Site Visit Report
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Northern California

Risk, Accountability, and Staying Power in Next-Generation Managed Care
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Acknowledgments

*Risk, Accountability, and Staying Power in Next-Generation Managed Care*, NHPF's February 1998 site visit to northern California, was the result of years of effort. While original plans called for an April 1995 visit, the press of legislative business in Washington prevented key congressional and agency staff from leaving their posts. In the intervening three years, competitive and economic pressures made managed care evolution in California an even more creative and aggressive phenomenon to observe.

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Risk, Accountability, and Staying Power in Next-Generation Managed Care

The rapid evolution of managed health care in California has virtually eliminated indemnity insurance products and led to a stabilization of premiums for five years, but the restrictions imposed by this delivery mode have provoked a backlash from some consumers and many physicians. At the same time, California's large uninsured population—22.3 percent of the state's nonelderly residents in 1997, one of the highest such rates in the nation—remains a challenge to policymakers. The dominant feature of California's managed care environment is change so rapid that it is difficult to measure, much less more strictly regulate. Nevertheless, policymakers in Washington and in Sacramento and other state capitals seem compelled to act in response to an increasing number of complaints that consumers and providers alike are lodging against health plans.

California is among the states that have a majority of residents enrolled in one variant or another of managed care. Both its private and public purchasers of medical care have favored the shift away from traditional indemnity insurance policies, which financed care provided mostly by solo fee-for-service physicians and not-for-profit community and teaching hospitals. The major change agents—HMOs and PPOs—have radically altered the traditional approach and, in the process, made providers and consumers more responsible for the financial consequences of their medical decisions. This realignment, on balance, favors the allocation of resources through market mechanisms rather than through greater reliance on government regulation.

The greatest measure of success of market forces at work has been, from 1992 through 1997, an unprecedented reduction in the growth of health insurance premiums, particularly in California but elsewhere as well. During this period, premiums were reduced for large purchasers as a result of the intense competition that pitted managed care plans against one another in a struggle to win greater market share. For example, the 1997 premiums paid by the California Public Employees Retirement System (CalPERS) were about the same in dollars as they were in 1992 for essentially the same standard benefit package. On an inflation-adjusted basis, CalPERS' premiums dropped about 13 percent during this five-year period. Most other large California employment groups—public and private—have experienced similar savings. Now, insurance premiums are once again on the rise as plans seek to cover rising costs and rebuild their financial positions and as for-profit managed care companies seek to attract new investors.

While the cost savings have been welcomed by purchasers and patients alike, in other respects California's market-driven health economy has proven less successful. As one of its leading proponents, Stanford professor Alain C. Enthoven, conceded, "markets are still prone to failure...free markets inevitably fail, for example, to generate sufficient quantities of public goods. Special characteristics of health care and health insurance...also cause the market to fail." He included among these the incentive effects of health insurance that undermine cost-consciousness (that is, moral hazard); lack of insurance because it is unaffordable or unavailable or because people choose to forego coverage and exploit the availability of care through safety net providers; and the very high cost and asymmetry of information (that is, doctors know important information that patients do not know, and vice versa).3

It is not only theorists like Enthoven who are calling for government intervention at the federal and state levels. Voices from every quarter and of every ideologic stripe clamor for government response to the backlash against managed care constraints on consumers and providers. In an effort to inform a 30-member group of professionals who help to shape federal health policy from the key government positions they hold, the National Health Policy Forum in February 1998 conducted a site visit to northern California. The overall mission was to examine its health care market and the changing relationships between patients, providers and purchasers. The group heard from a wide variety of individuals who work in government and the private sector and are thus invested in the way health care is delivered and financed in the northern half of our most populous state.

SETTING THE STAGE

Several weeks before departing for California, the Forum held two meetings in Washington, D.C., designed to prepare participants for the site visit. Attendees heard the perspectives of three individuals who are steeped in
California health care operations and policymaking. The first of them was Enthoven, Marriner C. Eccles professor of public and private management at Stanford University’s Graduate School of Business. Enthoven was the leading theorist in the development of “managed competition,” a health insurance purchasing strategy that evolved over two decades of research and refinement. At the Forum meeting, he discussed the recommendations of California’s Managed Health Care Improvement Task Force, which he chaired at the request of Gov. Pete Wilson. The state legislature authorized creation of the task force in early 1997 after Wilson announced that he would sign no more legislation affecting managed care until an advisory body could examine the countless issues in which health plans had become embroiled. Wilson told the 34 members of the task force, a diverse group whose views spanned the political spectrum and who were appointed by the governor and both parties of the legislature, that their mission was to improve California’s largely market-driven health insurance system.

After holding a series of meetings at which it heard testimony from a wide variety of constituents and discussed the many conflicting interests surrounding managed care, the task force issued 77 multi-part recommendations directed at federal and state government, industry, and the market. Before detailing the most important of the recommendations, Enthoven emphasized that a key ingredient in designing a well-functioning market is the establishment of rules through “regulation by government” and by the private actions of the market and industry. While Enthoven has been a strong proponent of market-driven solutions, he has not wavered in his assertion that, “When it comes to health care, market failures that leave people without necessary care are unacceptable—and therefore reliance on the market and industry alone is insufficient—because health care has a special moral status.”

The recommendations of the task force fell into three broad categories: (a) increasing consumer protection, (b) making the market work more efficiently, and (c) recognizing government’s obligation to subsidize the public goods (those goods that benefit everyone and from which no one can be excluded) of health care. Such goods— including education, clinical research, care of the poor, and public health functions—would not, they argued, be adequately funded in a purely private market. Thus, government must support these functions as the collective agent of society. How generously these functions are supported is an issue that federal and state governments continually address in a variety of ways.

Among the recommendations that Enthoven highlighted, the most far-reaching were the following:

- A new state regulatory agency should be created within the executive branch to oversee the operations of health plans and to provide consumers broader protections.
- Existing state regulations should be strengthened to improve the process by which disputes between plans and their members are resolved.
- Insurance premiums should be adjusted based on the estimated risk of the enrolled member.
- Plans should disclose the financial incentives they provide physicians in the legal contract that binds them.

The task force also recommended that plans provide consumers a “bill of rights” at their time of enrollment.

Enthoven noted that the complexity of health insurance contracts makes necessary special rules that establish “a meeting of minds” between enrolled members and plans. The task force recommended additions to the existing list of insurance contract requirements by which plans must abide, including allowance for women to have direct access to their obstetrician-gynecologists. The task force also recommended that health plans be required to disclose significant additional information that would enable consumers to compare plans directly, that they provide specific information on provider access, and that they disclose the general payment methods and incentives employed to compensate physicians with whom they contract.

In response to a Forum participant’s question, Enthoven said the task force did not estimate the cost of its recommendations because no state funds had been provided to pay for that task or any other. At the time the legislature authorized creation of the advisory body, its members stipulated that no appropriation be approved to fund its operations. The cost of Enthoven’s time was covered through the support provided by the California HealthCare Foundation. The task force staff was made up of employees of the California Department of Health and members of the governor’s staff. Enthoven also recruited Stanford graduate students to assist the advisory group.

Another Forum participant asked Enthoven whether he thought it likely that employers that self-fund their employees’ coverage would switch from health plans subject to additional state mandates to preferred provider organizations that are not. Enthoven responded by saying he wrote a letter to Wilson in which he warned of the potential danger to the market if the state legislature “starts laying costly burdens on health plans.” Enthoven said that the task force had considered but declined to support expanded use of the tort system to resolve medical disputes over medical decisions sanctioned by health plans.
A State in Great Flux

At a second meeting, analyst Jeff Goldsmith and consultant Michael Goran, M.D., offered their own interpretations of developments in the California marketplace. Goldsmith, a fifth-generation Californian who has worked extensively with providers there over the last 12 years, said the state could claim several firsts in health care:

- The first multi-hospital system (National Medical Enterprises).
- The first health maintenance organizations developed for the exclusive purpose of enrolling Medicaid beneficiaries. (Many of these HMOs became embroiled in scandal in the early 1970s, prompting the legislature to enact stringent regulatory controls).
- The first health insurance purchasing cooperative for public employees (sponsored by the California Public Employees Retirement System).
- The first medical group to enter the equity markets (Mulliken).
- The first billion-dollar Medicare fraud conviction.

Goldsmith and Goran highlighted other key developments that have influenced the shape of California's health insurance and delivery systems. Goldsmith underscored the prominent role of Kaiser Permanente in the evolution of managed care but also pointed out how the evolving marketplace has forced this group-model plan to institute important changes in the way it has operated for 50 years. "If one matches up the Kaiser Permanente template—enrolled members limited to receiving their care through closed panels of physicians in facilities owned by the program—against what many purchasers and consumers favored, it wasn't much of a match. In essence, purchasers and consumers sought broad, inclusive physician networks, choice of plans, and price stability." Goldsmith asserted: "The ultimate consumer message to [Paul M.] Ellwood and Enthoven (early advocates of the closed-panel group practice model) was there was not much of a market for the Kaiser Permanente template."

