2001 ANNUAL REPORT

Navigating a Changing Health System

MAPPING TODAY'S MARKETS FOR POLICY MAKERS

CENTER *for* STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

Table of Contents

Rough Seas Ahead
for Purchasers and Consumers

by Paul B. Ginsburg

A YEAR AGO, THE HEALTH CARE SYSTEM APPEARED RUDDERLESS and adrift as integrated delivery and tightly managed care unraveled in the wake of a consumer and provider backlash, stoked by a booming economy that reduced concerns about costs. Now, a new course is being charted to improve the health care system as employers and other purchasers begin to navigate the rocky shoals of rapidly rising costs. Steered by financial incentives, informed consumers will be asked to take more responsibility for their care. Under this approach, consumers will make trade-offs between costs and choice and possibly stimulate improvements in quality by gravitating to providers that offer higher quality and value.

A New Wave of Costs

The passage from the unraveling of the earlier vision to charting a new course was stimulated by the coincidence of two developments—the re-emergence of cost pressures and the end of the economic boom of the late 1990s. Premium increases for employment-based health insurance reached 11 percent in 2001, in contrast to an increase of less than 5 percent two years earlier. In 2002, many knowledgeable observers expect premiums to rise by approximately 13 percent.

Initially, the underlying cost increases in these premium raises were spurred by greater use of prescription drugs, driven largely by new technology and direct marketing to consumers, but recent increases have been more widespread. Hospital spending is again the major driver of spending, reflecting both higher use of services and higher prices paid by insurers. For the under-65

population, National Hospital Indicators Survey data show adjusted patient days—an aggregation of inpatient days and outpatient visits—in community hospitals increased by 8.1 percent in 2000, compared with only 1.6 percent in 1999. At the same time, HSC's Community Tracking Study (CTS) site visits in late 2000 and early 2001 found substantial hospital price increases, driven by both higher hospital labor costs, due in large part to nursing and other personnel shortages, and hospitals' greater success in negotiating rate increases with managed care plans. Interestingly, it was the slow growth in hospital spending in the mid- to late-1990s that had been the major factor earlier behind historically low health cost trends.

The retreat from tightly managed care undoubtedly has played a role in the rising wave of costs, influencing both use of services and prices paid to providers. Over the last two years, health plans have reduced required authorizations for hospital admissions, specialist referrals and expensive diagnostic procedures, such as magnetic resonance imaging (MRI). Although many plans made these changes based on assessments that the administrative costs of authorizations had exceeded savings from denials, the rapid and widespread end of the requirements may have led to changes in physician behavior in prescribing these services through a sentinel effect. For example, with fewer authorizations needed, anecdotal evidence points to sharply higher MRI use. The cumulative effect of individual managed care plans' responses to consumer and employer demands for broader provider choice through expanded networks led to market-level effects on prices. Combined with extensive provider

The Community Tracking Study (CTS)

Collecting Unique Data from Consumers and Physicians on a Changing Health Care System

Recognizing that health care is organized and delivered at the local level, the CTS consists of surveys of American consumers and physicians in 60 nationally representative communities and in-depth site visits in 12 of those communities. This unique design provides a national perspective on health system change and its effect on people and institutions across the country.

In 2001, HSC completed its third round of surveys and site visits. As of 2002, HSC has moved to a three-year cycle of surveys. The fourth round of Household and Physician Surveys will begin in January 2003 and January 2004, respectively. The site visits will continue on a two-year cycle, with the next round beginning in September 2002.

CTS Household Survey. Information about 60,000 people in 33,000 families helps examine the many aspects of consumers' experience in obtaining health care. Particular areas of inquiry include access to care, satisfaction with the care received, use of services and insurance coverage. Information about health status and sociodemographic characteristics also is collected. Mathematica Policy Research, Inc., (MPR) conducts the Household Survey for HSC.

HSC is currently pilot testing followback surveys that would go to employers and insurers of Household Survey respondents.

CTS Physician Survey. To gain perspective on how health care delivery is changing, HSC interviews 12,000 practicing physicians across the country. Physicians are asked questions about compensation, whether they are able to provide needed services for patients and the effects various management strategies have on their practices. The Gallup Organization conducts the Physician Survey for HSC.

CTS Employer Survey. To better understand the role employers play in shaping the health care system, HSC interviewed 22,000 public and private employers in 1997 in collaboration with RAND.

CTS Site Visits. HSC researchers examine the forces affecting health care organizations and how they are responding by interviewing 50 to 80 local health leaders representing health plans, providers, policy makers and employers in Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich; Little Rock, Ark; Miami; Northern New Jersey; Orange County, Calif; Phoenix; Seattle; and Syracuse, N.Y.

consolidation since the mid-1990s, much of it spurred by the threat providers felt from managed care, purchaser demands for broader networks led hospitals and some specialty physician practices to recognize their enhanced leverage with health plans to obtain higher fees.

The U.S. economic boom worked against a vigorous purchaser response to cost increases. In 1999 and 2000, businesses were highly profitable and struggling to recruit and retain employees in a tight labor market. After enjoying several years of low premium increases, employers had little interest in doing anything that would make their benefits less attractive. A key exception was prescription drugs, where the very large spending increases led many employers to adopt tiered copayments, which provide consumers with financial incentives to use generic drugs and a preferred list of brand-name drugs. Public purchasers like Medicare and Medicaid also exhibited less concern with cost trends than usual, since federal and state budgets had surpluses. Congress, for example, approved billions of dollars in so-called provider givebacks, and governors talked enthusiastically of expanding coverage to the uninsured.

