# Chapter 1: Health Reform

Originally written by Joanne Kenen,
New America Foundation
(Research assistance from Paul Testa)

Health care reform has once again returned to the national "to-do" list, with politicians of all stripes calling for action. Historic parallels with the early 1990s are striking. The economy is weak, health care costs are high and rising, and an anxious middle class is feeling the squeeze. Facing what could be a major recession, states need to trim spending, and businesses see health costs as undercutting their ability to compete globally.1,2

Our previous national health reform debates have focused on coverage – what to do about the uninsured. This time around, politicians and policymakers are talking about the intertwined issues of coverage, cost and quality. In the policy and clinical worlds, there is a greater understanding that the three are intrinsically linked.

Likewise, there's a growing bipartisan understanding that the health care delivery system – not just the health insurance system – needs reform.[3]

Our system, rooted in a mid-20th century acute care model, does not adequately meet the health care or economic needs of a nation where the overarching health challenge, and expense, is chronic disease among an aging population.[4]

There is less agreement about how to fix our system. Despite hopes that the U.S. could enter a less partisan era, it's unclear whether we will see more collaboration across the aisle for the long run in the 111th Congress.

Health care reform is hard because it's big and complicated, with lots of moving parts and unintended consequences. It's also hard because the Washington debates are not always about health care per se. Health policy gets caught up in politics and ideological conflict over the role of government.

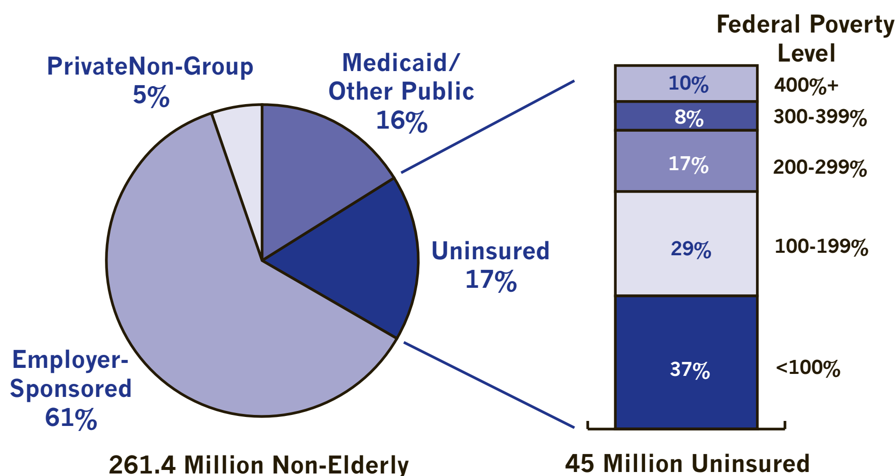
The starting point for the next big debate may well be these questions: Can we afford to fix health care, given that the federal budget deficit could top $1 trillion in the first year of the Obama administration?[5] Or must we fix health care despite the deficit, given that 45 million people lack coverage, costs are high and quality is spotty?[6,7,8] (See charts, "The Uninsured — As a Share of the Population and by Poverty Levels, 2007," "Actual and Projected National Health Expenditures, Selected Years," and "Scores for U.S. on Dimensions of a High Performance Health

For story ideas on the uninsured, see page 7. A list of experts and websites begins on page 8.

## FAST FACTS

- 45 million non-elderly people in the U.S. lacked health coverage for all of 2007, down from 46.5 million in 2006, according to the Employee Benefit Research Institute.[a] Much of the decrease stemmed from the number of people gaining coverage through Medicaid and other public programs.[b]
- Another 25 million Americans adults are considered by some analysts to be underinsured, up 60 percent from 2003. This means that they are exposed to high out-of-pocket health care costs relative to their incomes.[c]
- Nearly 83 percent of the uninsured live in families headed by workers.[d]
- Almost two-thirds of uninsured workers (63.1 percent) have an employer who doesn't offer coverage.[e]
- An estimated $2.2 trillion was spent on health care in the U.S. in 2007, 16.3 percent of the Gross Domestic Product (GDP),[f] yet we lag behind other industrial nations in many indicators of health care quality.[g,h]
- Researchers estimate that 30 to 40 cents of every health care dollar spent in the U.S. goes for poor quality care.[i]
- A study from the RAND Corporation suggests that adults receive the recommended care only about half the time.[j]

**The Uninsured - As a Share of the Population and by Poverty Levels, 2007**




Source: Kaiser Commission on Medicaid and the Uninsured (2007). "The Uninsured: A Primer." (http://www.kff.org/uninsured/7451.cfm).

