Providing Insights that Contribute to Better Health Policy

CENTER for STUDYING HEALTH SYSTEM CHANGE

Tracking Insights Trends Health Polic

Annual Report 1999

SEARCH

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A PERSPECTIVE ON HEALTH SYSTEM CHANGE IN 1999

By Paul B. Ginsburg, President, HSC

Each year, I take this opportunity to reflect back on key developments in health care financing and delivery. When I look back at 1999, what strikes me most is not the particular actions taken, but the extent to which important ideas were introduced and discussions initiated in both public policy arenas and the private sector. It was a year of laying the groundwork for potentially important future developments. The events of the past year remind me that despite the dramatic speedup in information dissemination and policy proposal activity, the time needed to develop ideas, and reach the consensus to implement them at the national level, is still measured in years rather than months.

Four issues have focused significant thinking and debate during 1999.

PUBLIC POLICY TO EXPAND INSURANCE COVERAGE

In 1999, this issue received unprecedented attention in the presidential primary campaigns, and new ideas were introduced into the debate from across the political spectrum.

RESPONSE TO RAPIDLY INCREASING EXPENDITURES FOR PRESCRIPTION DRUGS

Employers and health plans are developing mechanisms aimed at consumers so they will economize in this area. Increasing evidence of Medicare beneficiaries' difficulty in paying for prescription drugs launched a substantial discussion about how the federal government should design and administer such a benefit.

RETHINKING MANAGED CARE

Last year saw the continuing backlash against many elements of managed care and the beginning of what may be a significant withdrawal of direct controls on physician behavior. This rethinking of managed care is in response to consumer preferences and to the threat and reality of patient protection legislation at both state and federal levels.

PATIENT SAFETY

The Institute of Medicine's report on patient safety has provided impetus to public policy makers, large employers and those who lead health care delivery systems to find ways to reduce errors.[1]

EXPANDING INSURANCE COVERAGE

MANY INVOLVED IN HEALTH POLICY and private organizations are worried about increasing rates of uninsured persons in the face of an unprecedented strong economy. From 1993 to 1998, the number of nonelderly, uninsured persons increased by 13 percent.[2] At the same time, the proportion of employed adults increased by 9 percent, and per capita income increased by 13 percent, after adjustment for inflation.

Historically, an improving economy has led to more people obtaining coverage. HSC research examining the rate at which employees enroll in plans offered by employers highlighted a worrisome problem. Twenty percent of those uninsured in 1997 failed to enroll in offered plans, mostly due to cost.[3] Large premium increases predicted for 2000 and 2001, and likely continuation of a trend of employers paying a smaller portion of the premium for family coverage, may exacerbate the coverage problem.

Interest in policies to address the problem of the uninsured was strong in 1999. Many influential trade and professional associations developed proposals and attempted informally to find common ground. A January 2000 conference showed a remarkable degree of congruence among organizations representing distinct stakeholders.[4] This level of consensus reflects an emphasis on political feasibility and stakeholders having similar assessments of what could be achieved in the near term.

Interest in the issue in the current presidential campaign is substantial. Proposals to expand insurance coverage turned out to be the leading issue in the Democratic primaries. Vice President Gore developed a plan involving expansions of Medicaid and the State Children's Health Insurance Program (SCHIP) that emphasized targeting public funds toward low-income, uninsured persons. Parents with low incomes would also be eligible to obtain coverage for themselves through SCHIP. HSC research has revealed an important decline in coverage for low-income parents between 1997 and 1999.[5] Governor Bush's discussion of health care has mentioned a tax credit for low-income workers without access to employment-based coverage and expansion of SCHIP.

Senator Bradley also introduced a number of new ideas into the debate. His tax credit proposal for those with low incomes involved obtaining health insurance through the Federal Employees Health Benefits Program. Those eligible for Medicaid would also obtain private coverage through this mechanism. Parents, with government assistance for those who are low income, would be mandated to obtain coverage for their children.

There appears to be agreement that the federal government should take incremental steps to help low-income persons obtain insurance. There is conflict, however, over

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CHARLES N. KAHN III,
HEALTH INSURANCE
ASSOCIATION OF AMERICA

"The presidential candidates' proposals to expand health coverage reflect differences in philosophy, but both sides realize it will take new public policy to shrink the rolls of the uninsured. Interestingly, a real common ground is developing among industry and consumer groups about next steps that may help push the policy makers to solutions in 2001.

Perspectives

JOSEPH NEWHOUSE,
HARVARD UNIVERSITY

"Medicare pharmaceutical coverage was barely on the radar screen three years ago, but has quickly shot to the top of the policy agenda. Aside from the usual challenges of enacting an expansion to a public program, this one includes myriad complex implementation issues that must be confronted."

whether the principal tool should be expansions of federal and state financing programs or tax subsidies to individuals to purchase private insurance. But with government programs using private plans to provide coverage (e.g., Medicaid managed care), and tax credit proposals needing reforms of the individual insurance market to succeed, divergent ideas may converge when working through the nuts and bolts of mechanisms to blend the roles of the public and private sectors.

RESPONSE TO GROWTH IN PRESCRIPTION DRUG SPENDING

UNTIL RECENTLY, PRESCRIPTION DRUG benefits did not get a lot of attention from most health care decision makers. This began to change in the mid-1990s, when pharmaceutical spending began increasing at double-digit rates. Contributing to the spending growth are the accelerated rate at which new drugs are introduced, consumers enjoying more extensive drug coverage with their shift to managed care and direct-to-consumer advertising.

With this rapid growth coinciding with historically low rates of increase in spending on hospital and physician services, prescription drugs have reached a high enough percentage of private health insurance spending to get the attention of employers and health plans. Pharmaceutical costs accounted for 13 percent of the cost of a typical health insurance policy in 1998, compared to 8 percent in 1994.[6]

Employers and health plans have sought to manage pharmaceutical spending through contracting with pharmacy benefit management companies (PBMs). These companies negotiate price discounts from manufacturers and pharmacies and implement both closed formularies and tiered copayments to induce consumers and physicians to favor those products considered most effective and to enhance their ability to gain discounts. For specific chronic conditions, such as diabetes, PBMs are working to educate physicians about effective prescribing.

It is striking how rapidly these management initiatives are taking hold. According to a recent Watson Wyatt Worldwide survey of large employers, 47 percent are planning to move to a three-tier copayment system for drugs, and 46 percent are planning to increase the use of formularies.[7] This is likely to increase employers' or plans' pricing leverage with pharmaceutical manufacturers. But employees may not react favorably to changes that increase their cost sharing, especially if there are many situations in which a drug has clinical advantages for certain patients but carries the highest copayment. If experience is a guide, employer use of these cost-cutting approaches could fall short of expectations.

