



# Borrowing Business Practices to Improve Medicare

## Health Insurance Reform Project

### SUMMARY

From 1995 to 2001, [George Washington University](#) started the Health Insurance Reform Project to help policy-makers and others in the health care field understand changes and innovations occurring in the health care and insurance markets.

### Key Findings

Among the findings and recommendations were:

- Medicare could benefit from adapting some private sector innovations in providing health care to consumers.
- Recent Medicare reform, which allows both a government-run model and a private-sector model, could serve as a model for broader health care reform.
- HMO Medicare benefits should be subject to a minimal level of standardization in order to reduce beneficiary confusion when comparing plans.
- Flexible tax credits and other measures could help uninsured workers and their children receive health coverage.
- A national retirement policy that coordinates Medicare, Social Security and private pension reforms could make substantial progress in dealing with retirement problems in the baby-boom generation.

### Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through three grants totaling \$1,784,457.

### THE PROBLEM

Health care and health insurance have undergone rapid and dramatic changes with many new actors and new approaches to both the delivery and financing of services. Policy-makers and others want to know what role, if any, public policy might play in

accelerating, slowing, modifying or simply monitoring these changes. In addition, there is growing interest in looking at successful innovations in the private sector that can be applied to public-sector health care programs.

For example, Medicare and Medicaid are experimenting with making greater use of managed care practices tried in the private sector. Medicare's inexperience with a competitive managed care market forces it to look to the private sector for best practices and innovations that will enable it to be efficient and to wield its leverage in the market appropriately. The risk is that these changes could hurt patients, particularly high-expense, chronically ill individuals. The government and private entities with which they might contract will need information about successful and unsuccessful approaches and about what issues and problems they must address.

The research team from George Washington University used a previous RWJF grant (ID# 023629) to examine ways of improving private insurance markets.

## **THE PROJECT**

This series of grants was aimed at helping policy-makers and others in the health care field understand the changes and innovations occurring in the health care/insurance markets, particularly in Medicare and coverage for people without health insurance. The three grants, which funded the Health Insurance Reform Project—a nonprofit, nonpartisan program based at George Washington University—provided analysts with a wide degree of latitude in selecting significant and timely topics. Analysts focused on four broad categories:

1. Medicare Reform
2. Supporting Consumers and Decision Making About Health Care
3. Major Trends and Paradigms in Health Care Nationally
4. Tax Credits for the Uninsured.

Each grant generally followed a similar format. Investigators researched and drafted a paper on a critical area in health policy. They then convened a high-level meeting that brought together, by invitation only, a select group of leading experts — primarily researchers, health industry representatives and policy-makers — from various organizations in the field. (For a list of organizations with which analysts collaborated, see [Appendix 1](#).) The purpose of the meetings was to deliberate the issues discussed in the draft papers, as opposed to disseminating findings.

Meeting participants reacted to the draft papers and made recommendations for revisions. The researchers then revised and published the papers, chiefly through George Washington and the journal *Health Affairs*. Several times throughout the course of the three grants, project researchers testified before the Senate Committee on Finance and the Subcommittee on Aging at Congressional request, met with federal regulators at their request and made presentations to federal and state organizations on their findings.

Over the course of the three grants, analysts at the Health Insurance Reform Project identified and analyzed potential future trends or market innovations in health care; developed papers and workshops on ways to restructure Medicare by capitalizing on some promising innovations and changes taking place in the health care/insurance markets; expanded and extended efforts to advance Medicare reform at the legislative and administrative levels by refining recommendations for restructuring the Medicare program, with special emphasis on purchasing and delivering care to the chronically ill; examined market forces affecting Medicare reform; and developed options for assisting uninsured workers and their families to obtain coverage.

Project staff contracted with independent consultant Lynn Etheredge for work under all three grants. Additionally, these grants contributed to the project directors' work with two other RWJF-funded projects, the Institute of Medicine's panel on Public Accountability and Informed Choice under Medicare (see [Grant Results](#) on ID# 031002) and a National Academy of Social Insurance project on the future of Medicare (see [Grant Results](#) on ID# 037605).

## KEY FINDINGS/RECOMMENDATIONS

The following findings are key points from selected publications, organized by the four broad issue categories on which analysts focused. (For more findings, going back to 1996, see [Appendix 2](#).)

### **Medicare Reform**

- **Medicare fee-for-service can improve the way it delivers care to chronically ill persons using approaches tested in the private sector.** Those methods include:
  - Case management
  - Disease management
  - Centers of excellence
  - Contracting with local organizations for case management and disease management
  - Consumer-oriented report cards

— Educating primary care physicians on geriatric care.