System, 2006.")

Lawmakers and the Obama administration will likely debate whether reform should be comprehensive, or sequential ("sequential" being the favored word these days, replacing the more anemic "incremental"). Those who argue for comprehensive reform note that the pieces of our health care system are so interconnected that it's hard to address one element without others.

The rationale for a sequential approach is that comprehensive health care reform, as President Clinton and earlier reformers learned, may be too mammoth for Congress to swallow all at once. It may also be easier, politically, to achieve consensus around one policy step at a time.

If a consensus develops favoring a sequential approach, renewing and expanding the Children's Health Insurance Program (CHIP) was Step One. This popular program, which enjoys bipartisan support, was reauthorized and enlarged early in 2009, and could generate momentum for further reforms.

But expect significant debate about Step Two. Do we expand health insurance coverage first? Do we clamp down on costs? Do we enact delivery system and payment reform, shifting away from our specialist-heavy, procedure-intensive system and into one that places more emphasis on primary care and care coordination?

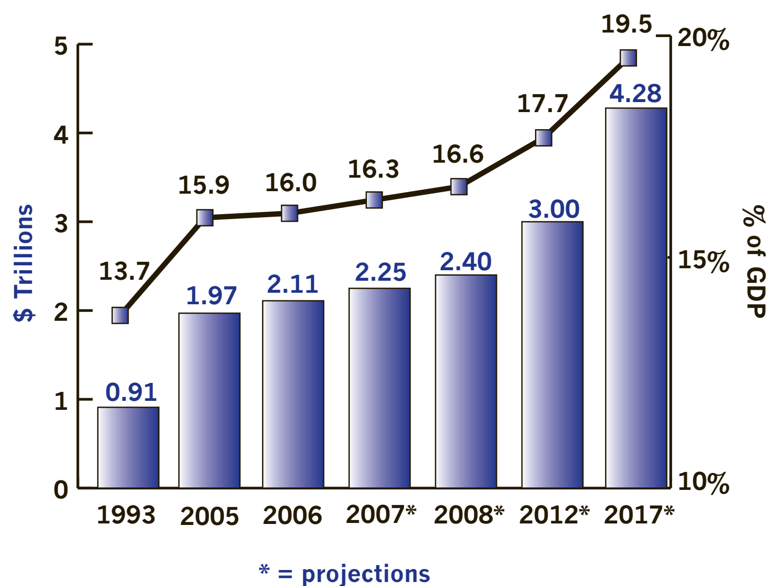
Some analysts say that given the political volatility of health care reform, we should begin with the "low-hanging fruit" in each of these areas. Yet in health care politics, just defining the low-hanging fruit can be contentious. Even if lawmakers achieve consensus on health care priorities, they will still likely encounter skepticism or outright opposition from interest groups, be they health care providers, business groups, insurers, or drug and medical device makers.

Others, such as health economist Uwe Reinhardt, argue for boldness – first implementing universal coverage, which could be done quickly, and then cost control, which could take a decade or more to show results.[9]

Given the obstacles to comprehensive national reform, some experts suggest that the states may be more fertile ground for coverage expansion experiments.[10] To accomplish this, the federal government could provide greater flexibility and incentives through changes in Medicaid waiver rules, tax laws, and perhaps the Employee Retirement Income Security Act (ERISA). (See glossary for definitions.)

If the states tackle coverage, the federal government could focus on cost and health care delivery, areas where the states have less influence. However, the economic decline so obvious by late 2008 and the ensuing strains on state budgets may dampen governors' and legislators' willingness and ability to explore bold coverage initiatives.

Though Medicare did not figure prominently in the 2008 campaigns, it could end up center stage again. In the coming year, Congress must grapple with the



Source: Sean Keehan and others (2008). "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare." Health Affairs Web Exclusive, Feb. 26, pp. w146. (www.healthaffairs.org)

Medicare physician payment formula. The bill passed in July 2008 provided only an 18-month "patch" to the problem, and physicians face a 20 percent cut in Medicare fees in January 2010.[11] Additionally, Congress will have to contemplate the large population of baby boomers nearing age 65.[12]

A major legislative push on Medicare cost-containment could derail efforts to expand health coverage for the under-65 population. Or Congress could follow recent ideas from the Medicare Payment Advisory Commission (MedPAC) about changing how we pay for and deliver health care to the elderly. MedPAC has recommended that Medicare encourage increased efficiency and quality by changing both payment systems and elements of the health care delivery system.[13] We discuss some of these options in the "Quality" section below.

