A host of local and national factors, it appears, play key roles as well. These findings, contained in three new Commonwealth Fund reports by analysts at George Washington University, highlight the need for both immediate and long-term program reforms to increase plan choice, stabilize enrollment, and regain beneficiaries' trust.

Beneficiaries Affected by HMO Withdrawals Nationally, 1999–2001



* "Beneficiaries Affected" is the number enrolled in a plan at the deadline for plans to announce withdrawal. For example, the 1999 bars refer to beneficiaries affected by withdrawals as of June 1999 in a plan that withdrew effective January 2000.

Source: Jennifer Stuber, Geraldine Dallek, and Brian Biles, *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice: Analyses of Seven Medicare+Choice Markets*, The Commonwealth Fund, October 2001.

In the last three years, nearly 1.7 million Medicare+Choice enrollees have been displaced because their health plan stopped serving Medicare beneficiaries.

Exiting Plans Creating Dislocation
In the last three years, nearly 1.7 million elderly Americans have been displaced because their health plan stopped serving Medicare beneficiaries. A total of 151 of 346 plans terminated their Medicare+Choice contracts during the 1999–2001 period, while another 165 plans reduced their service areas. In January 2001 alone, 159,000 beneficiaries were left without any health plan choice at all.

A study of Medicare+Choice plan withdrawals in seven large markets around the country told a similar story. In *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice*, Jennifer Stuber, Geraldine Dallek, and Brian Biles found a substantial decline in the number of Medicare+Choice plans in five of the cities in 2001. In Houston, for example, seven of eight plans stopped offering Medicare+Choice, affecting more than 66,000 beneficiaries, or 85 percent of those enrolled in Medicare+Choice. In Cleveland and Tampa–St. Petersburg, three of eight plans withdrew, affecting 33 percent and 11 percent of enrollees, respectively.

Low payment rates are a reason often cited for withdrawals. In recent years, most plans have been limited to 2 percent annual rate increases, at a time when health care cost inflation has been more than twice this amount. But the study found scant evidence that congressional action to increase payments to Medicare+Choice plans starting in 2001 has actually prevented plans from leaving Medicare+Choice. In Houston, where the vast majority of beneficiaries were dislocated by withdrawals, plans were receiving a generous average payment rate of \$651 per member per month.

“Although it might be necessary to increase Medicare+Choice plan

payment rates further to help stabilize the program, local market dynamics appear to have strongly influenced the decisions of managed care executives to get out of the Medicare business,” noted Stuber, the study’s lead author and currently a research associate at the New York Academy of Medicine. One of these factors, she said, is the decision by national plans to leave local Medicare markets in favor of more profitable employer-based enrollment. Sources in Minneapolis–St. Paul who were interviewed for the study believed that the nonprofit status of Twin City plans—even those with slim operational margins—made them more committed to the community and less likely to desert the Medicare market.

Other factors that contribute to plan withdrawals, the authors said, include providers’ unwillingness to accept plans’ payment levels and the increasing use and cost of medical services. Low market share and fear of adverse risk selection—whereby sicker, more costly patients gravitate toward plans offering better benefits—were also cited.

Physician Turnover Disrupting Patient Care

Thousands of Medicare+Choice enrollees around the country have also had to contend with the loss of a trusted physician or hospital as a result of instability in provider networks as well as plan withdrawals. In *Physician Withdrawals: A Major Source of Instability in Medicare+Choice*, Geraldine Dallek and Andrew Dennington find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher. Nevada plans had the nation’s highest turnover rate, 36 percent. Data also

show that there is substantial variability in provider turnover rates among plans within the same market.

The loss of a primary care physician, specialist, or hospital is often traumatic for Medicare beneficiaries, the authors say. This is especially the case for those with chronic conditions or those undergoing treatment. Moreover, provider contract terminations in some instances leave enrollees without access to the only academic medical center in a community.

There appear to be two major causes of plan network instability. Plan payment rates that providers consider insufficient to cover the cost of care, as well as claims denials and payment delays, have resulted in contentious relationships between plans and their provider networks, the report found. The financial problems of large provider organizations in three of the sites studied—Houston, Los Angeles, and Tucson—also contributed to provider instability.

