Robert Wood Johnson Foundation

Published: January 1, 2004
Program Results Report
Grant ID: 28060, 32799, 37605, 46416

Study Panels Suggest Ways to Restructure Medicare

National conference on social insurance

SUMMARY

From 1995 to 2003, the National Academy of Social Insurance convened seven study panels to examine issues pertaining to the restructuring of Medicare. The study panels were:

- Capitation and Choice
- Fee-for-Service Medicare
- Medicare's Larger Social Role
- Medicare's Long-Term Financing
- Medicare's Governance and Management
- Medicare and Chronic Care in the 21st Century
- Medicare and Markets

The Washington-based academy is a nonprofit, nonpartisan research and education organization devoted to the study of income security, health care finance and related public and private programs.

Key Recommendations and Findings

The National Academy of Social Insurance identified four general principles that emerged from the study panels that should serve as core values in restructuring Medicare:

- Medicare has made invaluable contributions to the health and financial security of beneficiaries.
- Medicare should be preserved as a social insurance program.
- Reform proposals should seek an appropriate balance between the financial security of Medicare beneficiaries and the need to ensure financing for Medicare's long-term future.

- Medicare's acute care focus should be modified to address the health care needs of beneficiaries, most of whom have chronic conditions.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through four grants totaling $2,902,859.

THE PROBLEM

In the mid-1990s, most leading health policy experts agreed that the Medicare program had to be restructured to continue to protect beneficiaries from the cost of illness.

If Medicare did not change, experts predicted that the Part A Trust Fund (which pays for inpatient hospital stays, care in skilled nursing facilities, hospice care and some home health care) would become insolvent in 10 years, and that rising outlays for Part B (which helps pay for doctors' services, outpatient hospital care and other medical services that are not covered by Part A) would increase both the premiums paid by enrollees and the taxpayer burden.

They also predicted that mounting budget pressures to curb spending and the challenges posed as the baby boom generation began to retire after 2010 were likely to aggravate the problem.

The National Academy of Social Insurance, based in Washington, is a nonprofit, nonpartisan research and education organization devoted to the study of income security, health care finance and related public and private programs. Among its members are some 50 individuals who are best known for their work on Medicare at all stages of its development and at least 100 others who have studied aspects of Medicare in the context of other public and private insurance.

Prior to seeking funding from RWJF, the academy had convened a bipartisan steering committee of 18 experts to identify and set priorities for questions to be addressed by study panels. See the Appendix for a list of committee members.

THE PROJECT

From November 1995 through January 2003, RWJF provided four grants totaling slightly more than $2.9 million to the National Academy of Social Insurance to convene a series of seven study panels to identify the long-term issues facing the Medicare program and to examine the pros and cons of the policy options available to solve them. The seven panels were:

- *Capitation and Choice*

- *Fee-for-Service Medicare*
- *Medicare's Larger Social Role*
- *Medicare's Long-Term Financing*
- *Medicare's Governance and Management*
- *Medicare and Chronic Care in the* 21st Century
- Medicare and Markets

Experts on each panel provided scholarly analysis, synthesis and dialogue on the options for ensuring that elderly and disabled people have financial access to needed health services. The first two grants (ID#s 028060 and 032799) allowed the academy to convene the first four study panels, to prepare reports on their findings and to begin planning for dissemination.

A third grant (ID# 037605) supported three additional study panels and their reports and provided funds to disseminate recommendations and findings. A final four-month grant (ID# 046416) supported a conference highlighting the recommendations of the study panels and reviewed recent research on race and ethnicity-related health disparities affecting Medicare beneficiaries.

Other Funding

Sources of additional funding for the panels came from:

- Pew Charitable Trusts ($300,000)
- California HealthCare Foundation ($152,863)
- Kaiser Family Foundation ($100,000)
- federal Agency for Health Care Policy Research ($50,000)
- federal Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration or HCFA) ($49,200)
- Commonwealth Fund ($25,000)
- Kaiser Permanente ($25,000)
- W.K. Kellogg Foundation ($10,000)
- Chrysler Foundation ($5,000)
- 22 corporations and labor organizations that participated in some of the conferences ($22,000).

