



# The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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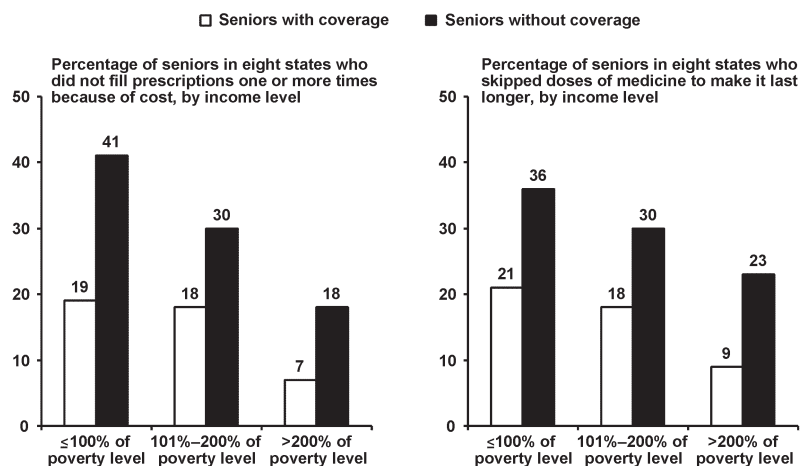
## Citing Cost, One of Four Seniors Skips Medication Doses or Doesn't Fill Prescriptions

**N**early one-quarter of the elderly say they skip medication doses or fail to get prescriptions filled because of cost concerns, a new survey finds. Conducted in eight states by the Henry J. Kaiser Family Foundation, The Commonwealth Fund, and Tufts–New England Medical Center, the study also finds that one of four seniors spent \$100 or more per month on their prescription medicines in 2001. Access to drug coverage and scope of benefits, furthermore, depend substantially on where one lives and on income: in some states, nearly one of three seniors are without prescription coverage.

The survey of nearly 11,000 Medicare beneficiaries age 65 and older was conducted in California, Colorado, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas. These states account for 42 percent of the 65-and-older population, and 41 percent of low-income elderly adults (those at less than twice the poverty level), nationwide. Dana Gelb Safran, who directs the Health Institute at

*Continued on page 3*

### A Third of Low-Income Seniors Did Not Fill Prescriptions or Skipped Doses Because of Cost Concerns



Note: Analysis of seniors in sample with classifiable drug coverage.

Source: Kaiser Family Foundation/Commonwealth Fund/Tufts–New England Medical Center 2001 Survey of Seniors in Eight States.

## Grantee Spotlight

# Stephen Ross, M.D.

Despite living in the information age, most patients today have only limited access to their medical records. That could soon change, however, if the work of innovators such as Stephen Ross, M.D., and C. T. Lin, M.D., of the University of Colorado comes to fruition. With a grant from The Commonwealth Fund, Drs. Ross and Lin are studying the attitudes and experiences of patients with congestive heart failure who are provided access to their electronic medical record (EMR) over the web. We asked Dr. Ross what the study team has learned so far.

*What proportion of hospitals are using electronic medical records, and how do you expect this to change?*

**Stephen Ross:** Hospitals are gradually adopting EMRs. The vast majority now have lab results, X-ray reports, and dictations accessible by computer. But only about 5 to 10 percent of hospitals have medical staff input all data into a computer, information like vital signs, progress notes, medication lists, and medical orders. Patient-accessible EMRs are used on a much more limited basis.

Whether these systems become widely adopted is really going to depend on patient interest, and as results from studies like this one become known.

*What are the benefits to patients?*

**Ross:** Standard EMRs already used by physicians clearly improve care—particularly by reducing errors and improving coordination of care. EMRs that are accessible to patients have the added benefit of improving doctor–patient communication. They can also clarify and reinforce doctors’ advice, making patients feel more empowered and treatment more effective. And satisfaction may be boosted if patients can gain better insight into their doctor’s thinking.

*What kind of results have you seen so far in your study?*

**Ross:** We’ve just begun surveying the six-month impact on patients of exposure to their EMR. The

key finding so far is that patients who choose to use it have appreciated the opportunity, and they use it in a rational manner, too. There have been no reported incidents of the record causing worry or confusion. We’re eager to see if there is an effect on the impact of disease and adherence to physicians’ instructions.

