The Commonwealth Fund
2010 Annual Report

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Cover photo: Dwight Cendrowski

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Working toward the goal of a high performance health care system for all Americans, the Fund builds on its long tradition of scientific inquiry, a commitment to social progress, partnership with others who share common concerns, and the innovative use of communications to disseminate its work. The 2010 Annual Report offers highlights of the Fund's activities in the past year.

2010 Annual Report President's Message

Realizing the Potential of Health Reform

Karen Davis
President
The Commonwealth Fund

Cover photo: Dwight Cendrowski

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Realizing the Potential of Health Reform

Karen Davis
President

Preface

The landscape of American health care has changed dramatically since the Patient Protection and Affordable Care Act was signed in March 2010. Federal and state agencies, the health insurance industry, and others are taking the first steps toward achieving the three goals President Obama set forth when Congress began crafting reform legislation last year:

- expand access to affordable health insurance for people without coverage;
- make health insurance more affordable for those who already have it; and
- slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.

Over the course of the heated debate leading to the health reform bill's passage, Congress dealt with many difficult political issues: whether to include a public plan, how to regulate the health insurance industry and make coverage affordable, how to control Medicare costs, and how to finance reform. As these critical decisions were being made, The Commonwealth Fund produced a steady stream of timely, on-point research and analysis, while our staff lent their considerable expertise whenever called upon.

Once the law passed, the Fund quickly marshaled its resources to help realize the potential of the comprehensive health reform by: helping health care leaders and the American people understand the changes and what they mean for them; informing implementation of the reform package and assessing its potential to move the United States on a path to a high performance health system; and laying the groundwork for future health care delivery system reforms and health policy action.

Given the law's scope and complexity, its potential is not yet assured. Success will depend on all parties coming together to put the pieces in place, as well as on careful oversight and tracking of health system performance. It will also be important to swiftly apply new knowledge gained as innovations are tested, so that best practices and models can be spread throughout the health system.

Some of the long-term questions that need to be addressed as experience is gained include:

- Will stronger measures be required to control health care costs?
- Are the provisions designed to ensure affordability for families adequate?
- What is the shared responsibility of employers?

- Will tighter regulation of the insurance industry be required? And will a public insurance plan be needed as a competitive alternative to private plans?
- What financing is needed to ensure long-term sustainability?

The following essays, published on The Commonwealth Fund Blog over a one-year period, take readers on a journey through the busy months leading to the passage of this historic law and the first stages of its implementation.

What Is Affordable Health Care? reviewed the affordability provisions in the three versions of the bill under consideration at the time: those proposed in the House of Representatives, the Senate Committee on Health, Education, Labor, and Pensions (HELP), and the Senate Finance Committee. Parsing the bills' differences in approaching Medicaid program expansion, essential insurance benefits, and premium subsidies for low- and moderate-income families, this essay stressed the importance of "reaching consensus on what constitutes affordability and committing the necessary funds to achieve it."

Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums also tackled affordability, looking at how dramatically premium inflation has outpaced wage increases over the last decade. Citing Commonwealth Fund and Congressional Budget Office analyses, I observed that offering a public health insurance plan, alongside private plans, to all individuals and employers is our most effective weapon in combating health care costs. The essay also considered other cost-containment options, such as a mechanism for negotiating provider payments under all plans—public and private.

The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms made a powerful case for reform by examining trends in health spending over the past 50 years. The analysis showed that if health reform measures proposed by previous presidents had been enacted and succeeded in slowing spending growth by as little as 1.0 or 1.5 percentage points annually, spending trends in the U.S. would have been closer to those seen in other major industrialized countries. Moreover, fewer adverse health consequences and economic burdens would have been borne by American families, businesses, and government.

In addressing the stagnation of health plan quality, Commonwealth Fund Senior Research Advisor Douglas McCarthy suggested in Committing to Improvement in All Areas of Health Care that this plateau might "reflect the limits of what managed care plans can achieve without integration of care delivery and support for physicians and patients in improving quality, as well as the absence of a broader commitment to public reporting and improvement."

In Health Reform: Insights from Around the World, Fund Senior Vice President Cathy Schoen, Vice President Robin Osborn, and I discussed how the health reform debate has been informed by health systems in other countries. With a Commonwealth Fund survey of primary care physicians in 11 countries finding U.S. shortcomings in access, quality, health outcomes, and value, we called for national leadership to make needed reforms in insurance coverage and health care delivery.

National Leadership to Achieve a Performance-Driven Health System called for developing a set of national performance goals and improvement targets, along with supporting policies, resources,

and actions. The essay also recommended that the president issue an annual report to Congress on the state of health system performance.

Published at a time when headlines were focused on discord in Congress, Forging Health Reform Consensus highlighted the marked similarities to be found across the three House and Senate reform bills—namely, more choices, greater incentives for accountability, increased transparency, shared responsibility, a redirection of resources, and new opportunities for learning and acting as reform is implemented.

The Way Forward with Health Reform addressed some of the misleading claims concerning the impact of health reform and the lack of understanding of its potential to improve patients' experiences.

In A New Era in American Health Care, Vice President Sara Collins, Ph.D., and I celebrated the passage of comprehensive health reform legislation and outlined the ways it will increase access to needed care, provide new benefits, and slow health care spending growth, as well as test new ways of paying health care providers to improve quality.

Who Is Helped by Health Reform? reviewed how different groups will benefit from the new coverage options, benefit standards, and insurance market rules. An accompanying essay, How Will the Health Care System Change Under Health Reform?, discussed a host of lesser-known provisions that, together, will place new emphasis on preventive and primary care and reward quality.

As these final essays suggest, The Commonwealth Fund has already embarked on its new goal of helping the country realize the potential of reform. Guided by the foundation's mission to promote a high-performing health system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, we have reorganized our research programs to better enable us to address emerging issues in this new era in American health care.

The Fund's programs are now organized into four key areas: Delivery System Improvement and Innovation; Health Reform Policy; Health System Performance Assessment and Tracking; and International Health Policy and Innovation.

Within the area of Delivery System Improvement and Innovation, the programs on Health System Quality and Efficiency, Patient-Centered Coordinated Care, and Picker/Commonwealth Fund Long-Term Care Quality Improvement aim to advance the adoption of promising approaches for improving the quality and value of health care services. The Fund will also promote delivery system models that provide population-based, patient-centered, accountable care that is integrated across the full continuum of services, as well as the underlying payment reforms.

Health Reform Policy, which encompasses the Affordable Health Insurance, Payment and System Reform, Federal Health Policy, and State Health Policy and Practices programs, will address health reform policy options at the federal, state, and local level. Together, these programs will foster the identification, development, evaluation, and dissemination of policy solutions that expand access to affordable, high-quality, and efficient care, particularly for vulnerable populations, while reducing the growth of health care spending.

The projects within Health System Performance Assessment and Tracking focus on comparing health system performance, evaluating and monitoring access to care and patients' reports on the quality of their care, and monitoring delivery system change. This work includes the Fund's national

and state scorecards on health system performance, an upcoming long-term care scorecard, analyses of international health system data, and WhyNotTheBest.org, a Web site that offers comparative information on health care provider performance. The Fund also conducts surveys in the U.S. and across countries to provide data that can inform health reform implementation.

Similarly, International Health Policy and Innovation aims to: benchmark U.S. health system performance on costs, quality, access, equity, and efficiency against that of other industrialized countries; understand the lessons to be learned from other countries' experiences in reforming their health care delivery and financing systems; and showcase international innovations that may be relevant to health reform implementation in the U.S.

Along with the Fund's Commission on a High Performance Health System, the integrated research and analysis that will be conducted within our new programmatic structure will help government agencies, payers, providers, and patients as the country moves toward achieving the goals embodied in the Affordable Care Act.

October 18, 2009

What Is Affordable Health Care?

By Karen Davis

Ensuring that all Americans have access to affordable health insurance and care is one of the major goals of federal health reform, if not the major goal. Under the three bills now before Congress, affordability is achieved through expansion of the Medicaid program, creation of an essential insurance benefit package, and sliding-scale subsidies to make premiums and cost-sharing affordable for low- to moderate-income families. However, the bills recognize that budgetary limitations may still leave some families subject to financial hardship and exempt families from the requirement to purchase insurance if such coverage proves unaffordable.

Determining what is and is not "affordable" for different groups is a challenge that is reflected in the varying levels of coverage and assistance offered across the three bills. In making these calculations, it is important to recognize that affordability is related both to premiums and out-of-pocket costs. If a family's premium is low but their out-of-pocket expenses are high, their care may ultimately be difficult for them to afford.

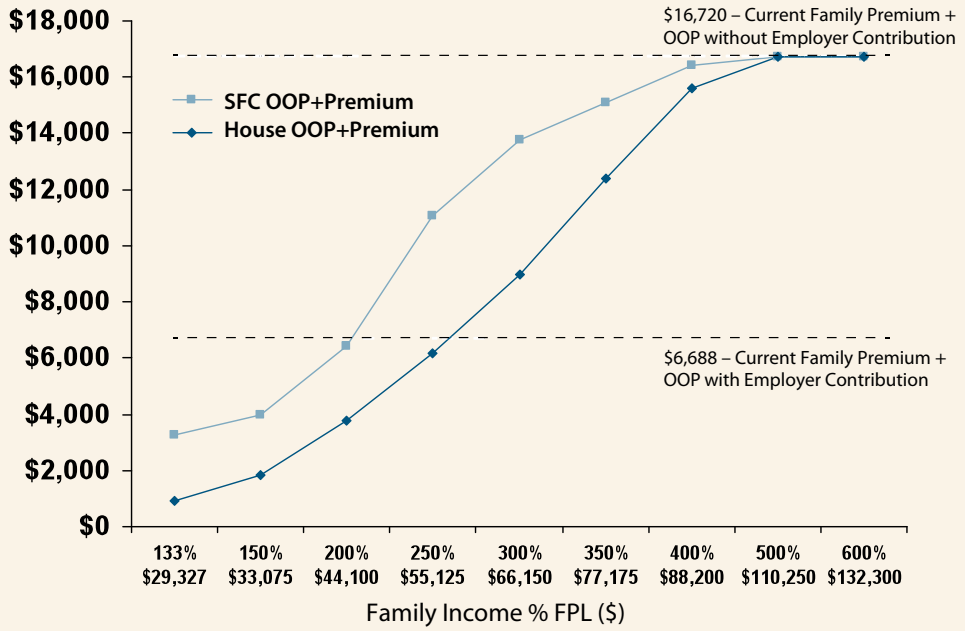
Medicaid Expansion. Expanding the safety-net insurance system through Medicaid is critical to reaching a large portion of the nation's uninsured, low-income working individuals and families. The three congressional bills–the House bill, the Senate Health Education, Labor, and Pensions (HELP) bill, and the Senate Finance bill–all provide for this essential floor of coverage. The House and Senate Finance bills expand Medicaid up to 133 percent of the federal poverty level (approximately $30,000 for a family of four in 2009), and the HELP bill expands coverage up to 150 percent of poverty. These expansions include previously ineligible populations, such as childless adults. According to estimates from the Congressional Budget Office, as a result of these expansions, the number of people under age 65 covered by Medicaid in 2015 would increase from 34 million to 43 million under the House bill and 44 million under the Senate Finance bill. Those covered by Medicaid would not face premiums or significant cost-sharing for medical bills.

Insurance Exchange and Insurance Regulation. Each bill would create a new health insurance exchange, or a marketplace managed and regulated by the government, through which eligible individuals and small businesses could choose among private plans or, in the case of the House bill and Senate HELP bill, a public health insurance plan. Requiring individual and small business health plans to cover everyone and charge the same premium regardless of health status increases affordability for those with serious health problems–a major concern in the current system. All plans would have to meet requirements of participation set by the exchange. Participants in the exchange with incomes up to four times the poverty level would be eligible for subsidies to offset the cost of premiums. A public plan would lower the cost of federal subsidies by an estimated $80 billion over 10 years, generating savings to help finance premium subsidies for low-income families.

Benefit Standard. To guarantee an adequate level of coverage, an "essential benefit package," with varying levels of cost-sharing, would be offered through the exchange. All three congressional bills call for such a package, including hospital, physician, and preventive care, prescription drugs, and pediatric dental and vision services, among other services.

While keeping the benefits constant, the three congressional bills define three to four levels of cost-sharing tiers by actuarial value, or the average share of medical expenses covered by a health plan. The lowest-tier plans in both the House and Senate proposals cover less than what is covered by the typical insurance plan for workers and members of Congress. In the House bill, the actuarial value of the basic plan covers 70 percent of medical expenses and rises to 95 percent in the highest

Family Premiums and Out of Pocket Expenses Under House and Senate Finance Proposals*



* For a family of four in 2009.
Source: Commonwealth Fund. For more detail on legislative provisions, see S. Collins et al., *Provisions of Comprehensive Health Reform Bills of 2009: Health Insurance, Delivery System, and Financing,* (New York: The Commonwealth Fund, October 2009).

tier. In the Senate Finance proposal, the lowest-tier plan has an actuarial value of 65 percent and rises to 90 percent. By comparison, the average actuarial value in employer-based plans is an estimated 80 percent. The average actuarial value in the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program, the typical plan for members of Congress and federal employees, is about 84 percent to 87 percent.

The bills also cap out-of-pocket spending. Spending is capped at $5,000 and $10,000 annually for individuals and families in the House bill. The Senate Finance bill caps spending at a higher limit, tied to the cap for health savings account/high-deductible health plans—which require that families spend more out-of-pocket. The limit is $5,950 for individuals and $11,900 for families, with reduced amounts for lower-income families.

Subsidies for Premiums and Cost-Sharing. The House and two Senate bills all provide assistance in paying premiums for families with income up to four times the federal poverty level (about $88,000 for a family of four). The House and Senate bills would set a maximum on the most that any family in this income bracket would pay for health insurance at 12 percent of income for higher-income families; the maximum is 12.5 percent of income under the HELP bill. Individuals with lower incomes or those covered by employer plans would pay less.

The House and Senate Finance bills provide sliding-scale subsidies that increase the actuarial values of the lowest-tier plans to make them more affordable. The House bill is somewhat more generous than the Senate Finance bill: for people with incomes under 350 percent of poverty, subsidies raise the actuarial value of the basic plan to 97 percent for those with incomes of 133 percent of poverty; the value slides down to 72 percent for those with incomes at 350 percent of poverty. The Senate Finance bill provides cost-sharing credits for those with incomes between 100 percent and 200 percent of poverty, raising the actuarial value of the lowest-tier plan to 90 percent for people with incomes up to 150 percent of poverty and

80 percent for those with incomes between 150 percent and 200 percent of poverty.

The chart illustrates how the premium and average out-of-pocket costs would vary across income levels. Our analysis shows that total net premiums and out-of-pocket expenses would be higher at each income level in the Senate Finance bill, compared with the House bill. Reflecting this difference in subsidies, the Congressional Budget Office estimates that the cost of subsidies would be $773 billion from 2010 through 2019 in the House bill and $461 billion in the Senate Finance bill.

Employer Contributions. Requiring employers to contribute a share of an employee's premium and setting standards on benefits will ensure affordability for most workers. The House proposal requires firms with more than $500,000 in payroll to contribute a minimum of 72.5 percent to individuals' premiums and 65 percent to families' premiums. If employers do not meet the standard, they must pay up to 8 percent of payroll into a health insurance fund. The Senate Finance bill does not require employers to provide coverage or contribute to a fund, but rather requires employers with more than 50 employees to pay a flat fee for workers who receive a federal premium subsidy for coverage purchased through the exchange. The Senate HELP bill requires firms with more than 25 workers to pay at least 60 percent of employees' premiums or pay a penalty of $750 per uncovered full-time employee or $375 per uncovered part-time employee.

Having employers contribute to coverage–as they now do for 162 million people–is extremely important to ensuring affordability. As shown in the chart, an average family with employers contributing to coverage could expect to pay $6,700 a year in premiums and out-of-pocket costs, while a family without employer contributions could expect to pay $10,000 more–or a total of $16,700.

Hardship Exemption. Finally, both the House and Senate Finance bills include hardship exemptions from the requirement that individuals purchase coverage to avoid penalizing those who can't afford coverage. The Senate Finance bill exempts those for whom premiums exceed 8 percent of income, effectively setting an "affordability" standard for coverage. The House bill has unspecified exceptions. The Congressional Budget Office estimates that 25 million Americans will remain uninsured under the Senate Finance proposal, compared with 17 million under the House bill.

Though these issues will be difficult to resolve, reaching consensus on what constitutes affordability and committing the necessary funds to achieve it are crucial in securing access to essential care for all and protection from the financial hardship that illness can now bring. Ensuring affordable health care for all will ultimately pay national dividends in terms of improved health and productivity of the workforce and economic growth.

August 18, 2009

Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums

By Karen Davis

As health reform advanced through congressional committees this summer, much attention was given to trimming the federal budget cost and slowing the growth in Medicare outlays. But equal attention needs to be focused on provisions to address the rising costs of health insurance premiums for employers and families. Health system reform will be effective only if the legislation considers the financial well-being of all participants, not just that of the federal government. It is time to ask what effect health reform will have on the cost of insurance for businesses and families—and to remember what will happen if we do nothing. Without reform, projected premium increases will put the country at high risk for having health insurance costs absorb all of the average family's future wage increases, eventually pricing middle-income families out of insurance altogether.

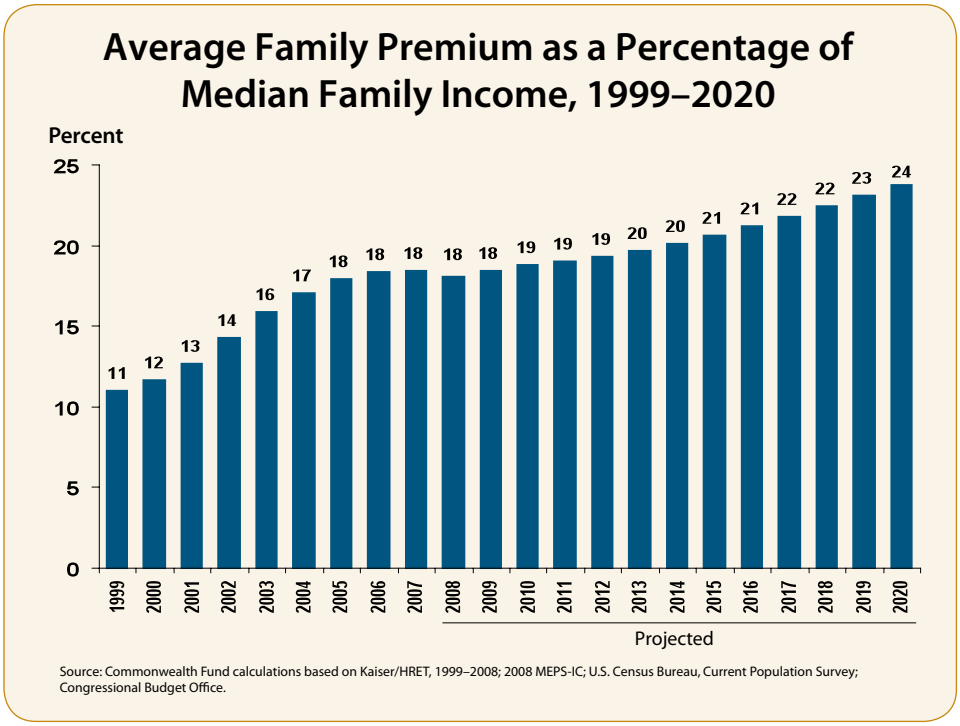
Health insurance is already becoming unaffordable for families and businesses, with premium inflation outpacing wage increases. Between 1999 and 2008, employer family health insurance premiums rose by 119 percent, while the median family income rose by less than 30 percent. As a result, average family premiums for group policies have risen from 11 percent to 18 percent of median family income. And if Congress fails to pass health reforms that control health care costs, premiums are projected to rise to 24 percent of a family's income by 2020. In any economic climate, but especially in today's recession, most families cannot afford to devote a fourth of their income to insurance coverage, nor can businesses afford their share of insurance premiums in addition to raises for employees.

In light of this reality, it is important to remember the principal goals of comprehensive health reform: 1) to cover the uninsured, 2) to enhance the affordability of insurance coverage for everyone, and 3) to slow the rise in health care costs. Achieving the first goal without the second and third is a recipe for long-term failure.

The Public Plan: The Leverage to Set Rates

Although the Obama Administration may be scaling back its support for a public plan, Commonwealth Fund and Congressional Budget Office (CBO) analyses show that offering a strong public health insurance choice as well as private plans through a health insurance exchange will help all Americans, not just the uninsured, by slowing the growth in premiums. A recent Fund analysis found that offering a public plan alongside private plans to all individuals and employers is our most effective weapon in combating health care costs. The study found that cumulative health system savings between 2010 and 2020—compared with projected trends for that period—could be as high as $3 trillion if reform includes a public plan that adopts innovative payment methods that reward value and uses its purchasing leverage, along with a reformed Medicare program, to control costs. The annual growth rate in health system spending would fall from 6.5 percent to 5.2 percent—consistent with an industry coalition pledge to slow spending by 1.5 percentage points annually over the next decade.

