



Health Insurance Coverage for All Americans



President's Message
1997 Annual Report

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Health Insurance Coverage for All Americans

Karen Davis, President

Since the defeat of the Clinton national health care plan, incremental change has replaced sweeping reform as the most promising method for addressing major problems in the area of health insurance. The problems fall into two major categories: first, lack of coverage, which keeps many Americans from getting the health care they need, and second, threats to the quality of care, especially given the incentives to cut costs within the burgeoning managed care industry.

The number of uninsured Americans has risen steadily since the mid-1970s, after falling dramatically with the enactment of Medicare and Medicaid in 1965. The major force behind the more recent trend is the erosion of employer-sponsored coverage. Between 1990 and 1995, the percentage of non-elderly Americans who got health insurance through their employers (or the employers of family members) dropped from 67 percent to 64 percent. The changing nature of jobs within and across industries—especially the growth of service sector jobs without health benefits and the increase in part-time and contract workers—and the unaffordably high cost of the employee share of premiums account for most of this decline. Recent figures indicate that 42 million Americans, or about 16 percent of the total population, are uninsured throughout the year.

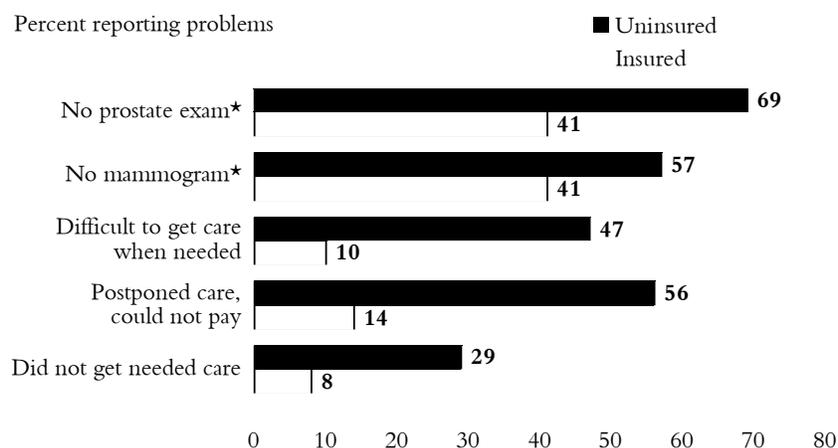
The consequences of being uninsured are brought home by the results of recent surveys supported by the Fund in collaboration with the Henry J. Kaiser Family Foundation. Preliminary findings from the Kaiser/Commonwealth Health Insurance Survey for 1997, the third in a series, indicate that half of uninsured adults do not have a regular doctor, fail to get regular preventive care, and find it difficult to get care when

needed. The survey also shows that 15 percent of the population and one-third of the uninsured had problems paying medical bills in the past year. Of these, over 40 percent had to change their way of life in order to pay their bills. The poor and near-poor, whether insured or not, are particularly hard-pressed: one in four had problems paying for care.

Although people with no insurance face the greatest barriers to receiving needed health care, the survey shows that those who are intermittently insured or have inadequate coverage are also exposed to potentially burdensome medical bills in the event of major or prolonged illness. About 35 percent of Americans under age 65 are either uninsured, intermittently insured, or inadequately insured. In addition, educational, cultural, and other barriers prevent even some who have insurance from seeking early care.¹

The 1997 bipartisan balanced budget agreement, designed to eliminate the federal deficit by the year 2002, makes an important start toward providing health insurance to children of low income, working families by extending coverage to 2 million of the approximately 10 million

Half of uninsured men and women face serious problems in getting access to needed medical care.



*Base: women (mammogram) or men (prostate exam) over age 50.

Source: Kaiser/Commonwealth 1997 National Survey of Health Insurance.

American children uninsured today.² Other provisions postpone without solving the long-range financial problems of the Medicare program and introduce some measures to improve quality standards for managed care. These steps may presage further strides in the years ahead, as the implications of gaps in health insurance coverage become more apparent.

