Charting *Change*:
A LONGITUDINAL Look *at* the AMERICAN *Health* SYSTEM

CENTER *for* STUDYING
HEALTH
SYSTEM
CHANGE

1997 Annual Report

Health System Change is a nonpartisan research organization funded exclusively by The Robert Wood Johnson Foundation.

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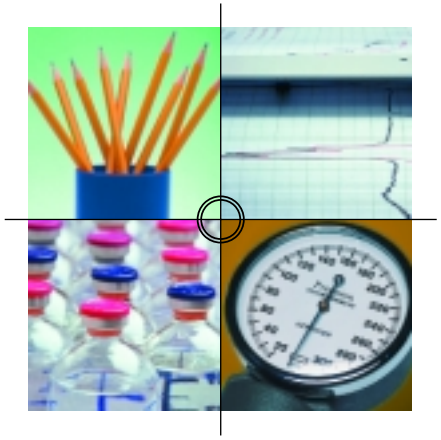

MISSION STATEMENT

Health System Change's (HSC's) mission is to inform 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.

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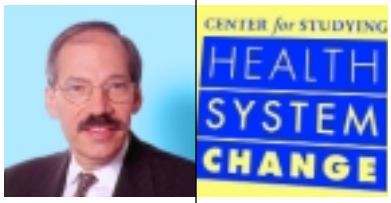

A PERSPECTIVE ON HEALTH SYSTEM CHANGE IN 1997

PAUL B. GINSBURG

HEALTH SYSTEM CHANGE IS COMPRISED OF VISIBLE EVENTS, such as public policy decisions, and less visible ones, such as strategic decisions by health care organizations, decisions by consumers to choose a provider of services and even decisions by physicians to order tests. Tracking the visible events is relatively easy; the challenge is in identifying which ones will prove to be important over time. Tracking the other events is more difficult. Systematic information is more reliable than anecdotes, but such information is often of limited value because it was not designed to assess the most pressing issues. Anecdotes are often misleading, but experts can frequently glean useful information from them.

At Health System Change (HSC), energies over the last three years have been directed to tracking change. In preparing this essay, I also conducted a series of interviews with individuals who have in-depth experience with one or more components of the health care system and are highly regarded for their insights.

The year 1997 was a particularly important one in the evolution of the financing and delivery of health care. Some previous trends continued, but some new directions became apparent for the first time, and some uniquely important events took place.[1]

Two broad developments appear to be most important. The first is the rise of the consumer. Consumers have triggered important changes through their demands for broader provider choice, and the market has responded. In addition, consumer concerns about managed care have led to extensive legislative activity. The second is the reemergence of public policy. In 1995, after the demise of the Clinton health reform proposal, the prevailing view was that public policy would play a much more limited role in health care, with markets having taken over. But in 1997, legislators took important steps with regard to expansion of health insurance coverage and regulation of health care markets.

CONSUMER CHOICE

As consumers have exchanged their traditional insurance coverage for managed care plans at a rapid rate—often at the behest of their employers—they have demanded that managed care provide a broader choice of providers. In HSC site visits conducted back in 1995, managed care executives described their out-of-network options, if they offered any, as a mechanism to help the less venturesome make the transition to "real managed care." But by the time of site visits in late 1996 and early 1997, preferred provider organizations and point of service plans were seen as a permanent part of the landscape. Indeed, both employers and health plans described efforts to broaden networks of providers. In some communities, all of the hospitals and a large proportion of physicians are now included in the networks of many health plans. Budding exclusive relationships between health plans and providers are giving way to a tremendous overlap of networks.

1. The date when new trends begin or are recognized cannot be precise.

"The rush to regulate managed care at the state level has reached fever pitch. According to one HMO representative, in New Jersey alone, 400 bills were introduced in 1997 that would impact HMOs. Never have so many states addressed a single legislative issue at the same time."

–Geraldine Dallek, Georgetown University

This demand for choice has profound implications for the organization of health care delivery. It reverses a drive on the part of health plans to develop closer relationships with a limited network of providers, a development found extensively in other industries. For example, in the auto industry, manufacturers have long-term contracts with selected suppliers, which participate in the design of new models. The notion of health plans supporting providers with clinical information systems and other cutting-edge care management tools seems unlikely in an environment in which each provider must deal with all of the health plans in a given community. Indeed, broad and overlapping networks will push health plans and providers farther apart rather than closer together.

Another implication of broad and overlapping networks is that the effectiveness of health plan care management activities that support physicians rather than second-guess them will likely be diminished because the importance of any single plan in a physician's practice will be less. In situations where provider organizations are capable of assuming and managing risk, this will make global capitation more attractive, shifting the locus of care management from the health plans to provider organizations. But this is dependent on developing mechanisms through which the capitated organization reimburses other providers in the plan's network whom patients are entitled to access.

Broader choice will also have implications for market dynamics. Health plans will be less differentiated to employers. Since a change in health plan will mean less disruption for enrollees' relationships with physicians than in the past, employers will find it easier to change health plans. This, in turn, will increase employers' bargaining power. Similarly, hospitals and organizations with a significant proportion of physicians in a specialty will have more bargaining power with health plans when consumers are demanding broad choice.

MANAGED CARE BACKLASH

Consumers and physicians have been pressing their federal and state elected representatives to restrict some managed care practices. Physicians probably have stronger feelings about these issues and are better organized than consumers, so they are playing a more prominent role. The interests of consumers and physicians are not always the same, especially on issues with significant economic components.

From the consumer perspective, the rapid and often forced shift to managed care is undoubtedly a factor that is driving the backlash. In contrast to the 1980s, when those who enrolled in managed care chose it over a traditional plan, many employees today are offered only a managed care plan.

From the provider perspective, loss of clinical autonomy and threats to income have fueled a strong backlash. In private actions, providers have sought to consolidate to increase their bargaining power with managed care plans and to form organizations capable of assuming the care management functions usually implemented by health plans. Through

"Many medical groups are forming PSOs out of knee-jerk machoism because they are sick and tired of being told what to do by insurers. Unfortunately, many such organizations will fail because they don't understand how to manage risk and don't have adequate capital."

–Joseph Davis, Medimetrix

public policy, providers are seeking to limit managed care plans' scope of authority over care delivery and to regulate their contractual relationships with providers.

At the federal level, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry has moved the discussion forward in an orderly manner by developing a "consumer bill of rights" that reflects a consensus among its members. I believe that adoption of these rights by the federal government in its role as a purchaser, and by a number of leading employers, is likely to lead to rapid implementation, whether or not these protections are mandated through legislation. Congress will now deal with the more contentious issues, such as the ability of patients to sue ERISA-protected health plans for damages and whether to require outside experts to review appeals. Concerns about the cost implications of specific provisions have been more prominent than objections to government's playing more of a role. States have jumped into consumer protection faster, with 17 states having enacted such legislation in 1997.

PROVIDER CONSOLIDATION

The pace of hospital consolidation declined in 1997 after years of increases. *Modern Healthcare* data show an 18 percent decline in the number of hospitals involved in merger and acquisition activity;[2] the investigation of Columbia/HCA is a key factor behind this. Not only did Columbia sharply curtail its acquisitions in the second half of the year, but this likely affected acquisitions where Columbia was not directly involved. HSC researchers were frequently told of acquisitions of hospitals thought to be targets of Columbia that were pursued primarily to keep the for-profit giant out of the market, and of hospitals entering into mergers to prepare to compete more effectively with Columbia.

In contrast, physician consolidation is continuing. HSC's survey of 12,000 physicians showed that in 1997, only 41 percent of physicians were practicing in one- or two-physician practices. Group practices continue to be formed, and physicians continue to sell practices to hospital systems or to physician practice management companies.

In contrast to a few years ago, when most attention was paid to organizing primary care delivery, great attention is also being paid now to specialty care. I see this as reflecting an evolution of managed care to approach the portion of the care spectrum that is the most expensive and that requires more sophistication to manage effectively. Physician practice management companies (PPMCs) are being formed that work with only a single specialty. Some health plans are deemphasizing capitation of primary care physicians and instead paying specialists on a capitated or per episode basis.

Hospitals and physicians pushed very hard for legislation favorable to provider service organizations (PSOs) and had some success in 1997. Their most substantial accomplishments were in public purchasing. Opportunities in

2. "An Off Year for Consolidation: '97 Tally Shows Sharp Cutback in Big Corporate Deals," *Modern Healthcare* (January 12, 1998): 40-48.

"Barriers to moving the quality agenda forward are significant but by no means insurmountable. They include an inadequate scientific evidence base, low-level investment in information systems, absence of risk adjustment payment strategies and many other issues."

