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CHRISTINE WILLIAMS

Todd -

I have enclosed a sample of our ULP workshops and seminars. I will get back to you in a week or so after I have spoken with John Eisenberg and received the reports.

Chris Williams

Christine G. Williams
Director

AGENCY FOR HEALTH CARE POLICY AND RESEARCH



Office of Health Care Information
2101 East Jefferson Street, Suite 501
Rockville, Maryland 20852
Phone 301-594-1360
FAX 301-594-2286
EMail: cwilliam@ahcpr.gov/



DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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AHCPR's User Liaison Program

Meeting the Information Needs of State and Local Officials

The Agency for Health Care Policy and Research (AHCPR) develops and disseminates research-based information to increase the scientific knowledge needed to enhance consumer and clinical decisionmaking, improve health care quality, and promote efficiency in the organization of public and private systems of health care delivery.

The AHCPR was created to help the Nation's health care system provide high-quality, cost-effective services; be accountable and responsive to consumers and purchasers; and improve Americans' health status and quality of life. AHCPR is the health services research arm of the Public Health Service, a component of the U.S. Department of Health and Human Services. As such, AHCPR works closely with other Federal health agencies, including the National Institutes of Health--the Public Health Service's biomedical research arm.

AHCPR's goals are to work with the private sector and other public organizations to:

- Help consumers make better informed choices.
- Determine what works best in clinical practice.
- Measure and improve quality of care.
- Monitor and evaluate health care delivery.
- Improve the cost-effective use of health care resources.
- Assist health care policymakers.
- Build and sustain the health services research infrastructure.

The User Liaison Program (ULP)

The User Liaison Program (ULP), established in 1978, contributes to AHCPR's mission by synthesizing and distributing research results to local, State, and Federal health policymakers--"users" of such research. Small policy-thematic workshops form the core of ULP's activities, although skill-building workshops and written products such as research syntheses or technical assistance documents may also be produced. In addition to providing information and tools with which informed health policy decisions can be made, ULP serves as a bridge between State and local health policymakers and the health services research community. Current and future information needs of key policymakers are relayed to AHCPR administrative staff and researchers so that these needs can be considered when the Agency develops its research agenda.

ULP workshops are user-driven and user-designed. They have been highly successful because ULP relies upon senior legislators, executive agency staff, and local officials to identify the key policy issues they are confronting and about which ULP should provide information. These key

stakeholders also indicate the specific questions that should be addressed during each workshop session. Presenters' materials are thoroughly reviewed by ULP staff, experts, and stakeholders to ensure that research findings and other information imparted during workshop sessions, such as best practices, are framed so that it can be easily understood and used. Additionally, presenters' materials are reviewed carefully to ensure that information is objective and non-partisan; ULP recognizes the scope and limitations of specific research findings and that the same solution may not be feasible or workable in all cases.

Another key feature of ULP workshops is the emphasis on information sharing between participants as well as between presenters and participants. Workshops are planned to be highly interactive; time for questions and small groups are built into the day's activities and group meals are arranged. Furthermore, presenters are encouraged to stay and participate in the entire meeting, allowing participants greater time for interaction with these experts.

In addition to offering national workshops, the User Liaison Program is responsive to meeting the needs of individual states. State officials often approach ULP about conducting workshops for that State's policymakers on issues of special concern to them. In these instances, States are asked to provide 75% of the workshop support costs either in dollars or in-kind services. ULP sets aside funds each year to assist several states with these seminars.

Policy-thematic workshops and seminars sponsored or supported through the ULP over the years have covered a wide variety of issues including: Ensuring Quality Health Care: The Challenges of Measuring Performance and Consumer Satisfaction; What Do We Do About the Uninsured; Local Health Departments in a Managed Care Environment; Rural Health and Rural Managed Care; Managed Care and Integrated Delivery Systems; Providing Quality Services to Children with Special Health Care Needs; and Long-Term Care.

ULP also co-sponsors workshops and participates in technical assistance activities with non-profit foundations and national organizations such as the National Conference of State Legislatures (NCSL); the Association of State and Territorial Health Officials (ASTHO); the National Association of County and City Health Officials; and the National Association of Counties (NACo). For example, AHCPR's publication *Assessing Roles, Responsibilities, and Activities in a Managed Care Environment: A Workbook for Local Health Officials* is a direct result of ULP's collaborative effort with ASTHO, NACCHO, and the Association of Maternal and Child Health Programs (AMCHP).

For more specific information regarding individual workshops or other ULP activities, write to the address below. The telephone number is (301) 594-6668; fax is (301) 594-2035.

The User Liaison Program
Office of Health Care Information
Agency for Health Care Policy and Research
2101 East Jefferson Street
Rockville, Maryland 20852

USER LIAISON PROGRAM**1999 Preliminary National Workshop Schedule****January**

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Mar 10-12 The Uninsured and the Safety Net: Trends and Challenges
Los Angeles, California

Apr 14-16 New Directions in Long Term Care
Kansas City, Missouri

May 3-4 Seminar: The Individual Insurance Market: Performance and Potential
Atlanta, Georgia

May 26-28 CHIP - What's Happening? What's Next?
Portland, Maine

Jun 9-11 Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems
Charleston, South Carolina

Jun 14-16 Assessing Quality: Beyond the Basics
Minneapolis, Minnesota

Jul 12-14 Using Evidence: Making Disease Management and Health Benefit Coverage Decisions
Nashville, Tennessee

Jul 19-21 Behavioral Health and Managed Care: Sorting Through the Issues, Models and Strategies
Albuquerque, New Mexico

Sep 13-15 Public Health and Managed Care: Working Together to Ensure Health Care Quality
Seattle, Washington

Oct 18-20 Educating and Regulating Health Care Professionals: Rethinking of Old Roles
Philadelphia, Pennsylvania

Nov 3-5 TBD
Cleveland, Ohio

Dec 1-3 TBD
Houston, Texas

Registration Information:

Because space is limited at each workshop, you may want to reserve your place at the workshop before you receive approval for travel, but never book your travel before you receive written confirmation that space is available. You can register by calling AHCPR's User Liaison Program (ULP) office at (301) 594-6668 or send a fax with your name, title, address, telephone and fax numbers to (301) 594-2035. Written inquiries should be directed to User Liaison Program, Agency for Health Care Policy and Research, 2101 E. Jefferson St., Rockville, MD 20852

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U.S. Department of Health
and Human Services

ULP WORKSHOP OVERVIEW AND AGENDA

U.S. Public Health Service

Agency for Health Care Policy and Research

WEBSITE: www.ahcpr.gov

Office of Health Care Information
The User Liaison Program

Presents:

The Individual Insurance Market: Performance and Potential

A WORKSHOP FOR STATE EXECUTIVE AND LEGISLATIVE OFFICIALS

Facilitated by:

Alpha Center
Washington, D.C.

Renaissance Atlanta Hotel
Atlanta, Georgia
May 3-4, 1999

ULP WORKSHOP OVERVIEW AND AGENDA

*...Bridging the gap between
researchers and policymakers...*

2101 EAST JEFFERSON STREET, ROCKVILLE, MD 20852

ULP TELEPHONE: (301) 594-6668

ULP FAX NUMBER: (301) 594-2035



USER LIAISON PROGRAM SEMINAR**THE INDIVIDUAL INSURANCE MARKET: PERFORMANCE AND POTENTIAL****SEMINAR COST: \$322.00****WHEN:** May 3-4, 1999**WHERE:** Renaissance Atlanta Hotel
590 West Peachtree Street
Atlanta, Georgia 30308
Tel (404) 881-6000
Fax (404) 815-5350**FULL COST:** \$322.00 (for lodging, group meals, seminar materials, registration fee)**PAYMENT
DUE DATE:** April 2, 1999**DRESS:** Casual (slacks, tee shirts and casual shoes)

If you need further information, or if you wish to sign up to attend, please send a fax to the User Liaison Program at 301-594-2035 or call Serena Toro at 301-594-2078 BEFORE MAKING YOUR AIRLINE RESERVATIONS.

CANCELLATION POLICY: In the event of cancellation prior to two (2) work days before the start of the seminar, the amount of the first day's expenses is non-refundable. The balance will be returned. **HOWEVER**, if you cancel less than two (2) work days prior to the start of the seminar, you may be required to forfeit the entire amount (or any part thereof) depending on the hotel policy regarding refunds.

Presents

The Individual Insurance Market: Performance and Potential

A Seminar for State Executive and Legislative Officials

*Renaissance Atlanta Hotel
Atlanta, Georgia
May 3 - 4, 1999*

Overview

Declines in employer-based insurance and insurer responses to the Health Insurance Portability and Accountability Act (HIPAA) have highlighted deficiencies in the individual insurance market. The combined effect has catalyzed policy discussions about how the individual market might be reformed or augmented to better serve those purchasing coverage in that market. For example, recent debate has included talk of enacting incentives for encouraging healthier employed individuals to purchase insurance in the individual market. Such incentives might include increasing the premium tax deduction for individuals to make it comparable with the tax incentives accorded employment-based policies. In addition, many States have implemented reforms to address problems of access (including risk selection) and affordability. These reforms range from rules governing insurance product pricing and guaranteed issue to facilitating pooling mechanisms. The Federal HIPAA legislation also took a modest step to address problems of access (but not affordability) for people leaving group coverage.

Consumers in the individual market are presumed to be unable to purchase health insurance through a group either because they are self-employed, retired or unable to work. Individual insurance consumers are, on average, significantly older than workers and their dependents with group coverage, the average costs of marketing and administration are greater, and unmanaged fee-for-service insurance products dominate. As a result, premiums in the individual market are higher than those in the group market for similar benefits. In addition, the tax subsidies to workers insured in the group market are not available to consumers in the individual market. Taken together, these factors make individual insurance products unaffordable to many, possibly increasing the ranks of the uninsured.

The purpose of this seminar is to bring together senior level State policy makers to develop a better understanding of the individual insurance market, the needs it should serve, and the impact of reforms implemented to date. Examples of several States will be used to illustrate successes and failures of reform activities in this market. In addition, the seminar will address how the market might respond to the various policy options currently being discussed. The seminar will include discussion of the desirability and likely impact on the individual market of policy proposals recently enacted or currently being discussed, including enhancing HIPAA by requiring rate regulation, increasing premium deductions for the self-employed and individuals, Health Marts, Medicare + Choices, and offering individual purchasers under age 65 a plan with benefits similar to those offered under Medicare.

The seminar will address the following kinds of questions:

Structure of the Individual Insurance Market:

What does the individual market look like now? Who is buying? What benefits are included? How much choice does the purchaser have? What problems have been identified, e.g., risk selection, price, etc., in the market? In general, what factors drive individuals' participation rates in the market, and what kinds of reforms will improve participation?

Market Dynamics:

How is the individual market different from other insurance markets — from the small group market? from the employer-based market? Why do insurers behave differently with respect to the individual market? Is there evidence of adverse selection in the individual insurance market?