In contrast to rapidly implementing efforts to increase patient cost

sharing, less has been done to influence physicians to prescribe more cost-effective drugs. For example, efforts to control utilization—or increase utilization to manage chronic disease more effectively—have focused on one disease at a time, and financial incentives for providers are rarely used. Indeed, physician organizations that seek to be at risk for hospital services as well as professional services have been resisting pharmaceutical spending risk, presumably because important trends in spending are outside their control. Overall, the development of mechanisms to control the growth of pharmaceutical spending resembles the evolution of managed care techniques to control spending on hospital and physician services, but it began much later.

Rising prescription drug spending has increased policy makers' concern about affordability for Medicare beneficiaries, which—in contrast to private insurers—did not add these benefits years ago. This has led to proposals for a Medicare prescription drug benefit by President Clinton and both Republican and bipartisan groups in the Congress. (An irony of the difficulty of predicting the policy agenda is that four years ago it appeared that widespread Medicare prescription drug coverage would result from the rapid growth of Medicare+Choice plans.)

At this point, the differences among Medicare drug benefit proposals are substantial. Some are fundamental policy differences that have been debated for decades—for example, should the benefit be limited to those with low incomes or should it be for all seniors? But other issues are new to the policy community, such as how to use pharmacy benefit managers in the program.[8]

Perhaps the most contentious issue concerns the prices paid for pharmaceuticals. With the pharmaceutical industry making clear its adamant opposition to price controls, all of the major proposals have disavowed such a mechanism. Some have proposed a "most favored nation" mechanism similar to that used in Medicaid. Many have proposed the use of PBMs in the traditional Medicare program to negotiate prices with pharmacies and manufacturers and to provide information services to improve drug use effectiveness. If the Medicare program were to replicate the experience of employers and private health plans, the program would contract with a single PBM for each region.

But the private sector experience might be difficult to replicate in Medicare. With Medicare beneficiaries unable to obtain coverage elsewhere, would policy makers tolerate a situation in which a significant minority of individual beneficiaries was unhappy with the practices of a PBM that was meeting its contractual objectives? Would it be acceptable to include a well-known drug in the formulary in one region, but not in another? Would a single PBM representing so much prescription volume be a de facto implementer of price controls?

These issues are leading some to develop models of multiple PBMs serving Medicare in each region. But these models will be more difficult to design and implement because of the absence of private sector experience to draw on. Employers and health plans do not give enrollees a choice of PBM.[9] Also, such a model would ask those beneficiaries who have elected not to enroll in a Medicare+Choice plan to choose a managed care entity for their pharmaceutical coverage. Resolving the mechanism by which prices are set will take time, but the budgetary implications are large enough to require this to be accomplished before a benefit can be enacted.

THE CHANGING FACE OF MANAGED CARE

In previous essays, I have described the backlash against managed care and the public policy and market responses to that backlash. Some

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MARGARET O'KANE,
NATIONAL COMMITTEE
FOR QUALITY ASSURANCE

"The public does not perceive the relationship between its message to the managed care industry to pull back on management and the problems of health care affordability that will result."

of the results have included broader choice of providers in managed care plans, more opportunities for direct access to specialists and better mechanisms for patients to appeal decisions that deny care.

I do not see any lessening of the backlash. If anything, the debate over patients' bill of rights legislation and state attorney general and class action lawsuits against health plans have intensified the public's negative perceptions of managed care. The return of high rates of premium increase—the earliest employer surveys are showing increases for 2000 in the 9 to 10 percent range—was expected to have made the public rethink the importance of managed care's role in containing costs. But extremely tight labor markets have made employers reluctant to return to more stringent forms of managed care. And prosperity and budget surpluses may be deferring public concerns about rising health care costs.

What we see instead are instances in which managed care plans have pulled back from the mechanisms they had been pursuing to contain costs. Two recent events may turn out to be seminal, signaling an important change in the way health plans manage care.

In November 1999, United Healthcare announced that it would no longer require physicians to obtain authorization to hospitalize a patient, perform or order a major procedure or refer a patient to a specialist. Although physicians are still required to report these actions, United Healthcare would no longer second guess doctors' decisions about appropriate care.[10]

United Healthcare provided as a rationale for the move the results of its analysis showing that authorization had not been saving money. It claimed that such a high percentage of authorizations were ultimately approved, although often not until appeals by physicians, that the cost of administering the process was exceeding the savings from those services that were ultimately denied. Not explicitly raised were deterrent effects of authorization requirements or the cost of ill will of physicians and their patients whose treatment had been denied. Some critics assert that the announcement exaggerated the magnitude of the change—either to achieve a marketing advantage over competitors or to influence policy makers working on patients' bill of rights legislation.

United Healthcare indicated that some of the administrative resources no longer required for authorization would go to expanded care coordination activities. Among the activities are readmission prevention, disease management and pharmacy management. The company also intends to expand its already significant physician profiling activities to provide additional feedback to physicians on how their practice patterns compare to national norms, and to provide reminders for required patient services. Some anticipate that physician profiling will be used to drop from the network physicians who perform or order a lot of services. Even

dropping only a small minority of physicians could influence many other practitioners. Indeed, such a policy could turn out to be even more unpopular among physicians than authorization requirements.

Other managed care companies reacted to United Healthcare's initiative by indicating their intent to move in a similar direction. To the degree that this policy is attractive to physicians and consumers, it could give United an advantage over its competitors. This competitive element could accelerate the degree to which others follow.

A second development was the recent settlement with Aetna Health Plans of a lawsuit brought by the attorney general of Texas against a number of health plans operating in the state. The suit sought to bar the plans from using a range of managed care practices. As part of the settlement, Aetna promised to expand its definition of medical necessity and give treating physicians more authority to determine necessary care. It also promised to stop requiring primary care physicians with small numbers of Aetna patients to be paid on the basis of capitation.

The latter provision may reflect health plans' declining interest in capitation. Use of capitation to pay for physician and other services has not been growing to the degree that had been widely expected three or four years ago.[11] Physician enthusiasm for capitation has fallen in response to disappointing financial returns. Health plan enthusiasm has also waned because of the problems many provider organizations have had in managing in this environment.

These developments, combined with others such as more direct access to specialists and broader networks, suggest that managed care may be evolving toward a model that places less emphasis on traditional methods of cost control. Although health plans claim that cost containment is not being sacrificed, the fact that they are reacting to strong pressure to reduce controls from both their customers and policy makers means this is unlikely to be the case.

What is uncertain is whether this period of less management will be brief or lengthy, and the shape of the next generation of strategies to control costs. The magnitude of cost increases experienced over the next two years will play a major role in shaping the outcome. Should costs rise more rapidly, employers will have to decide whether to attempt to shift them to employees or return to tighter management. Policy makers' perspectives are likely to be influenced by increases in outlays for Medicare and Medicaid and in the number of uninsured due to the affordability of coverage.

Information technology is likely to play a more important role in the next generation of managed care, but the nature of that role is still unclear. One possible direction is the care coordination that United Healthcare is promoting, which makes use of information technology to support physicians' practicing more effectively. But past disappointments in progress toward this goal lead me to be skeptical about its near-term promise. Information technology may facilitate the use of consumer choice as a cost-containment strategy. For example, the Internet could facilitate offering those enrolled in a health plan different networks of providers at different prices. Assessing the changing face of managed care is a priority in HSC's third round of site visits (see page 13), which began in June 2000.