–Janet Corrigan, Institute of Medicine

both the Medicare and Medicaid programs to contract on a risk basis have expanded. The period of implementing business strategies is now at hand, and many PSOs face enormous skepticism about their ability to assume and manage risk successfully. Consumer advocates are concerned about the effects of potential PSO insolvencies on patients.

THE UNINSURED

In 1997, Congress enacted the Child Health Insurance Program (CHIP), the largest expansion of health insurance for children since Medicaid was enacted in 1965. CHIP provides states with matching funds to offer health insurance to uninsured children from low-income families; the Congressional Budget Office estimates that 2.3 million uninsured children will be covered. Many governors developed programs in 1997 for legislative action in early 1998; these proposals addressed setting income criteria for eligibility and whether to serve these children through Medicaid programs or through contracts with private insurers. In either case, managed care is the standard vehicle used to deliver CHIP benefits. The higher the income limit that states are contemplating (up to 200 percent of the poverty line or greater in some cases), the more state officials must grapple with issues of equity with those in employment-based plans and the crowd-out problem.

CHIP is by far the most important incremental accomplishment to expand health insurance coverage. Previously, the focus had been on Medicaid eligibility expansions and reforming health insurance markets to improve access to insurance for those in poor health. President Clinton proposed that the next incremental step be an opportunity for the near elderly to buy into Medicare. If enacted, this proposal may have greater importance for future policy direction than for reducing uninsurance among the near elderly because so few of those eligible who are uninsured can afford such a premium.

Policies to reduce the number of insured seem to be moving away from an employment-based insurance solution. Initiatives for low-income persons have involved government purchase or provision of insurance rather than subsidies or mandates to employers. Increasingly, children are covered through a government program, while their parents, if covered at all, obtain that coverage through their employment. Recent proposals for the middle class have emphasized breaking the link between tax subsidies to purchase health insurance and obtaining it through employment.

Turning from public policy to private actions, the news on the nation's goal of reducing the number of persons without health insurance is not good. Research emerged from HSC and others pointing out that although the proportion of employers offering insurance has been increasing, this has been more than offset by a decline in the proportion of employees enrolling. The substantial increase

"Consumer protection is getting lumped in with quality—and this is confusing the policy debate. There is a legitimate function for government to assure basic consumer protections. We should legislate in this area—and then move on to address the separate and important, but devilishly difficult quality issues."

–William Roper, University of North Carolina, Chapel Hill

over the early '90s in the proportion of premiums that employees must pay is undoubtedly a factor, as is the long-term trend of premiums increasing more rapidly than earnings, especially for low-wage employees.

QUALITY

Although confused with consumer protection issues at times, quality problems are also getting increased attention. Evidence of uneven quality of care has been growing, with problems afflicting fee-for-service and managed care to degrees that are roughly comparable. Health care leaders appear to have an increased sense of urgency about addressing problems of inadequate quality.

Although a small number of large employers have led the move to hold health plans and provider organizations more accountable for quality, I believe that future opportunities for progress on this front will come from Medicare and Medicaid. These programs have begun to use their clout as purchasers to promote quality. Given their size, they have the wherewithal to force health plans and providers to collect and report data in a standardized format. These activities, in turn, will benefit private purchasers, many of which care about these issues but have been limited by their ability to get data. Thus, when Medicare and Medicaid require plans to report NCQA's Health Plan Employer Data and Information Set (HEDIS) measures, these measures are reported to employers as well.

MEDICAID MANAGED CARE

States have proceeded very rapidly to enroll Medicaid beneficiaries in risk-based managed care plans; at mid-year, almost half of beneficiaries were enrolled. The Balanced Budget Act of 1997 is expected to accelerate the process by making it easier for states to mandate enrollment and contract with health plans that serve predominantly Medicaid beneficiaries. While Medicaid programs initially concentrated on enrolling mothers and children in health plans, some states began to enroll disabled beneficiaries as well. This is more challenging because few models address issues such as tailoring payment rates to the health care needs of those enrolled (risk adjustment).

The implementation of Medicaid managed care in a community is a signal event, especially for providers who serve predominantly low-income populations, because of the rapidity of movement of large numbers of beneficiaries to a managed care environment. As such, its announcement, even when the start-up is years away, is a stimulus for substantial organizational change in communities.

To date, the Medicaid population has been served both by mainstream health plans that serve the general population and by plans serving predominantly Medicaid beneficiaries. Many of the latter have been sponsored by safety net providers. But some prominent national health plans have become disenchanted with payment rates from the program and have withdrawn. It is not clear yet whether Medicaid

"As the margins of health care organizations shrink, there is less tolerance for system failures and less latitude for mistakes. This may have the unintended consequence of stifling innovation."

–Helen Darling, Watson Wyatt Worldwide

will continue to have ample mainstream plans or whether it will attract only those plans with the lowest costs and plans sponsored by safety net providers—and what the implications for access and quality will be should this happen.

HEALTH CARE COSTS

In 1997, health care cost increases continued to be very low, although not as low as in the previous year. Milliman & Robertson data on provider revenues for the non-Medicare population showed an increase of 3.3 percent per capita, up from 2.1 percent in 1996. Still, the 1997 rate is extremely low by the standards of the last 30 years. Medicare payments per beneficiary increased 5.4 percent in 1997. The KPMG Peat Marwick survey of employers shows that premiums for a private insurance policy obtained by employers increased by 2.1 percent in 1997, compared with 0.5 percent in 1996.

The phenomenon of premium trends continuing to run below trends in underlying costs in 1997 was at odds with earlier predictions in the media. The unexpectedly low rates of premium increase were due to the continuing erosion of health plan market power, plan aggressiveness in attempting to enter new markets and continued low growth in underlying costs.

Pharmaceuticals now comprise the largest component of cost increases. Some of this reflects disease management efforts that generate offsetting savings in hospital and physician costs. But some of it reflects treatment options and long-term prevention strategies not available before. And patients are more knowledgeable about new applications, due in part to direct marketing to consumers. Advances in molecular biology and information technology hold the promise of more rapid development of important new drugs, implying that the pharmaceutical sector could become the dominant source of cost increases in the future.

The media are again predicting sharp increases in premiums. Factors likely to lead to these increases include:

- health plans' difficulty in gaining further provider discounts due to broader networks and provider consolidation;
- limitations of broad networks and out-of-network options with respect to efforts to manage care;
- less aggressiveness on the part of insurers in increasing market share due to low profitability; and
- tight labor markets limiting employer willingness to pursue tight cost controls that may anger employees.

On the other hand, many of the forces that have led to the slowing of cost trends are still in place. Providers and health plans face enormous pressure on prices and are continuing to cut costs. Care management mechanisms, such as disease management, continue to develop. While it is not there yet, the health care system appears to be getting closer to using information systems productively to support delivery of effective care. I believe that the era of moderate cost trends is far from over.

LOOKING AHEAD

It is difficult to forecast developments in health care. Change has not proceeded in an even fashion. Some developments have proved to be short-lived fads while others have had staying power. Most difficult to predict has been public policy, which responds to private developments and, in turn, influences them.

One persistent trend is the incorporation of evidence on effectiveness into medical practice. Over time, care delivery appears to be increasingly influenced by research on outcomes. But the mechanisms through which further strides will be made are very uncertain. The model of close partnerships between provider organizations and health plans is not surviving consumers' demands for broader choice of provider. Risk and responsibility for the delivery of care may shift to provider organizations of varying designs. They, in turn, will be looking to hospital systems, physician practice management companies, information technology vendors and health plans for infrastructure support.

Whether these developments have staying power will depend on how consumers react to the changes. We saw clearly in 1997 that consumers feel strongly about developments in health care financing and delivery and are prepared to act in the marketplace and through public policy. Will consumers be more comfortable signing on with a delivery system than they are with a health plan?

But even greater uncertainty about the future of health care comes from technological change. There is real potential that advances in science and information technology will dramatically change the nature of care and how that care is delivered. Not only will there be additional cures and preventive strategies for disease, but opportunities for life enhancement will become an increasingly important part of medical care. Increasingly, consumers—who have access to the latest innovations across the globe—will accelerate the pace at which medical innovation is incorporated into medical practice.

I am grateful to Janet Corrigan, Geraldine Dallek, Helen Darling, Joseph Davis, Robert Go, Jeff Goldsmith, Uwe Reinhardt, Patricia Riley and William Roper for insightful discussions. Ann Greiner provided valuable comments. None of these individuals is responsible for opinions stated (except those directly attributed to them).

