Analyzing the changing health system: the path taken and the road beyond

CENTER for STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

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danger signs ahead...

The trajectory of change for the health care system foretells danger signs ahead. It is a course that may lead to poorer outcomes for consumers, with prospects of higher costs, more barriers to care and missed opportunities to improve quality. Six years ago, many leaders were enthusiastic about integrated delivery systems that promised substantial cost savings and a more seamless experience for patients whose care would be coordinated and managed according to the most effective medical practices. Now, a powerful backlash against managed care—some of it well founded—has led to consumer desire for broad provider choice. This, in turn, is leading to a dismantling of many of the structures that were the source of optimism.

The key change that has reverberated throughout the health system is the retreat of managed care over the last several years. For reasons that include lack of plan choice on the part of consumers, physician unhappiness with loss of autonomy and low fees, clumsy execution on the part of health plans and media attention to these problems, a virulent backlash has developed against managed care:

- Fearful that their medical care will be compromised, consumers see broad choices among physicians and hospitals as their key protection.
- Employers that pressed employees to enroll in managed care plans have responded to the backlash by demanding that health plans make key changes.
- Plans have responded by including wider provider networks, products that offer direct access to specialists and benefits for out-of-network use, external appeals processes and fewer authorization requirements.
- Governments have directed similar changes through policies that regulate health maintenance organizations (HMOs).

Managed care's retreat is having profound ripple effects throughout the health system, and this is only the beginning. It will likely lead to higher costs, more cost sharing for consumers, new barriers to access, greater numbers of uninsured and a weaker platform from which to improve quality. But what is most troubling is the lack of a vision for the next wave of innovation in health care financing and delivery. Most of the energy of leaders today is going into dismantling structures to adjust to the retreat of managed care.

Higher Costs in 2001

After remaining under 4 percent from 1995 through 1998, health insurance premium increases exceeded 8 percent in 2000 and are expected to be higher in 2001.[1] A major determinant of health care cost trends over the last decade has been the interplay between health costs and the economy's performance. Employers started their push to move employees into managed care plans when health benefit costs were rising rapidly and loomed large compared with profits. A key sweetener for employees was the fact that the typical managed care benefit structure offered broader benefits (e.g., preventive services) and required much less cost sharing than traditional coverage. Indeed, out-of-pocket spending on medical services for those with insurance declined during the 1990s.[2] Of particular note, pharmaceuticals became more affordable to consumers because of lower cost sharing; in 1999, drugs accounted for 44 percent of the increase in costs underlying private insurance.[3]

This was a double-edged sword for consumers. Along with less financial responsibility for health care came more management of care. But when consumers encountered barriers to care, or heard through friends or the media about restrictions faced by others, they complained to their employers and lawmakers. With health care premium trends decreasing, profits increasing and labor markets unusually tight, employers responded to these complaints. They offered less restrictive plans with wide networks, direct access to specialists and fewer restrictions. Many of these changes are leading to higher costs now.

Another factor driving costs higher is increased provider leverage. More choice has substantially weakened health plan

bargaining power with providers. Hospitals and some specialty physicians have received substantial rate increases from plans as a result of consumer and employer demands that plans offer a broad choice of providers. Indeed, showdowns between health plans and hospitals over contract terms have occurred in many communities, often with substantial media attention.[4] Employer pressure on health plans to minimize instability of provider networks has further weakened plans' bargaining position and has led to higher rates.

More Cost Sharing

The retreat from managed care is likely to lead to much more extensive cost-sharing responsibilities for consumers. With premiums rising, corporate profits down and labor markets loosening, employers are beginning to consider options to keep their benefit outlays from growing rapidly. The backlash against managed care suggests that patients will have to pay more at the point of service. A harbinger is the recent action by the California Public Employees' Retirement System (CalPERS) to increase cost sharing in its HMO plans as a way to pare down a negotiated 13 percent premium increase to 6 percent.

Greater cost sharing is likely to take place for two reasons.

>> First, with the shift to looser restrictions in managed care moving ahead at full steam, it is unlikely that employers will take a 180-degree turn back to tight restrictions.

>> Second, with many restrictions dismantled, the typical managed care benefit structure is increasingly seen as providing inadequate financial incentives to control costs.

The need for incentives is noted most dramatically in pharmaceuticals, where the scope for discretion by both physicians and patients is relatively large. It is not surprising that many employers adopted a three-tiered copayment strategy for drugs before taking other steps to increase cost sharing.

Initially, increased cost sharing will come largely from higher deductibles, coinsurance and copayments. However, the field is ripe for innovation. Following the lead taken for prescription drugs, innovation will emphasize giving consumers choice at the point of service between degrees of restriction and related cost sharing. With drugs, the consumer faces a choice with each prescription whether to adhere to the

Stuart Altman
Brandeis University

"Managed care has been defanged, and the leverage providers have gained will not be easily reversed. This should send a chill down the backs of employers, public purchasers and consumers because we can expect our premiums to surge."

formulary and avoid the additional copayment. To reduce costs further, the three-tiered copayment for pharmaceuticals is likely to evolve to three-tiered coinsurance (based on percentage amounts of the prescription cost).

This approach is starting to be applied to provider networks. Some plans offer two networks with different copayments or coinsurance required (along with the highest coinsurance for providers not in either network). This approach dovetails with the ability of providers with the strongest brand names to demand higher payment rates from health plans. Although the classification of providers into high- and low-cost networks will be based initially on payment rates negotiated with health plans, one can envision a future in which profiling of practice patterns plays a role as well.