The CBO estimates that a public plan premium would be 10 percent lower than that of typical private plans offered in an insurance exchange—a cost break that would provide much-needed relief to families and businesses in every state in the country. The average family would save $2,200 per year by 2020 with reforms that include a public plan. President Obama pledged during the presidential campaign to save American families $2,500 a year through health reform. This goal needs to be on par with a deficit-neutral health reform plan.



Source: Commonwealth Fund calculations based on Kaiser/HRET, 1999–2008; 2008 MEPS-IC; U.S. Census Bureau, Current Population Survey; Congressional Budget Office.

The public plan would achieve these savings because it would use the federal government's power to set prices for health care providers and control the rate of increase in these prices over time. It would be most effective if it were linked to Medicare, either paying at or somewhat above Medicare rates. Today, nearly all hospitals and physicians choose to participate in Medicare, rather than lose the 20 percent to 30 percent of revenues or more they derive from such participation. This leverage prevents providers from obtaining prices far in excess of their costs–as they often do under private insurance "negotiations" based on their dominant market position. When providers refuse to participate in private insurance networks and simply charge patients whatever they choose, patients are left uninformed and unprotected from the financial consequences.

By using its substantial purchasing power, a public plan that links payment and participation to Medicare could provide relief to employers and households by offering a lower premium. Such a premium would challenge private insurers to bring more value to the insurance market by using tools such as utilization management; creating networks of providers that offer real value for the care they provide; and rewarding accountable care organizations and integrated delivery systems for preventing and controlling chronic conditions.

Private insurers have opposed the creation of a public plan, arguing that Medicare payment rates under a public plan would lead to a "cost-shift" of higher prices to private payers. Instead of proposing an alternative solution that would work to control costs, insurers have simply insisted that there be no public plan option.

It is certainly reasonable to demand that a public plan meet the same market conditions as private plans, for example by requiring it to be self-sustaining, with premiums sufficient to cover projected medical outlays and administrative overhead, and ensuring that public and private plans are held to the same standards for adequate financial protection and access for enrollees. But abandoning a public plan without proposing an alternative that would achieve real value and slow the growth in health spending undermines the long-term success of health reform and puts our economy at risk.

Unfortunately, as legislation has worked its way through congressional committees, the potential power of a public plan has been substantially eroded in three ways: by dropping the requirement that providers that receive Medicare payment also participate in the public plan; by requiring the U.S. Health and Human Services Secretary to negotiate provider payments rather than base prices on

Medicare rates; and by restricting access to a public plan option to individuals and small firms. As a result, a strong public option is no longer a component of several bills now being debated in Congress.

The Senate Finance Committee is considering nonprofit health care cooperative plans as an alternative to a public plan. While the details of this proposal are unclear, it is unlikely that such organizations would have sufficient purchasing power to control costs over time and would take years to evolve. Whether we are considering a public health insurance plan or nonprofit cooperative plan, if the plan does not link payment to Medicare rates, it loses the advantage of representing the share of enrollees, and therefore provider revenues, needed to obtain lower prices. The Congressional Budget Office estimates that only 9 million to 12 million people would be enrolled in these plans as currently designed. Negotiating provider payments for the 10 million or so people estimated to enroll in a public plan or private co-op plan is unlikely to yield significant savings.

In response to the increasing concentration of the insurance industry, the health care provider industry has formed its own large organizations that can command high payment rates. In many markets, one to four large hospital systems dominate. Such systems can easily decline to participate with a weakened public plan or private co-ops, knowing it will not affect a substantial share of their revenues. With only a limited number of individuals covered and restrictions on the ability to set payment rates, a public or nonprofit cooperative plan will be unable to counter the concentrated market powers of providers in a given geographic area. As a result, we are likely to continue on the current course, with employers and families seeing premiums continue to rise far faster than incomes.

Other Options for Cost Containment

To truly contain costs, health reform needs to include some mechanism for controlling both medical outlays and insurance administrative overhead. A strong public plan is one effective option; there are certainly others. For example, one approach would be to negotiate provider payments under all plans—public or private. This is the model followed by most industrialized countries that leverage purchasing power by having a single entity—either a government agency or a nonprofit entity acting in the public interest—negotiate provider payment rates and methods on behalf of the entire population.

Another option would be to charge states with designing and implementing all-payer methods of provider payment. States with a plan that ensures fair and reasonable payment rates and methods that reflect value, harmonizes payment under public programs and private insurance, and effectively controls the growth in costs over time could be permitted to establish their own systems.

Still another course would be to extend Medicare payment innovations to private insurers. The health reform bills in the House and Senate go a long way toward improving Medicare's payment system. They would establish a Center on Payment Innovation with the authority to test new methods of payment that reward value rather than the volume of services, and to rapidly spread the most successful payment methods. The bills call for in-depth analyses of ways to eliminate geographic disparities in Medicare payment. They also create strong independent authorities to establish Medicare payment rates and methods with requirements on Congress to act expeditiously or, failing action, for the recommended changes to take effect.

A broader charge to harmonize Medicare payment and private insurer payment—and to engage in multipayer payment innovations—could spur more rational payment methods throughout the health system, enhance their impact, and lower administrative costs and complexity. What should be unacceptable is to continue with our current system of provider payment—one that lacks leverage and coherence, results in an ever-rising share of economic resources going to the health sector without commensurate value, and has high administrative costs due to fragmented and inchoate payment mechanisms all pulling in different directions.

Health care, simply put, costs far more than it should. There is no justification for the prices and premiums our businesses and workers now pay for health care, which are the highest in the world. We should not accept a health reform plan that focuses only on coverage and savings in public programs. It should be unacceptable to continue with employer health insurance premiums that rise three to four times as fast as wages. The onus must be put on those who oppose a public plan to suggest an equally effective alternative that reforms payment methods, promotes delivery reform, and achieves value for health spending that is in the best interests of the American people.

December 21, 2009

The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms

By Karen Davis and Kristof Stremikis

The U.S. Congress is on the threshold of historic change that will usher in a new era in American health care. In the last 50 years, three presidents—Nixon, Carter, and Clinton—have made a serious effort to enact reform and failed. The nation simply cannot afford to fail again—too much is at stake for those Americans who fail to get the life-saving care they need and for those who pay the bills of the ever-rising cost of health care. History makes clear that failing to act on health reform has serious and far-reaching economic ramifications. An examination of trends in health spending over the past 50 years shows that if health reform measures proposed by previous presidents had been enacted and slowed the growth in spending by as little as 1.0 or 1.5 percentage points annually, spending trends in the U.S. would have been closer to those seen in other major industrialized countries and fewer adverse health consequences and economic burdens would have been borne by American families, businesses, and government.

Learning from Past Efforts

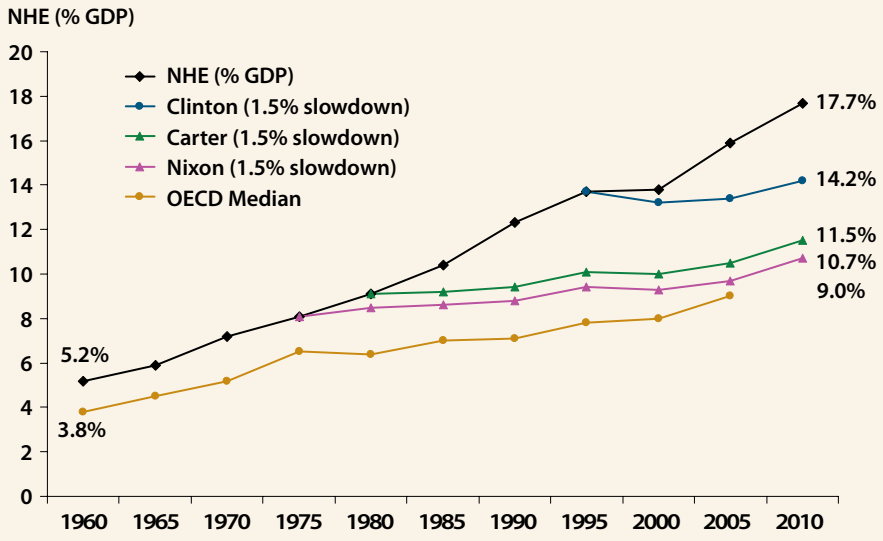
Over the last half-century, the nation has made several serious attempts to ensure health insurance coverage and control health care spending, either as part of comprehensive legislation or through companion measures.

President Richard Nixon imposed wage and price controls on the entire economy in 1971 in the wake of Vietnam War era inflation, with special mechanisms developed for controlling health care costs. He then proposed a Comprehensive Health Insurance Plan that received serious legislative consideration in 1974. The central features of the plan were employer-mandated private insurance coverage for workers and their families in firms with 25 or more employees, a plan for low-income families that would replace and improve Medicaid, and a federal health insurance plan that would replace and improve Medicare.[1] Reform efforts died when Nixon was removed from office, as proponents hoped to enact stronger legislation in the political aftermath of his impeachment. The Nixon health care cost controls were lifted in 1975 when the industry pledged to control costs voluntarily.[2]

President Jimmy Carter proposed hospital cost containment legislation in 1977. In 1979, he introduced a national health plan that included minimum standards on benefits and required employer contributions, as well as a new federal HealthCare program to replace Medicaid and Medicare and cover all low-income individuals, in addition to the elderly and disabled. The Carter hospital cost containment legislation, a response to the explosion in health care costs following the lifting of Nixon's health cost controls, was defeated when the industry mounted an alternative "Voluntary Effort." Unfortunately, this voluntary approach to cost control also quickly dissipated once the threat of legislation was removed.[3] Inflation in health care spending and a deteriorating economy contributed to the demise of the Carter national health plan in 1980.

President Bill Clinton introduced legislation in 1993 with cost containment measures built into health reform. In particular, his proposal called for controls on the rate of increase in health insurance premiums. The Health Security Act included an employer mandate that required employers to pay 80 percent of the premium (up to a maximum of 7.9% of payroll), with the family share of premiums not to exceed 3.9 percent of income.[4] The plan

National Health Expenditures (NHE) Under Alternative Scenarios, Percentage of Gross Domestic Product, 1960–2010



Data: The Centers for Medicare and Medicaid Services; Bureau of Labor Statistics, Office of Management and Budget, Congressional Budget Office.

was to be financed by substantial Medicare and Medicaid savings, an increase in tobacco taxes, and cross-subsidies among employers within risk pools. President Clinton's health reform ran into major opposition from small businesses and insurers, and the legislation stalled out in Congress.

U.S. Health Spending Trends and Projections

The federal government's repeated failure to enact health reform has had serious consequences for American families, businesses, and governmental budgets. The U.S. spent 5 percent of gross domestic product (GDP) on health care in 1960; health care now consumes 17 percent of the nation's economy and will reach 21 percent by 2020, if trends continue. While investment in health care has contributed to improved health and productivity, other countries have devoted a far lower share of GDP to health care and achieved comparable or better health outcomes.

Ever-higher health spending has directly contributed to stagnating incomes and rising health insurance premiums for middle-class families and workers. Commonwealth Fund analysis has shown that premiums have risen from 11 percent of family income in 1999 to 18 percent in 2009. If current trends continue, average family premiums will reach 24 percent of median income by 2020.

Rising health care costs—and the subsequent rise in health insurance premiums—have fueled an increase in the number of Americans without insurance over the past three decades. Nearly 50 million Americans are expected to be uninsured in 2010. Cost growth also has placed enormous pressure on employers' ability to provide comprehensive benefits, leading many to shift to less generous policies or drop coverage altogether. Employees of small businesses, which are much less likely to offer coverage, are at particularly high risk.

It is difficult to estimate with precision what would have happened had earlier proposed reforms been enacted. Still, it is instructive to consider where we would be today if those efforts had succeeded. Each included provisions designed to provide health insurance coverage for all.[5] Each set out regulatory restraints on the growth in provider payment or insurance premiums, or both. All had significant mechanisms to control costs, including changing provider payment, increasing competition in the insurance market, and controlling the growth in private insurance premiums.

The exhibit shows the growth in national health expenditures as a percentage of GDP and what we would have spent as a nation if effective measures to slow the growth

in health expenditures by 1.5 percentage points a year had been adopted in 1975, 1980, and 1995. In 1960, we spent 5.2 percent of GDP on health care, compared with the 3.8 percent of GDP median rate in all major industrialized nations. Today, we spend 17.7 percent—nearly twice the rate of 9 percent that is devoted to health care in other industrialized countries.

If President Nixon's health reform plans had been enacted in 1975 and slowed the annual rate of spending by 1.5 percentage points a year, today we would be spending 10.7 percent of GDP on health care. In dollar terms, we would spend only $1.6 trillion on health care in 2010, instead of projected health spending of $2.6 trillion. This savings of $1 trillion in 2010 alone would remove much of the financial burden on families, businesses, and government. Even if Nixon reforms had slowed spending growth by "only" 1 percentage point a year, health spending as a percent of GDP would have been $1.9 trillion in 2010, or 12.7 percent of GDP—a savings of 5 percent of GDP.

If cost containment measures slowing spending by 1.5 percentage points a year had been enacted in 1980 under President Carter, the trends would be similar, with spending rising to $1.7 trillion in 2010, or 11.5 percent of GDP. Even if we had acted as late as 1995 under President Clinton, health spending in 2010 would be $2.1 trillion, or 14.2 percent of GDP.

The federal government would have been a major beneficiary of comprehensive health reform under Presidents Nixon, Carter, or Clinton. Instead of consuming 6.2 percent of GDP in 2010, federal health outlays would have been 3.7 percent in 2010 under Nixon reforms that slowed spending growth by 1.5 percentage points, 4.0 percent under Carter, and 5.0 percent under Clinton.

Bending the Health Care Cost Curve Today

In the current round of health reform, the primary strategy for controlling costs has been legislative changes to Medicare and a public health insurance plan that encourages private insurers to control costs. While enrollment in the public health insurance plan in the House bill has been narrowly targeted on the uninsured and small businesses, the proposal faces an uncertain future in the legislative process.

The House of Representatives has added provisions to negotiate pharmaceutical drug prices, review insurance premium increases, and set standards on the share of premiums devoted to health care. Both the House and Senate have provisions for rapid testing of new methods of provider payment in Medicare. The Senate bill calls for an independent Medicare advisory board to facilitate rapid consideration of recommendations to limit the rate of increase in Medicare outlays.

Several commentators have questioned whether the cost containment provisions in the health reform bills passed by the House and under consideration in the Senate are sufficient. Neither bill includes the aggressive systemwide cost control measures that were part of the Nixon, Carter, and Clinton proposals. But the House and Senate bills would begin to bend the curve in total health spending and encourage the development of mechanisms for extending cost control measures more broadly once experience is gained. A recent analysis by the Council of Economic Advisers estimates that private and governmental spending would be slowed by 1.0 percentage points a year.

History shows that even modest cost-cutting has a significant impact over time and that inaction has a cost. The longer we wait to address the underlying problems in the U.S. health care system, the more health spending will continue on its rapid rise and the more drastic the measures that will be required to right our economy and our federal budget. Congress is right to move ahead. After 50 years of spiraling health care costs and the resulting price paid by American families, business, and government, we can no longer afford to postpone health reform.

Notes

1 K. Davis, *National Health Insurance: Benefits, Costs, and Consequences* (Washington, D.C.: The Brookings Institution, 1975).

2 K. Davis, G. Anderson, D. Rowland, and E. Steinberg, *Health Care Cost Containment* (Baltimore: The Johns Hopkins University Press, 1990).

3 K. Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort," Testimony before the House Committee on Energy and Commerce, December 15, 1981.

4 Congressional Research Service, *Health Care Reform: President Clinton's Health Security Act*, (Washington, D.C.: Congressional Research Service, 1993).

5 K. Davis, "Universal Coverage in the United States: Lessons from Experience of the 20th Century," *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* March 2001 78(1).

November 5, 2009

Committing to Improvement in All Areas of Health Care

By Douglas McCarthy

The Commonwealth Fund Commission on a High Performance Health System's 2009 State Scorecard shows that in areas of health system performance where we as a nation have made a commitment to reporting and improving performance, we see dramatic results. Since the first State Scorecard was released in 2007, almost all states improved on several indicators of quality of hospital treatment, for example. This change reflects the influence of national consensus on a single set of measures for hospitals, public reporting of results of these measures on the federal Hospital Compare Web site, and widespread hospital participation in reporting following a policy change in which the Centers for Medicare and Medicaid (CMS) linked reporting to Medicare payment updates. Hospital quality has also been the focus of an intense collaborative improvement campaign across the nation.

By contrast, the majority of states failed to improve on multiple indicators of ambulatory care quality and access over most of the two-to-four-year trends captured by the 2007 and 2009 Scorecards. For example, there were only modest improvements seen in preventive care for adults—and this improvement was seen in only half the states. Public reporting on ambulatory care quality is currently limited to a subset of the population enrolled in certain managed care plans that voluntarily publish their results through the HEDIS measurement tools developed by the National Committee for Quality Assurance (NCQA).

Last week NCQA reported that health plan quality stagnated in 2008 after several years of steady gains on key measures. In addition, some areas of quality such as mental health treatment have been consistently lackluster (an "unacceptable level of mediocrity" according to NCQA). Disturbingly, 2008 marked the third year that quality failed to improve appreciably for Medicaid and Medicare health plans. This plateau in quality might reflect the limits of what managed care plans can achieve without integration of care delivery and support for physicians and patients in improving quality, as well as the absence of a broader commitment to public reporting and improvement by all types of health plans and greater participation in reporting by all physicians. Such reporting will enable all Americans to judge the quality of care that they receive and feel confident that their provider is committed to delivering the best care.

NCQA also examined costs of care for several chronic conditions and found "no clear indication that higher resource use produces better quality results." This echoes the State Scorecards, which found no systematic relationship between quality and cost of care at the state level. The health plans and states that achieve higher quality at lower cost offer hope that improving health care performance need not cost more.

More widespread adoption of electronic health records and electronic health information exchanges should enable more robust reporting of clinical data in the future. In the meantime there are things that can be done with existing data and tools, such as NCQA's HEDIS measures and the use of registries to track care for patients with chronic conditions. In short, we as a nation need to commit to making the improvements seen in hospital quality the norm across all areas of health care. Patients deserve nothing less.

November 30, 2009

Health Reform: Insights from Around the World

By Cathy Schoen, Karen Davis, Robin Osborn

The United States stands at the brink of a historic change that would remove financial barriers to health insurance coverage and ensure access to essential health care services. Enactment of health reform legislation would enable the U.S. to join the ranks of major industrialized countries that offer their people a system of health insurance coverage. Most of the health reform debate has focused on ways to strengthen our uniquely American private–public system of health financing and expand coverage to those who fall through its cracks. Yet, the debate has also been informed by insights gained from health systems in other countries.

Making Care Affordable

A recent Commonwealth Fund survey of primary care physicians in 11 countries published in *Health Affairs* underscores just how much is at stake. Many of the shortcomings in the U.S. health system revealed by the survey—pertaining to access, quality, health outcomes, and value—would be addressed by the proposals under consideration by Congress.

Almost three of five U.S. physicians (58%) say their patients often have difficulty paying for care. In sharp contrast, about one of four primary care physicians in the other 10 countries say that costs are often an issue for patients. That's largely because most of these countries have a coverage system with benefits designed to facilitate access to essential services and provide financial protection against burdensome medical bills. Countries such as Norway, Sweden, and the U.K. include little or no patient cost-sharing for medical expenses and cap total financial exposure for the year. Some, such as France, base patient cost-sharing on how essential a particular service is for ensuring good health outcomes. Others, such as Germany, use reference pricing for prescription drugs, with patients paying the difference if they prefer a higher-cost but no more effective medication. Germany also limits total out-of-pocket costs as a share of income to 2 percent for the general population and 1 percent for sicker patients. France eliminates cost-sharing for seriously ill patients and those with specified chronic conditions on care plans.

Without a seamless coverage system like those offered in these other countries, many Americans cycle in and out of coverage. Nearly one-third of U.S. adults under age 65 are either uninsured at some point during the year or underinsured, meaning their insurance does not protect them from high medical expenses. Because there is no accepted standard for essential benefits, even the insured can encounter difficulty paying medical bills. Not surprisingly, half of U.S. physicians report that the time they spend helping patients get needed treatment or medications because of insurance restrictions is a major problem. One study supported by The Commonwealth Fund found that physicians spend $31 billion a year dealing with insurance companies. On a per-person basis, the U.S. spends more than twice as much as other countries on the net costs of insurance administration. Varying benefit designs, marketing costs, people churning in and out of coverage, underwriting, and insurance profit margins all contribute to higher overhead costs. A recent McKinsey study estimates that such complexity—including multiple reporting requirements—accounts for some $90 billion per year in excess costs.