RECOMMENDATIONS AND FINDINGS

The National Academy of Social Insurance identified four general principles from the study panels that, according to the academy, should serve as core values in restructuring Medicare:

- Medicare has made invaluable contributions to the health and financial security of beneficiaries.
- Medicare should be preserved as a social insurance program.
- Reform proposals should seek an appropriate balance between the financial security of Medicare beneficiaries and the need to ensure financing for Medicare's long-term future.
- Medicare's acute care focus should be modified to address the health care needs of beneficiaries, most of whom have chronic conditions.

The recommendations and findings of the seven study panels follow (see the Appendix for participant lists).

Study Panel on Capitation and Choice

This panel examined questions associated with introducing market-based competition to health care organizations serving Medicare beneficiaries (a strategy that began under the Balanced Budget Act of 1997 with the establishment of a Medicare+Choice demonstration project). (In 2003, Congress passed the Medicare Modernization Act, which included changes in payment rates to participating Medicare+Choice plans and renamed the program Medicare Advantage.) The principles of capitation (in which a flat per-month, per-member fee is paid to individual physicians or other providers), choice and shared financial risk were fundamental to this approach to restructuring Medicare. The panel identified strategies to improve Medicare's capitated payment options and investigated the balance between cost containment and quality services and how this drives the competition for enrollees. The panel's final report is entitled *Structuring Medicare Choices.*

The study panel concluded that any restructuring should maintain Medicare as a social insurance entitlement program, preserve Medicare benefits and protect beneficiaries against excessive cost sharing. Restructuring should also be based on a thorough analysis of:

- the strengths and weaknesses of market-based competition among health plans.
- methods of paying for services equitably, given the health care needs of Medicare beneficiaries.

- approaches to ensuring beneficiaries' access to quality health care.

Among the study panel's additional recommendations, which are contained in *Structuring Medicare Choices*, are the following:

Recommendations for Structuring Medicare Choices

- **The models used by government and private organizations to structure insurance choice for their employees, retirees and dependents should be studied closely so that their successes and failures can inform decisions related to Medicare.**
- **Medicare benefits should be redesigned to meet the health needs of current and future beneficiaries.**
- **Medicare should adopt annual open enrollment and information periods that are coordinated with enrollment into Medicaid, other federal health care programs and Medigap policies.** There should also be periodic opportunities for beneficiaries to opt out of choices that are unsatisfactory.
- **The Centers for Medicare & Medicaid Services (the federal agency that administers both programs) should assess options for standardizing the ways in which benefits are described to facilitate comparisons among plans.** It should also explore options for developing and evaluating the marketing of service packages that combine basic and supplemental benefits through managed care plans.

Recommendations for Paying for Medicare Managed Care

- **The Centers for Medicare & Medicaid Services should design a system for adjusting payments based on the best available methods for assessing risks.** The centers should support broad-based research and evaluation to examine cost-effectiveness, outcomes and quality of care of that system.
- **Full-risk capitation for all services should be prohibited in Medicare.** The Centers for Medicare & Medicaid Services should design research to determine what level of risk sharing, in a plan that blends capitation and fee-for-service payments, can protect against biased selection (i.e., avoiding or underserving high-cost cases) without reducing treatment efficiency to an unacceptable level.

Recommendations for Information Needs and Beneficiary Protection

- **All participating health insurance plans should provide standard information to beneficiaries about benefits, availability of services, policies and cost sharing in formats that are understandable and allow enrollees to make comparisons across plans.**
- **Nationally consistent standards should be adopted for all health plans participating in Medicare choice plans.** These standards should cover marketing;

access to care; continuity of care and adequacy of provider networks; confidentiality; nondiscrimination, performance measurement and reporting, quality review and sanctions; utilization review and systems for appeals and grievances; and criteria for incentive payment arrangements.

