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For more information, please contact:

Mary Mahon
Public Information Officer

The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Tel 212.606.3800
Fax 212.606.3500
www.cmwf.org

Health Care Reform a Major Issue for Voters, New Survey Finds

Rising health care costs and growing instability in insurance coverage have made health reform a key issue for Americans in the upcoming elections, a new Commonwealth Fund survey finds. Among those with coverage and those without, concern appears to be growing that health care security in the United States is eroding.

According to findings from the Fund's biennial health insurance survey, released at a March 29 briefing in Washington, D.C., nearly six of 10 Americans (57%) say that presidential and congressional candidates' views on health reform will be a "very important" factor in their vote this November. Whether they identify themselves as Democrats or Republicans, majorities of Americans support policies that would provide coverage to uninsured adults.

"These findings point to an affordability crisis in American health care," says Fund president Karen Davis. "The survey also indicates that there is widespread agreement among Americans that the United States should act on its chronic and growing health insurance problem."

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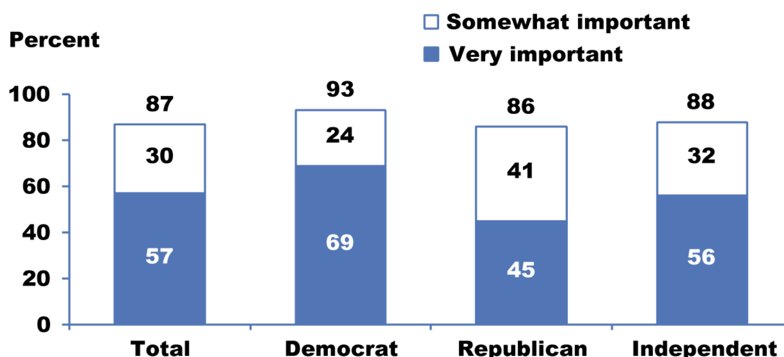
Majorities of Americans Across Political Affiliations Say That Candidates' Views on Health Care Reform Will Be Important Factor in Election Decisions



Responses include: very, somewhat, not too, not at all important, or don't plan to vote.

Source: S. R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, March 2004.

Grantee Spotlight

John Wasson, M.D., and Regina Benjamin, M.D.

How's Your Health is a community-based approach to improving health and health care that has been gaining national attention. Developed with Commonwealth Fund and other foundation support by John Wasson, M.D., of Dartmouth Medical School and Regina Benjamin, M.D., of Alabama's Bayou La Batre Rural Health Clinic, the program centers around an anonymous, free online survey (www.howsyourhealth.org) that lets people assess their health and receive information tailored to their particular needs. Individuals are encouraged to bring their health assessments with them on their next doctor's visit. With early tests indicating the program can improve care, community health alliances from Montana to New Jersey are now experimenting with ways to use How's Your Health to address local health issues. We asked Wasson and Benjamin how the project was progressing.

In your book, How's Your Health, America?, *you wrote that health care professionals and their patients often are "not on the same page." How does the survey improve communication between providers and patients?*

Regina Benjamin: I'm in solo practice, and I've noticed that patients don't always have the same idea as clinicians do. We want to know about blood pressure, while patients may want to know about colon cancer because their high school classmate just got diagnosed with it and it's been worrying them. The survey gives them a chance to express what they're thinking about.

Two thousand residents of Long Beach, California, and 1,000 residents of Mobile, Alabama, have taken the survey in pilot tests. What has been learned so far?

Benjamin: We were surprised to learn that in Mobile, a city of 250,000, one of people's top concerns was that there was nowhere to walk and get exercise. So, the city has been putting in sidewalks.

John Wasson: In Long Beach, we're learning that we have to reach out to people who lack access to computers or aren't comfortable using them. We may send vans equipped with computers into communities to facilitate the survey process. For elderly people, we rely on family members to help them take the survey. High school students have also helped seniors take the survey as part of their community service.

Benjamin: Most of my patients don't have computers, so we've set up a computer station in the waiting room. And now we're talking about going out to churches and other community centers with laptops.

This approach is also being used by Chicago's Chamber of Commerce as part of a workplace wellness program. What does How's Your Health offer businesses?

Wasson: In Chicago, smaller businesses were interested in doing something about their workers' health, but most commercial health risk assessments out there are prohibitively expensive and aren't tailored to what employers want. How's Your Health is inexpensive and easy to administer.

The survey is based on simple pictographs and straightforward questions. Why do you think this approach has been successful?

Benjamin: The idea is to put the patient in control—make them feel they can contribute to their care. This makes everybody more satisfied.

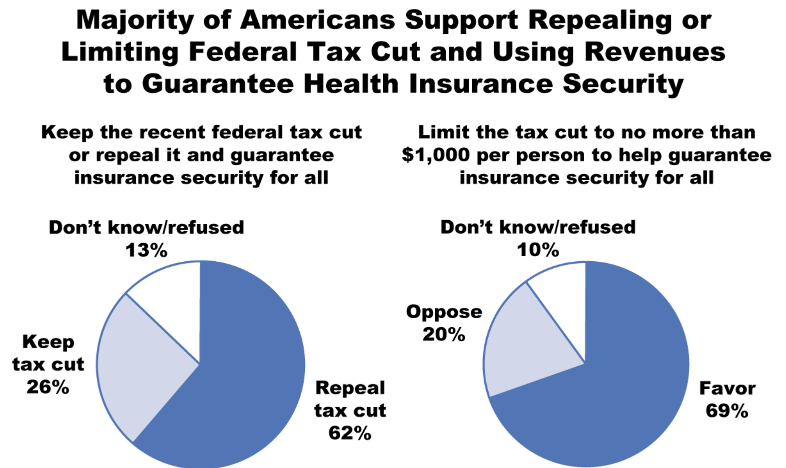
Wasson: Right, there's a huge amount of research that says patient-centered care is more effective and efficient, but the challenge is to actually implement this kind of care. How's Your Health started 25 years ago, when we did a study where doctors said they knew what mattered to their patients but were wrong half the time. That was a clear sign that something needed to change.

How can How's Your Health be part of larger quality improvement efforts?