Insurance reform is fundamental for access to care and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value, not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is publicly available information that gives patients comparative information on quality and price to facilitate choice and providers data to improve quality and efficiency.

The U.S. stands out among other countries for the high prices it pays for care. All other industrialized countries leverage their purchasing power to negotiate reasonable provider payment rates and prescription drug prices. Unlike countries with multiple payers and competing insurers—such as Germany, Switzerland, and the Netherlands—the U.S. lacks a mechanism to coordinate payment policies to achieve coherent price signals or use group purchasing power. As a result, the U.S. tends to pay higher prices for specialized services, including prescription drugs, particularly brand-name drugs without generic options. A recent McKinsey study found the U.S. pays 50 percent more than other countries for comparable drugs and pays for a more expensive mix of drugs than do other developed countries, leading to total costs per capita that are twice as high as other industrialized nations.

Improving Primary Care

Also notable are our nation's weak primary care foundation and poor care coordination. Other countries have insurance systems that promote continuity of care and provide a choice among primary care practices in the community. Many encourage or require patients to identify a "medical home"—a practice that will serve as their principal source of primary care and coordinator of specialist care when needed. With modest financial incentives, more than 90 percent of French adults voluntarily choose to sign up with a medical home. In the Netherlands, after-hours cooperatives take over for primary care physicians at nights and weekends, which explains why 97 percent of Dutch primary care physicians report that they have arrangements for after-hours care of patients. By contrast, only 29 percent of U.S. primary care physicians report any arrangement for the care of their patients after hours.

The U.S. relies on market incentives to shape its health care system, yet other countries are much further along in providing financial incentives to primary care physicians aimed at improving quality of care. The U.K. has had substantial success in improving quality of care with its pay-for-performance rewards to primary care physicians. Eighty-nine percent of U.K. primary care doctors report they can receive financial incentives for quality improvement. By contrast, only 36 percent of U.S. primary care physicians report that they can receive financial incentives based on meeting quality targets, delivering recommended preventive or chronic care, or meeting other care goals as of 2009. Incentives and targeted support for primary care in other countries include extra payments to add nurses to care teams, payment for e-mail consultations, and enhanced payments for after-hours care. Providers also receive extra payments for enrolling patients in disease management programs and for offering chronic care services such as patient self-management education. Several countries pay physicians in a way that narrows the spread between primary care physicians' and specialists' income—making a stark contrast to the widening gaps between primary and specialty providers in the United States. Countries that have traditionally paid for care on a fee-for-service basis are increasingly moving toward a mixed payment method, including per-patient monthly allotments for providing access, coordination, teams, and serving as a medical home as well as fees for visits or incentives for quality. In most other countries, hospital and inpatient physician services are "bundled" into a single system of payment, either as global fees based on diagnosis or hospital budgets including salaries of physicians caring for hospital patients.

Investing in advanced clinical information systems is instrumental to inform, guide, and drive innovation. Despite its reputation for use of technology, the U.S. lags way behind other countries in adoption of health information technology and creation of health information exchange networks that facilitate access to all of a patient's pertinent medical information for physicians and other health professionals, authorized by patients. In some countries, patients have direct access to their own medical records. Less than half of American primary care physicians report use of electronic medical records, compared with nearly all of their counterparts in the Netherlands, New Zealand, Norway, and the U.K. Other countries have invested to spread the adoption and use of health information technology, with the capacity for information exchange. The wide differences across countries reflect national efforts to standardize and promote use, often with financial incentives. The American Recovery and Reinvestment Act enacted earlier

this year should help speed adoption of information technology in the U.S.

Countries are also investing in assessing comparative clinical effectiveness to inform patient and physician decisions as well as pricing and benefit designs. Such assessment promotes innovation and enables reference pricing of medications and brings downward pressure on higher-cost alternatives. In addition, several countries are developing rich comparative information systems on performance. In Germany, peers visit hospitals where the quality of care is substandard and enter into a "dialogue" about why that is the case. The Netherlands and the U.K. are investing in transparency in reporting performance data, including data on patient experiences. In both countries, this information is posted on public Web sites as well as fed back to clinicians. The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

Overall, what most differentiates the U.S. from other countries is the leadership shown by government in setting coherent policies that drive health systems to high performance. This includes setting goals, measuring performance, and rewarding improvement. Over the last decade, a focused strategy and quality outcomes framework have helped transform the National Health Service in England. When other countries rely extensively on markets, government sets market rules in the public interest to focus competition on quality and efficiency and provide information to spur improvement and innovation. In countries with multiple payers and competing insurers, this includes provisions for public and private participation in a common set of policies that work in the same direction.

But today, the national leadership in the U.S. is working to put in place the coverage and delivery reforms that our country desperately needs to ensure the health and economic security of current and future generations. We have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high-quality care at lower costs. We can learn from the experiences of other nations as they continue to innovate to meet current and future needs for accessible, high-quality, and efficient care. By enacting national reforms that take steps to put the United States on a path to a high performance health system, there is the opportunity to reap a high return for the health of the population and the economy.

July 8, 2009

National Leadership to Achieve a Performance-Driven Health System

By Karen Davis & Stephen C. Schoenbaum

What is largely missing from the congressional health reform proposals is an overarching framework that establishes goals for a high-performance health system and includes a coordinated set of public policies and private sector actions that would ensure the U.S. reaches benchmark levels of performance by 2020. Without a mechanism for setting long-range goals as well as immediate priorities for performance improvement, we could fail to realize the enhanced impact and economies possible from concerted action.

Setting Health Goals and Priorities for Performance Improvement

The Commonwealth Fund's Commission on a High Performance Health System has documented that the U.S. is not achieving the health outcomes, quality of care, and access to care that could be achieved with the resources the country commits to health care. The lack of accountability for results at the national, state, and local health care delivery levels reflects an absence of goals, priority improvement targets, incentives, and support required to meet performance targets—as well as the lack of consequences for performance that does not meet such targets.

A major reason for this lack of accountability, and for highly variable, often poor performance, is the fragmentation of the health care financing and delivery system. Decisions shaping the U.S. health care system are made by thousands of private and public stakeholders, largely acting independently and often with a goal of shifting costs to other parties rather than achieving the best results for the system as a whole. What is needed is national leadership to coordinate the now-disparate components of the health care system.

There are a number of national health initiatives with defined objectives, including the U.S. Department of Health and Human Services' "Healthy People 2010," the National Quality Forum's "National Priorities Partnership," and the Institute of Medicine's priorities for comparative effectiveness research. The Commonwealth Fund's Commission on a High Performance Health System has developed and published a national scorecard on U.S. health system performance that includes achievable benchmarks across the domains of health outcomes, quality, access, equity, and efficiency.

Health reform proposals under consideration in the House and Senate include requirements for the development of national priorities for quality improvement and reports to Congress outlining national priorities and strategies for health care quality improvement. A Republican-sponsored alternative proposal calls for a new forum on the quality and effectiveness of health care, to be comprised of private-sector representatives. But these proposals focus primarily on health care quality, falling short of a comprehensive set of goals for health system performance that includes access to care, equity, and efficiency.

The U.S. health system will not reach its potential until we have an agreed-upon set of national performance goals and improvement targets with the government's imprimatur, along with supporting policies, resources, and actions. One process for establishing these goals, targets, and supports could be an annual "Health Performance Report," submitted to Congress by the president. This publication would report on health system performance, including:

- health outcomes across geographic regions of the U.S. and population subgroups;

- access to care;
- quality of care;
- efficiency; and
- capacity to innovate and improve.

Such a report would help create a clear picture of the state of the health system and complement the "Economic Report of the president" and data reports on economic growth and employment. Most important, it would include the president's 2020 goals for health system performance, priority targets for improvement, and recommended policies and private sector actions required to meet them, all based on consultation with the public and health care stakeholders. Congress would act annually to accept or modify these goals and priorities, and make the policy changes needed to help achieve them.

The power of driving performance improvement through presidential, Congressional, and private sector leadership might best be understood by considering the illustrative health system performance goals for 2020 and target indicators for improvement outlined in the exhibit below. These examples highlight the many components of health system performance, which encompasses health outcomes, delivery system organization, quality and safety, disparities, insurance coverage, and incentives to bend the cost curve.

A Whole-System Strategy

Once agreement on the long-range goals and shorter-term improvement targets is achieved, the president could oversee the development of an implementation plan and submit it to Congress for review; the plans would be updated each year. The president also could ensure that the public agencies or private organizations responsible for the key components of a high-performance health system had a clear mandate based on the goals and targets, and would be held accountable for fulfilling that mandate. For example, the goals and targets would shape priorities within the following areas:

- **Comparative effectiveness.** Priorities for the $1.1 billion allocated to various agencies within the U.S. Department of Health and Human Services by the American Recovery and Reinvestment Act for comparative-effectiveness research would be based on these goals and targets.
- **Health information technology.** Meaningful use of health information technology and design of health information exchanges provided for under the American Recovery and Reinvestment Act would be consistent with achieving these goals and targets.
- **All-population/all-payer database.** An all-population/all-payer data system would be developed and used to monitor and track performance on these goals and targets. Public reporting would be developed to ensure transparency and support improvement efforts.
- **Quality improvement.** Professional bodies and state agencies that set standards for quality, accreditation, certification, and licensure of health care providers and organizations would agree to align their processes with actions to achieve these goals and targets.
- **Workforce planning and development.** Public agencies charged with workforce planning and development would develop policies to address gaps in accessibility of services and in preparation of teams of health care professionals required to meet these goals and targets.
- **Public health.** Achieving population-oriented health goals and the best possible health outcomes would become the guiding principle for investment in public health activities and adoption of policies such as taxing products related to unhealthy behaviors.

- **Insurance exchange.** Health insurance exchanges or connectors at the national, state, or regional level would set standards for qualified health plans that would help meet these goals and targets.
- **Payment reform**. Perhaps most important, Medicare, Medicaid, and private and public plans participating in health insurance exchanges would be held accountable for payment policies that reward providers based on these goals and targets. The design and rapid testing of new incentives would be facilitated by creation of a Medicare Payment Board within the executive branch whose decisions would be reviewed periodically by Congress.

Coordinating national leadership for all of these components of the health system would enable the federal government to: 1) assign clear responsibility and authority for the key aspects of the health system singly and jointly, and 2) provide the necessary capacity to enable agencies and organizations to act to secure access for all, better health outcomes, and slow the rate of cost growth. The new leadership roles needed to provide a coordinated and systemic approach to improving population health and wresting better value from health spending should be addressed as part of health reform legislation.

A Gain for the Nation

To illustrate the potential gain for the nation of a comprehensive, integrated approach to health reform, the *Path to a High Performance U.S. Health System* report published in February 2009 by the Commonwealth Fund Commission on a High Performance Health System outlined specific reforms related to provider payment, information systems, population health, and coverage that—in combination—could ensure affordable coverage for all, achieve savings, and improve population health.

The U.S. must establish a process for reaching national agreement on long-range goals and priorities for improvement in order to accomplish comprehensive, integrated health reform. This will require national leadership and a mechanism for the federal government to consult with the public as well as private health care stakeholders. The recommendations outlined here would take us a long way toward ensuring that the U.S. has a high-performing health system that simultaneously ensures better access, improved quality, and greater value. The importance of goal-setting, coordinated policies, and leadership must be considered as health reform legislation takes shape in Congress.

Health System Performance Goals for 2020 and Shorter-Range Target Indicators: Illustrative Examples

2020 Health System Performance Goals	Shorter-Range Target Indicators
1. The U.S. is in the top five countries in achieving desired health outcomes for its population.	• Percent of population receiving key preventive services or screening • Percent of population with chronic conditions controlled
2. Every American has the opportunity to enroll in a patient-centered, primary care practice that is accountable for ensuring that patients receive accessible, coordinated care, including all recommended preventive, acute, chronic, and end-of-life care.	• Percent of adults and children enrolled in a patient-centered primary care practice • Percent of physicians practicing in accountable care organizations
3. All providers reach attainable benchmarks of performance on indicators of health care quality and safety, and racial and ethnic disparities in quality of care are eliminated.	• Percent reduction in gap between benchmark levels of quality and safety and 2009 levels • Percent reduction in disparities in quality by race and ethnicity
4. All Americans have the opportunity to be covered by an affordable health plan that ensures that premiums and out-of-pocket expenses do not exceed an affordability standard (e.g., 10 percent of income for median-income families, and less for those with incomes below the median).	• Percent of population insured • Percent of population with premiums and out-of-pocket expenses within an agreed-upon affordability standard
5. Health spending over 2010–20 is slowed by 1.5 percentage points a year from 2009 rate of increase.	• Percent of provider revenue that replaces fees-for-services with value-based payment for bundles of care, including per-patient fees for chronic care, medical home, acute care case rates, partial or full capitation, or pay-for-performance • Percent of physicians and hospitals with "meaningful use" of health information technology • Percent reduction in duplicative, avoidable, or ineffective services, and administrative overhead

September 30, 2009

Forging Health Reform Consensus

By Karen Davis

Cooler weather has arrived and, with it, cooler heads are moving forward with health reform. Despite the summer demonstrations against congressional health care legislation, there is widescale recognition that the U.S. health system cannot continue on its current course. Ever-rising numbers of uninsured, insurance premiums that are out of reach of even middle-income families, and the strain on businesses and government budgets from a health sector consuming a greater and greater share of the nation's economic resources make the status quo untenable.

Still, most Americans remain perplexed by the different versions of health reform presented in legislation from three committees in the House of Representatives and two committees in the Senate. The daily headlines highlighting differences in opinion on specific provisions suggest bipartisan and even Democratic party agreement is elusive. Yet, even though the Senate Finance Committee is still considering legislation and the final bills going to the House and Senate floors have yet to be formed, there is, in fact, significant consensus on the framework for reform across all the bills moving through Congress. It includes: affordable health insurance coverage for all; increased choices; incentives for accountability; greater transparency; shared responsibility; redirected resources; and opportunities for learning and acting as reform is implemented.

Affordable Coverage for All

On the key goal of ensuring affordable coverage for all, the proposals under consideration include four common elements: expansion of the Medicaid program to all of the lowest-income individuals and families; provision of income-related assistance to make premiums affordable for moderate-income families; an essential benefit package to ensure financial access to health care; and an affordability standard to ensure that no family faces serious financial hardship as a result of illness or injury.

The House proposal and Senate Finance Committee Chairman's Mark include expansion of Medicaid up to 133 percent of the federal poverty level (almost $30,000 for a family of four), while the Senate Health, Education, Labor, and Pensions (HELP) proposal would raise the bar to 150 percent of poverty. Both the House and the two Senate versions would provide assistance in paying premiums for families up to four times the federal poverty level (about $88,000 for a family of four). Each bill would set a maximum on the most that any family in this income bracket would pay for health insurance at about 12 percent of income for higher-income families. Individuals with lower incomes or who are covered by employer plans would pay less. While the differences in the subsidy amounts for different incomes across the House and Senate bills are important, all of the bills recognize that, with premiums now exceeding $13,000 a year, even average-income families cannot afford health insurance on their own.

All of the proposals also call for creation of an essential benefit package that covers hospital, physician, prescription drugs, preventive care, and other services, with the details left to those responsible for implementing the legislation. Different options would be available, with individuals able to make trade-offs between lower premiums and higher out-of-pocket costs. But all plans would be required to cover a minimum "actuarial value," or share of all expenses, ranging from 65 percent to 95 percent. This range is comparable to the share of expenses covered by the plans typically held by working families and members of Congress. The House bill and Senate Finance Committee Chairman's Mark ensure that lower-income families have affordable out-of-pocket costs.

Again, the differences among proposals on the table are important but there is consensus on the basic structure.

Increased Choices

The most contentious issue is whether a new public health insurance plan would be offered through a health insurance exchange or the marketplace. What is lost in this debate is that all of the proposals would establish such an exchange and set rules on participating plans, including their availability to all on the same terms regardless of health status. These rules would dramatically increase the availability and affordability of coverage for those who have been excluded from the insurance market because of serious health conditions.

The proposals also would expand people's insurance plan choices. The House would include a public health insurance option, which would be sponsored by the government. The Senate HELP proposal includes a community health insurance plan offered by the government but with claims administered by private parties, and the Senate Finance Committee Chairman's Mark includes a nonprofit, consumer-controlled private plan. The structure of the plans and potential premium savings differ, but there is shared recognition that the private insurance market needs to change—and that change can best be accomplished by offering new affordable public or nonprofit plan choices in the marketplace.

Incentives for Accountability

An important aspect of the reform bills that has remained under the radar screen is that all seek to transform the health system from one that rewards doing more to one that rewards getting better health outcomes for patients. Both the House and the Senate Finance Committee Chairman's Mark would improve the coverage of preventive services. Today, only half of adults are up to date with preventive care. No single provider takes responsibility for reminding patients of screenings and ensuring that such services are offered on a timely basis, and financial barriers lead many patients to put off care as long as possible. Likewise, many chronic conditions go uncontrolled because there is no system of accountability for monitoring care over time.

Both the House and Senate Finance Committee Chairman's Mark would establish a Center on Payment Innovation that would reward physicians, hospitals, and health care organizations that agree to be held accountable for ensuring their patients get the best care. This change in accountability for health outcomes, quality of care, and prudent stewardship of resources is a seismic shift from the current system, which simply pays for units of services—each test, each procedure, each face-to-face visit with a physician, each emergency room or hospital encounter. Instead, patients would be encouraged to identify a physician, nurse practitioner, or clinic as their principal source of care. That provider or practice would be responsible for that patient and rewarded for focusing on providing accessible, coordinated, patient-centered care delivered through interactions by telephone, telemedicine devices, or the Internet; during the day or on evening and weekends; and by a physician or a care team that includes nurses, pharmacists, and other health professionals.

Greater Transparency

One of the reasons the U.S. has the costliest health system in the world is that information on the quality and cost of care is not readily available to consumers in a system where profit on the provision of health care is accepted. What may turn out to be the sleeper in health reform are various provisions that would shine more sunlight on economic transactions, such as the profit margins and administrative expenses of insurance companies, the content of insurance policies purchased by consumers, and the financial relationships between physicians and medical device manufacturers and pharmaceutical companies.

Under the reforms, patients would have more information on the quality of care and prices. The gradual shift to global fee systems of payment for total care of a condition—like a hip fracture or heart surgery—would help patients know what to expect before selecting a source of care, as well as help physicians and hospitals benchmark their performance against their peers. The Commonwealth Fund Commission on a High Performance Health System National Scorecard found that performance improves on quality measures that are publicly reported. Even though the Congressional Budget

Office does not attribute significant savings from changes in provider behavior, greater transparency on quality and total fees could lead to substantial shifts in both provider and patient behavior and lower costs over the long term.

Shared Responsibility

It is not surprising that everyone is worried about who will pay for health reform. But the truth of the matter is that coverage for all is affordable if everyone does their part. Those without coverage are being asked to contribute to premiums on an affordable sliding scale based on income, whether they are young and healthy or older with complex health conditions. Young adults would pay lower premiums than older adults, and some proposals add options for young adults to continue coverage under their parents' plans up to age 26.

Employers are also expected to do their part, which will level the playing field between those companies that provide coverage and those that don't. Exceptions and special treatment will exist for very small businesses struggling to meet payroll and for workers whose share of the premium offered by employers is still burdensome.

Redirected Resources

The federal budget price tag for expanded health coverage seems staggering—$900 billion to over $1 trillion over a 10-year period under the House and Senate bills. Yet it's important to keep in mind that over the next decade the U.S. will spend $40 trillion on health care—and the new federal outlays represent about 2 percent to 3 percent of total health spending. To finance this expansion of coverage, about half of the resources will come from slowing growth in provider payment rates under public programs by about 1 percent a year—which hospitals and other health care providers have agreed is possible given savings that will be generated by efforts to improve productivity and eliminate waste. Pharmaceutical manufacturers have offered to cut the price of brand-name drugs in half for seniors hitting a gap in their Medicare drug plan, called the "doughnut hole." Other savings will come from eliminating overpayments to Medicare managed care plans and levying fees on insurers and device manufacturers. Under the House bill, additional revenues may be generated by reversing some of the tax cuts of the last three decades for the wealthiest households or, under the Senate Finance Chairman's Mark and possibly the revised House bill, by taxing nonessential insurance benefits or certain health industry suppliers.

Learning and Acting as Reform Is Implemented

Some have called for proceeding at a slower pace, cautioning that the reforms represent a major redirection in the health system and that not all of the consequences are known with certainty. But the proposals in the House and Senate have numerous provisions that call for phasing and monitoring and provide opportunities to make adjustments as reform is implemented. The health insurance exchange, for example, would be established in 2013, and initially open only to individuals and very small firms. This would provide ample time for planning and addressing design issues, and would give discretion to those operating the exchange to decide when to expand to larger firms. As the exchange goes into operation, new transparency on insurance administration and review of premiums would assess whether intended efficiencies are occurring.