However, the saga of Kaiser Permanente is far more complicated than that. Its fortunes over the last decade or more also have waxed and waned with the California economy, the intense competition to which it has been subjected by aggressive for-profit managed care companies, and the increased sophistication of large purchasers in wielding their negotiating power in the insurance marketplace. Given its costly organizational structure—contracts with well-paid, full-time physicians; ownership of many hospitals and medical facilities; and historically cordial relations with labor unions that represent its nurses and other employees—Kaiser Permanente's long-held position as the low-cost provider began to give way to competitors seeking to build their market share. Given the system's excess capacity, these competitors were able to exploit the availability of physicians who feared for their independent practices and community hospitals that operated well below capacity. At the same time, Kaiser Permanente had to pay for the maintenance and upgrading of the hospitals and clinics it owned and operated. Recognizing its vulnerability, Kaiser Permanente began to change. Goldsmith said: "After 50 years of these exclusive arrangements with the Permanente Medical Groups, the program, in a shocking development, began to organize private networks of doctors and contract with private community hospitals" as a way to broaden the number of ways enrolled members could seek care.

In the last year or so, Kaiser Permanente has more than regained the 500,000 members it had lost but is paying a heavy price for the intense price competition and organizational changes that were thrust upon it. The company reported a loss of $270 million in 1997 and may report continuing losses in 1998 because, in seeking to regain its membership, Kaiser Permanente held premium increases to a minimal level that is proving inadequate to provide medical services to its enrolled population. Now, in an effort to regain its financial footing, Kaiser Permanente, battered by "a huge loss last year and a costly nurses' strike and new contract," is seeking double-digit insurance premium increases, a development that left unsettled many of the program's major purchasers who have become accustomed to stable rates, according to the March 31, 1998, issue of the San Francisco Chronicle. For example, Kaiser Permanente sought a 12 percent premium increase from CalPERS, which has about one million state employees enrolled in the program. CalPERS finally agreed to an increase of 10.75 percent.

Goldsmith also highlighted other important developments that have influenced the evolution of California's rapidly changing health care landscape, such as "the collapse of not-for-profit hospital systems in the state," the rise and partial dismantling of Columbia/HCA, the "tremendous pressures" facing California's public health facilities in their struggle for survival, the growing influence of medical groups that believe their future prospects lie in bearing greater financial risk for managing patient populations, and the continued production by the state's teaching institutions of more doctors who will have an increasingly difficult time finding jobs to match their expectations. Goldsmith said: "It is clear that the disconnection between the supply and demand for physicians is profound...There is a stunning over-capacity of MRIs [magnetic resonance imaging machines] and cath [catheterization] labs, yet no diminution in the growth of production of new doctors."
Goran somewhat discounted Goldsmith’s negative view, saying, “there is a lot more good going on than you would believe based on Jeff’s presentation.” Goran conceded that the evolution of the state’s system is “fragile and may not survive” but said that it “appears to be working—there is no non-managed care in California. There is a continuum of plans, every variation on the theme, but it’s all managed care.” Goran cited as evidence of its effectiveness the control of costs, the growth in the number of enrolled individuals and the expressed satisfaction of a majority of patients. Without the imposing presence of Kaiser Permanente, Goran said, private medicine would have been far less amenable to aggregating into groups or, in the case of solo practitioners, joining networks formed through legal contracts with health plans.

Goran described as “a more problematic issue” organizing and actually managing independent physicians. “That is the No. 1 issue and the lesson from California is that it takes a very long time.” The aggregation of physicians into more manageable enterprises is occurring at the same time HMOs are getting out of the health care delivery business and delegating that responsibility to medical groups. Goran asked, rhetorically: “Where is the action? It’s with physician organizations that are accepting financial risk to manage health care delivery. There are 150 IPAs and medical groups in California. They are the true health plans—not the HMOs.” These physician organizations usually are affiliated with an organization that manages the business functions, they are locally based, and health plans tend to offer them all in a geographic region.

The IPAs are winning by and large over the medical groups … They all focus on provider selection. They are very careful in deciding which physicians to affiliate with, particularly the specialists. They negotiate global capitation rates with health plans which Goran said range from a monthly per-member per-month rate from the high $60s to the mid $80s to cover all services they can get their hands on, except pharmacy. Nobody is comfortable with pharmacy. They all see it as exploding, as a major problem that is not controlled by anything that I have seen so far.

Goran concluded by saying that physicians are beginning to recognize that they must bec more better organized, they must aggregate to manage or be managed more effectively and they have must align financial incentives in ways that make their interests compatible with those of patients and purchasers. A physician himself, Goran characterized this development as “good news.” In his vision of managed care, he said,

Instead of primary care doctors as gatekeepers, the primary care doctor becomes the patient’s advocate. … The primary care doctor must still authorize access to a specialist, but it isn’t the same battle because it isn’t an economic battle between these doctors. The bad news is that there is not enough money and this provokes an adversarial relationship with health plans. There is constant tension [between plans and medical groups] over what should be spent on the delivery of care.

SITE VISIT PERSPECTIVES

The Consumer View

Many consumers of health care, newly empowered theoretically by a market-driven insurance world to select the plan of their choice, have been thrust into this maelstrom often ill-equipped to understand its complexities. In California, 85 percent of people under age 65 are enrolled in some form of managed care arrangement. As is true across the country, managed care has suffered a backlash as a consequence of the concerns of consumers and providers. In an effort to diagnose the reasons for the backlash and identify ways to correct it, the governor’s Managed Health Care Improvement Task Force commissioned the Field Research Corporation to conduct a survey of insured Californians and enlisted Helen Halpin Schauffler, professor of public health at the University of California, Berkeley, to analyze it. The survey asked insured people if they were satisfied with their current insurance coverage and whether they had experienced any problems with it in the past year. (Those who experienced more than one problem were asked to designate one as “primary.”) The survey sought the opinions of people insured under all forms of coverage.

Some 76 percent of survey respondents reported being very satisfied or satisfied with their health plan, while 10 percent said they were dissatisfied and another 11 percent were uncertain. No previous survey results were available to determine whether the performance of health plans had deteriorated or improved compared with an earlier period. But, compared with “a minimum benchmark standard” established by the Pacific Business Group on Health—a satisfaction rate among enrollees of 80 percent for health plans with which its member companies contracted—the statewide average suggested there was room for improvement. To counter concerns that reported high levels of satisfaction with managed care derived from the fact that most people are healthy, the survey sampled, in addition to the general population, individuals who had been hospitalized in the last year or were afflicted with a serious chronic condition.

The survey also measured consumer attitudes by type of plan. Group model plans like Kaiser Permanente scored the highest ratings—with 7 percent of respondents reporting dissatisfaction, compared with 11 percent of members enrolled in IPA/network-model plans. Respondents whose care was financed through Medi-Cal reported the highest levels of dissatisfaction—13 percent—regardless of plan.
Among the primary problems identified by survey respondents, 33 percent dealt with a perceived quality of care issue, while 22 percent related to covered benefits, 16 percent to choice of provider, and 14 percent to insurance claims and payments. Respondents reported having the greatest number of problems with IPA/network-model plans.

The results of the statewide survey of consumer attitudes were similar to another recent survey of views on managed care that focused on residents who lived in and around Sacramento, the state capital. This area has one of the highest rates of managed care enrollment in the country. The Sacramento survey results were based on the reported experiences of 3,768 people. Its findings showed that 27 percent of surveyed households insured through managed care reported having some difficulty with their health plans in the previous 12 months. Persons insured through Medicare reported the highest rate of difficulties (42 percent). Persons insured through Medicare experienced the lowest rate of difficulties (17 percent). The survey showed a direct correlation between the amount of time an individual had been in the same plan and his or her level of satisfaction. Those members who were enrolled for the shortest periods reported the highest levels of dissatisfaction. Kaiser Permanente members, who in general have been in that plan longer than members of other plans have been enrolled in theirs, reported the lowest percentage of problems with managed care.

The most common complaint in both surveys was that health plans had delayed or denied coverage. Another important finding of both surveys was that the attitudes of respondents toward managed care were heavily influenced by their health status, the delivery system in which they were enrolled, and who paid the bill. In the Sacramento survey, consumers sought relief from their difficulties with health plans only 70 percent of the time. Half of these consumers said the matter of concern remained unresolved after two months. Of those who took action, 45 percent contacted their health plans. Virtually no one who had a complaint registered it directly with the Department of Corporations, the state agency that regulates health plans subject to the Knox-Keene Health Care Service Plan Act. This likely reflects lack of knowledge about health plan regulation, though perhaps, as one speaker suggested, it is also because “many enrollees have more distrust of government than of private organizations.” Some 25 percent of people reporting problems took no steps to address them.

The Push from Purchasers

In a market-driven economy, purchasers drive demand for products and services, while, in the health care systems of most industrialized nations, medical services are placed in another category. The United States is exceptional in this regard. Based on the American model of capitalism, the United States has come to allocate health care services through a blend of market-based products and government regulation. The blend continually changes, but at present its impact is some 4.1 million people without health insurance, largely because their employers do not provide it, they cannot afford to pay for it out-of-pocket, and they do not qualify for publicly financed coverage.

In California, large purchasers and purchasing groups, both private and public, have been pioneers in wielding their negotiating power to strike tough bargains with managed care companies. The success of these efforts has come in the form of substantial cost reductions for large private and public employers, as noted earlier. Representatives of four large purchasers discussed the role their organizations have assumed in California’s health insurance and delivery systems.