- **Funding for Medicare choice should include adequate resources to support local consumer information and individual counseling to beneficiaries about plan options.**

Recommendations for Preparing for Structured Choice in Medicare

- **Medicare competitive pricing demonstration projects should be developed and evaluated to identify alternative models for organizing local public/private consortia to manage group purchasing of Medicare health insurance.**
- **Defined contribution demonstration projects, in which Medicare pays a fixed amount on behalf of each beneficiary, rather than paying for a specified set of health benefits, should be established in several regions.** These demonstrations would offer a full fee-for-service coverage option as well as qualified managed care options.
- **Demonstration projects should be structured to allow for three years of preparation and five years of evaluation.**

Study Panel on Fee-for-Service Medicare

This panel examined Medicare's traditional fee-for-service payment structure, which remains the dominant mode of Medicare enrollment despite the growing number of beneficiaries enrolled in managed care plans. Through a series of meetings, commissioned papers and writings by individual members and staff over an 18-month period, the panel analyzed key characteristics and difficulties of the fee-for-service program, state-of-the-art management practices among private insurers and policy alternatives to prepare fee-for-service Medicare for the next generation. The panel's final report is entitled *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare.*

The study panel found that the evolution of private health insurance from fee-for-service to managed care principles could be instructive for Medicare. Panel members believed that the principles of disease and case management, incentives for using selected providers and competitive procurement could improve management by decreasing variances in care and costs, reducing threats to quality and minimizing the difficulty of meeting chronic care needs. However, they found that any changes in program philosophy or procedure would require new statutory authorization. In addition, according to the panel, nonstatutory barriers to innovation reflect the size and dominance of Medicare, political considerations and the slow rate of change that is typical in large

government agencies. Among the study panel's recommendations, which are contained in *Transforming Traditional Medicare,* are the following:

- **Congress should mandate that fee-for-service Medicare move beyond its traditional role as a bill-payer to become accountable for the quality and costs of services provided to beneficiaries.**
- **Congress should direct the Centers for Medicare & Medicaid Services to pursue innovations in fee-for-service Medicare on an ongoing basis by adapting (and going beyond) the best practices of private health plans.** The Centers for Medicare & Medicaid Services should experiment with new ways of managing services, including disease and case management (especially for beneficiaries with chronic diseases), incentives for beneficiaries to use selected providers and a unique competitive procurement process for fee-for-service Medicare.
- **In order to carry out these experiments in managing fee-for-service Medicare, the Centers for Medicare & Medicaid Services should have the authority to waive some statutory requirements.**
- **Congress should require the Secretary of Health and Human Services to report annually on how the Centers for Medicare & Medicaid Services has used its authority to innovate and with what results for quality, cost and access.** Congress should designate an advisory body to respond to this report and advise Congress about potential improvements.
- **Congress should require that the Centers for Medicare & Medicaid Services evaluate each new innovation and initiative to remain accountable to the public.**

Study Panel on Medicare's Larger Social Role

This panel examined the underlying principles and rationales of Medicare and how the program fits into the larger social insurance and welfare structures. It focused on four major tasks:

- a historical review of why Medicare was created and how it has evolved.
- an assessment of the principles of social insurance as embodied by Medicare, including other public goods paid for by Medicare, such as graduate medical education.
- a public opinion research project to understand how Americans view Medicare.
- a framework for the discussion of criteria used to evaluate options for Medicare reform that incorporate the social values and policy concerns of the American public.

The panel met four times, commissioned background papers and conducted targeted research, including a national poll in the early summer of 1997 and a series of 10 focus groups conducted in California in February 1998. (The national poll was subcontracted

through National Research, Inc. and the focus groups through Kleimann Communication Group; both firms are based in Washington). The panel's final report is entitled *Medicare and the American Social Contract.*

The study panel concluded that Medicare has improved the health status of the elderly in America and reduced the burden of responsibility for medical care costs for families but that its ability to fulfill its goals is now threatened in two ways by health care costs. As the program is currently structured, projected health care expenditures will exceed the revenues available to fund the program beyond the next decade; at the same time, the program is falling behind in its goal of providing financial security to beneficiaries and their families. Among the other findings of the study panel, which are contained in *Medicare and the American Social Contract*, are the following:

- **Although the aging of the population has contributed to the problems that Medicare is facing, the increasing use of services by the average beneficiary is the major factor driving the relentless growth of Medicare costs.**
- **The existing Medicare benefits package no longer reflects the way that medicine is practiced.** The costs and advantages of redesigning the benefit package need to be analyzed carefully, fully considering the total health care costs that will ultimately be borne by beneficiaries, families and other private and public payers.
- **Social insurance that spreads the risks of health care costs across generations remains the best and only politically feasible way to ensure the health and economic security of older Americans.**
- **Proposals for securing the future of Medicare should address what health care services Medicare will pay for, what mechanisms will determine how coverage and benefits will be adjusted to meet future circumstances, what portion of those costs can and should be borne by individual beneficiaries and how the costs of care for beneficiaries who cannot afford their share of payments will be allocated across other public programs, such as Medicaid.**
- **In order to be accountable, Medicare will have to develop a much clearer focus on serving the needs of the beneficiary population, rather than on just cutting costs.** This includes more active efforts to determine what works well in medical care, which technologies are most effective and how health care providers can be organized and paid to encourage service efficiency and quality.
- **Medicare's other social roles—e.g., supporting graduate medical education and providing care in rural hospitals and in hospitals with a high percentage of uninsured patients—should be addressed as separate public policy issues, rather than as a part of the debate about the future of Medicare.**

- **Medicare is generally popular, largely because the public understands that the risks facing the Medicare-eligible population cannot be met in the private health care market at a price that most people can afford.**
- **Concerted efforts should be made to provide the public with clear, usable information about the implications of Medicare reform so that it can play a meaningful role in the debate.**
- **Individuals should consider seven criteria values and public policy concerns important to debating Medicare's future:**
  - **financial security**
  - **equity**
  - **efficiency**
  - **affordability over time**
  - **political accountability**
  - **political sustainability**
  - **maximizing individual liberty.**
- **Incremental reforms that increase beneficiary cost sharing could undermine the basic financial protections Medicare was intended to provide.** In addition, this approach would not address the fundamental, system-wide problem of health care costs and how to make decisions about access and quality of care.
- **Structured competition and pre-funded individualized medical accounts would transfer some risk for health care costs from the government to individuals.**
- **New local, regional and national information and oversight systems may be necessary to implement restructuring options that depend on the market to control health care costs.**

Study Panel on Medicare's Long-Term Financing

This panel examined financial strategies associated with possible approaches to Medicare reform. A basic understanding of Medicare as a social insurance program designed to spread the financial risk of medical care for beneficiaries across the working population was essential to the panel's analysis. According to the panel, this fundamental tenet is being threatened by the rising costs of health care. Impending reform efforts may also affect Medicare's ability to spread risk. The panel commissioned projections of Medicare spending based on several contingencies: that Medicare remained unchanged; that the program is changed to produce savings; that benefits are expanded; and that Medicare cost sharing formulas are altered. The panel met six times between November 1997 and

January 2000. In addition to a final report (Financing Medicare's Future) and an interim report (*The Financing Needs of a Restructured Medicare Program*), the panel commissioned six unpublished papers.

The study panel identified four general approaches to meeting Medicare's projected financing needs: reducing program costs through efficiencies; asking beneficiaries to pay more; using the budget surplus of the 1990s; and raising revenues through taxes. In addition to elaborating on each of these financing options, the study panel made the following observations, which are contained in *Financing Medicare's Future:*

1. **Additional financing must be secured for Medicare to avoiding eroding the financial protection the program provides.**
2. **The ultimate solution to Medicare reform will involve trade-offs.** Specific options may be undesirable in one or more ways but they should not limit policy-makers from taking action.
3. **Raising taxes is neither popular nor without drawbacks.** Americans will have to decide whether new revenues are preferable to eroding the financial protections that Medicare offers as policy-makers consider how best to balance equity, efficiency and the administrative burden of each approach.