MEDICAL ERRORS AND PATIENT SAFETY

In November 1999, the Institute of Medicine (IOM) released its study, *To Err Is Human: Building a Safer Health System*,[12] to enormous media attention. The study highlighted the degree to which medical errors injured patients and

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BRUCE BRADLEY,
GENERAL MOTORS
CORPORATION

"Reducing medical errors is a big-tent issue if the emphasis can be put on examining the root causes of mistakes and making appropriate changes, as opposed to placing blame."

explained that most were not the result of carelessness by individual practitioners but resulted from shortcomings in systems. It also made a series of specific recommendations designed to stimulate the creation of safety systems within health care organizations. These included identifying and learning from errors on the basis of mandatory reporting (with public disclosure) of adverse events that result in death or serious harm and voluntary reporting (with confidentiality protected) of other errors. The study drew heavily on the experience of other industries—for example, airlines, in which system approaches have been highly successful in promoting safety.

Many were struck by the degree to which this report gained the attention of the general public, in contrast to earlier major reports on quality of care, such as the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.[13] This aspect of quality may be easier for the public to grasp. Whatever the reason, federal and state policy makers immediately seized the opportunity provided by the widespread public response and introduced legislation to reduce medical errors.

Like other issues that suddenly become visible to the public, experts have long recognized the significance of medical errors as a source of injury. Over the past several years, leading employers have been concerned about data on errors and have launched initiatives to prod health service providers, usually hospitals, to develop systems to prevent errors—for example, automated order entry systems.[14]

The question to contemplate is whether the IOM report and the reaction to it will lead to more rapid progress in this area. The report may spur large employers to do more and make more credible their attempts to get providers to develop systems to reduce errors. While some employers comprise an important enough share of the privately insured in a community to be in a position to influence hospitals, most do not. Employers are likely to have more leverage on this issue working through health plans. But recent consumer demands for broad choice of providers have diminished the clout of employers or health plans to push hospitals to invest in systems to reduce medical errors.

Policy makers have a great deal of potential to encourage or discourage efforts to increase patient safety. Funding research on ways to reduce errors would likely be a positive step, and it appears to have consensus support.

Reporting requirements are more complex. Public disclosure of errors would increase provider incentives to invest in systems to reduce errors, but it might also encourage more covering up. The IOM sought a balance between disclosure of the most severe errors (emphasizing accountability) and protecting the confidentiality of reports of less severe errors

(emphasizing the opportunities to learn from them). For the latter—the approach used in the airline industry—to work, providers would need strong assurances that the information could not be used as evidence in malpractice suits. A key task for the policy process is to understand this tradeoff: individuals not having access to information on fault, which could be used to sue for compensation for minor injuries, in order to enhance patient safety. Such information could be used for the common good, in that it could be analyzed to figure out how to reduce overall errors.

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REFLECTING ON THESE FOUR developments in 1999, it is striking how slowly some changes proceed. Those involved in public expansions of coverage are attempting only incremental change and fighting against a tide of rising premiums and a trend toward less employer support of family coverage. Responses to rising prescription drug spending are limited by a lack of experience with the use of relevant cost control mechanisms. Despite pressure to decrease the use of many traditional managed care tools, the next generation of care management tools is still being formulated and is years behind what had been predicted. And in efforts to draw on successes in other industries in improving safety, difficult tradeoffs that seem to be unique to health care must be carefully addressed.

My sense is that recent advances in communication will help both public and private decision makers to start implementing those changes that have garnered consensus more rapidly than they would have in the past. But health care is complex, and given all the powerful entrenched interests, progress is likely to be slow.

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5 Peter J. Cunningham and Michael H. Park. "Recent Trends in Children's Health Insurance Coverage: No Gains for Low-Income Children." *Issue Brief*, No. 29. Center for Studying Health System Change (April 2000).

6 Paul B. Ginsburg. "Tracking Health Care Costs: Long-Predicted Upturn Appears." *Issue Brief*, No. 23. Center for Studying Health System Change (November 1999).

7 "Putting Employees in Charge: A Survey of Employers, Health Care Providers and Health Plans." *Fifth Annual Survey Report on Purchasing Value in Health Care 2000*. Watson Wyatt Worldwide (2000).

8 The analysis and debate that began in 1999 (see *Health Affairs*, March/April 2000, for an excellent group of papers) will increase to a substantial degree our understanding of how to effectively provide a benefit.

9 For an excellent discussion of these design issues, see Haiden A. Huskamp et al., "The Medicare Prescription Drug Benefit: How Will the Game Be Played?" *Health Affairs* (March/April 2000).

10 This change would not affect determinations of whether a service is covered under the plan.

11 Cara Lesser and Paul B. Ginsburg. "Update on the Nation's Health Care System: Results from Tracking Change in 12 Communities." Presented at the HSC conference, Update on the Nation's Health Care System: Results from Tracking in 12 Communities. Washington, DC (November 16, 1999).

12 Kohn et al. (1999).

13 "Quality First: Better Health Care for All Americans." Washington, DC: U.S. Government Printing Office (1999).

14 "White Paper on Value-based Purchasing" (unpublished manuscript). Leapfrog Group (January 25, 2000).

IN PREPARING THIS ESSAY, I BENEFITED FROM HELPFUL COMMENTS FROM BRUCE BRADLEY, JANET CORRIGAN, JACK EBELER, ANN GREINER, JOE NEWHOUSE, CHIP KAHN, PETER KEMPER, DAVID MUNDEL AND PEGGY O'KANE.

HSC CELEBRATES ITS FIVE-YEAR ANNIVERSARY

When the Center for Studying Health System Change was launched five years ago, health care decision makers were recovering from intense and often bruising battles that were a part of failed reform efforts writ large. These efforts to reform the nation's health system took place during a tumultuous time for health care, with some arguing that the large-scale policy proposals even served to catalyze more rapid change. Leaders at The Robert Wood Johnson Foundation (RWJF) saw a need to monitor such changes as they unfolded and, more important, to assess how they were affecting consumers in different communities. And so, the Foundation conceived the Center for Studying Health System Change (HSC) and selected Mathematica, Inc., to create it (see page 28).

INSIGHTS FOR DECISION MAKERS

SINCE THAT TIME, THE COUNTRY has continued to experience major organizational changes in the health system with varying effects on consumers. The most dramatic of these—the wave of hospital consolidations, the backlash against managed care and physician practice management companies going bankrupt—have captured headlines. Other changes are more subtle, but important nevertheless, such as the broadening of provider networks or the loosening of gatekeeper requirements.