As cost sharing in general and tiering in particular become more significant, the gap in access to care based on income level is likely to capture the attention of policy makers. Today's horror stories about needed services being blocked by managed care bureaucrats could well be replaced by examples of people doing without important care because the cost sharing was beyond what they could afford. Policy attention might then turn to making sure that regulation does not interfere with products that require minimal cost sharing and depend instead on tight management to keep costs controlled. Indeed, a few years of experience with high cost sharing is likely to rekindle interest in the tightly managed products that are so out of favor in today's market.

New Barriers to Access

Disruptions to the health system caused by the retreat from managed care are also posing barriers to access to care. For the first time in decades, hospital capacity problems have emerged in a number of communities. Most visible are problems in emergency departments, where ambulance diversions are occurring with increasing frequency, resulting in patients being rerouted to other hospitals and delays in care.[5] Some of the reasons for crowding include regulations limiting managed care restrictions on emergency room use, stepped-up enforcement of the Emergency Medical Treatment and Labor Act and acute shortages of nurses and other skilled personnel.

Overall hospital capacity has played a role as well. From 1994 to 1999, the number of emergency departments declined by

Karen Ignagni
American Association of Health Plans

"Policy makers should know that we can't have it both ways: we can't by law or regulation take away basic tools of managed care or encumber plans, employers and doctors with more liability, and then still expect the system to deliver on its promise."

8 percent. Patients who need intensive care when beds are not available often must remain in the emergency department to get the care they need. Over the same period, inpatient beds declined by 15 percent, as intense pressure to cut costs—coming from both low payment rates in managed care contracts and reductions in the growth of Medicare payment rates under the 1997 Balanced Budget Act—led to closure of capacity deemed not essential. With hospitals vigorously adding facilities to provide the most prestigious and profitable services, investing in emergency facilities, which tend to lose money, may be losing out in the competition for scarce capital resources.

A different type of barrier to access seen over the past two years is network instability. In many communities, important providers have declined to renew contracts with health plans, largely because of disagreements over payment rates. For example, in Orange County, Calif., St. Joseph Health System terminated the largest of its managed care contracts, with PacifiCare, affecting 100,000 consumers. Such terminations can be highly disruptive to consumers, who often face a choice of changing providers—perhaps during a course of treatment—or paying substantially more out of pocket.[6,7] Closures of physician organizations, such as medical groups owned by failed physician practice management companies, also contribute to network instability.

Increase in the Uninsured

As we enter a period in which the economy may not be as robust and insurance premiums are increasing more rapidly again—in part due to the retreat from managed care—the proportion of people who are uninsured is likely to increase. The literature suggests a substantial sensitivity of health insurance coverage to premiums.[8]

Federal policy might offset this trend somewhat. Over the past year, diverse interest groups have reached out to each other to work on legislation to reduce the number of uninsured.[9] Many envision a compromise consisting of expansions of public programs providing coverage for

James Bentley
American Hospital Association

"Many hospitals are experiencing emergency room capacity problems and staff shortages and expect things to get worse before they get better. Looser managed care has resulted in patient logjams, and with premiums rising hospitals are likely to treat growing numbers of uninsured who have no place else to go."

the poor and tax credits for individuals with somewhat higher incomes to purchase private insurance. Initially, enactment of proposed federal legislation to expand public programs and offer tax credits to purchase coverage would outweigh the erosion of coverage from higher premiums. However, it is clear that rising health care costs will outstrip the gains over time, making the goal of universal coverage more difficult to reach.

Another dynamic affecting insurance coverage is state and local policy for the low-income uninsured. In recent site visits to 12 nationally representative communities, HSC noticed increased support at the state and local level for funding safety net providers, such as public hospitals and community health centers. A number of states, for example, have devoted large portions of tobacco settlement money to the safety net.

Although some analysts have raised the conceptual choice between policies promoting expansion of coverage and those providing more services for the uninsured, HSC has found that communities pursuing efforts in this area are doing more on both counts. President Bush has put forward initiatives related to both care and coverage. Discussions may lead to a consensus that some low-income individuals can best be assisted by enabling them to obtain health insurance coverage while others cannot be brought into the health insurance system and are best supported through funding safety net providers.

Concerns About Quality of Care

Integrated delivery had offered the hope of accountability for the quality of care provided to an enrolled population. The movement away from integrated delivery systems and capitated payment of provider organizations—aspects of the retreat from managed care—is removing a potential platform for providers to improve quality. Integrated delivery systems were seen as improving quality through the use of evidence-based medicine applied to the needs of a defined population.

Although longstanding integrated delivery systems, such as Kaiser Permanente, are pursuing this vision vigorously, the expectation of creating many more such systems has diminished. Some of this occurred because of the difficulty of getting large organizations with different cultures to work together effectively, but the retreat from managed care may have been a more significant blow.

John Rother
AARP

"Shifting costs onto consumers—directly or through artfully constructed defined-contribution schemes—is not the solution to rising premiums. The end result may be higher barriers to needed services and, ultimately, fewer working Americans with health insurance."