- **The role of timing in public finance reform decisions is crucial.** Starting early to raise revenues will be more financially and politically palatable than waiting until significant revenue needs are at hand.

Study Panel on Medicare's Governance and Management

This panel examined some of the questions about Medicare's institutional structures and management procedures that have been raised in the reform debate. In seven meetings, the panel used three criteria to evaluate Medicare's governance and management:

- Does Medicare have the capacity to fulfill the responsibilities Congress has given it?
- Is Medicare accountable for its decisions?
- Is the Medicare program administration viewed as credible?

The panel's final report is entitled *Improving Medicare's Governance and Management.*

The study panel found that a shortage of resources, congressional micromanagement and increased responsibilities have prevented the Centers for Medicare & Medicaid Services from fully discharging all of its responsibilities. The panel evaluated alternate governance models but found none to be clearly superior. Among its recommendations, which are contained in *Improving Medicare's Governance and Management,* are the following:

- **Regardless of whether broader Medicare reform occurs, policy-makers should address the administrative and management problems of Medicare.**
- **A panel of independent experts should be appointed to analyze the impact on Social Security and its stakeholders of the Centers for Medicare & Medicaid Services' transition from an operating agency within the federal Department of Health and Human Services to a freestanding agency.**
- **Congress should increase administrative funding to the Centers for Medicare & Medicaid Services.**
- **In the absence of a decision by Congress to fundamentally reform Medicare or to provide it with substantial new resources, Congress should not enact major changes in the program because the Centers for Medicare & Medicaid Services does not have the resources or capacity to implement them.** Additionally, Congress should shift its focus from micromanaging the Centers for Medicare & Medicaid Services to giving it more administrative latitude to accomplish the goals Congress sets for it.
- **Congress should consider removing some functions not directly related to Medicare or Medicaid from the Centers for Medicare & Medicaid Services so that the agency can focus on its core missions.** Examples include oversight of the Clinical Laboratory Improvement Act and responsibility for the Health Insurance Portability and Accountability Act.
- **Congress should furnish the Centers for Medicare & Medicaid Services with multiyear funding to develop and implement improved information systems.**
- **Congress should authorize the president to appoint with congressional approval the administrator of the Centers for Medicare & Medicaid Services to a fixed term and should furnish protection against arbitrary removal.**
- **Congress should increase the salary of the administrator to better reflect the stature and responsibilities of the position.** The salary should be commensurate with that of the commissioner of the Social Security Administration.
- **In order to recruit and retain staff with highly specialized skills, Congress should grant the Centers for Medicare & Medicaid Services some relief from salary and civil service personnel rules.**
- **Drawing on members of the House Ways and Means Committee, the House Commerce Committee and the Senate Committee on Finance, Congress should create a joint committee to coordinate congressional oversight of Medicare and to give Congress independent technical expertise.**
- **Congress should enact legislation that gives the Centers for Medicare & Medicaid Services more flexibility to contract with organizations to process**

Medicare claims. Service standards for customer service should be included in these contracts.

- **Congress should provide resources so that the Centers for Medicare & Medicaid Services can assist beneficiaries with Medicare-related problems by telephone or via the Internet, or by establishing Medicare help desks in Social Security field offices.**
- **To assure that beneficiaries and their families have the information they need to make informed choices, Congress should adequately fund the National Medicare Education Program, which operates through the Centers for Medicare & Medicaid Services to help Medicare beneficiaries better understand the Medicare+Choice program.**

Study Panel on Medicare and Chronic Care in the 21st Century

This panel sought to determine the health care and related needs of Medicare beneficiaries with chronic conditions, how well Medicare meets their needs, which features of the current Medicare program support or impede good chronic care and what can be learned from other chronic care models. The panel's charge was also to set a new vision for Medicare to improve care and financing for beneficiaries with chronic conditions, and then to propose recommendations to move toward this vision. Its final report is entitled *Medicare in the 21st Century: Building a Better Chronic Care System.*