Viewed optimistically, the 1997 legislation represents only the beginning of a search for a more efficient and effective health care system—one that provides access to health care and ensures good quality care to all Americans. Much remains to be done. Eight million children will still need health insurance, and problematic gaps remain in coverage for low income men and women. Proposed changes to the Medicare program—ultimately rejected, but seriously discussed—could have raised the cost of medical care for elderly Americans and increased the number of uninsured adults, prospects that raise warnings for future deliberations. Specific quality standards are needed to protect those most at risk under managed care: low income and chronically ill Medicare and Medicaid beneficiaries.

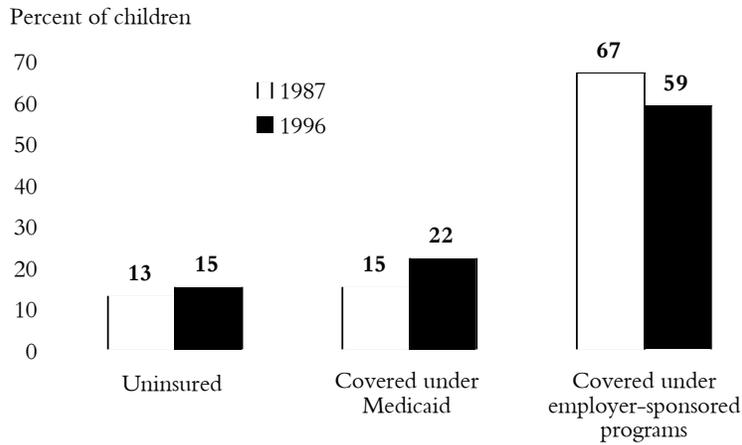
Over the next few years, opportunities will surely arise to extend and mend the health insurance safety net. Four areas that have seen recent action and continue to rank high on the federal health policy agenda deserve particularly close attention: coverage for low income children, Medicaid cost containment, the future of the Medicare program, and the quality of services under managed care.

EXPANDING COVERAGE FOR CHILDREN

Ten million American children are uninsured today. Although the new balanced budget legislation should provide coverage for approximately 2 million of those children, the number of uninsured children may rise again as welfare reform moves women from public assistance to low paying jobs. Many of those jobs come without health benefits, while others provide coverage to dependents only if the worker pays part or all of the cost—at premiums that are unaffordable for low income, working families.³

Failure to provide universal health insurance coverage for children has serious consequences.⁴ Children without health insurance are less

The percentage of children without health insurance is rising.



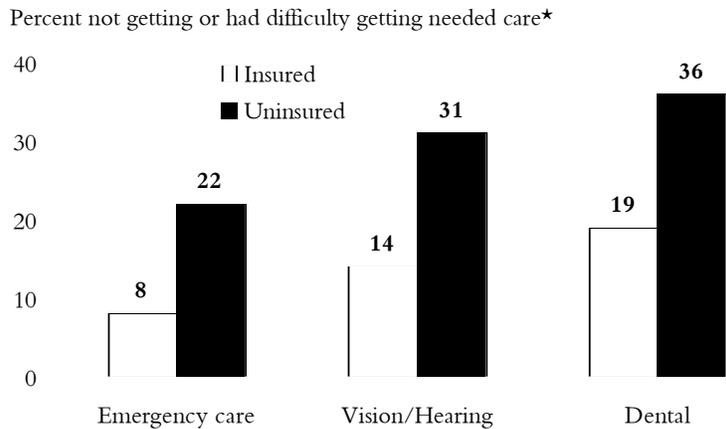
Source: Employee Benefit Research Institute, 1997.

likely to be immunized and less likely to receive care promptly, factors that can have lifelong repercussions: an untreated ear infection, for example, can lead to permanent hearing loss. Uninsured children are also less likely to receive vision, hearing, and dental care and more likely to rely on emergency rooms when care is needed. Research on Medicaid expansions in the 1980s shows that the converse is also true: low income pregnant women and children used the preventive services that were made available to them, yielding significant reductions in infant and child mortality and other improvements.⁵ In addition, new evidence on the physical, emotional, and cognitive development of young children indicates parental practices such as breastfeeding, reading aloud, and appropriate discipline may be even more important than was previously recognized—and that those practices can be supported effectively through a strong alliance between parent and physician.

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The 1997 balanced budget agreement is the first major expansion of publicly funded health insurance coverage in this decade. The act provides \$23 billion in block grants to states over the five years from 1998 to 2002

Without insurance, low income children may miss out on important services.