*Can you describe a scenario in which EMRs have been particularly useful?*

**Ross:** They’ve proven to be tremendously useful in everyday practice. At our hospital, the paper chart was frequently unavailable at the time of a patient visit, particularly if the patient was being seen at several specialty clinics in a short time. Now that clinical notes from all practices are available electronically, coordination of care among specialists and primary care doctors has improved substantially. One of the patients in our study gets specialty care at the

university and primary care in another city. He routinely makes copies of the information in the patient-accessible medical record to bring to his PCP.

*Will patient access to EMRs help prevent medical errors?*

**Ross:** There is potential for patients to find and correct significant errors in their record. There’s also potential for better coordination of care to reduce

errors—for instance, consultants can be alerted to allergies, medications, and lab findings that may influence selection of compatible treatments.

*What are the drawbacks of making these records accessible to patients?*

**Ross:** There have been concerns that patients would find their clinical notes worrisome or be confused by medical terminology. But we’ve found that patients with these concerns simply decline to participate in the program. Doctors have also worried that patients would overwhelm medical staff with clinically unimportant questions—but there’s been a negligible impact on staff workload. Also, some think doctors may be less candid about their thoughts if patients routinely read their records. We’ll find out more about how doctors may have charted differently when we interview them at the end of our study. ❖



Dr. C. T. Lin shows a patient at the University of Colorado how to use his electronic medical record. (Photo courtesy of Steve Starr)

Tufts–New England Medical Center, led the research team. Findings were reported in the July 31 online edition of *Health Affairs* and in a companion report, *Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States*.

### Coverage Varies

Seniors get their prescription coverage through an array of sources—employer-sponsored plans, Medicare HMOs, Medigap, Medicaid, and state pharmacy assistance programs—and the availability of benefits varies substantially from state to state. Employer-sponsored health plans, for example, provide drug coverage to approximately half of seniors in Michigan (50%) and Ohio (47%), but only a third of seniors in California, Colorado, Pennsylvania, and Texas. Medicare HMOs were a major source of drug coverage in California (30%) and Colorado (24%) but assisted fewer than 15 percent of elderly individuals in the other six states.

A substantial share of seniors in all eight states, however, reported having no drug coverage. Among low-income seniors, no-coverage rates ranged from 20 percent in California and New York to 38 percent in Michigan and Texas. Although Medicaid is a key source of drug coverage for the poorest of the elderly in all of the states surveyed, less than half of poor seniors (below the poverty level) were covered by Medicaid in seven of the eight states.

State pharmacy assistance programs were found to be of some benefit to low-income seniors, but not enough to close the coverage gap. In New York and Pennsylvania, whose pharmacy programs are among the largest and most extensive in the nation, a significant share of the low-income elderly still lack prescription coverage (20% and 25%, respectively). In Illinois and Michigan, the proportion of low-income seniors without drug coverage

(34% and 38%) was at least as high as that in states without drug subsidy programs.

### Skipping Medications, Not Filling Prescriptions

A significant number of seniors reported that they forgo prescribed medications because of high out-of-pocket costs. Nearly one-quarter of all seniors (22%) said they did not fill a doctor's prescription because it was too expensive or skipped doses of their medications to make them last longer. Not surprisingly, these numbers were even higher among seniors who lack coverage—more than a third (35%) of whom skipped doses or did not have prescriptions filled.

Low-income seniors—regardless of whether they had coverage or not—had great difficulty meeting their prescription drug needs: 31 percent of all low-income seniors, and 42 percent of those who lacked drug coverage, either skipped doses or did not fill a prescription.

Even elderly adults who have severe and chronic conditions like heart disease are often unable to afford medications. The survey found that among coronary patients without drug coverage, 33 percent reported that the cost of medications led them to skip doses; 25 percent, meanwhile, cited cost as the reason they did not fill a prescription.

### High Out-of-Pocket Spending, Even with Drug Benefits

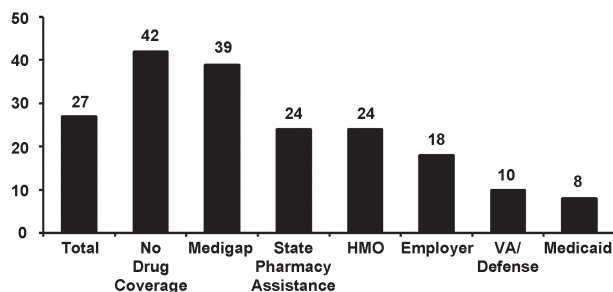
In 2001, nearly one-quarter of the elderly (23%), and 27 percent of those living at or below twice the poverty level, spent \$100 or more on average per month on prescription drugs—a hefty sum for those who live on a fixed income. Among the elderly who lack drug coverage, the proportion spending this amount climbs to 43 percent, compared with 17 percent of seniors with benefits.