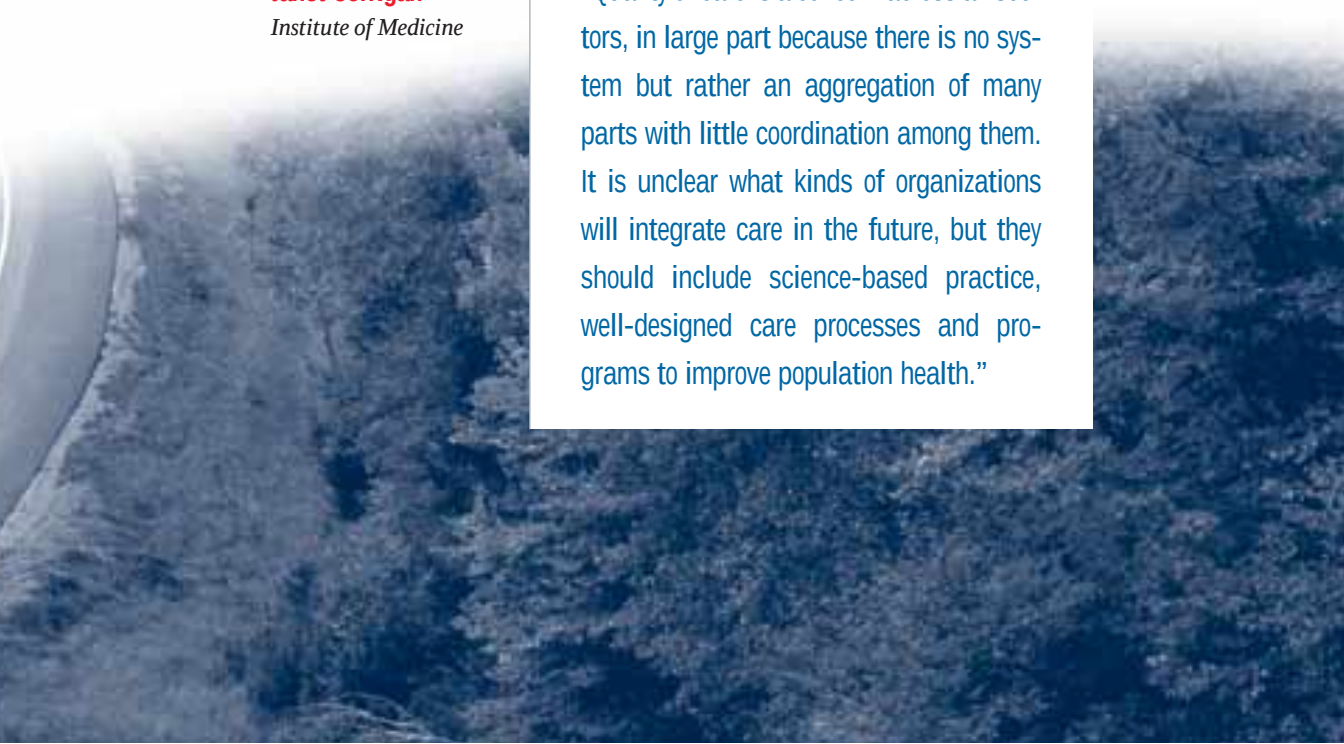
The desire for broad provider choice has meant that the archetypical integrated delivery insurance product—an HMO with the provider network comprising a single hospital system and physicians associated with it—is not an attractive one. HMOs today tend to offer enrollees access to most hospital systems in the area. Furthermore, in many communities, interest in HMO products has declined.

In addition, global capitation—hospitals and physicians together assuming all financial risk for health services—has not developed as expected. Both providers and health plans have pulled away from this arrangement over the past two years. In many cases, this retrenchment has been the result of unfavorable experience—providers losing money or plans having to support providers in financial difficulty. But the lack of growth in the market share of HMO products is an important factor as well. Preferred provider organizations (PPOs) do not lend themselves to capitated payment, and providers report important difficulties in accepting risk in point-of-service (POS) products.

The absence of capitated payment undermines the business case for providers to engage in quality improvement activities. For example, when hospitals are paid on a per diem basis, programs to reduce length of stay detract from the bottom line. When disease management programs have significant educational components or require investment in information systems by physician practices paid under fee-for-service arrangements, the practices receive lower payment for physician services but are not paid for the services that are a substitute for seeing the doctor. The potential exists for disease management and other such programs to fall out of favor, leaving patients facing fractured, uncoordinated and, potentially, poor-quality care. According to the recent Institute of Medicine report, *Crossing the Quality Chasm*,[10] the lack of functioning systems and related incentives is at the heart of quality problems plaguing health care in this country.

Janet Corrigan
Institute of Medicine

"Quality of care is a concern across all sectors, in large part because there is no system but rather an aggregation of many parts with little coordination among them. It is unclear what kinds of organizations will integrate care in the future, but they should include science-based practice, well-designed care processes and programs to improve population health."



No Vision Ahead

Many people perceive the retreat from managed care to be a positive development and welcome less interference with delivery of care. But the retreat has set in motion a number of negative trends for consumers:

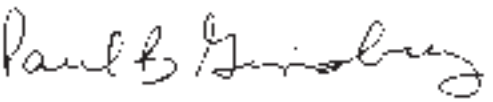
>> Cost trends will be higher and consumers will face more cost sharing.

>> New barriers to access are appearing, such as capacity shortages in emergency departments and disruptions in physician-patient relationships because of network instability.

>> Higher costs will lead to more people going without coverage, although public policy to expand coverage may postpone this development.

>> The integrated delivery platform to improve quality has been stymied by consumer demands for broad provider choice.

The situation in 2001 resembles that in the early 1990s, especially in terms of costs. But some differences do not bode well for the health system or consumers. One such difference is that the easy gains from managed care have already been exhausted. The potential for a rapid slowing of cost trends does not exist, especially given the higher degree of provider leverage. Another critical difference is the absence of a vision for an improved health system. In the early 1990s, many people shared a vision that managed care and integrated delivery would improve care. I cannot identify any comparable vision today.