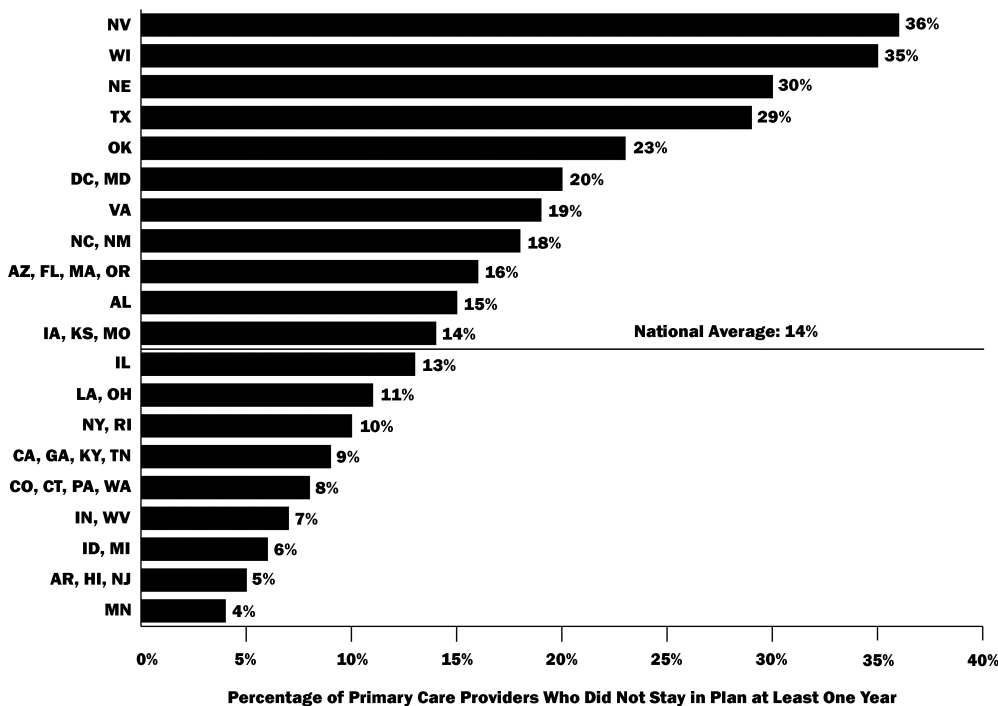
The authors say that until the

causes of recent instability in the Medicare+Choice program can be addressed, policymakers might want to consider allowing beneficiaries in the midst of treatment to continue to receive care for a specified time from a physician or hospital that is withdrawing from a plan. In addition, the proposed beneficiary “lock-in” now scheduled for 2002—which will prevent enrollees from leaving their plan for a certain period of time—could be postponed until greater stability is achieved within the Medicare+Choice market.

Need for Standardized Benefits Adding to the woes of Medicare+Choice enrollees is the limited ability to comparison shop on the basis of cost. Different plans have different benefits and cost-sharing requirements for prescription drugs, as well as for a host of Medicare-covered and supplemental benefits that traditionally were very comparable among plans, such as hospital and nursing home care.

The beneficiary “lock-in” scheduled for 2002 could be postponed until greater stability is achieved in Medicare+Choice markets.

Primary Care Provider Turnover Rates in Medicare+Choice Plans, 1999



Source: Geraldine Dallek and Andrew Dennington, *Physician Withdrawals: A Major Source of Instability in Medicare+Choice*, The Commonwealth Fund, forthcoming.

Since 1999, HMOs participating in Medicare+Choice have been pulling back on their prescription drug coverage.

In *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, authors Dallek and Claire Edwards discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, pouring over data, and making complicated calculations in order to make any kind of reasonable comparison.

The principal argument against standardization is that it would reduce plans' ability to introduce innovations in their benefit package design. Although not without merit, this argument becomes less salient as Medicare+Choice benefit packages grow increasingly complicated. "The foundation upon which the Medicare+Choice program was built," Dallek argued, "is undermined if beneficiaries are unable to make an informed choice among their health plan options." ❖

Medicare Drug Benefit Needed to Avert Crisis, Analysis Finds

Ominous trends in prescription drug coverage for Medicare beneficiaries all point to a looming crisis unless Congress takes concerted action soon. According to a new analysis of prescription benefits in the 1990s, the growth in availability of drug benefits seen in the middle part of the decade should not be taken as a sign that either the private market or current public programs will be enough to provide the elderly with the coverage they need. The study, which was supported by The Commonwealth Fund, finds that rising out-of-pocket prescription costs, shrinking Medigap and Medicare HMO drug benefits, and the erosion in retiree health insurance

coverage portend a deteriorating outlook for beneficiaries.