Wasson: There's a lot of interest out there in improving access to health care. For example, large retail pharmacies are talking about having a nurse educator on the premises to help people check their blood sugar, maybe get a flu shot, and take a health assessment like How's Your Health.❖

Indeed, concern has reached the point where significant support exists for rolling back the recent federal tax cut to help ensure coverage for everyone. The survey finds that 62 percent of U.S. adults would be willing to give up the entire tax cut in exchange for guaranteeing "health insurance security." Support climbs to 69 percent when respondents are given the option of capping the tax cut at $1,000 per person, with the remaining federal dollars earmarked for wider health insurance protection. Majorities of Americans across all income groups, even those with incomes exceeding $100,000, supported a full or partial repeal to enhance coverage.

The Commonwealth Fund survey, conducted from September 2003 through January 2004 by Princeton Survey Research Associates International, was based on a nationally representative sample of 4,052 adults age 19 and older living in the continental United States. Individuals were asked about the stability of their health insurance coverage, quality of their health benefits, affordability of needed health care, and ability to pay medical bills.



Note: Percentages may not sum to 100% because of rounding.

Source: S. R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, March 2004.

Coverage and Benefits Are Eroding

The widespread public support seen in the survey for federal action on health coverage may well be a function of discontent with the health care system. More people are without health insurance today than two years ago, when the Fund conducted a similar survey. More than a quarter of adults ages 19 to 64 (26%) were either uninsured at the time of the survey or had undergone a period in the previous 12 months when they were lacking coverage.

Erosion of insurance coverage since 2001 was most marked for those with household incomes between $20,000 and $34,999: 35 percent were without coverage in 2003, up from 28 percent in 2001. Coverage among African Americans also worsened considerably, as evidenced by the rise in the proportion who spent a time uninsured between 2001 and 2003 (from 27% to 38%).

The quality of health coverage is eroding as well, according to the survey. Nearly half (49%) of respondents who were insured all year through a private health plan said they had experienced either an increase in what they pay for premiums, an increase in their share of medical bills, or a reduction in benefits.

This combination of instability in coverage and higher out-of-pocket costs is preventing people from getting the care they need. The share of people who reported problems getting needed care because of costs increased from 29 percent in 2001 to 37 percent in 2003. Those problems included: not filling a prescription; having a medical problem but not going to a physician or clinic; skipping a medical test, treatment, or follow-up visit recommended by a doctor; or not seeing a specialist when a doctor or the respondent thought it needed. The problem was most severe for those who were uninsured for a time.

The widespread public support seen in the survey for federal action on health coverage may well be a function of discontent with the health care system.

Medical Debt a Serious Problem

Substantial numbers of Americans are also having problems paying medical bills and ridding themselves of health care-related debt, the survey finds. Forty-one percent of adults under age 65 said they had problems paying medical bills in the last 12 months or were paying off medical debt accrued in the last three years; some reported they were contacted by a collection agency for outstanding bills or were forced to make significant changes in their lives to pay such bills. Surprisingly, 62 percent of those with bill problems or accrued medical debt said they or the family member who had incurred the bills had insurance coverage at the time.

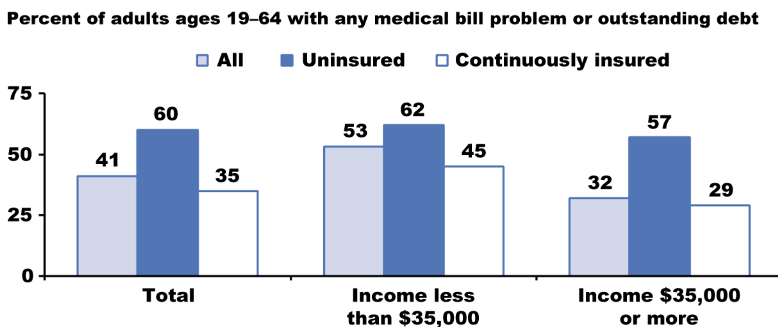
Medical bills are creating financial hardships for many families. Among those who said they had a medical bill problem in the last year or were paying off medical debt, more than a quarter (27%) had been unable to pay for basic necessities like food, heat, or rent. Two of five (44%) said they had used all or most of their savings to pay their bills.

"The survey shows that growing numbers of adults with and without insurance are forgoing necessary care because they simply can't afford it," says Sara R. Collins, the study's lead author. Expanding insurance coverage and making it more affordable, she notes, would help alleviate the financial stress currently plaguing many U.S. families.❖

Poor, minority, and urban young children are less likely to receive timely immunizations.

Two of Five Adults Have Medical Bill Problems or Accrued Medical Debt:* Uninsured and Low-Income Most at Risk

Percent of adults ages 19–64 with any medical bill problem or outstanding debt



* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.
Note: Income groups based on 2002 household income.

Source: S. R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, March 2004.

Shortcomings in Quality of Pediatric Care, Report Finds

Despite some notable successes, American children largely do not get the quality of health care they should, according to a new overview of children's health care. Up to three-quarters of children and adolescents do not receive care that is doctor recommended or has been scientifically proven effective.

Released at briefing in Washington, D.C., on April 15, *Quality of Health Care for Children and Adolescents: A Chartbook,* published by The Commonwealth Fund, describes a number of clear advances in children's health care and improved medical outcomes on a series of measures. But the report also notes that one-third of children with asthma fail to get appropriate medications to control their condition, and three-fourths of children with severe mental health problems are not properly evaluated and treated. Ongoing racial and socioeconomic disparities in care are also noted: poor, minority, and urban young children, for example, are less likely than non-poor, white, and suburban young children to receive timely immunizations.