From "Addressing the Needs of Chronically Ill Persons Under Medicare," *Health Affairs*, March/April 1998.

- **HMO Medicare benefits should be subject to a minimal level of standardization in order to reduce beneficiary confusion when comparing Medicare plans.** However, any standardization should begin modestly to avoid stifling innovation in HMO plans. From "Should Medicare HMO Benefits Be Standardized?" in *Health Affairs*, July/August 1999.
- **By adapting private sector purchasing practices and using competitive markets, Medicare could offer prescription drug benefits—at affordable premiums for beneficiaries—without resorting to national price controls for pharmaceutical products.** From, "Purchasing Medicare Prescription Drug Benefits: A New Proposal," in *Health Affairs*, July/August 1999.
- **Medicare and Medicaid need new organizational structures.** The Health Care Financing Administration should be replaced by separate agencies, one to administer Medicare and another to administer Medicaid plus other state grant programs. From "Medicare's Governance and Structure: A Proposal," *Health Affairs*, September/October 2000.
- **The Medicare+Choice (M+C) program could improve by changing its focus, which would reward private plans that improve quality and help manage care of Medicare beneficiaries with chronic diseases.** Congress created M+C in 1997 to give beneficiaries more choices in health plans. Since 2000, however, it has been shaken by plan pullouts and beneficiary disenrollments. From "Medicare+Choice: Double or Disappearing?" *Health Affairs*, November 2001. (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.)

### **Supporting Consumers and Decision Making about Health Care**

- **A proposed comprehensive system of managed care for seriously ill persons nearing the end of life called MediCaring could encompass the best elements of palliative care within a managed care structure.** Those elements include comprehensive, supportive, community-based services that meet personal and medical needs, a focus on patient preferences, symptom management, family counseling and support. From "Capitated Risk-Bearing Managed Care Systems Could Improve End-of-Life Care," in *Journal of the American Geriatrics Society*, March 1998.
- **Restructuring the Medicare program as a consumer-choice model is unlikely to improve product quality and efficiency without the active involvement of purchasers and policy-makers.** A consumer-choice model for mental health

coverage in the Federal Employees Health Benefits Program led to more restricted benefits and reduced plan payments, particularly for patients with severe and persistent conditions. From "Consumer-Choice Markets: Lessons from Federal Employees Health Benefits Program Mental Health Coverage," in *Health Affairs*, September/October 1999.

### **Major Trends and Paradigms in Health Care Nationally**

- **A national retirement policy that coordinates Medicare, Social Security and private pension reforms could make substantial progress in dealing with problems related to the baby-boom generation's retirement.** Such a policy should include: (1) work incentives for older persons—for example, a \$10,000 "retirement bonus" option paid by Social Security and Medicare for each year of delayed retirement; and (2) allowing workers without employer-sponsored pensions to use Social Security's payroll contribution system to invest in pension accounts. From "Three Streams, One River: A Coordinated Approach to Financing Retirement," in *Health Affairs*, January/February 1999.
- **Rising costs of anti-depressants have led some insurers to raise patients' cost-sharing to curtail expenses, but that strategy fails to promote clinically appropriate drug use.** Another means to address cost pressures of new drugs is to improve how well the health care system targets their uses to best clinical practices. From "Increasing Use of New Prescription Drugs: A Case Study," in *Health Affairs*, July/August 2000.

### **Tax Credits for the Uninsured**

- **Full-time workers without health insurance could receive coverage under a proposal that includes: equitable tax assistance, market reforms and competition among health plans that offer economic benefits.** From *Affordable Health Benefits for Workers without Employer Coverage*, George Washington University, February 1998.
- **A flexible benefits tax credit could make efficient use of the budget surplus to help meet the varied and changing needs of American families.** With a flexible tax credit benefit of \$1,000 to \$1,500 per worker, political decision-makers could achieve health insurance coverage for many uninsured workers and children and assure a future with real economic security for American families. Multiple uses of the credit—for retirement savings plans, higher education, first home ownership, and catastrophic medical expenses—are likely to increase its political attractiveness and viability. From "[A Flexible Benefits Tax Credit for Health Insurance and More](#)," *Health Affairs*, March 2001.