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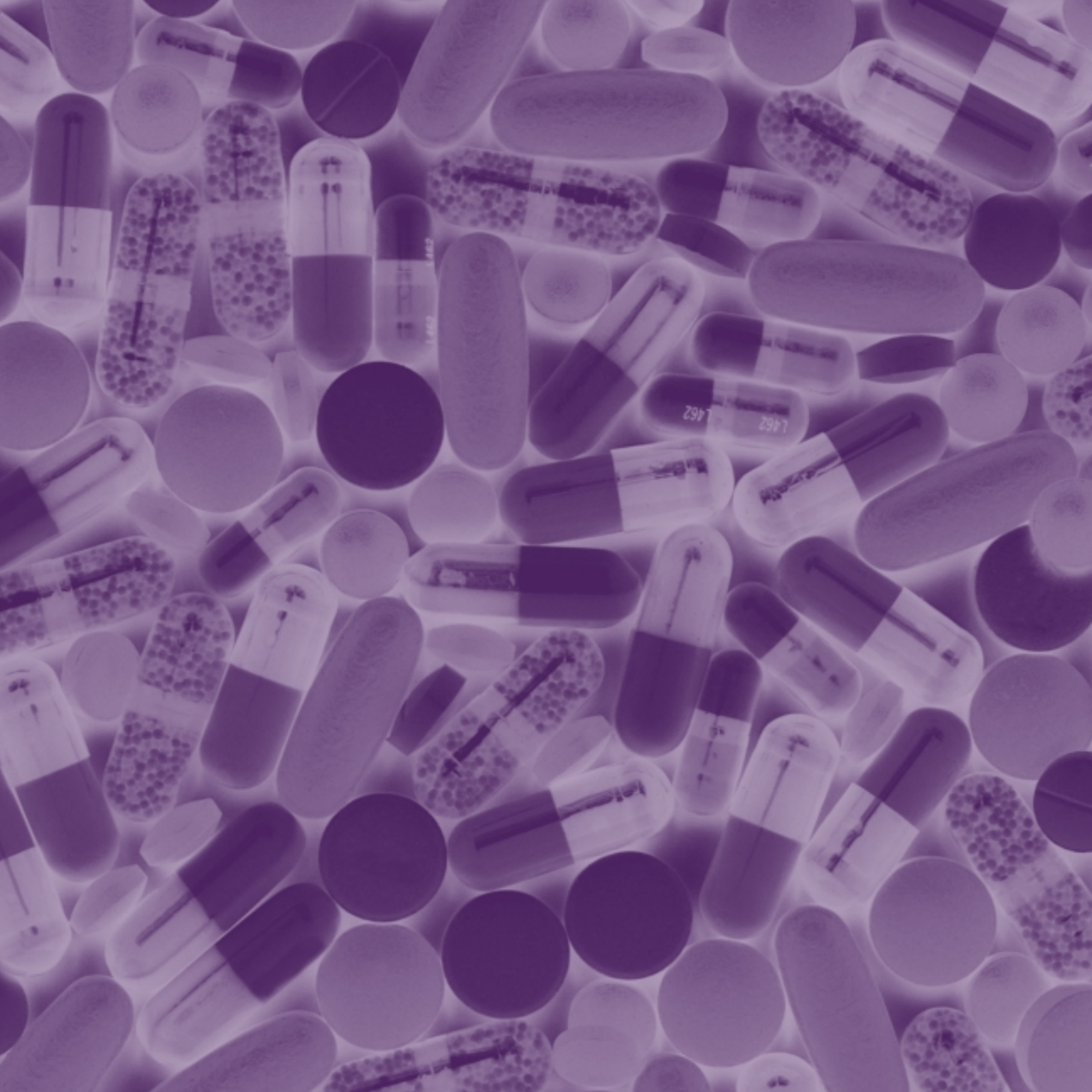
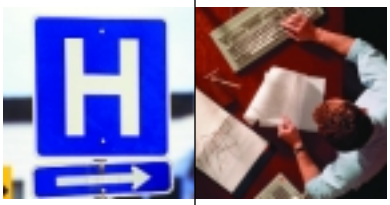




DOCUMENTING CHANGE: THE COMMUNITY TRACKING STUDY

WHY AND HOW HSC TRACKS CHANGES

In virtually every community in the country, the health care system is changing. Some of these changes are dramatic—a for-profit hospital chain buys a number of previously not-for-profit hospitals in a given community. Others are less obvious but nonetheless important—providers expand outreach for diabetics to get preventive care. Yet, until recently, there has been little work done to systematically note, analyze or fully understand these changes.

There are several reasons for this. Many key data are not collected on a longitudinal basis, and what are collected are not made available for analysis in a timely enough manner. Also, there is little systematic collection of data at the community level, where health care is organized and delivered. For example, to track changes in access by the uninsured, we can learn much more by studying people in a sample of communities with different proportions of uninsured and different safety nets than through a national sample.

To fill in these gaps, Health System Change is collecting data from multiple sources to investigate what is happening over time in health care financing and delivery at the community level. Equally important to tracking organizational change, HSC is assessing how these changes affect people.

COMMUNITY-FOCUSED AND LONGITUDINAL RESEARCH

The major effort of HSC is the Community Tracking Study, a longitudinal study that focuses on changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 of them. The first round of surveys and site visits, conducted in 1996 and 1997, provided baseline data—the starting point against which changes documented in subsequent surveys and site visits will be tracked. The second round got underway in June 1998. HSC staff supplement survey and site visit findings with secondary data from government and private-sector sources. The secondary data enable HSC to do national tracking before the second round of surveys is completed and also provide insight to help understand local variations.

Based on their multiple sources of data, HSC's researchers are answering two broad questions that are critical to all health decision makers:

- How is the organization of the health system changing? How are hospitals, health plans, physicians, safety net providers and other provider groups restructuring, and what key forces are driving organizational change?
- How do these changes affect people, and how are insurance coverage, access to care, use of services, health care costs, quality and satisfaction with health care changing over time?

SAMPLE HOUSEHOLD SURVEY QUESTIONS

- *Does your plan require that you sign up with a certain primary care doctor whom you must go to for all of your routine care?*
- *Was there any time during the past 12 months when you did not get medical care you needed?*
- *How would you rate how well your doctor listened to you and explained things in a way you could understand?*
- *If you smoke, did your physician counsel you to stop smoking in the past year?*
- *Do you trust your doctor to put your medical needs above all other considerations when treating your medical problems?*

TARGETING COMMUNITIES THAT REPRESENT THE NATION

HSC randomly selected 60 sites that are representative of large and small metropolitan areas and rural areas in the United States. From the 60 sites that have a population of more than 200,000 people, HSC staff randomly selected 12 communities: Boston, Mass.; Cleveland, Ohio; Greenville, S.C.; Indianapolis, Ind.; Lansing, Mich.; Little Rock, Ark.; Miami, Fla.; Newark, N.J.; Orange County, Calif.; Phoenix, Ariz.; Seattle, Wash.; and Syracuse, N.Y. These 12 communities are studied in more depth than the other 48 sites, with extensive site visits and larger sample sizes for the surveys.

GETTING ANSWERS FROM HOUSEHOLDS, PHYSICIANS AND EMPLOYERS

Much of the information for the Community Tracking Study comes from three surveys that were designed by or in collaboration with HSC staff to determine how health system change is affecting people.

What Americans Have to Say: The Household Survey

Many Americans are concerned about the changes that are taking place in health care. Is access to services getting better or worse over time? Are more people uninsured today in spite of legislative action in Congress and the states to expand insurance coverage?

From July 1996 to July 1997, nearly 60,000 persons in 33,000 families participated in a household telephone survey designed to address these issues. Questions covered health insurance, access, service use, satisfaction with and perceived quality of the care received and general characteristics, such as health status, family income, employment status, age, race and gender. The survey was conducted by Mathematica Policy Research, Inc.

Responses from Practitioners: The Physician Survey

Practicing physicians can provide important insights into how the health care system is changing. For example, has the complexity or

ACROSS AMERICA... Following are key findings about the health system in each of the 12 communities visited by HSC.

severity of the medical conditions that primary care physicians treat without referring patients to specialists increased, decreased or stayed the same during the past two years? What types of organizations are physicians moving into? What kinds of financial incentives do physicians face?

To capture such information, some 12,350 physicians who spend at least 20 hours a week in direct patient care were interviewed by telephone between August 1996 and August 1997. Survey questions covered physician supply and specialty distribution, practice arrangements, physician time allocation, sources of practice revenue and level and determinants of compensation, physicians' perception of their ability to deliver care, career satisfaction, effects of care management strategies and provision of charity care. The survey was conducted by The Gallup Organization.