The California Managed Risk Medical Insurance Board is a semi-independent state board created by the legislature in 1993 as part of a broad package of underwriting reforms aimed at improving the small-group insurance market. The board performs three functions: it administers a high-risk insurance pool for self-employed people who suffer from a pre-existing disease condition; it oversees the Health Insurance Plan of California (HIPC), a purchasing cooperative designed to provide small businesses with less expensive insurance options for their employees, and, recently, it assumed responsibility for implementing the new Healthy Families program, an initiative that grew out of the State Children’s Health Insurance Program enacted by Congress as part of the Balanced Budget Act of 1997. The underwriting reforms and the HIPC have been operative since July 1993. As of February 1998, 137,000 small-business employees and dependents had enrolled in one of the 24 health plans with which the HIPC contracts. Total HIPC enrollment represented about 2 percent of the potential small-group insurance market in California.

In its four years of managing the HIPC, the insurance board learned that, for a purchasing alliance to operate successfully, market-wide rules must stipulate limits on premium levels. The California HIPC began with a requirement that health plans set their premiums within a band of plus or minus 20 percent of a level established in advance through negotiations. After three years, the variation allowed was lowered to plus or minus 10 percent. The board also learned that a HIPC can be implemented quickly and inexpensively if three parties—the state, health plans and the third-party administrator—agree on its structure. The California HIPC began enrolling people nine months after the legislation was enacted. The HIPC’s administrative costs—predominantly marketing—totaled 3 percent of premium.

California HIPC enrollees attached high value to their ability to select their own plan (17 choices are offered in Los
Angeles, for example) and to switch once a year if they wished. Price was the overriding basis upon which decisions were made; 80 percent of the HIPC’s total enrolled population signed up with plans that offered the lowest cost benefits. All of the participating plans were required to offer a uniform benefit package, a feature that plans agreed to accept and that the board considered essential in order to establish rational choice and fair competition. The “managed competition model” upon which the board designed the HIPC worked well to hold down premium increases; in this respect, the HIPC’s experience closely tracked that of large private purchasers. Despite availability of the HIPC, however, the board recognized that California (and other states as well) will never achieve universal coverage with voluntary approaches.

The Pacific Business Group on Health (PBGH), which negotiates the purchase of health insurance for several million employees of its large employer members, is a national leader among such corporate alliances. The PBGH was developed in 1989, when executives of the Bank of America and Wells Fargo Bank, frustrated by their inability to control their companies’ double-digit health care cost inflation, formed the Bay Area Business Group on Health (name subsequently changed to PBGH). The group is a nonprofit coalition of 33 public- and private-sector purchasers. These employers collectively spend $3 billion annually on health services for their employees and dependents, which represent 2.5 to 3 million covered lives. All PBGH members participate in quality improvement initiatives; 19 of the largest members also are part of the Negotiating Alliance, which collectively negotiates rates, health care quality measures, and targets for improvement with 23 HMOs. Through the alliance, these large employers in 1998 paid premiums that averaged 13 percent lower than those paid in 1994.

With costs recently under control, the PBGH has focused its efforts on improving the quality of care provided by health plans, particularly because the business group believes that quality has been neglected—both before and after the emergence of managed care. PBGH member companies are currently studying patterns of inpatient care and ambulatory care delivered in medical groups, but, ultimately, the PBGH wants to track care as it is delivered by individual physicians. The PBGH’s top priority in its pursuit of better quality is improving the success rate of coronary artery bypass graft (CABG) surgery. As part of its initiative, the PBGH is collaborating with the California Office of Statewide Health Planning and Development to develop the California CABG Mortality Reporting Program. Kevin Grumbach and colleagues have documented that the likelihood of dying following CABG surgery is reduced by about half if the operation is performed in a hospital where surgeons do 500 or more of these procedures per year compared with a hospital that performs fewer than 100 such operations annually.

In California, only 8 percent of hospitals that perform CABG surgery performed more than 500 such procedures per year in 1987-89, compared with 32 percent of CABG-qualified New York hospitals. Moreover, only three hospitals in New York (10 percent) did fewer than 100 of these procedures, compared with 34 California hospitals (31 percent). Thus, despite the rapid emergence of managed care, there is little evidence that this insurance mode is driving low-volume providers from the market. Even when employers strive to improve quality, consumers are not always responsive to their efforts. Southern California Edison, for example, froze enrollment in one health plan because it did not measure up to the company’s quality standards. But very few workers who had already enrolled left the plan, despite Edison’s judgment that its performance was inadequate. In this instance, retirees were particularly reluctant to change plans.

The Medi-Cal program faces a different set of challenges as it seeks to transform itself from an agency that reimburses providers for the care they render to one that actively purchases managed care. Complicating this challenge are the facts that Medi-Cal has not granted a provider payment increase in 15 year; that it is administered at the county level, with varying program structures; and that many of its five million beneficiaries generally distrust government. Consumer attitudes toward the program suffered another blow when the state government acted to move the entire Medi-Cal population into managed care without informing beneficiaries that it planned to do so. This move was widely interpreted by advocates of the poor as a critical misstep by the state in the implementation of its sweeping plan to enroll the Medi-Cal population in managed care.

The decision by the state legislature to direct Medi-Cal beneficiaries into managed care included a critical policy question: Should the state develop a competitive scheme through which plans would bid to enroll Medi-Cal’s eligible population without regard for its potential impact on safety net providers or should it create a mechanism with some built-in protection that would enable these providers to maintain their role as the traditional caregivers of this population? The concern was that most Medi-Cal beneficiaries would find commercial health plans more attractive and enroll in them, rather than remain with the publicly sponsored clinics and hospitals on which they had previously relied. In such an event, safety net providers could lose many of their insured patients overnight, threatening their very existence.

In the end, the state legislature decided, given the necessary Health Care Financing Administration (HCFA)
waivers, to create a two-plan competitive model for selected counties. The 12 two-plan counties were chosen on the basis of their own interest in participating, whether they had an established managed care presence, and whether they had a minimum of 45,000 eligible beneficiaries. Under the model, beneficiaries were given 90 days to enroll in either a plan sanctioned by the county—usually an amalgamation of traditional safety net providers—or a commercially sponsored plan under contract with the county. Because beneficiaries had not been directly informed by the state agency that they needed to select a plan, very few did so in the initial months of implementation. In one of the first counties where the two-plan model was implemented, eight of every ten beneficiaries selected no plan within the allotted 90 days; in these instances, Medi-Cal assigned them to a plan. Some months later when Los Angeles County implemented its two-county model, the default rate had dropped to a more respectable 29 percent.

The state’s Department of Health Services, which oversees the Medi-Cal program, also is challenged by the movement to managed care. As an agency that for 30 years has performed the traditional functions of state regulator and payer of claims, the department has only begun to adjust to its new role of supervising the purchase of managed care.

Forum participants’ questions to members of the purchaser panel focused on issues surrounding how to improve the quality of care. Panelists suggested that government could exert its leverage most effectively as a purchaser by “dramatically stiffening requirements” for the clinical information systems providers must acquire to participate in Medicare and Medicaid. With state-of-the-art information systems in the offices of physicians and in hospitals, panelists reasoned, public and private purchasers could hold providers to greater account. HCFA could also strengthen its negotiating hand if it were allowed to terminate contracts with health plans that did not measure up to the agency’s quality standards. (Congress has been reluctant to arm HCFA with such authority, in part because it could mean granting the agency the power to put health plans out of business by barring access to Medicare and Medicaid participation.)

**Health Plans/Insurers**

Harold Luft, an economics professor at the University of California, San Francisco, served as moderator of the next panel and opened the discussion by underscoring how sharply the configuration of California’s managed care industry differs from Enthoven’s vision of health plans with exclusive physician panels in a market-based struggle for business. Luft observed, “I have been a member of all four plans that are represented on this panel. I also have been a member of four other plans.” He said his continual shifting of plans was not in conflict with his strong interest in maintaining a relationship with one physician.

I have had only two primary care physicians—one who was a member of the Permanente Medical Group and the other who belonged to the seven remaining plans. This raises the question: What does it really mean when a consumer changes plans so often, and what does all of this plan switching mean to the doctors with whom I am dealing? What are their incentives to improve quality when they are being beaten up by plans that want to get their HEDIS measures up? The question in my mind is what is the role of the health plan versus the medical group versus the people who are actually delivering services…. Why do we need health plans, why can’t we (that is, employers) just contract directly with medical groups, unless plans are doing an aggressive job of improving quality?

During the 1980s, most of the state’s major health plans became publicly traded corporations with a new imperative—demonstrating favorable financial results on a quarterly basis to investors. They battled for increased market share by undercutting each other’s premiums. Other pressures on premiums abounded, too, including an economic recession fueled by the partial collapse of the defense industry following the end of the Cold War and the new assertiveness of large purchasers.

Panelists talked very little about the impact of price discounting and the financial penalties that come with enrolling high-risk (and high-cost) individuals. Rather, they focused on the demands of purchasers to demonstrate improvements in the quality of care providers rendered under their contracts with plans. Panelists asserted that plans are in a stronger position to monitor comparative quality than are individual physicians or hospitals because plans are better positioned and equipped to collect clinical data on a patient population. For example, a plan that has built a repository of data on which women in its membership should have a periodic mammogram is able to alert both providers and patients when breast cancer screening is indicated and has not occurred. One plan has among its members 100,000 people who are afflicted with diabetes, a panelist reported. Treatment of these patients represents about 15 percent of health care costs in the plan. Despite the generally agreed-upon guidelines of what represents good diabetic care, treatment by different physicians varies widely. Every doctor thinks he or she practices good diabetic care, but often the care processes for diabetics are inadequate. The plan provides guidelines for optimal treatment approaches and helps physicians determine which of the diabetic patients need outreach.