## LIKELY POLICY DEBATES

### COVERAGE OPTIONS

Options for coverage reform run the gamut from a single-payer system like those in Britain or Canada to a mostly non-group market where people would shop for their own private coverage, helped by federal tax credits. Neither is perceived as politically viable at this time (although both have well-known and thoughtful advocates).[14]

More feasible options would involve a hybrid of public and private solutions, maintaining the current employer-based system, but filling in the gaps by expanding public programs such as Medicaid and the Children's Health Insurance Program (CHIP), and creating new "exchanges" or purchasing pools to help individuals and small businesses purchase affordable insurance.[15]

Even reform advocates debate how quickly the country can move toward covering everybody. Some suggest a "kids-first" approach, requiring that all U.S. children be covered, while creating incentives but not mandates for adult coverage (both features of President Obama's health plan during the campaign). Others call for individual mandates, so that everyone must purchase insurance, or a "play-or-pay" model that would require businesses to either cover their employees or pay into a fund for coverage.[16]

### COST

On Capitol Hill, neither a cap on overall health spending, nor government-imposed rationing is on the table. Policymakers instead are talking about savings through changing how we deliver health care – which has the added attraction of improving quality while containing cost. (See "Quality" section below and the chapter on quality.)

Some analysts promote "consumer-directed health care," market competition, and less first-dollar coverage as money-savers, arguing that if people had to spend more of their own money before insurance coverage kicked in, they'd shop around for good health care deals.[17] Others say universal coverage will improve health outcomes and may eliminate inefficient cost-shifting within the system.[18]

Across the political spectrum, many analysts promote savings through:

- more use of generic drugs
- e-prescribing and wider adoption of health information technology (see section below on health information technology and Chapter 2, "Cost of Health Care.")
- strengthening primary care
- comparative effectiveness research to determine what drugs, devices or procedures work best (see the quality chapter for more). Experts don't all agree on exactly who should conduct this research, with what funding, or when and how cost effectiveness should be factored in.[19]

**QUALITY**

We all have heard the assertion that the United States has the best health care in the world. We can no longer take this for granted. Our health care markers in several areas lag behind other industrialized nations, even though we spend much more per capita and a higher percentage of our GDP.[20]

In a 2007 study by The Commonwealth Fund, the U.S. health care system ranked next to last in quality compared to the United Kingdom, Germany, Australia, New Zealand and Canada. The U.S. was last among the six countries in delivering safe care, and next to last in delivering the right care, coordinated care and patient-centered care.[21]

Another example: About half of chronic care patients in the U.S. did not fill prescriptions, get the recommended care, or see a doctor in 2008 because of cost, compared to 7 percent to 36 percent in other industrialized countries.[22]

In the last few years, the dialogue about health care quality has changed in Washington. More and more experts, both liberal and conservative, including advisors to both of the 2008 presidential candidates, have arrived at the conclusion that we need to shift resources and priorities back into primary care, care coordination, prevention and wellness.[23]

We need to change how we pay doctors and hospitals, to reward care management and coordination, instead of giving doctors incentives to order expensive tests, images and procedures which are not necessarily the best option for the patient. The payment system should reward quality, not quantity.

Tools of a revamped high performing health system would include:

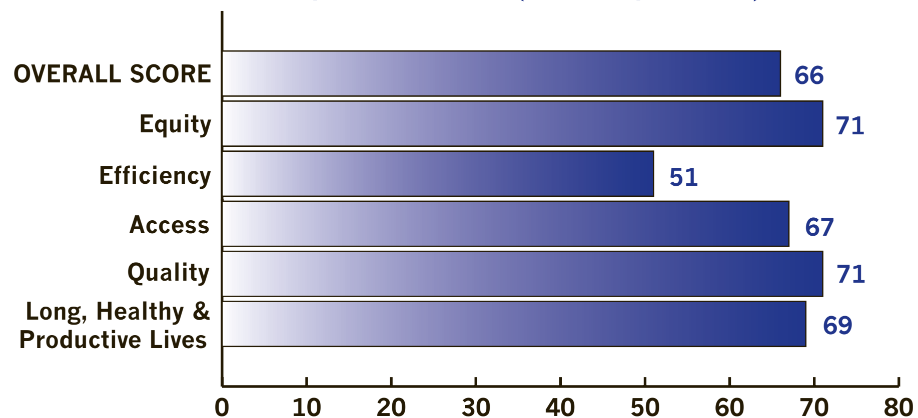
*Chronic disease management and medical homes:* The Centers for Disease Control and Prevention (CDC) estimates that 133 million Americans live with one or more chronic diseases such as hypertension, diabetes or asthma, and that chronic disease accounts for 70 percent of U.S. deaths and more than 75 percent of health care spending.[24] Giving patients "medical homes" where doctors are paid to manage and monitor chronic diseases may be part of the solution, though more research is needed.[25]