HSC is at the core of a comprehensive effort, funded by RWJF and known as Health Tracking, that includes a network of research organizations that are all systematically examining shifts in the nation's health care system and assessing what they mean for the country and for individuals at the community level. HSC's research—which is based largely on national, biennial surveys and visits to a dozen communities every other year—has focused on how organizational change is affecting cost, quality, access and coverage.

Studies by other collaborating groups that share the HSC research design include an effort to assess clinical quality of care, an examination of how market changes and public policies affect access to substance abuse and mental health services and a study of how physician organizations are managing care. In addition, a study of employment-based health insurance is ongoing (see page 16, HSC at the Core of a Research Network).

Given the common framework, HSC staff and researchers from this network of projects will be able to provide insights into what is happening over time to health care delivery and financing in the communities that each of them is studying simultaneously, laying out a rich national picture of our evolving health system and assessing whether quality and access to care is improving or declining, among other issues.

The data from these studies—which are made available to the public—and the analyses that come from them provide context for decision makers contemplating key policy issues, including how to expand insurance coverage, whether managed care patient protections are necessary and how to incorporate the best attributes of private coverage into public programs, among others.

TREND ANALYSES RELEASED

IN THE LAST YEAR, HSC RELEASED numerous studies using the first round of data and began releasing trend analyses examining changes between 1997 and 1999 based on findings from the Community Tracking Study (CTS), HSC's core research effort (see page 12). This effort involves surveys of households, physicians and employers across the country, with much of the sample concentrated in 60 nationally representative communities. HSC researchers also go on site to interview health care leaders in 12 of these 60 communities, which are representative of the nation.

The Community Tracking Study

The Community Tracking Study is national in scope, but is focused on the community level, where health care is organized and delivered. The study consists of national surveys every other year of those involved in or affected by changes in the health system—namely households, physicians and employers—as well as visits to 12 communities. The surveys, conducted by telephone, are concentrated in 60 communities and have a panel of respondents who are carried over from the previous round for tracking purposes. The third round of site visits began this June, and the third round of the surveys in August.

- HOUSEHOLD SURVEY. Sixty thousand individuals in 33,000 families comprise the Household Survey, which focuses on assessing whether consumer access to the health care system is improving or declining over time, nationally and at the community level. Particular areas of inquiry include access, satisfaction, use of services and insurance coverage. Information about health status and sociodemographic characteristics is also collected. An Insurance Followback Survey of the plans that household respondents are in is conducted to enhance information reliability, particularly as it relates to plan type and attributes—e.g., degree of plan management. Mathematica Policy Research, Inc. (MPR), conducts the Household Survey and the Followback Survey for HSC.

- PHYSICIAN SURVEY. Twelve thousand practicing physicians across the country provide perspective on how health care delivery is changing. Physicians respond to a series of questions about whether they are able to provide needed services for patients, how they are compensated and what effect various care management strategies have on their practices, as well as questions about their practice arrangements. The Gallup Organization conducts the Physician Survey for HSC.

- EMPLOYER SURVEY. Twenty-two thousand public and private employers are interviewed to understand how they are shaping the health system nationally and locally. These employers, which span size and industry sector, are asked questions about the choice of plans they offer, how much their employees contribute to paying for their coverage, whether they participate in a purchasing alliance and whether they provide quality information to their employees. HSC collaborates with RAND on the Employer Survey, which was last conducted in 1997 and will not be fielded this year.

- SITE VISITS. Researchers examine the forces affecting health care organizations and how they are responding by interviewing 40 to 60 health care leaders in 12 sites: Boston, Mass; Cleveland, Ohio; Greenville, S.C.; Indianapolis, Ind.; Lansing, Mich; Little Rock, Ark; Miami, Fla; Northern New Jersey; Orange County, Calif; Phoenix, Ariz; Seattle, Wash.; and Syracuse, N.Y. HSC conducts and manages the site visits, with involvement of outside researchers.

Among the analyses published in the last year is a study focusing on who declines to enroll in employer-sponsored coverage, which found that 20 percent of the uninsured had access to such coverage. This information was used by a variety of groups developing proposals to incrementally expand insurance to low-income families. The study was picked up by newspapers and trade publications across the country and cited in a Jane Bryant Quinn *Washington Post* column that discussed the various coverage proposals being promoted by presidential candidates.

Research published in the *New England Journal of Medicine*—showing that one in four primary care physicians is concerned about the care he or she is expected to provide to sicker patients without referral to specialists—was of keen interest to medical societies, health plans and the national news media.

Finally, the release of a series of analyses comparing health maintenance organizations (HMOs) to other types of plans on key dimensions drew more than 200 policy makers to a meeting where a panel of experts debated the implications of the research. The panel included Linda Bilheimer, RWJF; Janet Corrigan, Institute of Medicine; Robert Reischauer, Urban Institute; and John Rother, AARP.

Notable trend studies released in the last year include one focusing on changes in children's insurance coverage and another examining the amount of plan choice that families have. HSC's study of children's coverage gave policy makers their first sense of what is happening with low-income children's coverage since the implementation of SCHIP. The study found no net change in low-income children's coverage between 1997 and 1999, but significant shifts in where children obtain such coverage, as well as a decline in coverage for low-income parents. The analysis of plan choice showed a modest increase in choice for families between 1997 and 1999. Details of this study were featured in opposing editorials in *USA Today* and contributed to patient protection deliberations in Congress.

HSC staff is finalizing the instruments for the third round of surveys, which will be fielded starting this summer. While much will remain the same to allow for tracking, new questions will shed light on current and emerging issues, such as unmet needs for prescription drugs and specialty care, physicians' perceptions of the impact of consumer information on their practices and the use and perceived impact on physician encounters of drug-related direct-to-consumer advertising.

THIRD ROUND OF SITE VISITS BEGINS

THE INTERVIEWS THAT SITE VISIT researchers conduct in 12 communities reveal the strategies local organizations are pursuing and their motivations, how local norms and culture shape decision making and the effects of national policy on communities, all of which are difficult to discern from survey data.

For example, in the last year, the site visits highlighted five communities—including Lansing, Mich.—that were pursuing managed care programs for the uninsured and examined why they were launched. HSC research published in *JAMA*, showing that the uninsured in

HSC's Public Use Files

More than 300 organizations have used data from the 1996-1997 Household Survey and Physician Survey, which were made available in public use files through HSC's web site in 1998. The various organizations downloading the data include university faculty and students, researchers at think tanks and trade associations and government researchers.

Larry Green and his colleagues at the Washington, D.C.-based Center for Policy Studies in Family Practice and Primary Care are using the Physician Survey public use file to understand what factors—e.g., care management, methods of payment and degree of involvement with managed care—correlate with physician malaise, specifically as it relates to specialty groups. The underlying assumption of this study is that it is in the interest of the public and the overall health system to have satisfied physicians.

Green notes that HSC's physician sampling frame is particularly useful, as is the fact that both HSC surveys can be used together to better understand health policy issues. "We applaud the democratization of this type of data set," he said. "There are other relevant data out there, but we can't get our hands on them because they are proprietary. In contrast, this is a wonderful exemplar of how data can be used for the public good."