The panelists, like the employer representatives who preceded them, conceded that the pursuit of quality remained a challenge, in part because of problems related to data collection and analysis. Also, quality measurement
may be incompatible with other priorities that employers and employees also value, such as ready access to a broad network of providers. One panelist said, "quality is an orphan," citing as an example employers' reluctance to exclude low-volume hospitals from their networks, in spite of the compelling CABG data mentioned above.

Panelists acknowledged that increased attention is being paid to the idea that third-party purchasers could reduce their health insurance costs by contracting directly with medical groups and hospitals, thus eliminating the need for health plans. But they emphasized that large employers look to health plans for a variety of critical functions: licensure, broad geographic coverage, provider credentialing, managing contracts with medical groups, and addressing consumer complaints in a consistent fashion. One panelist said his plan managed an extraordinarily large, diverse network of 300 medical groups and 15,000 primary care physicians that are at radically different places in their evolution. Citing Southern California Edison as an example, he said that large corporations expect plans to maintain clinical consistency across their networks. He said that plans do not see their function as the actual provision of care, but rather as serving as a resource for purchasers who are seeking value for their purchase of insurance.

In another presentation, Kaiser Permanente was depicted as a program that, through its fully integrated clinical and managerial operations, has been able to deliver demonstrable improvements in the health status of enrolled members. An illustration is its program to detect colorectal cancers in men of middle age and beyond through mass screening programs. In 1992, Kaiser Permanente's Northern California region published a case-control study showing that screening sigmoidoscopy was a highly effective means of detecting and preventing mortality from colorectal cancers. In trying to apply these findings, Kaiser Permanente found itself in a situation familiar to most HMOs: aware of the potential benefits of a sigmoidoscopy-based approach to screening but without the necessary infrastructure to provide mass screening to its approximately 600,000 members aged 50 years and above. Energized by the results of its case-control study, Kaiser moved to provide sigmoidoscopies to 10 percent of the eligible population every year by establishing screening units in each medical center; 240,000 members have been screened during the four years the program has been in place.

Out of this mass screening exercise, Kaiser estimates that it prevented some 200 cases of colorectal cancer from developing and saved the lives of 75 men already stricken with the disease. In the process, it also learned that an appropriate balance between the cost of screening and its benefit could be struck by recommending that the test be done once every decade. In fee-for-service medicine, panelists suggested, physicians were inclined to perform the test more often because it generated a payment.

Hospital Systems

The California marketplace represents a major challenge for health care facilities. Site visit participants heard from two dominant systems in northern California: Catholic Healthcare West (CHW) and Sutter Health System. CHW operates 37 hospitals in California, Arizona, and Nevada. During the week of the site visit, its executives were in discussions with 12 additional hospitals about joining the system. Although CHW works closely with physicians, it does not own medical groups, citing the inherent difficulties of managing such relationships. Sutter is likewise aggressively expanding its presence. Sutter operates 28 hospitals in Northern California. Its merger with California Health Care Systems brought with it California Pacific Medical Center in San Francisco, Marin County General Hospital and Mills-Peninsula Hospital in Burlingame. Sutter serves some 800,000 people under various capitated arrangements. It has affiliation agreements with medical groups encompassing some 1,000 physicians and is aligned by contract with numerous independent practice associations.

These hospital systems are expanding to increase their leverage in rate negotiations with the managed care companies. And, while Sutter and CHW co-own an HMO with enrollment of 167,000 members, they are also competitors, vying with one another for patients and market share. In April 1998, Sutter beat out a rival bid by CHW to enter into "exclusive negotiations to add Summit Medical Center to its network," a Sacramento business journal reported. Summit, a 517-bed hospital, was Sutter's 27th acquisition. Earlier the same week, Sutter had announced that its California Pacific Medical Center reached an agreement to acquire the 361-bed Davies Medical Center in San Francisco, again besting CHW and bolstering its presence in the Bay area.

The Emergence of Medical Groups and Independent Practice Associations

Large medical groups and physician-sponsored independent practice associations (IPAs) have emerged as the major providers of managed care in California. These physician-driven organizations contract with insurance carriers on a non-exclusive basis to provide care to millions of individuals who are insured through their jobs or publicly financed programs. The exception to this general rule is Kaiser Permanente, which provides virtually all medical services to its 6 million California members through contracts with two Permanente Medical Groups. James C. Robinson, an economics professor at the University of California, Berkeley, moderated a discussion among
representatives of several medical groups that have figured prominently in the state’s transition to managed care. Unlike many health plans elsewhere, California HMOs pass on most of the financial risk for the cost of medical care and delegate the greatest portion of the responsibility for managing care to the medical groups and IPAs with whom they contract.13

By placing medical groups and IPAs at financial risk for their performance, HMOs have encouraged providers to reduce the number and length of hospital stays experienced by patients and be more cost-conscious in all forms of care rendered through these contracts. During the past two decades, the largest medical groups in California have reduced hospital utilization, as measured in bed days per 1,000 patients per year, to one-third of previous utilization. In California, the annual number of hospital days per thousand for enrolled health plan members under age 65 was 194 in 1996, compared with a national average of 250. The average monthly premium charged a commercial customer was $139 in California, compared with $153 in New York and $150 nationally.

Increasingly, physicians in California are aggregating in medical groups and IPAs to contract with plans and to attract a pool of HMO patients large enough to spread the risk of high-cost patients. Contracts with health plans are often available only via a group or IPA arrangement. One of the most prominent examples is Brown & Tolan, a not-for-profit multi-specialty group of some 1,350 physicians resulting from a merger of the California Medical Group and the faculty practice plan of the University of California, San Francisco. Member physicians each hold one voting share in the group. Brown & Tolan assumes full financial risk for the care provided in most of the contracts it has negotiated with health plans and seeks delegation by plans of some management functions (such as utilization review and physician credentialing) as well.

Brown & Tolan reflects the active brand of clinical management that medical groups and some IPAs employ in order to deliver cost-effective care in a highly competitive insurance market. Brown & Tolan physicians hospitalized patients, on average, 193 days per thousand members in 1993. By 1997, that figure had dropped to 153 days. The group is not striving for further reductions, believing that it has achieved a proper balance of cost-effectiveness and appropriate medical care. All of the medical groups and IPAs in California are feeling the pressures of purchasers who are seeking greater accountability from providers, but they would prefer to be measured by uniform performance standards rather than the multiple standards now applied by the Foundation on Accountability, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, and health plans themselves.

There is a substantial disconnection between the activities of physicians vying for greater advantage in the competitive marketplace and the advocacy that organized medicine pursues in Sacramento through the California Medical Association (CMA), which, in most instances, is aggressively anti-managed care. One panelist said that three separate organizations to which physicians belong—the CMA, the Medical Management Association and the IPA Coalition—do not present a united front when they speak on behalf of doctors, although they are in discussions in an effort to close the gap between their positions. Another panelist said CMA’s activities provide a good example of why organized medicine is failing, noting that, while the CMA decries the evils of managed care, more than three-quarters of insured Californians have coverage through the variants of this delivery mode. “That is the market reality,” he said.

The Consequences of Competition for the Safety Net

California maintains an extensive, if uncoordinated, set of health safety net institutions and facilities that serve people without coverage. They range from county hospitals and clinics to community and migrant health centers, homeless health services, school-based clinics, and private hospitals, especially their emergency rooms. Not surprisingly, given the diverse constituencies that look to these facilities for assistance and the waning public interest in supporting this infrastructure, health policies that apply to them are “extraordinarily fragmented and complex.”14 Their most challenging problems usually involve a shortage of resources, both human and financial. One panelist said San Francisco General Hospital receives calls daily from community hospitals saying, “get this (nonpaying) patient out of here.” Beyond the financial pressures of accommodating nonpaying patients, safety net providers must secure support to upgrade their facilities, build information systems and improve their ties to public health and medical education. Public hospitals are particularly challenged in a state that has already seen the closing of many of these institutions over the last decade. California’s safety net providers face many difficult challenges in making a successful transition to a market-driven system, but California’s new children’s health insurance initiative (Healthy Families) is pointed to as a demonstration of the state’s commitment to provide coverage to more than one million uninsured children—11 percent of all children in the state—and thus to increase the resources available to pay providers. The governor did move quickly to implement the new program after President Clinton signed the federal authorizing legislation into law. However, Wilson decided to accept only $325 million of the $855 million in the allocation of federal dollars that were designated for California. Reportedly, California did not accept the full
amount for fear that it would encourage private employers to stop offering private insurance to their workers, a phenomenon known in policy circles as "crowd-out"—and one that is by no means unique to California.