The recession that began in 2001, however, brought about a sea change. Employers found profits down, costs up and labor markets looser. State governments saw budgets swing from surplus to deficit, and the federal government wasn't too far behind. Public and private purchasers began to dust off options to contain costs—an activity that had lain dormant during the period of low cost trends and a booming economy.

The experience of the 1990s sheds light on how general economic trends affect health care costs. A weak economy tends to lead to vigorous efforts by purchasers to contain costs, while a strong economy diminishes such activities. In fact, this pattern has been modeled by actuaries at the Centers for Medicare and Medicaid Services, who use changes in per capita disposable personal income—with a substantial lag—to forecast trends in private personal health care spending over the next decade.

Troubling Undercurrents

Over the past two years, capacity shortages have surfaced in many segments of the health care system. Most visible has been crowding in hospital emergency departments. But tight capacity is showing up now in physician practices as well. CTS Household Survey data show that waiting times to get a physician appointment—especially with a specialist—has increased substantially.

Helen Darling ➤ President
WASHINGTON BUSINESS GROUP ON HEALTH

"HSC is the only organization that provides timely, useful information about major health market trends as well as what's happening in a number of key markets. Such detailed information helps employers validate what they often see and understand the context of what's happening."

In 2001, 28 percent of consumers reported waiting more than seven days to see a physician when they were sick, compared with 22 percent in 1997. The percentage of physicians accepting all new privately insured patients into their practices declined—a trend mirrored in such public programs as Medicare. While the media have focused on physicians who have stopped accepting new Medicare patients entirely, so far, these problems appear to be centered in practices that served few Medicare patients in the past. Although beneficiaries' choice of physicians is very good now, the continued large decreases in payment rates projected under current law do pose risks for beneficiary choice in the future.

The rising demand for services associated with the loosening of managed care likely is playing a role in this capacity crunch, hitting hospitals particularly hard because of the reversal from trends during the mid-1990s when demand declined. Then, under pressure to control costs, many hospitals closed surplus facilities or reduced the number of inpatient beds.

While some predict the need for substantial growth in hospital capacity, current capacity shortages could turn out to be transitory. If the adjustment to less restrictive managed care is, in fact, a significant factor, it may be mostly complete by now. This would lead to a slowing of the trend; the impact of new tools to control costs, such as increased consumer cost sharing, would augment this slowing.

Although the need for a sharp increase in investment in general capacity is uncertain, hospitals and physician groups have been building extensive specialized facilities, especially for cardiovascular, oncology and orthopedic services. The competition to develop additional specialized facilities is reminiscent of the medical arms race of the 1970s. Concerned about the possibility of too much specialty capacity that might encourage unnecessary care and decrease quality, some policy makers are thinking about reinstating regulation of inpatient and outpatient capacity. Another issue is whether Medicare and private insurers' reimbursement practices have inadvertently made some services highly profitable and others unprofitable and, as a result, are sending the wrong signals to the marketplace.

The Next Wave?

We may not truly know what the next phase of health care change will look like until 2003. By the time the nation became aware of the sharp decline

Jack Ebeler ➤ President
ALLIANCE OF COMMUNITY HEALTH PLANS

"This is a time of tremendous change in health care, and all of us are struggling to understand what is going on and how we can best improve on it. By translating its always rigorous research into relevant, nonpartisan information, HSC helps foster that understanding."

14 31

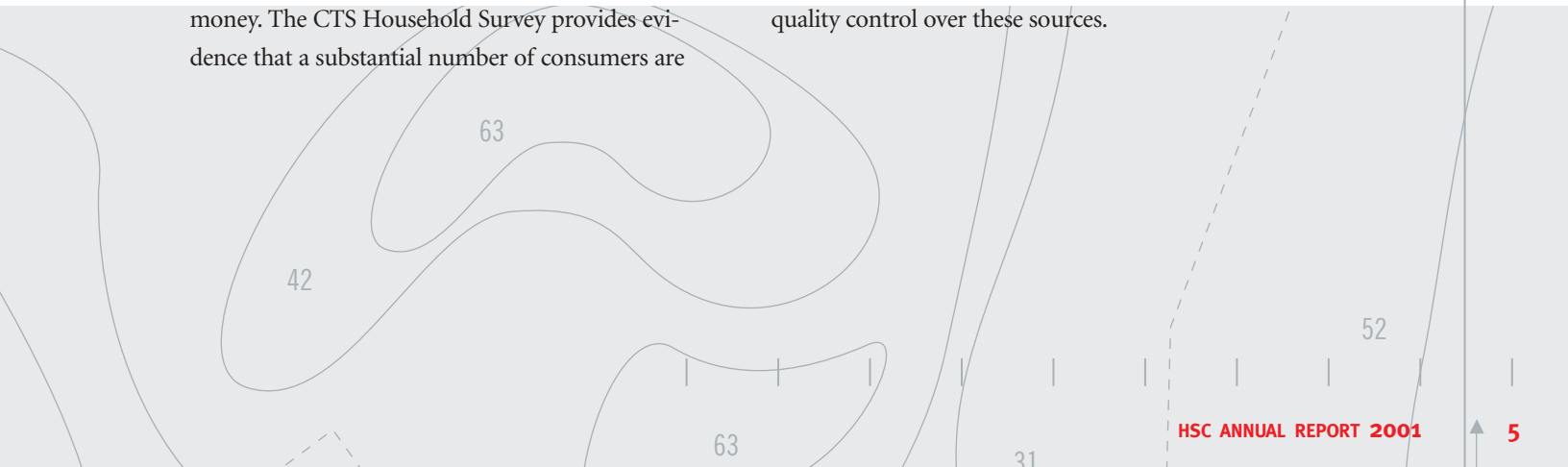
in economic activity in 2001, most employers had already made decisions about their health plans for the 2002 benefit year. So major changes in health benefits are unlikely to be implemented until the beginning of the 2003 benefit year. Benefits managers have indicated already that they plan to increase the amount of cost sharing required of employees and their dependents through larger deductibles, copayments and coinsurance rates. Employers are hopeful that these moves will result in changes in consumer behavior rather than simply in a shift in costs to employees. In many cases, the degree of cost sharing will revert to where it was before managed care, which replaced financial incentives with administrative controls.