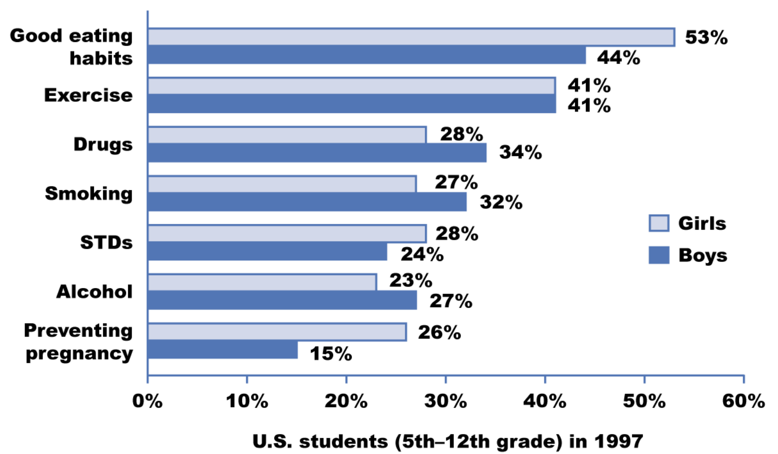
Distilled from a review of 500 studies, the report illustrates through charts and commentary the quality of children's preventive care, treatment for chronic illnesses, and many other health care services. It was produced by Sheila Leatherman of the University of North Carolina School of Public Health and Douglas McCarthy, president of Issues

Research, Inc., based in Durango, Colo., in consultation with national experts in child and adolescent care quality.

"Given the fact that we spend far more on health care than other countries, we should be doing better for our children," Leatherman said. "The report shows dangerous lapses in patient safety, substantial shortcomings in providing effective and recommended care, persistent racial and ethnic disparities in care, and widespread failure to provide needed preventive services to teens."

Leatherman and McCarthy find that the health system has made dramatic progress in certain areas of pediatric care. For example, there has been a reduction in hospital-acquired infections at some pediatric intensive care units, lead screening has been improved, and inappropriate use of antibiotics in children with the common cold has been cut in half.

Still, the authors say that the U.S. health care system has devoted less attention to measuring and reporting on quality of care for children and adolescents than it has for adults. "We need a better understanding of what quality health care means for children," said McCarthy. "As a society, we too often think of children as little adults. But they aren't. Their unique developmental needs, different disease patterns, and dependency on adults means that quality of health care for children deserves special attention. This report is a start," he added. ❖



S. Leatherman and D. McCarthy, *Quality of Health Care for Children and Adolescents: A Chartbook*, The Commonwealth Fund, April 2004, based on 1997 Commonwealth Fund Survey of the Health of Adolescents, as reported by Ackard and Neumark-Sztainer (2001).

Employers Willing to Pay Fair Share for Health Coverage

A new survey has uncovered a strong vein of corporate commitment to health insurance benefits, despite steeply rising insurance premiums in recent years. A majority of employers participating in the Commonwealth Fund Supplement to the 2003 National Organizations Study said they would support policies aimed at expanding health insurance coverage for workers and their families, even if the reforms entailed financial commitments from businesses.

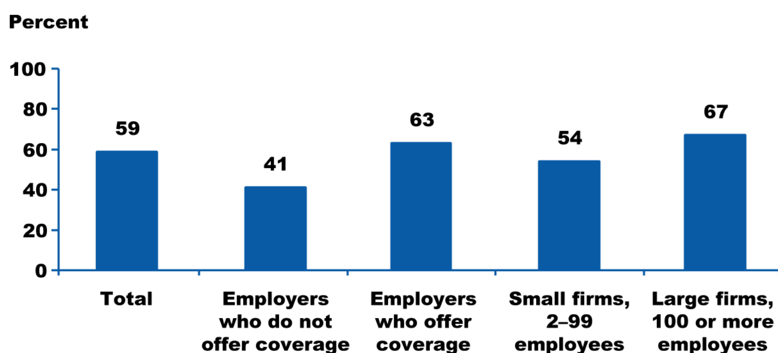
According to *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* an issue brief written by Fund researchers Sara R. Collins, Cathy Schoen, Michelle M. Doty, and Alyssa L. Holmgren, 81 percent of the 453 employers surveyed in 2002 and 2003 offer health insurance to their employees. Most view it as a core part of their compensation packages that helps in worker recruitment and retention.

"The message from employers is that they want to do the right thing for their employees, but are struggling to manage the rising costs of providing health coverage," said Commonwealth Fund president Karen Davis. "Employers show strong support for solutions such as employer coverage mandates and new group alternatives to employer coverage."

A majority of employers said they would support policies aimed at expanding health insurance coverage for workers and their families.

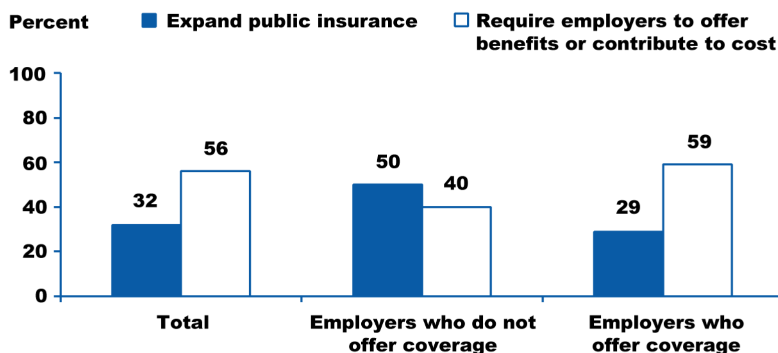
According to the survey results, the vast majority of businesses offering employee health benefits—91 percent—reported experiencing insurance premium hikes. In response, a third (33%) increased employees' copayments or coinsurance, nearly a third (31%) raised employees' share of premiums, and a quarter (25%) raised deductibles. One of five employers (18%), meanwhile, eliminated or restricted benefits. A similar share (18%) introduced products, such as medical savings accounts, designed to shift financial risk to employees.

Percent of Employers Who Think It Is "Very Important" that Employers Provide Health Coverage to Their Employees or Contribute to the Cost



Source: S. R. Collins et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* The Commonwealth Fund, March 2004, based on the Commonwealth Fund Supplement to the 2003 National Organizations Study.

Employer Preferences Between Policy Options to Cover Uninsured Workers



Note: "Don't Know" and "Refused to Answer" not shown.

Source: S. R. Collins et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* The Commonwealth Fund, March 2004, based on the Commonwealth Fund Supplement to the 2003 National Organizations Study.

Nearly all of the health insurance reforms proposed over the last few years to make coverage more affordable for workers—including plans advanced by President Bush, the Democratic presidential candidates, and private sector leaders—rely at least in part on tax credits jointly administered by employers and the government. A majority (83%) of the employers surveyed said they would be "very" or "somewhat" willing to reduce employees' withholding tax by the amount of the tax credit. A majority (77%) also said that they would be very or somewhat willing to collect the credit and apply it to employees' share of their health insurance premiums.