In the study panel's long-term vision, Medicare would provide beneficiaries with access to needed services and financial protection from costs that pose barriers to chronic care. The goal would be to create a seamless continuum of services across acute, chronic, long-term and end-of-life care. Among the recommendations of the study panel, which are contained in *Building a Better Chronic Care System*, are the following:

- **Medicare should protect beneficiaries with chronic conditions by capping out-of-pocket expenditures and covering services necessary to meet chronic care needs.**
- **Medicare should support the continuum of care by addressing gaps in Medicare's benefit structure (e.g., prescription drugs and preventive health services); including services related to function and health-related quality of life; and adequately involving families of beneficiaries.**
- **Policy-makers should promote new models of care for Medicare by fostering changes in delivery systems; increasing providers' knowledge of chronic and geriatric care; and developing and testing alternative payment models.**
- **Policy-makers should strengthen the role of the Centers for Medicare & Medicaid Services as a purchaser of care by measuring and reporting on the quality of chronic care and supporting research and demonstration projects directed at specific chronic conditions and at multiple conditions.**

- **Policy-makers should support enhanced information systems by fostering the implementation of electronic information systems and promoting the collection and standardization of health and functional assessment data.**

Study Panel on Medicare and Markets

This panel examined issues relating to how increased reliance on market forces could address concerns in the Medicare program. These questions included:

- **How might increased local or regional competition for Medicare beneficiaries affect the availability and cost of service?**
- **How might potential changes in the Medicare benefits package affect the supplemental insurance market, retiree health benefits, out-of-pocket liability, and the use and cost of health services for different segments of the beneficiary population?**
- **What issues will federal and state governments need to address with respect to regulation, oversight and consumer education and protection in the health insurance and health care markets in which Medicare operates?**

Recommendations for Medicare and Markets

- **The Medicare program should incorporate an annual limit on out-of-pocket spending for Medicare-covered services.**
- **The Medicare program should provide Medicare beneficiaries with access to outpatient prescription drug coverage to protect them against large out-of-pocket expenses.**
- **Beneficiaries must be assured that original Medicare is available in all areas and will remain so over time.** Most panel members believe that keeping original Medicare premiums affordable should be a priority, but that view was not unanimous.
- **Medicare supplemental policies should be community-rated, with greater freedom to switch among plans.** To prevent adverse selection, consideration should be given to restrictions on the number of times beneficiaries can switch between fee-for-service Medicare and Medicare+Choice plans, or on the number of plans that are available on a community-rated basis.
- **Medicare should conduct competitive pricing demonstrations to pay private health plans.** Most panel members think that original Medicare should be excluded from the demonstration to protect it against adverse risk selection, although a few panel members think it should be included. These demonstrations should test both competitive bidding and the Federal Employees Health Benefits Program (FEHBP) models.

- **The performance monitoring systems (CAHPS, HEDIS) used by the Centers for Medicare & Medicaid Services to measure access to care under original Medicare and Medicare+Choice should include new measures related to chronic illness, as well as increased sample sizes of disabled enrollees.**

- **The Centers for Medicare & Medicaid Services should modify the Medicare conditions of participation for hospitals to require mandatory reporting of adverse events that result in death or serious harm.** CMS should also develop the capacity to identify beneficiaries admitted to low-volume hospitals for procedures where outcomes are sensitive to the volume of procedures performed. The Centers for Medicare & Medicaid Services should be encouraged to consider a system that could prospectively screen such admissions.

- **The Centers for Medicare & Medicaid Services should develop and implement a payment system for health plans that incorporates explicit incentives for improving quality of care.** Parallel incentives should be established for fee-for-service providers. In the short run, these may be limited to physicians in group practice in fee-for-service Medicare, but eventually should be extended to all physicians.