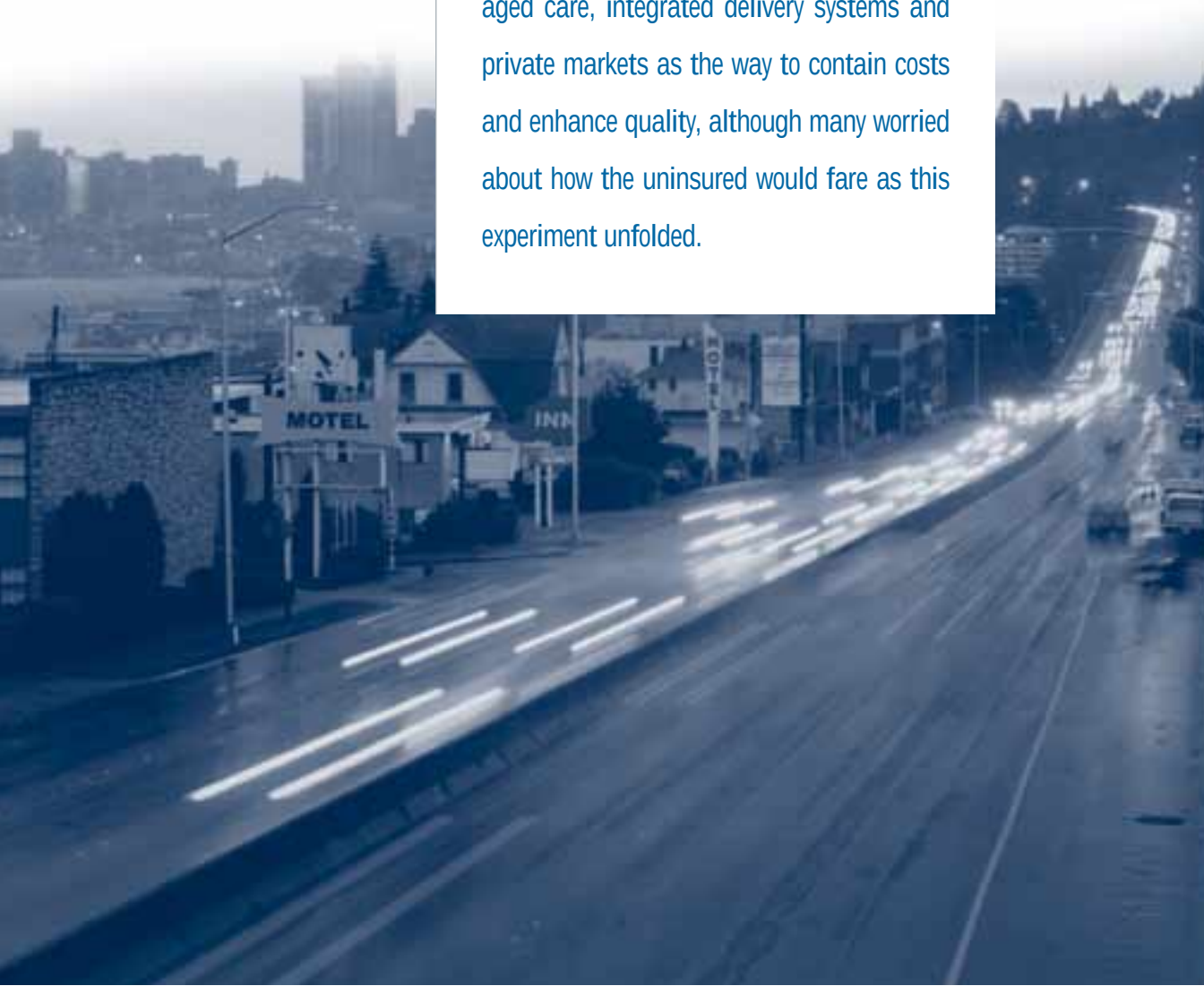
Paul B. Ginsburg

References

1. Gabel, Jon R., "Job-Based Health Insurance in 2000: Premiums Rose Sharply While Coverage Grows," *Health Affairs*, Vol. 19, No. 5 (September/October 2000).
2. Gabel, Jon R., Paul B. Ginsburg, Jeremy Pickreign and James D. Reschovsky, "Trends in Out-of-Pocket Spending by Insured American Workers, 1990-1997," *Health Affairs*, Vol. 20, No. 2 (March/April 2001).
3. Hogan, Christopher, Paul B. Ginsburg and Jon R. Gabel, "Tracking Health Care Costs: Inflation Returns," *Health Affairs*, Vol. 19, No. 6 (November/December 2000).
4. Strunk, Bradley C., Kelly J. Devers and Robert E. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief No. 40, Center for Studying Health System Change, Washington, DC (June 2001).
5. Brewster, Linda R., Liza S. Rudell and Cara S. Lesser, *Emergency Room Diversions: A Symptom of Hospitals Under Stress*, Issue Brief No. 38, Center for Studying Health System Change, Washington, DC (May 2001).
6. Strunk et al., op. cit.
7. Short, Ashley C., Glen P. Mays and Timothy K. Lake, *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, Issue Brief No. 39, Center for Studying Health System Change, Washington, DC (June 2001).
8. Kronick, Richard, and Todd Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," *Health Affairs*, Vol. 18, No. 2 (March/April 1999).
9. Kahn, III, Charles N., and Ronald Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, Vol. 20, No. 1 (January/February 2001).
10. Institute of Medicine, *Crossing the Quality Chasm*, Washington, DC: National Academy Press (2001).

...new direction

When The Robert Wood Johnson Foundation (RWJF) and Mathematica, Inc., formed HSC in 1995, many policy and industry leaders shared a common vision of the road ahead for health care. They saw a reliance on managed care, integrated delivery systems and private markets as the way to contain costs and enhance quality, although many worried about how the uninsured would fare as this experiment unfolded.



For the past six years, HSC has tracked changes in the health care system and assessed the implications for both insured and uninsured people through site visits and surveys, informing policy makers about how health care continues to evolve and, in some cases, unravel. Through interviews with consumers, physicians and leaders on the front lines of health care delivery and financing, HSC researchers have worked to decipher the twists and turns of the health system to determine the bottom line for patients.