In *Looking Forward, Looking Back: Trends in Prescription Drug Coverage for Medicare Beneficiaries*, health policy analysts Becky Briesacher and Bruce Stuart of the University of Maryland and Dennis Shea of Pennsylvania State University argue that beneficiaries' access to affordable drug benefits has declined substantially since 1998. They warn that access is likely to worsen in the years ahead without the addition of prescription coverage to Medicare's benefit package.

The report cites studies finding that since 1999, HMOs participating in Medicare+Choice—Medicare's managed care option—have been pulling back on their prescription coverage. Benefit caps have grown more stringent, copays are rising, and increasing numbers of plans offer no drug coverage at all in their basic contracts. While virtually all Medicare+Choice plans offered a drug benefit in 1997, only 70 percent did by 2001. At the same time, these plans' cost to beneficiaries has risen sharply. Eighty percent of plans in 1999 offered "zero-premium" policies; by March 2001, just 46 percent did so.

Making matters worse, more than 300 HMOs have pulled out of Medicare managed care or reduced their services areas in the last two years—leaving beneficiaries with fewer choices for drug coverage. Meanwhile, premiums for Medigap supplemental policies that cover prescription drugs have skyrocketed in the past two years.

Medicare beneficiaries are also experiencing an erosion in coverage through employer-sponsored retiree health plans—their single most important source of prescription benefits. Employer-based coverage rates leveled off after 1995, and recent indications are

that companies will continue to cut back or drop retiree coverage over the next several years.

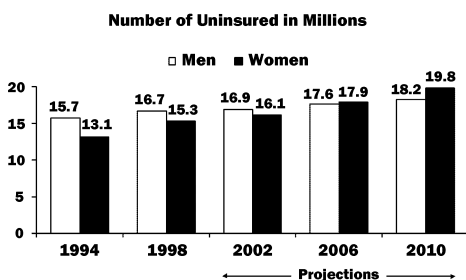
Behind many of these trends is the skyrocketing cost of prescription drugs themselves. Drug expenditures rose an estimated 19 percent from 1999 to 2000, capping four years of double-digit increases. Annual expenditure growth of 15 percent, the authors say, can be expected through 2004.

“The rise in prescription costs is felt most keenly by Medicare beneficiaries with no drug coverage,” said Briesacher, a coauthor of the study. “But those with coverage also feel the effects—through higher premiums, reduced benefits, and fewer choices.” ❖

Women Face Prospect of Less Health Coverage

A study of recent national trends by a leading health policy analyst shows that women often face greater difficulty obtaining health insurance and accessing medical services than men do. Moreover, these disparities appear to be worsening: the number of uninsured women has grown three times faster than the rate for men over the past five years. If this pace continues, the ranks of the uninsured in 2005 could include more women than men for the first time.

Number of Uninsured Women Is Growing Faster, and Could Surpass Men If Trend Continues

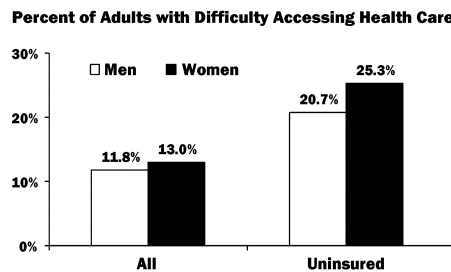


Source: Jeanne M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*, The Commonwealth Fund, August 2001.

In *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*, Jeanne Lambrew, an associate professor at George Washington University, analyzed data from the March 2000 Current Population Survey, 1996 Medical Expenditure Panel Survey, and 1999 Commonwealth Fund Survey of Adults Ages 50 to 70. She found the following:

- Women need and use more health care services than men.** More women than men have chronic illnesses, and women are more likely to use mental health services and, as they age, prescription drugs. More than 80 percent of women between ages 50 and 70 rely on prescription drugs, compared with 71 percent of men that age.
- Uninsured women are nearly 20 percent more likely to have difficulty obtaining health care services than uninsured men.** Among Americans in the 50-to-64 age group, women are nearly twice as likely as men to have trouble accessing care.