FOLLOW-UP

Site visit participants had two opportunities to ask follow-up questions and articulate their policy concerns, first in a debriefing session with Forum staff and later in a meeting with David Lawrence, M.D., chief executive officer of Kaiser Permanente. Lawrence talked with participants about the ferocity of competition among health plans in California, some of his company’s strategic changes, and the future of the health care system. He observed that state anti-managed care laws were having an impact on business decisions; for example, Kaiser Permanente chose to withdraw from Texas following enactment of a health plan liability statute. He also noted that some business decisions are derailed by public outcry, a classic example being Kaiser’s attempt to close a poorly performing hospital. Saying he believes that health plans have to participate in focusing attention on health care quality, Lawrence championed evidence-based medicine, that is, treatment based on sound scientific research, adopted as an objective standard.

REFLECTIONS

Forum participants were struck by the complexity and dynamic nature of the relationships among plans, contracting provider entities, and individual treating physicians. The shifts in financial risk and medical management from plans to providers that are occurring in northern California have significant implications for determining the appropriate nexus of regulation in terms of whom to hold responsible for patient protection and quality of care.

An overarching theme repeated in various discussions of policy implications was the question of how to structure government regulation of the market to assure adequate protection of the public benefit without stifling the innovation illustrated by the northern California market. The observation was made that the market in California does seem to be responding to consumer and purchaser concerns, for example, by offering point-of-service options and broadening provider panels. The group explored the question of what issues currently on the policy agenda the market could be expected to address and where policy intervention was warranted. Specific issues discussed included information disclosure, grievance and appeals procedures, dissemination of quality standards, liability limitations, and remedies. One participant said she wanted more clarity on the environment that shapes the California market and the barriers to entering it. Another wanted to gain a better understanding of how effectively the Knox-Keene Act regulated plans and whether its track record held lessons for Congress. Further questions concerned the difference to consumers and purchasers between not-for-profit and for-profit health plans; what anti-trust concerns might arise as physicians and hospitals aggregate to wield greater power in negotiations with plans; and whether it is possible for consumers to make meaningful choices between plans when all the plans have signed contracts with virtually all the same physicians.

Related to publicly financed programs and safety net providers, participants were struck by the complexities of county-level health administration, where directives from various agencies (federal and state) can seem to collide, as do a growing beneficiary and uninsured population and an endemic lack of funding. Questions were raised about continuing federal support for community and federally qualified health centers and about other incentives that may be necessary to keep safety net providers in the game.

Overall, participants accepted that California was well ahead of most of the country in deliberate and sophisticated market responses to consumer and provider concerns. How this translates to other locales remains to be seen. Participants agreed that the information presented in the site visit had been valuable but a bit overwhelming. An opportunity to delve deeper into questions surrounding risk allocation, contracting, and accountability for quality—along with a look at two counties not participating in the two-plan Medi-Cal demonstration—was suggested. As of this writing, plans were already underway to accomplish this during a November 1998 Forum-sponsored site visit to the southern part of the Golden State.

ENDNOTES


3. Singer and Enthoven, “California’s Struggle.”


5. Singer and Enthoven, “California’s Struggle.”


Agenda

Wednesday, February 18, 1998

7:15 am  Bus departure for Lone Mountain Conference Center, University of San Francisco

7:45 am  Continental breakfast [Room 100, Lone Mountain Conference Center]

8:15 am  SETTING THE SCENE: HEALTH SYSTEMS EVOLUTION [Room 100, Lone Mountain Conference Center]

Wendy Everett, Sc.D., Director, Institute for the Future

- What forces and responses, decisions and fortuities have made the California market what it is today?
- What are its distinguishing demographic, employment, and health system characteristics?
- What have been the critical events that shaped the development of health care delivery (advent of prepaid plans, Knox-Keene legislation, foundations, rise of managed care, network formation, etc.)?
- What are the current pressures and which trends will persist?
- What should we know about the political climate?
- Which examples are most worth watching?

9:45 am  SETTING THE SCENE: THE CONSUMER PERSPECTIVE

Peter V. Lee, J.D., Director of Consumer Protection Programs, Center for Health Care Rights
Helen Halpin Schauffler, Ph.D., M.S.P.H., Associate Professor, University of California, Berkeley

- What do survey data reveal about consumer perceptions of and experience with managed care?
- Where these are negative, what is the focus of dissatisfaction, and how could it best be remedied?
- Is legislation the preferred approach?

10:50 am  Break

11:00 am  THE PUSH FROM PURCHASERS

J. Douglas Porter, Deputy Director, Medical Care Services, California Department of Health Services
Suzanne C. Mercure, Health Care Programs Manager, Southern California Edison
Arnold Milstein, M.D., M.P.H., Medical Director, Pacific Business Group on Health, and
Partner, William M. Mercer, Inc.
Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board

- What are purchasers looking for? How do they assess competing plans/products? How have the products changed over time?
- What are the criteria used in selecting plans to contract with? Is employee input sought? How?
- What strategies have employers used to transform their function from the passive bill-payer to the actively negotiating manager? Are employers offering multiple plan choices? Transferring risk to plans and providers? Shifting more cost to employees? Contracting directly with providers?
- Is value purchasing more than a slogan? To what extent does cost alone still drive decision-making? Are we on the cusp of adding quality to the price equation?
What is the purchaser’s proper responsibility with respect to health care quality?

What quality measures are used? Who uses them? What is the impact of PBGH’s new rankings of health plans and (for the first time) physician groups? Is NCQA (or other) accreditation a significant advantage?

What is the state of the small group market? What are small and medium-size firms buying? Who is selling to them? Do they try to follow the lead of larger firms? What is the role of brokers, agents, and TPAs in selling to this segment? What role is played by the HIPC?

Do employers prefer to work on their own, or are coalitions a smarter way to do business? How does this vary by firm size?

What are employers doing with respect to retirees? Is employer-provided coverage for both pre-65 and Medicare-eligible retirees on its way to oblivion? Are there other options for the pre-65 group?

Do public-plan purchasers differ in their strategies? How do they coordinate with the private sector? What different strategies come into play when purchasing for the Medi-Cal population?

12:30 pm  Lunch [Room 141, Lone Mountain Conference Center]

1:00 pm  THE PUSH FROM PURCHASERS (cont.)

2:15 pm  IN THE CENTER RING: HEALTH PLANS AND INSURERS

Bruce Bodaken, President/Chief Operating Officer, Blue Shield of California

Jerry C. Fleming, Senior Vice President and Chief Administrative Officer, California Division, Kaiser Permanente

Sam Ho, M.D., Vice President, Quality Initiatives, PacifiCare

Myra C. Snyder, R.N., Ed.D., President/Chief Executive Officer, California Association of Health Plans

Arthur M. Southam, M.D., President/Chief Executive Officer, Health Net

Resource expert:

Harold S. Luft, Ph.D., Caldwell B. Esselty Professor of Health Policy and Health Economics, University of California, San Francisco

How is the “business of insurance” in California changing? Does the restructuring we are seeing represent real change in how medical care is delivered? Does it change the role of the insurer? Are you more or less involved in actual care delivery as time goes on?

As you see it, what are purchasers looking for from a health plan? Does their scrutiny reach inside the plan to the hospitals and medical groups involved? Have their criteria evolved over time?

What is the basis for product differentiation among health plans (benefit package, coverage of alternative treatments, network composition, service area, cost, marketing, pool of insured lives, performance measurement, demand management)?

Now that everyone has figured out, for example, that reducing hospital length of stay saves money, how does a managed care plan distinguish its performance from competitors’? Can managed care’s cost containment success be sustained?

How would you characterize the current insurance market? Who are the desirable and undesirable populations from an insurance point of view? How are insurers deciding what new business to pursue? Are different insurers coming to different conclusions?

Where are the growth opportunities: competing for corporate accounts; pursuing new segments of the population, including the uninsured; expanding one’s range of products; geographic expansion?
- What role do Medicare and Medi-Cal play in your strategic planning? Do you plan to participate in the new Medicare+Choice program?
- What are health plans doing to foster consistent quality in health care delivery? Must the relationship with providers be adversarial? How (and among whom) should responsibility for quality be apportioned? How can accountability be enforced?
- What defines the cutting edge in health care delivery? What progress have we made toward managing care, as opposed to managing risk? What are plans doing to manage demand?

5:00 pm Adjournment

5:15 to 6:45 pm Reception [Room 141, Lone Mountain Conference Center]

Thursday, February 19, 1998

7:30 am Bus departure for Lone Mountain Conference Center, University of San Francisco

8:00 am Continental breakfast [Room 100, Lone Mountain Conference Center]

8:30 am SYSTEM INTEGRATION [Room 100, Lone Mountain Conference Center]
   Sharon Lee Levine, M.D., Associate Executive Director, The Permanente Medical Group
   Steven R. Zatkin, J.D., Senior Vice President, Kaiser Permanente

- What are the advantages and disadvantages of a tightly integrated health plan? What are the ramifications of ownership? We can point to integration of ownership, governance, and profits, but is there yet such a thing as integration of patient care?
- For some years, vertical integration was seen as the grail of health system management. Does it still have adherents, or has it been superseded by the virtual integration model?
- Will direct contracting between physicians and employers be the model for the future? Will physicians be able to refrain from trying to manage risk? That is, if physicians themselves engage in medical underwriting, how will the public (and regulators) respond?
- As insurers increasingly shed direct involvement in the delivery system, to what extent do payers remain a legitimate component of an integrated system?
- Kaiser has taken some actions recently that are not unrelated to positioning itself in the market. Would you comment on the company’s call for federal-level quality standards?