RWJF was visionary in establishing an authoritative information source about the market forces and regulatory changes transforming the nation's health care system. At the time, much existing information was anecdotal, dated or focused on cutting-edge communities. Little was known about how changes in health system organization at the market level, as well as local and national policy initiatives, affected coverage, access to care for the uninsured, quality and costs. Policy makers often lacked credible information, often needing to rely on research produced by special interests or think tanks with strong ideological points of view.

The Community Tracking Study (CTS)

...national in scope, focused

National in scope but focused on communities where care is organized and delivered, the CTS consists of national surveys every other year of households and physicians and visits to 12 communities. A third survey of employers was conducted in 1997.

The telephone surveys are concentrated in 60 communities and have a panel of respondents carried over from previous rounds for tracking purposes. The third round of site visits was completed in March 2001, and the third round of the surveys also will be completed in 2001.

>> **Household Survey.** Sixty-thousand individuals in 33,000 families participate in the Household Survey, which assesses whether consumer access to the health care system is improving or declining over time. Particular areas of inquiry include access, satisfaction, use of services and insurance coverage. Information about health status and sociodemographic characteristics is also collected. An Insurance Followback Survey of the plans that household respondents are enrolled in is conducted to enhance reliability. Mathematica Policy Research, Inc., (MPR) conducts the Household and Followback Surveys for HSC.

>> **Physician Survey.** Twelve thousand practicing physicians across the country provide perspective on how health care delivery is changing. Physicians answer questions about compensation, whether they are able to provide needed services for patients and the effect various care management strategies have on their practices. Gallup conducts the Physician Survey for HSC.

>> **Employer Survey.** Twenty-two thousand public and private employers were interviewed to understand

In its six years, HSC has:

>> *Designed, launched and refined a major data collection effort* focused on private-market dynamics. Currently in its third round, the Community Tracking Study includes multiple, national surveys and visits to local communities. This combination of surveys and site visits provides HSC with a real-world focus and the ability to examine the interplay among health care sectors and between the private market and public policy at the community and national levels.

>> *Established a policy research program* noted for its objectivity and focused on providing information for policy makers concerned about growing numbers of uninsured, rising costs, access to care under managed care and other pressing policy issues.

>> *Developed a visible public affairs effort,* including numerous publications, regular conferences, extensive contact with news media and ongoing interaction with the health policy community.

at the local level

how they are shaping the health system. These employers, which span size and industry sector, are asked questions about the choice of plans they offer, how much their employees contribute to the cost of coverage, whether they participate in a purchasing alliance and whether they provide quality information to their employees. HSC collaborated with RAND on the Employer Survey.

>> **Site Visits.** Researchers examine the forces affecting health care organizations and how they are responding by interviewing 50 to 80 health care leaders in 12 sites: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich; Little Rock, Ark.; Miami; Northern New Jersey; Orange County, Calif; Phoenix; Seattle; and Syracuse, N.Y. The interviews generally cover hospital systems, employers, benefits consultants, health plans, medical groups, safety net providers and consumer groups.

>> **CTS-Related Research.** Other RWJF initiatives related to the CTS include: RAND researchers Beth McGlynn and Steve Asch's work to analyze the quality of care in HSC's 12 communities; efforts by UCLA/RAND researchers, including Kenneth Wells, Audrey Burman and Roland Sturm, to examine how public policies and markets affect access to substance abuse and mental health services; RAND researchers Stephen Long and Susan Marquis' analysis of employment-based health insurance; and research by Stephen Shortell at the University of California at Berkeley analyzing physician organizations.

To continue building on the success the organization has achieved, HSC leaders embarked on a strategic-planning process in 2000, gathering input from HSC staff, the HSC Board—especially Harold Beebout—and key individuals at RWJF and MPR.

Through the strategic-planning process, HSC honed its mission, crafted a vision statement to chart the organization's course and developed goals and objectives to enhance the policy impact of HSC's research.

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 effect on people's health care.

HSC's new mission focuses the organization's purpose and clearly identifies its primary audience—policy makers. The mission statement, coupled with HSC's vision, has already guided HSC leaders and staff as they map out a research agenda and make data collection design decisions.

The most important HSC strategic planning goals are as follows:

>> Establish key policy research areas and provide both narrow analyses and broader syntheses of relevant topics. Key policy research areas include:

- Private insurance coverage
- Access to care for the uninsured
- Managed care and markets

>> Make HSC's rich and varied data—already widely available to researchers—more accessible to policy makers and the news media.

>> Manage research planning and dissemination of findings strategically to have maximum impact on health policy.

HSC's areas of research focus are critical to health policy discussions and speak to HSC's strengths in terms of staff knowledge about local markets and the private sector and the organization's qualitative and quantitative trend data at the national and market levels.

While HSC expects its three broad policy areas to remain a focus long into the future, specific research topics will change, depending on the market and policy environment. Given HSC's vantage point on the cutting edge of market changes, HSC can identify important trends and anticipate future policy issues. HSC also will leverage ongoing relationships with external stakeholders and researchers, including those at MPR, its sister organization, to identify gaps in knowledge and information and to stay abreast of current policy thinking.

HSC is well suited to inform policy making in the early stages, as issues emerge and policy makers try to understand underlying market dynamics. In the past, HSC has provided early warnings about emerging problems, assessed the extent of problems, busted myths—often fueled by anecdote—and filled in important missing links about specific issues. For example, HSC research debunked the notion that plan choice was diminishing and drew policy makers' attention to the fact that 20 percent of the uninsured have access to employer-sponsored coverage.

An explanation of each research policy area follows, along with examples of recent, current and planned analyses for illustrative purposes.

Key Policy Area 1 >> Private Insurance Coverage

For nine of the last 10 years and during the longest economic expansion in American history, the number of Americans without health insurance has increased. Today, there are almost 43 million uninsured people—nearly 10 million more than a decade ago. In the near term, rising premiums will likely drive the number of uninsured even higher and affect the kind of coverage people have and how much they have to pay for it.