In addition, RWJF, through its Changes in Health Care Financing and Organization (HCFO) Program, based at the Academy for Health Services Research and Health Policy (AHSRHP), has funded 17 researchers' use of HSC's public use survey data. A conference, jointly sponsored by HSC and AHSRHP, offered a venue for researchers using these data to present their results to national and state policy makers this past June.

Lansing had considerable difficulty getting access to care, compared with the 11 other HSC communities, in part motivated leaders in Lansing to launch their managed care program for the uninsured.

HSC has been tracking market events that occurred since the last round of site visits and began the third round of site visits this June. HSC's affiliation with Mathematica Policy Research, Inc. (MPR), allows it to draw upon MPR's well-regarded staff to fill out site research teams and to provide additional expertise in qualitative research methods (see page 28).

In addition, **Jon B. Christianson,** University of Minnesota, and **Lawrence D. Brown,** Columbia University, will continue their work on the site visit project and will be joined by **Lawrence Casalino,** University of Chicago, **Aaron Katz,** University of Washington, and **Robert Hurley,** Medical College of Virginia.

Among the topics site visit researchers will focus on for this round are the changing nature of health plans, employer responses to premium increases and the ability of the safety net to care for low-income people who lack coverage. As in the last round, shortly after the site visits HSC will issue Community Reports that describe what has changed in each community over the past two years.

HSC STAFF AND COMMITTEES

WHILE THE CORE STAFF HAS NOT changed, new people have joined HSC in the last year. In addition to MPR staff who are now playing substantive roles in terms of both the survey and site visit work, HSC has added **Jeffrey J. Stoddard,** a physician researcher; **Kelly J. Devers,** who specializes in qualitative and mixed methods research; **J. Lee Hargraves,** an expert on patient satisfaction surveys; and a number of research analysts and research assistants. **Jack Hadley,** professor of health services research at Georgetown University's Institute for Health Care Research and Policy, is at HSC as a visiting scholar for calendar year 2000.

Joy M. Grossman, a researcher who started at HSC shortly after the organization opened its doors, was promoted to associate director and joined the management team, which includes **Paul B. Ginsburg, Peter Kemper** and **Ann C. Greiner.** Grossman's new responsibilities include overseeing HSC data collection activities, managing the organization's research agenda-setting process and contributing to the organization's overall leadership.

HSC also added to its public affairs capacity by hiring a public affairs firm and an outside consultant. These additions enable HSC to better bridge the worlds of policy making and research by regularly providing information about key, ongoing policy topics to HSC staff and acting as a conduit for research ideas from public and private decision makers.

Although HSC's work is used by policy makers across the spectrum, the organization does not take policy positions. It is committed to chronicling key trends in the health care system and their effects on consumers, and then drawing out the range of policy implications.

The organization's advisory committees—comprising both users of research and researchers themselves (see page 29)—assist in making the connection between research and policy by contributing to HSC's research agenda and commenting on HSC publications. Briefings with key groups in advance of the release of analyses have also proved to be a useful way to identify new research topics of policy interest.

HSC at the Core of a Research Network

OVER THE LAST SEVERAL YEARS, RWJF HAS BUILT A network of research organizations studying various facets of the changing health care system at the national and local levels. These research groups are simultaneously examining the Community Tracking Study communities and will be collaborating on future studies.

At RAND, **Beth McGlynn** and **Steve Asch** are leading a team that is analyzing data about the quality of care for people in the 12 HSC site visit communities. To measure clinical quality, researchers are examining medical records and, in select sites, conducting health exams. RAND's second round of data collection is scheduled to begin this summer and will be augmented with a national supplement. Researchers eventually will be able to assess how clinical quality of care is affected by insurance coverage and various market factors over time.

At UCLA/RAND, researchers led by **Kenneth Wells, Audrey Burman** and **Roland Sturm** are examining how public policies and markets are affecting access to substance abuse and mental health services. Two rounds of data have been collected using a sample of individuals from the Household Survey. Also at RAND, **Stephen Long** and **Susan Marquis** are continuing to analyze issues around employment-based health insurance, including examining data from the 60 CTS sites.

The newest collaborative project, which was launched this year and is led by **Stephen Shortell** at the University of California at Berkeley, will study physician organizations across the country, including those located in selected HSC study sites. This project focuses on how physician group practices and independent practice associations are governed and financed, and how they manage care.

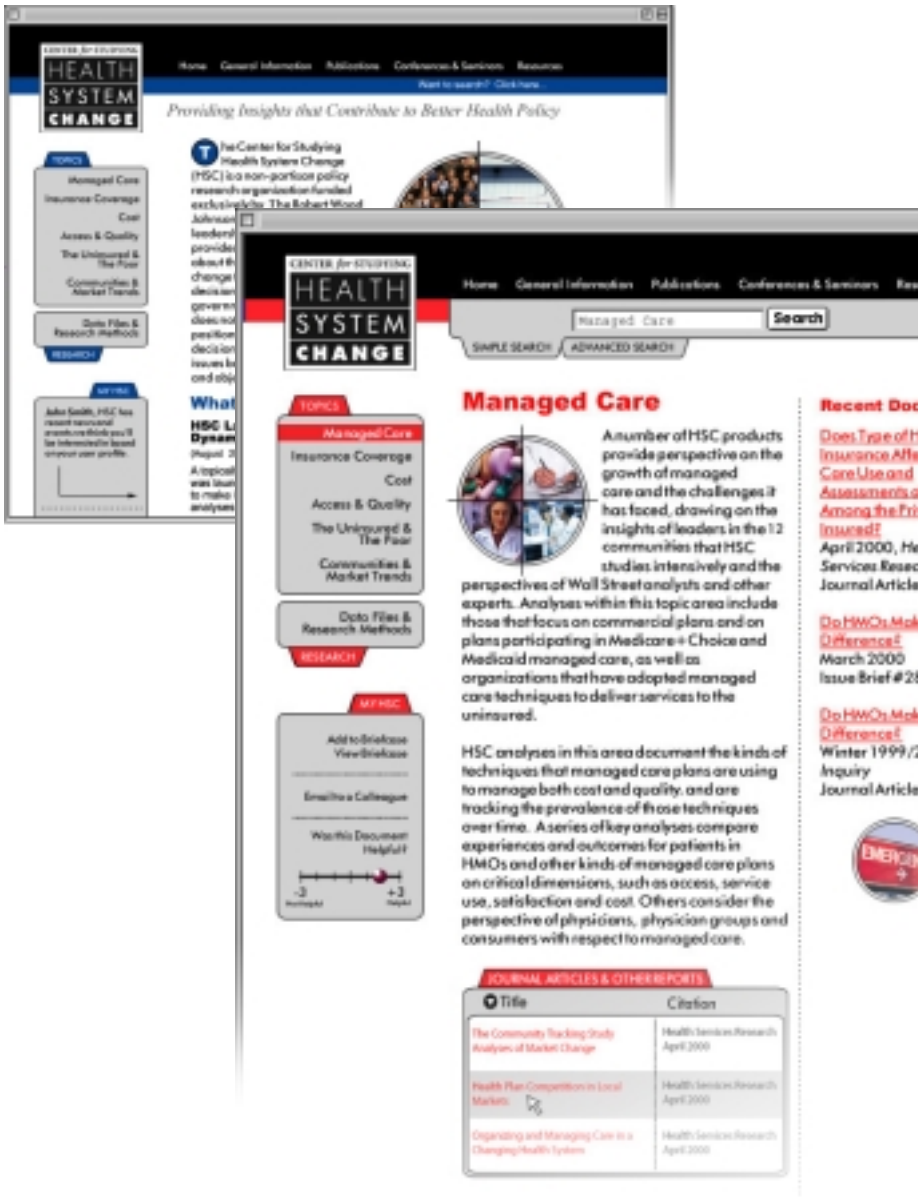
This network of research groups will yield far more than each of its individual parts, as researchers draw on each other's data and expertise to understand what drives change at the community level, how these forces interact and affect various aspects of the system and what the changes mean for the nation's health care system and individual consumers.