*Children in families with incomes under 250% poverty.
Source: *Kaiser/Commonwealth Five-State Low Income Survey, 1995-96.*

to expand health insurance coverage for children in families with incomes up to 200 percent of the federal poverty line. The Congressional Budget Office estimates that 2 million previously uninsured children, plus an additional 1.4 million currently insured children, will be covered under the program.

Under the terms of the block grants, states will have considerable flexibility to design their own approaches, subject to minimum standards on benefits and maximum required family contributions to premiums and cost-sharing. Some states may choose to expand Medicaid eligibility, while others may use the federal funds to establish a separate program for children. Those with subsidized child health insurance programs already in place—such as Florida, Pennsylvania, and New York—may decide to augment their existing plans. States are required to match federal funding, but at a rate lower than the current Medicaid formula: an average of 31 percent of total funding will come from states under the new program, compared with 45 percent under Medicaid. In addition, changes to Medicaid give states the option of guaranteeing children’s coverage for

12 months regardless of changes in family income and of expediting Medicaid enrollment for children served by Head Start, subsidized child care, and the federal Women, Infants, and Children (WIC) nutrition program.

Yet, as important as the new coverage is, it still leaves significant gaps. The new program does not guarantee coverage to all low income children, nor could it pay for such coverage under currently authorized funding. The inevitable result in most states will be restrictions on who is covered: for example, after available funds are spent, some states may freeze enrollment and establish waiting lists.

The new children's health insurance program will be closely watched to see how many uninsured children are covered and to monitor the effectiveness of particular state approaches and strategies. One area that demands experimentation, for example, is identifying families and informing them of their eligibility. Today, as many as 3 million children may be missing out on Medicaid coverage because their families are unaware of the program or do not realize they are eligible. Under the new program, up to 10 percent of funds may be spent for outreach, administration, or other services to improve child health. Other forms of outreach—such as home visits by trained nurses or child development specialists, parenting education, child development information, and other supports—could also help low income mothers and fathers foster the healthy development of their young children.

COVERING LOW INCOME FAMILIES THROUGH MEDICAID

Medicaid remains the most important source of health insurance coverage for poor and near-poor Americans. About 18 million adults and 17 million children are currently insured under the program, although eligibility is limited by stringent restrictions on income, assets, and other categorical requirements. Without Medicaid, as many as half of all low income adults would be uninsured.

Medicaid also plays an essential role in funding supplementary coverage for approximately 6 million poor and near-poor Medicare beneficiaries.⁶ That coverage picks up Medicare premiums and cost-sharing, while

also paying for half of all nursing home care. Thus, although Medicaid is primarily seen as a provider of health insurance to pregnant women and children, 70 percent of all program outlays go toward elderly and disabled beneficiaries.

Medicaid spending rose rapidly between 1989 and 1995, creating considerable strains on federal and state budgets—and on relations between the federal and state governments. Governors and state legislatures resented “mandated” expansions of coverage, whose costs they were expected to match. States responded by exploiting loopholes in the Medicaid program to shift a greater share of the costs onto the federal government. Hospitals and other providers paid “provider taxes” or “donations” to finance the state share of Medicaid; in turn, states increased payment rates to providers or dispensed funds generously under a provision established to assist hospitals serving disproportionate shares of low income and uninsured patients. This give-and-take approach moderated costs for states but increased total spending by the federal government.

Tensions in the federal/state Medicaid partnership produced federal legislation limiting state use of provider taxes and disproportionate share payments to hospitals. Governors, in response, pressed to have Medicaid funding converted to block grants, which would carry few restrictions regarding who or what would be covered; it was even proposed that states be given the discretion simply to make direct payments to health care providers rather than providing insurance or managed care coverage to a defined set of beneficiaries. That proposal was opposed by the President and rejected by the last Congress. The President’s counter-proposal, setting limits on federal per capita spending under Medicaid, was strongly opposed by the governors and excluded from the 1997 balanced budget legislation.

A marked slowdown in Medicaid outlay growth in 1996—only 3.3 percent, compared with an annual average of 22.4 percent over the period from 1988 to 1992 and 9.5 percent from 1992 to 1995—relieved some of the pressure to restructure Medicaid.⁷ Even so, the balanced budget agreement of 1997 gives states the right to move Medicaid beneficiaries into managed care without a federal waiver approval process or oversight.