Incremental coverage proposals at the state and federal levels are numerous and gathering some steam, including tax credits targeted at employers and the individual market and expansion of public programs. HSC will continue to draw on its understanding of consumers, employers, providers and health plans to assess the current and future behavior of these groups and how they interact with respect to insurance coverage.

Recent and planned HSC analyses on this topic are numerous and varied. Selected examples follow: Why don't people take advantage of employer-sponsored insurance offered to them? How have small firms' offer and take-up rates changed over time and why? Where should tax credits be targeted—individuals, families or employers? How effective would a tax credit be in communities with high uninsurance rates or in areas where the uninsured are less healthy?

As the economy falters and labor markets loosen, employers already are changing or paring back health benefits and shifting costs to employees. HSC researchers have tracked—and will continue to track—changes in types of insurance coverage, benefit design and who bears the cost of coverage. As HSC did with defined contributions, it will strive to anticipate possible new models of insurance and their implications, particularly how costs, risk and responsibility for decisions are shared between employers and employees.

Related Publications by HSC Staff

Inquiry, Vol. 37, No. 1
Spring 2001

What Accounts for Variation in Uninsurance Rates Across Communities?

by Peter J. Cunningham and Paul B. Ginsburg

Issue Brief No. 36
April 2001

Tax Credits and Purchasing Pools: Will this Marriage Work?

by Sally Trude and Paul B. Ginsburg

Issue Brief No. 32
October 2000

Are Defined Contributions a New Direction for Employer-Sponsored Coverage?

by Sally Trude and Paul B. Ginsburg

Speaking about various defined-contribution schemes, HSC senior researcher Sally Trude warns, "Older and sicker workers may be unable to obtain or afford health insurance."

—*Medicine & Health*, November 13, 2000

Key Policy Area 2 >> Access to Care for the Uninsured

Related Publications by HSC Staff

Issue Brief No. 38
May 2001

Emergency Room Diversions: A Symptom of Hospitals Under Stress

by Linda R. Brewster, Liza S. Rudell and Cara S. Lesser

Issue Brief No. 34
January 2001

Race, Ethnicity and Preventive Services: No Gains for Hispanics

by J. Lee Hargraves

Data Bulletin No. 19
October 2000

Some Communities Make Progress in Reducing Children's Uninsurance

by Michael H. Park and Peter J. Cunningham

Rising numbers of uninsured will increase the burden on safety net providers. These hospitals, community health centers and other organizations are stretched thin already and are facing financial pressures from managed care and cuts in federal subsidies.

Through site visits and the CTS Household Survey, HSC monitors the capacity and financial viability of the safety net as markets become more competitive, insurance expansions are implemented and innovative ways to provide uncompensated care—such as through managed care—are put in place. Drawing on the CTS Physician Survey, HSC also examines the role doctors play in providing charity care and how that care may be evolving under managed care and other market forces.

How might a Bush Administration initiative—that includes an expansion of the safety net through community health centers and tax credits—enhance coverage while improving access to care for those who remain uninsured?

Earlier HSC research suggests that expansions in insurance coverage are more effective in improving access for the uninsured than expanding direct care services. HSC is continuing research in this area by examining variation across markets in the use of insurance expansions versus directly supporting the safety net and assessing the effectiveness of these different approaches. The results of these and related studies will provide policy makers with a clearer picture of how successful the mixed approach may be in improving access, or whether it reinforces the existing two-tier system of care. As these changes unfold, ongoing tracking of uninsured persons' ability to access care will provide a strong indicator of whether the safety net, while frail, remains largely intact—as HSC's current research suggests—or is fraying and putting people in jeopardy.

"The most troubling trend is the increase in uninsured low-income parents who, unlike their children, do not have access to public programs," said Peter Cunningham, author of a study on the uninsured that showed a significant increase in the percentage of uninsured working parents—from 31 percent to 35 percent between 1997 and 1999.

—Associated Press, April 24, 2000

Key Policy Area 3 >> Managed Care and Markets

Managed care is increasingly regulated, in part because of consumer concerns about how cost-containment techniques affect quality. HSC research has tracked the extent of such techniques and examined how they may be affecting care delivery and consumer and physician perceptions of quality. Contrary to the anecdotes, HSC researchers have found few differences in access and use of services among types of managed care plans and between managed care and indemnity insurance. At the same time, HSC found that negative perceptions about HMOs taint people's ratings of their health care.

Drawing on successive rounds of site visits, HSC has tracked the evolution of managed care and helped policy makers to understand implications of the consumer backlash that is now dismantling the original vision. In the future, HSC will document whether consumer satisfaction improves as plans relax care management and whether physicians have less trouble obtaining needed services for patients—or more problems, as may be the case for hospital services.

Burgeoning health care information on the Internet, the rising tide of aging baby boomers who promise to be far more demanding consumers and other factors portend a new age of consumerism in health care. It is interesting to note that HSC research has found that consumers are not all that knowledgeable about how their health plans work. HSC surveys will continue to track how consumer access to information may affect patient-physician interactions and, from doctors' perspective, the cost and quality of care.

Market changes—including instability in health plan provider networks, consolidation among providers and insurers and the loosening of managed care—could lead to a range of policy responses or a decision to back away from regulation. For example, greater market consolidation of plans or hospitals may lead to antitrust actions or attempts to limit rate increases. On the other hand, some aspects of proposed federal patient protection legislation may be moot as plans move to provide better access to specialists and discard preauthorization requirements.