*Thirty-one percent of all low-income seniors either skipped medicine doses or did not fill a doctor's prescription.*

Medigap supplemental coverage apparently does little to ease the burden of out-of-pocket spending. Among low-income seniors with a Medigap plan, 39 percent still spent \$100 each month on prescription medications. By comparison, only 8 percent of seniors on Medicaid, a key source of drug coverage for the poorest seniors, reported such levels of spending. “Low-income seniors on Medicaid have lower

#### Low-Income Medicare Beneficiaries’ Out-of-Pocket Spending on Prescription Medications Varies by Type of Insurance

Percentage of seniors in eight states with income at or below 200% of federal poverty level who spend \$100+ per month on drugs, by source of drug coverage



Note: Analysis of seniors in sample with classifiable drug coverage; out-of-pocket drug costs exclude premiums.

Source: Kaiser Family Foundation/Commonwealth Fund/Tufts–New England Medical Center 2001 Survey of Seniors in Eight States.

out-of-pocket drug spending than seniors with any other form of drug coverage,” noted Safran, the study’s lead author. “This is true despite the fact that Medicare beneficiaries on Medicaid tend to be in poorer health than other seniors and rely more heavily on multiple medications.”

Many low-income seniors who may qualify for Medicaid or state pharmacy assistance programs, however, do not enroll in these programs, often because they do not think they would qualify. Of poor seniors who are not on Medicaid, one-third said they never thought of applying (35%) or believed they had too much money to qualify (30%). Sixteen percent did not apply because they associated Medicaid with welfare, while another 14 percent feared losing other benefits or their home if they applied. ❖

State pharmacy assistance programs help only 3 percent of people on Medicare, or 1.2 million beneficiaries of 39 million overall.

## State Drug Subsidy Programs Help Few Seniors, Study Shows

State programs intended to help low-income Medicare beneficiaries pay for their prescription drugs fall well short of constituting a national safety net, a new study shows. Current pharmacy assistance programs help only a small proportion of people on Medicare—3 percent, or 1.2 million of 39 million beneficiaries overall. Moreover, just three states, New Jersey, New York, and Pennsylvania, account for nearly three-quarters of all pharmacy assistance expenditures and more than half of enrollment nationwide.

The study findings are described by Rutgers University researchers Kimberley Fox, Thomas Trail, and Stephen Crystal in *State Pharmacy Assistance Programs: Approaches to Program Design*, a new report from The Commonwealth Fund. After surveying officials in the 28 states that had pharmacy assistance programs in place as of 2000, the authors concluded that a new federal program is needed to fill gaps in beneficiaries’ prescription coverage.

State pharmacy programs, made necessary by the absence of a Medicare prescription drug benefit, vary in breadth of coverage, eligibility criteria, and level of cost-sharing required of beneficiaries. All programs cover seniors age 65 and older, although only half allow disabled beneficiaries under 65 to participate. Eligibility rules differ greatly from state to state: Arkansas limits participation in its program to beneficiaries living at 80 percent of the federal poverty level or below, while New York extends coverage to those at up to 419 percent of the poverty level. Few programs, the study found, adjust their eligibility requirements for individuals with cata-

strophic drug expenses. Those that do define catastrophic costs as anywhere from 3 percent to 40 percent of income.

Although all state programs require participants to share some of the costs—usually in the form of copayments—few states have monthly premiums, which can limit enrollment. Some states, however, require participants to pay a percentage of the cost of each drug they purchase, ranging from 10 percent in Florida to 85 percent in Rhode Island for higher-income enrollees.

One of the main problems with current pharmacy programs, the authors say, is that funding for them has generally not kept pace with rising net program expenditures, estimated by program officials to be growing at 15 to 18 percent annually. In light of tight state budgets, policymakers are struggling to balance expanding coverage for needy populations and containing costs. Many states are interested in seeking Medicaid waivers that would allow them to provide drug benefits to low-income people otherwise ineligible for Medicaid on a federally matched basis. The report concludes that a national Medicare drug benefit is needed, and that it should be closely coordinated with various state programs to fill gaps in low-income seniors' coverage. ♦

## Trade-Offs Essential in Designing Medicare Drug Benefit

**A** voluntary prescription drug benefit for Medicare that appeals to a wide range of beneficiaries while helping those most in need will cost considerably more than the estimate frequently cited in proposals before Congress, according to a new analysis by one of the nation's foremost experts on Medicare. With

careful design, however, a drug benefit could be crafted that protects low-income beneficiaries and places a cap on the yearly costs for which all beneficiaries are responsible.