States also gained greater discretion in setting payment rates for hospitals and nursing homes. These changes raise concerns about quality of care across states and accountability in the use of federal funds. The repeal of the Boren Amendment, which requires states to pay hospitals and nursing homes a rate sufficient to cover reasonable costs, could lead to a deterioration in quality of care, especially in nursing homes. Relaxing quality standards and extending eligibility for federal matching funds to additional types of long-term care facilities could lead to poorer care in unregulated residential facilities.⁸

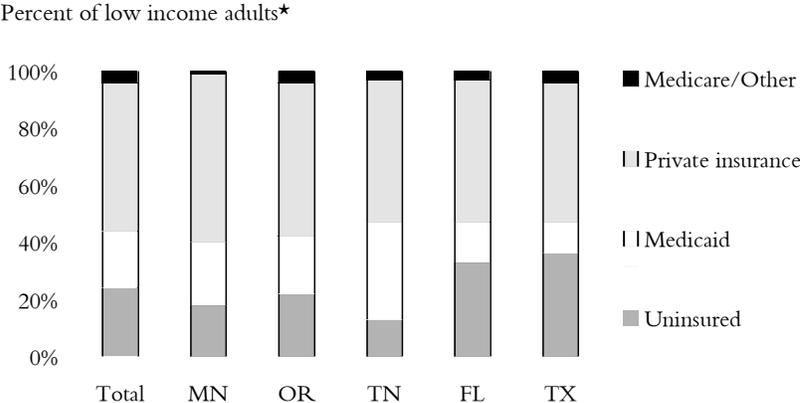
Yet the move toward greater flexibility for states should also produce new opportunities to test strategies and compare results, a process that has already begun. Over the past few years, for example, some states have experimented with moving Medicaid beneficiaries into managed care, while others have developed models to extend coverage to additional groups of low income residents.

Managed care has emerged as a popular cost-saving strategy in state Medicaid programs. Under previous regulations, some states sought and obtained federal waivers to require beneficiaries to enroll in managed care plans, then moved aggressively to make the shift. As a result, 40 percent of Medicaid beneficiaries are now in managed care plans, compared with under 10 percent in 1991. Patients' experiences with Medicaid managed care have been mixed. Studies sponsored by the Kaiser/Commonwealth Low Income Coverage and Access Project have found that Medicaid beneficiaries enrolled in managed care are more likely to report problems with access to care than are those enrolled in traditional Medicaid. Case studies in selected states also show that making managed care work well for Medicaid beneficiaries with complex problems requires considerable effort and stringent quality standards, safeguards that often lose out in the race for quick savings.⁹

A few states have received federal waivers to expand coverage to additional low income adults, with compelling results.¹⁰ A recent Kaiser/Commonwealth survey shows that in Tennessee—which extended Medicaid eligibility to all low income adults by implementing a sliding scale premium—only 13 percent of adults with incomes below 250 percent

of poverty are uninsured, compared with a high of 36 percent in Texas, which follows traditional eligibility rules. Relatively low rates also prevail in Minnesota and Oregon, which tested their own mechanisms to extend Medicaid eligibility.

Medicaid is an important source of health insurance for low income adults.



*Incomes under 250% poverty
 Source: Kaiser/Commonwealth Five-State Low Income Survey, 1995-96.

Further incremental improvements may be possible in states that seek to provide health insurance coverage to more of their low income residents. At the same time, the new legislation will undoubtedly set off a new round of cost-saving activity, with uncertain results.

SECURING THE FUTURE OF THE MEDICARE PROGRAM

Medicare is a costly program but a successful one: in the past 30 years, it has achieved its objectives of assuring access to needed health care for older Americans and protecting them and their children against the catastrophic financial burdens of medical expenses. Today, the program finances health insurance for 38 million elderly and disabled Americans. Medicare beneficiaries give the program high marks, and voters of all ages indicate their strong support. Medicare has also contributed to

progress in medical technology and innovation through its higher payments to teaching hospitals and through direct payments for such procedures as hip replacements, cataract surgery, and treatment of coronary artery disease. Life expectancy for elderly Americans has increased by three years since the start of Medicare and is among the best in the world.