Regulatory Reforms:

What attempts have been made to improve the individual market and what are the impacts to date of Federal reform (HIPAA) and State reform efforts in NJ, NY, and WA? Is there evidence that these types of reform are addressing the identified problems and/or the needs of the uninsured? What are the effects of State-wide reforms on insurance agents and brokers working in the individual market?

Policy Options:

What are the possible impacts of recently discussed policy interventions? What problems are likely to be fixed by moving people into the individual market?

Audience

The intended audience for this seminar includes senior level State officials in the executive or legislative branches of government who are responsible for policy development and/or implementation related to health insurance regulation, market reforms, and strategies to improve access and affordability of health coverage. The seminar may be of particular interest to governors' health policy advisors, insurance commissioners and senior staff, Medicaid officials, and health department staff involved with efforts to expand health insurance coverage.

Presents

The Individual Insurance Market: Performance and Potential

A Seminar for State Executive and Legislative Officials

*Renaissance Atlanta Hotel
Atlanta, Georgia
May 3 - 4, 1999*

Narrative Agenda

Session 1: **Welcome, Introductions, and Overview of Seminar**

Date and Time: Monday, May 3, 8:30 a.m. - 9:00 a.m.

Presenters: Marcia Clark
Senior Program Analyst
User Liaison Program
Agency for Health Care Policy and Research (AHCPR)
U.S. Department of Health and Human Services
Rockville, Maryland

Deborah Chollet, Ph.D.
Vice President
Alpha Center
Washington, DC

Content: This opening session will serve to introduce the program and the participants.
It will:

- Highlight AHCPR's role in health policy and health services research
- Introduce participants, presenters and resource persons
- Review the seminar objectives and format

Session 2: **Introduction to the Individual Insurance Market**

Date and Time: Monday, May 3, 9:00 a.m. - 10:00 a.m.

Presenter: Deborah Chollet
Alpha Center

Content: This session will focus on the demographics, trends, and structure of the individual insurance market. The presenter will examine who is in the market and how they compare demographically with the uninsured and employer-insured populations.

Key Questions:

- Why is individual health insurance important?
- Who buys insurance in the individual market?
- What kinds of insurers offer products in the individual market?
- What else should legislators and regulators know about the individual market to improve public policy making?

Session 3: Black Boxes in Individual Insurance: Underwriting and Marketing Practices

Date and Time: Monday May 3, 10:00 a.m. - 11:00 a.m.

Presenter: William Lindsey
President
Benefit Management and Design, Inc.
Denver, CO

Content: This session will focus on two poorly understood aspects of individual health insurance industry practice: underwriting and marketing. It will examine practices prevalent in the industry and examine the ways in which those practices shape the market.

Key questions:

- What role do agents play in this market, and how do insurers make decisions about marketing and distribution channels?
- Do insurers market to niches within this already small market, and if so, why, and on what basis do they select those niches?
- What are the costs of marketing and underwriting in this market?
- How do insurers arrive at their underwriting criteria, and to what degree do they adhere to them? How have underwriting practices changed over time?
- How do State reform efforts affect underwriting and marketing practices?

Session 4: Dynamics of Individual Market Reform

Date and Time: Monday, May 3, 11:15 a.m. - 12:30 p.m.

Presenter: Len Nichols, Ph.D.
Principal Research Associate
The Urban Institute
Health Policy Research Center
Washington, DC

Content: This session will focus on how individual insurance reforms work: the interrelationships between insurer, consumer, and regulator behavior in the individual insurance market. It will discuss State regulations that have shaped the current structure and function of the market.

Key questions:

- How do the States regulate the individual insurance market relative to the small group market?
- What research is available to inform insurance policy makers about the effects of individual market reform?

Session 5: Experience with Market Wide Reforms

Date and Time: Monday, May 3, 1:30 p.m. - 3:00 p.m.

Presenters: Adele Kirk
Associate
Alpha Center
Washington, DC

State official from NY (TBA)

Content: This session will provide an overview of State experiences with market-wide reforms, focusing on the experience of States that have implemented guaranteed issue and some form of community rating in their individual markets. Washington, Kentucky and New York will be featured.

Key questions:

- What prompted these States to enact reforms, and what was the context for reform?
- What reforms did each State enact, and how were they implemented?
- What were the effects of reform on access, rates, products, and market structure?
- What lessons might these States offer to States contemplating similar reforms?

Session 6: Experience with High-Risk Pools

Date and Time: Monday, May 3, 3:15 - 5:00 p.m.

Presenters: Lynn R. Gruber (*Invited*)
President, Minnesota Comprehensive Health Association
Chair, National Association of State Comprehensive Health Insurance Plans (NASCHIP)
St. Louis Park, MN

Sally Stearns, Ph.D.
Assistant Professor
University of North Carolina
Department of Health Policy Administration
Chapel Hill, NC

Content: More than half the States have implemented high risk pools for individuals denied coverage in their individual markets, and many of these States are using their high risk pools as their HIPAA individual portability mechanism. Although some States have implemented high risk pools as their sole or primary individual market reform, others such as Iowa and Utah have combined risk pools with other access reforms. This session will highlight experiences in MN, CA, and CT.

Key questions:

- How do high risk pools interact with and affect the functioning of the individual market?
- How well do they meet the needs of individuals denied coverage in the market?
- How have States addressed risk pool policy decisions such as funding mechanism, benefits, and subsidy level, and how have those decisions influenced the State's risk pool experience?

Session 7: Coupling Group and Individual Markets

Date and Time: Tuesday, May 4, 8:30 a.m. - 10:15 a.m.

Presenter: Kathy Swartz, Ph.D.
Associate Professor
Harvard University
Department of Health Policy and Management
Boston, MA

Nancy Turnbull (*Invited*)
Chair of the Massachusetts Nongroup Health Insurance Advisory Board
Brookline, MA

Content: This session will examine the experience of States that have combined market-wide individual market reforms with provisions to “couple” their individual and group markets by requiring insurers in the group market to also participate in the individual market.

Key questions:

- What motivated these States to link their group and individual markets?

- What has been the reform experience of these States, and how has it been shaped by the participation of group insurers?
- What lessons might these States offer to other States?

Session 8: Options for Federal Reform and Implications for States

Date and Time: Tuesday, May 4, 10:30 a.m. - 11:45 a.m.

Presenter: Karen Pollitz
Project Director
Georgetown University
Institute for Health Care Research and Policy
Washington, DC

Content: This session will examine proposed policy interventions under discussion at the Federal level. HIPAA rating reform and tax preferences for consumers in the individual market will be among those discussed.

Key questions:

- How can group market delivery systems and financing structures be applied to the individual market, in order to better distribute risk?
- What is the optimal policy solution... “fixing” the individual market, thereby reducing or eliminating risk selection, or providing incentives for movement into groups (e.g., the formation of associations)?
- What implications might individual market reforms have for the uninsured? Who will not be able to afford to purchase coverage even in an expanded group market?
- How will these proposals be financed? How would individual tax preferences be supported? What would be the impact of the revenue reductions?
- What lessons have the Federal government and the States learned from HIPAA implementation?

Session 9: Evaluation and Concluding Comments

Date and Time: Tuesday, May 4, 11:45 a.m. - 12:00 noon

Presenter: Marcia Clark
AHCPR

Content: Participants will be invited to make concluding comments about the seminar and their need for additional follow-up activities. Future workshops of the User Liaison Program will be previewed. Finally, participants will be asked to complete an evaluation form.

The User Liaison Program Presents
THE ULP MASTERS SEMINAR SERIES

The First in a Series of Invitational Masters Seminars
for Senior State Officials

**WHAT CAN STATES DO TO FOSTER
REENGINEERING
OF THE HEALTH CARE DELIVERY SYSTEM?**

*Adam's Mark Hotel
Denver, Colorado
February 16-17, 1999*

Facilitated by Alpha Center

*U.S. Department of Health and Human Services
Agency for Health Care Policy and Research
WEBSITE: www.ahcpr.gov
Office of Health Care Information*



*...Bridging the gap between
researchers and policymakers...*

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ULP TELEPHONE: (301) 594-6668 ULP FAX NUMBER: (301) 594-2035

DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. Public Health Service
AGENCY FOR HEALTH CARE POLICY AND RESEARCH
USER LIAISON PROGRAM



***** **MASTERS SEMINAR SERIES** *****

By Invitation Only

**WHAT CAN STATES DO TO FOSTER REENGINEERING OF THE
HEALTH CARE DELIVERY SYSTEM?**

SEMINAR COST: \$175.00

WHEN: February 16-17, 1999

WHERE: Adam's Mark Hotel
1550 Court Place
Denver, CO 80202
Tel: (303) 893-3333
Fax: (303) 626-2543

REGISTRATION: Registration is on a first-come, first-served basis. Because space is limited, please fax the preliminary registration form to Serena Toro, AHCPR at (301) 594-2035 as soon as possible to reserve your spot. **REMEMBER TO DRESS CASUALLY!**

AIRLINES: United Airlines is the official airline of this AHCPR Masters Seminar. If you, or your travel agent, call United's toll-free number (1-800-521-4041) to book your reservations, you will receive a 5% discount off the lowest applicable discount fare, or a 10% discount off full-fare unrestricted coach fares, purchased 7 days in advance of your travel date. Discounts also apply on shuttles by United and United Express. Call United Specialized Meeting Reservations Center at 1-800-521-4041 to obtain best fares and schedule information. Please call Karen Samuels, Alpha Center at (202) 296-1818, for the Meeting ID Number.

PAYMENT DUE: Payment of \$175.00 is due by Friday, January 15, 1999. This payment includes: lodging for Tuesday night, February 16; meals beginning with dinner on February 16 and ending with lunch on February 17; and workshop materials. Credit cards are not accepted. Checks should be made payable to the Alpha Center, and mailed to along with the payment form to:

Karen Samuels, Office Manager
Alpha Center
1350 Connecticut Avenue, Suite 1100
Washington, DC 20036
Phone: (202) 296-1818 Fax: (202) 296-1825

Presents

What Can States Do to Foster Reengineering of the Health Care Delivery System?

A Masters Seminar for Senior State Executive and Legislative Staff

Adam's Mark Hotel

Denver, Colorado

February 16-17, 1999

OVERVIEW

Several "reengineering" advances underway hold promise for improving quality and customer service, gaining efficiencies which may improve the affordability of health services, or enhancing the quality of clinical services by incorporating the newest technological advances. These reengineering advances generally have been initiated by providers or purchasers. However, some policymakers are seeking ways of identifying sentinel reengineering advances and promoting those that can further their goals of protecting consumers, expanding access, and ensuring that quality of care standards are maintained. While many changes are occurring without the need for government intervention, others may require States to change current laws, regulations, and/or other practices.