Purchasers' Perspective: The Employer Survey

Most Americans have access to private health insurance through the workplace, so what employers do plays a particularly critical role in shaping the health care system. To analyze the types of plans offered by employers and the cost of premiums to employers and employees, HSC collaborated with RAND to develop community-level findings from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

From September 1996 to October 1997, more than 22,000 private and public employer establishments were interviewed, primarily by telephone. Survey questions covered a range of issues relating to employer-offered insurance, including the number, types and cost of premiums of health plans offered by employers; the number of employees enrolled in the plans and their share of premiums; and techniques used by employers to control costs, such as participating in purchasing pools and modifying financial incentives to encourage employees to shop for low-cost plans. The survey was conducted for RAND by the Research Triangle Institute.

SAMPLE PHYSICIAN SURVEY QUESTIONS

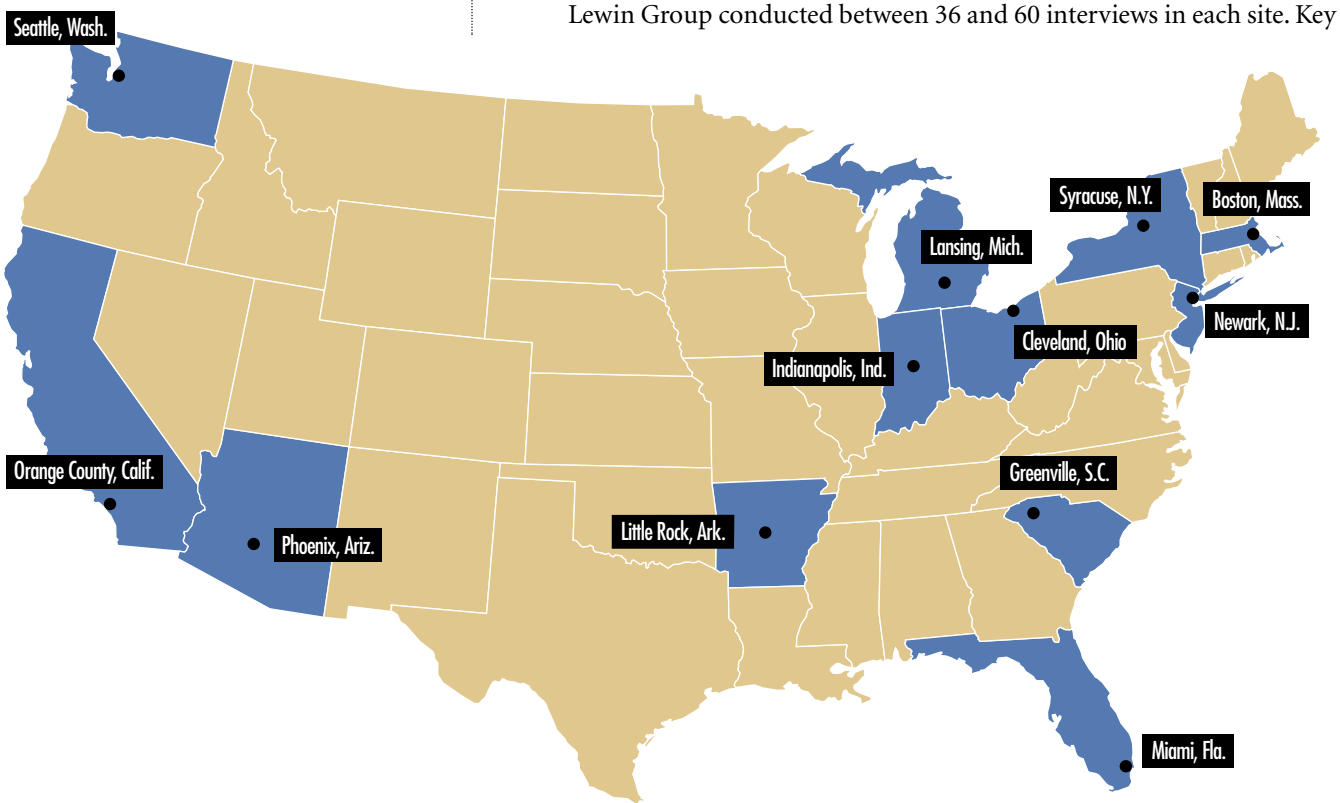
- *In the last two years, were you part of a practice that was purchased by another practice or organization?*
- *For roughly what percent of your patients do you serve as a gatekeeper?*
- *During the last two years, has the number of patients whom you refer to specialists increased a little or a lot, stayed the same or decreased a little or a lot?*
- *Is it possible for you to provide high-quality care to all of your patients?*
- *How large an effect does feedback from patient satisfaction surveys have on your practice of medicine?*

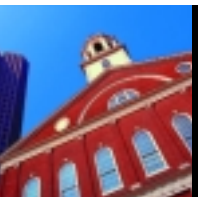
MIAMI... Care for the poor is being threatened by a changing tax base that finances indigent care.

VOICES IN 12 COMMUNITIES

An important component of the Community Tracking Studying is the series of interviews with key players in the health system in each of the 12 sites. By asking probing questions of leaders from the major organizations in the community, HSC was able to obtain an understanding of the health care system in each site that complements the survey data. Based on this information, HSC was able to document similarities and differences in the health systems across communities, explain trends and identify issues to track nationally in the future.

From May 1996 to April 1997, researchers from HSC and The Lewin Group conducted between 36 and 60 interviews in each site. Key





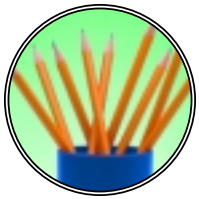
BOSTON... Safety net providers are facing serious competition for Medicaid enrollees as the state moves more beneficiaries into managed care plans.

among the people interviewed were leaders of insurance companies and health plans, hospitals, physician groups, employer and other purchaser groups, health departments, community health centers and agencies and policy and consumer groups. After analyzing the data, individual case studies were written describing each local market, including how care is organized and delivered, the role of employers and other community forces and the impact of public policy. Findings from the case studies are referred to throughout this report.

RESEARCH COLLABORATION

HSC has established numerous collaborative arrangements with individual researchers and research institutions. David Blumenthal of Massachusetts General Hospital helped develop the physician survey and will contribute to the analysis of its findings; Jon Christianson of the University of Minnesota helped develop the design of the site visits and has participated as a team leader and report author. Research institutions working with HSC include: The Gallup Organization (Physician Survey, under the direction of Linda Keil); The Lewin Group (site visits, under the direction of Raymond Baxter); Mathematica Policy Research (Household Survey, under the direction of Richard Strouse); and RAND (Employer Survey, under the direction of Stephen Long and Susan Marquis). Jon Gabel of KPMG Peat Marwick, working in partnership with HSC, analyzed trends in employment-based insurance.

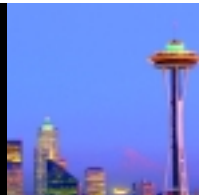
HSC is also working with researchers on a number of collateral studies that build upon the Community Tracking Study. Kenneth Wells of RAND is tracking issues related to substance abuse and mental health care in the 60 sites. RAND's Robert Brook, Beth McGlynn and Steve Asch are conducting a pilot study assessing quality in the 12 sites by reviewing medical records of respondents to the Household Survey. With funding from the U.S. Department of Health and Human Services, Rose Martinez of Mathematica Policy Research is undertaking a study of public health departments in the 12 sites.



SAMPLE EMPLOYER SURVEY QUESTIONS

- *How many different plans do you offer at this location?*
- *Do you pay part of the premium for employees and, if so, how much?*
- *Are plan enrollees required to select a gatekeeper to make referrals to most specialists?*
- *If enrollees use a provider who is out of the plan network, must they pay the full cost of these visits?*
- *Do you use the results of patient satisfaction surveys or scores on a report card of selected outcomes, such as HEDIS measures, to select health plans?*

SEATTLE... Health plans are merging or affiliating to bolster coverage to statewide and multistate purchasers.



"This study by HSC about the uninsured is an important contribution to the Medicare policy debate. It clearly demonstrates that a significant gap exists between the cost of coverage and the ability of the uninsured near elderly to pay."

–Robert Reischauer,
The Brookings Institution

HSC also consults with its two advisory committees to provide guidance on research design and dissemination. Members of the Researchers Group and the Users Group are listed on page 29.

