National Health Policy Forum

The Year in Review – 2006

HEALTH POLICY IN REVIEW

Health policy in 2006 opened with the much anticipated debut of the Medicare Part D drug benefit on January 1 and closed, in late December, with the signing of the Tax Relief and Health Care Act of 2006. The Tax Relief bill, among other things, included new provisions to encourage greater enrollment in high-deductible health plans paired with health savings accounts. Highlights during the year included the President's signature in February on the Deficit Reduction Act of 2005, which gave states new flexibility in designing Medicaid benefit packages; the reauthorization of the Ryan White CARE Act; and the ramp up of efforts by Massachusetts and other states to expand coverage to the uninsured.

Medicare

While the early months of Part D implementation were rocky for some beneficiaries, particularly those dually eligible for Medicare and Medicaid, millions received outpatient prescription drugs from hundreds of new stand-alone prescription drug or Medicare Advantage plans at premiums that were lower than anticipated. On the whole, beneficiaries seemed to be generally satisfied with the drug coverage they chose. Although early predictions that the market would shake out quickly did not come true—an additional 500 plans were offered by sponsors for 2007—a handful of major insurers did capture the majority of enrollment in 2006. A similar outcome was expected for 2007 enrollment.

Last-hour action by the Congress averted a 5 percent scheduled cut in Medicare payments to physicians, but provider payment—and the sustainable growth rate (SGR) payment methodology for physician payment in particular—was expected to be back on the agenda in 2007.

Medicaid and SCHIP

On the Medicaid front, the Deficit Reduction Act of 2005, signed into law by President Bush in February 2006, gave states the green light to design alternative Medicaid benefit packages for selected populations and to increase cost-sharing requirements. A few states took advantage of this new "state plan option" for modifying their Medicaid programs, but it appeared that most states would need to continue seeking federal approval for major programmatic changes through waivers.

One of the most controversial provisions of the DRA was the requirement that individuals seeking enrollment in Medicaid must provide evidence of U.S. citizenship in order to be eligible for the program. The provision was intended to keep undocumented immigrants from fraudulently enrolling in Medicaid. However, states

anticipated significant problems for thousands of U.S. citizens who could lose or be denied coverage because of their inability to produce the necessary documents.

The Medicaid Commission, appointed by Department of Health and Human Services (DHHS) Secretary Michael Leavitt in mid-2005, issued its final report and recommendations in late December. Recommendations generally called for individuals to take more responsibility for their health and long-term care needs and for states to have greater flexibility in designing and implementing benefit packages. Whether any of the specific recommendations will be taken up by the 110th Congress remains to be seen.

The discussion around the reauthorization of the State Children's Health Insurance Program (SCHIP) was already well underway by late 2006. The program, which technically expires on September 30, 2007, was increasingly being mentioned as a potential vehicle for larger scale health coverage expansions, both for children and adults. However, vows by Democrats to re-impose "pay go" rules for the 110th Congress suggested that maintaining existing funding levels, let alone expansions, might be difficult.

Public Health and Safety Net

The National Institutes of Health Reform Act of 2006 was passed in December and signed into law early in 2007. Following increased public scrutiny of conflict of interest concerns and other perceived problems at NIH, the legislation encouraged coordination across Institutes, expanded its director's authority to manage the agency, and reformed the process through which the agency reports to Congress on its research portfolio.

Reflecting congressional concerns related to the flawed response to Hurricane Katrina and the potential threat of an influenza pandemic, the Pandemic and All Hazards Preparedness Act was passed with a high degree of bipartisan support. The legislation reauthorized a variety of existing preparedness and response programs, created a new office within DHHS to oversee the development of new vaccines and bioterrorism countermeasures, and moved the National Disaster Medical System from the Department of Homeland Security to DHHS.

The Ryan White Program was reauthorized in December 2006 for three years. Structurally the program was kept intact, but significant changes were made to the formula for distributing funds to eligible cities and states as well as in the requirements for how those funds must be spent. Under the reauthorized program, funding will be distributed based on living HIV/AIDS cases instead of estimated HIV/AIDS cases, as was used in the past. This change will result in funding shifts across cities and states and will require a number of states to overhaul their HIV/AIDS case data systems or risk losing funding.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) underwent significant regulatory review in 2006 with the U.S. Department of Agriculture issuing a proposed rule to update the WIC food packages to align them with the latest nutritional science and to respond to public health concerns. Of key concern was the current food packages' heavy reliance on dairy products and juice

and exclusion of fruits and vegetables, in contradiction to the nutrition messages of the federal government's 2005 Dietary Guidelines. A final rule has yet to be issued.

The community health centers' authorization expired on September 30, 2006. In the 109th Congress, both the House and Senate introduced straight reauthorization bills that differed in the length of the authorization and appropriation levels but made no programmatic changes. The House passed its bill and referred it to the Senate. The Senate bill made it out of committee but was not passed by the entire Senate. Supporters appeared less worried about the authorization lapse than about a protracted substantive debate that might result in structural changes to the health centers program. Thus, similar straight reauthorization bills are expected in the 110th Congress.