Given the dramatic changes that have swept the health care delivery system in recent years, some health care prognosticators believe that the next major wave of health care market efficiencies will be achieved only by changing the actual processes by which health care is provided. For example, Russ Coile, editor of *Health Trends* newsletter, believes that health facilities of the future will focus on new models of care, innovative services, and alternative settings, such as "lite" hospitals (which offer an array of ambulatory and postacute services), mega-emergency departments, and complementary/alternative medicine clinics.

According to Dr. Arnold Milstein, medical director for the Pacific Business Group on Health, the kinds of reengineering changes which have to date been adopted in response to pressure from purchasers are akin to "crash dieting"-- cutting out excess services and squeezing prices. On the horizon, however, he sees that the next generation of improvements will need to focus on fundamental changes -- analogous to "life style changes" -- whereby health professionals reshape the actual way in which care is delivered. Rather than focusing on doing fewer of the same old things faster, or at lower contract prices, reengineering innovations should engage the patient differently (such as via telephone or in groups), use new kinds of specialists (such as case managers, health educators, or allied health professionals rather than physicians), and/or reorganize work processes and information flows.

In the landmark study of health care integration, *Remaking Health Care in America*, Steve Shortell of Northwestern University and colleagues describe the characteristics of eleven of the nation's leading health care delivery organizations. They discuss how successful organizations are pursuing functional integration (coordinating the system's components), physician integration (linking doctors with the system), and clinical integration (maximizing patient value).¹

While observing that none of the organizations they studied yet meet the full definition of integration, they assert that public policies designed to ensure or accelerate these processes can be categorized into two groups: those that remove current barriers to forming integrated systems, and those that actively promote or provide incentives for forming such systems.² Barriers needing attention include the licensing or certification of health professionals and antitrust laws and regulations. Possible incentives include developing common financial incentives, providing a coordinated benefits package, producing new types of health professionals, and others.

Numerous examples of reengineered systems are already in place, but others may be hampered by State laws or practices designed for an earlier era. For example, even as some delivery systems are developing new, effective “disease management” protocols for select conditions, other delivery systems may not be embracing them. Are there ways for State policymakers to encourage their adoption? While many States have narrowed the range of their certificate of need (CON) laws, do the remaining restrictions hamper the development of useful and efficient high-technology services? Similarly, are licensing requirements for health care facilities and/or professionals constraining new organizational arrangements and professional duties?

The following are other examples of reengineering advances and the kinds of public policy questions they might trigger.

- ***Integrated care providers:*** As hospitals re-invent themselves to adapt to the new market place, some are seeking exemptions from certain restrictive State rules for staffing levels and professional qualifications. Could States develop a new kind of “integrated care provider” category?
- ***Disease management programs:*** For selected conditions, such as HIV infection or congestive heart failure, new treatment methods and patient education processes are reducing costs and improving health outcomes. How can Medicaid and State benefits agencies support these disease management programs?
- ***Systematic self-management education and telephone advice programs:*** With new technologies and growing emphasis on encouraging individuals to take more responsibility for their own health, some programs are lowering costs and improving patient satisfaction. How can States respond to the development of these programs?
- ***“Hospitalists”:*** The development of a new type of medical specialty for physicians who focus solely on providing inpatient care is generating large reductions in hospital utilization without measurable reductions in quality or patient satisfaction. What new licensure and/or credentialing standards may be needed? What are the implications for medical education and residency training?
- ***Community health improvement:*** Some providers are actively engaging schools, churches, social service agencies in the delivery of health care services and health education programs, focused on domestic violence, teen pregnancy, or bicycle/helmet safety. How can resources used to purchase health plan coverage be channeled into these population-based interventions? To what extent should such activities qualify as “public benefits” in considering the nonprofit status of health care organizations?

The purpose of this seminar is to explore what States can do to foster reengineering of the health care delivery system. Specific objectives include the following:

- Describe the concept of health care delivery system reengineering and provide examples of specific innovations.
- Identify ways in which current public policies may impede potentially useful reengineering advances and how such barriers can be reduced or eliminated.
- Discuss incentives States can use to promote positive changes in the health care delivery system (e.g., demonstrations).
- Discuss the implications of these changes for State policy, especially in the areas of insurance regulation, public health, assuring access to services for vulnerable populations, and purchasing for public employees and Medicaid enrollees.
- Discuss how State policymakers can become aware of new and significant reengineering advances and assess the implications for public policy on an ongoing basis.
- Identify possible questions for further research.
- Create an opportunity for peer-to-peer interaction among senior-level State health policymakers to share State their knowledge with one another.

Participants:

This masters seminar will provide an intensive and interactive forum for approximately 25 senior State executive and legislative staff and selected practitioners and researchers. Invited researchers will assist in translating the needs of policymakers into new ideas for research, an intended byproduct of the meeting.

Featured Speakers/Resource Persons:

Russell C. Coile, Jr., M.B.A.

Mr. Coile is managing partner and senior vice president of strategic planning for Superior Consultant Company, Inc.-- Chi Systems Practice. Based in Dallas, Superior is an integrated healthcare consulting firm specializing in strategy, operations, facility planning, information technology, and outsourcing, with more than 1,000 clients across the United States. Mr. Coile provides market forecasts, strategic planning and managed care strategies for provider-sponsored organizations, health plans and suppliers on a nationwide basis. In the past year, Mr. Coile has participated in over 100 seminars for groups including: American Hospital Association; American College of Health Care Executives; and Rand Healthcare Roundtables. He holds a B.A. from Johns Hopkins University and an M.B.A. in Health Services administration from the George Washington University.

Arnold Milstein, M.D., M.P.H.

Dr. Milstein directs the national clinical consulting practice at William M. Mercer, Inc. and is the Medical Director of the Pacific Business Group on Health. His work focuses on improving managed care programs for providers, large purchasers, insurers and government. His articles which have encompassed quality measurement, behavioral health and workers compensation performance evaluations, have been published in *Barron's*, *HMO Magazine* and the *New England Journal of Medicine*. Business Insurance magazine selected him as "one of the 20 people who has made a difference in employee benefits management in the past 20 years."

Dr. Milstein holds a B.A. in economics from Harvard, an M.D. from Tufts and an MPH in health services planning from UC-Berkeley.

1. Stephen M. Shortell, Robin R. Gillies, David A. Anderson, Karen Morgan Erickson, and John B. Mitchell. *Remaking Health Care in America*. San Francisco: Jossey-Bass Publishers, 1996, page vii.

2. Ibid, page 292-300.

Presents

What Can States Do to Foster Reengineering of the Health Care Delivery System?

A Masters Seminar for Senior State Executive and Legislative Staff

*Adam's Mark Hotel
Denver, Colorado
February 16-17, 1999*

Narrative Agenda

Session 1: Welcome, Introductions, and Overview of Workshop

Date and Time: Tuesday, February 16, 2:00 p.m. - 2:30 p.m.

Presenters: Sandra Isaacson, M.S.N., M.B.A.
Director
User Liaison Program
Agency for Health Care Policy and Research (AHCPR)
U.S. Department of Health and Human Services
Rockville, Maryland

David Helms, Ph.D.
President
Alpha Center
Washington, DC

Content: This opening session will serve to introduce the program and the participants. It will:

- Highlight AHCPR's role in health policy and health services research
- Introduce participants, presenters and resource persons
- Review the seminar objectives and format

Session 2a: Major Trends and Forecasts for the Future of the Health Care System

Date and Time: Tuesday, February 16, 2:30 p.m. - 3:30 p.m.

Presenter: Russell Coile Jr., M.B.A.
Senior Vice President
Superior Consultant Company, Inc.
Dallas, Texas

- Content:** This session will lay out the major themes that will have an affect on the American health care system in the next five to ten years. It will:
- Describe major trends in the health care sector, including both financing and delivery system changes.
 - Discuss key aspects of delivery system integration, including clinical rationalization, market consolidation, and cost competitiveness.
 - Highlight how these trends can vary by region of the country

Session 2b: Discussion

Date and Time: Tuesday, February 16, 3:45 p.m. - 4:45 p.m.

Content: Participants will have an opportunity to discuss how they see these trends playing out in their States.

Session 3a: Evolving Roles for the States in the Health Field

Date and Time: Tuesday, February 16, 5:00 p.m. - 5:30 p.m.

Presenter: David Helms
Alpha Center

Content: This session will illustrate how traditional State roles are evolving to meet current needs and anticipate future developments. It will:

- Briefly review traditional State roles in the health care field
- Outline challenges to States presented by current trends in the health care delivery environment

Session 3b: Discussion

Date and Time: Tuesday, February 16, 5:30 p.m. - 6:00 p.m.

Content: Participants will have an opportunity to discuss what role they think their States will want to play in shaping the system.

Session 4a: The Need and Potential for Reengineering the Health System

Date and Time: Wednesday, February 17, 8:00 a.m. - 9:00 a.m.

Presenter: Arnold Milstein, M.D., M.P.H.
Managing Director
William M. Mercer, Inc.
San Francisco, CA

Content: This session will define the concept of delivery system “reengineering” and provide examples of reengineering advances that hold promise for improving the quality and reducing the cost of health care services. The presenter will draw examples from different domains such as:

- Systematic identification and management of high risk individuals.
- Elevating the patient to partner in the care management process.
- Changing the protocols for inpatient and outpatient care.

Session 4b: Discussion

Date and Time: Wednesday, February 17, 9:00 a.m. - 10:00 a.m.

Content: Participants will have the opportunity to discuss the nature of these and other reengineering possibilities.

Session 5: What Can States Do to Foster the Most Promising Delivery System Reengineering Innovations?

Date and Time: Wednesday, February 17, 10:15 a.m. - 12:00 p.m.

Moderator: David Helms
Alpha Center

Panelists: Russ Coile, Superior Consultant Company, Inc.
Arnie Milstein, William M. Mercer, Inc.

Content: Participants will be led through a facilitated discussion to identify how State policymakers can promote reengineering advances they view as positive. Using examples of delivery system innovations presented earlier, participants will discuss:

- How States can use traditional roles and levers to foster reengineering of the delivery system;
- How to learn about other innovations being tested; and
- How to harvest the innovations best fitting the policy goals of their State.

Session 6: What Are the States' Needs for Further Research and Policy and Technical Support/Assistance to Foster Delivery System Reengineering?

Date and Time: Wednesday, February 17, 12:30 p.m. - 1:45 p.m.

Moderator: Sandra Isaacson
 ULP/AHCPR

Presenters: Ross H. Arnett III, Ph.D.
 Director, Center for Cost and Financing Studies
 AHCPR

Irene Fraser, Ph.D.
Director
Center for Organization and Delivery Studies
AHCPR

Content: Participants will have the opportunity to identify/suggest research questions for which they need answers to facilitate their decisionmaking process and technical support needs that could aid implementation of innovative changes in their States. To inform this discussion, the presenters will:

- Present current findings from AHCPR's health care studies.
- Highlight current delivery system research projects conducted or supported by AHCPR.
- Elicit participant feedback about what information research participants believe they need to support their decision making.