The Center for Payment Innovation would implement new methods of payment for physicians, hospitals, and health care organizations ready and willing to participate, with discretion for the Secretary of Health and Human Services to spread successful innovations more broadly. A new commission has been suggested in the Senate to monitor trends in federal budget spending and identify areas of waste and potential additional savings and to expedite the implementation of remedies. This might reasonably be extended to system-wide review of health expenditures for employers and working families. Based on the system reviews, Congress could act to modify reforms, including phasing in various provisions more slowly or quickly, or adding additional safeguards or savings.

A Consensus-Minded Approach

All of the provisions described—in combination with those in the American Recovery and Reinvestment Act of 2009 that are investing in health information technology and comparative effectiveness research—would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the

long term. Each bill now in Congress would also make sure that Americans with insurance maintain stable, affordable coverage and that uninsured Americans gain coverage.

Focusing on areas of consensus rather than our differences or most preferred solution should help make reform this year a reality. The framework for health care transformation has been laid out—our final task is to work through the remaining issues without derailing our efforts and pass this legislation, which has the power to improve the financial health of our nation and the financial and physical health of its people.

January 28, 2010

The Way Forward with Health Reform

By Karen Davis

In his State of the Union address, President Obama urged Congress to stay the course and enact comprehensive health reform. He reminded us that the problems that health reform is intended to address pose a serious threat to the health of Americans and our economy.

Nearly 50 million Americans are uninsured, as those who lose their jobs often lose their health insurance. And it's not just the uninsured who are at risk: with the rise in health care costs in the last decade, even middle-class families with jobs and coverage are struggling to pay their share of premiums and medical expenses. Seventy-two million working-age adults have difficulty paying medical bills or accumulated medical debt, while rising health care costs force employers to choose between hiring new workers, paying higher wages, and providing adequate health insurance to their employees.

For all that families, businesses, and government spend on health care, the health system fails to deliver reliably safe and high-quality care that is easily accessible to patients. Instead, nearly three-fourths of Americans report difficulty getting a doctor's appointment promptly, reaching their physician by phone, or obtaining care on nights or weekends. Half of patients say they don't receive their test results or their doctors don't have their medical information when needed. One-third of the public undergo duplicative tests or other care that is unnecessary or of little health benefit. And more than one-fourth experience administrative hassles when handling insurance claims or paying medical bills.

The high costs of health insurance and health care also force people to go without needed care, whether it's a doctor's visit or a prescription refill. Because of all of these inadequacies, too many Americans are suffering—even dying—without the care they need. And the health system will continue to deteriorate if we do nothing to change course.

But misleading claims about the impact of health reform, and lack of understanding of its potential to improve patients' experiences, have undermined public support. What have been obscured are the many aspects of the proposed health reform legislation that would make health care accessible to all Americans and begin to transform the delivery system to improve the quality and coordination of care. Both the House and Senate bills:

- Cover over 30 million uninsured Americans who now fail to get the care they need; improve 24/7 access to doctors and nurses; and provide the information necessary to ensure the best care for patients.
- Provide families who make less than about $90,000 a year and don't have employer coverage with help in paying their insurance premiums; offer coverage under Medicaid for families with incomes under about $30,000; and set a ceiling on family out-of-pocket medical expenses.
- Ensure health insurance is available to all, without regard to health conditions and without artificial limits on covered expenses, and establish a standard for essential comprehensive benefits.
- Lower premiums and improve benefits, especially for those buying insurance on their own and employees of small firms, and provide tax credits to small businesses.
- Launch an intensive effort to develop and implement innovations to transform health care delivery to improve quality of care, preventive care, and control of chronic conditions, while

eliminating waste, duplication, and the need for costly hospitalizations and reducing insurance waste and overhead.

- Help ensure Medicare's fiscal solvency while improving prescription drug benefits for beneficiaries and helping pay for home care and long-term care for tomorrow's disabled.
- Reduce the federal budget deficit and middle-class families' expenses.
- Ensure that no one in America is unable to obtain the care they need because of cost—so that the U.S. is no longer the only advanced, wealthy country where losing a good job or taking a major cut in pay means losing access to, and the ability to pay for, health care.

Myths and Reality

One way to move forward is to look at what health reform is and isn't—to separate myth from reality.

1. Myth: Health reform would ration needed care.
   Reality: Reform would increase patients' choice and improve access to care.

The charge that the American health system will be "government-run" or "socialized," with the government telling doctors what they can do for patients, stirs a deep-seated fear that care will be rationed. The truth is that nothing in the health reform legislation calls for rationing effective care. The law would support research on the comparative effectiveness of diagnostic and treatment services so that physicians and patients know which drugs and treatments work best; it would not, however, limit doctors' ability to treat patients. The U.S. would retain its largely private system of health care delivery and continue to have a well-resourced system capable of meeting the needs of all. In fact, improved access to affordable coverage though a national health insurance exchange (in the House bill) or state exchanges (in the Senate bill), as well as proposed expansions of Medicaid, would improve access to care and choice among providers for many Americans.

2. Myth: Health reform would raise insurance premiums and fail to reduce future health costs.
   Reality: Without reform, many Americans stand to lose their coverage or face higher premiums and medical bills as benefits erode. Health reform would offer a return to rising incomes.

Many American families are living on the edge and hard-pressed to meet their day-to-day expenses. Not surprisingly, they worry that health reform might mean losing the coverage they already have—or even higher costs as uninsured people gain coverage. Yet the reality is that rising health care costs have undermined wage increases over the last decade and increased workers' premium costs and out-of-pocket health care expenses. Without health reform, those trends will continue unabated.

Between 1999 and 2008, employer family health insurance premiums rose by 119 percent, while the median family income rose by less than 30 percent. As a result, the total average family premiums paid by employers and workers have risen from 11 percent to 18 percent of median family income. If Congress fails to pass reforms that are effective in controlling the rise in health care costs, premiums are projected to rise to 24 percent of the typical family's income by 2020. In any economic climate, but especially today, families cannot afford to devote one-fourth of their income to maintaining insurance coverage, nor can businesses afford to pay their share of insurance premiums while also giving raises to employees.

Comprehensive health reform would reduce administrative costs for insurers and help modernize the delivery of health care services, both of which would result in reductions in private insurance premiums. A recent analysis finds that, without reform, family premiums are expected to increase from $13,649 in 2010 to $22,535 in 2019. By 2019, family premiums would be $1,900 lower with reform. Along with reductions in out-of-pocket costs and lower taxes for Medicare and Medicaid, estimated savings for the typical family would be about $2,500, relative to predicted costs, if we stay the current course.

3. Myth: Health reform would cut Medicare benefits.
   Reality: Reforms would improve prescription drug coverage and protect future Medicare benefits by giving doctors and hospitals incentives to improve care and efficiency and reduce costs.

Seniors and the disabled are concerned that health reform would undermine their Medicare benefits. Yet Medicare benefits would actually improve under health reform. For example, the so-called doughnut hole in the prescription drug benefit would be eliminated under the House bill and reduced under the Senate bill. The House bill would give the government the authority to negotiate prices of prescription drugs, a move that would further benefit people with Medicare and reduce their out-of-pocket costs. Additionally, preventive services would be covered in full, without copayments.

Medicare reforms in the bills would also save the federal government money. Hospitals have agreed to shave one percentage point off their annual price increase under Medicare over the next decade, recognizing that coverage of the uninsured would reduce bad debt and other efficiencies would make it possible to improve productivity. Providers also fare well under the reforms. Even with this one-percentage-point price reduction, Medicare payments to providers would be more than adequate, exceeding the growth in our economy overall and increasing by 67 percent by 2019. Most important, a new Innovations Center within the Centers for Medicare and Medicaid Services would pilot innovative payment methods that reward providers who succeed in improving care, reducing the need for hospitalization and cutting waste, duplication, and ineffective services.

The government would stop paying private managed care plans extra for participating in Medicare. These plans were paid $11.4 billion more in 2009 than what the same beneficiaries would have cost were they enrolled in the traditional Medicare fee-for-service program. Health reform would gradually eliminate this inequity. Some extra benefits financed by these overpayments—received by a minority of beneficiaries but financed by all—would likely be eliminated. But all beneficiaries would continue to receive the basic Medicare benefits to which they are entitled.

4. Myth: Health reform would raise the average American's taxes.
   Reality: Reforms avoid any new broad taxes and instead seek to pay for better insurance by slowing spending growth.

Most Americans agree with the goals of health reform: covering the uninsured, improving the affordability of coverage and care, and cutting costs. But they are concerned that paying $800 billion to $1 trillion over 10 years for improved coverage would increase their taxes. They question whether the nation—and taxpayers—can afford such a commitment on top of government expenditures under the stimulus bill that was enacted to bring the economy out of serious financial crisis.

In fact, most middle-class families would not face tax increases. Almost half of the cost of improved coverage is financed by slowing increases in prices paid to health care providers and insurers. The remaining financing comes mostly from payroll taxes on families with incomes over $250,000 a year (in the Senate bill) and income taxes for families with incomes over $1 million (in the House bill), as well as fees on insurers, manufacturers or importers of brand-name drugs, and medical device manufacturers. An excise tax on insurers selling plans with premiums in excess of $24,000 might affect premiums for some workers—although few employees have plans that exceed this threshold, and safeguards could be added to protect workers who pay high premiums because of where they live, their age, or health risk.

5. Myth: Health reform would add to the deficit.
   Reality: Reform would reduce the deficit and reduce costs for businesses and families.

Related to the concern about taxes is a concern about red ink and the implications for future generations of unfunded expansions in coverage. The president, however, has made good on his pledge not to add to the federal budget deficit, and the Congressional Budget Office (CBO) estimates a net reduction in the budget deficit of $132 billion, in the Senate bill, to $138 billion

in the House bill. CBO also estimates that revenues would exceed expenses in the second decade, from 2020 to 2029.

In short, health reform as designed in the House and Senate would achieve the goals set forth by the president: 1) to ensure the stability and security of insurance coverage for those who have it; 2) to provide coverage for those who don't; and 3) to slow the rise in health care costs for employers, individuals, and government.

Health reform would help all Americans receive the care they need to lead healthy and productive lives, while removing the financial strain of inordinately high health insurance premiums and out-of-pocket medical expenses. Rather than inflicting high costs on those who are sickest, as in the current health system, the legislation's proposed financing is balanced and fair, drawing from households, government, and employers. It changes the incentives in our health system, from rewarding a high volume of services to rewarding prevention, management of chronic conditions, and the best health outcomes for patients. Health reform preserves the best of American health care, while fixing what doesn't work for patients.

While the way forward politically is not yet totally clear, the president reassured Americans in his State of the Union address that he is not going to walk away from the problem. He urged Congress to enact health reform that will relieve the burden on middle-class families, address the worst practices of the insurance industry, and reduce health care costs and insurance premiums.

The odds are that, like President Obama, you, a family member, or a close friend has experienced a problem with health care coverage, medical bills, or care. The health reform legislation is about addressing the problems we all face; we cannot let the opportunity to improve our lives and our livelihoods slip by.

March 22, 2010

A New Era in American Health Care

By Karen Davis and Sara Collins

The historic action by the House of Representatives in passing comprehensive health reform legislation will usher in a new era in American health care—one in which all Americans will be able get the care they need without incurring financial hardship, and no American will be denied health insurance coverage simply because they have a preexisting medical condition.

Health reform will provide new security for working-age Americans across the income spectrum, increasing access to needed care for millions who are currently uninsured and underinsured. It will cover an additional 32 million people by 2019, or 95 percent of legal residents, by expanding eligibility for Medicaid and by bringing sweeping change to the individual and small group health insurance markets with new premium subsidies. New regulations will prohibit insurers from excluding or charging higher premiums to individuals and small businesses on the basis of health status or preexisting medical conditions, charging excessive premiums to older adults, revoking coverage when people get sick, or setting lifetime and annual limits on what plans will pay. Young adults will be able to remain on their parents' health plans up to age 26 beginning in 2010.

New state-based insurance exchanges will provide structured marketplaces, where small businesses and people without employer coverage may select health plans that will have to meet new standards for comprehensive coverage and consumer information. Families with incomes between $30,000 and $88,000 a year will be eligible for premium subsidies for plans purchased through the exchanges (those with incomes up to $30,000 for a family of four would become eligible for Medicaid). These subsidies would cap premium costs as a share of income at 3 percent for families earning just over $30,000, and would rise with income to 9.5 percent for families earning $88,000. In addition, families in that income range would also have their out-of-pocket costs capped, or would be eligible for cost-sharing subsidies that would reduce their medical bills.

Small businesses, which have suffered from rising health care costs and the recession, will benefit from new market regulations against underwriting and will be able to purchase health coverage through the insurance exchanges, which will reduce the costs they incur in searching for health insurance. In addition, a new tax credit will be available for up to a two-year period starting in 2010 for small businesses with fewer than 25 employees and with average wages under $50,000, to offset the cost of their premiums. The full credit would be available to companies with 10 or fewer employees and average wages of $25,000, and would phase out for larger firms. Eligible businesses would have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit would cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit would cover 50 percent of that contribution.

Health reform will also bring important new benefits to people over the age of 65. It will improve Medicare prescription drug benefits by providing a $250 rebate to people who reach the coverage gap, or "doughnut hole," in 2010, and the doughnut hole will phase out completely by 2020. Preventive care will be strengthened in both traditional Medicare and private plans, as the bill eliminates cost-sharing for proven preventive care services, and provides an annual wellness visit for Medicare beneficiaries with no copayment. The new legislation will also help workers finance long-term care should they become disabled or frail.

Many Americans will feel the effect of the reform this year, as significant changes start to go into effect. Within the year:

- underwriting of children in the individual market will be prohibited;
- young adults will be able to stay on their parents' health plans to age 26;
- insurance companies will be prohibited from revoking coverage when people become ill, and from setting lifetime limits on benefits;
- small businesses will be eligible for new tax credits to offset their premium costs;
- people with preexisting conditions will be eligible for subsidized coverage through a national high-risk pool;
- new limits will be set for the percent of premiums that insurers can spend on nonmedical costs and, beginning in 2011, carriers that exceed those limits will be required to offer rebates to enrollees;
- Medicare will provide $250 rebates to beneficiaries who reach the doughnut hole; and
- Medicare will eliminate cost-sharing for preventive services in Medicare and private plans.

All of these improvements in health benefits for Americans will occur in a way that does not add to the federal budget deficit or accelerate the growth in health care spending.

The Congressional Budget Office estimates that health reform, as passed by the House of Representatives, will reduce the federal deficit by $143 billion over the next 10 years (2010–19). Congress is making the tough choices to both achieve savings of about $500 billion in the current federal budget over the next decade, and raise the revenues needed to finance the balance of the federal budget cost of this important reform. The legislation creates a new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services to test new methods of payment for medical homes, accountable care organizations, and bundled hospital and post-acute care. These efforts will markedly increase incentives to reduce avoidable hospitalizations. It also adjusts provider payments to account for improvements in productivity. And it restructures Medicare Advantage payment rates to make them more reflective of the costs that private plans face with rewards for low-cost areas and high-performing plans.

Commonwealth Fund estimates indicate that total health spending will slow under this reform—from a 6.6 percent annual rate of increase to less than 6 percent. Employers and workers will also realize savings. Health insurance premiums will be reviewed—preventing increases of 20 percent to 40 percent that have recently been proposed by insurance companies. Reform will save the average American family $2,500 in 2019.

Most important, the legislation will put the U.S. health system on a path to high performance, by providing for the testing of new ways of paying doctors and hospitals to reward results rather than fees based on the volume of services delivered and for the development of strategies to promote prevention and improve quality. An Independent Payment Advisory Board will be established and charged with issuing recommendations to achieve federal health spending targets, as well as nonbinding recommendations for private payers to harmonize private and public payment and achieve systemwide savings.

The U.S. will now join all other major industrialized countries with a system for ensuring access to essential health care, and we will lay the foundation for a high performance health system that yields access to care for all, improved quality, and greater efficiency. It is a victory for all Americans, who deserve the finest health system in the world.

June 17, 2010

Who Is Helped by Health Reform?

By Karen Davis

This spring—98 years after Theodore Roosevelt first proposed comprehensive health care—the United States joined the world's other major industrialized nations in providing all its citizens with access to essential health care.

Commonwealth Fund analysis shows that the Patient Protection and Affordable Care Act will deliver on all three of the goals President Obama set forth when Congress began crafting reform legislation last year:

- expand access to affordable health insurance for those without coverage;
- increase the affordability of insurance for those who already have it; and
- slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.

Given the complexity of the law, questions linger about how it will affect people's lives, specifically about what groups of Americans will be helped by health reform and how our experiences with the health care system will change. In this first part of a two-part blog post on the law's impact, I will explore how different groups will benefit from the new coverage options, benefit standards, and insurance market rules. The upcoming post will look at the benefits for patients of the health system changes contained in the new law.

- Uninsured individuals, whether low- or modest-wage workers or unemployed, will be able to get and afford the coverage and care they need.

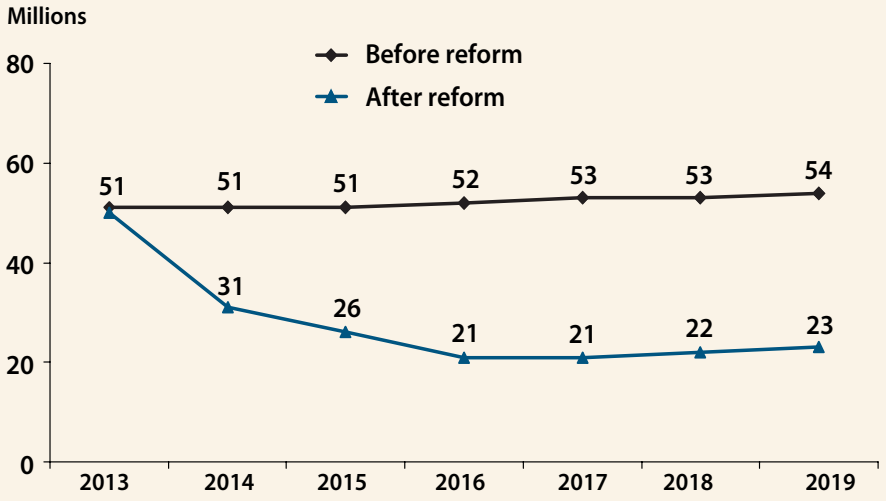
The Congressional Budget Office (CBO) estimates that by 2019 health reform will increase the proportion of the insured population from 83 percent to 94 percent. About half of the 32 million newly insured will be covered by Medicaid, and the other half will receive help in purchasing private coverage. Some will take up employer coverage for the first time. Those without employer coverage can receive federal assistance to purchase qualified health plans through the insurance exchanges; this applies to individuals and families earning between 133 percent and 400 percent of the federal poverty level (between $29,327 and $88,200 for a family of four). Within that income range, premium contributions will be limited to between 3.0 percent and 9.5 percent of a family's income.

- Young adults graduating from high school or college will no longer be uninsured and no longer dependent on emergency rooms for care.

Nearly 30 percent of young adults are uninsured, often aging out of their parents' plans and unable to find jobs that offer health insurance benefits. Fifty-three percent report going without needed care in the last year, and four of 10 report difficulty paying medical bills or accumulated medical debt. One-fourth of young adults use emergency rooms during the year, incurring bad debts that may affect their future credit as well as the financial stability of safety-net institutions serving those who cannot pay.

Effective September 2010, young adults will be permitted to stay on their parents' insurance policies up to age 26, or until they find a job with health benefits. In 2014, about 7 million young adults with incomes below 133 percent of the poverty level ($14,404 for a single adult) will become eligible for Medicaid; states have the option to cover low-income adults beginning in 2010 at the current federal matching rate. In addition, young adults will be able to purchase coverage through health insurance exchanges in 2014; 85 percent of those young adults (those with incomes below four times the poverty level of $43,320 for a single adult) will be eligible to receive help paying premiums and medical bills.