Private Sector

In the private sector, employers continued to look for ways to moderate health care cost increases. The adoption of high-deductible health plans paired with health savings or health reimbursement accounts grew modestly; by year's end, approximately 4.5 million Americans were enrolled in such plans. Health risk appraisals and on-site fitness centers and health clinics were back in the news as more employers attempted to engage their employees in health promotion and disease prevention programs.

Health information technology (HIT) continued to receive attention in both the public and private sectors, though legislation to encourage its adoption languished. The Office of the National Coordinator for HIT entered into several contracts aimed at furthering HIT adoption. Notable were one with the private-sector Certification Commission for HIT to certify electronic health records products and one with the National Governors Association to establish the State Alliance for e-Health. Transparency became a rallying cry for the administration as the President issued an executive order requiring federal agencies that administer or support health insurance programs to provide consumers with information on the quality and price of their health care. Pay-for-performance in Medicare took a step forward with the enactment of the Tax Relief and Health Care Act of 2006, which authorized the establishment of a physician quality reporting system by the Centers for Medicare & Medicaid Services. As with hospital reporting previously, the first phase offers physicians an incentive (up to 1.5 percent of total allowed charges) to participate.

THE FORUM IN REVIEW

NHPF programming in 2006 touched on a wide range of health policy issues with significant programming on both Medicaid and SCHIP, as well as Medicare payment policies and the implementation of the Part D prescription drug benefit. By the end of the year, planning was well underway for the next iteration of the Medicare and Medicaid briefings to be held for new congressional staff in early 2007. A site visit to Los Angeles examined efforts to improve care management for the chronically ill and chronically underserved. A one-day, local site visit looked at the implementation of electronic health records in two

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large integrated delivery systems, Kaiser Permanente and the Veterans Administration. The Forum's programming also focused on safety net programs and behavioral health issues through direct programming and by calling attention to the needs of low-income and other special populations in broader policy and program discussions.

Considerable effort in 2006 was also devoted to strategic planning. With support from the W.K. Kellogg Foundation and help from consultants, the Forum conducted interviews and focus groups with internal and external stakeholders, fielded a participant survey, and held numerous meetings aimed at reviewing and revising the organization's mission statement and goals and developing an implementation plan. While this formal activity is set to wrap up in mid-2007, the Forum's ongoing commitment to evaluation, feedback, and program modification ensures that the process will continue well into the future.

December brought the good news that The Atlantic Philanthropies had awarded a three-year, $1.58 million dollar grant to the Forum beginning January 1, 2007, to support programming on aging and long-term care with a special emphasis on disadvantaged elders. In addition to supporting expanded programming on these issues, the grant will allow NHPF to hire additional senior staff.

Through both formal group meetings, and informal conversations with staff, the Forum's Steering Committee and Technical Advisory Group on federalism continued to provide valuable guidance on programming priorities. Numerous small working groups and individual consultations also were helpful in elucidating specific policy issues.

Summary of Products

Short descriptions of programming and publications—including issue briefs, background and fundamentals papers, basics, and site visits, as well as small- and large-group meetings and briefings—completed by the Forum in 2006 are provided below.

Medicare and MMA Implementation

The Forum's work in 2006 continued to focus on implementation of the Medicare Modernization Act of 2003 (MMA), particularly the Part D drug benefit. Part D programming included an in-depth look at the low-income benchmark premium as well as an overview of implementation of Part D stand-alone prescription drug plans. For the third year in a row, the Forum convened a panel of state Medicaid directors, other state experts, and officials from the Centers for Medicare & Medicaid Services to explore how states were dealing with MMA implementation issues. The Forum also produced several papers and a meeting on physician and other provider payments and spending under Medicare, as well as a background paper on the mental health benefit provided under Medicare.

Summary of Products

Medicare and MMA Implementation

■ **Forum Session** [March 31, 2006]

Medicare Provider Payments: Proposals from MedPAC and the Administration
Session Manager – Laura A. Dummit

Each year, the March report of the Medicare Payment Advisory Commission (MedPAC) and the President's budget shape policy and political debates about how much Medicare should pay providers. The backdrop for this year's proposals is the rapid increase in program expenditures and the expected surge in spending due to the aging of the "baby boom" generation. MedPAC and the Bush administration want to slow the growth in payment rates, which provider groups assail as payment "cuts." This Forum session examined the rationale for these recommendations and how MedPAC and the administration will confront the challenges of readying the Medicare program for the next year and beyond.

◆ **Issue Brief 813** [August 2, 2006] *Related to Forum Session, November 17*

A Closer Look at the Medicare Part D Low-Income Benchmark Premium: How Low Can it Go?
Author – Mary Ellen Stahlman

This issue brief explains how the Medicare Part D low-income benchmark premium is calculated, what factors influence the level of the low-income benchmark premium in any given year, and the implications of the benchmark amount for Medicare drug plans and beneficiaries as it changes from year to year. The paper provides a simplified, two-year example of how the low-income benchmark premium is calculated in order to illustrate the key factors that influence it.