Session 7: Evaluation and Concluding Comments

Date and Time: Wednesday, February 17, 1:45 p.m. - 2:00 p.m.

Presenter: Sandra Isaacson
 ULP/AHCPR

Content: Participants will be invited to make concluding comments about the new Masters Series Seminar and what additional topics should be included in the series. Future ULP workshops/seminars scheduled for 1999 will be previewed. Participants will be asked to complete a seminar evaluation form.



U.S. Department of Health
and Human Services

ULP WORKSHOP OVERVIEW AND AGENDA

U.S. Public Health Service

Agency for Health Care Policy and Research

WEBSITE: www.ahcpr.gov

Office of Health Care Information
The User Liaison Program

Presents:

The Uninsured and the Safety Net: Trends and Challenges

A WORKSHOP FOR STATE AND LOCAL HEALTH POLICYMAKERS

Facilitated by:

Alpha Center
Washington, D.C.

Wilshire Grand Hotel
Los Angeles, California
March 10-12, 1999

ULP WORKSHOP OVERVIEW AND AGENDA

*...Bridging the gap between
researchers and policymakers...*

2101 EAST JEFFERSON STREET, ROCKVILLE, MD 20852

ULP TELEPHONE: (301) 594-6668

ULP FAX NUMBER: (301) 594-2035



USER LIAISON PROGRAM WORKSHOP**THE UNINSURED AND THE SAFETY NET: TRENDS AND CHALLENGES****WORKSHOP COST: \$530.00****WHEN:** March 10-12, 1999**WHERE:** Wilshire Grand Hotel
930 Wilshire Boulevard
Los Angeles, California 90017
Tel (213) 688-7777
Fax (213) 612-3987**FULL COST:** \$530.00 (for lodging, group meals, workshop materials, registration fee)**COMMUTER
RATE:** \$205.00 (for breakfast, lunch, and workshop materials)**PAYMENT
DUE DATE:** February 5, 1999**DRESS:** Casual (slacks, tee shirts and casual shoes)

If you need further information, or if you wish to sign up to attend, please send fax to 301-594-2035 or call the User Liaison Program Office at 301-594-6668 BEFORE MAKING YOUR AIRLINE RESERVATIONS.

CANCELLATION POLICY: In the event of cancellation prior to two (2) work days before the start of the workshop, the amount of the first day's expenses is non-refundable. The balance will be returned. **HOWEVER**, if you cancel less than two (2) work days prior to the start of the workshop, you may be required to forfeit the entire amount (or any part thereof) depending on the hotel policy regarding refunds.

Presents

The Uninsured and the Safety Net: Trends and Challenges

A Workshop for State and Local Health Policymakers

Wilshire Grand Hotel
Los Angeles, CA
March 10 -12, 1999

Overview

Now over 43 million, the number of uninsured Americans continues to rise, despite unprecedented economic growth and low unemployment in most parts of the country. After hovering around 17 percent for several years, the proportion of persons under age 65 without health insurance edged above 18 percent in 1997, compared to less than 16 percent a decade ago.¹ Two important contributors to this growing problem have been the erosion in employer-sponsored coverage – especially affecting low-wage workers – and declines in Medicaid caseloads after eligibility was “de-linked” from cash assistance programs in 1996.

Policymakers have long been concerned about the uninsured for many reasons. Compared to the insured population, uninsured persons are sicker when they first present for care, are diagnosed at later stages of disease, are more likely to be hospitalized on an emergency basis, and are more seriously ill upon hospitalization.² The uninsured lack continuity of care and spend more time waiting to receive care than the privately insured. In addition, the growing number of uninsured is further straining the health care “safety net.” Hospitals and community health centers that provide significant levels of charity care to the medically indigent are disadvantaged in competing for managed care contracts compared to institutions that provide less uncompensated care. Compounding these hardships, some safety net providers are also suffering from declining Medicaid enrollments and revenues, further reducing their ability to subsidize care for the uninsured.

Tackling the uninsured problem requires understanding the characteristics of this diverse population. In 1996:

- Over half of the uninsured were in families with incomes below 200 percent of poverty.
- Sixty percent were full-time workers and their families.
- Workers in small firms are less likely to have an employer-sponsored plan, but 22 percent of the uninsured are workers in firms of 1000 or more employees.
- About 25 percent were under age 18.
- In the first half of the year, 33 percent of Hispanics and 23 percent of African Americans were uninsured, compared to 14 percent of other race/ethnicity groups (mostly whites), per AHCPR’s Medical Expenditure Panel Survey.³
- Lack of insurance is much more common in some States than in others, ranging from 9 percent in Wisconsin to 27 percent in Texas in 1997 (see attached table for uninsured rates by State).⁴

Federal and State leaders have attempted to reach this varied population in a number of ways: by extending Medicaid coverage to children and pregnant women in low-income families above poverty and by funding the State Children's Health Insurance Program (SCHIP). State efforts to build on the nation's employer-based insurance system, which provides health insurance for 65 percent of the nonelderly population, have targeted non-insuring small employers. These efforts have included direct subsidies to employers, employer tax credits, exemption from State-mandated benefits (authorizing "bare-bones" insurance plans), and pooled purchasing cooperatives to gain economies of scale in purchasing coverage. Some have subsidized coverage for low-wage workers directly.

Undergirding these efforts are a series of State and Federal health insurance market reforms to prevent health insurers from selecting or "skimming" healthy groups and individuals by rejecting higher-risk groups and individuals who are costly to insure. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established minimum Federal standards for guaranteed issue, guaranteed renewal, and pre-existing conditions exclusions in group and individual health insurance plans. HIPAA authorizes States to enact or retain stricter rules (including restrictions on prices, which HIPAA did not address) and gives the States substantial flexibility in how they comply with the intent of the law.

Two key lessons have emerged from past efforts to expand employment-based health coverage. First, many employers do not offer coverage because they can attract and retain workers sufficiently without doing so. Second, uninsured low-wage workers and their families will require substantial subsidies to afford health insurance on their own. These lessons have prompted a series of proposals to retarget the Federal governments' tax expenditure for the exclusion of employer contributions (an estimated \$71.5 billion in 1998) to subsidize group health insurance for low-wage workers and/or to extend tax incentives for buying individual coverage. Reform that would give individuals rather than employers a tax advantage or incentive to purchase health insurance could have a dramatic affect on both American business and health insurance markets.

This workshop offers a forum for State and local policymakers to examine the problem of the uninsured and to discuss policy options for expanding coverage and securing the safety net serving populations without financial access to health care. Specific workshop objectives include the following:

- Describe the uninsured population and how they vary demographically and geographically from those with health insurance coverage;
- Examine the latest research findings on the uninsured, including the effects on utilization and health status;
- Describe the factors that affect the survival of safety net providers;
- Examine innovative managed care programs for the medically indigent;
- Describe State initiatives and strategies for expanding coverage to uninsured workers; and
- Review key elements of proposed Federal tax reforms to move health insurance deductibility from the employer to the individual, and the potential impact of such changes for State and local governments

Intended Workshop Audience

The intended audience for this workshop includes State and local officials who make policy decisions regarding health insurance coverage and access to care for low income individuals and families. It also includes administrators who run these programs as well as safety net programs that provide health care services to the uninsured directly.

Endnotes:

1. Alpha Center tabulations of the Current Population surveys, March 1998 and 1988.
2. Kaiser Commission on Medicaid and the Uninsured, 1998. *Uninsured in America: A Chart Book*. June.
3. Beauregard, Karen M., Susan K. Drilea, and Jessica P. Vistnes, "The Uninsured in America - 1996," Medical Expenditure Panel Survey, Agency for Health Care Policy and Research, Number 1, May 1997.
4. Alpha Center Tabulation of the Current Population Survey, March 1998.

Uninsured Persons Ages 0 to 64 Years by State (1997)

<u>State</u>	<u>Total Insured</u>	<u>Uninsured</u>	<u>Percent Uninsured</u>	<u>Total Nonelderly Population</u>
Alabama	2,977,043	656,116	18.06%	3,633,159
Alaska	413,555	115,286	21.80%	528,842
Arizona	2,883,226	1,134,532	28.24%	4,017,758
Arkansas	1,596,697	637,264	28.53%	2,233,961
California	22,375,690	7,026,256	23.90%	29,401,946
Colorado	2,890,944	585,834	16.85%	3,476,777
Connecticut	2,452,557	395,514	13.89%	2,848,071
D.C.	362,476	81,640	18.38%	444,116
Delaware	544,423	97,956	15.25%	642,379
Florida	8,884,802	2,794,409	23.93%	11,679,211
Georgia	5,479,360	1,337,644	19.62%	6,817,004
Hawaii	838,789	88,062	9.50%	926,851
Idaho	886,531	223,040	20.10%	1,109,570
Illinois	9,235,598	1,497,712	13.95%	10,733,310
Indiana	4,541,296	665,792	12.79%	5,207,088
Iowa	2,132,870	334,972	13.57%	2,467,842
Kansas	1,867,842	302,754	13.95%	2,170,597
Kentucky	2,830,439	587,221	17.18%	3,417,660
Louisiana	2,825,925	822,528	22.54%	3,648,453
Maine	869,497	179,863	17.14%	1,049,360
Maryland	3,742,063	661,535	15.02%	4,403,598
Massachusetts	4,449,629	749,502	14.42%	5,199,132
Michigan	7,396,752	1,126,737	13.22%	8,523,490
Minnesota	3,862,254	438,171	10.19%	4,300,424
Mississippi	1,866,527	550,450	22.77%	2,416,977
Missouri	3,873,520	666,406	14.68%	4,539,926
Montana	603,507	173,514	22.33%	777,021
Nebraska	1,249,610	176,740	12.39%	1,426,350
Nevada	1,190,771	299,357	20.09%	1,490,128
New Hampshire	911,244	141,047	13.40%	1,052,291
New Jersey	5,749,258	1,300,786	18.45%	7,050,044
New Mexico	1,223,774	412,683	25.22%	1,636,456
New York	12,534,716	3,140,358	20.03%	15,675,074
North Carolina	5,184,690	1,137,287	17.99%	6,321,978
North Dakota	432,859	96,596	18.24%	529,455
Ohio	8,449,451	1,283,551	13.19%	9,733,002
Oklahoma	2,192,949	590,593	21.22%	2,783,542
Oregon	2,492,064	433,116	14.81%	2,925,180
Pennsylvania	9,029,690	1,201,596	11.74%	10,231,287
Rhode Island	686,233	96,453	12.32%	782,686
South Carolina	2,746,564	637,484	18.84%	3,384,048
South Dakota	520,469	82,826	13.73%	603,295
Tennessee	4,146,311	753,548	15.38%	4,899,859
Texas	13,119,457	4,792,495	26.76%	17,911,952
Utah	1,594,072	278,683	14.88%	1,872,755
Vermont	453,539	54,709	10.76%	508,248
Virginia	4,901,484	838,968	14.62%	5,740,451
Washington	4,512,227	648,291	12.56%	5,160,518
West Virginia	1,135,132	296,119	20.69%	1,431,251
Wisconsin	4,092,675	408,471	9.07%	4,501,147
Wyoming	349,140	76,455	17.96%	425,595
	191,582,191	43,108,922	18.06%	234,691,115

Source: Alpha Center Tabulations of Current Population Survey, March, 1998

Presents

The Uninsured and the Safety Net: Trends and Challenges

A Workshop for State and Local Health Policymakers

*Wilshire Grand Hotel
Los Angeles, California
March 10-12, 1999*

Narrative Agenda

Session 1: **Welcome, Introductions and Overview of the Workshop**

Date and Time: Wednesday, March 10, 8:00 a.m. - 8:30 a.m.