In her Commonwealth Fund policy brief, *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources*, Marilyn Moon, a senior fellow at the Urban Institute, tackles the question of how to structure a Medicare drug benefit that stays within federal budget constraints but provides at least some coverage to all beneficiaries, protects individuals against very high expenditures, and subsidizes cost-sharing for those with low-incomes. Moon demonstrates that a federal program costing \$350 billion, the amount attached to a number of congressional proposals, would make it nearly impossible to meet all these goals.

“Making good policy choices for a prescription drug benefit will be expensive, but without such an effort beneficiaries will continue to face only unacceptable choices,” said Moon.

Currently, Medicare beneficiaries spend an average of nearly \$2,000 a year for prescription drugs. Projected spending on prescription drugs for Medicare beneficiaries over the next 10 years is \$1.8 trillion.

Working with colleague Matthew Storeygard, Moon analyzed three possible versions of a prescription drug plan, assuming a \$350 billion federal allocation over eight years: a standardized benefit that pays a percentage of all beneficiaries' drug costs across the board; a benefit that covers only individuals' initial costs; and a benefit that covers expenses once they exceed a certain threshold. All three approaches, Moon found, would help certain beneficiaries while neglecting others.

*A Medicare drug benefit could be crafted that protects low-income beneficiaries and places a cap on the yearly costs for which all beneficiaries are responsible.*

*Lack of health insurance is one of the most pressing issues facing Hispanics: nationally, 40 percent of Hispanic adults ages 19 to 64 and 27 percent of Hispanic children are uninsured.*

Offering equal benefits to all enrollees, for example, would fail to protect those with either high costs or low incomes. Since federal funding would cover only 23 percent of beneficiaries' projected spending on prescription medications, individuals would have to shoulder more than three-quarters of their total drug costs. The second option, which provides "first dollar" coverage up to a maximum of about \$600 annually, would offer all beneficiaries some degree of relief but nonetheless would fail to protect the chronically ill and others with high drug costs, who spend from \$3,000 to \$6,000 per year. The third option, on the other hand, would target those with high costs, providing stop-loss protection to individuals incurring drug expenses upwards of \$3,400 per year. But such an approach would fall far short of providing a universal drug benefit to Medicare beneficiaries, only one-fifth of whom would gain any protection at all.

The authors conclude that with a higher federal contribution of \$450 billion, a modest, universal prescription benefit would be possible that offers low-income subsidies as well as a cap on beneficiaries' catastrophic spending. Such a plan could lay the groundwork for a more comprehensive benefit down the road. ❖

## **Congressional, State Leaders Meet on Hispanic Health Concerns**

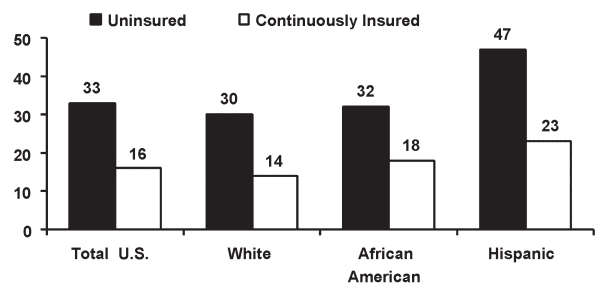
**C**ongressional and state leaders met in Los Angeles July 1 to hear testimony about how California's innovative programs for improving health care and insurance

coverage within the Hispanic population could provide strategies for Hispanic communities across the nation. The media briefing was sponsored by The Commonwealth Fund and the National Hispanic Medical Association (NHMA).

Lack of health insurance is one of the most pressing issues facing Hispanics across the country. Nationally, 40 percent of Hispanic adults ages 19 to 64 and 27 percent of Hispanic children are uninsured. In California, where one of three residents is Hispanic, a recent Commonwealth Fund study found that 57 percent of uninsured Hispanics had not had a routine medical checkup in the last two years—the highest rate for any ethnic group. Hispanics also experience the greatest problems communicating with their physicians: nearly half of uninsured Hispanics (47%) said they did not understand their doctor, felt

### **Hispanics Are Among Americans Most Likely to Have Problems Communicating with Doctors**

Percentage of nonelderly adults reporting one or more communication problems



Base: Adults with health care visits in past two years.