Employers are likely to take this cost-sharing approach an important step further in 2003. Having tasted some success with the tiered approach to pricing pharmaceuticals, benefits managers are looking to apply it to hospital and physician services as well. In its simplest form, patients will pay a larger copayment for hospitals or physicians that charge higher prices. Some health plans also are aiming to incorporate quality and efficiency measures into the construction of tiers. Their success in doing so will be important if consumers are to base their choices not just on cost but on quality as well.

The tiered approach to cost sharing responds to a number of crosscurrents in today's health care system. It restores some health plan leverage over providers, which was lost through broader provider networks. It also accommodates many consumers' desire for a broad choice of providers, while giving those willing to narrow their choices a way to save money. The CTS Household Survey provides evidence that a substantial number of consumers are willing to make these trade-offs. When presented with the statement: "I would be willing to accept a limited choice of physicians and hospitals if I could save money on my out-of-pocket costs for health care," 57 percent of adults said they are willing to make that trade, including 22 percent who are strongly willing. Still, 42 percent of Americans said they are unwilling to sacrifice choice for savings, and 25 percent are strongly unwilling. This pattern has changed little over the three CTS survey rounds. But the plan choices available to most consumers do not provide the opportunity to make that trade-off.

With consumers facing greater financial incentives related to their choice of provider and treatment decisions, a critical question emerges: Will they be able to make these choices with confidence? A key issue will be the amount and quality of the information available to them. For example, will consumers have solid, easy-to-understand information about the effectiveness and risks of alternative courses of treatment and the quality of different hospitals and physicians? The wide geographic variation in the practice of medicine suggests having patients better informed about their options and about the evidence behind certain approaches to care may lead to better results.

Employers and health plans will provide some of the information—in many cases via the Internet—needed to help consumers navigate these unexplored waters. We also know that increasing numbers of price- and quality-conscious consumers seek information from magazines, newspapers and Web sites that provide discussion forums to aid consumer decision making. But there is precious little quality control over these sources.



Our skill in finding ways to transmit information may be ahead of our ability to obtain the needed content because of the ongoing difficulty of developing reliable quality data on providers. Information vendors will likely press the government to provide raw data needed to rate providers, such as data from the Medicare program. At this point, the degree to which patients are better able to make these choices—and feel more comfortable making them—is highly uncertain, despite many years of effort.

The notion of consumers relatively free from administrative controls but subject to significant financial incentives and an information infrastructure to support them is embodied in what today is called a consumer-driven health plan. Pioneered by such Internet companies as Definity Health and Lumenos, these products typically offer consumers high-deductible catastrophic coverage and an annual allowance to cover both insured and uninsured health services. If this allowance is not used, it can be carried over to future years—but not to future employers. Sponsors of these plans also give enrollees information about providers through restricted-access Internet sites. If consumer-driven plans catch on, they are likely to increase the speed with which mainstream plans shift to higher cost sharing and provide information to enrollees, a key step toward greater use of consumer financial incentives.

But consumer-driven plans also raise a series of public policy concerns. For example, most are offered as an option alongside health maintenance organizations (HMOs) and preferred provider organizations and raise questions about risk selection. When health plans with extensive cost sharing are offered alongside plans with more comprehensive benefits, consumers who expect to use relatively few services choose the former. This tends to shift costs to those expecting to use more services, such as people with chronic conditions, and can even threaten the viability of the comprehensive plan through a death spiral of adverse selection. Employers can limit risk selection if they choose a single carrier to offer all of the plan choices and set employee contributions for the plans on the basis of relative actuarial value of the benefit structure rather than the relative claims experience of the options. But the single-carrier restriction may come at the cost of eliminating some valuable plan options, such as an integrated staff-model HMO.

A significant shift toward greater cost sharing probably would have profound implications for care delivery. Cost sharing will definitely get the atten-

Ron Pollack ➤ Executive Director
FAMILIES USA

"Policy makers need to know the likely impact of their decisions on consumers. HSC provides valuable information—both national and community-based—that gives us 'real-time' data on how the system is changing. The big question going forward is how will rising costs and higher cost sharing affect insurance coverage and access to care, especially for those with low incomes."

tion of patients and affect their decisions about when to seek care and what treatments to pursue. The burden of paying for care will shift somewhat, from those who are healthy to those who are sick. Choice of provider will be linked more closely with one's ability and willingness to pay more for care, with low-income people having to limit themselves more often to the less expensive provider.

Sailing in Uncharted Waters?