Presenters: Sandra Isaacson, M.S.N., M.B.A.
Director
User Liaison Program
Agency for Health Care Policy and Research (AHCPR)
U.S. Department of Health and Human Services
Rockville, Maryland

W. David Helms, Ph.D.
President
Alpha Center
Washington, DC

Content: This session will provide an opportunity for participants to introduce themselves and briefly share with other attendees their particular interests and responsibilities as they relate to expanding health insurance coverage or securing the safety net. This introductory session will conclude with a brief review of the overall structure of this workshop and highlight the topics to be addressed in each session.

Session 2: **Overview of the Uninsured Problem**

Date and Time: Wednesday, March 10, 8:30 a.m. - 10:15 a.m.

Presenters: Diane Rowland, Sc.D.
Executive Director
The Kaiser Commission on Medicaid and the Uninsured
Washington, DC

Jessica P. Vistnes, Ph.D.
Senior Economist
Center for Cost and Financing Studies
Agency for Health Care Policy and Research (AHCPR)
Rockville, Maryland

Content: This session will review current trends and factors affecting the rate of uninsurance and will present research findings on differences in health care access and health status of the uninsured compared to the population with insurance. The session will conclude with recent highlights from the AHCPR Medical Expenditure Panel Survey (MEPS). The session will examine questions such as:

- Who are the uninsured?
 - Trends, take-up rates, profile
 - The working uninsured
- What are the consequences of being uninsured?
 - Health status and utilization of health services
 - Economic impact, out-of-pocket expenditures
- How does coverage vary across States?

Session 3: **Providing a Social Service/Mission in a Competitive Market: Challenges for the Safety Net**

Date and Time: Wednesday, March 10, 10:30 a.m. - 12:15 p.m.

Presenter: Raymond Baxter Ph.D. (*Invited*)
Senior Vice President
The Lewin Group
Fairfax, VA

Content: This session will present preliminary observations from the IOM study of the Safety Net. This study, funded by the Health Resources and Services Administration (HRSA) and called "The Changing Market, Managed Care, and the Future Viability of Safety Net Providers," examines the impact of Medicaid managed care and other changes in health care coverage on the future integrity and viability of safety net providers operating primarily in ambulatory care and primary care settings. The study explores a series of important questions, such as:

- What is happening to safety net providers in the new market?
- What is happening to people who use safety net providers, in terms of access and health outcomes?
- What are the potential advantages and drawbacks of current trends and policies related to the Medicaid program and managed care?

Session 4: Discussion Groups: Assessing the Safety Net in Your State/Community

Date and Time: Wednesday, March 10, 1:15 - 2:15 p.m.

Content: Participants will meet in small groups and discuss the state of the health care "safety net" and particular challenges facing their State or local community. They will discuss the following kinds of questions:

- Who relies on safety net providers for health care services in your State/community and are their needs being met adequately?
- Who are the principal safety net providers in your jurisdiction and what challenges do they face in serving the uninsured, as well as Medicaid enrollees or other publicly-subsidized populations?
- What strategies are your State/local governments considering for supporting safety net providers?

Session 5: Developing Managed Care Systems for Indigent Populations

Date and Time: Wednesday, March 10, 2:30 p.m. - 4:30 p.m.

Moderator: Daniel Campion
Senior Program Manager
Alpha Center
Washington, DC

Panelists: David Price, M.D.
Director of Education
Kaiser Permanente of Colorado
Denver, Colorado

George Hammond (*Invited*)
Director, Division of Health Care
Hillsborough County Department of Health and Social Services
Tampa, Florida

Rene Santiago
Director, Medicaid Demonstration Project
L.A. County Department of Health Services
Los Angeles, California

Content: This session will provide an overview of model programs currently implementing managed care systems to serve indigent populations including Hillsborough HealthCare and Los Angeles County Medicaid Section 1115 Waiver program. Representatives from these programs will describe the following aspects of their programs:

- History
- Target populations
- Eligibility criteria
- Benefits and services provided
- Financing, including public subsidies where applicable
- Provider networks
- Evidence of program's impact
- Policy lessons learned about program design and implementation

This session will also include a description of research findings from the CU CARE demonstration in Denver and provide a facilitated panel discussion on the policy implications of this and the two operational programs.

Breakfast Roundtable Discussions: Thursday, March 11, 7:30 a.m. - 8:30 a.m.

Session 6: Lessons from State Efforts to Expand Health Insurance Coverage

Date and Time: Thursday, March 11, 8:30 a.m. - 9:45 a.m.

Presenter: David Helms
Alpha Center

Content: This session will provide a framework for understanding State policy options for expanding health insurance coverage. It will review lessons from State health reform initiatives, and describe the “incremental” strategies that leading States are pursuing to build on voluntary, employment-based health insurance systems. Evaluation findings from subsidized insurance programs targeting the working uninsured will be highlighted. The session will also describe the kinds of resources States need in order to design and implement such reforms, including adequate staffing, policy analysis capacity, data systems, and funding, as well as the ability to obtain and maintain political support.

Session 7: Federal Tax Subsidies and Health Coverage

Date and Time: Thursday, March 11, 10:00 a.m. - 11:15 a.m.

Presenter: Lynn Etheredge
Health Policy Consultant
George Washington University

Content: In recent months there has been renewed interest in Federal tax reform measures regarding health coverage. This session will explore the potential impact of proposed tax reforms on the health care system. It will examine proposals that seek to improve economic efficiency; retarget tax subsidies from higher earners to lower earners; and remove the tax code bias toward employment based coverage. It will discuss how States might prepare for such changes that have both short and long-term consequences.

Session 8a: State Strategies for Providing/Financing Health Care for the Uninsured

Date and Time: Thursday, March 11, 11:30 a.m. - 12:45 p.m.

Moderator: David Helms
Alpha Center

Presenters: Mark Reynolds (*Invited*)
Deputy Commissioner
Massachusetts Division of Medical Assistance
Boston, MA

Sandra Shewry
Executive Director
Managed Risk Medical Insurance Board
Sacramento, CA

Content: States that are known for expanding access or coverage to those who are uninsured seldom rely on just one or two approaches; rather, they usually have several different programs, targeted to different categories of people and sometimes to the same categories but with different incomes or circumstances. This first of two sessions, will provide an overview of policies and strategies in Massachusetts and California for addressing the issue of health care for the uninsured, highlighting the relationships between entitlement programs for low-income families/children, voluntary subsidies for individuals or small businesses, insurance market reforms, and incentives for providers to furnish coverage directly to the uninsured.

Session 9: Understanding AHCPR and the User Liaison Program

Date and Time: Thursday, March 11, 2:00 p.m. - 2:15 p.m.

Presenter: Sandra Isaacson
User Liaison Program

Content: This session will describe the overall objectives of AHCPR's User Liaison Program and discuss Agency resources available to State policymakers.

Session 8b: State Strategies for Providing/Financing Health Care for the Uninsured

Date and Time: Thursday, March 11, 2:15 - 3:30 p.m.

Presenters: Mark Gibson
Policy Advisor for Health Care, Human Services and Labor
Oregon Governor's Office
Salem, OR

Anne Weiss
Senior Assistant Commissioner for Health Care Systems Analysis
New Jersey Department of Health and Senior Services
Trenton, New Jersey

Content: States that are known for expanding access or coverage to those who are uninsured seldom rely on just one or two approaches; rather, they usually have several different programs, targeted to different categories of people and sometimes to the same categories but with different incomes or circumstances. This second session will provide an overview of policies and strategies in Oregon and New Jersey for addressing the issue of health care for the uninsured, highlighting the relationships between entitlement programs for low-income families/children, voluntary subsidies for individuals or small businesses, insurance market reforms, and incentives for providers to furnish coverage directly to the uninsured.

Session 10: Medicaid: The Story Behind Recent Enrollment Declines

Date and Time: Friday, March 12, 8:30 a.m. - 9:45 a.m.

Presenter: Mary Jo O'Brien
Vice-President
The Lewin Group, Inc.
Fairfax, VA

Content: The sudden and significant decline in Medicaid enrollment that began in 1995 after 10 years of continual and rapid growth raises the question of cause. Researchers and policymakers are asking if it could be related to welfare reform and the change from AFDC to TANF. When that change occurred, Medicaid and cash assistance were delinked programmatically but may not have been delinked in the minds of potential recipients. This situation presents a challenge to policymakers and program administrators whose objective it is to enroll eligible persons in Medicaid. This session will look at such questions as:

- Is there a relationship between welfare reform and Medicaid enrollment?
- What is the impact of other public policy changes?
- How do economic factors influence the number and characteristics of persons enrolled in Medicaid?

**Session 11: Developing Your Strategy for Expanding Health Care Coverage and
 Securing the Safety Net**

Date and Time: Friday, March 12, 10:00 a.m. - 11:45 a.m.

Moderator: David Helms
 Alpha Center

Resource

Persons: Various presenters from previous sessions

Content: During the first part of this session, participants will divide into breakout sessions to question the "experts" and discuss future strategies/programs for their States. Following the breakout sessions, the large group will reconvene for reporting out and discussing what information/research is needed to help develop a strategy in participants' States.

Session 12: Concluding Comments

Date and Time: Friday, March 12, 11:45 a.m. - 12:00 noon

Presenter: Sandra Isaacson
 User Liaison Program

Content: Participants will be invited to make concluding comments about the seminar and their need for additional follow-up activities. Future workshops of the User Liaison Program will be previewed. Finally, participants will be asked to complete an evaluation form.