REACHING DIVERSE AUDIENCES WITH HSC FINDINGS

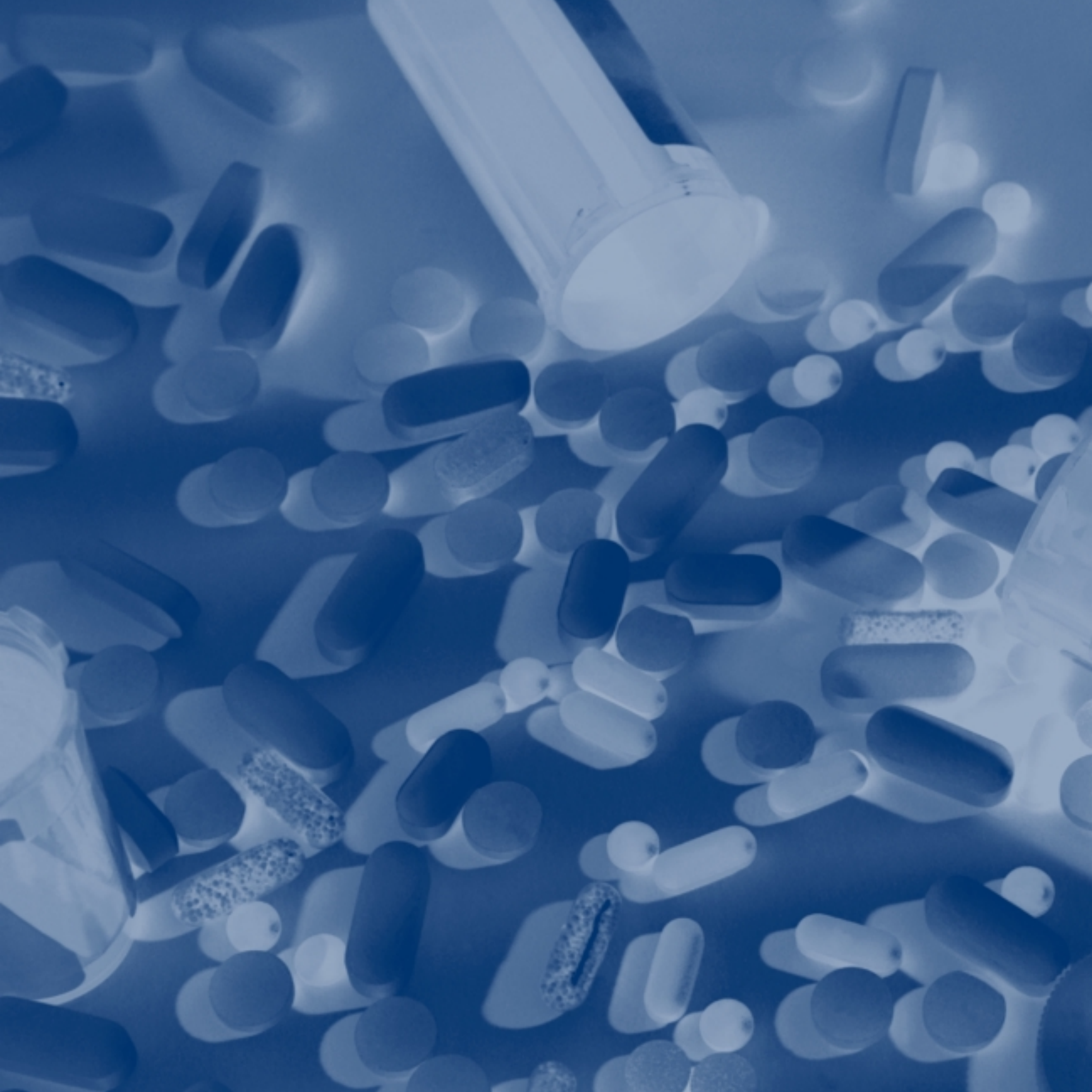
As a result of the surveys, site visits and data analyses, key decision makers—from members of Congress to community leaders—are learning more about the health care system and how it is changing at the national and local levels.

At the national level, for example, as Congress debated allowing near-elderly individuals to buy in to Medicare, HSC published a timely analysis of the vulnerability of different age groups with respect to uninsurance. After analyzing data from the Household Survey, HSC concluded that most uninsured persons ages 55 to 64 would have serious problems affording coverage under the proposed buy-in.

At the local level, communities are learning how they measure up relative to other markets, fueling discussion about how to improve. Release of an HSC analysis about uninsured children inspired a front-page story in the *Miami Herald* and a round of questioning by local leaders about why the uninsurance rate for children in their community was 50 percent higher than any other site studied by HSC. HSC's research, which was based on Household Survey data, identified a number of factors that appear to contribute to Miami's high uninsurance rate, including the prevalence of small firms, which are less likely to offer health insurance, and the constant influx of immigrants into the area.

HSC is eager to get more researchers involved in tracking change and comparing health systems across communities, and so will be releasing data from the Household and Physician Surveys in public use files this year. Also helpful to research and policy activity are HSC's recent primers on how to make sense of seemingly disparate cost data and how to discern trends on access to care.

CLEVELAND... The business community is very involved in health care issues and is credited with helping to ensure quality health care services.



"If your market intelligence comes from exposure to the speaking circuit, your blueprint of reality will be woefully inadequate. The systematic collection and analysis of data will help us separate fads from trends, and provide a far more accurate picture of how the health system is evolving."

– Uwe Reinhardt,
Princeton University

ROUND ONE: WHAT HSC IS LEARNING

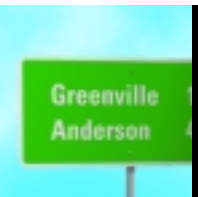
HSC's 1997 annual report focuses on early findings from the Community Tracking Study in three important areas: the extent of managed care; access to care, particularly for the uninsured; and health care costs. Since the first round of HSC surveys and site visits provides mostly baseline data, tracking changes over time is not yet possible. (There are a few exceptions to this, where survey questions and site visit interviews specifically asked about changes.) Ongoing analyses of round-one data in 1998 will permit staff to conduct more in-depth analyses, including how being in a managed care plan affects access and the perceived quality of care delivered, why insurance coverage varies across communities and other issues.

MANAGED CARE

In a relatively short period of time, managed care has become well diffused across the country and has changed the way most Americans receive their health care. By 1996, according to KPMG Peat Marwick data, more than 70 percent of both small and large firms offered some form of managed care plan. As an indication of how far the managed care pendulum has swung, only 57 percent of large firms (those with more than 200 employees) even offered a conventional, fee-for-service plan.

Managed care today means far more than just getting a discounted rate from providers for services. HSC staff were able to document the pervasiveness of a vast array of care management activities that are changing the doctor-patient relationship, physicians' relationships with plans and hospitals and other key interactions in the health system—all of which have the potential to affect care delivery from the consumer perspective. These care management activities include gatekeepers, capitation, disease management programs to address chronic conditions and outreach efforts to ensure that all children receive necessary preventive care services, among many other techniques.

But managed care is not evolving in recognizable stages across communities. There is no single pathway being followed. This provides



GREENVILLE... Hospital systems are purchasing physician practices and investing in physician-hospital organizations.

its own set of challenges for analysts and underscores the importance of HSC's community-based research approach. The work described below reflects HSC's initial focus on the extent of managed care techniques. Staff are currently analyzing the impact of managed care on consumers.

Gatekeepers

HSC's Household and Physician Surveys document just how pervasive gatekeeping has become. Nationwide, 40 percent of Americans with health insurance report that they are in some form of a gatekeeping arrangement. While nearly two out of three insured persons in a community with high managed care penetration such as Boston are in gatekeeping arrangements, as many as one out of three in low managed care penetration communities such as Greenville and Syracuse has a primary care gatekeeper. Looking at this from a different perspective, more than 90 percent of primary care physicians report that they serve as gatekeepers for at least some of their patients.

Consumer Choice

What do consumers think about having limits placed on their choice of providers? The general public is divided about which is preferable: limiting the choice of physician and spending less, or having choice and spending more money. Nearly three-fifths of Americans responding to HSC's Household Survey said they were willing to accept managed care's limits on choice of physician to save money (see Figure 1, p. 20). At the same time, a sizable minority—40 percent—were not willing to give up choice to save money. This divergence of opinion was fairly constant nationwide.

These findings may help explain the surging popularity of preferred provider organizations (PPOs) and point-of-service (POS) products, which accommodate these divergent perspectives. Based on visits to the 12 communities, employers are seeking to further increase choice for employees by getting managed care plans to expand the number of providers in a plan's network and providing more options for out-of-network care at affordable prices.

NATURE OF PLANS IN COMMUNITIES

It seems that national plans should have an advantage over regional plans, particularly in terms of economies of scale and access to capital. However, HSC found that regional plans dominate. Their advantage is based on name recognition and established relationships with providers.

With one exception, none of the national plans controls any of the markets in the 12 sites. In most cases, these regional plans have a long local history, for example, the Harvard Pilgrim Health Plan, Tufts Associated Health Plan and Blue Cross and Blue Shield of Massachusetts in Boston. The exception is Orange County, where the dominant competitors—PacificCare/FHP, Kaiser Foundation Health Plan and Foundation Health Systems—were active regionally before going national.