Related Publications by HSC Staff

Health Affairs, Vol. 20, No. 2
March/April 2001

Do Consumers Know How Their Health Plan Works?

by Peter J. Cunningham, Charles Denk and Michael Sinclair

Issue Brief No. 35
February 2001

Back to the Future? New Cost and Access Challenges Emerge: Initial Findings from HSC's Recent Site Visits

by Cara S. Lesser and Paul B. Ginsburg

Issue Brief No. 30
September 2000

Health Care Perceptions and Experiences: It's Not Whether You Are in an HMO, It's Whether You Think You Are

by James D. Reschovsky and J. Lee Hargraves

"We have been through a lot, and we're not any closer to a long-term resolution of the system's fundamental problems," says Paul Ginsburg, president of a Washington, D.C., think tank called the Center for Studying Health System Change.

—*The Wall Street Journal*, February 21, 2001

Making HSC's Data More Accessible

With each successive round, HSC's multiple surveys and site visit data grow in value because they document changes in health care over a longer period. By gathering information from all the major actors—consumers, purchasers, health plans, physicians and hospitals—in the same markets, HSC can reveal to policy makers the various dynamics and perspectives shaping health care at the community and national levels.

HSC has made CTS survey data available quickly to researchers in public-use files accessible over its Web site, generally within a year. Now, HSC is taking the step to make survey data available to a broader audience through regular, descriptive trend reports on key indicators largely related to its three main policy areas.

For private insurance coverage, HSC will issue regular reports on who does and does not have coverage, offering behavior of employers, employee take-up of insurance and other factors. For access to care for the uninsured, there will be reports on an array of access measures, racial and ethnic disparities and other topics. And for managed care and markets, HSC will issue reports on access and quality under managed care, prevalence of care management techniques and other indicators. These reports will serve to put emerging issues on policy makers' radar screens and confirm or refute anecdotes—guiding policy makers about whether intervention is warranted.

HSC also will take steps to better acquaint the policy research community with the CTS and is considering ways to create additional data files that are more accessible to policy makers and the news media.

Strategically Managing Research and Dissemination for Maximum Policy Impact

HSC is committed to strategically managing and disseminating its research for maximum policy impact. As part of this commitment, HSC will deepen existing

relationships and build new ones with congressional and agency staff, industry associations and consumer groups to help anticipate emerging policy topics and discern information gaps about current issues. These interactions, both through formal forums, such as speaking engagements and congressional testimony, and informal exchanges, such as briefings and discussions about market trends and related policy, are guiding HSC in developing research that helps policy makers come up with practical, real-world solutions to health care problems and challenges.

Over the last two years, the HSC Users' Advisory Committee—which includes prominent experts from leading consumer and employer groups, policy organizations and industry associations—has provided important guidance in developing HSC's research agenda.

In addition to this committee, many other less formal relationships with policy makers, and relationships with policy research colleagues at MPR, are helping to link HSC's research to the policy community. HSC will work over the coming years to make those connections even stronger.

Finally, HSC will continue working closely with journalists who serve as a critical filter for policy makers inundated with health policy research. Over the last few years, the media increasingly have turned to HSC as an honest broker of information, viewing it as an organization that is not beholden to special interests or an ideological point of view. Both news coverage of HSC and visits to HSC's Web site—*www.hschange.org*—are up significantly.

The key strategic planning goals—establishing a policy research focus in three main areas, making data more accessible and widely available and managing the research and dissemination process for maximum policy impact—represent the cornerstone of HSC's future and promise to make the organization an even more important resource for the policy community.

...informing and supporting

Along with other grantees, HSC informs the research and program activities at 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 is working well in the American health care system and what is failing, both at the national level and in communities across the country.

The Foundation concentrates grantmaking support in three broad areas: access to care, substance abuse and chronic care. These also are areas covered by the network of organizations associated with HSC's Community Tracking Study (see p. 11). To accomplish its overall goals, RWJF supports research and evaluation, training and education, program demonstrations and communications.

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

HSC Staff

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Selected Staff Biographies

Paul B. Ginsburg, Ph.D., president, is nationally recognized for his work in health economics and health policy, especially health care market changes and cost trends. He previously served as executive director of the Physician Payment Review Commission and as deputy assistant director of the Congressional Budget Office. Ginsburg earned his doctorate in economics from Harvard University.

Peter Kemper, Ph.D., vice president, has been principal investigator of the Community Tracking Study since HSC's inception. He is a nationally recognized expert on care of the elderly and the effects of managed care. He was formerly director of the long-term care division of the Agency for Health Care Policy and Research, now the Agency for Healthcare Research and Quality (AHRQ), and director of the Madison, Wis., office of MPR. Kemper received his doctorate in economics from Yale University.

Joy M. Grossman, Ph.D., associate director, oversees 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.

Ann C. Greiner, M.C.P., director of public affairs, oversees HSC's publications, conferences and outreach activities. Previously, she was an assistant vice president at the National Committee for Quality Assurance, directing communications and marketing efforts, and served as a research associate at the Economic Policy Institute. Greiner holds a master's degree in urban planning from the Massachusetts Institute of Technology.

Peter J. Cunningham, Ph.D., senior health researcher, specializes in access, the uninsured 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.

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

James D. Reschovsky, Ph.D., senior health researcher, leads HSC's research efforts in health care delivery and quality. His research focuses on health care, insurance and managed care 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.

Jeffrey J. Stoddard, M.D., senior physician researcher, specializes in service delivery, physician and children's issues. A practicing pediatrician, he previously held a faculty position at the University of Wisconsin Medical School. Stoddard received his medical degree from the University of Wisconsin Medical School and completed his pediatric residency at The Johns Hopkins Hospital. He also completed a postdoctoral fellowship sponsored by the Pew Health Policy Program at the University of California at San Francisco.

Sally Trude, Ph.D., senior health researcher, specializes in managed care and physician issues. Previously, she was a senior analyst at the Medicare Payment Advisory Commission and the Physician Payment Review Commission and a health policy analyst at RAND. Trude received her doctorate in public policy analysis from RAND.