To help expand enrollment, 93 percent of surveyed employers would in addition be willing to provide their employees with information about applying for Medicaid or the State Children's Health Insurance Program. Many low-income workers are eligible for public coverage but fail to sign up for the benefits.

Such reforms would require mainly administrative efforts from employers. But the survey found that employers were willing to go further—by contributing financially to a health insurance expansion for workers and their families. A majority (59%) felt it is important for businesses to share the costs of their employees' coverage, either by providing coverage directly or contributing to a public fund. Sixty-one percent said they would be very or somewhat interested in allowing their employees to buy coverage in an alternative group plan, with part of the premiums paid by employers. When asked if they would prefer an expansion of public health insurance programs financed through the tax system to a policy mandating that employers offer

coverage or pay into a fund, a majority (56%) chose the employer mandate. That preference, however, was strongest among companies that currently offer health benefits.❖

Karen Davis Testifies on Improving Care, Controlling Costs

Improving quality and streamlining administration are the keys to achieving affordable health care, not shifting rising costs onto patients, says Commonwealth Fund president Karen Davis. In invited testimony before the Senate Committee on Health, Education, Labor, and Pensions on January 28, Davis outlined a number of steps the United States could take to reduce wasteful health care spending and expand access to high-quality, affordable care.

"What we all want from our health care system is not necessarily cheaper care, but the efficient use of resources to provide high-quality care to all Americans," Davis told the committee. The U.S. cannot afford "wasteful spending on care that does not benefit patients," she said, or the high administrative costs that result from the nation's fragmented health insurance and health care delivery systems. Davis pointed out that simply shifting the increasing costs of care and insurance coverage to consumers—an increasingly common tactic—not only imposes excessive financial burdens on many patients but can also lead some to skip needed medical care.

Davis believes the nation needs an "integrated public–private strategy to purchase health services efficiently, demand quality performance, and streamline administrative costs." Short of fundamental reform, some of the near-term solutions she cited include:

- Public and private investment in health information technology to reduce medical errors and improve coordination of care.
- Public reporting of data related to the cost and quality of care provided by physicians, hospitals, nursing homes, and health plans.
- Making Medicare a leader in rewarding health care providers who are both high-quality and low-cost.
- Developing clinical guidelines and quality standards.
- Improving administrative efficiency of public coverage programs by simplifying eligibility determination and enrollment processes.
- Making health insurance both automatic and affordable for all Americans.

"What we all want from our health care system is not necessarily cheaper care, but the efficient use of resources to provide high-quality care to all Americans."

Few Workers to Date Sign Up for Health Insurance Tax Credits

There have been few takers so far for tax credits authorized under a recent federal law enacted to help certain unemployed workers buy health insurance, a new study finds. Although enrollment is likely to increase over time, some provisions of the 2002 law may present barriers to wider participation.

Research funded by The Commonwealth Fund and the Nathan Cummings Foundation reveals that enrollment in the Health Coverage Tax Credit program that was created by the 2002 Trade Act was just 8,400, or 3.6 percent of 235,000 potentially eligible workers, at the end of 2003. The number of additional eligible workers who chose to take the tax credit when they filed their 2003 income tax returns will

be reported by the Internal Revenue Service in June.

Trade Act tax credits pay 65 percent of health insurance premiums for workers who lose their jobs because of international trade, including foreign outsourcing, and for certain early retirees whose pensions are affected when their former company goes bankrupt. The credits, which may be used to buy COBRA coverage, state-arranged insurance, or individual policies, are fully refundable—meaning they may be claimed in full by all eligible individuals regardless of whether they owe federal income tax. The credits are also advanceable, so that beneficiaries do not have to put up all the money for their health coverage first; the credit instead can go directly to the insurer when monthly premiums are due.

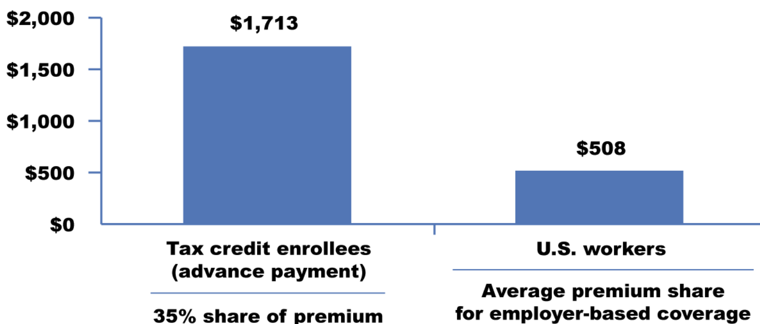
While the program is still in its early stages, premiums appear to be too high for many unemployed workers, even with a tax credit that covers two-thirds of the premium.

Stan Dorn and Todd Kutyla of the Economic and Social Research Institute, authors of *Health Coverage Tax Credits Under the Trade Act of 2002,* say the precise reasons for the low rate of uptake thus far are unclear—as is whether low participation rates will continue. But while stressing that the program is still in its early stages, the authors say that premiums appear to be too high for many unemployed workers, even with a tax credit that covers two-thirds of the premium. The 35 percent share of insurance premiums for which tax credit enrollees are responsible averages $1,713 a year for single coverage; by contrast, U.S. workers contribute an average of $508 a year for single coverage furnished by their employers. In some cases, premiums are much higher for older or sicker workers. The authors also cite as a possible enrollment barrier the requirement that laid-off workers "front" one or more months of premiums in full before the advance tax credit kicks in.

Despite these shortcomings, implementation of the Health Care Tax Credit program has gone remarkably smoothly, the researchers say. Federal administrators have successfully forged an innovative federal, state, and private partnership to advance income tax credit payments to beneficiaries electronically. Most beneficiaries, furthermore, have access to state health plans for which the credits can be used. By the end of 2003, state-based coverage was available in 26 states and the District of Columbia, representing three-fourths of all projected eligible workers.