*Workforce/primary care:* Fewer U.S. medical students are choosing primary care careers, such as family medicine, pediatrics, geriatrics and related fields.[26] Fields such as radiology, orthopedics, anesthesiology and dermatology, with higher pay and easier hours, are in demand.[27]

Policymakers are considering loan forgiveness, new payment structures, or other solutions to entice more young doctors to enter primary care. Some look to nurse practitioners to meet part of the primary care demand.[28] (Nurse practitioners are RNs with master's or doctoral degrees who have advanced clinical training.)

But workforce shortages are affecting nurses too. In part because of limited capacity of nursing schools and partly because of the changing needs of an aging population, we also have a growing nursing shortage, which the Health Resources and Services Administration (HRSA) projects will top one million by 2020.[29]

*Payment reform*: Pay-for-performance (P4P) – rewarding doctors for good outcomes or for innovations like adopting e-prescribing – figures in many health reform plans.[30] Bundling, or paying a team of providers per episode of care across several health care settings, is a related option aimed at rewarding quality, coordination and good outcomes.[31]



Source: The Commonwealth Fund (2006). "National Scorecard on U.S. Health System Performance: Complete Chartpack." Sept., p.1. (www.commonwealthfund.org/publications/publications_show.htm?doc_id=403925)

### HEALTH INFORMATION TECHNOLOGY

Physicians have been slow to embrace health information technology (IT) and most still write prescriptions on pieces of paper. Only 4 percent had a fully functional electronic health record system as of early 2008[32], even though we routinely use IT in other aspects of our lives and businesses, including privacy-sensitive ones such as banking. Barriers to wider adoption include cost, debates over who should pay, worries about obsolescence, learning curve, maintaining patient privacy and assuring that the various health IT systems are interoperable.[33]

In addition, as the Congressional Budget Office has pointed out, there is an "opportunity cost" of lost productivity in a medical practice as people get up to speed on using it.[34] And instead of being paid for an office visit, doctors under most payment systems in use today are not compensated for time they spend communicating by email.

But health IT, if wisely integrated into other health advances, can enable providers to deliver better-quality health care and eventually (after the initial investments) may help control costs.[35] Electronic medical records and e-prescribing lead to more consistent use of treatment guidelines, fewer drug errors, better chronic disease tracking, more opportunities for patient self-management and less duplicative testing, as well as savings on clerical work. In the public health arena, large pools of privacy-protected data could lead to early identification of epidemics or bioterrorism, and help comparative effectiveness research.

### PUBLIC HEALTH

Both employers and states are putting new emphasis on wellness and prevention, particularly regarding obesity, exercise, tobacco and diabetes prevention and management.[36] Bioterrorism legislation since 9/11 has also helped modernize the public health infrastructure in ways that enhance emergency preparedness for either a natural epidemic or a bioterrorist attack. (See the chapter on public health for more.) Public health researchers have stepped up efforts to understand and address the persistent and sometimes perplexing racial and socioeconomic disparities in our health care system. (See the chapter on disparities for more.)

### MENTAL HEALTH

Mental health advocates scored a long-sought victory at the end of the 2008 congressional session, with passage of a parity law that requires insurance plans that cover treatment for mental illness to have the same fees, caps and co-pays for that treatment as for treatment of other diseases.[37] (See the text box in the mental and behavioral health chapter for more.)

Serious challenges remain. Many cities have a shortage of psychiatric beds, which is a factor in emergency room crowding.[38] Mental health workers are bracing to deal with traumatized veterans who have been on multiple deployments in Afghanistan and Iraq.