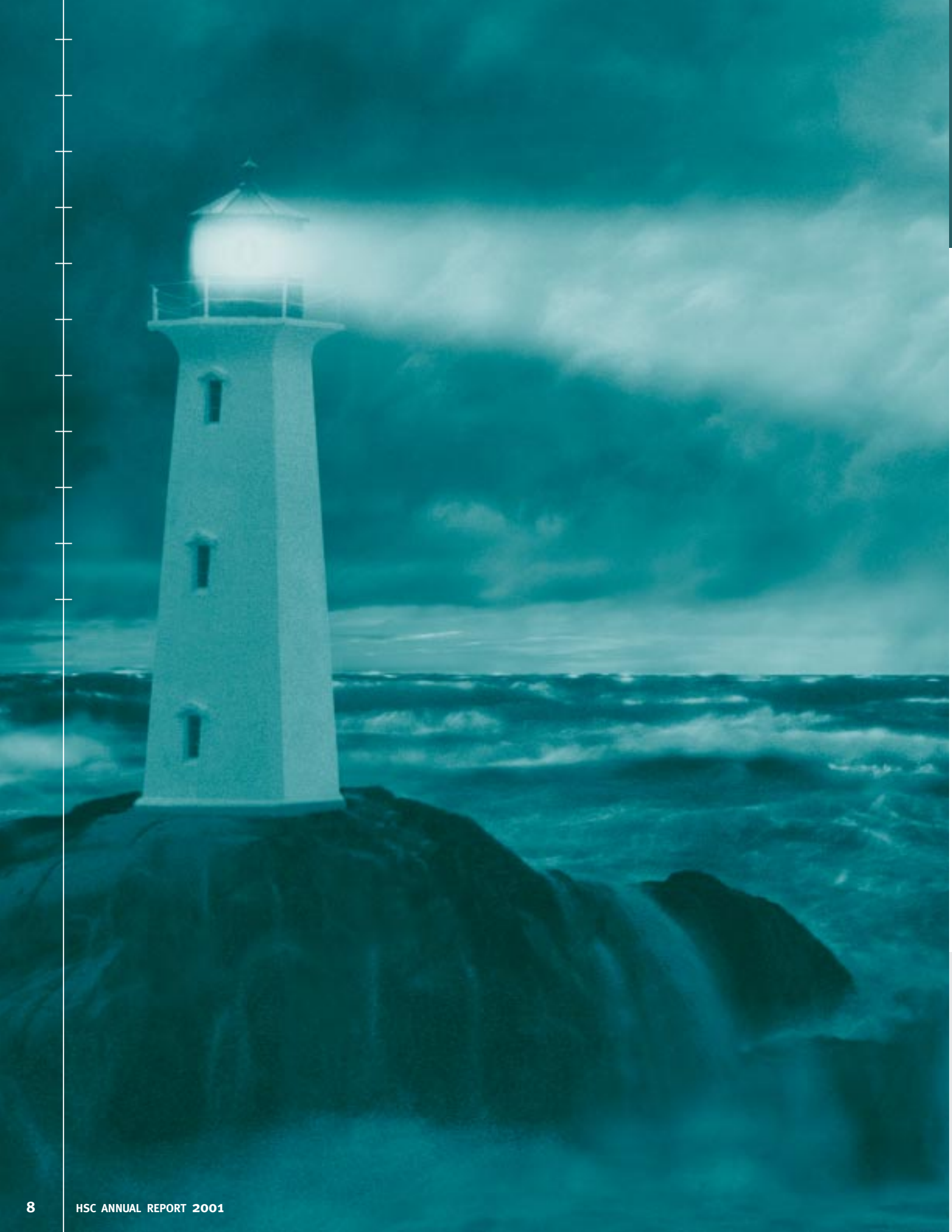
These are not entirely uncharted waters. Before the managed care era, more cost sharing was the norm. The RAND Health Insurance Experiment of the 1970s showed that consumers facing cost sharing did not reduce unnecessary care to a greater extent than necessary care, so much will be riding on consumers being better informed. One also wonders, with most health care dollars spent on a small proportion of people who are very sick, just how large is the potential of cost-sharing tools that still provide financial protection against major expenses.

The financial burdens on those living with chronic disease and increasing inequality of access to care from substantial cost sharing would likely concern policy makers. In contrast to debates over managed care restrictions, a parallel response—prohibiting various cost-sharing arrangements—is unlikely. Instead, these issues could lead to more serious discussions about existing tax subsidies for health coverage and whether they should be refocused on those with lower incomes. Replacing the tax exclusion for employer-sponsored health insurance with a tax credit has long had intellectual adherents from both the left and the right but few supporters with political clout.

Ironically, the move toward more cost sharing probably will rekindle interest in tightly managed care. Unhappy consumers will prefer less provider choice and more administrative controls over large cost-sharing obligations. A system that allows people to choose among alternative tools to constrain the costs of their care would be attractive in light of society's split on these issues. People with lower incomes, in particular, might welcome administrative controls in place of cost sharing that would pose a more formidable barrier to care.

If our experience charting the course of health system change over the past few years has taught us anything—and it has—it is that we must pay attention to the critical interactions among the economy, the political system and the financing and delivery of health care. A combination of these factors has taken us from integrated delivery systems and tightly managed care to broad and loosely structured systems and, now, a renewed reliance on cost sharing to curb utilization. Whether the system remains on course or runs aground is uncertain and will depend on the performance of the economy and the experience of both the general public and key stakeholders.