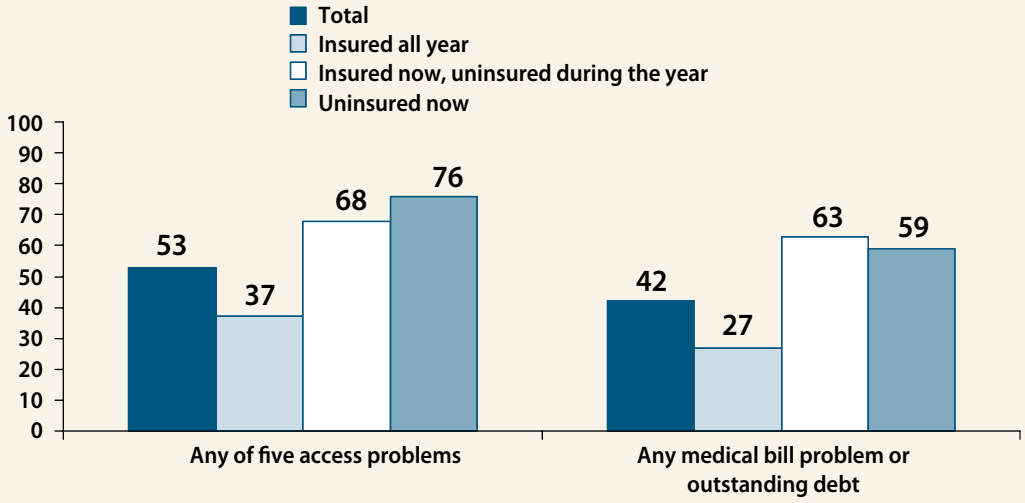
Trend in the Number of Uninsured Nonelderly, 2013–2019 Before and After Health Reform



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% of legal nonelderly residents are projected to have insurance under the new law.
Source: K. Davis, *A New Era in American Health Care: Realizing the Potential*, (New York: The Commonwealth Fund, June 2010).

Uninsured Young Adults Most Likely to Have Cost-Related Access Problems and Medical Bill or Debt Problems in the Past Year

Percent of adults ages 19–29 reporting cost-related access problems or medical bill or debt problems:



Notes: Access problems include not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care. Medical debt or bill problems include not being able to pay medical bills; being contact by a collection agency; changing way of life to pay medical bills; and medical bills/debt being paid off over time.
Source: S. R. Collins and J. L. Nicholson, Rite of Passage: *Young Adults and the Affordable Care Act of 2010*, (New York: The Commonwealth Fund, May 2010).

- Workers will no longer lose coverage when changing jobs.

Thirty-two percent of adults report at least one change in their health plan in the past three years. These changes in coverage often result in spells without any insurance, loss of certain benefits, or the need to change doctors. Such changes can have serious consequences for continuity of care and proper management of chronic conditions.

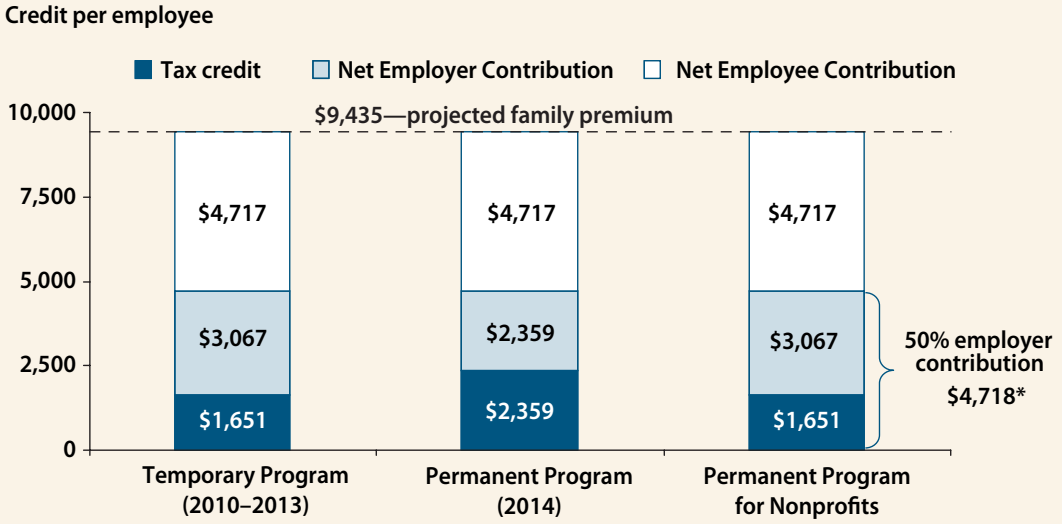
The new health reform law will help workers at every income level keep their insurance coverage if they already have it, or purchase coverage if they don't. Beginning in 2014, workers in small businesses or those buying insurance in the individual market will be able to purchase coverage through insurance exchanges that more efficiently pool risk and reduce administrative costs. After 2017, states have the option of opening the exchange to businesses of any size.

- Small business owners will be able to offer health coverage and afford premiums.

About 78 percent of firms with 10 to 24 employees and 49 percent of businesses with three to nine employees now offer coverage to their workers—even though insurance premiums for small businesses tend to be higher than premiums for larger businesses for health plans with similar benefits. These percentages may increase as workers seek to fulfill their obligation to carry health insurance. In Massachusetts, for example, the share of workers with employer coverage increased from 80 percent to 84 percent under health reform, as more employers offered coverage and some workers who had been eligible for coverage opted to take it up.

As an added incentive for employers to offer coverage, tax credits will be available to offset up to 35 percent of employers' premium contributions for two years for low-wage businesses with fewer than 25 employees.

Small Business Tax Credits Under Affordable Care Act for Family Premiums



* To be eligible for tax credits, firms must contribute 50% of premiums. Firms receive 35% and later 50% of their contribution in tax credits.
Note: Projected premium for a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Small businesses are eligible for new tax credits to offset their premium costs in 2010. Tax credits will be available for up to a two-year period, starting in 2010 for small businesses with fewer than 25 employees and with average wages under $50,000. The full credit will be available to companies with 10 or fewer employees and average wages of $25,000, phasing out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit will cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit will cover 50 percent of that contribution. Tax-exempt organizations will be eligible to receive the tax credits, though the credits are somewhat lower: 25 percent of the employer's contribution to premiums in 2010–13 and 35 percent beginning in 2014.
Source: S. R. Collins, K. Davis, J. L. Nicholson, S. D. Rustgi, and R. Nuzum, *The Health Insurance Provisions of the 2009 Congressional Health Reform Bills: Implications for Coverage, Affordability, and Costs*, (New York: The Commonwealth Fund, January 2010).

More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt

		Insured All Year		Uninsured Anytime During Year	
Percent of adults reporting:	Total	No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	26	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007,* (New York: The Commonwealth Fund, August 2008).

A temporary program is slated to begin in 2010; the permanent program, scheduled to start in 2014, will provide up to a 50 percent credit for two years.

In 2014, small employers can elect to purchase coverage for their employees through the exchanges, taking advantage of the reduced administrative costs and lower premiums they will bring.

- Families will face fewer difficulties paying out-of-pocket expenses.

Shrinking coverage—the typical employer plan now covers 80 percent of average medical expenses—and increasing deductibles during the past decade have resulted in a sharp rise in the number of Americans who face substantial out-of-pocket costs, rendering them "underinsured." One-fourth of insured Americans who have difficulty paying their medical bills report using all their savings or taking on credit card debt to pay those bills.

Beginning in 2014, insurance plans must meet essential benefit standards covering hospital care, physician services, prescription drugs, preventive services without cost-sharing, and pediatric dental and vision care, among other benefits. The benefit requirements do not apply to grandfathered plans or self-insured plans. Plans will be classified into different "tiers" to allow families to understand their out-of-pocket liability. Actuarial values—the proportion of costs actually covered—will range from 60 percent (bronze tier) to 90 percent (platinum tier). The percentage of expenses covered will vary depending on family income, and out-of-pocket expenses will be limited for individuals and families of all income levels.

- Low-income mothers will be able to afford prenatal care and have a healthy baby.

Work by the Commonwealth Fund shows that many women face problems securing affordable health coverage and care. Women are less likely to have employer-sponsored insurance available to them and often must seek coverage in the more expensive individual market. The practice of gender rating means that women pay substantially more than men for similar or worse

insurance. Pregnant women without employer coverage face particular difficulty securing adequate individual coverage for prenatal care: a recent study showed that across the country, just 13 percent of individual insurance market plans available to a 30-year-old woman provided maternity coverage.

Beginning in 2014, insurers will be prohibited from charging higher premiums because of gender, health status, or family history. Pregnant women in the Medicaid program will see new coverage options for freestanding birth centers and have access to free smoking cessation programs. The Department of Health and Human Services, meanwhile, is authorized to make grants to states to promote improvements in maternal, prenatal, and infant health. And states are eligible to receive federal funds to provide home visitation services for maternal health and prenatal care.

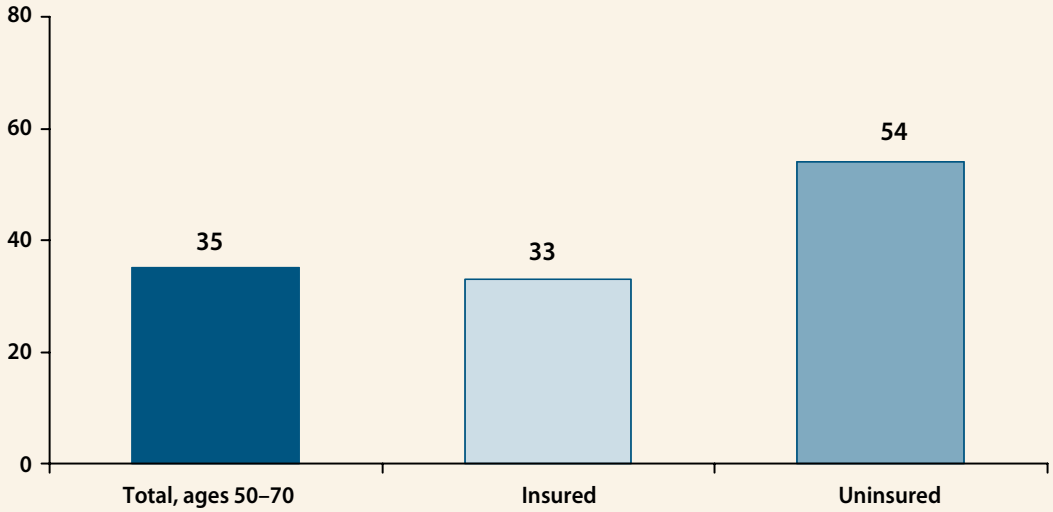
- Men and women will have access to preventive care and cancer screening for early detection.

Despite significant strides in improving the delivery of preventive services, many adults still fail to receive recommended preventive care and cancer screening. The Commonwealth Fund's National Scorecard on U.S. Health System Performance finds that only half of all adults, and less than one-third of uninsured adults, are up to date with recommended preventive care and screening services.

Beginning in 2010, all recommended preventive services will be covered without cost-sharing under new individual and group plans (for Medicare beneficiaries, this will begin in 2011). States that expand Medicaid coverage to include approved preventive services with no cost-sharing will receive increased federal funding for these services. This will remove financial barriers to care and save lives.

More Than One-Third of Older Adults Report Medical Bill Problems

Percent of adults ages 50–70 with any medical bill problems or outstanding medical debt*



* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.
Source: S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

- Older adults will no longer be denied coverage because of health problems and preexisting conditions.

Older adults seeking health insurance coverage typically face prohibitively high premiums, large deductibles, and troubling exclusions for health problems and preexisting conditions. A Commonwealth Fund study found that 24 percent of the near-elderly (ages 50 to 70) failed to get health care services because of the cost. More than one-third (35%) had a problem paying their medical bills in the last year or were paying off medical debt they had accrued over the last three years.

Beginning 90 days after enactment of the law, older adults with preexisting conditions who have been uninsured for at least six months will be eligible for subsidized insurance through a national or state high-risk pool. Older adults will pay no more than four times what younger adults pay for coverage.

In 2014, insurance companies will be required to cover all individuals regardless of health status and charge the same premium regardless of preexisting conditions. Premiums may vary based on age, but by no more than a three-to-one ratio. These provisions will greatly increase the affordability and availability of coverage for older adults with health problems.

- Individuals with functional limitations will be able to afford help to continue living at home.

More than 10 million Americans are estimated to need long-term care assistance and support to perform daily activities, but long-term care is simply unaffordable for the majority of the population. While Medicare covers some short-term skilled nursing and home health care, Medicaid is the only program available to finance care for those with long-term disabilities and needs and without significant income or assets. Unfortunately, workers and retirees with functional limitations must "spend down" their savings—essentially impoverishing themselves—before becoming eligible for Medicaid assistance.

The health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports in 2012. Known as the CLASS program, it will provide a cash benefit to individuals with limitations, enabling them to purchase nonmedical services and supports necessary to remain at home. After a five-year vesting period, the program will begin to provide benefits to those who need assistance. The program is financed through voluntary payroll deductions—all working adults will be automatically enrolled in the program unless they opt out.

- Medicare beneficiaries will receive free preventive care and no longer face the prescription drug "doughnut hole."

Medicare prescription drug coverage currently includes a gap—known as a "doughnut hole"—where beneficiaries are required to pay 100 percent of their prescription drug costs between $2,700 and $6,154. Under health reform, Medicare beneficiaries entering the coverage gap will receive a $250 rebate in 2010. In 2011, beneficiaries covered by private drug plans (other than those with high incomes) will receive a 50 percent discount on brand-name drugs. Beneficiaries will then receive additional discounts on brand-name and generic drugs, to close the doughnut hole by 2020. Rather than paying 100 percent of prescription costs in the gap range, beneficiaries will pay 25 percent.

In addition, beginning in 2011, Medicare beneficiaries are eligible for an annual wellness visit and all recommended preventive services, without any cost-sharing.

It's clear that a majority of Americans stand to benefit from the Affordable Care Act. This law ushers in a new era in U.S. health care—one in which every American has access to affordable health insurance coverage and no one is turned away simply because they have a preexisting condition. The new insurance market protections are designed to work in concert with important payment and system reforms that will improve access and quality and reduce cost growth for everyone; I will address these reforms in my next blog post.

June 29, 2010

How Will the Health Care System Change Under Health Reform?

By Karen Davis

In my last blog post, I discussed the ways the new health reform law improves the affordability of insurance for a variety of populations, including the uninsured and the underinsured and older and younger adults. The Affordable Care Act also includes a host of lesser-known provisions that, together, place a new emphasis on preventive and primary care and reward quality. These key features will ultimately push the health care system to deliver more patient-centered, accessible, and coordinated care. Below, I outline some of the reforms that will change people's experiences in the doctor's office and hospital.

Under the new reforms, patients will be more likely to have:

A physician practice that is accessible 24/7 and helps arrange specialist appointments.
A strong network of primary care physicians is central to a high performance health system that works for everyone. Yet only two-thirds of American adults under age 65 report having an accessible primary care provider (Exhibit 1). In addition, nearly three-quarters of all adults were not able to see their doctor quickly when sick, found it difficult to get through to their doctors by phone, or said it was difficult to get care after regular work hours without going to the emergency room.

Health reform will test a new model of care that changes the way health care is organized. Patients can enroll in a patient-centered medical home, which is accountable for ensuring that patients get all recommended care. By offering care on nights and weekends, by using information technology and office systems to remind patients about preventive care, and by assisting them with obtaining needed specialty care, medical homes provide high-quality, coordinated care.

Financial incentives will help these practices succeed. New pilot programs will support and reward practices with an extra "medical home fee" paid by insurers and public programs. Moreover, they can earn bonuses for ensuring that their patients receive preventive care and help with managing a chronic illness. Care teams, including physicians, nurses, pharmacists, and other health professionals, will ensure coordination of care and shared accountability for health outcomes. To support provider groups as they reorganize—a challenging task even for large providers—the government will begin to fund regional or state health information exchange networks, and test strategies for ensuring access to after-hours care, case management help, and more.

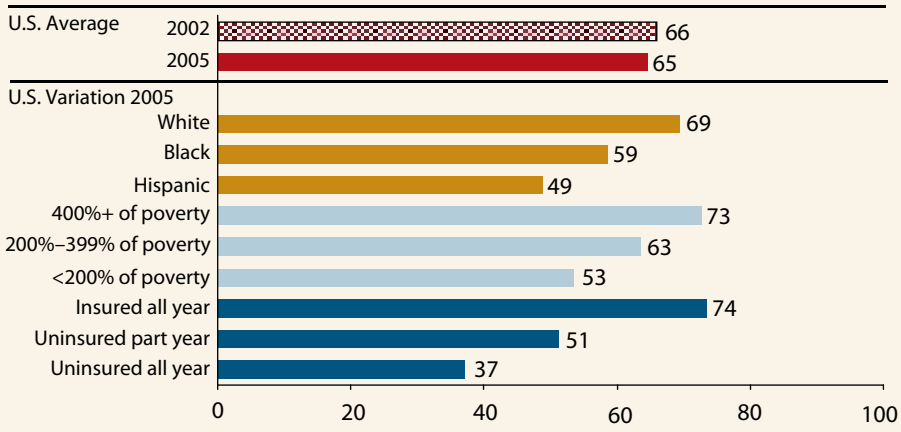
The new law will also establish a Center for Medicare and Medicaid Innovation, effective January 2011, to oversee and test these and other innovative payment methods. Priority will be given to models that both improve quality and reduce costs, such as medical homes, accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, funding for care coordination, and bundled payment for hospital acute and post-acute care.

By increasing primary care payment rates, and making low-interest student loans more available, the Affordable Care Act also aims to increase the supply of primary care physicians and advanced practice nurses, making it easier for patients to find a primary care provider.

Better access to community health centers able to serve more patients.
Federally qualified health centers provide comprehensive primary care and mental health services to some of our nation's most vulnerable individuals and families. Recent Commonwealth Fund analysis shows that of the 16 million patients who received care from health centers

Exhibit 1. Only 65 Percent of Adults Report Having an Accessible Personal Clinician

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.
Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance*, 2008 (New York: The Commonwealth Fund, July 2008).

in 2007, 90 percent were at or below 200 percent of the federal poverty level, 45 percent had public insurance, and 40 percent had no insurance at all.

The Affordable Care Act expands funding to community health centers by $11 billion over five years beginning in 2010; provides state grants for health care providers that serve a large percentage of medically underserved populations; and provides for a Medicaid global payment system demonstration project that allows up to five states to make global capitation payments—covering all services provided to a patient during an episode of care—to safety-net hospitals from 2010 to 2012. It also provides grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to serve low-income or medically underserved communities from 2011 to 2015.

Electronic medical records that ensure, with the patient's authorization, complete medical records are accessible when needed.

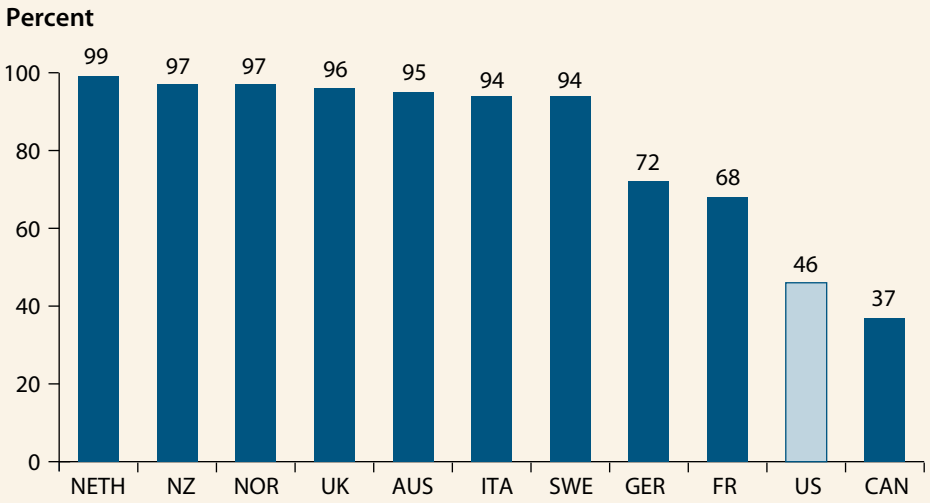
U.S. health providers have been slow to adopt electronic health information systems, in part because of concerns about the value and the costs of implementation. A 2009 Commonwealth Fund survey of primary care physicians shows that the U.S. is far behind most of its industrialized peers in the use of health information technology (IT) (Exhibit 2).

Without an information system that ensures the right information is available at the right time, tests are repeated, appointments with specialists have to be rescheduled, and patients are not informed about abnormal lab tests in a timely manner (Exhibit 3). The American Recovery and Reinvestment Act of 2009 provides financial assistance for physicians and hospitals to adopt health information systems to report quality information, deploy decision support to help providers provide the best care, and improve the quality of care. The Affordable Care Act provides further incentives to establish such information systems: it rewards high-quality care and enables health care organizations that assume responsibility for total patient care to share in the savings.

Doctors and hospitals that are rewarded for higher quality and better patient outcomes.

The prevailing fee-for-service payment system rewards physicians for the volume of care they provide, rather than the value of that care. The U.S. lags behind its counterparts in this regard (Exhibit 4).

Exhibit 2. Doctors Use of Electronic Patient Medical Records



Note: Not including billing systems.
Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.

Exhibit 3. Nearly Half of U.S. Adults Report Failures to Coordinate Care

Source: S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).