Source: Karen Scott Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*, The Commonwealth Fund, March 2002.

their doctor was not listening to them, or left the doctor's office with unanswered questions.

At the event, representatives of 12 local programs dedicated to increasing insurance coverage for California's Hispanics and improving quality of care discussed their experiences. Congressional leaders learned, for example, how officials in one health

care facility discovered that it was more beneficial to patients, as well as more cost-effective, to require mandatory Spanish-language classes for doctors rather than hiring interpreters.

“California has always been a trendsetter, and that is no different in health care,” said Rep. Hilda Solis (D-CA), who spoke at the symposium. “We hope to learn from California’s example and take those solutions back to Congress for action so millions of Americans everywhere can benefit from what California spearheaded.” ❖

## Health Plan “Report Card” Can Help Identify Disparities in Care

Over the past decade, there has been growing evidence of racial and ethnic disparities in access to health care services and the quality of care patients receive. Many studies show that even among insured individuals with the same type of health coverage, differences among racial and ethnic groups exist—with minorities generally faring worse.

In response, health organizations have begun to take steps to identify disparities in their own patient populations. In 1998, The Commonwealth Fund supported the Minority Health Report Card Project, led by David R. Nerenz of Michigan State University, which took on the task of developing quality-of-care measures to identify differences in quality. The new “report card” was tested two years ago in eight health plans serving large minority populations to see if it was possible to collect data on race and ethnicity of patients and to assess health care data broken down by patients’ race and ethnicity.

As documented in the Common-

wealth Fund report, *Developing a Health Plan Report Card on Quality of Care for Minority Populations*, all eight plans were able to obtain data on the race and ethnicity of their members without significant difficulty. Plans used one or more of the following methods: Medicaid enrollment files, medical record data, self-reported items in surveys, and surname-recognition software.

Analysis of the data was quite revealing. Disparities of 5 percentage points or more were found in over half the comparisons of HEDIS quality-of-care measures. Disease-based surveys revealed disparities as well. In one health plan, for example, only 20 percent of African American children with asthma received appropriate follow-up care after an acute episode, compared with 40 percent of white children.

Differences were also found for several comparisons of patients’ responses to the Consumer Assessment of Health Plans Survey (CAHPS). Some showed lower care ratings for African American respondents than whites, although most disparities were mixed, with both minority and majority groups alternately reporting higher ratings. For example, among diabetic patients in one health plan, more Hispanics than non-Hispanics said that their physicians discussed diabetes complications with them during all office visits (58% vs. 35%).

The authors say that such variations could provide an impetus for health plans to assess and monitor health care quality. Analysis of health data by race and ethnicity, they note, is essential to efforts to improve quality and eliminate disparities. ❖

*In one health plan, only 20 percent of African American children with asthma received appropriate follow-up care after an acute episode, compared with 40 percent of white children.*

## Employers Shifting Health Plan Costs to Workers

**T**he traditional role of health insurance—to spread risk among a large pool of individuals—is being eroded by new market-driven policies that place responsibility for choices and costs on employees, according to the July issue of *Consumer Reports*. As a result, millions of American workers may face high copayments and deductibles at a time when they are most vulnerable because of sickness or injury.

In the article “The Unraveling of Health Insurance,” reporter Trudy Lieberman provides a road map for new trends in employer-sponsored insurance: growing employee cost burdens, increased use of personal health accounts, and new disease management programs. The study, which was prepared with support from The Commonwealth Fund, draws on findings from the Fund’s 2001 health insurance survey of 3,500 adults.

A growing number of employers are passing along the cost of rising insurance premiums to their employees in the form of higher deductibles, copayments, and coinsurance. In some cases, these expenses are as much as 100 percent higher, causing many employees to avoid getting the care they need. Twenty-five percent of the Fund’s

survey respondents with employer-sponsored health insurance failed to obtain needed medical attention because of such burdensome costs. “High out-of-pocket expenses may lead employees to neglect their health until they become really sick and need highly expensive care,” Lieberman warns. “As a result, the personal and economic costs of poor health could soar for employees, employers, and society.”