A WINDOW ON HSC RESEARCH

HSC has reorganized its web site by six topical areas to make its growing number of analyses more accessible. The site (www.hschange.org) allows users to select from three different perspectives—policy maker, researcher or journalist—and to access bundles of related publications or those related to a relevant policy issue. The site also has a robust search function so that users can find information quickly on any topic.

Visitors to the site can choose to receive e-mail alerts about new analyses in topic areas of interest and can forward those analyses to colleagues.

The following pages provide a window into the new site through the six topical areas.



Health Services Research
Vol. 35, No. 1, Part I, April 2000

HEALTH PLAN COMPETITION IN LOCAL MARKETS

by Joy M. Grossman

Although the competitive threat from national plans is pervasive in 12 communities studied as part of the Community Tracking Study, local plans in most sites continue to retain strong, often dominant positions in historically concentrated markets. According to an analysis by HSC, three strategies to increase market share and market power were used in all sites in response to purchaser pressures for stable premiums and provider choice and the threat of entry of plans: (1) consolidation/geographic expansion; (2) price competition; and (3) product line/segment diversification that focuses on broad networks and open-access products. In most markets, in response to the demand for provider choice, the trend is away from ownership and exclusive arrangements with providers. Although local plans are moving to become full-service regional players, there is uncertainty about the ability of all plans to sustain growth strategies at the expense of margins and organizational stability, and to effectively manage care with broad networks.

This article is based on site visits conducted in 1996 and 1997.

Issue Brief
No. 27, February 2000

WHO HAS A CHOICE OF HEALTH PLANS?

by Sally Trude

Policy makers are concerned that consumers have no voice in the changing health care system. They debate, however, whether the consumers' voice should be heard through regulation or the marketplace. For market forces to work in the consumers' interest, consumers must have a choice of plans. New survey data from HSC suggest that more consumers have a choice of plans than is generally believed, and that the proportion of consumers who have plan choice is increasing. According to HSC's 1998-1999 Household Survey, 64 percent of families have a choice of health plans—two percentage points higher than two years ago. This Issue Brief reports on these and other findings from HSC on consumer choice.

This Issue Brief is based on Household Surveys conducted in 1996-1997 and 1998-1999 and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

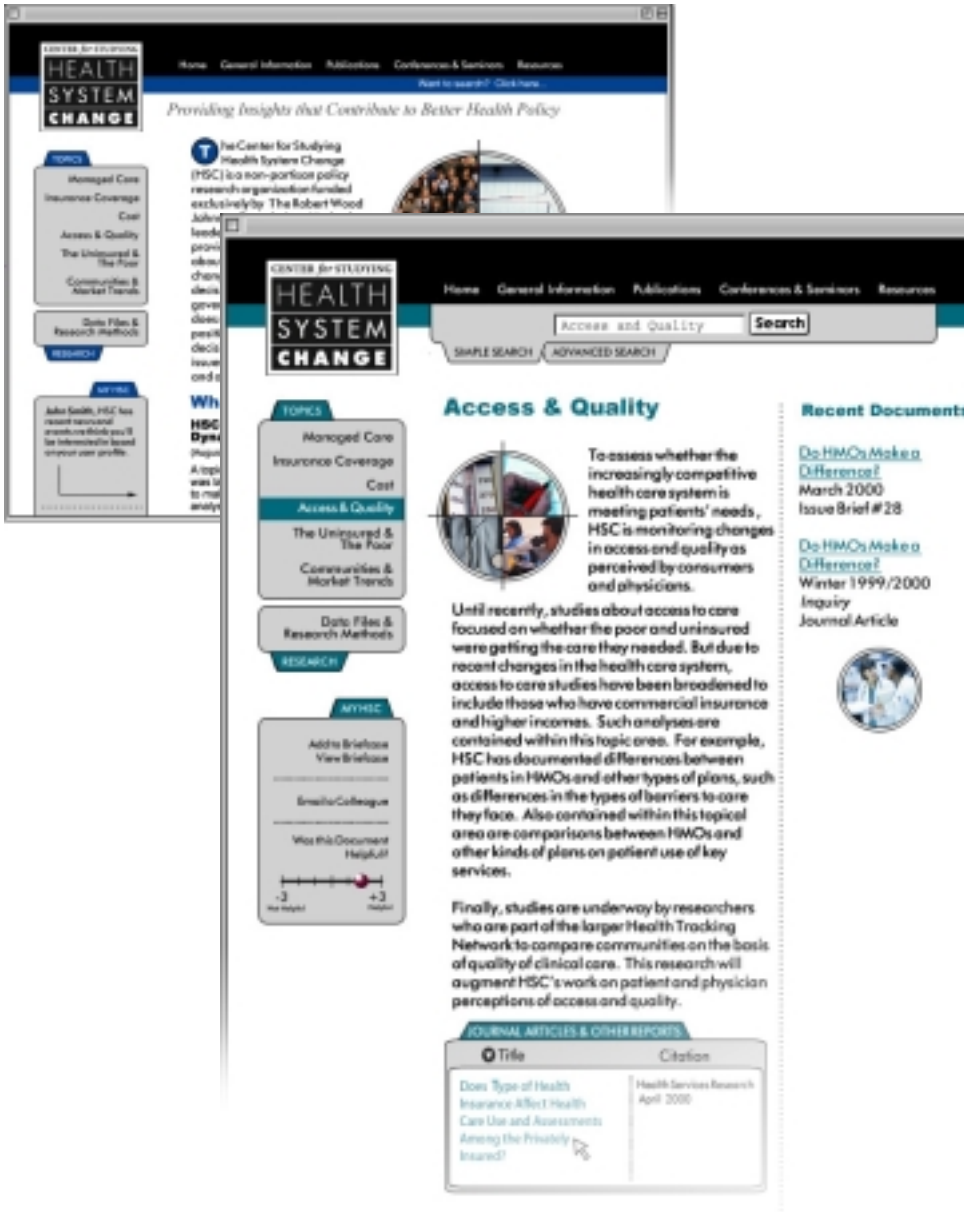
Issue Brief
No. 23, November 1999

TRACKING HEALTH CARE COSTS: LONG-PREDICTED UPTURN APPEARS

by Paul B. Ginsburg

After three years of anticipation, health care cost trends have taken an upward turn. In employment-based insurance, premium increases for 1999 were in the 5 percent range, up from 3 percent for 1998. The rate of increase in underlying costs of private insurance—lagged by one year—also rose by approximately two percentage points. Many had expected a sharper upturn in premium increases than in underlying cost increases. This would have heralded a turn in the insurance underwriting cycle, which has not yet occurred. This Issue Brief tracks trends in the rate of growth of health care costs and the experience with premiums for employment-based health insurance and discusses the impact of these trends on consumers.