PHOENIX... Physicians are creating single-specialty provider networks to contract with managed care plans and self-insured employers.

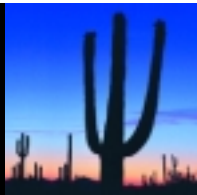
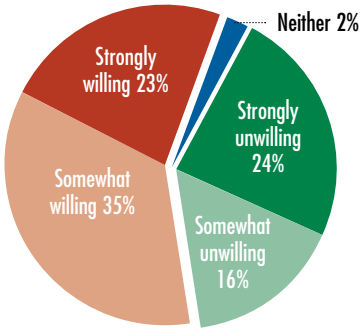


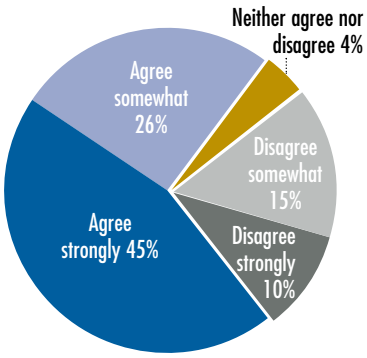
FIGURE 1: HOW WILLING ARE AMERICANS TO ACCEPT LIMITED CHOICE TO CONTAIN COSTS?



Source: Community Tracking Study

FIGURE 2: FINANCIAL INCENTIVES AND CLINICAL DECISION MAKING

Physicians' responses to the statement: "I can make clinical decisions in the best interests of my patients without the possibility of reducing my income."



Source: Community Tracking Study

The movement toward more provider choice and unrestricted access is seen by some observers in the 12 communities as a win-win situation. It helps satisfy employees and makes it easier for employers to enroll workers in managed care plans. However, there likely will be a price to pay: providers gain bargaining power, and expanded networks are more difficult to manage from both a cost and quality perspective.

Financial Incentives

While discounts for fee-for-service still dominate, financial incentives for physicians are being used more extensively. The HSC Physician Survey documented that among those physicians in practices with capitated arrangements, the average proportion of practice revenues from capitated contracts accounted for more than one-quarter of total practice revenues, and half of all physicians were eligible to receive some type of financial bonus based on how they or their practice performed.

From the perspective of most physicians, financial incentives have not challenged their ability to practice good medicine: Seven of 10 physicians say they can make clinical decisions in the best interests of their patients without the possibility of reducing their income (see Figure 2). However, three out of 10 doctors do perceive a conflict between the financial incentives they are working under and their clinical decision-making authority. This finding does not address how physicians resolve the conflict.

ACCESS TO CARE

Access to care takes on different meanings, depending on whether a person has health insurance. Access for the growing number of uninsured—rising from 34.7 million in 1990 to 41.7 million in 1996—is focused on whether these individuals are able to get care for which they cannot pay. For people with insurance, access tends to mean how much choice they have within their health plan to select doctors and to get care from specialists when they perceive it is necessary.

HSC's community-based research approach helps to shed light on the reasons why uninsurance rates are rising in communities, and will

INDIANAPOLIS... Many of the major HMOs have global capitation contracts with PHOs owned by health systems.

eventually help decide whether new legislative approaches are successful in addressing fundamental problems that contribute to uninsurance. With respect to the insured, HSC's surveys will help to better define and track newly emerging issues of access for those who have coverage.

Access for the Uninsured

After the failure of President Clinton's Health Security Act in 1995—which promised to address the uninsured problem comprehensively—policy makers began to take an incremental approach to improving access for the uninsured by targeting particular age groups; 1997 was a banner year for this.

- The Balanced Budget Act created the Children's Health Insurance Program (CHIP), which gives grants to states to cover low-income children through Medicaid or private insurance.
- President Clinton proposed that near elderly—people between the ages of 55 and 64—be able to buy in to Medicare for about $300 a month, and that displaced workers ages 55 to 62 be able to buy in for about $400 a month.

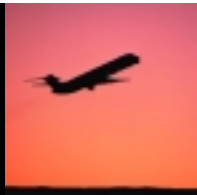
Insurance for Children: Uninsured children represent a diverse group, but they are largely children of the working poor. According to HSC's Household Survey, nearly four-fifths have parents in the work force, even though many of them live in poverty or just above the poverty line.

By expanding eligibility for public insurance, CHIP has the potential to significantly reduce the number of uninsured children in America. But many would argue that other approaches need to be pursued to address the problem, including market reforms to expand affordable, employer-sponsored coverage. HSC research indicates that half of the children who lack health insurance are in this predicament because their parents either work for firms that do not offer insurance or are ineligible for their employer's health benefits. In addition, some parents cannot afford family coverage, even when it is available. This combination of public and private programs may result in equity and crowd-out problems.

"As states roll out CHIP, many of them are grappling with sticky equity issues. For example, how can we provide CHIP benefits to workers making 200 percent of poverty in companies that do not provide insurance, while expecting individuals with similar incomes at companies that do offer insurance to pay high contributions for coverage?"

–Patricia Riley,
National Academy
for State Health Policy

NEWARK... Managed care enrollment has increased rapidly, but the outlook is uncertain due to provider resistance and a high demand for choice.



TARGETING VULNERABLE AGE GROUPS: DOES IT MAKE SENSE?

If incremental change is to proceed by age group, policy makers need to define their objectives related to expanding access to health insurance. HSC found that if the goal is to target assistance to people with significant health care needs, there is some justification for focusing on the near elderly. Sixteen percent of all uninsured people under age 65 who were interviewed reported being in fair or poor health, but 32 percent of uninsured people ages 55 to 59, and 28 percent of those ages 60 to 64, reported poor health status.

However, if the goal of incremental expansion of health insurance is to target assistance to those with unmet need, it is less clear that any particular age group should be targeted. Uninsured adults of all ages appear to encounter significant financial barriers to getting the care they need.

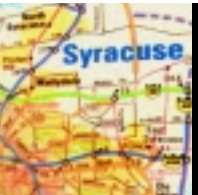
Insurance for the Near Elderly: HSC found that most uninsured near-elderly persons ages 55 to 64 would have problems affording coverage under the President's buy-in plan, but that those in the poorest health would have the most difficulty. Specifically, the average uninsured near-elderly person would have to spend 20 percent to 25 percent of his or her income on Medicare premiums, while that person's counterparts in poor or fair health would have to spend between one-third and one-half of their income to obtain coverage.

The uninsured near elderly are among the poorest and sickest of all uninsured persons. One-fourth to one-third characterize themselves as being in poor or fair health, compared with 16 percent of all uninsured. These sicker near elderly have average annual incomes of less than $10,000, while overall the near elderly have average incomes of about $46,000 a year. These findings are based on an analysis of HSC's Household Survey data.

The Safety Net: The traditional sources of care for the poor—the so-called safety net—are being challenged to adapt to health system changes in their communities. The most significant factors include:

- hospitals experiencing cutbacks in federal funding and, in those states that abandoned rate setting, loss of subsidies to serve the indigent; and
- community health centers facing increased competition for Medicaid patients, resulting in a loss of some patients and lower payments for those they retain.

HSC's visits to 12 communities provided new insights into how communities are responding to these pressures. In Lansing, the Ingham County Health Department spearheaded a community-wide effort to see that all the local hospitals are providing their proportionate share of indigent care, and is experimenting with managed care for the uninsured. And in Orange County, the Medicaid program reserves a portion of managed care funds for direct contracting with traditional safety net providers.



SYRACUSE... Mandatory Medicaid managed care is expected to improve access to primary care for low-income people.

Access for the Insured

Historically, most people with health insurance were not very concerned about their access to care, with the exception of people who lived in rural areas where there were few physicians and relatively few high-technology services. There is a new dimension to any discussion of access to care for the insured today, however, largely due to the expansion of managed care.

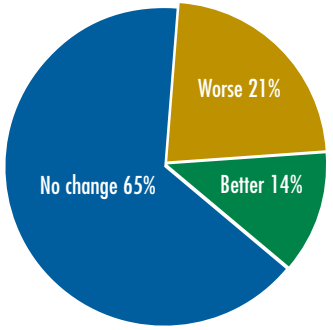
As noted earlier, issues of access for people with insurance tend to focus on choice. Do they have a choice of plan? How wide a choice of doctors do they have? Can they see a specialist when they think they need one? Findings from HSC's Household Survey show that most reported no change in their ability to get care over the past three years, but 21 percent insured nonelderly said it had become more difficult over time (see Figure 3).

One group that was dramatically less likely to perceive declining access to care was the elderly. Only 11 percent of people age 65 and older reported that it was more difficult to get care. A likely reason for this relatively good response is that the elderly are almost universally covered by Medicare and experience greater consistency in coverage.