Paul B. Ginsburg
President, HSC



Shedding Light on Health Care Markets with Research

by Len M. Nichols

EVERY RESEARCH ORGANIZATION CONTINUALLY ASKS ITSELF two fundamental questions: which topics should it study, and how should it communicate the findings to the outside world? Indeed, research organizations define themselves as distinct types by the way they answer these questions. At HSC, we answer both questions in a way that maximizes the objective insights we contribute to current and future health policy discussions.

Each year we carefully survey the policy environment before we select our research topics. This review includes consultations with our advisory committee members; ongoing conversations with senior federal and state policy staff; feedback HSC researchers receive when they speak at meetings, participate in advisory panels and referee journal articles; and ongoing monitoring of the key players in our 12 site visit communities. Senior management prepares a memo summarizing the near- and intermediate-term policy environment to help HSC researchers frame their research proposals. Additional research is initiated by management in response to unique opportunities our data or insights have for contributing to emerging policy issues. For example, in early 2002 Paul Ginsburg testified before Congress as lawmakers debated the impact of a reduction in Medicare physician fees. HSC was able to use data from our 2000-01 Household and Physician Surveys to identify signs of tightened capacity and access problems for seniors that occurred just before the payment cut.

By tracking these changes across the six years of our surveys, we could identify trends and put this result in context by reporting on similar access problems experienced by the near-elderly population. Underlying all of this is our policy that all intellectual work at HSC is designed to improve understanding so policy decisions can be made with less uncertainty and rhetorical heat and more analytical light.

Of course, no matter how rigorous, pertinent and timely the research is, actually improving the information and policy makers' understanding of it requires an effective communication strategy. Here, HSC has two guiding principles:

- **Researchers themselves**—after an extensive internal and (where appropriate) external review process—draw policy inferences and explain the limits of the analysis; and
- **Multiple product types**—e.g., refereed journal articles, HSC publications (Issue Briefs and Data Bulletins) that draw from published research and HSC publications that represent original research—combine to enhance the power of any communication effort to inform policy makers.

Adherence to these principles empowers our audiences to make their own judgments and to avoid dependence on subjective translators (i.e., lobbyists). In this way, HSC's publications provide an independent source of information our readers can rely on. To clarify the message, implications and limits of our research findings, we also offer briefings to small groups of policy makers, researchers and others.

In the short term, policy makers—public and private—are our primary audience, and we design much of our research to provide them with timely and unbiased data and analyses to inform their deliberations on everything from public policy choices to private decisions that affect people's access to care and coverage opportunities. The media serve as an important conduit to policy makers, so we try to make our research findings and products as accessible to them as possible.

Our ultimate audience is fellow researchers. Their peer review of our research allows policy makers and the media to be confident that they can depend on our objectivity and rigor, serving as both a filter for and validator of our work. By enriching our knowledge of the way the health care system operates, we make an immediate contribution to current debates and help to shape the nature of future ones. Only by meeting both of these tests—rigor and relevance—can we succeed in either area. Thus, in our view, HSC's policy focus motivates the research process and improves our products because our results really matter, even as the rigor of the research makes our contribution to policy debates respected and appreciated by all sides.

The following illustrate ways in which our research has been relevant to policy makers in three key policy areas: insurance coverage and costs; access to care; and local markets and managed care.

Policy Area One ➤ INSURANCE COVERAGE AND COSTS

Tracking Health Care Costs

By documenting that hospital costs once again are the most important driver of health care inflation, HSC demonstrated that rising costs are not just a reflection of continuing rapid growth in prescription drug spending but now are spread more widely across the health care sector. HSC identified several key factors feeding hospital cost growth, including greater use of services because of loosening managed care, higher prices due to hospital consolidation, consumer demand for broader provider networks, reductions in excess capacity and rising labor and other costs. HSC research also detailed that health plans were raising insurance premiums by more than they expected costs to rise to recoup earlier losses.

Expanding Insurance Coverage

Federal and state policy makers once again began focusing on ways to deal with the seemingly intractable problem of the uninsured. Proposals spanned the spectrum, from expanding such public programs as Medicaid and the State Children's Health Insurance Program (SCHIP) to providing tax subsidies to individuals and small firms to encourage purchase of coverage. HSC research identified several critical challenges policy makers face in implementing such strategies, including the impact aggressive underwriting of individual policies (e.g., denials of coverage, higher premiums and/or restrictions on coverage) could have on those with chronic conditions, the limited reach of certain public programs and the potentially high cost of subsidies. We also tracked state and local efforts to subsidize worker contributions and offer subsidies to small employers. So far, neither employers nor employees have embraced these programs with much enthusiasm. HSC research suggests that very large subsidies would be needed to increase coverage in small firms by even a modest amount.

On a brighter note, SCHIP has nearly eliminated differences across communities in children's eligibility for health insurance. Yet, some communities continue to have a very high percentage of unin-

The Wall Street Journal ➤ September 27, 2001

"It's not a question of if consumers will pay more," said Paul Ginsburg, president of the Center for Studying Health System Change, a nonpartisan policy research organization in Washington. "The slower the economy gets, the sooner that day is going to come."

sured children, due in part to low participation in SCHIP and other public programs. HSC research pointed to the need for policy makers to eliminate enrollment barriers and profiled states that are turning to local communities, in partnership with health care organizations, schools, employers and community and religious groups, to help them reach children.