The new reform law will reward hospitals for achieving benchmark levels of performance in heart attack, heart failure, and pneumonia care, and for preventing surgical infections. Starting in October 2012, hospitals that meet or exceed the designated performance standards will receive enhanced Medicare payments, taken from a pool of money collected from all hospitals. By 2012, the Secretary of Health and Human Services (HHS) is required to submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing payment system.

The legislation also includes physician payment reforms that encourage physicians, hospitals, and other providers to join together to form accountable care organizations to gain efficiencies and improve quality of care. Those that meet quality-of-care targets and reduce costs relative to a spending benchmark can share in the savings they generate for Medicare. Furthermore, all physicians and hospitals meeting benchmarks for high-quality care will be eligible for bonuses under new value-based purchasing provisions.

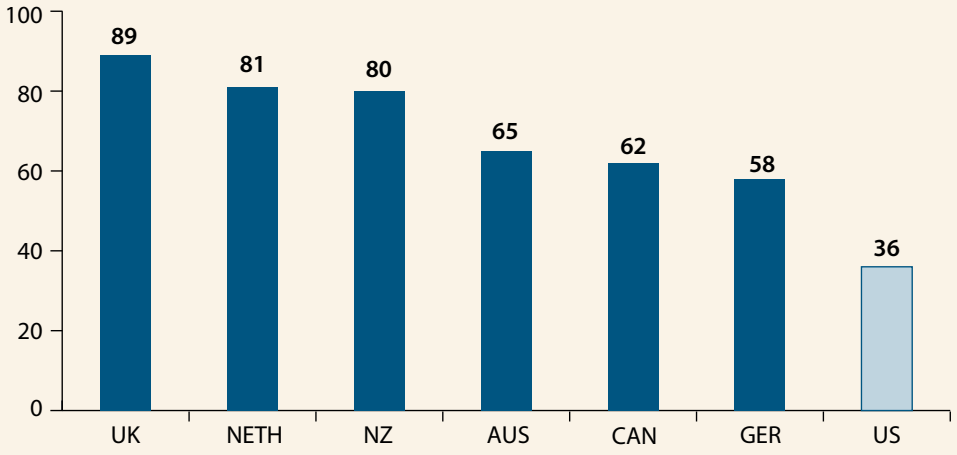
Better information and support when discharged from the hospital.

U.S. hospital readmission rates for Medicare patients within the first 30 days following discharge range from 14 percent to 21 percent. Inadequate communication during care transitions—when patients are discharged from the hospital to home or to a nursing facility, for example—often contributes to readmissions or avoidable complications. The Commonwealth Fund is working with Massachusetts, Michigan, and Washington State on the State Action on Avoidable Rehospitalizations (STAAR) initiative to test interventions that reduce readmissions, such as making sure patients have the information they need for self-care and have scheduled a follow-up appointment with their physician.

Medicare payments will be reduced for hospitals with high rates of potentially preventable readmissions for certain eligible conditions or procedures, as determined by the HHS secretary. In addition, by 2013, HHS will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to test "bundled" Medicare payment models spanning three days before and 30 days after a hospitalization. If the

Exhibit 4. Physicians in U.S. Less Likely to Receive Incentives for Quality or Meeting Goals

Percent of physicians reporting any financial incentive for targeted care or meeting goals*



* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding non-physician clinicians to practice, and non-face-to-face interactions with patients.
Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.

pilot programs improve care and reduce spending, HHS is required by 2016 to submit a plan for expansion.

Hospitals with an incentive to reduce hospital-acquired infections.
The new legislation demands greater transparency and public reporting on hospitals' performance at preventing infection. Later this year, the Centers for Medicare and Medicaid Services (CMS) will begin reporting rates of medical errors and selected hospital-acquired conditions on its Hospital Compare Web site. Starting in 2011, federal payments for Medicaid services related to hospital-acquired conditions will be prohibited. Beginning in 2015, hospitals that have among the highest rates of these hospital-acquired conditions will have their Medicare payments reduced by 1 percent.

More patient information on quality of physicians, hospitals, and health plans.
Physicians who report data on the quality of their care through a qualified program will be eligible for one-half percent Medicare bonus payments. In addition, HHS will develop a Physician Compare Web site by January 2011. Combining Medicare data on quality with that of private insurers should improve the scope and reliability of information on performance. To further this aim, the legislation also authorizes, effective January 2012, the release of Medicare claims data to measure the performance of providers and suppliers in a way that protects patient privacy.

More choice of health insurance plans, including nonprofit plans.
A 2007 Commonwealth Fund survey showed that 42 percent of workers with employer-based coverage had only one choice of health plan. Even when workers have a choice of plans, the plans are often different products offered by the same insurer. Nor do all plans provide adequate benefits or ensure adequate participation of physicians in essential specialties.

Under health reform, state-based health insurance exchanges will increase the choice of high-quality private plans and health care cooperative plans, and will make it easy to compare these choices. In addition, the federal government will contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit. The government will negotiate contracts, much as it does for the Federal Employees Health Benefits Program.

The new Consumer Operated and Oriented Plan program, meanwhile, will foster the creation of nonprofit, member-run health insurance companies, or cooperatives, that will provide coverage and deliver health services. In making grants, priority will be given to cooperatives that operate on a statewide basis, are organized as integrated care systems, and have significant private support.

The insurance exchanges provide an important avenue for setting quality standards on insurance and care. In overseeing the exchanges, the HHS secretary is charged not only with ensuring a sufficient choice of qualified plans and providers but also with establishing certification criteria for qualified plans, requiring plans to provide the essential benefits package and meet marketing requirements, and ensuring that essential community providers are included in networks and accredited on quality.

Private plans that are rewarded for better care.
Currently, employers and Medicare beneficiaries tend to make choices based largely on premiums, without information showing whether plans are actively trying to ensure high-quality care—either through the way they select participating physicians and hospitals, or through the information and support they offer to providers regarding benchmark quality care.

Under health reform, Medicare private managed care plans that receive a four- or five-star quality designation will receive bonuses. Health plans that operate through the new health insurance exchanges will report on their quality improvement activities, including their efforts to prevent hospital readmissions. By 2015, health plans operating in the exchanges will be allowed to enter into contracts with hospitals with fewer than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for patient discharge.

Reduced health insurance premiums and health spending.
Between 2000 and 2009, health insurance premiums rose by 108 percent, while workers' earnings rose by just 32 percent. As a result, average family premiums for group policies have risen from 11 percent to 18 percent of median family income. In the absence of reform, premiums were projected to rise to 24 percent of a family's income by 2020. Under the new reform law, the average family stands to save nearly $2,000 or more in 2019.

Premiums will be held down by requirements that limit the percentage of premium revenue going to administrative costs, and that require carriers seeking certification as qualified health plans to submit a justification in advance for any premium increase. Premium growth will be monitored and used as a criterion for allowing plans into the exchanges.

The establishment of health insurance exchanges in 2014 will further lower administrative costs and premiums in the individual and small-business markets as transparency, choice among plans with comparable actuarial value, and new nonprofit plans enhance competition, and the requirement for people to obtain coverage broadens the risk pool.

The upward spiral of health care costs will also slow as those that pay for health care begin to adopt innovative payment methods that reward quality and value, rather than volume. For example, the new Independent Payment Advisory Board within the executive branch will have significant authority to identify areas of waste and additional federal budget savings.

A Commonwealth Fund report found that the impact of health reform on health insurance premiums and health spending will be significant. It estimates that, on net, the combination of provisions in the new law will reduce health care spending by $590 billion over 2010–19. The annual growth rate in national health expenditures would be slowed from 6.3 percent to 5.7 percent.

All Stakeholders Needed for Success

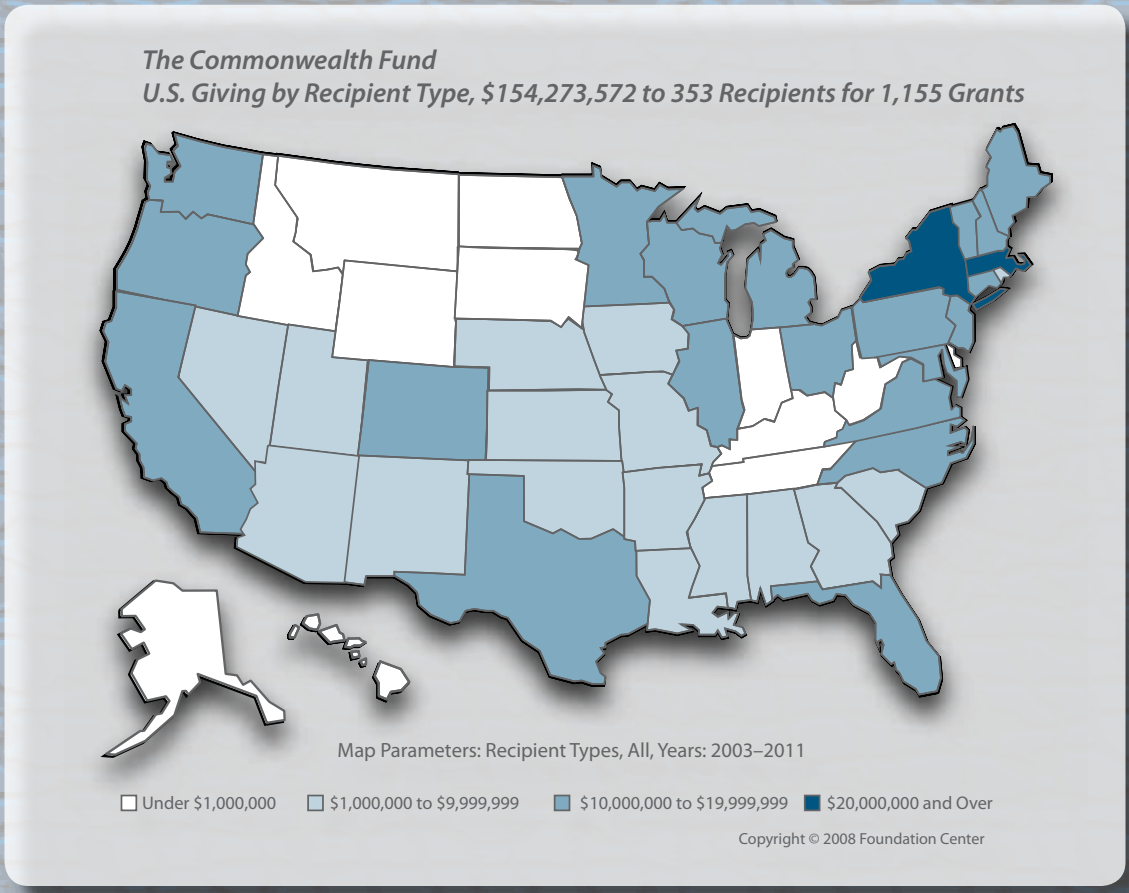
The Affordable Care Act's important payment and system reforms, along with the new insurance market protections discussed in my last post, will improve access and quality and reduce cost growth for everyone. Reform is a historic victory for all Americans. But it will require the efforts of all stakeholders to make the promise a reality.

2010 Annual Report
Executive Vice President-COO's Report

THE COMMONWEALTH FUND

Modernizing the 990-PF to Advance the Accountability and Performance of Foundations

A Modest Proposal



John E. Craig, Jr.
Executive Vice President-COO
The Commonwealth Fund

Cover: *The 990-PF tax return for private foundations requires reporting all grants annually, but few foundations are able to file their returns electronically, and the submitted information on grants can not be assembled into a comprehensive, researchable database. In contrast, The Foundation Center's technologically advanced Grantsfire and eGrants reporting system, which includes mapping capabilities, generates a comprehensive database on foundation grants. A modernized 990-PF would encourage foundations to use that system as an alternative to reporting grants directly on the tax return.*

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Modernizing the 990–PF to Advance the Accountability and Performance of Foundations: A Modest Proposal

John E. Craig, Jr.
Executive Vice President-COO

Overview

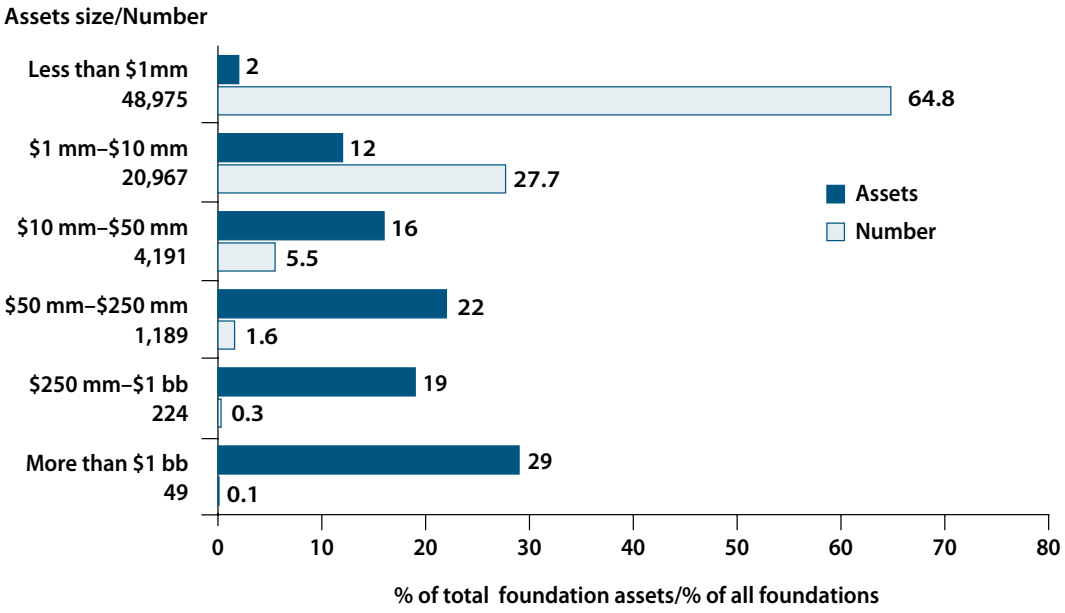
Today there are more than 75,000 private foundations in the United States, with total assets of around $565 billion.[1] The size distribution of these organizations is highly skewed: 273 large foundations with endowments of $250 million or more account for 48 percent of the sector's total resources (Exhibit 1). On the other end of the distribution, some 49,000 very small foundations with assets under $1 million hold about 2 percent of the sector's wealth, and another group of 21,000 with assets between $1 million and $10 million hold 12 percent. This diversity of size is more than matched by diversity of missions, operating models, goals, and strategies—making the objective of ensuring the accountability and performance of these important institutions a formidable one.

Private foundations exist under the watchful eye of the United States Congress, which has delegated their oversight to the Internal Revenue Service. In each state, offices of the state attorneys general also bear regulatory responsibility, but because of the limited resources typically available for this purpose, the IRS is by default the only real regulator of foundations—except in instances where an attorney general has been alerted to the possibility of significant misbehavior by a foundation.

To obtain the information needed to exercise its regulatory responsibilities, the IRS relies principally on an annual filing by private foundations—the Form 990-PF tax return. While it also conducts periodic audits of individual foundations, the sheer number of organizations, together with the IRS's record of reaping minimal revenue from costly audits, makes the 990-PF filing the overwhelming choice of regulatory tool. The 990-PF also provides foundations with an important tool for self-regulation, helps journalists serve as accountability watchdogs, and generates data used by the Foundation Center to maintain its databases and research reports on the foundation sector.[2]

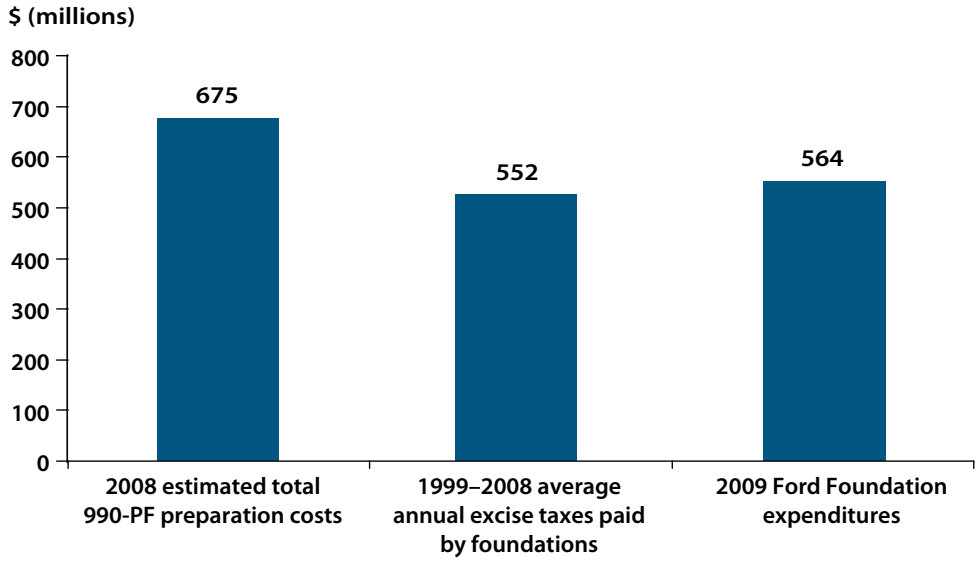
If the 990-PF is a necessary requirement of private foundations, it is also a costly one: estimated total filing costs in 2008 for all foundations was $675 million (Exhibit 2).[3] To put this number in perspective, it is the equivalent of the required payout for charitable purposes of a perpetual foundation with $13 billion in assets. Such a foundation would be the second largest, falling somewhere in between the Bill and Melinda Gates Foundation and the Ford Foundation. Further, combined 990-PF preparation costs are greater than the $552 million in average total annual excise tax receipts generated by the return.[4] Clearly, the return should

Exhibit 1. With more than 75,000 organizations and enormous variations in size, missions, and strategies, the foundation sector presents many regulatory and accountability challenges.



Source: The Foundation Center.

Exhibit 2. The annual cost for all foundations of filing the 990-PF return is greater than the average annual excise tax revenues that it generates, and the foregone charitable expenditures amounted to more than the annual outlays of the second largest foundation in 2008.



Note: Estimated total 990-PF preparation costs based on time estimates in IRS 990-PF filing instructions and hourly costs estimated by The Commonwealth Fund.
Source for Excise Tax Revenues: www.irs.gov/taxstats/charitablestats, IRS data files.
Source for Ford Foundation: 2009 Annual Report Financial Statements.

be structured for maximum efficiency so that it can meet its regulatory aims while minimizing forgone charitable expenditures.

As described below, the 990-PF has served its principal purpose of eliminating the abuses in the foundation field that existed prior to 1970 and has helped steer foundations away from inappropriate activities since that time. But it has failed to keep up with the evolution of the foundation sector over the last 40 years. As both an instrument of basic regulation and tax collection and a tool for promoting strong performance among private foundations, the 990-PF is seriously flawed. Its modernization could yield many benefits to the sector and, more important, to the hundreds of thousands of nonprofit organizations that foundations serve.

This essay traces the history of the 990-PF to reveal how its current structure and content came to be. It then analyzes the return's shortcomings and discusses how the 990-PF could be transformed into a more effective instrument for promoting accountability and best practices in the foundation sector. Although it will not be possible to implement all of the recommendations, in the debate over reform and simplification of our federal tax code, modernizing Form 990-PF should be given serious consideration.

Evolution of Form 990-PF

In a seminal article from 2000 in the *Exempt Organization Tax Review*, distinguished attorney and foundation expert Thomas A. Troyer traced the history of congressional legislation on, and IRS regulation of, private foundations, providing history-in-the-making insights of which every foundation official should be aware.[5] Troyer explains how the IRS regulatory filing requirement for foundations originated in the early 1940s, when Congress sought to address the then-serious issue of foundations and other tax-exempt organizations holding and controlling businesses unrelated to their charitable purposes and using assets for the benefit of trustees and managers.

Beginning in 1941, a Form 990 information return became required of all organizations, including foundations, that were exempt from income tax. The Commonwealth Fund's return for that year reveals that it consisted of two pages, the first requiring very brief information on charitable activities and any potentially improper distributions to board members or officers, and the second, a summary of receipts and disbursements and of assets and liabilities.[6]

Succeeding versions of the tax-exempt organization/foundation filing over the next 33 years reflect further efforts by Congress to address abuses in the foundation sector. By 1949, Form 990 was a three-page return requesting additional information on the nonprofit's affiliations with other organizations, including for-profit concerns, on business relationships with trustees and managers, and on political activities. In addition, from 1950 onwards, nonprofits with income unrelated to their charitable purpose were required to file Form 990-T (Exempt Organization Business Tax Return).

Following federal legislation in 1950, the 990 was replaced with Form 990-A, a four-page document that moved the question concerning charitable activities of the nonprofit from the beginning of the form to a later section. The new form led off with a revenues-and-expenses statement focused on business activities of charitable organizations—the aim being to identify such activities that were not charitable in purpose. On the second page were questions on issues of considerable concern to Congress at the time: foundations' holdings

of controlling interests in for-profit corporations; whether those businesses paid dividends; conflicted business dealings between foundations and donors or foundation-controlled for-profit corporations; lobbying activities intended to influence specific legislation; and participation in political campaigns. For the first time, it was required that the financial statement parts of the return (income and expenses and balance sheet) be made available to the public.