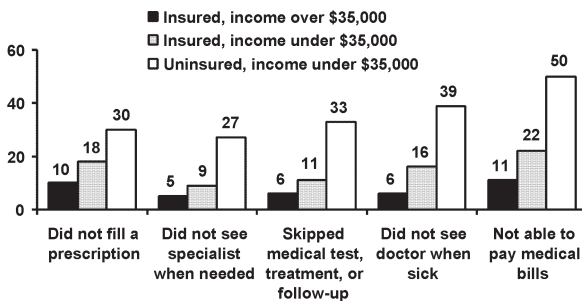
The Bush administration recently endorsed “personal health accounts,” which offer employees more control over how to spend their limited health care dollars. The rationale behind such accounts is that as employees become more aware of the actual costs of health care, they will become more conservative in their use of medical services and thus help drive down costs. But the article points out that while the young and healthy may benefit from personal health accounts—for example, by having coverage for voluntary procedures—those with a chronic condition requiring constant care will have to pay much higher deductibles once they have exhausted their funds.

A more promising market trend, Lieberman finds, is the advent of disease management strategies for patients with chronic illnesses. Health plans that offer these programs usually provide educational services and group case management for people suffering from a particular illness. ❖

*A growing number of employers are passing along the cost of rising health insurance premiums to employees in the form of higher deductibles, copayments, and coinsurance.*

### Even for the Insured, Health Care Costs Undermine Care

Percentage of consumers who had problems paying for health care in the previous year



Source: The Commonwealth Fund 2001 Health Insurance Survey.

## Wellspring Nursing Homes Promise Better Care

**A**long with prescription drug coverage, quality of nursing home care is one of the central health care issues for the nation’s elderly and their families. Despite the passage of major reforms in 1987, serious quality-

of-life problems are endemic throughout many of the nation's 17,000 nursing homes. But a recently developed model of nursing home care based on a collaborative team approach demonstrates that high quality can in fact be achieved.

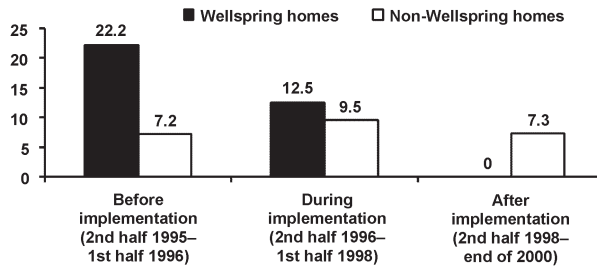
Wellspring Innovative Solutions, Inc., an alliance of 11 nonprofit nursing homes in Wisconsin formed in 1994, is seeking to improve care principally by empowering staff. Facilities that belong to the alliance provide their "frontline" workers—particularly certified nursing assistants—with training in nationally recognized "best practices" while at the same time allowing all staff a voice in how their work should be performed. In addition, each home in the alliance participates in joint training sessions on clinical care and organizational change, and each shares results of its quality-improvement activities. Findings from a Commonwealth Fund-supported study comparing Wellspring nursing homes with other facilities in Wisconsin have clearly been encouraging:

- Rates of staff turnover have declined, or increased more slowly, in Wellspring nursing homes.
- Wellspring facilities have performed better on annual inspections conducted by the state department of health.
- Some evidence suggests that Wellspring staff are more vigilant in assessing problems with quality and take a more proactive approach to resident care.
- Observation and interviews indicate that Wellspring residents enjoy a better quality of life and benefit from improved interaction with those who care for them.
- No additional increases in net resources were required for imple-

mentation of the model. Moreover, Wellspring facilities generally had lower costs than other homes.

**Wellspring Nursing Homes Are Cited for Fewer Deficiencies Than Other Wisconsin Facilities**

Percentage of facilities with severe deficiencies cited by inspections before, during, and after implementation of the Wellspring program



Source: Robyn I. Stone, Susan C. Reinhard et al., *Evaluation of the Wellspring Model for Improving Nursing Home Quality*, The Commonwealth Fund, August 2002.

"The Wellspring model has withstood the most intensive and rigorous evaluation of any of the various methods for creating culture change in nursing homes—and it's come through with high marks," said Robyn Stone, an expert in long-term care at the Institute for the Future of Aging Services and the study's lead author.