Medicare benefits, however, have not kept pace with the times. Premiums and cost-sharing have increased faster than general inflation. Medicare does not cover prescription drugs, unlike 95 percent of employer health plans, and provides only limited long-term care services. As a result, Medicare beneficiaries overall spend 21 percent of their incomes out-of-pocket on health care—30 percent for low income beneficiaries—and most purchase some type of supplementary coverage or receive it through their employers.¹¹

The balanced budget act of 1997 made major changes in the Medicare program. Medicare expenditures had been projected to grow at 9 percent annually over the next five years, reflecting the rising cost of health care, a growing elderly population, and particularly rapid growth in services such as home health care that are not constrained by prospective payment methods. The new legislation slows the annual growth rate to approximately 6 percent—down significantly but still outpacing the annual 5 percent projected growth in the payroll tax and general tax revenues that finance Medicare. The changes also fail to address the rapid growth in numbers of Medicare beneficiaries that will occur beginning in about 2010, as the baby boom generation reaches retirement.¹²

Many experts and policy officials look to managed care as a way of controlling rising Medicare outlays; although growth has not been as dramatic as in the Medicaid program, managed care has been used increasingly in the program in recent years. Enrollment in HMOs stands at 14 percent of Medicare beneficiaries today, up from 6 percent in 1990. The Congressional Budget Office estimates that 35 percent of Medicare beneficiaries will be enrolled in managed care plans by the year 2007.

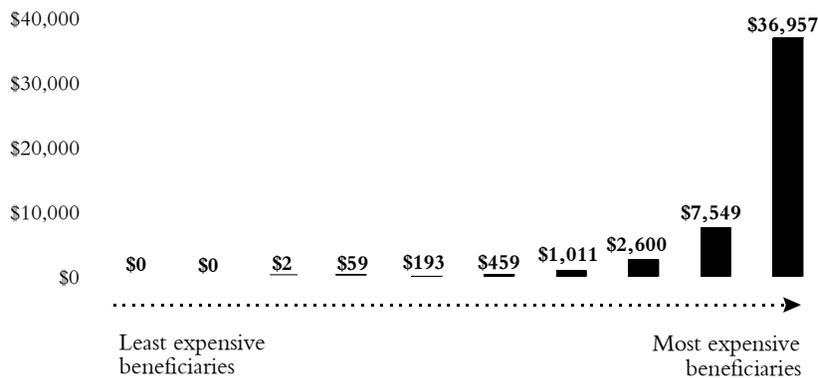
Yet optimism about the potential of managed care may be misplaced, since flaws in the method for paying HMOs have served to increase rather than reduce total program costs. Medicare pays HMOs a monthly

rate based on 95 percent of average program costs in the local market; no variations are made to accommodate the health status or projected health expenditures of the beneficiary.¹³ If HMOs enroll Medicare beneficiaries with better-than-average health, those plans will be overpaid by Medicare, resulting in profits to HMOs and, by law, supplemental benefits or reduced premiums to enrollees. A Fund-supported summary of the available evidence estimates that each enrollment in managed care costs Medicare 6 percent more than if the beneficiary had remained in traditional Medicare coverage.¹⁴ The overpayment is a direct result of generally healthier-than-average beneficiaries choosing to join HMOs, while those with more severe health problems stay in the traditional program.

The basic difficulty arises from the highly skewed nature of health expenditures by Medicare beneficiaries in the traditional program, on which average costs are based. Ten percent of Medicare beneficiaries account for 75 percent of Medicare outlays—an average of \$37,000 per person in 1996. By contrast, the 20 percent of Medicare beneficiaries at the healthiest end of the spectrum cost the Medicare program nothing.

The most expensive 10 percent of beneficiaries cost the Medicare program an average of \$37,000 each per year.

Average Medicare spending per beneficiary by decile



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Source: Marilyn Moon, *Restructuring Medicare's Cost Sharing*, The Commonwealth Fund, December 1996.