9:30 am Break

9:45 am HOSPITAL STRATEGIES FOR CHANGING TIMES
   Sandra R. Hernandez, Chief Executive Officer and Director, San Francisco Foundation
   Van R. Johnson, President and Chief Executive Officer, Sutter Health
   Bridget McCarthy, R.S.M., Executive Vice President, Catholic Healthcare West
   Resource Expert: Bruce W. Spurlock, M.D., Executive Vice President, California Healthcare Association

- The Bay area is known for an overcapacity of hospital beds. Is this changing? As the focus of patient care moves away from an inpatient setting, how do hospitals (and other providers) respond?
- Is virtual integration (long-term contractual relationships) replacing vertical integration (common ownership) as a delivery system ideal?
As you see it, what are purchasers looking for from a health plan? Does their scrutiny reach inside the plan to the hospitals and medical groups involved? Have their criteria evolved over time?

Columbia/HCA’s specific problems aside, will merger and acquisition fever continue in hospital ownership? What about the acquisition of physician practices by hospitals?

What are the pressures that prompt consideration of conversion to for-profit status? Is conversion beneficial or harmful to the delivery of quality care?

What role do Medicare and Medi-Cal play in your strategic planning?

Is there a trend toward hospital specialization? How far can this go?

12:15 pm  Lunch [Room 141, Lone Mountain Conference Center]

1:15 pm  PHYSICIAN GROUPS: SEEKING RISK AND LIMELIGHT?

Michael E. Abel, M.D., Chairman and Chief Executive Officer, Brown & Toland
Lori L. Hack, M.B.A., Executive Director, Alta Bates Medical Group
Shelley A. Horwitz, Administrator, Bay Valley Medical Group
Resource expert:
James C. Robinson, Ph.D., Professor of Public Health, University of California, Berkeley

Strategies:

- How are physician groups structured? What are the distinctions among group practices, IPAs, MSOs, PHOs? How do these illustrate different strategic responses to market changes? What is the role of physician practice management firms? Is there an optimal size for a physician group? What role does access to capital play in structural decisions?

- What are providers doing to preserve/augment their power in the healthcare equation? Are they successful? Are we going to see a plethora of PSOs in California?

- As you see it, what are purchasers looking for from a health plan? Does their scrutiny reach inside the plan to the hospitals and medical groups involved? Have their criteria evolved over time? Have provider groups evolved in response?

- Given that group practices predate what we now know as managed care in California, what other forces have determined their composition, structure, and influence over the years?

- Does the market restructuring we are seeing represent real change in how medical care is delivered, or is it more a matter of moving the boxes around?

- What role do Medicare and Medi-Cal play in your strategic planning?

- To what extent are providers shouldering insurance risk? What are the regulatory implications? Is direct contracting with employers the model for the future? Is the health insurance “middleman” role still needed?

Operations:

- What are the prevalent contracting patterns between physician groups and hospitals? Insurers? Networks such as HMOs and PPOs? Their own member physicians? What are the lines of accountability?

- How are physician groups compensated? How do they allocate compensation among physicians? Have incentives been designed/implemented that move beyond capitation? Is there a mechanism to reward quality care, even of the sickest (i.e., most expensive) patients?

- How does a group go about changing individual physician behavior, e.g., to refer to clinical decision support criteria, to accept new data reporting responsibilities?

- How are physician groups held accountable? Is there/should there be an objective accreditation process?
To what extent do providers support/employ/question the validity of outcomes measurement? Clinical protocols/decision criteria? Risk adjustment?

5:00 pm Adjournment

6:30 pm Dinner [Waterfront Restaurant]

Friday, February 20, 1998

7:00 am Bus departure for Lone Mountain Conference Center, University of San Francisco

7:30 am Continental breakfast [Room 100, Lone Mountain Conference Center]

8:00 am THE CONSEQUENCES OF RECONFIGURATION: COUNTY SYSTEMS, SAFETY NET, SPILLOVER [Room 100, Lone Mountain Conference Center]

Leona M. Butler, Chief Executive Officer, Santa Clara Family Health Plan

David J. Kears, L.C.S.W., Director, Health Care Services Agency, Alameda County

Does the restructuring we’re seeing in the private health care market represent real change in how medical care is delivered? What is the spillover effect on counties? How are changes in the private market affecting the volume and composition of the population you serve?

What shape is the safety net in? How are counties able to cope with the increasing demands on their resources?

How is the two-plan Medi-Cal model working in practice?

By law, counties are the health care providers of last resort. Are new population pressures and scarcer resources going to mean the demise of Section 17000? Then what?

9:45 am Bus departure for Sacramento

11:45 am CONSUMER CONCERNS AND THE MANAGED CARE IMPROVEMENT TASK FORCE (working lunch) [California Healthcare Association, 1201 King Street, 7th Floor]

Maryann O’Sullivan, Project Director, Medi-Cal Community Assistance Project, Health Access

Philip J. Romero, Ph.D., Executive Director, Managed Care Improvement Task Force

Ellen Severoni, R.N., President, California Health Decisions

Established by legislation and charged with reporting to Governor Wilson by January 1998, the task force considered a broad range of issues related to the operations and impact of managed care. The group’s deliberations forestalled the governor’s signature on health care measures in 1997.

What did the task force conclude? What actions will follow from those conclusions?

Has there been an attempt to assess the cost implications of these recommendations?

How should managed care be restructured for the new millenium?

1:00 pm IMPLEMENTING CHILDREN’S HEALTH INSURANCE AND OTHER STATE INITIATIVES

S. Kimberly Belshé, Director, California Department of Health Services

Many states have chosen to expand children’s coverage via their Medicaid programs. Why did California choose a different route?

Who is responsible for monitoring and shaping the healthcare market? What are the respective functions of the Departments of Insurance, Health Services, and Corporations?
What problems is the government responding to (uninsured children, denial-of-treatment allegations, inadequate product offerings for small groups, changing demographics, etc.)?

What steps have been taken to try to bring people into the market?

What strategies has Medi-Cal employed to provide coverage to the poor, and how have these evolved over time? How have selective contracting and shifting risk to providers worked in a public program? Who is applying, and qualifying, to contract with Medi-Cal?

What is the proper balance between regulatory and market approaches to fostering consistent health care quality?

3:00 pm  WRAP-UP DISCUSSION: WHERE ARE WE HEADED?

Beau Carter, Executive Director, Integrated Healthcare Association

Hattie Skubik, Assistant Director, Health Care Policy, California Department of Health Services

What will be the division of power/responsibility between the federal and state governments? Can they work together? What conclusions should we draw from the legislature’s decision to let the feds take responsibility for HIPAA implementation? How will the federal statute authorizing PSOs coordinate with Knox-Keane?

Is real cost containment achieved in this market, or are there only various types of cost-shifting?

To the extent that costs are shifted, what is the domino effect?

How much of health care “coverage” is actually insurance and how much of it is prepayment for predictable health-related services?

Who is benefitting from market restructuring? Who is hurt? Is restructuring changing the way care is delivered, or is it just a financial exercise?

Given the rivalries among components of the health care system, are we likely to grow toward a seamless continuum of care for patients?

What that we have observed is likely to translate successfully to other states?

What defines the cutting edge in healthcare delivery? What are plans/providers doing to manage demand? To prepare for the increased chronic care needs of an aging population?

5:00 pm  Bus departure for San Francisco

Saturday, February 21, 1997

9:00 am  Departure for On Lok

9:30 to 11:30 am  VISIT TO ON LOK, A PACE PROGRAM (optional)

Jennie Chin Hansen, Director
Federal and Foundation Participants

Glenda Booth
Legislative Assistant
Office of Sen. Dianne Feinstein
U.S. Senate

David S. Cade
Director
Family and Children’s Health Programs Group
Center for Medicaid and State Operations
Department of Health and Human Services

Richard Chambers
Associate Regional Administrator for Medicaid
San Francisco Regional Office
Health Care Financing Administration

Debra S. Curtis
Legislative Director
Office of Rep. Pete Stark
U.S. House of Representatives

Beth C. Fuchs
Specialist in Social Legislation
Congressional Research Service
Library of Congress

Edward G. Grossman
Assistant Counsel
Office of the Legislative Counsel
U.S. House of Representatives

Paul C. Harrington
Health Policy Director—Majority
Committee on Labor and Human Resources
U.S. Senate

Elizabeth Hilder
Staff Attorney
Bureau of Competition, Health Care Division
Federal Trade Commission

Stacey Hughes
Policy Advisor
Office of the Assistant Majority Leader
U.S. Senate

Julia Ann James
Chief Health Policy Analyst
Committee on Finance
U.S. Senate

Peter J. Levin, Sc.D.
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U.S. Senate

Janet Lundy
Program Officer
Henry J. Kaiser Family Foundation

Ned McCulloch
Legislative Assistant
Office of Sen. Joseph Lieberman
U.S. Senate

David H. Nexon
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U.S. Senate

Anne Phelps
Health Policy Advisor
Subcommittee on Public Health and Safety
Committee on Labor and Human Resources
U.S. Senate

Joseph S. Piacentini
Senior Policy Analyst
Pension and Welfare Benefits Administration
U.S. Department of Labor

David Podoff
Chief Economist and Chief Health and Social Security Counselor—Minority
Committee on Finance
U.S. Senate

Richard Price
Section Head
Education and Public Welfare Division
Congressional Research Service
Library of Congress

Rush Russell
Senior Program Officer
Robert Wood Johnson Foundation

William J. Scanlon, Ph.D.
Director, Health Financing and Systems Issues
U.S. General Accounting Office
Christine Schmidt
*Deputy to Deputy Assistant Secretary, Health Policy*
Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

Dede Spitznagel
*Professional Staff Member*
Committee on Finance
U.S. Senate

Bernice Steinhardt
*Director, Health Services Quality and Public Health Issues*
U.S. General Accounting Office

Bridgett Taylor
*Professional Staff Member–Minority*
Committee on Commerce
U.S. House of Representatives

Barbara O. Wynn
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Project HOPE

NHPF Staff

Judith Miller Jones
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Lisa Sprague
*Senior Research Associate*
(Site Visit Director)

Gwen Hughes
*Site Visit Arrangements Coordinator*
Biographical Sketches—California Participants

Michael E. Abel, M.D., is chairman and chief executive officer of Brown & Toland Medical Group, the largest independent practice association in San Francisco. He is a surgeon in private practice at California Pacific Medical Center and associate clinical professor of surgery at the University of California, San Francisco. Dr. Abel is a diplomate of the American Board of Surgery and the American Board of Colorectal Surgery.