## Policy Results

Although it is complicated to sort out causes and effects in the health policy milieu, the project director cites a number of areas in which major policy changes followed the Health Insurance Reform Project. These included:

- The adoption by the Health Care Financing Administration of a new strategic vision of itself as a beneficiary-focused purchaser, which according to the project director is one of the most dramatic and significant changes in the Medicare program since its inception.
- The passage of legislation in 1997 that directs Medicare to develop new models of care for the chronically ill and allows successful models to be extended into the traditional fee-for-service program.
- The passage of legislation that authorizes Medicare to develop new competitive purchasing demonstrations for the Part B services (except physicians), and allows for the integration of successful demonstrations into the fee-for-service program. (Part B of Medicare helps pay for doctors' services, outpatient hospital care and other medical services that are not covered by Part A, such as physical and occupational therapy; it is the medical insurance component of Medicare. Part A of Medicare pays for inpatient hospital stays, care in a skilled nursing facility after hospitalization, hospice care and some home health care and is the hospital insurance component of Medicare.)
- A legislative compromise in which Medicare was granted the authority to blend two different visions of the program's future by both upgrading the Medicare fee-for-service program and making health plans available, and letting the market decide which model would dominate in Medicare's future.

## Communications

In all, project staff held 15 workshops drawing more than 250 experts, published 20 articles, 8 policy briefs and 3 book chapters. Many of the articles produced by these grants were published in the journal *Health Affairs*. Project staff also circulated issue briefs and article reprints directly to the Washington health policy community.

## LESSONS LEARNED

1. **With respect to issues of Medicare reform, managed care industry performance and improving care and coverage for chronically ill populations, there is much value in engaging leaders from outside Washington in informal dialogue.**  
Although they are not principally concerned with policy matters, their knowledge and expertise can be productively tapped through well-structured discussions with policy analysts and each other. If the groups are small and the participants carefully selected, these discussions can yield extremely valuable insights into current market dynamics

and emerging trends, predictable problems and ideas for designing attractive and practical policy solutions. (Project Director)

## AFTERWARD

RWJF has funded two initiatives that were instigated in part by the investigators' recommendations. One was a \$7.7 million national program called the *National Health Care Purchasing Institute*, which sought to advance the capabilities of the nation's largest public- and private-sector health care purchasers to use their buying power to improve access to and quality of care.

The second project (ID#s 036668 and 039645) established the National Forum for Health Care Quality Measurement and Reporting, a private-sector entity that coordinates the nation's health care quality measurement and reporting agenda for all sectors of the industry. The project director thinks the organization could play a similar role to the Financial Accounting Standards Board, which sets the bar on financial disclosure for all publicly traded corporations. See [Grant Results](#) for more information.

RWJF awarded four renewal grants to continue funding the Health Insurance Reform Project. The grants build on previous efforts to develop and promote new ideas for improvements in health care policy. Among the possible topics are:

- Strategies for expanding health insurance coverage.
- Medicare.
- Promoting health for individuals with disabilities.
- Quality of care.

For more information, see [Grant Results](#) on ID#s 041223, 041828 and 048295 as well as [Grants Results](#) on ID# 048827.

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**Report prepared by: Susan G. Parker**

Reviewed by: Robert Crum and Molly McKaughan

Program Officer: Nancy Barrand

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## APPENDIX 1

### Organizations with which the Health Insurance Project collaborated

*(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)*

- AdvanceParadigm
- Alliance for Health Reform
- Alpha Center
- American Hospital Association
- Blue Cross Blue Shield Association
- Center for Improved Care of the Dying at George Washington University
- Center for State Health Policy at Rutgers University
- Eli Lilly Health Outcomes Department
- Health Affairs
- Health Care Financing Administration
- Heritage Foundation
- Institute of Medicine
- Kaiser Permanente
- National Academy of Social Insurance
- National Council on Aging
- National Health Policy Forum
- PDF (Peter Fox)
- Progressive Policy Institute
- Research Center of the National Rehabilitation Hospital
- U.S. Office of Personnel Management
- Washington Business Group on Health