Although the average Medicare cost per beneficiary was \$4,750 in 1996, 80 percent of beneficiaries are below this “average.” If plans can avoid beneficiaries with cancer, heart disease, Alzheimer’s disease, Parkinson’s disease, diabetes, stroke, and pulmonary disease, they can do quite well. Fund-supported analysis has found, however, that even within these chronic condition categories, some patients are far less expensive than others.¹⁵

Several protections against HMOs selecting better risks are in place. Medicare beneficiaries can enroll in any qualified HMO at any time, and a plan cannot exclude a beneficiary because of a health problem or pre-existing condition. Yet these protections are clearly not sufficient. Favorable risk selection does occur, either because plans concentrate marketing efforts on healthier beneficiaries or because sicker beneficiaries are less willing to give up their current physicians and source of coverage. Beneficiaries are also showing a tendency to leave HMO plans when they become seriously or chronically ill and return to traditional Medicare. One study found that managed care enrollees spent only 63 percent as much on health care as the average Medicare beneficiary prior to enrolling in managed care, while disenrollees had health care costs 60 percent above average.¹⁶ There are also concerns about how well HMOs can care for patients who are seriously ill. One major study published last year found that chronically ill elderly patients enrolled in managed care experienced worse health outcomes over a four-year period than those covered by traditional Medicare.¹⁷

Despite these warning signs and the success of Medicare in ensuring high-quality services, the recently enacted balanced budget act will result in major changes to the program. Most important, the Medicare savings are immense—\$115 billion over five years, the lion’s share of total net savings from all federal programs of \$127 billion. This represents the most significant savings in the history of Medicare and will require substantial belt-tightening on the part of hospitals and other health care providers. The new law achieves these savings through six major provisions:

- tighter provider payment rates and prospective payment methods to home health providers, skilled nursing facilities, and hospital outpatient departments

- a reformed managed care payment methodology, designed to address geographic disparities, reduce overpayments, and slow increases in payment rates over time
- expanded choices among competing health plans, including provider-sponsored organizations and preferred provider organizations, and comparative information for beneficiaries through an annual open enrollment process
- new preventive health benefits, including annual mammography, triennial Pap smears, and clinical breast examinations not subject to the Part B deductible; annual prostate exams; colorectal screenings; coverage for diabetes self-management; and higher payments for preventive vaccinations
- a shift of about one-third of home health benefits from Part A of Medicare, financed by the payroll tax, to Part B, financed by a combination of general revenues (75 percent) and beneficiary premiums (25 percent), for the purpose of extending the solvency of the Part A Trust Fund for at least 10 years
- higher beneficiary premiums with modest new premium subsidies for low income Medicare beneficiaries

Of particular concern is the expansion of the variety of plans open to Medicare beneficiaries.¹⁸ These include medical savings accounts, private fee-for-service plans, and newer types such as provider-sponsored organizations (PSOs), Medicare-only plans established by a hospital or group of physicians. The Medicare program will manage an annual open enrollment process to help beneficiaries make informed choices across this array of plans.

Monitoring the changes set in motion by these new options will be important. New quality standards and the open enrollment process may help assure that beneficiaries make wise choices and receive needed care, yet current safeguards may not be adequate to assure the careful application of those standards or to prevent adverse risk selection.¹⁹ New plans

will expand before payment reforms are implemented to tie payment to health risks of enrolled beneficiaries.²⁰ If sicker beneficiaries remain in basic Medicare, as expected, supplemental Medigap premiums may spiral, making this needed coverage less affordable to beneficiaries.²¹ Risk selection may also introduce financial volatility into plans, leading to financial failure for those getting an above-average share of poor risks.

Two major proposals were eliminated during the legislative process, one to raise the age of eligibility to 67 and the other to base Part B premiums on beneficiary income. Eligibility was left at age 65 after it became clear that the change would provoke a dramatic increase in the number of uninsured older adults.²² Support for an income-related premium was broader, but the proposal became mired by concerns that the additional revenues generated would not offset the cost of administering an income test.²³ Both these issues are likely to be revisited as a newly established Medicare commission weighs options for assuring the program's long-run fiscal solvency.