## TIPS FOR REPORTERS

- One of the most common errors reporters make is equating universal health care with government-run or socialized medicine. They aren't the same thing. Socialized medicine means that hospitals are owned by the government, and most

## Insurance Exchanges, or Connectors

This health reform concept leaves the current employer-based system largely intact but creates an exchange or purchasing pool where individuals and small businesses would buy insurance. It resembles the menu of health plans offered to federal employees, from senators to postal clerks. Private insurance plans compete for business, but plans are regulated and have to sell to people regardless of their health status or health history (guaranteed issue). Some versions of this concept call for a public option, similar to Medicare, to be offered alongside the private plans.

A variant of the exchange model is an essential part of health care reforms in Massachusetts, which has reduced the uninsurance rate dramatically.[1] Massachusetts faces unanticipated spending increases because of higher demand for coverage than originally expected,[2] so a national exchange or connector would probably have to include delivery system and payment reforms aimed at cost containment. An exchange could be created with or without individual or employer mandates. Politically, mandates are harder, but bringing everyone into the risk pool, including healthier people, could contain costs. The merge of the small group and non-group markets "was expected to reduce non-group premiums by approximately 15 percent and raise small group premiums slightly...however non-group premiums have declined more than expected."[3] Jonathan Gruber, MIT economist and Obama campaign advisor, put it this way: "As long as we can make health insurance affordable and accessible for everyone, this is a reasonable requirement."[4]

[1] Division of Health Care Finance and Policy (2008). "Health Care in Massachusetts: Key Indicators," August, (http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/key_indicators_11_08.pdf). Also see Meckler, Laura (2007). "How 10 People Reshaped Massachusetts Health Care." Wall Street Journal, May 30. (www.allhealth.org/BriefingMaterials/WSJ-MAConnector-941.pdf).

[2] Kaiser Commission on Medicaid and the Uninsured (2008). "Massachusetts Health Care Reform: Two Years Later." (http://www.kff.org/uninsured/7777.cfm).

[3] Draper, Debra; Felland, Lauri; Liebhaber Allison; Lauer, Johanna (2008). "Massachusetts Health Reform: High Costs and Expanding Expectations May Weaken Employer Support." Center for Studying Health System Change Issue Brief No. 124. (http://www.hschange.com/CONTENT/1021/?words=). See also Gorman Actuarial, LLC, et al., Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets (2008). Marlborough, Mass., June 12. (http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf).

[4] Daschle, Tom; Lambrew, Jeanne; Greenberger, Scott (2008). "Critical: What We Can Do About the Health-Care Crisis." St. Martin's Press, p. 166. See also Gruber, Jonathan (2008). "Medicine for the Job Market." New York Times, December 4. (www.nytimes.com/2008/12/04/opinion/04gruber.html?scp=1&sq=gruber&st=cse).

health providers are government employees. Universal health care simply means that everybody is covered: whether in a public system, a private system, or more probably in the United States, a public-private hybrid.[39]

- More health care does not always equal better health care. Get familiar with the basic ideas of the Dartmouth Atlas of Health Care (www.dartmouthatlas.org). In more than 30 years of research, the Dartmouth researchers have discovered huge differences in how people are cared for in different parts of the country. Regions that spend more on very sick people do not necessarily have better outcomes. In fact, lower-spending regions often show better results, partly because they tend to use more primary care and proportionately fewer specialists.[40]

- Health policy as an academic field has grown tremendously since the early 1980s, in and outside of Washington. And nowadays it's all online, which makes the Washington think tanks more accessible to regional reporters. In addition, journalists can now tap into expertise in health or public policy departments at universities. These academic experts can both help translate national policy and explain the impact of national proposals on a specific region or state.

- Almost every story can be a health care story. Whether a reporter is covering a labor dispute, the local economy, personal bankruptcy, local politics or early childhood well-being, health care can nearly always be part of the picture.

- More clinicians and provider groups have begun to encourage health care improvements on a local scale. Identify innovators in your community through organizations such as the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement, and the American Academy of Family Physicians.

- Find out what's unique about your state's health care system. Many of the reform proposals being made in Washington are already being tried in some state. Massachusetts, Vermont and Maine

have enacted laws aimed at covering all or nearly all residents. Governors in New Mexico, California, Illinois and Pennsylvania all have put comprehensive plans on the table. The State Coverage Initiatives program, sponsored by the Robert Wood Johnson Foundation and administered by AcademyHealth in Washington, DC, keeps tabs on reforms at the state level (www.statecoverage.org). The program offers policy and technical assistance to help states expand coverage and launch other reforms.