HHS

**FY 2000 USAID and HHS Funding
Africa and International (non-Africa)**

PREVENTION

USAID

Africa	\$93.1 million	(70% of \$133 m)
International	\$46.9 million	(70% of \$67 m)
CDC Africa	\$10.25 million	

Subtotal: Africa: \$103.35 million
Intl: \$46.9 million

MTCT

USAID:

Africa	\$6.65 million	(5% of \$133 m)
Int'l.	\$3.85 million	(5% of \$67 m)

CDC: \$2.75 million – Africa

Subtotal: Africa: \$9.4 million
Int'l: \$3.85 million

CARE

USAID

Africa	\$9.31 million	(7% of \$133 m)
International	\$4.69 million	(7% of \$67 m)

CDC Africa \$9 million

Subtotal: Africa: \$18.31 m
Intl: \$ 4.69 m

ORPHANS

USAID: Africa	\$10.64 million	(8% of \$133 m)
International:	5.36 million	(8% of \$67 m)

CAPACITY BUILDING *

USAID

Africa	\$13.3 million	(10% of \$133 m)
International	\$6.7 million	(10% of \$67 m)

CDC Africa \$13 million

Subtotal: Africa: \$26.3 million
Int'l \$6.7 million

Note: Africa Bureau is \$94.6 m + 19.4 m from G Bureau for AFRICA = ¹³³~~114~~ m
Remainder is international (\$67 m)

* Capacity Building includes surveillance



DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental
Health Services Administration

Center for Mental Health Services
Center for Substance Abuse
Prevention
Center for Substance Abuse
Treatment
Rockville MD 20857

FACSIMILE

Lucille C. Norville Perez, M.D., Director

SAMHSA - CSAP

DATE: December 13, 1999

TO: Ms. Sandra Thurman

Fax # 202-456-2439

of Pages 3 (including cover)

Message

Declined


DEPARTMENT OF HEALTH & HUMAN SERVICES
**Substance Abuse and Mental
Health Services Administration**
December 13, 1999
**Center for Mental Health Services
Center for Substance Abuse
Prevention
Center for Substance Abuse
Treatment
Rockville MD 20857**

**Sandra Thurman
Director, White House Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, D.C. 20503**

Dear Ms. Thurman:

Thank you for agreeing to participate in the Substance Abuse Prevention and HIV Prevention New Grantee Meeting sponsored by the Center for Substance Abuse Prevention's Office of Medical and Clinical Affairs (CSAP/OMCA). The meeting will be held at the Grand Hyatt Washington, 1000 H Street, NW Washington, D.C. The telephone number of the hotel is (202) 582-1234. You are scheduled to speak on Wednesday, December 15 from 2:30 to 3:30 p.m. The topic of your presentation is "HIV Infection/AIDS: Update on Advocacy, Policy & Program Development". There are many socio-economic as well as political reasons why African Americans and other communities of color are at greatest risk for HIV disease. Your expertise in HIV/AIDS Policy will be critical for increasing the capacity of these new grantees to provide appropriate services to African American youth, Youth of Color and Women of Color and their children.

The Substance Abuse Prevention & HIV prevention program is the result of funding secured by the Congressional Black Caucus (CBC) to address the health emergency in the African American community caused by HIV disease. The intent of the CBC legislation and its resultant programs are to assist communities of color, and specifically the African American community in leveraging the multi-billion dollar resources that the federal government spends on HIV disease. The CBC has characterized the burden of HIV infection on racial and ethnic minorities as a severe and ongoing crisis which requires both immediate measures and long term commitment to resolve.

The grant program focuses on providing substance abuse prevention and HIV prevention services to African American youth and women of color, with a particular emphasis on building capacity, through training and technical assistance in those communities with the highest incidence rates.

Page 2 - Ms. Sandra Thurman

Funds are provided to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, faith-based entities, and other coalitions and/or partnerships for the purpose of strengthening the integration of substance abuse prevention and HIV prevention services.

The logistical arrangements for the meeting will be provided by JW & Associates. The contact person is Monica Jackson at (301) 495-9471. You will be provided a modest honorarium of \$300.00 plus reimbursement for local travel.

I am looking forward to your presentation on Wednesday, December 15. If more information is needed, please do not hesitate to contact me at (301) 443-5266.

Sincerely,

A handwritten signature in cursive script that reads "Lucille C. Perez" followed by a stylized circular flourish.

Lucille C. Norville Perez, M.D.
Director, OMCA/CSAP



DEPARTMENT OF HEALTH & HUMAN SERVICES

HIV/AIDS Bureau

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

NOV 17 1999

Sandra L. Thurman
Director
The White House
Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, D.C. 20503

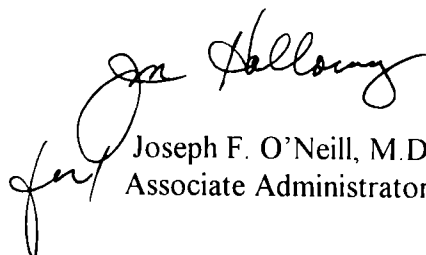
Dear Ms. Thurman:

Thank you for agreeing to speak at our Ryan White CARE Act All Title National Meeting. The meeting will take place from January 18 through January 21, 2000 at the Renaissance Washington, D.C. Hotel. The theme of the meeting is "HRSA's HIV/AIDS Programs: Making a Difference." We expect that about 1,700 people will attend the meeting. Of these, approximately 1,550 will be representatives of 650 CARE Act grantees. The remainder of the people in attendance will be the HIV/AIDS Bureau and other Federal staff.

We would like for you to speak at one of the plenary sessions, when all CARE Act grantee representatives will be in the main ballroom. There will be an opening plenary on Tuesday, January 18, and two luncheon plenaries on Wednesday and Thursday, and a closing plenary on Friday, January 21. We would be pleased if you would speak at the opening plenary on Tuesday, January 18. The plenary will take place from 2:00 p.m. to 4:30 p.m.. Other speakers during this session would be Dr. Fox, Dr. Mindy Fullilove, Dr. Waffa El Sedr, and me. We would be pleased if you could emphasize the Administration's commitment to addressing the problem of HIV/AIDS in America. We will also provide time for a question and answer session.

Please call me if you should have any questions. I would be pleased to talk to you about the meeting and the message that we want to get across to the CARE Act grantees. I can be reached on (301) 443-1993. If I am not available, please call Mr. Robert Soliz of my staff, who is in charge of planning the meeting, who would be pleased to provide you with whatever information you may desire to assist you in planning your presentation. He may be reached on (301) 443-0349.

Sincerely,


Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

OCT 29 1999

Food and Drug Administration
Rockville MD 20857

Dear Colleague:

Dr. Eric Goosby, the Director of the Office of HIV/AIDS Policy at the Department of Health and Human Services, has organized a satellite downlink program to assist the Surgeon General of the United States, David Satcher, M.D., Ph.D., to disseminate two important HIV-related messages to members of the African American community: HIV treatments are available, safe, and effective for combating HIV/AIDS; and full adherence to the dosing regimens of these treatments is necessary to maintain therapeutic effectiveness.

I join Dr. Goosby in inviting you to view the Surgeon General's African American Community HIV/AIDS Satellite Conference on **November 30, 1999, from 4:30 – 6:00 PM, EST**, and ask that you let your constituents know about the event, so that they may take advantage of the program. I also encourage you to consider downlinking the program if you have the capacity, so that others in your local community may view this event.

This satellite conference will be co-hosted by the Tuskegee Bio-Ethics Institute, and four Historically Black Colleges and Universities (HBCU), Meharry, Howard, Drew, and Morehouse, as well as by community-based AIDS Service Organizations that provide care to African Americans living with HIV/AIDS in these HBCU communities.

The objective of this program is to deliver these messages to the African American community, including education, business, faith, civic, and political leaders; public health officials, and people living with HIV/AIDS.

You can find additional information about this program on the Surgeon General's web site, which can be found at <http://www.betah.com/betah/conferences/aids.html>

The conference will also be available on the World Wide Web at the following sites:

Blackfamilies.com

Videocast.nih.gov/

You will need Realplayer to view the webcast version of the program. It can be downloaded free from www.real.com.

The Surgeon General will open the program with a brief message highlighting the conference messages, followed by a discussion HIV prevention, research, care, and adherence issues by a senior federal official. A person living with HIV will discuss their own experiences with currently available therapies, and problems adhering to a treatment plan. The conference will close with a question and answer period, and another brief message from the Surgeon General. Primary viewing sites may also present pre- or post conference activities in addition to the downlink portion of the program.

Please consider hosting a downlink at your institution. The following technical specifications are provided to permit you to downlink this conference at your institution. There is no cost associated with accessing the satellite downlink.

Date	November 30, 1999
Frequency Test	4:00 – 4:30 P.M. EST (to tune to the correct coordinates)
Time	4:30 – 6:00 P.M. EST
Coordinates:	Ku-Band, Telestar 5 /Transponder 19
Downlink Frequency	12053 MHz (V)
Audio Frequency	6.2 / 6.8

For additional information, including viewing sites, please contact Gina Spann, Field Coordinator at BETAH Associates, 301.657.4254, toll-free 1.877.657.4254, or by e-mail at ginas@betah.com

Sincerely,

Richard Klein
Food and Drug Administration

FDA Approves Once-Daily Dosing of Videx **for HIV and Strengthens Label Warnings**

FDA approved, on Thursday, October 28, 1999, a new 200 mg strength of Videx indicated for once-daily dosing. Videx (didanosine, ddI), is a nucleoside reverse transcriptase inhibitor (nucleoside analog) that is prescribed in combination with other antiretroviral drugs for the treatment of HIV infection.

Like other antiviral treatments, Videx helps reduce the growth of HIV, helping the body maintain its supply of CD4 cells, which are important for fighting HIV and other infections.

Simplified regimens, such as once-a-day dosing, may help improve adherence to therapy in patients who are currently being treated for HIV infection with complex, multidrug regimens necessitating dosing several times a day.

Along with the supplemental approval for the once-daily dose of Videx, the already existing product labeling describing possible clinical complications related to pancreatitis is being strengthened.

The manufacturer of the drug, Bristol-Myers Squibb, of Princeton, New Jersey, will be sending detailed safety information about the use of Videx to health care professionals prescribing drugs for treating HIV within the next two weeks. This information will help guide care providers to most safely prescribe the drug and monitor patients.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

DATE: 9/27/00
TO: Sandy Thurman
FAX#: 456-2438

FROM: Dave Sobelman
Office of the Chief of Staff

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

*Secy Shalala's Statement
&
CDC Press Release &
Q's & A's*

7 Pages [including this cover]

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, Sept. 27, 2000

Contact: HHS Press Office
(202) 690-6343

**STATEMENT BY
DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES
Regarding Institute of Medicine Report, "No Time to Lose"**

"The Institute of Medicine report, 'No Time to Lose,' confirms that prevention works and challenges us all to do more to prevent HIV/AIDS. Over the past several years, HIV prevention efforts in the United States have significantly reduced the incidence of HIV infections, even as we've made new strides in research and treatment. Prevention initiatives have helped slow the rate of new HIV infections in the United States from more than 150,000 in the late 1980s to approximately 40,000 today. Specifically, the number of U.S. infants who acquire AIDS from mother-to-child transmission dropped by 75 percent from 1992 to 1998.