Changing Face of Insurance

A booming U.S. economy helped to shelter most consumers from premium increases. Employers continued to offer coverage with broader networks and less tightly managed care, but recently they have begun to shift some costs to employees by increasing copayments and deductibles for medical services and introducing three-tier pharmacy drug benefits that require consumers to pay more out of pocket for higher-cost drugs. Concerned about the continuing rise in premiums, employers have begun considering the concept of a defined contribution to coverage. Due to its potential impact on markets and consumers, HSC is closely tracking this issue, focusing in particular on the potential for splintering employee risk pools and the need for more sophisticated information to help consumers make the choices demanded of them. HSC researchers laid the foundation for this work by studying worker sensitivity to out-of-pocket premiums.

Related Publications by HSC Staff on Insurance Coverage and Costs

Health Affairs, Vol. 21, No. 1, January/February 2002

Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes

by Sally Trude, Jon B. Christianson, Cara S. Lesser, Carolyn A. Watts and Andrea M. Benoit

International Journal of Health Care Finance and Economics, Vol. 1, No. 1, 2002

Worker Decisions to Purchase Health Insurance

by Linda J. Blumberg, Len M. Nichols and Jessica Banthin

Issue Brief No. 47, December 2001

Premium Subsidies for Employer-Sponsored Health Coverage: An Emerging State and Local Strategy to Reach the Uninsured

by Leslie Jackson Conwell and Ashley C. Short

Issue Brief No. 46, December 2001

Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly

by James D. Reschovsky and Jack Hadley

Issue Brief No. 44, October 2001

Communities Play Key Role in Extending Public Health Insurance to Children

by Laurie E. Felland and Andrea M. Benoit

Health Affairs, Web exclusive, Sept. 26, 2001

Tracking Health Care Costs: Hospital Care Surpasses Drugs as the Key Cost Driver

by Bradley C. Strunk, Paul B. Ginsburg and Jon R. Gabel

Health Affairs, Web exclusive, July 25, 2001

Targeting Communities with High Rates of Uninsured Children: Despite Improved Eligibility, Enrollment Outreach Remains the Key to Getting Children Insured

by Peter J. Cunningham

Policy Area Two ➤ ACCESS TO CARE

A new series of HSC publications—Tracking Reports—identifies trends in access, coverage, managed care and local markets. The first reported that despite the strong U.S. economy, overall rates of access failed to improve between 1997 and 2001. More Americans reported problems getting timely physician appointments, insurers refusing to pay for services and providers refusing to accept their insurance.

Closing Ethnic and Racial Disparities

While there has been small reductions in disparities between racial and ethnic minority Americans and whites, disparities in access to care persist. HSC has joined this national debate by focusing research on the link between gaps in insurance coverage and problems accessing needed services. A second study revealed that minority physicians have more trouble than their white counterparts obtaining medically necessary care for their patients, including hospital admissions and specialist referrals.

Living with Chronic Conditions

People living with chronic medical conditions face particularly difficult barriers to care. Often perceived primarily as a problem of the elderly, HSC research showed that chronic conditions are widespread among working-age adults. People living with chronic conditions are less likely than healthy adults to be able to afford individual insurance. While Medicare and Medicaid play a key role in providing coverage for the most vulnerable, more than 7 million working-age adults with chronic conditions remain uninsured, and almost two-thirds of them have low incomes. Uninsured working-age adults with chronic conditions are more likely to report poorer health and more functional limitations than the privately insured with chronic conditions and are substantially more likely to have unmet or delayed health care needs. Yet, an HSC analysis of proposals to expand insurance coverage—from tax credits to SCHIP expansions—found most would provide only limited relief to the chronically ill.

Related Publications by HSC Staff on Access to Care

Tracking Report No. 2, June 2002
The Insurance Gap and Minority Health, 1997-2001
by J. Lee Hargraves

Issue Brief No. 51, April 2002
Prescription Drug Access: Not Just a Medicare Problem
by Peter J. Cunningham

Tracking Report No. 1, March 2002
Treading Water: Americans' Access to Needed Medical Care, 1997-2001
by Bradley C. Strunk and Peter J. Cunningham

Issue Brief No. 50, February 2002
Options for Expanding Health Insurance for People with Chronic Conditions
by Ha T. Tu and Marie C. Reed

Issue Brief No. 49, February 2002
Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America
by Marie C. Reed and Ha T. Tu

Health Services Research, Vol. 36, No. 5, October 2001
Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans
by J. Lee Hargraves, Peter J. Cunningham and Robert G. Hughes

Medscape, Web exclusive, Aug. 9, 2001
Minority Physicians' Experiences Obtaining Referrals to Specialists and Hospital Admissions
by J. Lee Hargraves, Jeffrey Stoddard and Sally Trude

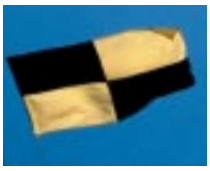
Changing Nature of Managed Care

Responding to the consumer backlash against tightly managed care, health plans are offering less restrictive managed care products and eliminating or relaxing referral and authorization requirements. Health plan efforts to rein in growth in pharmaceutical spending through price reductions and changes in prescribing habits have largely failed. Instead, plans moved rapidly to a three-tier benefit that seeks to make consumers more cost conscious by requiring them to pay more for more expensive drugs. New plan products are extending the tiered design to hospital and provider networks, requiring consumers to pay more to visit certain, often higher-cost, providers. While such approaches may allow health plans to regain some of their lost leverage with providers, they also can adversely affect low-income consumers and those in poor health.

Meanwhile, state policy makers have been implementing Medicaid prescription drug cost-containment strategies that appear to be creating significant gaps in access to drugs for low-income Americans in the program. One in four nonelderly adult Medicaid beneficiaries surveyed by HSC reported being unable to afford to fill a prescription in the previous 12 months, with beneficiaries in states with more restrictions tending to have more access problems.