Alwyn Cassil, public affairs manager, handles HSC's media relations and publications. Previously, she was a press officer

at the U.S. Department of Health and Human Services' Office of Inspector General and Health Care Financing Administration 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.

Kelly J. Devers, Ph.D., health researcher, specializes in managed care, provider organizations and competition. She also has expertise in qualitative and mixed-methods research. Previously, she was a senior research fellow at AHRQ. Devers received her doctorate in sociology from Northwestern University and completed a postdoctoral fellowship at the University of California at Berkeley and San Francisco.

J. Lee Hargraves, Ph.D., health researcher, specializes in patient and consumer assessments of health care and quality of medical care. He was a senior survey scientist at the Picker Institute, where he was 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., health researcher, directs HSC's site visit work and specializes in market change issues. 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.

Ha T. Tu, M.P.A., health researcher, focuses on service delivery issues. She was an economic consultant to the Center for Health Policy Studies in Columbia, Md., and the Health Care Financing Administration. Tu holds a master's degree in applied economics from Princeton University.

Recent HSC Publications

Issue Briefs

30 *Health Care Perceptions and Experiences: It's Not Whether You Are in an HMO, It's Whether You Think You Are* by James D. Reschovsky and J. Lee Hargraves

31 *Wall Street Comes to Washington: Market Watchers Evaluate the Health Care System*

32 *Are Defined Contributions a New Direction for Employer-Sponsored Coverage?* by Sally Trude and Paul B. Ginsburg

33 *At the Brink: How Harvard Pilgrim Got in Trouble* by Linda R. Brewster and Paul B. Ginsburg

34 *Race, Ethnicity and Preventive Services: No Gains for Hispanics* by J. Lee Hargraves

35 *Back to the Future? New Cost and Access Challenges Emerge: Initial Findings from HSC's Recent Site Visits* by Cara S. Lesser and Paul B. Ginsburg

36 *Tax Credits and Purchasing Pools: Will this Marriage Work?* by Sally Trude and Paul B. Ginsburg

37 *Defined Contributions: The Search for a New Vision*

38 *Emergency Room Diversions: A Symptom of Hospitals Under Stress* by Linda R. Brewster, Liza S. Rudell and Cara S. Lesser

39 *Provider Network Instability: Implications for Choice, Costs and Continuity of Care* by Ashley C. Short, Glen P. Mays and Timothy K. Lake

40 *Health Plan-Provider Showdowns on the Rise* by Bradley C. Strunk, Kelly J. Devers and Robert E. Hurley

Data Bulletins

19 *Some Communities Make Progress in Reducing Children's Uninsurance* by Michael H. Park and Peter J. Cunningham.

20 *Tracking Health Care Costs: An Upswing in Premiums and Costs Underlying Health Insurance*

Community Reports

1 Indianapolis, Ind., *Provider Systems Thrive in Robust Economy*

2 Cleveland, Ohio, *Increased Consolidation Raises Concerns*

3 Seattle, Wash., *Market Instability Puts Future of HMOs in Question*

4 Phoenix, Ariz., *Rapid Population Growth Attracts National Firms*

5 Syracuse, N.Y., *Insurers Consolidate, Hospitals Struggle Financially*

6 Lansing, Mich., *Highly Consolidated Market Poses Cost Control Challenges*

7 Greenville, S.C., *Hospitals Compete for Specialty Care*

8 Little Rock, Ark., *Hopes Dim for More Competition*

9 Orange County, Calif., *HMO Model Shaken but Remains Intact*

10 Miami, Fla., *Hospitals Profit from Aggressive Negotiations*

11 Boston, Mass., upcoming Summer 2001

12 Northern New Jersey, upcoming Summer 2001

Journal Articles and Book by HSC Staff and Collaborators

Understanding Health System Change: Local Markets, National Trends, edited by Paul B. Ginsburg and Cara S. Lesser. Chicago, IL: Health Administration Press, June 2001.

"What Accounts for Variations in Uninsurance Rates Across Communities?" Peter J. Cunningham and Paul B. Ginsburg. *Inquiry,* Vol. 37, No. 1 (Spring 2001).

"Do Consumers Know How Their Health Plan Works?" Peter J. Cunningham, Charles Denk and Michael Sinclair. *Health Affairs,* Vol. 20, No. 2 (March/April 2001).

"Trends in Out-of-Pocket Spending by Insured American Workers, 1990-1997," Jon R. Gabel, Paul B. Ginsburg, Jeremy D. Pickreign and James D. Reschovsky. *Health Affairs,* Vol. 20, No. 2 (March/April 2001).

"Physicians' Assessments of the Ability to Provide High Quality Care in a Changing Health Care System," James D. Reschovsky, Marie Reed, David Blumenthal and Bruce Landon, *Medical Care,* Vol. 39, No. 3 (2001).

"Tracking Health Care Costs: Inflation Is Back," Christopher Hogan, Paul B. Ginsburg and Jon R. Gabel. *Health Affairs,* Vol. 19, No. 6 (November/December 2000).

"Update on the Nation's Health Care System: Results from Tracking Change in 12 Communities," Cara S. Lesser and Paul B. Ginsburg. *Health Affairs,* Vol. 19, No. 6 (November/December 2000).

"Withering on the Vine: The Decline of Indemnity Insurance," Jon R. Gabel, Paul B. Ginsburg, Heidi H. Whitmore and Jeremy D. Pickreign. *Health Affairs,* Vol. 19, No. 5 (September/October 2000).

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 lifespan, from children's health and welfare to long-term care for the elderly.

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

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

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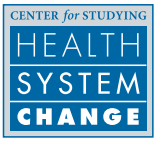

Providing Insights that Contribute to Better Health Policy

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