- Trudy Lieberman, director of the health and medical reporting program in the graduate school of journalism at City University of New York, wrote regularly on health issues during the presidential campaign for the Columbia Journalism Review's Web site. Most of her articles contain valuable tips and suggestions for reporters covering health reform. Search for her name at http://www.cjr.org/campaign_desk/archives.php

- The Association of Health Care Journalists (www.healthjournalism.org) has links to many resources of use to reporters covering reform, including a webcast cosponsored by the association featuring tips by veteran health care reporters Marilyn Werber Serafini of the National Journal and Julie Rovner of NPR, archived at www.healthjournalism.org/talkinghealth.php.

## STORY IDEAS

- Primary care shortage. How easy is it to get a primary care doctor? What is your state or community doing to encourage more doctors to go into primary care? Understand the role of primary care providers as care coordinators, not necessarily as HMO-style gatekeepers.

- Much of our spending is – and will be – on the sickest patients near the end of life. But some of the money we spend in that period is on care that people do not really want, or care that we know will not improve their health or even prolong their life. How is the new field of palliative medicine evolving, and can it save money while improving quality? What kind of hospitals (non-profit, academic, for-profit, public?) offer palliative care and how easy is it to access?

### The Individual Market and Tax Treatment of Health Insurance

One approach to reforming the individual, or non-group, insurance market would eliminate the tax break that workers get for health coverage they receive on the job, and instead give people a tax credit they could use to buy insurance anywhere in the country. Advocates say insurers would compete for business, offering a variety of plans that would meet people's needs and bring down costs. Health Savings Accounts, linked to high-deductible insurance policies, are prominent in this model.

Critics say this approach would mean insurance would likely be more affordable for relatively young and healthy people, but very expensive (if available at all) for people who are older or have pre-existing health conditions. Some versions of this plan call for a government-subsidized high risk pool for the "uninsurable."[1]

[1] Furman, Jason (2008). "Health Reform Through Tax Reform: A Primer." Health Affairs. 27.3.622. (www.healthaffairs.org).

- “Medical homes” are attracting attention. A definition from the American Academy of Pediatrics: “Primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective.”[41] Are there medical homes in your community? If so, what do they look like? How can patients access them? What is it like to be a patient in one of them? Is this a genuine innovation or new name for primary care?

- Spend some time with local medical students. How much do they know about the health care system that they are entering?

- Your local emergency room is a barometer for the health of your local medical system. Is it crowded? If so, it may be not only because of the growing numbers of uninsured. Explore how much of the overcrowding in your community is due to lack of insurance, how much is caused by the inability of the insured to access timely primary care (including nights and weekends). How much is due to internal management and patient flow problems within the hospital? If your ER isn’t crowded, what are they doing right? How are people getting appropriate community-based care?

- The Centers for Medicare and Medicaid Services, the federal government's Medicare agency, recently introduced "never event" payment rules, meaning they won't pay for certain avoidable conditions such as wrong-site surgery or certain hospital-acquired infections.[42] Some states and private insurers are introducing similar policies. This isn't expected to radically change payments to hospitals in the early years, but it is designed to make hospitals take a hard look at how they can improve quality. How do hospitals in your community stack up? How are they responding to the new policy?

- More employers are introducing workplace wellness and prevention programs. Are they working? Are they cost-effective?

- Inpatients are now often taken care of by "hospitalists," physicians who only take care of hospitalized patients. How widespread is this practice in your area? Is this new specialty more efficient because the doctors have expertise in caring for very sick patients, and they are there all the time? Or does it create new risks because of the lack of continuity of care when patients leave the hospital?

- How is the economic crisis affecting health care – and vice versa? Are people in your community skimping on or delaying recommended care? Are there layoffs at local hospitals? Will patients face even bigger medical bills if they don't get timely care – and who will pay? Are big health care bills a major factor in the mortgage meltdown and foreclosures in your community? And as people lose their jobs – and their insurance – how are safety net institutions being affected at a time when state budgets are strained and philanthropies are challenged from many directions?