■ **Forum Session** [August 4, 2006] *Related to Meeting Report, December 6*

Complexity, Coordination and Compromise: States and the Medicare Drug Benefit
Session Managers – Judith D. Moore and Lee Partridge, Consultant

This invitation-only Forum session focused on implementation issues related to the new Medicare drug benefit that began on January 1, 2006, with special consideration of state activities, problems, and concerns. A facilitated discussion brought together current and former state Medicaid directors, other state officials and experts, federal officials, Medicare drug plan representatives, and beneficiary advocates to discuss the special issues related to the transition for dual eligibles from Medicaid drug coverage to Medicare Part D. Participants described implementation experiences and addressed continuing challenges, such as better use and sharing of data and information technology, financial impact on states, new roles for plans and states, and the enhancement of communications and partnerships to better serve dual eligibles and other low-income beneficiaries of the new drug benefit.

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◆ **Issue Brief 815** [October 9, 2006] *Related to Forum Session, October 13, and Issue Brief 818, November 10*

Medicare Physician Payments and Spending
Author – Laura A. Dummit

The Medicare program's physician payment method is intended to control spending while ensuring beneficiary access to physician services, but there are signs that it may not be working. The physician's role in the health care delivery system as the primary source of information and treatment options, together with growing demand for services and the imperfect state of knowledge about appropriate service use, challenge Medicare's ability to achieve these two goals. This issue brief describes the history of physician spending and the contribution of escalating service use and intensity of services to the rise in Medicare outlays, setting the stage for further discussion about the use of the Medicare payment system to control spending and ensure access.

■ **Forum Session** [October 13, 2006] *Related to Issue Brief 815, October 9*

Medicare Physician Spending: Past as Prologue?
Session Manager – Laura A. Dummit

This meeting presented an historical perspective on physician spending in the Medicare program and Medicare's attempts to curb its growth. It included a national overview of physician responses to Medicare's payment approach and views from the primary care and specialty physician communities.

◆ **Issue Brief 817** [November 8, 2006] *Related to Forum Session, November 17*

The Nuts and Bolts of PDPs
Author – Mary Ellen Stahlman

This issue brief provides an overview of Medicare prescription drug plans (PDPs), with a focus on fundamentals such as enrollment, premiums, formularies, cost sharing, prices, payment, cost management, and appeals and grievance processes. It also highlights major changes to the PDP landscape between 2006 and 2007.

◆ **Issue Brief 818** [November 10, 2006] *Related to Issue Brief 815, October 9*

Updating Medicare's Physician Fees: The Sustainable Growth Rate Methodology
Author – Laura A. Dummit

Medicare's method to annually update the fees it pays physicians has been under fire for some time—specifically, since the method determined that physician fees should be reduced rather than increased. The update method, called the sustainable growth rate (SGR), was implemented to control the growth in Medicare physician spending. Yet Congress, in response to physician concerns about beneficiary access to care, has acted to avert physician fee cuts since 2003.

Although this signals dissatisfaction with the SGR methodology, there is yet to be a widely accepted physician fee update proposal that balances federal budgetary realities with the need to ensure beneficiary access. And the cost of changing the update method continues to mount, adding to the difficulties of developing a solution that meets the needs of all stakeholders. This issue brief describes the SGR methodology, the reasons why projected physician fee updates are negative, and some options that have been proposed to remedy the current situation.

■ **Forum Session** [November 17, 2006] *Related to Issue Brief 813, August 2, and Issue Brief 817, November 8*

The Medicare PDP Market: Build It and the Plans Will Come
Session Manager – Mary Ellen Stahlman

Medicare's second annual beneficiary enrollment period for prescription drug plans (PDPs) started on November 15, 2006. This Forum session examined 2007 plan offerings and how they differ from 2006 offerings. The speakers explored the business strategies of PDPs and the factors that may shape this market in the years to come. The use of formularies and cost management tools by these plans was explored. Efforts to reach and enroll low-income beneficiaries in Medicare Part D was a specific focus.

▲ **Background Paper** [November 27, 2006]

Medicare and Mental Health: The Fundamentals
Authors – Christopher W. Loftis and Eileen Salinsky

This background paper provides a review of mental health coverage in the Medicare program. It examines the prevalence of mental disorders among Medicare beneficiaries, treatment available through Medicare, and the cost of such treatment. A brief summary of relevant policy issues is provided, including Medicare's outpatient mental health limitation and the potential effect of the prescription drug benefit on the provision of mental health services.

➤ **Meeting Report** [December 6, 2006] *Related to Forum Session, August 4*

A Report from the Forum Session "Complexity, Coordination and Compromise: States and the Medicare Drug Benefit"
Author – Lee Partridge, Consultant
Project Manager – Judith D. Moore

This National Health Policy Forum meeting report reviews a technical session that took place on August 4, 2006. The invitation-only meeting was designed to discuss implementation issues related to the new Medicare drug benefit, with special consideration of state activities, problems, and concerns. This meeting followed similar ones sponsored by the Forum in 2004 and 2005 in which the state perspective was the primary focus of conversation. Participants, including current and former state Medicaid directors, other state officials and experts, federal

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officials, Medicare drug plan representatives, and beneficiary advocates, described their experiences during the implementation process and addressed continuing challenges. Key topics discussed and summarized in this report include better use and sharing of data and information technology, financial effects of the Medicare drug benefit on states, new roles for plans and states, and opportunities for enhancing communications and partnerships to better serve dual eligibles and other low-income beneficiaries.