S. Kimberly Belshé was appointed by Gov. Pete Wilson as director of the California Department of Health Services in 1993. She had previously served as deputy secretary of the California Health and Welfare Agency and, earlier, as a legislative assistant to then-Senator Wilson in Washington, D.C.

Bruce Bodaken, president and chief operating officer of Blue Shield of California, oversees the company’s statewide managed care operations. Prior to joining Blue Shield in 1994, Mr. Bodaken served as senior vice president and associate chief operating officer of FHP International Corporation. He serves on numerous boards of directors, including those of the California Association of Health Plans and the Integrated Healthcare Association.

Leona M. Butler was recently named CEO of the Santa Clara Family Health Plan, after serving in the same position with the Health Plan of San Joaquin, which she designed and implemented to provide managed care to the Medi-Cal population. Previously vice president for provider affairs with Blue Cross of California, she developed the Prudent Buyer Plan, a pioneering PPO.

Beau Carter has been executive director of the Integrated Healthcare Association since 1995. Prior to that, he served in a series of executive positions with the Hospital Council of Northern and Central California, finally as senior vice president, public policy and advocacy.

Wendy Everett, Sc.D., directs the Institute for the Future’s health care programs. Her past positions include vice president of Brigham and Women’s Hospital in Boston, program director for the Kaiser Family Foundation, and co-founder of a medical software company.

Jerry C. Fleming is senior vice president and chief administrative officer, California Division, with Kaiser Permanente. He joined the company in 1977 as a market research analyst, advancing through positions of increasing responsibility in the areas of medical economics, planning and program development, and health plan management. In 1995 he became senior vice president, administrative services, and he was named to his current position last fall.

Lori L. Hack, M.B.A., has been executive director of Alta Bates Medical Group in Berkeley since 1992. Earlier, she served as director of managed care for the Antelope Valley Hospital and worked in provider relations for CIGNA. Ms. Hack is the current board chair of the National IPA Coalition.

Sandia R. Hernandez is chief executive officer and director of the San Francisco Foundation. Formerly she was director of health for the City and County of San Francisco Department of Public Health. She holds an appointment as assistant clinical professor in the School of Medicine of the University of California, San Francisco. Ms. Hernandez is a member of the President’s Commission on Consumer Protection and Quality in the Health Care Industry.

Sam Ho, M.D., is vice president, quality initiatives, for PacifiCare Health Systems, a position he attained in 1997 after serving for three years as vice president, health services. Prior to joining PacifiCare, Dr. Ho held management positions with Health Net, the San Francisco Health Department, and Maxicare.

Shelley A. Horwitz is the administrator of Bay Valley Medical Group, a multispecialty group practice. She has held this position since 1991, having joined the group in 1987. Ms. Horwitz is chair of the Integrated Healthcare Association and serves on the board of the American Medical Group Association.

Van R. Johnson, president and chief executive officer of Sutter Health, has been a member of the Sutter senior management team since joining the organization in 1985. His experience also includes a series of management positions with Intermountain Healthcare Corporation, based in Salt Lake City.

David J. Kears, L.C.S.W., has been director of the Alameda County Health Care Services Agency since 1986, stepping up from his earlier position as assistant director. Since 1994 he has concurrently served as chief executive officer of the Alameda Alliance for Health. He began his career as a psychiatric social worker and has
held several positions with Alameda County Mental Health Services.

Peter V. Lee, J.D., is the director of the Center for Health Care Rights' Consumer Protection Programs, overseeing research and advocacy efforts. Previously, he was an attorney with the Los Angeles firm Tuttle & Taylor; in the 1980s, he served as director of programs for the National AIDS network in Washington, DC.

Sharon Lee Levine, M.D., is associate executive director for physician and professional support services of the Permanente Medical Group (TPMG), a position she has held since 1991. She previously held management positions, including Physician-in-charge and chief of pediatrics, at TPMG's Fremont Medical Offices. Dr. Levine joined TPMG in 1977.

Harold S. Luft, Ph.D., is Caldwell B. Esselstyn Professor of Health Policy and Health Economics and director of the Institute for Health Policy Studies at the University of California, San Francisco. Prior to coming to UCSF in 1978, Dr. Luft was an assistant professor in the Health Services Research Program at Stanford. He currently serves on the National Advisory Committee of the Agency for Health Care Policy and Research and on the board of the Association for Health Services Research.

Bridget McCarthy, R.S.M., serves as executive vice president of Catholic Healthcare West (CHW) and is responsible for its strategic and operational performance of CHW's northern California operations. Prior to joining CHW in 1997, Sister Bridget was for ten years president and chief executive officer of Mercy Healthcare Sacramento.

Suzanne C. Mercure is health care programs manager at Southern California Edison. Her experience in all aspects of employee benefits, as a manager and as a consultant, has had a consumer as well as a purchaser focus, with emphasis on consumer information, input processes, and problem resolution. Ms. Mercure serves on boards or committees of numerous healthcare groups, including California Health Decisions and the Managed Health Care Association.

Arnold Milstein, M.D., M.P.H., directs the national clinical practice at William M. Mercer, Inc., and is the medical director of the Pacific Business Group on Health. He has written extensively on managed care program design and was cited by Business Insurance as “one of the 20 people who have made a difference in employee benefits management in the past 20 years.” Dr. Milstein is an associate clinical professor at the University of California, San Francisco Medical Center.

Maryann O’Sullivan is an independent consultant and project director for Health Access's Medi-Cal Community Assistance Project. She is the former Director of special health initiatives at Children Now and was the founding executive director of Health Access. Ms. O’Sullivan is a member of the California bar.

J. Douglas Porter is deputy director of the Department of Health Services’ Medical Care Services program, which administers the state’s Medi-Cal program. Before joining the Department in 1996 as assistant deputy director, Mr. Porter resided in Maine, where he was chief operating officer of a full-service psychiatric facility. From 1987 to 1993, he served as deputy commissioner of programs in the Department of Human Services, the state’s Medicaid agency.

James C. Robinson, Ph.D., is professor of public health at the University of California, Berkeley, where he chairs the Ph.D. program in health services and policy analysis. Dr. Robinson has received several national awards for research excellence, including the Robert Wood Johnson Foundation’s Investigator Award in Health Policy Research in 1994.

Philip J. Romero, Ph.D., is chief economist in the office of Gov. Pete Wilson, and also serves as a deputy cabinet secretary, overseeing agencies with business and economic responsibilities. He has just completed a term of service as executive director of the Managed Care Health Improvement Task Force. Earlier, he served as chief deputy director of the Governor’s Office of Planning and Research. Dr. Romero’s private-sector experience includes positions with Carrier Corporation and the RAND Corporation.

Helen Halpin Schaufller, Ph.D., M.S.P.H., is an associate professor of health policy and the director of the Program in Health and Public Policy at the University of California, Berkeley, School of Public Health and Graduate School of Public Policy. She is also the principal investigator of the Health Insurance Policy Program, a $1.6 million, five-year grant from the California Wellness Foundation to study Californians’ access to comprehensive, affordable health insurance.

Ellen Severoni, R.N., is co-founder and president of California Health Decisions, a nonprofit organization dedicated to bringing the consumer’s voice into healthcare decision making. Ms. Severoni began her career in medical-surgical and psychiatric nursing in Philadelphia. After moving to California in 1979, she became executive director of the Orange County chapter of Physicians for Social Responsibility. She currently serves on the board of the Foundation for Accountability (FACCT).

Sandra Shewry is the executive director of the Managed Risk Medical Insurance Board. The board administers two programs providing subsidized health insurance to Californians, as well as administering the state’s small employer
purchasing pool. Ms. Shewry serves on the boards of several national and state organizations, including the National Association of State Comprehensive Health Insurance Programs and the Pacific Business Group on Health.

**Myra C. Snyder, R.N., Ed.D.,** is president and chief executive officer of the California Association of Health Plans. Previously, she served as deputy mayor for health and human services for the City and County of San Francisco and, subsequently, as associate director for public health. She also has held the executive director/chief executive officer position with the California Nurses Association.