The federal Revenue Act of 1964, which limited the tax-deductibility of gifts to foundations, was preceded by congressional hearings in which the Department of the Treasury agreed to conduct a major study of foundations' activities. In 1965, Treasury produced the first data-based set of findings on the foundation field—relying, notably, not on the limited information produced by the 990-A return, but on a survey of 1,300 foundations. This key report debunked the then-current view that foundations exercised inordinate economic power in the U.S. economy, though it did identify serious abuses among a minority of foundations and recommended legislative action to combat them.

In his article, Troyer describes how a series of missteps by a few foundations in the highly charged political environment of the late 1960s led to action on Treasury's recommendations for further regulatory action. The result was the inclusion in the Tax Reform Act of 1969 of the basic provisions for foundation regulation and IRS tax return filing that remain in place to this day. These include: proscriptions against self-dealing activities by foundation trustees and officers; for the first time, a required annual minimum payout for private foundations; prohibitions against holding controlling interests in for-profit concerns; restrictions on select programmatic activities (specifically, grants to individuals and the expenditure responsibility requirement for grants made to organizations other than nonprofits); restrictions on lobbying and prohibitions on participation in political campaigns and voter registration drives; penalties on expenditures for noncharitable purposes; an excise tax, also for the first time, on foundations' net investment income; and reduction of the charitable deduction for contributions of appreciated property to private foundations.

As a result of the 1969 tax legislation, the 990-A that was required of all tax-exempt organizations was revised in 1970 (and renamed simply "Form 990") to include sections for foundations for computing the new excise tax on investment income and information on any activities or conditions prohibited or regulated in the legislation. For purposes of the excise tax calculation, foundations were now also required to submit detailed schedules on realized capital gains and losses arising from their endowment investments. Further, foundations were required to list all of the securities in their portfolios and all grants and contributions paid or approved for future payment during the year.

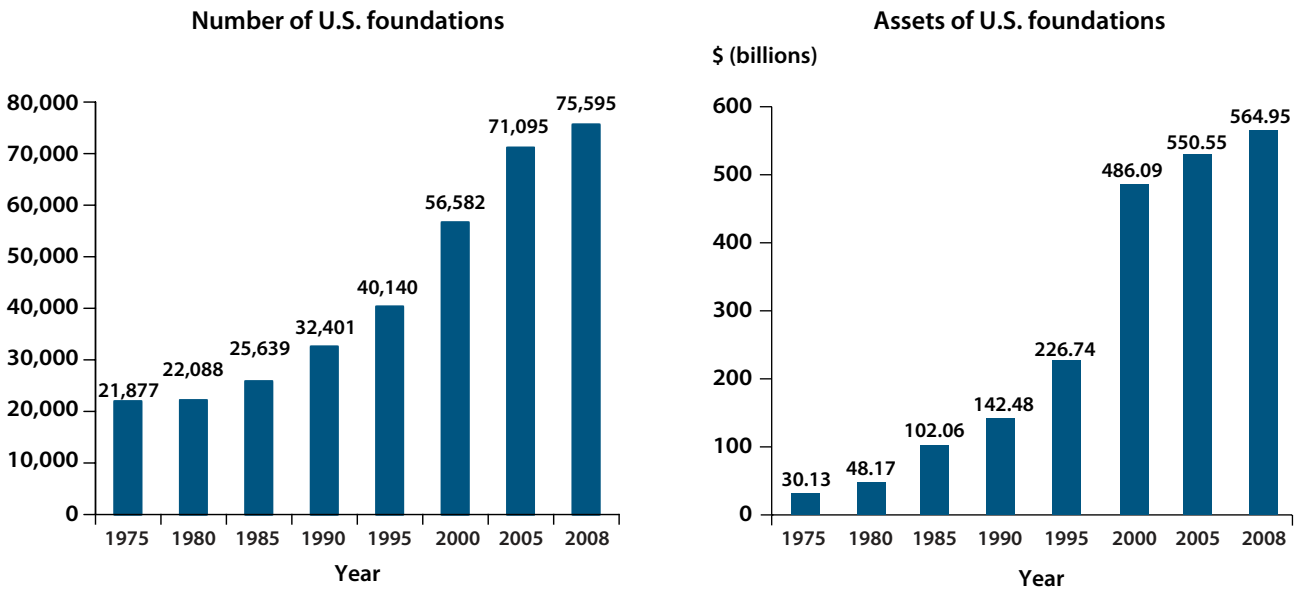
In addition to this three-page return, foundations were required to submit a three-page Form 990-AR, "Annual Report of Private Foundation," which requested information on foundation managers and their business dealings with the foundation or with corporations in which the foundation had substantial holdings. Foundations were also required to file Form 4720, Return of Certain Excise Taxes, if they engaged in self-dealing, political, or other prohibited practices (for example, investments jeopardizing their charitable purposes) on which tax penalties could be levied.[7] In the following year, Form 990 was further revised to include the calculation of taxes on excess business holdings and sections listing the compensation of officers, directors, and trustees, the compensation of the five highest-paid employees, and the five highest-paid persons providing professional services.

By 1974, all of the regulatory and tax ramifications of the 1969 tax legislation had been incorporated into a separate, seven-page, annual tax return for foundations, which at that time was renamed Form 990-PF, "Return of Private Foundation." This form, with relatively minor revisions that have expanded the form's length to 13 pages, plus 32 pages of instructions, remains in place to this day.[8]

To their enormous credit, the 1969 regulations on foundations and the resulting 990-PF, along with strong self-regulatory activities such as the 1969–70 Peterson Commission on Foundations and Private Philanthropy and the 1973–77 Filer Commission on Philanthropy and Private Needs, have eliminated most of the abuses that were targeted in 1969. Foundations no longer control businesses for noncharitable purposes; they more than meet the annual payout requirement;[9] instances of self-dealing, at least among larger organizations, are few and far between; and continuing progress is being made in identifying best practices for nonprofits (including foundations) and promoting their spread throughout the sector.[10] A measure of the extent to which the abuses of 42 years ago have disappeared is the negligible annual revenue from all 75,000 foundations produced by the Form 4720 penalty taxes in 2006: $2.1 million from self-dealing taxes; $3.0 million from undistributed income penalties; $146,000 from taxable expenditures; and $66,000 from excess business holdings penalties.[11]

This chronicle of how the current 990-PF came to be demonstrates, however, that it is, like all tax returns, the product of accretion—not a modern document carefully constructed to efficiently regulate a sector dramatically different in both size and activities from what it was in 1974. After all, the census of foundations has grown almost 250 percent since 1975, and the assets of foundations, by 395 percent (Exhibit 3). As the following section

Exhibit 3. The number of U.S. foundations has grown by 246 percent and the total assets of U.S. foundations by 395 percent since 1975—while the 990-PF regulatory structure has remained static.



Source: The Foundation Center.

will demonstrate, the 37-year-old filing form, the components of which were built up over an earlier 33-year period dating back to 1941, falls considerably short in addressing efficiently the current regulatory needs of the IRS and state attorneys general and the accountability and best-practice needs of the foundation sector.

Shortcomings of the Current 990-PF

The shortcomings of the current 990-PF are a serious concern not only because of the additional filing costs that result, but also because the form is the only one universally filed by foundations. In addition to its regulatory and tax collection use by the IRS, the form is widely used by:

- foundation trustees, who are counseled by Independent Sector that they have a fiduciary responsibility to review the return before it is filed;
- nonprofits, which use it for fundraising purposes;
- researchers, who use it to assess the work of the sector and promote best practices;
- the Foundation Center, the Council on Foundations, Guidestar, and other such organizations, which use it to promote accountability;
- journalists, who use it in their reporting on the foundation sector; and
- members of the general public, who use the return to help assess local or regional foundations' accountability.

Yet, the 990-PF is not well designed for the uses to which it is put.

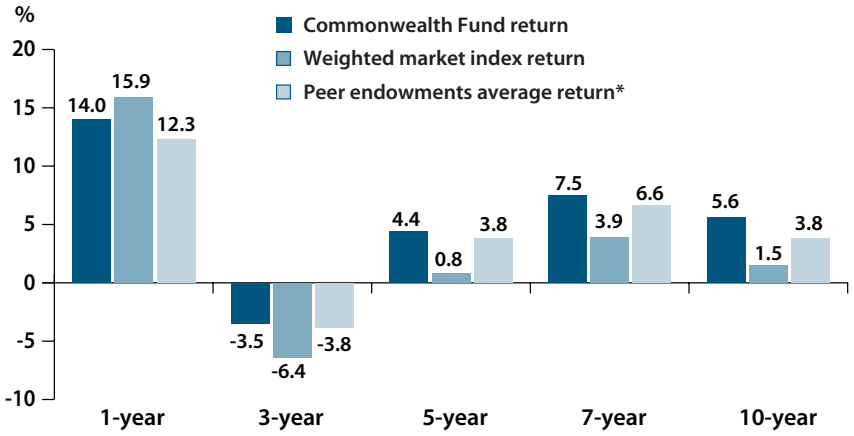
Misstated administrative expenses. The information requested in Part I, "Operating and Administrative Expenses" (lines 13–26) is particularly problematic for value-adding foundations like The Commonwealth Fund that both make grants and conduct their own research programs and communications activities, and whose staff is extensively involved in developing, monitoring, and disseminating the results of grant-funded work. The absence of a functional allocation of foundation expenses in this section results in most of the intramural expenses of such foundations being mislabeled as "administrative" by those who do not appreciate that an increasing number of foundations do much more than write checks, but in fact work in partnership with their grantees and operate programs directly.

Additionally, the failure of this section to request a functional breakdown of expenses according to whether they are for grants, the administration of grants, the foundation's own direct charitable activities (such as operating museums, running service programs, research, or communications), endowment management, or general administration has confounded efforts to establish benchmarks for administration ratios.[12] The latter are not only of great interest to foundation trustees and managers, but also to congressional overseers, researchers, and journalists.

Missed opportunities to shed light on endowment performance. Information on the investment performance of the foundation's endowment is solicited nowhere in the 990-PF. Since the endowment is the only source of income for most foundations, this is an egregious omission—equivalent to not requiring for-profit corporations

Exhibit 4. Requiring foundations to report the quarterly investment performance of their endowments would produce the comprehensive database needed for benchmarking and improving endowment management.

Investment returns, periods ending June 30, 2010



* 82 foundations with assets between $250 mm and $999 mm.
Source: Cambridge Associates.

to report their earnings in their tax returns and financial statements.

Effective oversight and management of foundation endowments are a source of great concern for any experienced observer and practitioner in the field. Too many foundations still do not track their investment performance at all, or relative to market and peer benchmarks, fail to attract qualified trustees to serve on their investment committees, and lack the sophisticated skills needed to manage their endowment effectively on their own, yet persist in trying to do so. Moreover, the risks of conflicts-of-interest involving investment committee members and money managers are substantial.[13]

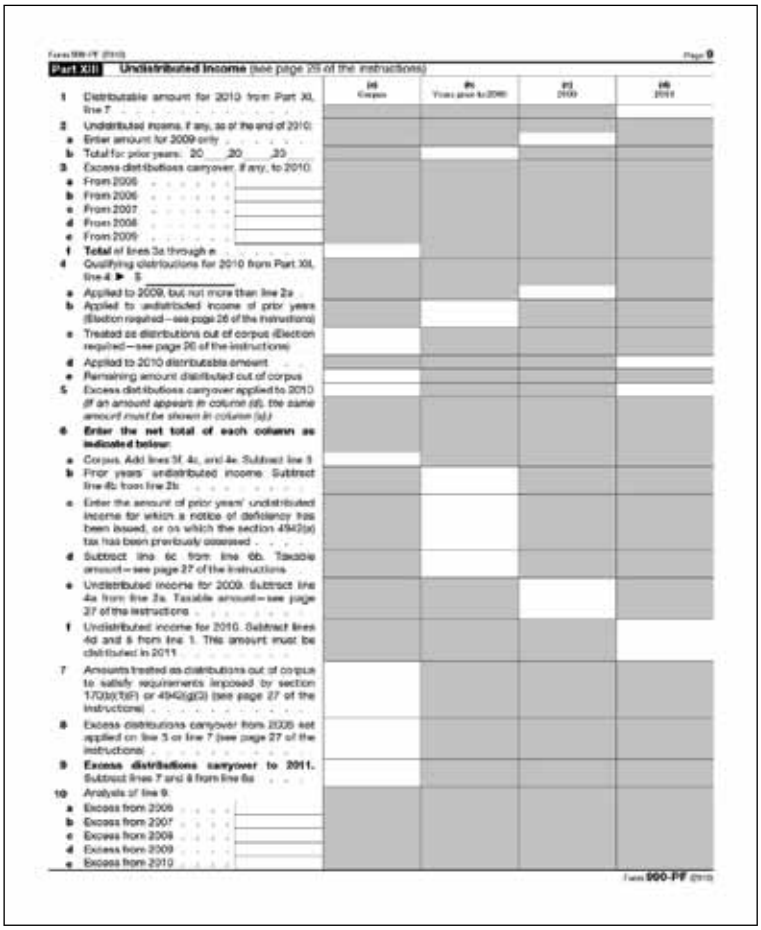
Peer comparisons of investment returns like those in Exhibit 4 can be very helpful to investment committees of foundation boards in assessing and improving their performance. But the 990-PF provides no help in this regard; consequently, groups of foundations and consultants undertake separate, costly efforts to compile performance databases that are very limited in scope and unlikely to be truly representative of the sector.

Unwieldy format and poorly targeted content. Reflecting the numerous additions over time, the 990-PF is unnecessarily long, complicated, and poorly organized, with little attention to the needs and priorities of its users. In contrast to corporations and many nonprofits, most foundations are fundamentally simple organizations, typically with a single source of income (their endowment) and a single product line (their grants). The IRS's major concerns are that foundations meet the required annual payout, pay the required excise tax (and in a limited number of cases, an unrelated business income tax), not have controlling interests in for-profit businesses, and avoid practices that involve conflicts of interest (self-dealing) or that stray outside their philanthropic purpose. But the content and structure of the return do not reflect these realities.

- The determination of the all-important annual payout requirement, comparison with actual payout, and calculation of any necessary catch-up payout that must be made in the following year are spread over four sections (Parts X–XIII) and two pages and do not appear until near the end of the return. As a result, it is likely that only sophisticated readers are able to discern readily and accurately whether the foundation is meeting its payout obligations.
- Part I, "Analysis of Revenue and Expenses," requires in four columns different presentations of this information, with column totals that do not correspond to each other and that are confusing to users. A single column presenting revenues and expenses in an accounting method consistent with the foundation's books would be more useful to the interested audience.
- The Part II requirement that foundations attach schedules showing individual securities in their endowment portfolios at fiscal year-end serves little purpose. Most portfolios are actively traded and a snapshot is therefore of limited use. More significant is that even small foundations have dozens of securities in their portfolios, and large ones, hundreds or thousands; clearly, summative information revealing any untoward concentration of holdings in individual companies would better serve the IRS's regulatory needs.
- Part II, "Balance Sheets," is more disaggregated than necessary, and the requirement to show columns with book values for the beginning and end of the fiscal year and the market value for the end of the year is anachronistic, dating back to an earlier time when foundations' balance sheets used book values. Foundations' balance sheets now routinely use market values, and the balance sheet part of the 990-PF could easily and appropriately be consolidated into a dozen or so lines, compared with 31, and two columns, rather than three, showing beginning and end-of-year market values.
- A considerable amount of the information requests apply to only a few foundations or to only particular types of foundations (for example, operating foundations). Rather than complicating the basic form, such information should be solicited, when applicable, in separate schedules.
- Sections such as Part XIII (Exhibit 5) that consist largely of shaded boxes not to be filled in could obviously be tightened up.
- Parts VII-A and VII-B, which deal with regulated, prohibited, or taxable activities, consist of some 50 yes/no questions that are unnecessarily long and, disconcertingly, not always up-to-date with regard to current law or best practices. For example, there are no questions about the two Sarbanes–Oxley requirements for nonprofits, whistle-blower and records-retention policies, or the requirement for written investment and spending policies under states' Uniform Prudent Management of Institutional Funds Act legislation.
- Some sections of the return are a carryover from earlier IRS corporate tax returns that have little relevance in the foundation field—for example, Part III, "Analysis of Changes in Net Assets or Fund Balance." Such vestigial information requirements could be removed from the return with no loss to users.

Exhibit 5. The Form 990-PF is unnecessarily long, complex, and confusing—adding to the costs of filing it and diminishing its value to users.

- Misrepresents foundations' administrative expenses
- No information on endowment performance
- Unwieldy format and poorly targeted content
- Major challenges to e-filing
- Poor functionality as a research database
- Misleading or indecipherable terms
- Missing focus on the foundation's purpose



Source: Internal Revenue Service.

Costliness of e-filing. Like other nonprofits, foundations filing more than 250 IRS forms (for example, W-2 income tax withholding forms and 1099-Miscellaneous Income forms) are now required to file the 990-PF electronically, but only a small number of foundations currently meet this threshold. Because of the potential efficiencies in both submitting data and creating researchable databases on foundations' tax returns, requiring electronic filing is a desirable aim for the administration of the 990-PF. But realization of this goal is greatly hampered by the complexity of the existing form. Those that do file electronically find it to be a costly undertaking, and review of the small number of e-filed 990-PFs reveals the results in some cases to be less than satisfactory.

Poor functionality as a database. As the only mandatory information filing required of all foundations, the 990-PF—like other tax returns—should provide the ancillary function of generating a valuable database for researchers, journalists, and policymakers. Efforts to use it for such purposes reveal its deep flaws: too often, the information requested is of little current relevance; major gaps such as those noted above on endowment performance and functional allocation of expenditures limit its utility; and

the complexity of the return make it a researcher's nightmare.

Lack of disclosure of relationships with service providers. The return also requests information on compensation and fees paid to foundations' trustees, managers, higher-paid staff, and contractors, and it asks about potentially inappropriate transactions that could trigger the filing of Form 4720 and payment of self-dealing penalty taxes. But it does not require disclosure of names of individuals involved in interlocking relationships between foundation trustees/managers and institutions or individuals that provide services to the foundation.

Lack of clarity on "jeopardizing investments." The 990-PF has yes/no questions on investments that could jeopardize the foundation's charitable purpose, and requires filing Form 4720 if tax penalties must be paid on such investments. What constitutes a jeopardizing investment, however, is not clear-cut, and on Form 4720, only a brief description—not explanation—of such an investment is required. The engulfment of a number of foundations in the Madoff scandal demonstrates the need for disclosure of significant endowment losses arising from excessive concentrations in holdings, unusual leverage through derivatives or borrowing, or fraud—not only in the interest of public accountability, but as a means of alerting other foundations to hazardous kinds of investing to be avoided.[14]

Missing focus on the foundation's purpose. Not until Part IX-A, "Summary of Direct Charitable Activities" (page 7), is any information requested on what the foundation actually does to justify its tax exemption. More important, the result of the broad latitude that foundations are given in answering an open-ended question about their activities and performance, combined with the rigidities of a tax return, is that the form does little to promote understanding of what foundations do and the extent to which they are accomplishing their missions and making a difference in society.

Misleading or indecipherable terms. Because of its reliance on tax code terminology, much of the language in the form is unintelligible to the many lay readers, including trustees and journalists, who use it—leading to harmful misinterpretations. For example:

- "Minimum Required Payout" would be a much clearer title for Part X than the current "Minimum Investment Return";
- "Adjusted Required Payout" (Part XI) would be more informative than "Distributable Amount"; and
- "Actual Current Year Payout" (Part XII) would be less mystifying than "Qualifying Distributions."[15]

Weakness in promoting best practices. The 990-PF has served a very useful role in weeding out "worst practices" in the foundation field, but it plays a very limited role in prodding for best practices. As discussed below, there are significant limitations on the extent to which the 990-PF can be expected to play the latter role, but in key areas like requiring reporting on endowment investment returns, the foundation's work and overall performance, and adherence to certain legally required best practices, it falls short.

Modernizing the 990-PF

Recommended Guidelines

This limited review of the shortcomings of the existing 990-PF suggests guidelines for its modernization.

Reporting of expenses should be disaggregated functionally. Doing so would enable users to readily identify which parts of the foundation's expenses are devoted to grants and direct charitable activities, grants administration, endowment management costs, unrelated business costs, and general administration.

The major missing gap of endowment investment performance should be filled. Requiring all foundations with assets of $10 million or more to report the net investment returns on their endowments for each of the last four calendar quarters would quickly produce a comprehensive time series on endowment returns that could be parsed by foundation size, intended life expectancy, and other variables to enable reliable peer benchmarking.