Private Markets

NHPF programming under the private markets rubric included a wide range of papers, meetings, and site visits focused on various aspects of health care financing, delivery, and organization. Early in the year, a background paper on the status of employer-sponsored health benefits for retirees set the stage for a meeting on health care expenses in retirement and the ability of current and future retirees to finance these costs. Another background paper provided a comprehensive look at the market dynamics of the vaccine industry.

On the technology front, the Forum conducted a local site visit to observe the electronic health record (EHR) as used in practice by two U.S. leaders in technology and quality, the Veterans Health Administration and Kaiser Permanente. The site visit was followed by a paper describing personal health records and their potential for improving the delivery and quality of care. Technology, and how it can be used to improve care delivery, also figured prominently in a December 2005 site visit to Boston; the report of this visit was issued in early 2006. Finally, a background paper examined evidence- and value-based approaches to evaluating new technologies and their application to coverage decisions in the United States and the United Kingdom.

Physicians also figured prominently in the Forum's private markets programming. A paper looked at the basics of physician qualification; the processes by which physicians are licensed, credentialed, and board-certified; and the ability of pay for performance and other quality initiatives to change physician behavior. The role of volume and intensity in driving up spending for physician services, as well as the value of that spending, provided the focus for another meeting. Finally, evidence of a growing "arms race" between physicians and hospitals for specialty services was presented and discussed at a meeting for senior members of the Forum's audience.

▲ **Background Paper** [January 25, 2006]

The Vaccine Industry: Does It Need a Shot in the Arm?
Authors – Eileen Salinsky and Cole Werble, Consultant

This paper broadly examines the scientific, regulatory, and economic factors that contribute to constrained vaccine production capacity, periodic vaccine shortages, and perceptions of inadequate investment in new vaccine product development. It describes the vaccine development and production processes and summarizes

how regulatory requirements influence these activities. Market dynamics related to vaccine supply and demand are also explored, including an examination of the industry's cost structure, potential market size, and purchaser price sensitivity. A broad range of policy interventions designed to address shortcomings of the vaccine market are considered.

▲ **Background Paper** [February 8, 2006] *Related to Forum Session, February 24*

Health Benefits in Retirement: Set for Extinction?
Author – Mark Merlis, Consultant
Project Manager – Sally Coberly

Nearly 18 million people rely on employer-provided retiree health benefits to fill gaps in Medicare's coverage or to provide basic insurance until they reach Medicare age. Rising costs have led many employers to limit benefits, require participants to pay a larger share of the costs, or stop offering coverage at all for workers who have not yet retired. This background paper describes recent developments in retiree health benefits, possible future trends, and policy options for slowing the erosion of coverage or providing alternative ways for retirees to meet their expected medical expenses.

■ **Forum Session** [February 24, 2006] *Related to Background Paper, February 8*

Financing Health Care in Retirement: A Day Late and a Dollar Short?
Session Manager – Sally Coberly

This Forum session reviewed projections of health care expenses in retirement and examined the ability of current and future retirees to finance these expenses. The outlook for factors that affect financial security in retirement, such as retiree health benefits, savings rates, and Medicare financing, was reviewed; the effectiveness of various savings vehicles, such as health savings accounts, to meet the challenge of saving for health care expenses in retirement was also discussed. A consumer perspective on how current retirees are coping with health care expenses was offered.

◆ **Issue Brief 809** [February 28, 2006]

Fitness, Knowledge, Progress: Assessing Physician Qualification
Author – Lisa Sprague

The informed and empowered consumer is an ideal invoked by many would-be health care reformers. An actual consumer wishing to don the mantle of power may be hindered by the scarcity of information available, particularly with respect to choosing among physicians. How is one to know who is best qualified? This issue brief looks at the basics of physician qualification and the processes by which physicians are licensed, credentialed, and board-certified. It examines how the evolution of these processes (for example, the move from lifetime certification to ongoing maintenance of certification) affects clinicians and their patients. The rise of quality measurement and pay-for-performance programs is considered as well.

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● **Site Visit Report** [March 6, 2006]

Redesigning Practice to Improve Care Delivery (December 4-6, 2005)
Authors – Laura A. Dummit and Lisa Sprague

This report summarized the impressions of participants in a December 2005 Boston site visit that focused on how the practice of medicine is changing or can be changed to improve care delivery across the spectrum of patient populations. Regarded as a "medical Mecca," Boston is home to the academic health centers and teaching hospitals where many of the nation's physicians are trained. As a center of innovation, Boston prides itself on its high bar with respect to standards of care. Panels addressed the use of clinical information technology (IT) in the physician's office, in the hospital, and community-wide. Participants observed how IT is being used to further the mission of community health centers. Physician-managers described initiatives in their practices to design workflows and develop incentives that would encourage physicians to achieve quality and resource-use goals. Communication among physicians, other providers, and patients was examined, with emphasis on health literacy and cultural sensitivity.