## APPENDIX 2

### Some Other Findings and Recommendations from Papers Published by the Health Insurance Reform Project

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

#### Medicare Reform

- **The Medicare reforms signed into law as part of the Balanced Budget Act of 1997 represent a bipartisan achievement that provides Medicare enrollees with almost unlimited freedom of choice.** The Balanced Budget Act provides consumers with choice not only among providers but also among price-regulated fee-for-service insurance and a spectrum of private health plans. The reforms ratified, through a national political process, market-oriented approaches as the new national health policy for dealing with health care costs. In addition, the reforms represented a pragmatic compromise between traditional price-controlled, fee-for-service Medicare and private sector health plans. From "The Medicare Reforms of 1997: Headlines You Didn't Read," *Journal of Health Politics, Policy and Law*, 1998.
- **The Balanced Budget Act of 1997 created a new role for the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) as a consumer service agency.** Two different objectives could be proposed to define the administration's success in this new role: (1) Medicare consumers are able to make choices that will produce the greatest value for themselves; and (2) health plans, health care professionals and other providers have a well-functioning market in which they can prosper by offering better quality, service and efficiency. From "The Health Care Financing Administration as a Successful Consumer Agency," book chapter in *Developing an Information Infrastructure for the Medicare Choice Program*, 1999.
- **Medicare could be refined to be more responsive to the needs of beneficiaries with severe disabilities.** This refinement could include: (1) expanding coverage for outpatient prescription drugs and treatment for severe mental illness; (2) eliminating the requirement that beneficiaries must be homebound to receive home health services (which, by allowing beneficiaries access to community institutions and events would help to integrate them in their communities); and (3) eliminating the two-year waiting period between when beneficiaries qualify for disability cash payments and when they become eligible for Medicare. From "Disability Profile and Health Care Costs of Medicare Beneficiaries Under Age 65," *Health Affairs*, November-December, 2001.
- **Because of the difficulties that health plans are having in all of their markets (not just in Medicare+Choice, which offers Medicare benefits through health plans), it may be time to reconsider the purpose of the Medicare+Choice program and to fundamentally redesign how payments are made to managed**

**care organizations contracting with Medicare.** Two alternative approaches are suggested: (1) severing the formal between spending for Medicare+Choice plans and traditional Medicare (the Medicare+Choice plan payment increases are not based on their own performance but rather are tied directly to the annual success or failure of fee-for-service Medicare, which operates in a different financial and political environment), and (2) overhauling the program by creating a value-based purchasing orientation, rewarding plans that provide higher quality care to beneficiaries with chronic diseases. From "Medicare+Choice: Doubling or Disappearing?" *Health Affairs*, November 2002.

### **Supporting Consumers and Decision-Making about Health Care**

- **Government or private agencies should provide beneficiaries with at least the best practices large employers use to help their employees choose among health plans.** From "The Medicare Beneficiary as Consumer," in *Medicare: Preparing for the Challenges of the 21st Century*, 1998.
- **To inform consumers about Internet resources for reliable information, a nonprofit, national Health Channel—sponsored perhaps by foundations and/or government—could offer trustworthy, first-rate programs that consumers could also use, as needed, via the Internet or "video on demand" cable or satellite connections.** From "Consumer-Oriented Broadcasting and Video Archives for Health," Lloyd Etheredge, 2002.
- **Facilitating public access to excellent health information resources that are responsive to consumers' needs will help individuals improve their own health and create pressure on the health care system to produce higher quality care.** Strategies to strengthen consumer health information services include: (1) engaging physicians in guiding patients to appropriate information tools; (2) facilitating public access to excellent health information resources that are responsive to individual needs; and (3) combining innovative information strategies in community experiments designed to achieve targeted health outcomes. From *Strategies to Improve Consumer Health Information Services*, Health Insurance Reform Project Research Brief, January 2002.

### **Major Trends and Paradigms in Health Care Nationally**

- **New, fundamental forces are now driving health system change.** During the period of open-ended, fee-for-service insurance payments, factors such as technology, demographics, physician and hospital supply and physician decision-making were usually identified as key drivers of change. Today's dynamics involve a new set of influences, such as (1) employers' price-focused purchasing, which often ignores good quality/value measures; (2) health plans' growing successes and market clout; (3) providers' declining prospects and fears about their future; and (4) consumers' worries about less choice. Future influences will include Medicare reforms, better information and pro-consumer regulation of managed care, as well as rising social

distress. The health system's future is now open for resolution in an evolving, imperfect market. From "What is Driving Health System Change?" *Health Affairs*, 1996.

- **Government should move cautiously in crafting new regulatory policies concerning managed care because of the inherent difficulties of reconciling through government action the conflicting imperatives that currently divide the consumer, provider and purchaser of health care.** From "Federal Regulation of Managed Care: An Impulse in Search of a Theory," *Health Affairs*, 1997.
- **Three major eras occurred in national health policy over the past 25 years:** (1) the "Age of Traditional Health Insurance" (1965–1982), which began with the enactment of Medicare and Medicaid, and which was based on open-ended, fee-for-service health insurance; (2) the "Age of Regulated Prices for Government Programs" (1983–1992), which was launched with the enactment of the Medicare diagnosis-related groups purchasing system; and (3) the "Age of Markets, Purchasing and Managed Care" (1993–present), the era that has seen most of the population move to managed care plans in both private and public coverage. From *On the Archeology of Health Care Policy*, Institute of Medicine, 1998.