So far, five other groups of nursing homes have considered forming Wellspring alliances, mostly in Illinois and Wisconsin. Wider adoption of Wellspring, however, will require some adjustments to address the technical difficulties identified in the evaluation, says Stone, including the development of explicit mechanisms for translating training into practice. ❖

*Compared with other Wisconsin nursing facilities, Wellspring homes have performed better on annual inspections conducted by the state department of health.*

**Success of NYC Medicare+Choice May Be Short-Lived**

While withdrawals of managed care plans from Medicare+Choice have weakened the program in many regions of the country, New York City's five-

year-old Medicare+Choice program continues to perform notably well. Indeed, the 200,000 enrollees in the city enjoy a greater choice of M+C plans, lower monthly premiums, and more generous benefits than their counterparts in other major cities or even in New York suburbs. According to a new study, however, there are several signs that New Yorkers may soon face the ills that afflict the program nationally.

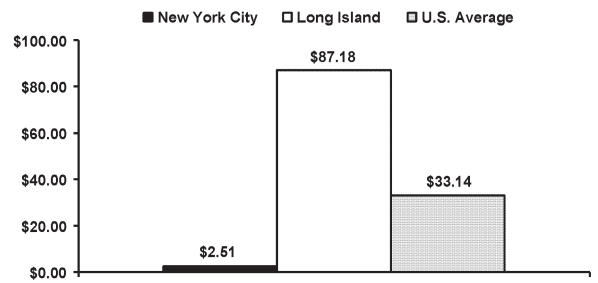
In the Commonwealth Fund report *Medicare+Choice in New York City: So Far, So Good?*, health policy analysts Jennifer Stuber of the New York Academy of Medicine, and Andrew Dennington and Brian Biles, M.D., of George Washington University, chart four major trends that threaten the viability of Medicare managed care in the city:

- Medicare payment increases over the past few years—2 to 3 percent—have not kept pace with health care inflation, which has increased at more than double those rates.
- Three of the five largest health plans in New York City—Aetna, Oxford Health Plans, and United Healthcare, all large, for-profit insurers—have withdrawn from Long Island as well as other major cities around the country.
- New York physicians and hospitals are showing signs that they are less willing to accept reduced rates from, or even sign contracts with, Medicare HMOs.

Traditionally, New York City's Medicare+Choice program has been strengthened through high payments to plans and through the city's large pool

of physicians and hospitals, thereby fostering competition. National trends indicate, however, that these strengths may not hold up much longer. According to the report, elderly and disabled Medicare HMO enrollees will likely soon feel the effects of large-scale

**Average Medicare+Choice Plan Monthly Premium, 2002**



Note: Enrollment-weighted averages calculated using March 2002 CMS enrollment data. Figures computed using "basic plan" options.

Source: Jennifer Stuber et al., *Medicare+Choice in New York City: So Far, So Good?*, The Commonwealth Fund, August 2002.

health plan withdrawals, premium increases, benefit reductions, and instability in provider networks, as have beneficiaries in most other markets. ❖

## Medicaid Children Receiving Few Developmental Services

**A** new survey of families with young Medicaid-insured children has found that while two of five parents have concerns about their infant or toddler's social, behavioral, or cognitive development, only about one of five said his or her child receives the full range of preventive and developmental services recommended by experts in pediatric care. The findings confirm the need for continued efforts to bridge the gap between pediatric care guidelines and physician practice.

The Promoting Healthy Development Survey-PLUS, administered by FACCT (the Foundation for Accountability) in North Carolina, Vermont, and Washington, asked

*New Yorkers enrolled in Medicare HMOs will likely soon feel the effects of large-scale health plan withdrawals, premium increases, benefit reductions, and instability in provider networks.*

approximately 6,000 mothers of Medicaid-enrolled children under age 4 whether their pediatrician talks to them about “anticipatory” guidance topics such as feeding and nutrition, sleeping, nurturing, injury prevention, communication, discipline, and language development. The survey was also used to determine whether health plans and providers offer follow-up counseling for parents whose children may be at risk for developmental problems, and whether they assess the family’s home life—including parents’ mental health, alcohol and drug use, violence, and emotional and economic supports.

The Commonwealth Fund commissioned the study in the three states to obtain information on the status of health promotion and developmental services for Medicaid children. Along with Utah, these states are participating in the Fund’s Assuring Better Child Health and Development (ABCD) project to help state Medicaid agencies improve their capacity to furnish preventive and developmental services.