Dorn and Kutyla's study, which was discussed at the spring 2004 meeting of the Commonwealth Fund Task Force on the Future of Health Insurance, provides some of the first published data on the impact of fully refundable and advanceable federal income tax credits for health insurance. Many policymakers in both parties consider tax credits as part of the solution to the nation's uninsured crisis. Both President Bush and Senator Kerry, for example, have proposed using tax credits as one means of covering the uninsured. ❖

Health Coverage Tax Credit Enrollees' Share of Insurance Premiums Is More Than Triple the Premium Share of U.S. Workers



Source: Based on S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002,* The Commonwealth Fund, April 2004.

Study Warns About Solvency Risks in Association Health Plans

Policymakers and others who advocate association health plans as a solution to rising health insurance costs received some sobering news recently when a Commonwealth Fund study detailed a troublesome history of financial insolvency, unpaid medical claims, and consumers left without health coverage. At the root of association plan insolvencies are licensing requirements that are far less stringent than those imposed on traditional insurers.

Association health plans, a type of "multiple employer welfare arrangement" (MEWA), allow small business owners to band together through their membership in a trade or professional association to purchase health coverage for their families and employees. Legislation to promote association health plans is pending in Congress, and President Bush expressed support for such plans in his most recent State of the Union address.

According to Mila Kofman, a Georgetown University researcher and author of *MEWAs: The Threat of Plan Insolvency and Other Challenges,* these plans' solvency standards—including the amount of cash surplus they are required to maintain—are weaker than those of traditional insurers. Consequently, there is a far greater danger of insolvency when a plan's claims unexpectedly exceed its ability to pay. MEWAs, moreover, are exempt from state taxes on premiums and from assessments that fund state safety net programs, such as guaranty funds that pay claims when an insurer becomes insolvent. In case of insolvency, employers and workers enrolled in the plan are responsible for unpaid medical claims.

The MEWAs that have become insolvent in recent years include California-based Sunkist Growers, Inc., which covered 23,000 people, in 2001, and New Jersey's Coalition of Automotive Retailers, which covered 20,000 people, in 2002. The latter had $15 million in outstanding medical bills.

"Policymakers have made a tradeoff," said Kofman. "On one hand, weaker standards than those applicable to insurers may make the health coverage offered by associations less expensive. On the other hand, lower solvency requirements increase the risk of financial failure, which means consumers can get stuck with medical bills that should have been paid."

Association health plans' solvency standards are weaker than those of traditional insurers.

Some states have attempted to prevent insolvencies and provide additional consumer protections through regulation and oversight, Kofman says. Because even the most aggressive oversight cannot prevent a MEWA's insolvency, some states assist consumers in finding find new coverage when MEWAs fail; they also sometimes reduce the amount of unpaid medical bills for which patients are responsible. Michigan, for example, requested that the association sponsoring an insolvent plan work out agreements with health care providers to accept reduced payments on outstanding claims. ❖

Insurance Coverage May Be Driving 'Overuse' of Some Drugs

Use of the most costly prescription pain medication for osteoarthritis is twice as high among the elderly with the best prescription drug coverage compared with seniors who have no or very limited drug coverage—even when less expensive over-the-counter drugs could be

substituted. The findings, reported in a recent *Health Affairs* study (Web Exclusive, Feb. 18, 2004), suggest that overuse of more expensive drugs could lead to unexpectedly high costs for Medicare once the new prescription benefit is phased in.

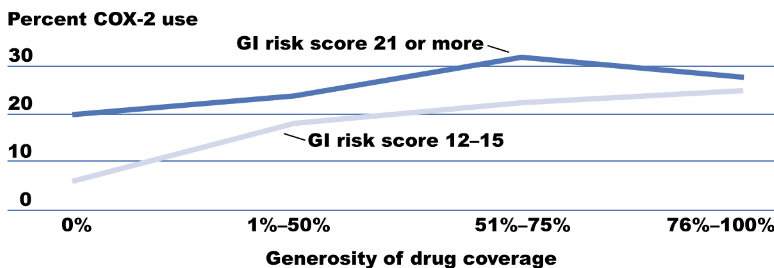
Overuse of more expensive drugs could lead to unexpectedly high costs for Medicare once the new prescription benefit is phased in.

The study, which was supported by The Commonwealth Fund, examined the use of pain relievers known as COX-2 inhibitors among elderly Medicare beneficiaries with osteoarthritis. University of Pennsylvania researchers Jalpa A. Doshi and Nicole Brandt and the University of Maryland's Bruce Stuart found that average use of a COX-2 ranges from 13 percent among the least well insured (no third-party coverage) to 26 percent among those with the most generous coverage (76% to 100% of annual drug costs paid by insurance). COX-2 inhibitors, which are sold under the brand names Celebrex and Vioxx, have not been proven more effective than over-the-counter medications such as ibuprofen, the authors say. They are, however, less likely to cause gastrointestinal problems, such as bleeding and ulcers, than less expensive alternatives.

As would be expected, the study found that patients at increased risk for adverse gastrointestinal side effects were prescribed COX-2s more often by physicians. But the researchers also discovered that the generosity of patients' drug coverage actually trumped their level of health risk: Medicare beneficiaries with the most generous drug coverage and only a moderate risk for gastrointestinal problems were actually more likely to be prescribed a COX-2 than beneficiaries who had no or only limited drug coverage but were at substantial risk for health complications (25% vs. 20%).

"While drug coverage is clearly associated with greater use of expensive COX-2 inhibitors, most of the increase in use is among those least in need," says Doshi, the study's lead author. "Our study suggests that policymakers should also be concerned with potential overuse of drug therapy by Medicare beneficiaries once the benefit is implemented." Drug utilization management tools, she notes, may be required to prevent excessive use of costly medications when less expensive variants are suitable. ❖

Prevalence of COX-2 Inhibitor Use by Gastrointestinal (GI) Risk Score and Generosity of Drug Coverage Among Aged Community-Dwelling Medicare Beneficiaries with Osteoarthritis, 2000



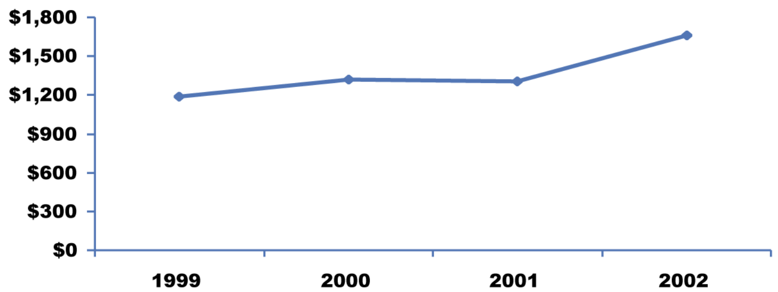
Notes: All differences in COX-2 use by generosity of drug coverage within GI risk groups are statistically significant at $p < .05$. Differences in COX-2 use by GI risk scores within the 0% generosity group are statistically significant at $p < .05$, while those among the 76%–100% generosity category are statistically nonsignificant.