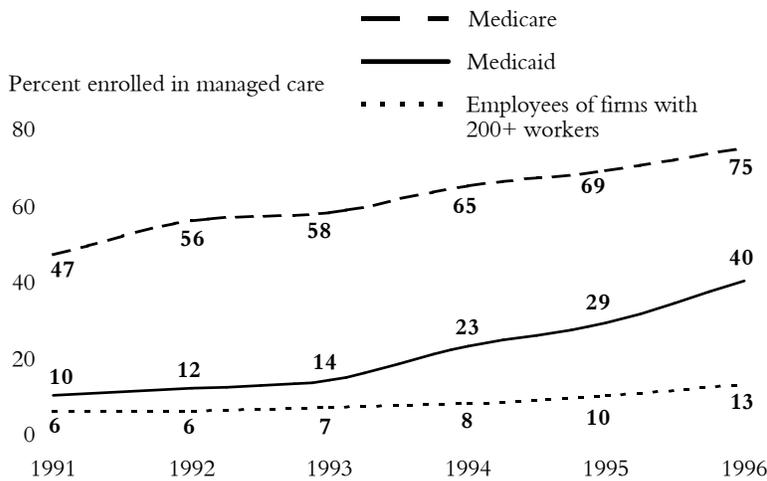
ENSURING QUALITY UNDER MANAGED CARE

Although public programs such as Medicare and Medicaid are in the early phases of a shift toward managed care enrollment, employer-sponsored plans have been moving strongly in that direction over the past decade. In 1991, slightly less than half of workers in firms with 200 or more employees were enrolled in managed care; by 1996, three-fourths were enrolled.

Evidence on the effectiveness of managed care in controlling health care costs is still uncertain. Most of the initial savings seem to be coming from price discounts in independent practice association (IPA) and network model HMOs and from some one-time reductions in hospital use.

Employers' premiums have been fairly stable, especially during the 1993-95 period, when private health expenditures per capita grew at an annual rate of 3.5 percent. Whether this stability is a product of managed care, concern about the Clinton health plan, or an insurance cycle with a delayed response to wage and price stability in the economy as a whole is unclear, nor is it clear whether this stability is a permanent or a temporary phenomenon.

The dramatic growth in managed care enrollment in the 1990s has been led by private-sector coverage.

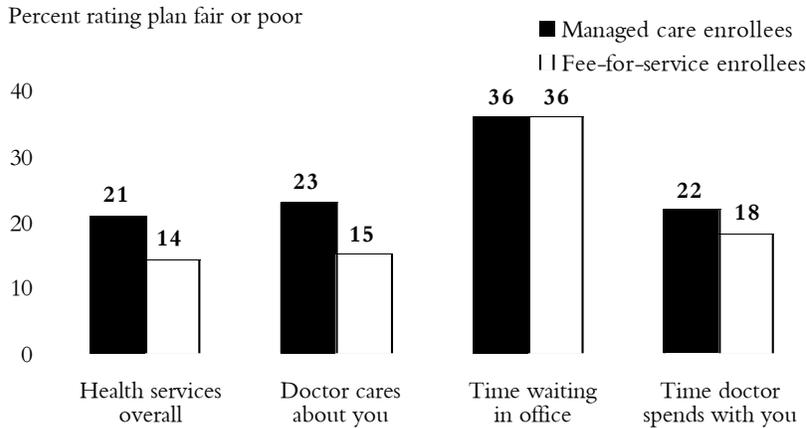


Sources: *Health Care Financing Review*, 1996 and 1997; KPMG Peat Marwick, 1996.

What is clear is that a backlash is occurring, both among patients and within the health sector, focusing on issues of quality. Concern about 24-hour discharges of new mothers was instrumental in passage of federal legislation mandating 48-hour coverage for maternity care. Thirty-four states have enacted legislation ranging from “anti-gag rules” that protect physicians’ right to tell patients what medical treatment they recommend to provisions that safeguard patients’ right to appeal denials of care.²⁴

The managed care industry remains in a state of flux, making it difficult to assess whether quality problems are potentially widespread or concentrated in a stratum of plans. The Fund’s work has found that the type of plan makes a major difference in patient and physician experiences and satisfaction. Group and staff model HMOs perform better as a class than do IPA or network model plans. Nonprofit plans, in general, perform better than for-profit plans. Although there are undoubtedly important variations within these broad classifications, it is troubling that the plan types typically rated lower by patients and physicians are among the most rapidly growing.