An increasingly important access issue for people with insurance is the ability to get referrals to high-quality specialists when they are medically necessary. While most physicians feel that they can make such referrals, 20 percent of primary care physicians responding to HSC's Physician Survey said that they cannot always or almost always obtain these referrals. This finding closely parallels what consumers think about the issue: 15 percent of people responding to HSC's Household Survey felt that their physicians might not refer them to a specialist when needed (see Figure 4).

Although managed care has processes to limit referrals to specialists, the role of managed care in explaining differences in problems with specialty referrals is not easily identified. While Boston has the highest rate of primary care gatekeeping in the Community Tracking Study and a relatively high HMO enrollment rate, it is significantly below the national average for the proportion of physicians and patients concerned about access to specialists.

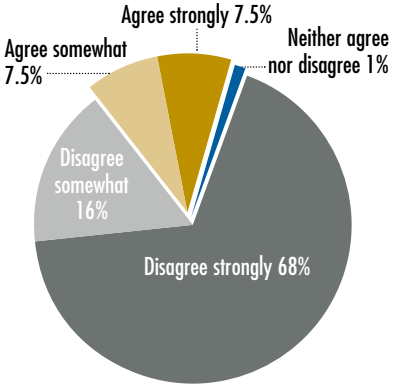
FIGURE 3: ACCESS TO CARE COMPARED TO THREE YEARS AGO FOR INSURED POPULATION



Source: Community Tracking Study

FIGURE 4: INSURED PATIENTS' TRUST IN THEIR DOCTOR TO REFER THEM TO A SPECIALIST WHEN NEEDED

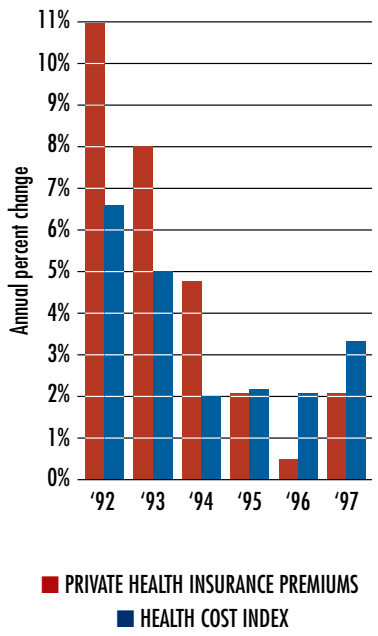
Patients' responses to the statement: "I think my doctor may not refer me to a specialist when needed."



Source: Community Tracking Study

ORANGE COUNTY... Mid-size to large physician groups have emerged as powerful players in the local market.

FIGURE 5: PRIVATE INSURANCE PREMIUMS HAVE DECLINED MORE RAPIDLY THAN COSTS



Sources: Private Health Insurance Premiums, KMPG Peat Marwick; Health Cost Index, Milliman & Robertson

Other communities also known to have high managed care penetration, such as Miami and Orange County, have higher proportions of physicians and patients concerned about this. Clearly, factors beyond simply the amount of managed care or even gatekeeping—for example, the supply of specialists in the community and the competitiveness of the market—influence this important aspect of access to care.

COST OF CARE

The cost of health care profoundly affects all aspects of the health system and, from the purchasers' perspective, the news about health care costs has been relatively good: The soaring increases in health care costs that characterized the 1980s have been steadily declining since 1990. The numbers are dramatic: Since 1994, there have been historically low rates of increase. In 1997, a health cost index for the non-Medicare population increased by 3.3 percent and private health insurance premiums rose only 2.1 percent (see Figure 5).

Tracking the Slowdown of Cost Increases

By documenting this far-reaching trend, HSC played an important role in convincing decision makers that low rates of increase are real and not merely an oddity or a short-lived reaction to pressures for health care reform. At the national level, it has been widely predicted that premiums would start rising again, but to date they have not. A group of experts convened by HSC concluded correctly in mid-1997 that the forces that have kept health care costs in check during the past few years will remain in effect for the immediate future, and that rates of increase will continue to remain low. In fact, insurance premiums for 1997 still ran below underlying costs, and while there are anecdotal reports of premium increases for 1998, the average increase turned out to be only 3.3 percent.

While this is the general cost trend, it is important to note that local markets likely will vary. For example, across the 12 Community Tracking Study sites, the Employer Survey found that the rate of premium increase was lowest in Orange County and highest in Little Rock. These commu-

LANSING... In pursuit of better rates with providers, purchasers are supporting analysis of comparative hospital data on cost and quality.

nity-by-community variations were modest compared with the substantial variations in premium changes reported by individual employers. In 1997, according to the Employer Survey conducted by RAND, when the average annual premium increase was 1.9 percent, 7 percent of employees were in firms that had decreases of 10 percent or more and 19 percent were in firms whose increases exceeded 10 percent. This highlights the importance of drawing data from a representative sample rather than making inferences from the experience of a single employer.

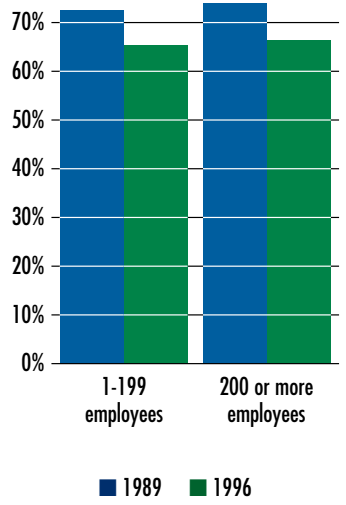
Overall, HSC site visit teams noted aggressive price shopping by public and private purchasers, who increasingly are more resistant to premium increases and are willing to switch plans to save money. A pervasive theme in all 12 communities was purchasers' pressure to reduce health care expenditures and the competitive response of plans and providers.

Employees' Share Rising

Data from national employer surveys show that in the early 1990s employees did not benefit from low premium increases to the extent that employers did, although recent data indicate that the trend is leveling off. Many employers were requiring their employees to pay a higher proportion of health insurance costs. Overall, the average monthly contribution for family coverage for workers in large firms grew from $29 in 1988 to $127 in 1996—a 20 percent increase per year on average. For workers in small firms with fewer than 200 employees, contributions increased considerably more—from $34 in 1988 to $175 in 1996, for a staggering 23 percent average yearly increase. At the same time, total premiums for small firms increased only 8 percent annually.

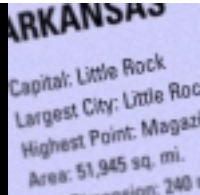
Perhaps as a result of these growing costs for employees, HSC researchers found that while more small firms are offering health insurance, fewer employees are enrolling (see Figure 6). The percentage of employees in small firms enrolled in their firms' plans decreased from 72 percent in 1989 to 66 percent in 1996. The pattern of this decline is reflected among large firms as well. The result is a net decline in the rate of employment-based health coverage.