**Arthur M. Southam, M.D.,** is president and chief executive officer of Health Net, one of California’s largest managed care companies. Before accepting this position in July 1996, he was president and chief executive officer of CareAmerica Plans. Currently, Dr. Southam also serves as chairman of the California Association of Health Plans and on the boards of several other healthcare organizations.

**Bruce W. Spurlock, M.D.,** joined the California Healthcare Association in 1996 as executive vice president and serves as its expert in physician group relations, clinical and emergency issues, and quality and performance measures. He also practices internal medicine as a senior physician with the Permanente Medical Group, Inc., and as a clinical instructor at the University of California, Davis.

**Steven R. Zatkin** is senior vice president, government relations, for Kaiser Permanente. Prior to joining Kaiser in 1978, he was employed for nine years by the Assembly of the California Legislature as a consultant to various committees with jurisdiction over health-related legislation. Mr. Zatkin serves on the boards of both the American and the California Associations of Health Plans.
Biographical Sketches—Federal and Foundation Participants

Glenda Booth is legislative assistant to Sen. Dianne Feinstein. Past congressional staff positions include deputy staff director of the Subcommittee on Commerce of the House Commerce Committee and legislative director for, successively, Reps. Doug Walgren (D-Pa.) and Peter Hoagland (D-Neb.).

David S. Cade is director of the Family and Children’s Health Programs Group in HCFA. He previously served as the acting deputy director of the Medicaid Bureau and was for 11 years in the Office of the General Counsel’s health care financing division.

Richard Chambers is associate regional administrator for Medicaid in the San Francisco regional office of the Health Care Financing Administration, a position he has filled since 1995. For more than eight years prior to that, he was director of the agency’s Office of Intergovernmental Affairs in Washington. At HCFA’s 1977 inception, Chambers signed on as legislative analyst and congressional affairs liaison.

Debra S. Curtis was recently named legislative director, with health policy responsibilities, for Rep. Pete Stark (D-Calif.). Previously, she had been health policy legislative assistant to Rep. Ben Cardin (D-Md.), another member of the House Committee on Ways and Means health subcommittee. Positions in several other congressional offices and as congressional affairs director for Citizen Action round out her public policy experience.

Beth C. Fuchs is a specialist in social legislation with the Education and Public Welfare Division of the Congressional Research Service (CRS). Before coming to CRS in 1987, she worked as a professional staff member for the Senate Special Committee on Aging and as a legislative assistant for a member of the House of Representatives. Dr. Fuchs also taught political science and public policy at Duke University and the University of North Carolina.


Paul C. Harrington is health policy director, majority staff, for the Senate Labor and Human Resources Committee. Prior to taking this position in 1996, he was deputy commissioner of the Vermont Department of Labor and Industry. Earlier, Mr. Harrington served as a board member of the Vermont Health Care Authority and a member of the Vermont House of Representatives, where he chaired the Commerce Committee for two terms.

Elizabeth Hilder is a staff attorney in the Health Care Division, Bureau of Competition of the Federal Trade Commission, a position she has held since 1982. She began her federal career as an attorney for the Bureau of Consumer Protection.

Stacey Hughes is a policy advisor in the office of the assistant majority leader of the Senate, Don Nickles of Oklahoma. Before accepting this position in 1996, she served as a regional policy director for the American Medical Association and a legislative assistant to Sen. Connie Mack (R-Fla.).

Julia Ann James is chief health policy analyst for the Senate Finance Committee. Prior to joining the Finance Committee staff in 1991, she held various health-policy positions in the state of Oregon, including associate director of the Oregon Comprehensive Cancer Program and of the Northwest Oregon Health Systems Agency.

Peter J. Levin, Sc.D., is health policy counsel in the office of Sen. Connie Mack (R-Fla.), where he earlier held a health policy fellowship. He has served as dean of two colleges of public health, at the University of South Florida and the University of Oklahoma, and earlier as the executive director of Stanford University Hospital.

Janet Lundy is program officer for two grant programs at the Henry J. Kaiser Family Foundation, the Changing Health Care Marketplace Project and the California Grants Program. Before joining the foundation in 1995, she was a senior health policy/legislative analyst for the Congressional Research Service.

Ned McCulloch is counsel and legislative representative in the office of Sen. Joseph Lieberman (D-Conn.), a position he has held for two years. Previously, he served for more than seven years as a senior legislative representative with the Service Employees' International Union.
David H. Nexon is the minority staff director for health for the Senate Labor and Human Resources Committee; he has been health staff director for the committee (as minority or majority) since 1994, having moved up from a previous position as health policy counsel. Earlier, he was a senior budget examiner with the Office of Management and Budget.

Anne Phelps is health policy advisor on the Senate Labor and Human Resources Subcommittee on Public Health and Safety. She had previously served as a health policy fellow to the full committee under the chairmanship of Nancy Kassebaum (R-Kans.). Before coming to Capitol Hill, Ms. Phelps worked at the National Institutes of Health in a series of legislative and science policy positions.

Joseph S. Piacentini is a senior policy analyst with the Pension and Welfare Benefits Administration in the U.S. Department of Labor. Prior to joining PBWA in 1996, he spent five years as director, health issues, at Aetna, Inc. Earlier, he was a research associate at the Employee Benefits Research Institute.

David Podoff is minority chief economist and minority chief health and social security counselor for the Senate Finance Committee. Prior to joining the staff as chief economist in 1993, he was a senior economist with the Joint Economic Committee. Earlier in his career, he directed various research units in the Social Security Administration, and taught economics at universities in Massachusetts and California.

Richard Price heads the Health Section of the Education and Public Welfare Division of the Congressional Research Service. In addition to his managerial duties, he serves as the section's lead analyst on long-term care financing issues.

Rush Russell is a senior program officer at the Robert Wood Johnson Foundation, currently overseeing the Making the Grade program, All Kids Count, and the Urban Health initiative. He came to the Foundation in 1992 from Washington, D.C., where he served as executive director of the Joseph P. Kennedy, Jr., Foundation and as legislative assistant to Sen. Bill Bradley (D-N.J.).

William J. Scanlon, Ph.D., is director of the Health Financing and Systems Issue Area at the U.S. General Accounting Office (GAO). Before joining GAO in 1993, he was co-director of the Center for Health Policy Studies and an associate professor of family medicine at Georgetown University; earlier, he was a principal research associate in health policy at the Urban Institute.

Christine Schmidt is deputy to the deputy assistant secretary for health policy in the Department of Health and Human Services. A previous position was director of the Health Benefits and Income Security Division in DHHS' Office of Management and Budget. From 1979 to 1991, Ms. Schmidt held a series of positions with the Department of Agriculture.

Dede Spitznagel is a professional staff member with responsibility for health policy for the Senate Finance Committee. She took the Senate position in 1997, following a period of service with the House Budget Committee.

Bernice Steinhardt has been director of the Health Services Quality and Public Health Issues group in the GAO since 1996. Previously, she was associate director for energy, natural resources and science issues and, earlier, for environmental protection issues. Before joining GAO as a staff member in 1989, Ms. Steinhardt had worked as a consultant to the agency for a number of years. Her experience includes positions with the Department of the Interior and the President's Council on Environmental Quality.

Bridgett Taylor is a professional staff member on the Democratic staff of the House Commerce Committee. Prior to her move to Capitol Hill in 1995, she was associate director for health in the Office of the Assistant Secretary for Legislation, Department of Health and Human Services. She earlier was employed by the Washington office of the state of Texas as its primary policy expert in the areas of health, education, and human services.

Barbara O. Wynn is director of the Plan and Provider Purchasing Policy Group in the Health Care Financing Administration (HCFA). Earlier HCFA positions included deputy director of the Bureau of Policy Development, director of the Division of Hospital Payment Policy, and special assistant associate administrator for policy.
Biographical Sketches—
NHPF Consultants

Sheila Burke, R.N., M.P.A., F.A.A.N., is executive dean and a lecturer in public policy at the John F. Kennedy School of Government, Harvard University. From 1986 to 1996, she served as chief of staff to Sen. Bob Dole (as both majority and minority leader). Earlier, she had been deputy staff director of the Senate Finance Committee.

Jack C. Ebeler is a consultant in health care policy and administration, currently serving as a special consultant to the Robert Wood Johnson. He also holds an associate professor appointment in the School of Hygiene and Public Health at Johns Hopkins. In 1995 and 1996, he was deputy assistant secretary and then acting assistant secretary for planning and evaluation. In the private sector, he was a principal in Health Policy Alternatives and a vice president of Group Health (now HealthPartners) in the Twin Cities.

Sandra Foote is an independent consultant in healthcare policy. She was co-founder, board member, and senior executive of Community Care Network (CCN), a preferred provider healthcare management company in San Diego. Founded in 1982, CCN was sold to Value Health, Inc., in 1997. Earlier, Ms. Foote worked as a health planner and manager in public programs at both the county and federal level.

John K. Iglehart is editor of Health Affairs, a policy journal that he founded in 1981 under the aegis of Project Hope. From 1981 to 1996, he concurrently served as national correspondent for the New England Journal of Medicine. Earlier, he was a vice president of the Kaiser Foundation Health Plan and director of its Washington, D.C., office.