Medicaid patients enrolled in managed care are more dissatisfied with their coverage than are those in the traditional, fee-for-service program.



Source: Kaiser/Commonwealth Five-State Low Income Survey, 1995-96.

Also troubling is a tendency among state Medicaid programs to move aggressively to enroll beneficiaries in managed care plans, although quality standards and monitoring are still rudimentary. Evidence from a Fund-supported study found that only 15 percent of Medicaid managed care plans are “mainstream” HMOs that participate in the Health Plan Employer Data and Information Set (HEDIS) quality measurement system of the National Committee for Quality Assurance (NCQA).²⁵ As the market matures, it is possible that patients will make more informed choices based on quality, and that employers and government purchasers will hold plans accountable for meeting performance targets and quality standards. Best practice information may eventually help plans adopt more clinically sensitive and appropriate guidelines. To date, however, the market can fairly be characterized as premium driven, not quality driven.

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Medicare is leading the way in establishing quality standards by requiring all participating HMOs to submit HEDIS data. A survey of Medicare beneficiaries in each participating plan should provide the first comparative data on patient experiences with Medicare managed care

plans. Even so, additional steps—such as requiring accreditation of plans—may be needed.²⁶

The extent to which Congress will become actively engaged in regulating the quality of managed care plans for all Americans, regardless of funding source, remains unclear. The President has established an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which will issue a series of reports on ensuring health care quality. At present, several possible actions stand out as potentially useful safeguards of quality in managed care:

- require that managed care plans be accredited by NCQA or a comparable private agency
- require plans to provide uniform audited quality information, including cooperation in patient surveys and making such information publicly available
- establish rules to protect patients' rights, such as the right to external appeal or to emergency care
- protect physicians' rights to advocate on behalf of patients for appropriate medical treatment
- promulgate fair marketing practices

There seems to be little impetus to reverse the trend toward managed care. With public programs such as Medicare and Medicaid beginning to move more assertively toward managed care, the need to assess how well managed care works for those who are sickest and most at risk will heighten. Quality performance should be monitored continuously to see if standards and consumer information are shaping managed care in desirable directions.

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IMPLICATIONS FOR THE FUND AND CHALLENGES AHEAD

The Fund has endeavored to provide timely, relevant, and scientifically sound information to those in a position to address issues on the national health policy agenda. For example, its work has highlighted the risks and

problems faced by low income uninsured families and helped make them priority candidates for assistance in an incremental approach to expanding health insurance coverage. The Fund's documentation of access problems undercuts the popular myth that those who genuinely need health care are able to obtain it and has delineated the benefits that can be expected from improved coverage of low income children and parents. Case studies and surveys are monitoring state experiences with Medicaid managed care and feeding information back on the lessons to be learned from those diverse experiences.

The Fund's work on Medicare has clarified and quantified the plight of low income Medicare beneficiaries and their out-of-pocket costs, thus contributing to the discussion of needed expansions in Medicare premium subsidies through Medicaid. Fund-supported analyses have grappled with solutions to the "skimming" of favorable health risks under Medicare managed care, including new methods of paying managed care plans, improved beneficiary information on choices and plan performance, and an open enrollment process that guarantees beneficiaries' right to disenroll from poor quality plans and reenroll in traditional Medicare with MediGap supplemental coverage.

The Picker/Commonwealth Program on Health Care Quality and Managed Care has attempted to move the field of quality measurement and monitoring forward with projects aimed at developing quality measures and monitoring systems, encouraging patient-centered components of quality assurance systems, and urging the incorporation of improved quality standards into managed care accreditation systems and into federal and state standards for managed care plans participating in Medicare and Medicaid. These and future projects will position the Fund to make important contributions to this complex issue.

18 Over the next five years, the Fund anticipates making programmatic outlays of more than \$100 million. Exploring options for spending this sum wisely to improve the health and productivity of Americans, assuring that the Fund's work contributes to social progress, and providing the information needed to effect change are the challenges ahead. The Fund is engaging leading experts and partnering with organizations sharing a

common concern to assure access to quality health care for all as the nation enters the 21st century. Our overriding priority in the coming years will be to provide the information essential to weighing practical solutions for assuring that all Americans needing health care are able to obtain it.

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