Source: J. A. Doshi et al., "The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare," *Health Affairs* Web Exclusive (Feb. 18, 2004): W4-94–W4-105.

States Offer Lessons in Managing Drug Coverage Costs

As the new Medicare prescription drug benefit is phased in, the federal officials and private drug plans administering it could learn valuable lessons from states' efforts to manage costs within their pharmaceutical assistance programs for the elderly and disabled. Researchers at the Rutgers Center for State Health Policy report that several states have achieved savings by limiting use of higher-priced drugs or by negotiating discounts from pharmacies and drug manufacturers. Other strategies have, in some cases, helped states reduce medication errors and improve patient safety.

Average Drug Expenditures per Enrollee in State Pharmacy Assistance Programs Rose from $1,191 in 1999 to $1,663 in 2002, an Increase of Nearly 40 Percent



T. Trail, K. Fox, J. Cantor, M. Silberberg, and S. Crystal, *State Pharmacy Assistance Programs: A Chartbook,* The Commonwealth Fund, forthcoming.

According to *Managing Program Costs in State Pharmacy Assistance Programs,* the third in a series of Commonwealth Fund publications examining the experiences of state pharmacy assistance programs (SPAPs), practices to encourage or mandate the prescribing of lower-cost generic drugs have been particularly effective in achieving program cost savings. In some states, generic drugs account for nearly half of claims paid. Rebates obtained from drug manufacturers also have saved money for states, with some programs recovering as much as a third of their costs. The amount of these rebates, which are paid by the manufacturer after the drugs have been purchased, is based on the volume of drugs purchased by SPAP enrollees.

Preliminary findings, meanwhile, show that online prospective drug utilization review—which alerts pharmacists to potentially inappropriate prescriptions based on clinical data—has resulted in fewer medication errors as well as significant cost savings. Pennsylvania and New Jersey have gone a step further by convening panels of experts to develop prescribing criteria specifically for the elderly and blocking payment for drug combinations and doses that are deemed unsafe. In Pennsylvania, state officials estimate that the prospective review process helps prevent 140,000 medication errors annually. The new Medicare law requires that health plans providing the drug benefit implement systems to monitor patient safety and reduce the opportunity for medication errors.

To the extent that low-income SPAP enrollees have access to other drug coverage, some of the drugs paid for by the state programs may actually be reimbursable by third parties, such as Medicare+Choice plans, Medigap insurance, or retiree health plans. Few states, however, have attempted to recover such costs retrospectively, and those that have tried have achieved little success.

"The states' role in pharmacy assistance will continue to be extremely important even after the Medicare benefit is implemented," says Stephen Crystal, principal investigator for the Rutgers research team that prepared the report. "But their experience interacting with other sources of coverage suggests that considerable effort by the new private pharmacy plans, states, and the federal government will be needed to coordinate benefits effectively."

The other reports in the Fund's series on SPAPs are *State Pharmacy Assistance Programs: Approaches to Program Design* (May 2002) and *Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It* (September 2003).❖

State practices to encourage or mandate the prescribing of lower-cost generic drugs have been particularly effective in achieving cost savings.

Drug Coverage for Those Under 65 Is a Problem, Too

While the recent debate surrounding the Medicare prescription drug benefit has managed to shed light on the drug

Insured, nonelderly adults without drug coverage are nearly twice as likely as those with it not to fill a prescription because of the cost.

coverage needs of the elderly, little public attention has been paid to the often considerable needs of adults under age 65. Despite the ever-climbing use of prescription medications in the United States, a study published by The Commonwealth Fund finds that nearly one of 10 insured Americans under 65 receives no drug benefits from his or her health plan.

Lack of drug coverage is often a sign of other holes in basic health coverage, according to *Lack of Prescription Coverage Among the Under 65: A Symptom of Underinsurance,* by NORC/University of Chicago researchers Claudia L. Schur and Marc L. Berk and the Fund's Michelle M. Doty. Not surprisingly, insured, nonelderly adults without drug coverage are nearly twice as likely as those with it not to fill a prescription because of its cost (28% vs. 16%). But this group is also significantly more likely than people with drug coverage to skip recommended tests or follow-up care (24% vs. 11%) or forgo seeing a doctor when sick (27% vs. 13%). When they do receive health care, those without drug coverage often face high out-of-pocket costs and medical bills.

In response to rising drug prices and health insurance premiums, private health plans and Medicaid have been cutting back on the scope of benefits and increasing cost-sharing for drugs and other services. These actions, including the possible growth in the number of plans lacking basic drug coverage, are likely to exacerbate the unmet needs and financial burdens of under-65 adults.

"These findings tell us that we need to attend to the content of insurance benefits," the researchers say, "not just whether or not individuals are insured."❖

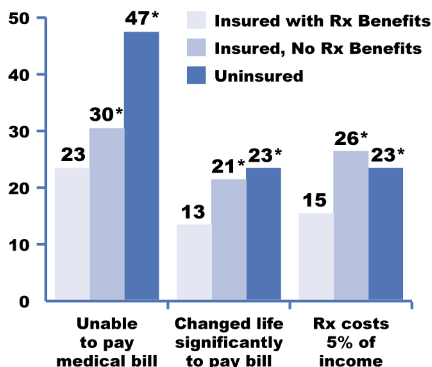
Fund Targets Children's Mental Development

Young children's mental development is an often neglected area of pediatric primary care. As highlighted in a recent Commonwealth Fund report, only half of children with social or emotional problems are identified by their primary care physicians and only a fraction receive appropriate care.