This Issue Brief is based on data from the 1999 Kaiser Family Foundation/Hospital Research and Educational Trust Survey of Employer-Based Health Plans, the Milliman & Robertson Health Cost Index, the Hay Benefits Report, the Department of Labor's Consumer Expenditure Survey and Bureau of Labor Statistics.



Health Services Research
Vol. 35, No. 1, Part II, April 2000

DOES TYPE OF HEALTH INSURANCE AFFECT HEALTH CARE USE AND ASSESSMENTS AMONG THE PRIVATELY INSURED?

by James D. Reschovsky, Peter Kemper and Ha T. Tu

The type of insurance people have—not just whether it is managed care but the type of managed care—affects their use of services and their assessments of the care they receive. Based on the Community Tracking Study Insurance Followback Survey, a supplement to the Household Survey, HSC researchers found that as people move from indemnity insurance to more managed care products, use of primary care increases modestly, but use of specialists is reduced. Few differences were found in preventive care, hospital use and surgeries. The likelihood of having unmet or delayed care does not vary by insurance type, but enrollees in more managed products are less likely to cite financial barriers and are more likely to perceive problems in provider access, convenience and organizational factors. Consumer assessments of care—including satisfaction with care and trust in physicians—are generally lower under more managed products, particularly closed-model health maintenance organizations (HMOs).

This article is based on the Community Tracking Study Household Survey conducted in 1996-1997 and the Insurance Followback Survey.

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Issue Brief
No. 22, October 1999

WHO DECLINES EMPLOYER-SPONSORED HEALTH INSURANCE AND REMAINS UNINSURED?

by Peter J. Cunningham, Elizabeth Schaefer and Christopher Hogan

Twenty percent of all uninsured persons are offered health insurance by their employer or a family member's employer, but choose not to enroll in the offered plan(s). Most persons who do not "take up" or enroll in available employer-sponsored coverage cite cost as the main reason. This Issue Brief, based on two surveys conducted as part of the HSC Community Tracking Study, presents new findings on who declines employer-sponsored coverage and is uninsured as a result. Given the importance of cost in an individual's decision whether to enroll in employer-sponsored coverage, policy makers need to consider ways to address the problem identified by this study: low take-up rates among lower-income workers.

This Issue Brief is based on the Household Survey conducted in 1996-1997 and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

Issue Brief
No. 26, January 2000

INSOLVENCY AND CHALLENGES OF REGULATING PROVIDERS THAT BEAR RISK

by Linda R. Brewster, Leslie A. Jackson and Cara S. Lesser

Risk contracting and capitation are two widely used financial mechanisms that give incentives to health care providers to control costs. Risk-bearing arrangements have failed in a number of communities, however. This has shaken local markets, disrupting consumers' access to health care services and triggering losses for physicians and hospitals. It also has raised questions about the adequacy of related regulatory oversight, which holds important implications for local and national policy makers. This Issue Brief examines failed risk-contracting arrangements in two of the 12 communities that HSC tracks intensively—Northern New Jersey and Orange County, Calif.—and describes how state policy makers have responded to protect consumer and provider interests.

This Issue Brief is based on information obtained in site visits conducted in 1998 and 1999.

HSC'S MISSION

The Center for Studying Health System Change's mission is to inform health care decision makers about changes in the health care system at both the local and national levels and the effects of such changes on people. HSC seeks to provide objective, incisive analyses that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

SUPPORTING RWJF'S MISSION

ALONG WITH OTHER GRANTEES, HSC informs the research and programmatic activities at RWJF, helping to support the Foundation's overall mission to improve the health and health care of all Americans. Specifically, HSC's research contributes to understanding what is working well in the American health care system and what is failing, at both the national level and in communities across the country.

In carrying out its mission, the Foundation concentrates its grantmaking support in three broad areas: access to care, substance abuse and chronic care. These are also areas that the network of organizations associated with HSC's Community Tracking Study cover. To accomplish its overall goals, RWJF supports research and evaluation, training and education, program demonstrations and communications.

James Knickman, vice president for evaluation and research, and **Robert Hughes,** vice president, initiated the network of organizations focused on tracking change and nurtured its development over the last five years. Both continue to play a leadership role with respect to the research network. Along with them, **Maureen Michael,** program officer, provides leadership to the project and is responsible for managing the network on a day-to-day basis. **Paul Tarini,** senior communications officer, provides public affairs counsel to the project, and **Rona Henry,** senior financial officer, provides financial oversight. HSC is among the many projects under RWJF's Health Care Group led by **Jack Ebeler,** senior vice president and director, health care group.

HSC STAFF

Paul B. Ginsburg, Ph.D., President
Peter Kemper, Ph.D., Vice President
Joy M. Grossman, Ph.D., Associate Director
Ann C. Greiner, M.C.P., Director of Public Affairs

Peter J. Cunningham, Ph.D., Senior Health Researcher
Jack Hadley, Ph.D., Visiting Scholar
James D. Reschovsky, Ph.D., Senior Health Researcher
Jeffrey J. Stoddard, M.D., Senior Physician Researcher
Sally Trude, Ph.D., Senior Health Researcher

Kelly J. Devers, Ph.D., Health Researcher
J. Lee Hargraves, Ph.D., Health Researcher
Cara S. Lesser, M.P.P., Health Researcher
Ha T. Tu, M.P.A., Health Researcher
Laurie E. Felland, M.S., Health Research Analyst
Leslie A. Jackson, M.H.S., Health Research Analyst
Michael H. Park, J.D., M.P.H., Health Research Analyst
Marie C. Reed, M.H.S., Health Research Analyst
Elizabeth A. Schaefer, M.A., Health Research Analyst
Liza S. Rudell, Health Research Assistant
Gina K. Rule, Public Affairs Specialist
Ashley C. Short, Health Research Assistant
Bradley C. Strunk, Health Research Assistant
Alison K. Vratil, Health Research Assistant

Teresa Armstrong, Manager of Administration
Heather Anne Berry, Research Coordinator
Roland Edwards, Senior Public Affairs Coordinator
Lucille Richardson, Senior Office Assistant
Vernette Roberts, Executive Assistant

SELECTED STAFF BIOGRAPHIES

PAUL B. GINSBURG, PH.D., president, is nationally recognized for his work in health economics and health policy, especially health care market changes and cost trends. He previously served as executive director of the Physician Payment Review Commission and as deputy assistant director of the Congressional Budget Office.