■ **Forum Session** [March 17, 2006]

Physician Spending Growth: Do We Get What We Pay For?
Session Manager – Laura A. Dummit

Medicare fees for physician services in 2006 will be held to 2005 levels, yet Medicare physician spending is projected to rise by $1.5 billion. Increases in the volume of physician services provided as well as their complexity have been driving up spending and are expected to continue to do so. This trend adds to concerns about the growing share of the federal budget devoted to health care and whether the added spending is improving health outcomes. This Forum session examined recent trends in physician spending, the value of additional physician services, and public and private payers' efforts to get the most value out of the health care dollar.

● **Site Visit** [June 23, 2006]

The Electronic Health Record in Practice: Why, How, and What Next?
Site Visit Managers – Lisa Sprague and Sally Coberly

This local site visit was intended to allow participants to observe the electronic health record (EHR) as used in practice by two U.S. leaders in technology and quality, the Veterans Health Administration (VHA) and Kaiser Permanente (KP). The VHA has employed an EHR system since 1997; KP is in the process of implementing a standard system for all clinicians nationwide. The site visit was designed to provide an opportunity for participants to explore both the expected benefits from EHR adoption and the specific lessons these two large, integrated delivery systems have learned in their transition from paper to electronic records. How the experiences of the VHA and KP might apply to smaller, more fragmented medical practices also was a topic. Issues explored included privacy protection, infrastructure building, beneficiary access, and interoperability. More fundamentally, the group was asked to consider

what barriers might be removed or incentives created to speed the dissemination of health information technology. A report summarizing the impressions of participants was published on September 26, 2006.

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■ **Forum Session** [September 22, 2006]

Specialty-Service Lines: Healthy Competition or Arms Race?
Session Manager – Lisa Sprague

This invitation-only meeting, developed for senior-level members of the NHPF audience, was built around a *Health Affairs* Web Exclusives article called "Specialty-Service Lines: New Salvos in the Medical Arms Race" (vol. 25, no. 5, 2006, pp. w337-w343). Lead author Robert Berenson summarized the article's key points. His research found that hospitals and doctors who had traditionally marketed their services as a comprehensive package were developing and marketing single-specialty service lines such as cardiology, cancer care, and orthopedics. While collaboration between a hospital and its physicians is a strategy employed in some cases, a strong trend is the migration of specialty services from the community hospital to the specialty hospital or ambulatory service center, where physicians are likely to have an ownership interest. Health plan respondents generally think this new competition is not producing desirable price competition but rather contributing to a medical arms race. Discussion probed the reasons for this trend, its impact on health care quality, and possible policy responses.

▲ **Background Paper** [November 29, 2006]

Value-Based Coverage Policy in the United States and the United Kingdom: Different Paths to a Common Goal
Author – Wilhelmine Miller, Consultant
Project Manager – Lisa Sprague

This background paper traces the development within American health care of two interrelated trends and activities: an evidence-based approach to medical practice and the critical evaluation of new technologies with respect to their costs and effectiveness. Over the past 35 years each of these developments has increasingly shaped the coverage decisions of public and private health insurers, and their importance for coverage policy is certain to grow. The paper also contrasts the different approaches to such "evidence-" or "value-based" coverage policy in the mixed public and private U.S. health care enterprise with the approach taken in Great Britain's single-payer National Health Service.

◆ **Issue Brief 820** [November 30, 2006]

Personal Health Records: The People's Choice?
Author – Lisa Sprague

Information technology (IT), especially in the form of an electronic health record (EHR), is touted by many as a key component of meaningful improvement in health care delivery and outcomes. A personal health record (PHR) may be an element of

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an EHR or a stand-alone record. Proponents of PHRs see them as tools that will improve consumers' ability to manage their care and will also enlist consumers as advocates for widespread health IT adoption. This issue brief explores what a PHR is, the extent of demand for it, issues that need to be resolved before such records can be expected to proliferate, and public-private efforts to promote them.

Medicaid and SCHIP

With significant changes to Medicaid included in the passage of the Deficit Reduction Act in late 2005 and impending reauthorization of the State Children's Health Insurance Program (SCHIP) in 2007, the Forum focused considerable attention on these programs in 2006. SCHIP programming focused on premium assistance, the history and future of the program, and reauthorization issues. Medicaid-related papers looked at the history of the home and community-based service waiver program and its effect on improving access to long-term care services; trends in section 1115 waiver development and the impact of the DRA on Medicaid; and the role of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in meeting the needs of low-income children. A basic on Medicaid financing was also updated. Forum meetings focused on the continuing evolution of the Medicaid program, differences in state and federal perspectives on program financing and fiscal integrity, and the role of EPSDT in providing services to children with special health care needs.

▲ **Background Paper** [March 3, 2006]

Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program
Author – Cynthia Shirk, Consultant
Project Manager – Jennifer Ryan

This paper reviews the history and background of the Medicaid home and community-based services (HCBS) waiver program. It describes the eligibility, benefits, and financing structure, as well as the trends in program expenditures over time. The paper considers the contribution of the HCBS waiver program toward improving access to community-based care for Medicaid beneficiaries who are elderly and disabled and discusses the barriers that remain. This paper also summarizes the provisions included in the recently enacted Deficit Reduction Act of 2005 that may further expand Medicaid HCBS and considers how it may continue the process of redefining the concept of long-term care.