"Across the department, several activities are underway to prevent HIV and AIDS. But until we can prevent all new infections, there is still more to do. We must continuously reevaluate our strategies and reexamine the tools and technology at our disposal in the fight to stop the spread of AIDS. We are committed to working together to promote prevention activities that work and to ensuring that prevention is a national priority."

###



EMBARGOED FOR RELEASE: WEDNESDAY, SEPTEMBER 27, 11:00 AM

CDC Statement Following the Release of IOM Report

*Statement from Helene Gayle, M.D., M.P.H., Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention (CDC)*

Our nation's HIV prevention initiatives have helped slow the rate of new HIV infections from more than 150,000 annual infections in the late 1980s to approximately 40,000 annual infections today. The number of infants in the United States who acquire HIV from mother-to-child transmission declined by 75 percent from 1992 to 1998. Yet, at the same time, the HIV epidemic has become increasingly complex and new challenges for HIV prevention have surfaced. The expansion of the HIV/AIDS epidemic to diverse populations, the advent of highly active antiretroviral therapy (HAART), and the emergence of complacency all contributed to the Centers for Disease Control and Prevention's decision last year to undertake a series of steps to reevaluate and refine HIV prevention efforts.

One of the steps CDC took was to commission the Institute of Medicine (IOM) to study HIV prevention in the United States and publish a report to provide a visionary framework for national HIV prevention activities.

The IOM today released the report, *No Time to Lose: Getting More from HIV Prevention*. CDC appreciates the work of IOM and the expert committee they convened to address one of the most complex and critical public health issues facing our nation — the prevention of HIV infection. We welcome the contribution this report can make to an informed public dialogue about HIV prevention and to what we hope will be a renewed national commitment to averting as many HIV infections as possible.

The report makes it clear, first and foremost, that HIV prevention works. CDC applauds that central finding, as it lends further support for the fact that scientifically based prevention is core to winning our nation's battle against HIV and AIDS.

The "visionary framework" of the IOM report includes many important

recommendations. CDC is nearing completion of a new five-year national prevention plan – currently available for public comment -- that addresses many of the issues outlined in the IOM report. CDC's ongoing commitment is to make prevention programs as targeted, relevant, and cost-effective as they can be. We look forward to carefully reviewing the IOM report and engaging our partners at state and local health departments, community-based organizations, and public health, academic and medical institutions in discussions about the detailed recommendations. All of us have an important role to play in once again making HIV prevention a national priority.

#

IOM REPORT ON HIV PREVENTION

Questions and Answers

September 27, 2000

Q1. Do you agree that there is a lack of leadership in HIV prevention at the federal level?

A2 No, not at all. The Clinton-Gore Administration has always supported HIV prevention activities and HHS and its agencies are working to create further strategies for addressing HIV prevention in the United States.

The Institute of Medicine report, "No Time to Lose," confirms that prevention works and challenges us all to do more to prevent HIV/AIDS. Over the past several years, HIV prevention efforts in the United States have significantly reduced the incidence of HIV infections, even as we've made new strides in research and treatment. Prevention initiatives have helped slow the rate of new HIV infections in the United States from more than 150,000 in the late 1980s to approximately 40,000 today. Specifically, the number of U.S. infants who acquire AIDS from mother-to-child transmission dropped by 75 percent from 1992 to 1998.

Across the department, several activities are underway to prevent HIV and AIDS. But until we can prevent all new infections, there is still more to do. We must continuously reevaluate our strategies and reexamine the tools and technology at our disposal in the fight to stop the spread of AIDS. We are committed to working together to promote prevention activities that work and to ensuring that prevention is a national priority.

Q2. Has the IOM report caused you to reconsider your policy on needle exchange programs?

A2. No. The Secretary of Health and Human Services, after consultation with her scientific advisers, determined in 1998 that the scientific evidence shows that needle exchange programs reduce the risk of HIV infection, and do not encourage the use of illegal drugs.

The Administration decided at that time that the best course of action was to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from science so that communities can construct the most successful

programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Q3. What is your policy on abstinence-only programming and has your view changed in light of IOM's recommendation that rules mandating that public funds be used solely for abstinence-only education be removed?

A3. We believe that abstinence is a key part of our prevention strategy. We also believe that communities, schools, and parents are best able to determine the needs of children - not Washington, and that local governments must be allowed to design programs that are right for them. But it is simply not acceptable - emotionally, physically, and financially - for 14-year-olds and 15-year-olds to be having sex and having children. We must all send the strongest possible message to teens, as the welfare law signed by President Clinton does, that postponing sexual activity, staying in school, and preparing for work are the right things to do.

The "Abstinence Only Education Program," passed as part of the welfare reform bill, enables states to provide abstinence education through activities such as mentoring, counseling, and adult supervision. The program, administered by the Health Resources and Services Administration (HRSA), has a mandatory appropriation of \$50 million for each Fiscal Year from 1998 through 2002.

In addition, for more than 12 years, CDC has provided funds for state education agencies and 18 large urban education agencies, as well as a wide range of national non-governmental organizations, to prevent HIV infection among our nation's young people. CDC, through these agencies, has worked to increase the percentage of young people who do not engage in sexual intercourse and to increase the percentage of those who do engage in intercourse to use condoms. We believe that such programs should be locally determined and should be consistent with community values.

Q4. Do you agree with IOM's recommendations?

A4. We look forward to carefully reviewing the report and engaging our partners at state health departments, community-based organizations and public health, academic and medical institutions in discussions about the detailed recommendations.

We share the view that we must not become complacent in the fight against HIV and agree that the changing demographics of the epidemic call for us to reevaluate our strategies and reexamine the tools and technology at our disposal in the fight to stop the spread of AIDS. That is why we requested that IOM conduct this study, and we welcome this new report as an important contribution to a renewed national commitment to responding to the AIDS epidemic.

September 27, 2000 5:10 PM
FOR INTERNAL USE ONLY

The report makes it clear, first and foremost, that HIV prevention works. I applaud that central finding, as it lends further credence to the fact that scientifically based prevention is core to winning our nation's battle against HIV and AIDS.

Office of HIV/AIDS Policy

Office of Public Health and Science
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel. (202) 690-5560



☐ Room 736-E

Fax. (202) 690-6584

Fax. (202) 690-7560

TO:

Cheryl / Sandy / Richard

FAX:

FROM: Deborah von Zinkernagel
Deputy Director

(This fax contains _____ page(s) + cover)

*I told Ray Beth Donohue w'd
"send this over to you" this morning.
Unfortunately, this is the best
part of the report.*

If there are any problems with this transmission, please call Terrie Alvarez at (202) 690-5560

No Time to Lose:

Getting More from HIV Prevention

Committee on HIV Prevention Strategies in the
United States

Division of Health Promotion and Disease Prevention

Monica S. Ruiz, Alicia R. Gable, Edward H. Kaplan,
Michael A. Stoto, Harvey Fineberg, and
James Trussell, *Editors*

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C.

Executive Summary

Two decades after the first case of the acquired immunodeficiency syndrome (AIDS) was recognized in the United States, the nation does not have a comprehensive, effective, and efficient strategy for preventing the spread of the human immunodeficiency virus (HIV). The need for such a plan is becoming even more pressing as, ironically, advances in treating AIDS have helped foster a growing sense of complacency in many sectors of both the government and the general public, as well as in some populations of HIV-infected persons and those at high risk of becoming infected. Improved treatment is critically important, and efforts should be continued to extend such advances. With better treatment, more Americans are living with HIV/AIDS than ever before. However, this creates more opportunities for transmitting the virus and thus a greater need for prevention. Therefore, it is time—indeed, past time—for the nation to adopt a coordinated set of strategies to prevent the spread of HIV/AIDS. We must learn from our past successes, as well as from our failures, in prevention and we must focus prevention efforts on those individuals and communities who are increasingly affected by the epidemic.

By the end of 1999, a total of 733,374 AIDS cases and 430,411 AIDS-related deaths had been reported in the United States (CDC, 2000). During the first decade of the epidemic, the number of new AIDS cases increased by 65–90 percent each year (CDC, 1996). In 1996, the number of new AIDS cases and deaths fell for the first time in the history of the epidemic (CDC, 1997). By 1998, the number of AIDS deaths had declined by almost two-thirds from the 1995 record high (CDC, 2000). These declines can be attributed to advances in antiretroviral therapies (CDC, 1999a) and, in part, to a number of HIV prevention efforts carried out by federal, state, and local government agencies, nonprofit organizations, and the private sector. Most notable were prevention efforts that led to: changes in sexual behavior among men who have sex with men, reduced transmission among injection drug users, increased the safety of the nation's blood supply, and reduced perinatal transmission from infected mothers to their children. Recent data suggest that the declining trends in AIDS incidence and deaths may be stabilizing, however.

Despite the enormous successes in HIV prevention over the past decade, there are additional prevention challenges. The populations that need to be reached by prevention interventions have changed considerably. Women, youth, and racial and ethnic minorities now account for a growing proportion of new AIDS cases, and increasing numbers of cases are emerging in rural and smaller urban areas (CDC, 2000), whereas many prevention programs have previously focused on gay white men in major metropolitan areas. In addition, an increasing proportion of new

HIV PREVENTION

AIDS cases are now being linked to heterosexual exposure, while a declining proportion of new cases are being attributed to men who have sex with men. Men who have sex with men still remain the largest exposure group, however (CDC, 2000). These new at-risk populations are not being reached for prevention as effectively, or on as large a scale, as at-risk populations have been in the past, and prevention programs tailored to specific social contexts of an earlier period in the epidemic are not proving as effective during the current period.

As a result of such challenges, the Centers for Disease Control and Prevention requested that the Institute of Medicine convene a committee to review current HIV prevention efforts in the United States, to develop a visionary framework for a national HIV prevention strategy that could significantly reduce new infections, and to suggest the roles that public and private-sector agencies should have within this framework. The Committee examined the available evidence, and received much useful information and advice from federal, state, and local agencies, as well as from community organizations involved in research on HIV prevention and in implementing HIV prevention programs. The Committee's review revealed several important findings.

Above all, HIV prevention works: there is a wide range of proven strategies to reduce behaviors that increase the risk of transmitting or acquiring HIV. However, the ways in which prevention efforts are currently being implemented do not allow the nation to fully reap the benefits of these proven strategies. The Committee identified a number of problems.