Uninsured Women Are 20 Percent More Likely to Have Access Barriers



Source: Jeanne M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*, The Commonwealth Fund, August 2001.

- Mothers account for three of five low-income, uninsured parents.** Poor mothers also account for one-quarter of all uninsured women.

If current trends continue, the ranks of the uninsured in 2005 could include more women than men for the first time.

- **Women ages 55 to 64 are more than 20 percent more likely to be uninsured than men.** As the baby boom generation turns 55 beginning this year, the number of uninsured women in this group will likely increase by at least 50 percent.

Lambrew examined the impact of different policy approaches for insuring women. She found that increasing federal financing for states to cover low-income parents through Medicaid and CHIP could rapidly and efficiently cover one-fourth of uninsured women. It also would be relatively easy to accomplish, since these parents' children are already eligible for or enrolled in one of the programs. Meanwhile, for the growing number of women in their 50s and early 60s, the opportunity to "buy into" Medicare early by paying a subsidized premium would provide a much-needed, affordable alternative to expensive individual health insurance, the report says. ❖

New Insurance Program for Adult New Yorkers Holds Promise

Healthy New York, a fledgling insurance program for workers in small firms and low-income adults who lack access to group health coverage, has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market, a new analysis shows. Healthy New York premiums for qualified individuals were 50 to 70 percent less than premiums charged by insurers, and 15 to 30 percent less than those available in the small-group market, as of February 2001.

Healthy New York, which began enrolling people in January 2001, has

three parts: one for businesses with 50 or fewer employees, one-third of whom earn \$30,000 or less annually; one for low-income sole proprietors; and one for low-income uninsured workers. Harvard University researcher Katherine Swartz, author of the Commonwealth Fund report *Healthy New York: Making Insurance More Affordable for Low-Income Workers*, says that the program has, in the early going, succeeded in making health insurance more affordable. Its most important feature is a fund set aside by the state to pay up to 90 percent of the costs of enrollees with annual claims between \$30,000 and \$100,000. In effect, the state takes on the role of reinsurer—implicitly subsidizing the premium by removing much of insurers' risk of high-cost claims.

Swartz says that while the program indeed offers lower premiums, these still account for more than 5 percent of before-tax income for most individuals and many eligible low-income workers in small firms. Consequently, it is not clear that Healthy New York's target beneficiaries will purchase coverage through the program in large numbers.

New York can reduce premiums further and increase program participation in three ways, the report argues. The first option is to provide direct subsidies to help individuals purchase coverage. Workers in small firms that enroll in Healthy New York have a distinct advantage over workers whose employer does not: the employer pays at least half of the premium, paring most employees' share of the premium to under 5 percent of their income. However, for most eligible individuals and sole proprietors, Healthy New York premiums exceed 5 percent of income. Providing them with subsidies that approximate premiums charged to low-wage workers

Premiums under the Healthy New York program were 50 to 70 percent less than those charged by private insurers for individuals.

in small firms would encourage more people to enroll, Swartz says.

An alternative approach is to adjust the program's reinsurance mechanism so that insurance carriers are not crippled by a disproportionate share of high-cost claims above \$100,000. The author suggests a graduated reinsurance structure whereby carriers pay diminishing portions of claims as total costs increase. Removing insurers' risk of very high-cost claims would help stabilize premiums.

Broadening the choice of benefits packages available to firms and enrollees is a third option. "One of the initial complaints about Healthy New York is that the benefits package is a 'one size fits all,'" explained Swartz. "Some small firms and business groups want a wider selection of policies with a variety of benefits—like those available in the regular small group market." If a second benefits package is added to the standard one, then all insurers should be required to offer both packages, the author says. ❖

Small Firms Need Public Sector Help to Provide Coverage

Private sector efforts alone are not enough to help small companies provide health insurance for their workers. In a new study, policy analysts find that purchasing cooperatives and other programs initiated by business coalitions over the last decade have had only limited success in making insurance more affordable to small-business employees. To be successful, they say, these programs will require federal and state support in the form of seed money, expertise, regulatory reform, and help in defraying high-cost insurance claims.