◆ **Issue Brief 810** [March 29, 2006] *Related to Forum Session, May 16*

Medicaid in 2006: A Trip Down the Yellow Brick Road?
Author – Jennifer Ryan

This issue brief explores the continuing evolution of the Medicaid program on several fronts. It discusses the benefits and cost-sharing flexibility that is included in the Deficit Reduction Act of 2005 (DRA) and examines the implications of these provisions for states, beneficiaries, and providers. The paper also explores recent

trends in section 1115 waiver development and considers the use of waivers as a vehicle for restructuring Medicaid financing systems and for testing completely new approaches to health care delivery. The role of section 1115 waivers in the context of the DRA and as a mechanism for continued state innovation is also discussed.

■ **Forum Session** [May 16, 2006] *Related to Issue Brief 810, March 29*

Medicaid in 2006: A Trip Down the Yellow Brick Road?
Session Manager – Jennifer Ryan

This session explored the continuing evolution of the Medicaid program. Speakers discussed recent trends in Medicaid section 1115 waiver development and considered the use of waivers as a vehicle for restructuring Medicaid financing systems and for testing new approaches to health care delivery. The speakers also provided state-specific examples of recently designed Medicaid waivers and offered insights into the goals and objectives of these innovative approaches. Finally, the panel discussed the role of section 1115 waivers as a mechanism for continued state innovation in the context of the Medicaid policy changes included in the Deficit Reduction Act of 2005.

◆ **Issue Brief 812** [July 17, 2006]

Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?
Authors – Cynthia Shirk, Consultant, and Jennifer Ryan

This issue brief explores the use of premium assistance in publicly financed health insurance coverage programs. In the context of Medicaid and the State Children's Health Insurance Program (SCHIP), premium assistance entails using federal and state funds to subsidize the premiums for the purchase of private insurance coverage for eligible individuals. This paper considers the evolution of premium assistance and some of the statutory and administrative limitations, as well as private market factors, that have prevented widespread enrollment in Medicaid or SCHIP premium assistance programs. Finally, this issue brief offers some ideas for potential legislative and/or programmatic changes that could facilitate the use of premium assistance as a mechanism for health coverage expansion.

■ **Forum Session** [July 21, 2006]

The State Children's Health Insurance Program: Past, Present, and Future
Session Manager – Jennifer Ryan

This Forum session explored the history of the State Children's Health Insurance Program (SCHIP), including the policy and political context in which it was conceived. Speakers offered federal and state perspectives of the program from the time of its inception as part of the bi-partisan Balanced Budget Act of 1997, its first years of implementation, attaining outreach and enrollment milestones, struggling through the state budget crises of the early 21st century, and looking to the future. Speakers offered their insights into the program's achievements and challenges, focusing on the influence the much younger SCHIP has had on the more mature

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Medicaid program. Finally, the discussion touched on some of the potential policy and financing issues that will likely emerge in the process of reauthorizing the program, the authority for which expires on September 30, 2007.

★ **The Basics** [September 13, 2006] *Related to Forum Session, September 15*

Medicaid Financing
Author – Jennifer Ryan

This publication provides an overview of how the Medicaid program is financed. It explains the basic structure of the federal-state matching relationship and briefly describes how money flows from the federal government to the states as well as some of the strategies states have identified to help them maximize federal Medicaid matching funds.

■ **Forum Session** [September 15, 2006] *Related to The Basics, September 13*

Where You Stand Depends on Where You Sit: Perspectives on Medicaid Fiscal Integrity and Intergovernmental Relationships
Session Manager – Judith D. Moore

This Forum session reviewed a new report by the National Academy for State Health Policy (NASHP), "Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity." The report, based on a one-day meeting of state and federal Medicaid officials and other experts, describes the tensions that have developed over the last 25 years between federal and state Medicaid program administrators around the financing of the program. The Medicaid program, which in 2004 spent over $115 billion in state and $172 billion in federal funds, supports health care coverage for over 55 million vulnerable people. The NASHP report identifies a cycle of federal action and state response, a cycle that intensifies the difficulty of delivering care to needy people and breaks trust between federal and state partners, making Medicaid reform and change more complex. Speakers offered their insights about the report and commented on the different perspectives, attitudes, and views held by federal and state decision makers and administrators, as well as the potential actions that might be taken to break the cycle and potentially defuse the ongoing intergovernmental stalemate.

➤ **Special Meeting** [October 5, 2006]

SCHIP Reauthorization Workshop
Session Manager – Jennifer Ryan

This meeting brought together representatives from the provider and child advocacy communities to identify the key issues that need to be addressed in conjunction with the reauthorization of the State Children's Health Insurance Program which officially ends on September 30, 2007. The meeting was planned in consultation with the Georgetown Health Policy Institute's Center for Children and Families and the National Academy for State Health Policy. Two major themes—financing issues

and eligibility and benefits design—emerged from the discussion and will be explored further in future Forum programming on SCHIP reauthorization.