Leveraging the Retreat from Managed Care

With the retreat from tightly managed care and increasing provider leverage, many hospitals have returned to a traditional retail strategy of competing for patients and physicians rather than competing for managed care contracts. Hospital investment in a broad array of expensive new services and marketing efforts may contribute to rising health care cost trends. As a result, some policy makers are contemplating a return to or tightening of such traditional regulatory strategies as certificate-of-need laws.



USA Today ➤ February 20, 2002

"It's like Wendy's vs. McDonald's," says Kelly Devers, a health researcher in Washington, D.C. "If one adds a service, the other will copycat it. They're fighting for their lives and want to make sure they don't give up turf." (From an article describing the medical arms race.)

Responding to Medicare Changes

HSC has tracked the rise and fall of Medicare+ Choice (M+C) in local communities closely. Positive market conditions before passage of the Balanced Budget Act of 1997 (BBA) helped to spur M+C growth in plan and beneficiary participation, while declining market conditions, especially rising health care costs, intensified the impact of BBA changes in payment and other policies. It was this collision of public policy and private market forces, rather than policy changes alone, that brought M+C growth to a halt. HSC researchers also contributed to the M+C payment reform debate. Finally, Paul Ginsburg used HSC data in his testimony to Congress on the potential impact of Medicare physician fee cuts, warning that continued cuts in payment rates risked reducing beneficiaries' access to care because of an overall tightening in physician capacity.

Related Publications by HSC Staff on Local Markets and Managed Care

Issue Brief No. 52, May 2002

Reversal of Fortune: Medicare+ Choice Collides with Market Forces

by Joy M. Grossman, Bradley C. Strunk and Robert E. Hurley

Issue Brief No. 51, April 2002

Prescription Drug Access: Not Just a Medicare Problem

by Peter J. Cunningham

Health Affairs, Vol. 21, No. 1, January/February 2002

The Changing Face of Managed Care

by Debra A. Draper, Robert E. Hurley, Cara S. Lesser and Bradley C. Strunk

Written testimony and opening statement before the Subcommittee on Health of the House Committee on Ways and Means, Hearing on Medicare Physician Payment, Feb. 28, 2002, www.hschange.org

by Paul B. Ginsburg

Presentation at HSC conference, *Emerging Health Care Market Trends,* Dec. 10, 2001, www.hschange.org

The Return of the Medical Arms Race

by Kelly Devers

American Journal of Managed Care, Vol. 7, No. 11, November 2001

Managed Care in the Doctor's Office: Has the Revolution Stalled?

by Jeffrey Stoddard, James D. Reschovsky and J. Lee Hargraves

Issue Brief No. 45, November 2001

Consumers Face Higher Costs as Health Plans Seek to Control Drug Spending

by Glen P. Mays, Robert E. Hurley and Joy M. Grossman

Health Care Financing Review, Vol. 23, No. 2, Winter 2001

Premium Rebates and the Quiet Consensus on Market Reform for Medicare

by Roger Feldman, Bryan Dowd, Robert Coulam, Len Nichols and Ann Mutti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45

Charting a Course Together
HSC, RWJF and MPR

Supporting RWJF's Mission

Along with other grantees, HSC informs the research and program activities of The Robert Wood Johnson Foundation (RWJF), helping to support the Foundation's overall mission to improve the health and health care of all Americans. HSC is a major component of RWJF's health tracking initiative, which features a network of research organizations studying various facets of the changing health care system at the national and local levels. Specifically, HSC's research contributes to understanding what works well in the American health care system and what does not, both nationally and in communities across the country. The Foundation concentrates grant-making support in four broad areas:

- assuring that all Americans have access to basic health care at reasonable cost;
- improving care and support for people with chronic health conditions;
- promoting healthy communities and lifestyles; and
- reducing the personal, social and economic harm caused by abusing tobacco, alcohol and illicit drugs.

These areas also are covered by the network of organizations associated with HSC's Community Tracking Study. 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. Both continue to play a leadership role within the research network. Along with them, **Maureen Michael,** program officer, provides leadership to the project and is responsible for managing the network day-to-day. **Paul Tarini,** senior communications officer, provides public affairs counsel to the project; **Jean Lim,** program associate, provides important guidance on our work with states; and **Rona Henry,** senior financial officer, provides financial oversight. HSC is among the many projects under RWJF's Health Care Group led by **Risa Lavizzo-Mourey, M.D.,** senior vice president and director.

HSC Staff

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Selected Staff Biographies

Paul B. Ginsburg, Ph.D., is the founding president of HSC. He provides overall leadership to the organization, with particular involvement in site visit research and analysis of health care costs. Ginsburg is nationally recognized for his work in

health economics and health policy, especially health care market changes and cost trends, and is a noted speaker and consultant. He was the founding executive director of the Physician Payment Review Commission (now the Medicare Payment Advisory Commission) and deputy assistant director of the Congressional Budget Office. Ginsburg conducted health policy research at RAND and on the faculties of Duke University and Michigan State University. He earned his doctorate in economics from Harvard University.

Len M. Nichols, Ph.D., vice president, provides leadership in shaping HSC's research to inform the policy process in a timely and nonpartisan way and conducts research related to private health insurance and health care markets. Previously, Nichols was a principal research associate at The Urban Institute, a senior adviser for health policy at the Office of Management and Budget, a visiting Public Health Service Fellow at the Agency for Health Care Policy and Research, now known as the Agency for Healthcare Research and Quality (AHRQ), and an associate professor and chair of the Economics Department at Wellesley College, where he taught from 1980 to 1991. He earned his doctorate in economics from the University of Illinois.