In *Business Initiatives to Expand Health Coverage for Workers in Small Firms*, a report published by The Commonwealth Fund, Jack A. Meyer of the Economic and Social Research Institute and Lise S. Rybowski of the Severyn Group assess the potential of initiatives that pool risk to improve bargaining power for small firms. About 47 percent of the working uninsured are employed by firms with fewer than 100 workers.

Business coalitions help small firms get health coverage in one of two ways. In most cases, a large employer group creates, or takes control of, a health insurance purchasing cooperative for small employers. In other cases, large employer groups share their health care provider networks—and thus the discounts they are able to negotiate—with small businesses.

The authors found that some of these efforts have made a difference in providing coverage to uninsured employees of small firms. In particular, New York's HealthPass program, a joint creation of the New York Business Group on Health and the City of New York, has drawn a steady stream of employers attracted by its ability to offer a choice of health plans that together cover a wide geographic area.

Overall, however, large-employer initiatives have been mostly unable to lower the number of uninsured workers. With the exception of HealthPass, only 10 to 20 percent of small companies that have enrolled in these programs since the mid-1990s are offering insurance for the first time.

If the goal is to expand health insurance coverage within the small-business sector, then the public sector will have to step in to make private insurance more accessible and affordable to workers, says Meyer, the study's lead

Health insurance purchasing cooperatives launched by business coalitions over the last decade have had only limited success in making coverage more affordable for small firms.

author. That will require government to stimulate the business community's interest in lending its expertise to smaller firms, provide seed money and other resources to support programs until they are self-sufficient, and develop regulations to attract small firms. ❖

Collecting Racial and Ethnic Health Data: It's Legal and Necessary

A gap exists between the goals of federal initiatives to eliminate racial and ethnic disparities in health care and the manner in which government agencies collect the data needed to achieve these goals, a new report finds. The problem stems in part from concerns and confusion over the legality of collecting data on patients' race, ethnicity, and language. The report's authors call for the federal government to assume a leadership role in addressing legitimate concerns over the misuse or misinterpretation of this sensitive information, as well as in clarifying and enforcing data collection standards throughout federal agencies.

Most health officials agree that administrative, health services, and research data should include information on individuals' race, ethnicity, and primary language spoken. Such information, collected and reported systematically at the federal and state levels, is critical for the success of efforts to achieve more equitable access to health care, improve quality of care, counter racial discrimination, and promote delivery of culturally appropriate services to diverse populations. Currently, there are several federal initiatives to reduce health disparities, including Healthy People 2010 and the Culturally and Linguistically

Appropriate Care Standards developed by the U.S. Office of Minority Health.

The authors of the study, Ruth T. Perot of the Summit Health Institute for Research and Education and Mara Youdelman of the National Health Law Program, recommend that the U.S. Department of Health and Human Services take the following steps to ensure proper data collection and reporting:

- Ensure that federally supported programs such as Medicare, Medicaid, and the State Children's Health Insurance Program include race, ethnicity, and primary language among the data they collect on enrollees.
- Require that the Health Plan Employer Data and Information Set (HEDIS) and standards for implementing the Health Insurance Portability and Accountability Act (HIPAA) incorporate this data.
- Help ensure that people with limited English proficiency have access to quality health care by collecting data and monitoring adherence to federal guidelines.
- Require that state block grant programs and other new initiatives collect and report racial and ethnic data and provide the resources needed to comply.
- Inform health plans, providers, and the public that racial and ethnic data collection and reporting are legal and often required by law.

"Ensuring that the data needed to help eliminate racial and ethnic health disparities are gathered and reported will require budgetary resources," noted Perot. "In addition, Health and Human Services will need to supervise dissemination, implementation, and compliance with the policy." ❖

Most federal officials agree that health data collected by the government should include information on individuals' race, ethnicity, and primary language.

One of 10 Medical Residents Feels Unprepared for “Non-traditional” Patients

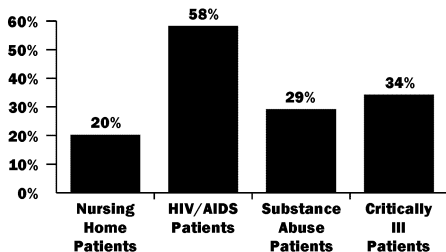
More than one of 10 medical residents say they feel unprepared to handle certain treatments and procedures relative to their specialties despite years of solid training, according to a study in the *Journal of the American Medical Association* (Sept. 5).