- **Congress should give the Centers for Medicare & Medicaid Services the necessary resources and authority to stimulate changes to improve quality of care for beneficiaries, such as expanded requirements for geriatric training for clinicians treating Medicare beneficiaries and capacity to promote regionalization of care for procedures shown to have a relationship between volume and quality.**

- **The Centers for Medicare & Medicaid Services should measure and assess disparities in preventive care, primary care, essential medical and surgical procedures and follow-up treatment on a regular basis.** Disparities based on race, ethnicity, socioeconomic status and gender should be studied in both original Medicare and Medicare+Choice. Aggregate measures should be reported on an annual basis. Plan-specific measures should be used whenever possible to encourage improvement at the local level.

- **The Centers for Medicare & Medicaid Services should help beneficiaries better understand that they are enrolled in Medicare regardless of whether they receive care through original Medicare or a Medicare+Choice plan, and the conditions under which they can disenroll from Medicare+Choice and return to original Medicare.** This educational effort must be carefully designed to clarify the structure of the program, while not confusing beneficiaries about the terms under which they have enrolled in particular Medicare+Choice plans.

- **Mechanisms should be developed to ensure greater consumer, political and managerial accountability that more effectively stimulates learning between original Medicare and Medicare+Choice.**

- **Congress should create a more stable environment for the Medicare+Choice program by refraining from legislating frequent changes in the program's structure and payment rates.**

Communications

The academy issued final reports from each panel, prepared briefs and briefings, published articles (in *Health Affairs* and other journals) and made presentations. Project staff provided congressional testimony four times (as requested by several members of Congress) and briefed congressional staff frequently. Two of the National Academy of Social Insurance's annual conferences were devoted to Medicare restructuring issues, and other conferences featured presentations on the subject. The final RWJF grant for this project (ID# 046416) funded two pre-conference forums and two conference sessions at the 15th annual national conference on Social Insurance in a Diverse America, which the academy sponsored. Its website provides extensive information on the project, along with downloadable reports. See the Bibliography for details.

AFTERWARD

Although the academy's study panels on restructuring Medicare have completed their work, and RWJF funding has ended, the steering committee has become a part of the academy's organizational planning process and continues to meet. According to Pamela Larson, executive vice president at the academy, the steering committee is currently developing proposals to assemble study panels to examine three other Medicare issues:

- how to sharpen Medicare's policy tools to reduce disparities.
- how federal benefits can be extended to meet the needs of individuals who are eligible for both Medicare and Medicaid.
- designing a long-term care program for the future (the long-term care work is supported by a separate grant from RWJF (Grant ID# 046880).

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Grant ID# 28060, 32799, 37605, 46416
Program area: Coverage, Vulnerable Populations

APPENDIX

Panels and Committees

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

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"Social Security and Medicare: Individual vs. Collective and Risk & Responsibility," January 27–28, 1999, Washington. Attended by 285 individuals from 130 organizations, including the Social Security Administration and the Health Care Financing Administration. Five sessions and two workshops. Proceedings available through the Brookings Institution Press.

"Ensuring Health and Income Security for an Aging Workforce," January 26–27, 2000, Washington. Attended by 290 people from 105 organizations, including ERISA Industry Committee, AFL-CIO, Social Security Administration and the Center for Medicare Advocacy, Inc. Four sessions and two roundtable discussions sponsored by the Medicare project.

"The Future of Social Insurance: Incremental Action or Fundamental Reform," January 24–25, Washington. Attended by 375 people from 150 organizations, including Goldman Sachs & Co., Center on Budget and Policy Priorities, Institute for Women's Policy Research and the United Hospital Fund. One session sponsored by the Medicare project.

"Long-Term Care and Medicare Policy: Can We Improve the Continuity of Care?" January 24–25, 2002, Washington. Attended by 280 people from 160 organizations, including the Centers for Medicare & Medicaid Services, the Academy for Health Services Research and Health Policy, the Urban Institute and the Brookings Institution. Five sessions and one workshop. Proceedings available through the Brookings Institution Press.

"Strengthening Community: Social Insurance in a Diverse America," January 29–31, 2003, Washington Attended by more than 300 people from 135 organizations, including the General Accounting Office, National Urban League, Congressional Research Service and AARP. Five sessions and two workshops. Proceedings available through the Brookings Institution Press.

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