Richard Sorian, director of public affairs and senior researcher, oversees HSC's publications, media activities and public policy outreach while conducting research into communication of health policy to policy makers and the public. He previously was a senior researcher at Georgetown University's Institute for Health Care Research and Policy and deputy director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Sorian also was an award-winning journalist and editor of *Medicine & Health,* a nationally recognized newsletter covering U.S. health policy development, and author of three books on health policy. He has a joint degree in political science and journalism from The George Washington University.

Joy M. Grossman, Ph.D., associate director, coordinates HSC's data collection and research activities. Her research specialties are health plan and provider competition and managed care. She previously was a health policy analyst at the Prospective Payment Assessment Commission and an investment banker. Grossman received her doctorate in economics from the University of California at Berkeley.

Richard C. Strouse, vice president, directs HSC's surveys. Previously, he was deputy director of MPR's Survey Division, where he was responsible for design and marketing of health surveys for foundations, medical associations and other nonprofit organizations. His other research interests include public attitudes toward tobacco policy issues. He received a bachelors' degree in history from Trinity College and did graduate work in Russian history at Columbia University.

Jack Hadley, Ph.D., senior fellow, focuses his work at HSC on studies of the health insurance market and physician behavior. Hadley is a principal research associate at The Urban Institute, a past president of the Association for Health Services Research and a former editor of *Inquiry.* He received his doctorate in economics from Yale University.

Peter J. Cunningham, Ph.D., senior health researcher, specializes in access to care, the unin-

sured and safety net issues. Previously, he was a researcher at AHRQ, where he worked on the National Medical Expenditure Survey. Cunningham received his doctorate in sociology from Purdue University.

J. Lee Hargraves, Ph.D., senior health researcher, specializes in patient and consumer assessments of health care, racial and ethnic disparities in health care and quality of medical care. Before joining HSC, he was senior survey scientist at the Picker Institute and an investigator on AHRQ's Consumer Assessment of Health Plans (CAHPS) project. Hargraves received his doctorate in sociology from Boston College.

Cara S. Lesser, M.P.P., senior health researcher, directs HSC's site visit work and specializes in studies of consolidation and market change. Previously, she was a senior research associate at the Institute for Health Policy Studies at the University of California at San Francisco. Lesser received her master's degree in public policy from the University of California at Berkeley.

James D. Reschovsky, Ph.D., senior health researcher, focuses his research on health insurance, managed care and physician issues. Previously, he held academic positions at Michigan State University and Cornell University and was a research fellow at AHRQ. Reschovsky received his doctorate in public policy studies from the University of Michigan.

Sally Trude, Ph.D., senior health researcher, focuses on physician issues and employer-sponsored insurance, including consumer-driven health plans. Previously, she was a senior analyst at the Physician Payment Review Commission and a health services researcher at RAND. Trude received her doctorate in public policy analysis from RAND.

Kelly J. Devers, Ph.D., health researcher, specializes in managed care, hospital and physician organization and quality. She also is an expert in qualitative and mixed-methods research. Previously, Devers was a senior research fellow at AHRQ. She received her doctorate in sociology from Northwestern University and completed an RWJF Scholars in Health Policy Research postdoctoral fellowship at the University of California at Berkeley and at San Francisco.

Ha T. Tu, M.P.A., health researcher, focuses on the effects of managed care and the health care experiences of people with chronic conditions. Formerly, she was an economic consultant to the Center for Health Policy Studies in Columbia, Md., and the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS). Tu received her master's degree in public affairs from Princeton University.

Alwyn Cassil, public affairs manager, directs HSC's media relations and contributes to its publications. Previously, she was a press officer at the U.S. Department of Health and Human Services' Office of Inspector General and CMS and Washington editor of *AHA News,* the weekly newspaper published by the American Hospital Association. She received a bachelor's degree in journalism from the University of Florida.

Recent HSC Publications

Issue Briefs

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Reversal of Fortune: Medicare+Choice Collides with Market Forces

Joy M. Grossman, Bradley C. Strunk and Robert E. Hurley

No. 51

Prescription Drug Access: Not Just a Medicare Problem

Peter J. Cunningham

No. 50

Options for Expanding Health Insurance for People with Chronic Conditions

Ha T. Tu and Marie C. Reed

No. 49

Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America

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Treading Water: Americans' Access to Needed Medical Care, 1997-2001

Bradley C. Strunk and Peter J. Cunningham

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No. 5

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HSC and MPR

Since its founding, HSC has been a sister organization to 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 has conducted some of the most important evaluations of key federal, state and local public programs and demonstrations. These studies have focused on issues across the life span, 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, including 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. MPR conducts the CTS Household Survey and Insurer 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 and other statisticians. Debra Draper, Sue Felt-Lisk, Glen Mays and other MPR researchers actively participate in HSC's site visits.

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HSC Mission

HSC's mission is to inform policy discussions about how changes in national and local health care markets affect people's health care. HSC collects and analyzes data from those who finance, deliver and receive health care services. HSC provides timely, objective and incisive analyses on health care developments of national significance, thereby enhancing policy makers' capability to improve health and health care.

HSC Vision

HSC is committed to becoming the leading health policy research organization devoted to understanding developments in health care markets and communities and the effects on people's health care.

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