First, expenditures on HIV prevention activities appear to be allocated to states in rough proportion to the distribution of persons with AIDS. If the goal were to increase access to HIV treatment, this basis for distributing resources would be very reasonable. But, this distribution model does not facilitate the *prevention* of new HIV infections, nor does it take into account the effectiveness or costs associated with prevention interventions. Second, due to long-standing concerns about AIDS-related stigma and discrimination, prevention efforts have largely avoided interventions directed at individuals who are HIV-infected, the very persons who are in a unique position to stop the spread of HIV. Third, community organizations that try to conduct prevention programs are often hampered by inadequate dissemination of state-of-the-art prevention research and limited technical assistance for program adaptation, implementation, and evaluation. Fourth, neither the public nor the private sector has invested sufficiently in developing new biomedical tools and technologies that can help in HIV prevention. Finally, social barriers, such as poverty, racism, gender inequality, and the stigma attached to HIV and AIDS, continue to seriously impede HIV prevention efforts.¹

The Committee also found that there is a definite lack of federal leadership with regard to HIV prevention. While the Committee does not focus in this report on the role of federal leadership, we are well aware that there have been longstanding problems related to such issues as agency organizational and structural factors and the lack of intra- and interagency coordination. Many different agencies now share responsibility for federal HIV prevention activities (see Appendix C). These agencies are funded through different sources, serve different constituents, have programmatic responsibilities other than HIV, and report to different congressional oversight and appropriations committees. Sometimes these agencies compete for resources and public attention. While federal agencies and officials have tried several different leadership models, none has been very effective in bringing about the type of overarching guidance needed to coordinate federal

¹ Although the Committee's charge was limited to examining and providing a visionary framework for HIV prevention in the United States, significant attention must also be directed to improving HIV prevention efforts at the global level and to ameliorating the devastating impact that HIV/AIDS has had in developing nations.

prevention agencies and activities, as well as to bring together the wide variety of DHHS, non-DHHS, and outside agencies that are involved in HIV prevention efforts. Reclaiming federal leadership of the nation's HIV prevention strategy requires better coordination of efforts currently too dispersed. The implementation of even the best prevention strategy will not be fully effective under conditions of poor leadership and inadequate political commitment. The Committee believes that, for HIV prevention efforts to have maximum impact, there must be a strong, clear leadership structure in the Department of Health and Human Services.

From these findings, the Committee recommends a new strategy for preventing HIV infections. As a starting point, the nation should adopt an explicit prevention goal: **To avert as many new HIV infections as possible with the resources available for HIV prevention.** While this may seem an obvious goal, the Committee found that many current HIV prevention efforts are inconsistent with this principle. To reach this goal, a new vision is needed that will improve the way the epidemic is monitored, change how prevention resources are allocated and how activities are prioritized and conducted, foster interactions between the public and private sectors to promote new prevention tools and technologies, and reduce or eliminate social barriers to HIV prevention.

This strategic vision comprises six elements:

- Develop an accurate surveillance system, focused on new HIV infections, that can better predict where the epidemic is headed.
- Allocate prevention resources to prevent as many new HIV infections as possible, guided by principles of cost-effectiveness rather than simply by the number of AIDS cases.
- Direct prevention services to HIV-infected persons, who often have been excluded from prevention activities, and integrating prevention activities into the clinical setting in order to reach people at high risk of becoming infected.
- Translate findings from prevention research into action at the community level.
- Invest in the development of new tools and technologies to expand HIV prevention efforts.
- Strive to overcome social barriers and to remove policy barriers that impede HIV prevention.

DEVELOPING AN ACCURATE SURVEILLANCE SYSTEM FOCUSED ON NEW HIV INFECTIONS

To best plan and evaluate prevention activities and allocate resources for HIV prevention, a national surveillance system is needed that identifies new HIV infections (HIV incidence). The current epidemiological surveillance system—which is based primarily on AIDS case reporting and, more recently, on HIV case reporting in selected states—does not provide a complete or accurate picture of HIV incidence. By focusing mainly on AIDS cases, where diagnosis lags approximately 10 years after HIV infection without treatment and even longer than 10 years with potent new antiretroviral therapies, today's surveillance system looks at the past rather than to the future. The system tracks where the epidemic has been rather than where it is going. This lag is particularly problematic in light of the reality that the epidemic has shifted into new population groups. Thus, to more effectively target prevention interventions to communities at risk, the Committee recommends that:

The Centers for Disease Control and Prevention create a surveillance system that can provide national population-based estimates of HIV incidence. The recom-

mended surveillance system would estimate new HIV infections using blinded serosurveys of well-characterized sentinel populations (e.g., drug users in treatment, and people attending sexually transmitted disease clinics and tuberculosis clinics, and clinics serving women of reproductive age), surveys that characterize the populations served by those sites, and advanced testing technologies that are able to identify recent HIV infections.

ALLOCATING RESOURCES TO PREVENT AS MANY NEW HIV INFECTIONS AS POSSIBLE

The current distribution of federal funds for HIV prevention can best be described as an amalgam of administrative and legislative decisions that have been shaped in response to available data, Congressional mandates and earmarks, constituency pressures, personal values, and the professional judgment of program managers. The allocation strategy that results from these cumulative decisions can best be described as "proportionality." As a prevention strategy, proportionality has one important advantage, in that it begins with an objective criterion of need—that is, observed AIDS cases. However, proportionality has serious limitations, including the fact that it is an inadequate marker of need for the purposes of prevention. Proportionality rewards the reporting of AIDS cases rather than the prevention of new infections. Also, current funding decisions too often ignore the cost-effectiveness of interventions, and agencies that fund prevention research activities often fall short of requiring (and funding) assessments of the cost-effectiveness of programs or interventions tested. The Committee believes that in order to avert as many new infections as possible, better decisions about the overall investment of prevention resources must be made. To this end, the Committee recommends a strategy of allocating funds based on HIV incidence and the use of cost-effective interventions. Directing prevention efforts to populations at high risk of infection, and using interventions of proven efficacy and cost-effectiveness, could prevent an estimated 20 percent to 30 percent more infections than does the current allocation of HIV prevention funds (see Chapter 3). Thus, the Committee recommends that:

Prevention resources should be allocated to prevent as many new infections as possible. Such an allocation must take into account the cost and effectiveness of programs, in addition to estimates of HIV incidence. Evaluation should be a major component of resource allocation decisionmaking. With better evaluation data reflecting the cost, efficacy, and reach of programs, resources could be more profitably invested in interventions that work. Interventions that do not work, or that are very expensive relative to the number of infections prevented, could be abandoned.

USING THE CLINICAL SETTING FOR PREVENTION

Every new HIV infection begins with someone who is already infected—yet current prevention programs do not emphasize directing prevention efforts to individuals who are HIV-infected and who may still engage in risky behavior. Ideally, prevention interventions should be available for all HIV-infected persons. According to recent data, the majority of HIV-infected persons who know their status are in the treatment system (Bozzette et al., 1998) and may receive at least some information about prevention. However, it is estimated that up to one-third of infected persons do not know their HIV status (CDC, 1999b). Efforts should be made to

increase the number of infected individuals who are aware of their status. In addition, individuals at high risk for HIV infection often come in contact with the health care system for services at a variety of different entry points, and each of these clinical settings provides valuable opportunities for delivering HIV prevention services. Thus, the Committee recommends that:

Prevention services for HIV-infected persons should be a standard of care in all clinical settings (e.g., primary care centers, sexually transmitted diseases clinics, drug treatment facilities, and mental health centers). Health care providers should have adequate training, time, and resources to conduct effective HIV prevention counseling. Enabling this activity may require adjustments in health care provider time allocations and/or specific financial incentives from public and private sources of health coverage.

TRANSLATING RESEARCH INTO ACTION

Limited information is available on the performance and cost-effectiveness of prevention programs when implemented in community settings under nonexperimental conditions. This type of information is needed to ensure that programs of proven efficacy achieve maximum possible effectiveness and cost-effectiveness once integrated into practice, to ensure that sound evaluation data are available at the community level, and to ensure that effective prevention programs are translated and disseminated into communities. As a result, the Committee recommends that:

Key Department of Health and Human Services agencies that fund HIV prevention research and interventions should invest in strengthening local-level capacity to develop, evaluate, implement, and support effective programs in the community. The Committee further recommends that these agencies invest in research on how best to adapt effective programs for use in community-level interventions and research on what constitutes effective technical assistance for optimal research-to-community transfer of prevention programs; these agencies should also be responsible for the widespread dissemination of the results of this research. Such efforts will require the participation and collaboration of the funding agencies, researchers, service providers, and communities.

INVESTING IN THE DEVELOPMENT OF NEW TOOLS AND TECHNOLOGIES FOR HIV PREVENTION

Given the success that technologies have had in preventing HIV—such as antibody tests used to screen the blood supply, and drugs to prevent perinatal transmission of HIV—investment in new tools and technologies is clearly warranted. Research and product advances in the areas of HIV vaccines, antiretroviral and antimicrobial therapy, microbicides, and barrier methods (female condoms) can significantly increase the effectiveness of HIV prevention efforts. However, there are significant barriers to development, approval, and distribution of technological innovations. Such barriers include insufficient funding to maintain research on product development and testing, as well as lack of interest in the development of specific products. The timely development of new products will require the promotion of public and private sector collaborations and the development of incentives to increase involvement by private sector industries and philanthropic sources. Thus, the Committee recommends that:

Federal agencies should continue to invest in the development of products and technologies linked to HIV prevention. In particular, the National Institutes of Health should place high priority on the development of anti-HIV microbicides and vaccines, and this prioritization should be accompanied by increases in funding. Similarly, the Food and Drug Administration should accelerate its efforts to approve prevention technologies that show promise in clinical trials (e.g., new antiretroviral therapies, new microbicidal vaccine candidates) or are already being successfully utilized elsewhere in the world (e.g., rapid testing assays other than the Single Use Diagnostic System [SUDS]). For all new prevention tools, investigations of cost-effectiveness and user acceptability should be included as part of the research agenda. Federal agencies should also seek to develop stronger research collaborations with private industry, and they should offer incentives to encourage private industry investment.

STRIVING TO OVERCOME SOCIAL BARRIERS

Social, economic, and cultural forces not only shape the progression and course of the AIDS epidemic but also influence this nation's response to the epidemic. Societal attitudes surrounding sexual activity and drug use have fostered policies that have created barriers to the implementation of proven HIV prevention interventions and the efficient use of prevention resources. The consequence is missed opportunities to prevent new HIV infections, resulting in lost lives and wasted expenditures. National leadership is urgently needed to provide a coordinated strategy for effectively overcoming these social barriers in order to capitalize on the unrealized opportunities in HIV prevention. Thus, the Committee recommends:

- Increasing drug abuse treatment funding to levels that are sufficient to provide drug treatment to all those requesting it;
- Removing legal and policy barriers that limit access to sterile drug injection equipment;
- Eliminating congressional, federal, state, and local requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability programs in schools; and
- Removing policy barriers that hinder the implementation of effective prevention efforts in correctional settings.

The Committee believes the nation can and should do more to prevent HIV infection—and we have no time to lose. Doing better will require a new way of thinking about cost-effectiveness as a guiding principle for HIV prevention. It will require new leadership, accountability, and coordination. It will require directing interventions to those who are HIV-infected and to those—the women, youth, and racial and ethnic minorities—who are increasingly affected by the epidemic. It will require more effective translation of interventions that prevent HIV in research settings into activities that are effective in communities. And it will require removing obstacles that impede the implementation of those interventions that we now know to be effective.

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