◆ **Issue Brief 819** [November 20, 2006] *Related to Forum Session, December 8*

EPSDT: Medicaid's Critical but Controversial Benefits Program for Children
Author – Christie Provost Peters

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid provides the most comprehensive set of health benefits for children and adolescents in the public or private sector. A cornerstone of early childhood preventive and treatment services in the nation's health care "safety net," the EPSDT program serves nearly 30 million low-income children, including children with disabilities and special needs. Over the years, states have expressed frustration with the administrative burdens of EPSDT requirements. Rising Medicaid costs have put all Medicaid benefits, including the EPSDT program, in the budgetary crosshairs. This issue brief reviews the fundamental characteristics of the EPSDT program and highlights some of the challenges it has faced over the years. This paper also describes some of the changes proposed to preserve access to comprehensive care while controlling costs and encouraging administrative simplification and flexibility.

■ **Forum Session** [December 8, 2006] *Related to Issue Brief 819, November 20*

Children with Special Health Care Needs and the Role of Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program
Session Manager – Christie Provost Peters

This meeting examined children with special health care needs (CSHCN) and the role of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in providing care to this population. The speakers at this session explored the diverse and often costly needs of CSHCN, public and private health coverage for these children, and the challenges states face in administering EPSDT benefits. Speakers also provided their insights regarding state experiences with the EPSDT framework and new state opportunities provided under the Deficit Reduction Act of 2005.

Access to Care and Population Health

The Forum's programming on access and population health issues spanned a wide range of topics. The impending reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provided the opportunity to explore how the program is balancing quality, access, equity, and resources. Another meeting looked at the potential effect of the recent Massachusetts health reform initiative on safety net institutions and providers. A third meeting, building on a related issue brief, examined emergency department crowding, its causes and consequences, and potential approaches—both local and federal—for alleviating crowding. A special issue of the journal Health Affairs *provided the foundation for a meeting*

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that examined financing, organization, and delivery trends for mental health services. A site visit to Los Angeles, which included a pre-visit briefing on the organization and financing of health care provided by LA County, highlighted efforts to improve care for the chronically ill and chronically underserved. Finally, two papers, both drawing from Institute of Medicine reports and recommendations, looked at different aspects of child nutrition. One examined the link between food marketing and obesity while the other outlined the proposed changes to the food package under the Women, Infants, and Children program and attendant implementation challenges.

■ **Forum Session** [March 14, 2006]

Caring for "Ryan White": Balancing Quality, Access, Equity, and Finite Resources
Session Manager – Jessamy Taylor

This Forum session focused on the evolution of HIV/AIDS treatment and policies to make care advancements available to low-income, uninsured people living with the disease through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Variation in access to and quality of treatment across the country was discussed. The session explored current and past funding distribution mechanisms, questions of equity related to the distribution formulas, and the potential impact of changing those formulas through the reauthorization. The importance of diagnosing HIV early to prevent further infections and to limit future demands on publicly funded health care programs that treat low-income populations with HIV/AIDS was also highlighted.

➤ **Special Briefing** [April 5, 2006] *Related to Site Visit, April 18–20*

Improving Care Management in Los Angeles: A Site Visit Overview
Session Managers – Eileen Salinsky and Jessamy Taylor

This special briefing was designed for federal health policymakers participating in the National Health Policy Forum site visit to Los Angeles on April 18–20, 2006. It featured the former director and chief medical officer of the Los Angeles County Department of Health Services who spoke about the organization and financing of the county health care system, including past and current Medicaid waivers. His presentation also highlighted innovations in care management being utilized by county hospitals and clinics.

● **Site Visit** [April 18–20, 2006]

LA Story: Improving Care for the Chronically Ill and Chronically Underserved
Site Visit Managers – Eileen Salinksy and Jessamy Taylor

This Los Angeles–based site visit examined safety net and private sector efforts to improve care coordination for underserved and vulnerable populations, including the homeless, the uninsured, the undocumented, and individuals with chronic conditions like diabetes, asthma, and severe mental illness. The visit highlighted challenges

and innovations in the use of disease management programs, information systems, performance incentives, and managed care as tools for improving care coordination. A report summarizing participant impressions was published August 30, 2006.

■ **Forum Session** [June 14, 2006]

"Mental Health: Progress and Pitfalls," the **Health Affairs** ***Special Issue— A Discussion of Trends in Mental Health Services***
Session Manager – Christopher W. Loftis

This Forum session highlighted the work of three researchers who published articles in a *Health Affairs* special issue, "Mental Health: Progress and Pitfalls." The meeting reviewed historical trends in the financing of mental health services and explored the implications of these trends for the organization and delivery of mental health care. Speakers also discussed what improvements are needed to provide quality and accessible behavioral health care today in the context of increasing pressures to control costs and improve standards of care.

■ **Forum Session** [June 20, 2006]

Health Care for All in Massachusetts: Implications for a Changing Safety Net
Session Managers – Laura A. Dummit and Lisa Sprague

The recent passage of Massachusetts health reform has reignited national discussions about how to provide care to people who do not have health insurance. The Massachusetts governor and legislature, with considerable input from residents and from the insurer and provider communities, developed a plan to expand insurance coverage to most of the commonwealth's uninsured. The strategy involves a gradual shift from direct financial support of the hospitals and community health centers that comprise the safety net to expanded insurance coverage for individuals. How the new approach in Massachusetts plays out will depend on the adequacy of financing and on the participation of individuals, providers, employers, and insurers. Even before its success can be evaluated, the Massachusetts experiment presents an opportunity for policymakers to examine the types of trade-offs needed to bring all stakeholders together to address the goal of universal coverage.