While residents surveyed for the study feel prepared to handle most of the common conditions they would likely encounter in their clinical careers, surprising percentages reported they are not confident in treating less-traditional categories of patients. Specifically, the survey found that:

- More than 20 percent of primary care residents feel unprepared to handle nursing home patients, HIV/AIDS cases, substance abusers, and critically ill patients.

Primary Care Residents’ Self-Assessment of Preparedness for Patients

Percent of Residents Who Feel Very or Somewhat Unprepared



Source: David Blumenthal et al., “Preparedness for Clinical Practice: Reports of Graduating Residents at Academic Health Centers,” *Journal of the American Medical Association* 286 (Sept. 5, 2001): 1027–1034.

- 32 percent of anesthesiology residents say they are not equipped to manage chronic pain.
- 19 percent of obstetrics and gynecology residents do not feel they are able to counsel patients about depression.

- 42 percent of internal medicine residents lack confidence in counseling patients about domestic violence.
- More than 10 percent of psychiatry residents feel unprepared to treat borderline personality or substance abuse, or to diagnose and treat eating disorders.

The study, conducted with support from The Commonwealth Fund Task Force on Academic Health Centers, is the first comprehensive analysis of resident preparedness in more than a decade. Participating were more than 4,800 residents in over 630 graduate medical education programs across the country.

“This survey tells us that residency programs may not be changing quickly enough to keep up with the reality of medical practice today. We may be seeing a residency–practice mismatch,” said the study’s lead author, David Blumenthal, M.D., director of the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare System. “Teaching hospitals and medical schools need to provide residents with quality training that reflects the diversity of the patients they will one day treat.” ❖

NCQA Developing Physician Quality Measures for Consumers

The National Committee for Quality Assurance (NCQA), the nonprofit accrediting organization for managed care plans, is now developing measures of physician care quality for public use. Under a grant from The Commonwealth Fund, NCQA recently conducted a series of consumer focus groups to learn what

More than 20 percent of primary care residents feel unprepared to handle nursing home patients, HIV/AIDS cases, substance abusers, and critically ill patients.

people perceive to be the most important aspects of physician care.

The sessions, which will aid in the design of performance indicators and inform future public reporting efforts, revealed the importance of conveying information about health care quality in straightforward, accessible terms to ensure its value to consumers. This and other findings are described in the upcoming report *Exploring Consumer Perspectives of Good Physician Care: A Summary of Focus Group Results*, by L. Gregory Pawlson, M.D., and colleagues at NCQA. Among the other findings:

- Consumers said they want to work together with their physicians and be included in the decision-making process but do not want to assume sole or primary responsibility for their own care.
- Medicare beneficiaries, in particular, tended to equate good care more with aspects of the doctor–patient relationship and less with the physician’s level of experience.
- Medicare beneficiaries, like other consumers, were aware of and concerned with medical safety problems, but they appeared to be more accepting and forgiving of physician errors than other patients. ❖

Physician Websites Found to Lack Key Information

While a growing number of consumers are turning to the Internet for information on health and health care, much of what they are finding on websites—especially about physicians—is unreliable.

In a review of 40 physician direc-

tory websites, researchers found that many suffered from incomplete physician listings, few search options, and empty, inaccurate, or outdated data fields. Only 25 of the 40 sites (63%) posted the doctor’s medical school, for example, while just 10 (25%) listed the number of years in practice. Other physician characteristics that patients typically want to know were also absent: for example, less than half the sites provided doctors’ gender and languages spoken, and none listed their race. Moreover, very few websites provided information on disciplinary actions, malpractice claims, mortality rates, or other clinical outcomes.

The websites that were reviewed included those of hospitals, health plans, professional associations, and state medical licensing boards, as well as a number of commercial sites. The study, *Using the Internet for Information About Physicians: A Report on Consumer Access*, was supported by The Commonwealth Fund. It was prepared by Elliot M. Stone, Jerilyn W. Heinold, and Lydia Ewing of the Massachusetts Health Data Consortium, along with the Fund’s Stephen C. Schoenbaum, M.D.