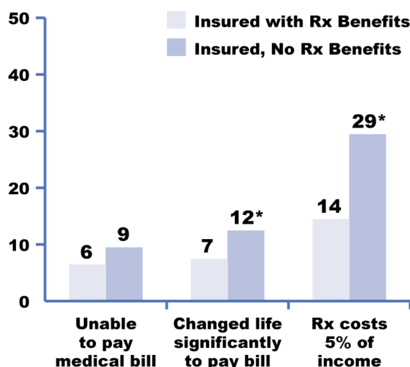
Under the second phase of the Fund's Assuring Better Child Health and Development (ABCD) initiative, launched in January, five states are developing ways to deliver and finance health care services aimed at promoting the healthy mental development of low-income children under age 5. Those states—California, Illinois, Iowa, Minnesota, and Utah—are seeking to improve children's readiness to learn and avert the need for more intensive, and expensive, remedial care at

Medical Bill Problems and High Out-of-Pocket Costs Are Greatest for Adults Without Drug Benefits and the Uninsured

Percent of adults 19–64 who experienced the following problems in 2001:



Percent of adults 65+ who experienced the following problems in 2001:



Note: Adjusted percentages controlling for poverty and health status.
* Indicates significant differences between those insured with Rx benefits at $p < .05$.

Source: C. L. Schur et al., *Lack of Prescription Coverage Among the Under 65: A Symptom of Underinsurance,* The Commonwealth Fund, February 2004, based on the Commonwealth Fund 2001 Health Insurance Survey.

later ages. The Illinois initiative is being cofunded by the Michael Reese Health Trust and the Chicago Community Trust.

In the first phase of ABCD, which concluded in May 2003, four state Medicaid agencies worked with staff from the Fund and the National Academy for State Health Policy (NASHP) to expand their capacity to provide low-income young children and their families with a range of developmental services. In North Carolina, Medicaid officials teamed with physicians to implement a developmental screening, referral, and case management model that produced a dramatic rise in the percentage of children screened for development delay and a threefold increase in rates of referral for identified problems. Vermont, meanwhile, trained more than 900 physicians, public health providers, and government officials in a curriculum designed to enhance communication with parents of young children.

Fund and NASHP officials are hoping that ABCD II, which is expected to run until 2006, can achieve similar success.❖

New Films Spotlight Cross-Cultural Care

Open and clear communication between patients and their doctors is a crucial component of good health care. *Worlds Apart,* a recently released series of films produced with partial support from The Commonwealth Fund, dramatizes some of the difficulties of patient–physician communication in our culturally diverse society.

Filmmakers Maren Grainger-Monsen, M.D., and Julia Haslett followed four individuals from their homes, neighborhoods, and places of worship to the community clinics and hospitals where they seek medical care. Each short film documents tensions between modern medicine and cultural beliefs or problems stemming from racial and ethnic discrimination.

One film tells the story of an Afghani man with stomach cancer who refuses chemotherapy in part because of poor communication between his doctors and his daughters, who act as his translators.

In another film, a four-year-old girl from Laos needs surgery for a congenital heart defect. While her grandmother, who adheres to traditional Laotian and Buddhist beliefs, worries that the scar will affect her granddaughter's spirit in her subsequent lives, the girl's mother worries that the family will blame her if something goes wrong.

Clips from the films, as well as an accompanying study guide, are available on the Fund's Web site.❖

Each short Worlds Apart *film documents tensions between modern medicine and cultural beliefs or problems stemming from racial and ethnic discrimination.*

Web Is Linking People to Health Coverage

Getting and keeping health insurance can be a tricky business, especially if you are self-employed. There is a Web site, however, that is helping to connect people with sources of reliable and reasonably priced health coverage. Although designed originally for actors and other entertainment professionals, the site now assists all kinds of self-employed individuals and small business employees with their health insurance needs.

The site is called Access to Health Insurance/Resources for Care (AHIRC) (www.actorsfund.org/ahirc/). It is maintained by the Artists' Health Insurance Resource Center, part of the Actors' Fund of America, a nonprofit organization dedicated to the social welfare of professionals in film, television, radio, theatre, dance, and music.

The AHIRC Web site was expanded to include resources for many groups, including the self-employed, low-income workers, and the underinsured.

After the site first went live in 1998, the center's managing director, James Brown, began receiving queries from people around the country who were self-employed or worked in small businesses that didn't offer coverage. "I'd hear from people who'd say, 'I was in two of my high school plays, do I qualify?'," Brown recalled. "It became clear to me that there were many groups, not just actors, who were outside of the whole employer health insurance system and who could benefit from information about how to get coverage." Brown has a unique perspective on the issue: he was a professor of theater for more than a decade, then worked to negotiate contracts for various health insurance plans.

So with support from The Commonwealth Fund, the AHIRC Web site was expanded to include resources for many groups: the self-employed, low-income workers, the underinsured, people with HIV/AIDS, immigrants and refugees, domestic partners, veterans, and individuals with chronic conditions. The site, which draws about 700 visitors daily, is mainly a gateway, with links provided to hundreds of resources tailored to specific needs. "We're the opposite of most Web sites—we don't want people to spend a lot of time on our site," says Brown.

With additional Fund support, AHIRC recently teamed up with graduate students and their mentors at six different universities around the country to augment the site with health coverage information for all 50 states. ❖

2004–05 Harkness Fellows Appointed

The Commonwealth Fund recently announced the 2004–05 Harkness Fellows in Health Care Policy. Under a new partnership between The Commonwealth Fund and The Health Foundation, two additional U.K. fellowships were established in 2004, bringing the total in the United Kingdom to seven. Harkness Fellowships provide a unique opportunity for health policy researchers, clinicians, managers, public health officials, and journalists from Australia, New Zealand, and the United Kingdom to spend up to a year in the United States conducting research and working with leading U.S. health policy experts. The new fellows and their research projects are:

Marie Bismark, M.B., Ch.B., L.L.B., M.B.H.L. (New Zealand), Legal Advisor and Researcher, Health and Disability Commissioner. *Using Lessons Learned from Patients' Complaints as a Catalyst for Systemic Improvement in Health Care: The Role of Health Care Ombudsman Programs.*

Jane Burns, Ph.D. (Australia), Senior Program Manager, beyondblue: the national depression initiative. *Prevention or Treatment in Adolescent Mental Health? A Comparison of U.S. and Australian Strategies and Approaches.*