◆ **Issue Brief 811** [July 7, 2006] *Related to Forum Session, July 27*

Don't Bring Me Your Tired, Your Poor: The Crowded State of America's Emergency Departments
Author – Jessamy Taylor

If the time comes, people expect that the emergency department (ED) will have the resources necessary to treat them in a timely, high-quality manner. Increasingly, however, EDs may not be able to meet that expectation. Hospitals in urban areas with large populations, high population growth, and higher-than-average numbers of uninsured are particularly crowded: ambulances are often diverted to other hospitals and patients are frequently forced to "board" in the hallways (while

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they wait to be transferred to another facility or part of the hospital). This issue brief places EDs in the context of the U.S. health care system and its economics, discusses existing ED capacity and utilization, where crowding is happening and ways of measuring it, what is causing crowding in EDs, and the consequences of crowding. It highlights a number of potential ways to alleviate crowding at both the health system and the individual hospital level.

■ **Forum Session** [July 27, 2006] *Related to Issue Brief 811, July 7*

Canary in the Coal Mine or Crying Wolf? Examining Crowding in America's Emergency Departments
Session Manager – Jessamy Taylor

This Forum session explored the crowded state of many emergency departments (EDs) in the United States. Speakers described where crowding is happening, how it is measured, its key causes, and its consequences on patients, payers, and staff. The discussion considered potential ways to mitigate and alleviate crowding, from hospital-specific solutions to broader federal policy fixes. Key findings and recommendations from the Institute of Medicine's June 2006 report *Hospital-Based Emergency Care: At the Breaking Point*, part of the Future of Emergency Care series, were highlighted.

◆ **Issue Brief 814** [August 15, 2006]

Effects of Food Marketing to Kids: I'm Lovin' It?
Author – Eileen Salinsky

This issue brief reviews key findings and recommendations from the Institute of Medicine study on food marketing and its effects on childhood obesity. The brief describes the childhood obesity epidemic, discusses key trends associated with rising childhood obesity rates, and considers the relative role of marketing practices on diet and obesity within the broader context of complex contributory factors. The brief also summarizes the current legal framework for regulating marketing directed at children; discusses voluntary, self-regulatory mechanisms; and highlights proposals to re-orient marketing practices to combat childhood obesity.

◆ **Issue Brief 816** [November 2, 2006]

Updating the WIC Food Packages: It's About Time
Author – Jessamy Taylor

This issue brief reviews key revisions to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program proposed by the U.S. Department of Agriculture, which are based substantially on recommendations by the Institute of Medicine. Should the changes become regulation, they will be the most significant revision of the WIC food packages in over 25 years. This brief describes the changes, the impetus for their consideration, and possible implementation issues from the perspectives of vendors, state and local WIC agencies, and participants.

NATIONAL HEALTH POLICY FORUM
Budget Summary, *January 1 – December 31, 2006*

	California Endowment	Hartford	Kellogg	MacArthur	Nemours	Packard	RWJF	General	TOTAL
Salaries	51,884	211,490	634,212	127,921	41,981	114,478	360,882	0	**$1,542,848**
Fringe Benefits	12,297	50,123	150,308	30,317	9,949	27,131	71,455	0	**351,580**
Meetings	18,572	29,538	52,054	16,620	4,301	19,317	32,970	4,704	**178,076**
Speaker Travel	19,315	6,101	29,690	3,102	0	15,425	5,369	453	**79,455**
Staff Travel	18,788	6,125	10,407	1,971	512	1,183	2,528	2,087	**43,601**
Printing	1,617	2,830	3,458	864	292	1,544	4,525	0	**15,130**
Postage	660	860	1,828	381	24	730	1,368	193	**6,044**
Telephone	3,620	2,944	7,938	1,851	528	1,305	5,088	68	**23,342**
Books/Subscriptions	92	612	8,662	113	45	0	4,861	0	**14,385**
Leasing/Maintenance	510	2,358	8,689	1,527	482	968	4,276	0	**18,810**
Supplies	4,671	2,386	26,731	2,238	427	1,688	7,308	165	**45,614**
Services	1,503	38,322	183,016	14,962	6,368	22,233	59,802	1,953	**328,159**
Rent	6,008	28,701	88,027	18,591	5,372	13,824	51,097	6,320	**217,940**
Indirect Costs	20,930	35,369	0	0	0	0	20,025	0	**76,323**
TOTAL EXPENSES	**$160,467**	**$417,759**	**$1,205,020**	**$220,458**	**$70,281**	**$219,826**	**$631,554**	**$15,943**	**$2,941,308**

Note: The figures have been compiled from NHPF records. This is not an audited certified accounting. A complete audited accounting for the entire University, including expenditures of the Forum, is presented in the University's annual report.

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