## EXPERTS AND WEBSITES

### *Analysts/Advocates*

Stuart Altman, *Professor of National Health Policy,* Brandeis University, 781/736-3804, altman@brandeis.edu

Stuart Butler, *Vice President*, The Heritage Foundation, 202/546-4400

Michael Cannon, *Director of Health Policy Studies*, Cato Institute, 202/789-5200, mcannon@cato.org

Nancy Chockley, *President*, National Institute for Health Care Management, 202-296-4426, nchockley@nihcm.org

Gary Claxton, *Vice President/Director*, Health Care Marketplace Project, Kaiser Family Foundation, 202/347-5270

David Colby, *Vice President for Research and Evalution*, Robert Wood Johnson Foundation, 609/627-5754, dcolby@rwjf.org

Sabrina Corlette, *Director of Health Policy*, National Partnership for Women and Families, 202/986-2600, scorlette@nationalpartnership.org

Peter Cunningham, *Senior Fellow*, Center for Studying Health System Change, 202/484-5261, pcunningham@hschange.org

Richard Curtis, *President*, Institute for Health Policy Solutions, 202/789-1491, rcurtis@ihps.org

Karen Davis, *President*, The Commonwealth Fund, 212/606-3800, KD@cmwf.org

Stan Dorn, *Senior Research Associate*, Urban Institute, 202/833-7200,

Michelle Doty, *Associate Director of Research*, The Commonwealth Fund, 212/606-3800, mmd@cmwf.com

Lynn Etheredge, *Consultant, Health Insurance Reform Project*, George Washington University, 301/654-4185

Pamela Farley Short, *Professor and Director,* Center for Health Care and Policy Research, Penn State University, 814/863-8786,

Judy Feder, *Professor*, Public Policy Institute, Georgetown University, 202/687-8397,

Paul Fronstin, *Director*, Health Research Program, Employee Benefit Research Institute, 202/775-6352, fronstin@ebri.org

John Geyman, *Professor Emeritus of Family Medicine*, University of Washington, 360/ 378-4814, jgeyman@u.washington.edu

Paul Ginsburg, *President*, Center for Studying Health System Change, 202/484-5261, pginsburg@hschange.org

Jocelyn Guyer, *Senior Program Director,* Center for Children and Families, Georgetown University, 202-784-4077

Edmund Haislmaier, *Research Fellow,* The Heritage Foundation, 202/546-4400,

Antoinette Hays, *Dean*, Regis College School of Nursing and Health Professions, 781/768-7122, antoinette.hays@regiscollege.edu

Ida Hellander, *Executive Director*, Physicians for a National Health Program, 312/782-6006, Ida@PNHP.org

David Himmelstein, *Associate Professor of Medicine*, Harvard Medical School, 617/ 497-1268, dhimmelstein@challiance.org

John Holahan, *Director of Health Policy Research*, Urban Institute, 202/261-5666,

Joy Johnson Wilson, *Federal Affairs Counsel,* National Conference of State Legislatures, 202/624-5400, joy.wilson@ncsl.org

Judith Miller Jones, *Director*, National Health Policy Forum, 202/872-1469, jmjones@gwu.edu

Risa Lavizzo-Mourey, *President & CEO,* Robert Wood Johnson Foundation, 888/631-9989, rlavizz@rwjf.org

Barbara Lyons, *Deputy Director*, Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 202/347-5270, blyons@kff.org

Enrique Martinez-Vidal, State Coverage Initiatives, 202/292-6700

Don McCanne, S*enior Health Policy Fellow,* Physicians for a National Health Program, 949/493-3714, Don@McCanne.org

Catherine McLaughlin, *Director of Health Research*, Mathematica Policy Research, 734/794-1122, Cmclaughlin@mathematic-mpr.com

Tom Miller, *Resident Fellow,* American Enterprise Institute, 202/862-5886, tmiller@aei.org

Robert Moffit, *Director*, Center for Health Policy Studies, The Heritage Foundation, 202/546-4400,

Len Nichols, *Director*, Health Policy Program, New America Foundation, 202/986-2700, nichols@newamerica.net

Ron Pollack, *Executive Director,* Families USA, 202/628-3030, Communications director David Lemmon: dlemmon@familiesusa.org

Karen Pollitz, *Project Director*, Health Policy Institute, Georgetown University, 202/687-3003,

Uwe Reinhardt, *James Madison Professor of Political Economy*, Princeton University, 609/258-4781

Sara Rosenbaum, *Chair of Department of Health Policy*, George Washington University, 202/530-2343