Elana Taipapaki Curtis, M.B., Ch.B., Dip PH, M.P.H. (New Zealand), Public Health Medicine Specialist, Ministry of Health. *An Analysis of Ethnic Disparities in Breast Cancer Mortality and Survival: Understanding the Role of Access and Quality in Breast Cancer Screening and Treatment.*

Rhiannon Tudor Edwards, D.Phil. (United Kingdom), Director and Senior Research Fellow in Health Economics, Institute of Medical and Social Care Research, University of Wales, Bangor. *An Economic Analysis of Preventive Health Care in Managed Care.*

Rachel Elliott, Ph.D., Dip Clinical Pharmacy, M.R.Pharm.S. (United Kingdom), Clinical Senior Lecturer, University of Manchester. *What Is the Relative Importance of Factors That Influence Patients' Decisions to Adhere to Medicines and Are They Taken Account of in Health Policy?*

Dominic Ford, M.A. (United Kingdom), Mental Health Development Manager, Commission for Health Improvement. *Performance Assessment in Mental Health Services: A User Perspective.*

Stephen Monaghan, M.B., Ch.B., M.P.H., L.L.M. (United Kingdom), Public Health Director, Cardiff Health Board, and Consultant in Public Health Medicine, National Public Health Service for Wales. *What Kinds of Strategies Have Been Successful in Changing Physician and Organizational Behavior to Improve Quality of Care in the U.S. versus the U.K.?*

Nadeem Qureshi, M.B., B.S., M.Sc. (United Kingdom), Clinical Lecturer in General Practice, University of Nottingham. *Medicine in the 21st Century: Anticipating and Preventing Inequalities in Genetic Health Care Provision for Vulnerable Minority Populations.*

Kathryn Rowan, D.Phil. (United Kingdom), Director, Intensive Care National Audit and Research Centre, and Honorary Senior Lecturer, London School of Hygiene and Tropical Medicine. *How Can Utilization of Performance Data by Health Care Providers Be Optimized/Maximized?*

Peter Spirvulis, M.B., B.S., Ph.D. (Australia), Clinical Director, Department of Health, Government of Western Australia. *The Business Case for Investment in Quality.*

Claire Stebbing, M.B., B.S. (United Kingdom), Senior House Officer in Paediatric Renal Medicine, Guys' and St. Thomas' NHS Trust. *A Trans-Atlantic Comparison of Medication Errors in Children and an Assessment of Strategies for Their Prevention.*❖

Recent and Forthcoming Commonwealth Fund Publications, Winter/Spring 2004

Fund Reports

B. H. Barraclough, *Advancing the Patient Safety Agenda: An Australian Perspective,* January 2004

H. Cayton, *Patient Engagement and Patient Decision-Making in the United Kingdom,* March 2004

C. M. Clancy, *Advancing the Patient Safety Agenda in the United States,* January 2004

S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* March 2004

S. R. Collins and A. Ho, *From Coast to Coast: Regional Variations in the Affordability of Health Care,* March 2004

S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* March 2004

J. E. Craig, Jr., *An Undervalued Species: Private Value-Added Foundations,* Executive Vice President & Treasurer's Report from The Commonwealth Fund 2004 *Annual Report*

K. Davis, *Achieving a High Performance Health System,* President's Message from The Commonwealth Fund 2004 *Annual Report*

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Publications described in this *Quarterly* can be downloaded by visiting the Fund's website at **www.cmwf.org.**

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K. Davis, *Making Health Care Affordable for All Americans,* Testimony before the Senate HELP Committee, January 28, 2004

S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002,* April 2004 [issue brief]

S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation,* April 2004 [full report]

M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities,* April 2004

K. Fox, T. Trail, S. Reinhard, and S. Crystal, *Managing Program Costs in State Pharmacy Assistance Programs,* February 2004

W. E. Hammond III, *Electronic Medical Records—Getting It Right and Going to Scale,* January 2004

M. Kofman, E. Bangit, and K. Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges,* March 2004

S. Leatherman and D. McCarthy, *Quality of Health Care for Children and Adolescents: A Chartbook,* April 2004

C. L. Schur, M. M. Doty, and M. L. Berk, *Lack of Prescription Coverage Among the Under 65: A Symptom of Underinsurance,* February 2004

T. Trail, K. Fox, J. Cantor, M. Silberberg, and S. Crystal, *State Pharmacy Assistance Programs: A Chartbook,* forthcoming

Journal Articles and Other Publications

A. C. Beal, J. P. T. Co, D. Dougherty, T. Jorsling, J. Kam, J. Perrin, and R. H. Palmer, "Quality Measures for Children's Health Care," *Pediatrics* 113 (January 2004): 199–209

J. A. Doshi, N. Brandt, and B. Stuart, "The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare," *Health Affairs* Web Exclusive (February 18, 2004): W4-94–W4-105

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R. L. Gruen, S. D. Pearson, and T. A. Brennan, "Physician-Citizens—Public Roles and Professional Obligations," *Journal of the American Medical Association* 291 (January 7, 2004): 94–98

K. Johnson and N. Kaye, *Using Medicaid to Support Young Children's Healthy Mental Development,* September 2003, revised January 2004

R. L. Johnson, S. Saha, J. J. Arbelaez, M. C. Beach, and L. A. Cooper, "Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care," *Journal of General Internal Medicine* 19 (February 2004): 101–110

H. Pelletier and M. K. Abrams, *ABCD: Lessons from a Four-State Consortium,* December 2003

Q. Ngo-Metzger, A. T. R. Legedza, and R. S. Phillips, "Asian Americans' Reports of Their Health Care Experiences," *Journal of General Internal Medicine* 19 (February 2004): 111–19

E. C. Schneider, A. M. Zaslavsky, and A. M. Epstein, "Use of High-Cost Operative Procedures by Medicare Beneficiaries Enrolled in For-Profit and Not-for-Profit Health Plans," *New England Journal of Medicine* 350 (January 8, 2004): 143–50

S. C. Schoenbaum and R. R. Bovbjerg, "Malpractice Reform Must Include Steps to Prevent Medical Injury," *Annals of Internal Medicine* 140 (January 6, 2004): 51–53

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