Results of the study are described in a new Fund report, *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid*, by Christina Bethell, Colleen Peck, Melinda Abrams, Neal Halfon, M.D., Harvinder Sareen, and Karen Scott Collins, M.D. Among the major findings:

- A significant number of children are at risk for developmental delays. Forty percent of parents reported at least one concern about their child’s social, emotional, behavioral, and/or cognitive development. Moreover, the concerns of approximately one of five parents (19%) were significant enough to indicate that their child was at moderate to high risk for delays.

- Only 23 percent of children received the full range of preventive and developmental services recommended by the American Academy of Pediatrics. Among these, the survey found that pediatric clinicians were least likely to provide a basic assessment of psychosocial well-being and safety within the family (49%).
- Parents have concerns that are not addressed by pediatric clinicians. Two of five parents reported that their child’s pediatric clinician did not routinely ask them whether they had concerns about their child’s development and well-being. Less than half (46%) of parents with potentially serious concerns about their child said they received the information they needed to address these concerns.
- Having a personal pediatric clinician or nurse makes a difference. Children who had a regular, personal pediatric clinician or nurse were one-and-a-half times more likely to receive a basic level of comprehensive care than children without one (24% vs. 16%). Nevertheless, nearly one of five children lacked a personal pediatric provider (17%).

“While recent expansions in health insurance coverage for children are critical, survey findings suggest that this coverage is not sufficient to ensure that children receive even a basic level of preventive and developmental services,” noted Bethell, the report’s lead author. State Medicaid agencies, she said, need to implement policies to monitor and improve the quality of pediatric care. Pediatricians, meanwhile, should seek opportunities to learn about parents’ concerns and assess children’s development and well-being. ❖

*A study of Medicaid-insured children under age 4 found that only 23 percent received the full range of recommended preventive and developmental services.*

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## Recent and Forthcoming Commonwealth Fund Publications, Summer 2002

### Fund Reports

- Deborah Bachrach and Karen Lipson, *Health Coverage for Immigrants in New York: An Update on Policy Developments and Next Steps*, July 2002
- Christina Bethell, Colleen Peck, Melinda Abrams, Neal Halfon, Harvinder Sareen, and Karen Scott Collins, *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid*, August 2002
- Kimberley Fox, Thomas Trail, and Stephen Crystal, *State Pharmacy Assistance Programs: Approaches to Program Design*, May 2002
- Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers, *Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States*, July 2002
- Stephanie Maxwell, Matthew Storeygard, and Marilyn Moon, *Modernizing Medicare Cost-Sharing: Policy Options and Their Impact on Beneficiary and Program Expenditures*, August 2002
- Mark Merlis, *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity*, June 2002
- Marilyn Moon and Matthew Storeygard, *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources*, August 2002
- David R. Nerenz, Margaret J. Gunter, Magda García, Robbya R. Green-Weir, Kimberlydawn Wisdom, and Christine Joseph, *Developing a Health Plan Report Card on Quality of Care for Minority Populations*, July 2002
- 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*, August 2002
- Robyn I. Stone, Susan C. Reinhard, Barbara Bowers, David Zimmerman, Charles D. Phillips, Catherine Hawes, Jean A. Fielding, and Nora Jacobson, *Evaluation of the Wellspring Model for Improving Nursing Home Quality*, August 2002
- Jennifer Stuber, Andrew Dennington, and Brian Biles, *Medicare+Choice in New York City: So Far, So Good?*, August 2002

### Journal Articles and Publications

- Stephen Davies, "What Is Clinical Governance?" — Questions and Answers," *Journal of Health Services Research and Policy* 7 (June 2002)
- David F. Doolan and David W. Bates, "Computerized Physician Order Entry Systems in Hospitals: Mandates and Incentives," *Health Affairs* 21 (July/August 2002): 180–188
- Nicola J. Gray et al., "Buying Medicines on the Internet: Young Consumers' Perceptions," *Journal of the American Pharmaceutical Association* 42 (March/April 2002): 313.
- Trudy Lieberman, "The Unraveling of Health Insurance," *Consumer Reports* (July 2002, web exclusive); available in the Consumer Advice section of [www.consumerreports.com](http://www.consumerreports.com)
- Helen Pelletier and Melinda Abrams, *The North Carolina ABCD Project: A New Approach for Providing Developmental Services in Primary Care Practice*, National Academy for State Health Policy, July 2002
- Dana Gelb Safran et al., "Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?" *Health Affairs* (July 31, 2002, web exclusive): W253–W268; available at [www.healthaffairs.org](http://www.healthaffairs.org)

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