“Websites that provide consumers with physician information are sorely in need of standards,” said Stone, the study’s lead author. “Ideally, each site should include a disclosure statement about sources of data, whether physicians must pay to be included on the site, and whether their profiles are independently verified.” Stone said websites should also have information about the timeliness of the information displayed, an explanation of why a data field is empty, and a statement alerting users to the limitations of physician performance measures and the size of the database.

Improving the accuracy and breadth of information on the Internet about physicians and their performance,

“Websites that provide consumers with physician information are sorely in need of standards.”

the study says, will require a common set of standards agreed upon by accrediting organizations, health plans, hospitals, physician and hospital associations, and government, including state licensing boards. ❖

U.S., U.K. Sign Pact on Bioterrorism, Quality of Care

The United States and the United Kingdom have agreed to new joint health efforts aimed at improving the quality of care and responding to future incidents of bioterrorism. At an October 10 session of The Commonwealth Fund's 2001 International Symposium on Health Care Policy, U.S. Secretary of Health and Human Services Tommy Thompson and U.K. Secretary of State for Health Alan Milburn signed two joint statements of intent: one to collaborate on the collection and sharing of data on health care quality, and another to develop emergency plans for countering bioterrorism. Also represented at the Washington, D.C., meeting were the health ministers of Canada and Mexico and leading health officials from Australia and New Zealand.

Secretary Thompson told the symposium that international partnerships will be essential for addressing national and global health threats. "Disease does not respect national boundaries, and today's agreements can serve as a model for collaboration among nations on behalf of world health," he said.

Under the agreement on health care quality monitoring and reporting, the United States and Britain will focus on medical errors and patient safety, primary care, and disparities in the care provided to different ethnic populations. Under the bioterrorism agreement, the

two countries will work to enhance their capacity to detect biological incidents, prevent mass casualties, and diagnose and treat any disease inflicted deliberately. ❖

Fund to Contribute to NYC Recovery Efforts

In response to the September 11 terrorist attack on the World Trade Center, Commonwealth Fund president Karen Davis announced plans to allocate \$300,000 to New York City's recovery efforts. "Our hearts go out to all families of those whose lives were lost," Davis said. "The Fund's home is New York, and we want to do our part to help relieve the suffering and distress of those affected by this calamity."

Davis said that part of the allocation is being set aside for Fund staff members to designate a donation to a charity or relief organization of their choice. A \$50,000 grant to Betances Health Center, a clinic located one mile from Ground Zero that serves primarily low-income families, will enable it to hire two outreach workers, encourage patients' participation in Disaster Relief Medicaid, and stabilize patient volume and revenues. The balance of the Fund's allocation will be used for projects undertaken by health care organizations that address short- and long-term needs arising from the attack.

In speaking about the future, Davis said that the Fund would stay the course, working on one of the most important issues of our times—the failure of the U.S. health system to provide all Americans with access to affordable, quality care. "When the current crisis is over," she said, "that fundamental problem will still be with us, and we shouldn't be deterred from doing everything possible to address it." ❖

The U.S. and U.K. have formally agreed to new joint health efforts aimed at improving the quality of care and responding to future incidents of bioterrorism.

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Recent and Forthcoming Commonwealth
Fund Publications, Fall 2001

Fund Reports

Lori Achman and Marsha Gold, *Estimated Out-of-Pocket Health Spending for Beneficiaries in Medicare HMOs by Health Status, 1999–2001*, forthcoming

Lori Achman and Marsha Gold, *Medicare+Choice 1999–2001: An Analysis of Plans Withdrawing and Trends in Benefits and Premiums*, forthcoming

Becky Briesacher, Bruce Stuart, and Dennis Shea, *Looking Forward, Looking Back: Trends in Prescription Drug Coverage for Medicare Beneficiaries*, forthcoming

Rima Cohen and Taida Wolfe, *Implementing New York's Family Health Plus Program: Lessons from Other States*, November 2001

Geraldine Dallek and Andrew Dennington, *Physician Withdrawals: A Major Source of Instability in Medicare+Choice*, forthcoming

Geraldine Dallek and Claire Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, October 2001

Jeanne M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*, August 2001

Jack A. Meyer and Lise S. Rybowski, *Business Initiatives to Expand Health Coverage for Workers in Small Firms*, October 2001

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