PETER KEMPER, PH.D., vice president, has been principal investigator of the Community Tracking Study since HSC's inception. A commissioner on the Medicare Payment Advisory Commission, he is a nationally recognized expert on care of the elderly and the effects of managed care. He was formerly director of the long-term care division of the Agency for Healthcare Research and Quality (formerly AHCPR) and director of the Madison, Wisc., office of MPR.

JOY M. GROSSMAN, PH.D., associate director, oversees HSC data collection activities and manages the research agenda-setting process. Her research specialties are provider and health plan competition and managed care. She was a health policy analyst at the Prospective Payment Assessment Commission and an investment banker.

ANN C. GREINER, M.C.P., director of public affairs, oversees HSC's

publications, conferences and outreach activities. Previously, she was an assistant vice president at the National Committee for Quality Assurance, directing communications and marketing efforts, and served as a research associate at the Economic Policy Institute.

PETER J. CUNNINGHAM, PH.D., senior health researcher, specializes in access, the uninsured and safety net issues. He was a researcher at the Agency for Healthcare Research and Quality, where he worked on the 1987 National Medical Expenditure Survey.

JACK HADLEY, PH.D., visiting scholar, is a professor of health services research at Georgetown University's Institute for Health Care Research and Policy. He is a past president of the Association for Health Services Research and a former editor of *Inquiry*. His work with HSC focuses on studies of the market for health insurance and of physicians' behavior.

JAMES D. RESCHOVSKY, PH.D., senior health researcher, focuses on health care, insurance and managed care issues. Previously, he held academic positions at Michigan State University and Cornell University, and was research fellow at the Agency for Healthcare Research and Quality.

JEFFREY J. STODDARD, M.D., senior physician researcher, specializes in service delivery, physician and children's health issues. A practicing pediatrician, he previously held a faculty position at the University of Wisconsin Medical School.

SALLY TRUDE, PH.D., senior health researcher, specializes in managed care and physician issues. She was a senior policy analyst for the Physician Payment Review Commission and a health policy analyst at RAND.

KELLY J. DEVERS, PH.D., health researcher, specializes in managed care and provider organization and competition. Her expertise in qualitative and mixed methods research design is critical to HSC's site visit work. Previously, she was a senior research associate at the Agency for Healthcare Research and Quality.

J. LEE HARGRAVES, PH.D., health researcher, specializes in patient and consumer assessments of health care and quality of medical care. He was senior survey scientist at the Picker Institute, where he was an investigator on the Agency for Healthcare Research and Quality's Consumer Assessment of Health Plans project.

CARA S. LESSER, M.P.P., health researcher, directs HSC's site visit work and specializes in market change. She was a senior research associate at the Institute for Health Policy Studies at the University of California, San Francisco.

HA T. TU, M.P.A., health researcher, focuses on service delivery issues. She was an economic consultant to the Center for Health Policy Studies in Columbia, Md., and the Health Care Financing Administration.

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4 "Tracking Recent Changes in Health Coverage for Low-Income Children with the Community Tracking Study, 1996-1997 and 1998-1999," by Peter J. Cunningham and Michael H. Park

JOURNAL ARTICLES BY HSC STAFF AND COLLABORATORS

"Managed Care Backlash: The View from Communities," Paul B. Ginsburg. *Journal of Health Policy, Politics and Law,* Vol. 18, No. 1 (October 1999).

"Changes in the Scope of Care Provided by Primary Care Physicians," Robert St. Peter, Marie Reed, Peter Kemper and David Blumenthal. *New England Journal of Medicine,* Vol. 341, No. 26 (December 23, 1999).

"Do HMOs Make a Difference?" *Inquiry,* Vol. 36, No. 4 (Winter 1999/2000).

- Introduction, James D. Reschovsky and Peter Kemper
- Data and Methods, James D. Reschovsky
- Access to Health Care, James D. Reschovsky
- Use of Health Services, Ha T. Tu, Peter Kemper and Holly J. Wong
- Consumer Assessments of Health Care, Timothy Lake
- Summary and Implications, Peter Kemper and James D. Reschovsky

"Monitoring Market Change: Findings from the Community Tracking Study," *Health Services Research,* Vol. 35, No. 1, Part I (April 2000).

- "The Community Tracking Study Analyses of Market Change: Introduction," Paul B. Ginsburg, Peter Kemper, Raymond Baxter and Linda T. Kohn
- "Health Plan Competition in Local Markets," Joy M. Grossman
- "Organizing and Managing Care in a Changing Health System," Linda T. Kohn

"Does Type of Health Insurance Affect Health Care Use and Assessments Among the Privately Insured?" James D. Reschovsky, Peter Kemper and Ha T. Tu. *Health Services Research,* Vol. 35, No. 1, Part II (April 2000).

"Health Plan Switching: Choice or Circumstance?" Peter J. Cunningham and Linda T. Kohn. *Health Affairs,* Vol. 19, No. 3 (May/June 2000).

HSC AND MPR

SINCE ITS FOUNDING, HSC HAS BEEN affiliated with Mathematica Policy Research, Inc. Both organizations share a strong commitment to producing objective, high-quality policy research and providing sound information for decision makers. MPR, like HSC, is a wholly owned subsidiary of Mathematica, Inc. MPR has conducted some of the most important evaluations of key U.S. public programs and demonstrations. These studies have focused on issues across the lifespan, from children's health and welfare to long-term care for the elderly.

In addition to shared values, both organizations are housed in the same Washington, D.C., location and have a common administrative infrastructure that includes contracting, human resources, accounting/payroll and facilities management. MPR also has offices in Princeton, N.J., Cambridge, Mass., and Columbia, Md.

MPR staff are key contributors to HSC's data collection and analysis work. Specifically, MPR conducts the Community Tracking Study Household Survey and Insurance Followback Survey on behalf of HSC, and oversees management of the Physician Survey. In addition, HSC draws on MPR staff for specialized assistance, including **Frank Potter,** senior statistician, for statistical support, and **Richard Strouse,** vice president, for overall survey management and design support. Finally, MPR is actively participating in HSC's third round of site visits with staff on the site visit teams.

HSC is guided by a board that includes members of Mathematica's board of directors and key MPR staff.

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Researchers Group

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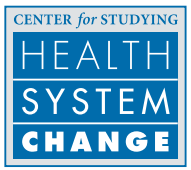

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600 Maryland Avenue SW, Suite 550
Washington, DC 20024-2512
Tel 202.554.7549 Fax 202.484.9258
www.hschange.org

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