### **Tax Credits for the Uninsured**

- **Incremental reform based on federal tax credits could be included in revised versions of recent legislation to assure basic benefit coverage for 33 million adults in working families who do not have employer-sponsored benefits.** A basic benefit package would cost about \$1,400 per individual, with financing shared among federal tax credits (\$780 per person), individual premiums (\$525 per person) and state tax credits (\$95 per person). Federal costs for this program would have been about \$22 billion in 2000. From *Tax Credits for Uninsured Workers*, Health Insurance Reform Project Research Brief, 1999.

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## Sponsored Workshops

"What is Driving Health System Change?" July 8–9, 1996, Washington. Attended by 20 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with Milliman and Robertson, the Lewin Group, Health Futures, Princeton University, Mount Sinai Medical Center and the Henry Ford Health Care System among others.

"GAG Rules and the Changing Relationship of Physicians, Insurers, and Patients/Subscribers under Managed Care Plans," November 12, 1996, Washington. Attended by 20 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the U.S. Health Care Financing Administration, the National Alliance for the Mentally Ill, Duke

University, the Association of Academic Health Care Centers and the Wharton School, University of Pennsylvania among others.

"Models for Government Regulation of Insurance and Managed Care Markets," June 15–16, 1997, Washington. Attended by 20 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with Brandeis University, the National Association of Social Insurance Commissioners, PepsiCo, the University of Pennsylvania, Empire Blue Cross Blue Shield of New York and Kaiser Permanente among others.

"How the Standard Medicare Program Can Be Improved to Better Serve Persons with Disabilities," October 16–17, 1997, Washington. Attended by 18 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with Brown University, Humana Health Plans, Community Medical Alliance, UCLA School of Medicine, and Independence Blue Cross among others.

"Expanding Coverage for Uninsured Workers," December 10–11, 1998, Washington. Attended by 24 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the University of California, Berkeley, U.S. Senate Finance Committee, United Hospital Fund of New York and the Alpha Center among others.

"Should Medicare HMO Benefits be Standardized?" November 12–13, 1998, Washington. Attended by 22 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the U.S. Health Care Financing Administration, Kaiser Foundation Health Plans, the Commonwealth Fund, the American Association of Health Plans and Aetna/U.S. Health Care among other organizations.

"Expanding Coverage for the Working Uninsured," December 10–11, 1998, Washington. Attended by 24 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the American Hospital Association, the U.S. Senate Labor and Human Resources Committee, the Alpha Center, the University of California, Berkeley, the United Hospital Fund of New York and the Urban Institute among others.

"Expanding Prescription Drug Coverage for Medicare Beneficiaries," April 8–9, 1999, Washington. Attended by 15 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with Blue Cross Blue Shield of South Carolina, Reden and Anders, the National Health Policy Forum and Merck-Medco Managed Care Division among other organizations.

"Managing Mental Health Benefits: Implications for Populations with Severe and Persistent Conditions in Consumer Choice Markets," June 3–4 1999, Washington. Attended by 16 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with Rutgers University, Magellan Behavioral Health, Health Affairs and Towers Perrin among others.

"Implications of Rapidly Changing Biomedical Technology for Health Care Management and Insurance," November 2–3, 1999, Washington. Attended by 16 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the University of Maryland, MedPartners, Mathematical Policy Research and Eli Lilly and Company among others.

"The Future Governance of Medicare," March 13–14, 2000, Washington. Attended by 20 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with WellPoint Health Networks, the U.S. General Accounting Office, Johns Hopkins University and the U.S. House Ways and Means Health Subcommittee among others.

"Consumer Choice for Medicare Beneficiaries with Disabilities," September 21–22, 2000, Washington. Attended by 23 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the Institute of Rehabilitation and Research, the U.S. Congressional Budget Office, Neighborhood Health Plan and the College of Health and Urban Studies among others.

"Integration of Medical and Social Services for Medicare Beneficiaries," November 3, 2000, Washington. Attended by 21 participants from bodies of government, academia, nonprofit organizations and the private sector. Participants were affiliated with the National Council on Aging, Elder Services of Merrimack Valley, the Lahey Clinic, and Brown University among others.

"The Future of Medicare Managed Care," May 3–4, 2001, Washington. Attended by 23 participants from bodies of government, academia and the private sector. Participants were affiliated with the Medicare Rights Center, Oxford Health Plan, AARP, and the University of Minnesota among others.