Diane Rowland, *Executive Vice President,* Kaiser Family Foundation, 202/347-5270, drowland@kff.org

Matt Salo, *Director*, Health & Human Services Committee, National Governors Association, 202/624-5336, msalo@nga.org

Greg Scandlen, *President and CEO*, Consumers for Health Care Choices, 301/606-7364

Gordon Schiff, *Associate Director of the Center for Patient Safety Research and Practice*, Harvard Medical School, 617/ 732-4814, gdschiff@aol.com

Gail Shearer, *Director*, Health Policy Analysis, Consumers Union, 202/462-6262, sheaga@consumer.org

John Sheils, *Vice President,* The Lewin Group, 703/269-5610,

Judith Stein, *Executive Director*, Center for Medicare Advocacy, 860/456-7790, jstein@medicareadvocacy.org

James Tallon, *President*, United Hospital Fund, 212/494-0700, jtallon@uhfnyc.org

Ken Thorpe, *Professor and Chair,* Rollins School of Public Health; *Executive Director,* Partnership to Fight Chronic Disease Advisory Board, Emory University, 404/727-3373

Grace-Marie Turner, *President*, Galen Institute, 703/299-8900

Alan Weil, *Executive Director*, National Academy for State Health Policy, 202/903-0101

Gail Wilensky, *Senior Fellow,* Project Hope, 301/656-7401, gwilensky@projecthope.org

Steffie Woolhandler, *Associate Professor of Medicine*, Harvard Medical School, 617/ 497-1268, swoolhandler@challiance.org

Steve Zuckerman, *Principal Research Associate*, Urban Institute, 202/833-7200

### Government

Marjorie Kanof, *Managing Director,* Health Care, Government Accountability Office, 202/512-7114,

John McDonough, *Senior Health Policy Advisor*, Office of Senator Edward Kennedy, 202/224-4543

Charles Nelson, *Assistant Division Chief,* Income, Poverty and Health Statistics, US Census Bureau, 301/763-3183, charles.t.nelson@census.gov

C. Stephen Redhead, *Specialist in Health Policy*, Congressional Research Service, 202/707-2261, credhead@crs.loc.gov

### Stakeholders

David Abernethy, *Senior Vice President*, HIP Health Plans, 202/393-0660, DAbernethy@EmblemHealth.com

Alissa Fox, *Senior Vice President*, Office of Policy and Representation, Blue Cross Blue Shield Association, 202/626-8681, alissa.fox@bsbsa.com

Mary Grealy, *President*, Healthcare Leadership Council, 202/452-8700, mgrealy@hlc.org; cguttmann@hlc.org (assistant)

George Halvorson, *Chairman and CEO*, Kaiser Permanente, 510/271-5660

Angela Hunter, *Director of Federal Affairs*, Council for Affordable Health Insurance, 703/836-6200 x387, anghunter@cahi.org

Charles Kahn, *President*, Federation of American Hospitals, 202/624-1500

Sister Carol Keehan, *President*, Catholic Health Association, 202/296-3993

Jeff Lemieux, *Senior Vice President,* Center for Policy and Research, America's Health Insurance Plans, 202/778-3200, jlemieux@ahip.org

Robyn Martin, *Senior Policy Analyst,* Service Employees International Union, 202/7307359, robyn.martin@seiu.org

James Mongan, *President and Chief Executive Officer*, Partners Healthcare, 617/278-1004

Meg Murray, *Chief Executive Officer*, Association for Community Affiliated Plans, 202/204-7509, mmurray@communityplans.net

Michael Rodgers, *Vice President for Public Policy and Advocacy*, Catholic Health Association, 202/296-3993, mrodgers@chausa.org

Christy Schmidt, *Senior Director of Public Policy*, American Cancer Society, 202/661-5719,

Gerry Shea, *Assistant to the President of Government Affairs*, AFL-CIO, 202/637-5237, gshea@aflcio.org

Laura Trueman, *Executive Director*, Coalition for Affordable Health Coverage, 202/626-8573

### Websites

AFL- CIO
www.afl-cio.org

Alliance for Health Reform
www.allhealth.org

Alliance of Community Health Plans
www.achp.org

America's Health Insurance Plans
www.ahip.org

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Center for Health Care and Policy Research, Penn State University
www.hhdev.psu.edu/chcpr/

Center for Studying Health System Change
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www.cahc.net

Consumers for Health Care Choice
www.chcchoices.org

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www.ebri.org

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