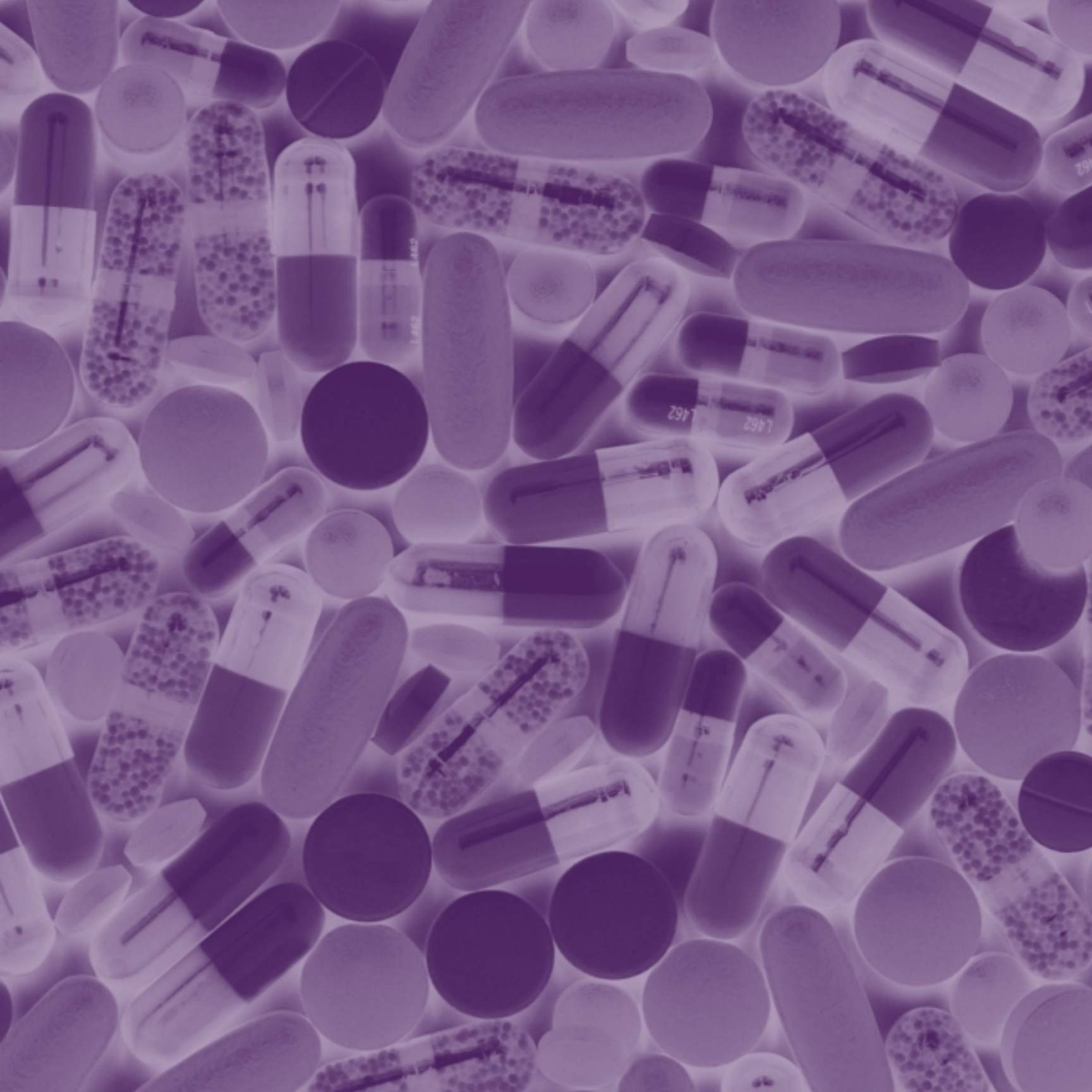
FIGURE 6: EMPLOYERS OFFERING INSURANCE VS EMPLOYEES ENROLLING



Source: Health Insurance Association of America, 1989; KPMG Peat Marwick, 1996

LITTLE ROCK... Many local HMOs are jointly sponsored by insurers and hospitals through shared equity arrangements.





ON THE AGENDA

In 1998, HSC researchers are continuing to work on analyses that will provide decision makers with answers to the following kinds of questions:

• How is primary care physicians' scope of care changing under managed care? To what extent are they providing care historically delivered by specialists? Are they comfortable with these changes?

• Does the type of insurance coverage affect consumer satisfaction and perceived quality? Are people in HMOs more or less satisfied with their overall care, and how do they perceive its quality as opposed to those covered under traditional insurance? Does patient trust in physicians differ by insurance type?

• What are physicians' perceptions of their ability to provide high-quality care? What kinds of factors influence physicians' perceptions with respect to quality, in terms of individual attributes, type of practice and market-level variables such as the extent of managed care?

• What is the impact of managed care regulation on local markets? How are these initiatives seen either as protecting consumers or as a backlash against managed care? How are they perceived to affect costs, network strategies and care management techniques?

• How has managed care affected physicians' provision of charity care? Are safety nets fraying? Are doctors taking on more of the charity care burden? Are providers more responsive to patient needs due to increased competition for Medicaid business?

• How are Blue Cross-Blue Shield plans redefining their roles and transforming their local market positions? As traditional insurers of the last resort, and in some markets the last bastion of fee-for-service medicine, how are plans restructuring to compete in a managed care environment? What happens to hard-to-insure people as the Blues convert from nonprofit to for-profit organizations?

To give other researchers the opportunity to work with HSC's rich survey data, public use files will be made available in 1998.

SECOND-ROUND DATA

HSC has embarked on its second round of data collection, which will continue through 1998 and part of 1999. Site visits are underway, and field work on the Household and Physician Surveys will begin this summer. (There will be no employer survey in this round.) With baseline data from the first round, researchers will start to track changes in access, delivery, costs, perceived quality and dynamics of health system change.

Analyses of this information will help HSC gain a richer understanding of how the "big picture" in health care is changing and the effects of those changes on consumers. This information will help to inform public and private decision makers as they consider legislative alternatives, select health plans for their employees and grapple with how to address problems of the uninsured and many other health-related issues of national import, as well as those unfolding on the local level.

HSC PUBLICATIONS

ISSUE BRIEFS

1 "The Community Tracking Study: A Focus on Change in the Health Care System," August 1996.

2 "Tracking Changes in the Public Health System: What Researchers Need to Know to Monitor and Evaluate These Changes," September 1996.

3 "Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid?" October 1996.

4 "Policy Implications of Risk Selection in Medicare HMOs: Is the Federal Payment Rate Too High?" November 1996.

5 "A Primer on Understanding Health Care Cost Trends: The Story Behind the Numbers," December 1996.

6 "Tracking Health Care Costs: A Slowing Down of the Rate of Increase," January 1997.

7 "An Inadequate Supply of Qualified People Will Slow the Pace of Health System Change," March 1997.

8 "Access to Health Care: Bridging the Gap Between Policy and Research," April 1997.

9 "Patients, Profits and Health System Change: A Wall Street Perspective," May 1997.

10 "Health Care Costs: Will They Start Rising Rapidly Again?" June 1997.

11 "Will Hospital Report Cards Make the Grade?" July 1997.

DATA BULLETINS

1 "Access to Care: Is It Improving or Declining?" Fall 1997.

2 "Access to Specialists: Perspectives of Patients and Primary Care Physicians," Fall 1997.

3 "Satisfaction and Quality: Patient and Physician Perspectives," Fall 1997.

4 "Strong Opinions Held About the Tradeoff Between Choice of Providers and Cost of Care," Fall 1997.

5 "Uninsurance Rates Vary Widely Across Communities and Regions," Fall 1997.

6 "Primary Care Physicians Concerned About Patients' Access to Mental Health Services," Fall 1997.

7 "Gatekeeping Arrangements Are in Widespread Use," Fall 1997.

8 "Payment Arrangements and Financial Incentives for Physicians," Fall 1997

TECHNICAL PUBLICATIONS

1 *Site Definition and Sample Design for the Community Tracking Study*, October 1996.

2 *Methods in Case Study Analysis*, June 1997.

3 *Community Tracking Study Physician Survey Instrument*, August 1997.

4 *Community Tracking Study Household Survey Instrument*, October 1997.

SPECIAL PUBLICATIONS

Health System Change in Twelve Communities, Linda Kohn, Peter Kemper, Raymond Baxter, Rachel Feldman and Paul B. Ginsburg, editors, Health System Change and The Lewin Group, September 1997.

JOURNAL ARTICLES

"Association Leaders Speak Out on Health System Change," Janet M. Corrigan and Paul B. Ginsburg. *Health Affairs*, vol. 16, no. 1 (January/February 1997): 150-157. (HSC Reprint, R-103)

"Trends Toward a National Health Care Marketplace," Janet M. Corrigan et al. *Inquiry*, vol. 34 (Spring 1997): 11-28. (HSC Reprint, R-104)

"The Dynamics of Market Level Change," Paul B. Ginsburg. *Journal of Health Politics, Policy and Law,* vol. 22, no. 2 (April 1997): 363-382.

"Tracking Health Care Costs: An Update," Paul B. Ginsburg and Jeremy D. Pickreign. *Health Affairs*, vol. 16, no. 4 (July/August 1997): 151-155. (HSC Reprint, R-105)

"A Changing Picture of Uncompensated Care," Peter J. Cunningham and Ha T. Tu. *Health Affairs*, vol. 16, no. 4 (July/August 1997): 167-175. (HSC Reprint, R-106)

"Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence," Jon Gabel, Paul B. Ginsburg, Kelly A. Hunt. *Health Affairs*, vol. 16, no. 5 (September/October 1997): 103-110. (HSC Reprint, R-107)

"Changes in Health Plans Serving Medicaid, 1993-1996," Suzanne Felt-Lisk and Sara Yang. *Health Affairs*, vol. 16, no. 5 (September/October 1997): 125-133. (HSC Reprint, R-108)

"The Risks of Risk Adjustment," Lisa I. Iezzoni. *Journal of the American Medical Association*, vol. 278, no. 19 (November 19, 1997): 1600-1607.

"Choosing a Health Plan: Do Large Employers Use the Data?" Judith Hibbard, Jacquelyn Jewett, Mark Legnini, Martin Tusler. *Health Affairs*, vol. 16, no. 6 (November/December 1997): 172-180.

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