Many foundations will, doubtless, object to this new requirement on grounds that it is burdensome and could be misused by critics who do not understand the vagaries of financial markets, acceptable variations in risk tolerance for different foundations, and the need for perpetual foundations to take a long-term view with respect to endowment management. The burden argument does not hold up, however, as any foundation investment committee doing its job properly should have readily on-hand data on quarterly investment returns, and should use such data to compare results over multiyear periods to market benchmark and peer-institution returns. The burden of this proposed requirement would also be reduced by exempting from it the nearly 70,000 foundations with less than $10 million in assets. While very large in number, these foundations account for only 14 percent of foundation assets, and they have a wide variety of investment objectives and risk profiles that are generally quite different from those of larger foundations.

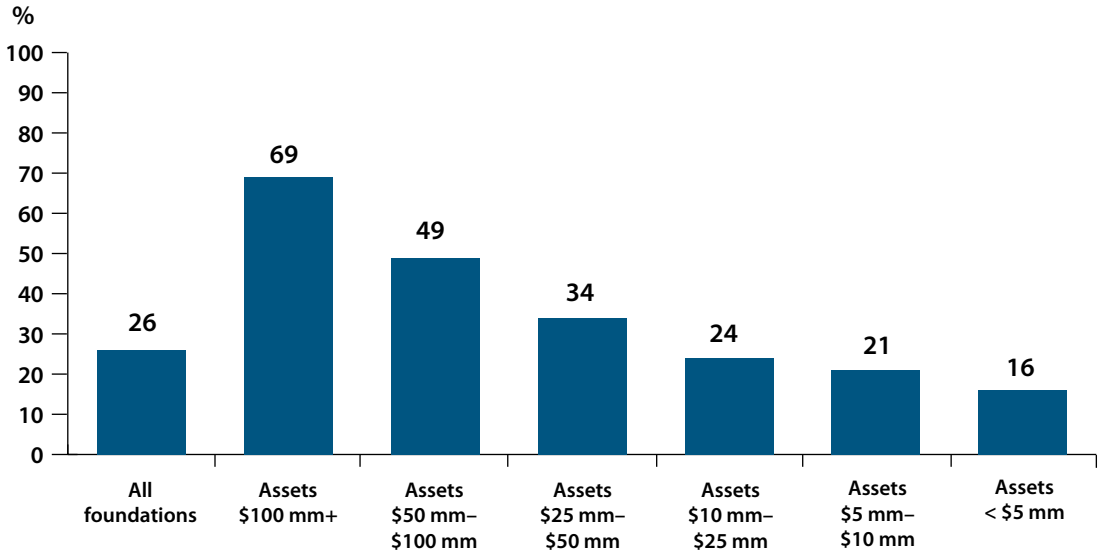
It is indeed likely that, once investment returns of foundation endowments are public, they will be the subject of commentary from the media and foundation observers. University endowment managers have long been subject to such scrutiny, and the foundation community would benefit from similar accountability.

The return should be used to prod foundations to use Web sites to report information on their programs and performance that cannot be readily conveyed on a tax return—thereby also enabling more rapid adoption of e-filing of returns.

- The 990-PF should add a question on whether the foundation maintains a Web site and solicit the address. The Foundation Center reports that only 26 percent of foundations currently have a Web site, although the trend is distinctly upward (Exhibit 6).[16] Even among foundations with assets of $100 million or more, 31 percent do not have a Web site, and among foundations with assets between $50 million and $100 million, the shortfall is 51 percent. Only 16 percent of foundations with less than $5 million in assets have an online presence.

  Surely in the Internet age, maintenance of a Web site that discloses basic information on the foundation's activities, governance, and management should be a fundamental test of accountability. The burden of this expectation has been greatly reduced by the

Exhibit 6. Only 26 percent of foundations have Web sites informing the public and grantseekers of their missions, activities, and performance. A modernized Form 990-PF could spur foundations to develop Web sites to report programmatic information not easily reported on a tax return.



Source: Foundation Center, www.glasspockets.org, 2009 survey.

Foundation Center's willingness to develop a basic Web site at no cost for any requesting foundation, and its willingness to develop more sophisticated sites for very reasonable fees.

- Greater emphasis—upfront—should be placed on foundations reporting their missions, goals, strategies, and results. To facilitate e-filing and to encourage foundations to take full advantage of the Internet in carrying out their missions, organizations should be permitted to meet the informational requests of this section of the return with a link to their Web site. Allowing this would enable far more comprehensive, timely, and accessible reporting of the information than a tax return could ever achieve. The 990-PF should push foundation communications in this direction.
- One of the biggest obstacles to e-filing is the return's Part XV requirement to list detailed information on all grants. A foundation that reports this information on their Web site should be able to meet the requirement by providing a link and by participating in the Foundation Center's Web-based Grantsfire and eGrant Reporter system, which allows foundations to post information on grants nearly in real time.

By taking this step, the 990-PF would no longer serve as a print repository for lists of grants made by individual foundations. Instead, raw data on grants by individual foundations would be available on their Web sites, while cleaned and structured data would be available through the Foundation Center's electronic databases. Foundation transparency would be enhanced, while the currency of data provided to the Foundation Center would be greatly improved. This would also have the salutary effect of ensuring that the research

and trend studies produced by the Foundation Center and others are based on current-year data—something that is not possible with the current 990-PF grants-reporting system, with its time lags and variable fiscal years for foundations.

The basic return should be as short and uncomplicated as possible and written in plain English. Essential tax code terminology should be provided parenthetically. The return should have a logical progression that guides users to sound conclusions on the foundation's compliance with regulations and adherence to fundamental, recognized best practices for the sector.

- The calculations of the required payout, payout shortfall, and excise tax on investment income should be concise and presented in a format easily followed by lay users.
- Secondary information should be requested in supplemental schedules, to be supplied by foundations as appropriate.
- The requirement to list individual securities in the endowment portfolio should be replaced with one to list securities of any one company constituting more than 5 percent of the endowment, or that amount to 20 percent or more of a portfolio company's net assets.

The yes/no questions on foundation compliance with regulations should be updated to include legally required best practices in governance and management. Among these should be questions on whether the foundation has written endowment investment, spending, whistle-blower, and records-retention policies. Consideration should also be given to adding questions on key best practices recommended by Independent Sector on conflicts-of-interest and travel reimbursement policies. Such questions, with explanations required for negative responses, would be as productive a prod for the widespread adoption of basic best practices as the existing questions on business holdings and political activities have been. The burden of these additions could be alleviated by tightening up the existing regulatory compliance questions.

Separate schedules should be required for reporting payments to related parties and by commonly controlled organizations. Close relationships between foundation trustees and managers and institutions or individuals providing services to the foundation should be disclosed. Most such relationships are likely to be innocuous—for example, a grant for a project conducted by a researcher within a large university whose president is a trustee of the foundation. But requiring disclosure would promote accountability.

Foundations should be required to disclose and explain instances of material investment losses (more than 5 percent of assets) arising from excessive investment concentration or leverage (greater than 5 percent of assets), or fraud. In addition to serving as a monitor of stewardship, this requirement would foster the exchange of information on endowment management hazards to be avoided.

Modern foundation accounting practices should be followed throughout the return, especially in the financial statements sections. The 990-PF should be updated regularly to keep apace with generally accepted accounting practices for foundations.

First Steps in Revising the 990-PF

Working groups of Independent Sector's 2005–06 Panel on the Nonprofit Sector recommended modernizing the 990-PF, and follow-up work by a leading group of foundation financial officers and tax experts has resulted, fortunately, in a prototype revised 990-PF incorporating many of the above guidelines.[17] Indeed, the principal items proposed above that are not in the prototype are the requirements for reporting endowment investment returns, the existence of a foundation Web site, and occurrence of a material endowment loss arising from excessive concentration, excessive leverage, or fraud.[18] In stark contrast with the existing 990-PF, the prototype revised basic form is four pages, rather than 13. The Commonwealth Fund estimates that its costs for preparing the modernized return would be approximately $10,000, compared with current costs of $18,000.

The IRS began a process for revising the Form 990 for nonprofits that are not foundations ("Return of Organizations Exempt from Income Tax") in 2005, and the new Revised Form 990 went into effect in the 2008 tax year. It was expected that the Service would move forward with modernization of the 990-PF once the work on the return required of other nonprofits was completed. Regrettably, the IRS has not seized on the opportunity provided by the work of foundation accounting and tax experts.[19]

The IRS should be encouraged not to delay revision of the 990-PF, for the following reasons:

- The shortcomings of the existing form are manifest, and the filing falls well short of its potential for advancing both the Service's foundation regulatory functions and the foundation sector's self-regulatory efforts.
- The annual excise tax on investment income collected from foundations has never been used for the original intended purpose of strengthening regulation of the sector; instead, these taxes are added to the general federal revenue pool.[20] Surely, channeling a very small portion of the excise tax revenues, for a few years, for the purpose of revising the 990-PF would advance the public interest.
- Tax return revisions are normally laborious and involve weighing many competing interests and issues, such as data discontinuities and taxpayer burdens resulting from revisions of an established form. This is not the case for the private foundation return: a workable prototype already exists; the sector is able to afford any short-term costs that arise from implementing a new form; and because of its shortcomings, the data currently collected on the 990-PF are rarely used for research or analysis.
- How well implementation of the Revised Form 990 for other nonprofits works out has little or no bearing on what should be done about the 990-PF. Since 1972, Congress and the IRS have recognized that the foundation sector is quite distinct from the general nonprofit sector and requires more regulation and specialized tax-form reporting.

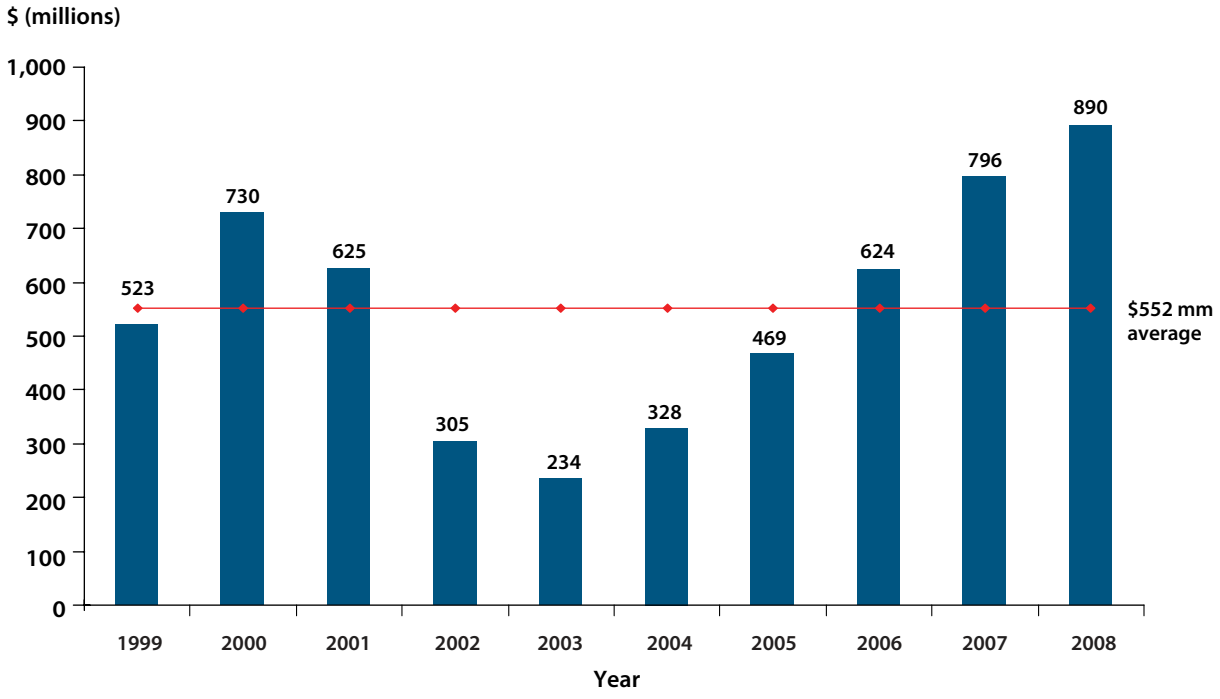
Whither the Excise Tax on Foundations' Net Investment Income?

Approximately two pages of the 990-PF are devoted to the calculation of the 2 percent excise tax that must be paid on net investment income (income from interest, dividends, other sources, and net realized capital gains). The computation is complicated

by the provision that the tax rate is lowered to 1 percent periodically for foundations that pay out more than the required annual minimum charitable distribution for a certain period. The argument for replacing the dual excise tax rate structure with a single rate generating the same amount of revenue—1.39 percent, as proposed in legislation introduced by U.S. Senator Charles Schumer (S. 676), or 1.35 percent, as proposed in President Obama's federal budget for fiscal 2012—is sound. A single rate would advance the goal of tax simplification, reduce filing preparation costs, and obviate the unproductive gaming of the current system in which some foundations engage.

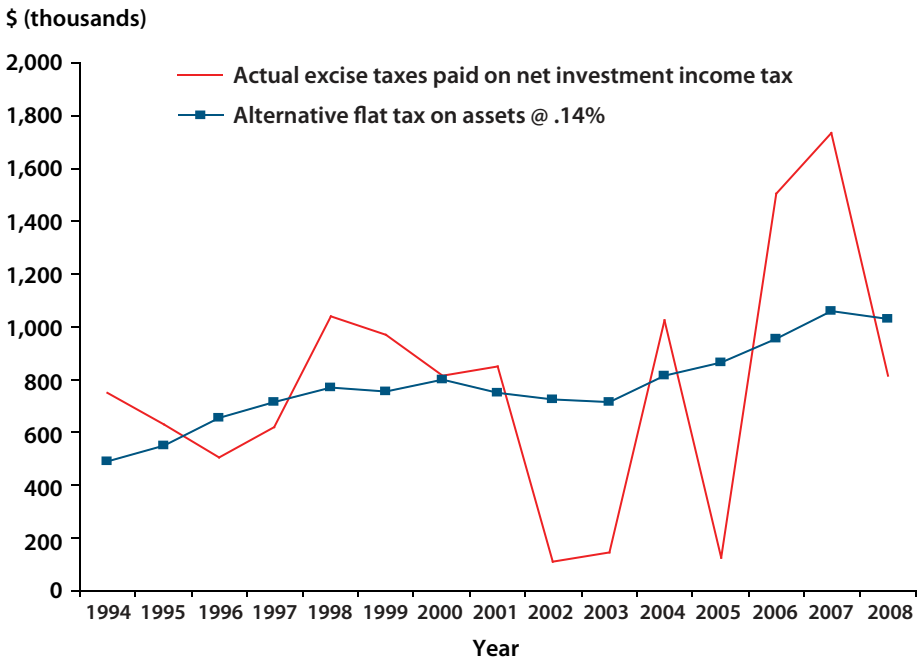
Should Congress entertain simplifying the excise tax, it should also take under consideration an alternative approach that would advance simplification even further, while also reducing the pronounced variability in revenues produced by the tax (Exhibit 7): replacing the excise tax on net investment income altogether with a flat tax on foundation assets that, on average over a defined period, would produce the same amount of revenue. As shown in Exhibit 8, using The Commonwealth Fund as an example, a flat assets tax of 0.14 percent would have produced the same $12 million in revenues over the 1994–2008 period as the actual excise tax—but with much less volatility and more predictability. This simplified alternative excise tax method, requiring only a few lines in the return, offers multiple benefits: foundations could more reliably predict their annual tax bills; the IRS could more reliably predict revenues from this source; and foundations would have no incentive, as they do under the current method, to vary their grant activities in order to minimize their tax bill.[21]

Exhibit 7. Excise taxes on net investment income paid by foundations average $552 million annually, with large fluctuations from year to year.



Source: www.irs.gov/taxstats/charitablestats, IRS data files.

Exhibit 8. A flat excise tax on foundations' assets could produce the same revenues as the current excise tax on net investment income, but with much less annual volatility and unpredictability—and would be a much simpler computation on the Form 990-PF.



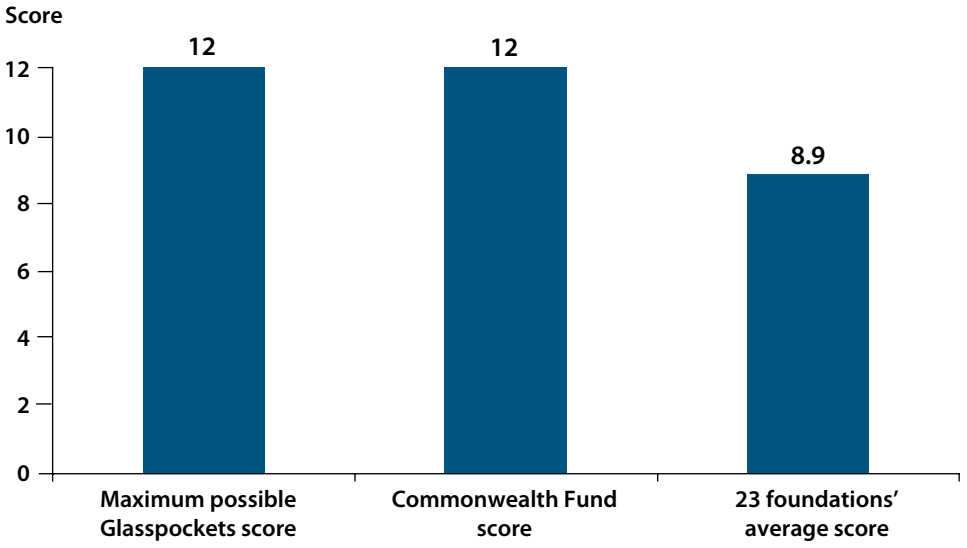
Source: The Commonwealth Fund.

Advancing Transparency, Accountability, and Best Practices

These recommendations for modernizing the 990-PF recognize the limitations on the extent to which the tax filing can ever serve as a guide for the foundation sector on transparency, accountability, and best practices. The IRS will always see the main purpose of the return to be determining compliance of foundations with the U.S. tax code and Treasury regulations. A revised return would improve the principal databases for monitoring foundation activities and encourage the adoption of legally required or widely agreed-upon best practices. But the size and diversity of the sector, the perils of the IRS attempting to use a limited amount of data for promulgating performance benchmarks, and serious IRS resource constraints lead to the conclusion that the foundation community itself should take the primary responsibility for ensuring that transparency, accountability, and best-practice adoption are a cultural norm for the sector.

In response to concerns of the U.S. Senate Finance Committee about misconduct by some nonprofits, Independent Sector's Panel on Nonprofits promulgated in 2007 *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*. These guidelines, together with work by the Center for Effective Philanthropy and groups like Grantmakers for Effective Philanthropy, efforts of the Council on Foundations and regional associations of grantmakers, and the CFA Institute's recently issued code of

Exhibit 9. Data on The Foundation Center's Glasspockets Web site have enabled development of an accountability metric for the Fund's own performance scorecard.



Source: Foundation Center, www.glasspockets.org (29 measures plus endowment performance reporting measure added by The Commonwealth Fund).

conduct for endowment management, demonstrate a strong sectoral response to the need for robust self-regulation.[22]

Among the most promising approaches for encouraging foundations to assess and improve their practices and to expose themselves to helpful public scrutiny is the Foundation Center's Web-based Glasspockets project.[23] Aimed at bringing transparency to the philanthropic community, Glasspockets is increasing understanding of best practices in foundation transparency and accountability, drawing on information available on institutions' Web sites. The Center has identified 29 indicators of transparency and best practices across six domains: basic contact information, governance policies and information, human resources/staffing policies and information, financial information, grantmaking information, and performance measurement. It asks foundations to voluntarily submit profiles indicating the extent to which their Web sites demonstrate pursuit of best practices.

As of February 2011, 24 foundations, including The Commonwealth Fund, have placed their profiles on Glasspockets. In a continuing effort to improve its own performance scorecard, the Fund has used these data to develop a new accountability metric (Exhibit 9).[24] The metric uses weights appropriate to the Fund's own values for each indicator in the Glasspockets profile to arrive at a weighted average accountability score for itself, the other participating foundations, and the group as a whole.[25]

Brad Smith, President of the Foundation Center, argues that greater transparency is the best means to protect the freedom that philanthropies need to pursue their missions.[26] The 990-PF is a major tool for ensuring basic transparency on the part of all foundations. Modernization would make it even more valuable and would strengthen the sector's own self-regulatory efforts to ensure effective use of the nation's philanthropic resources.

Notes

[1] *Foundation Yearbook, 2010 Edition*, (New York: The Foundation Center), foundationcenter.org. Data are for 2008.

[2] The privately funded and nonprofit Foundation Center maintains the most comprehensive database on U.S. and, increasingly, global grantmakers and their grants and operates research, education, and training programs to advance knowledge of philanthropy.

[3] Based on IRS estimates of average time requirements for different aspects of the filing process, in Internal Revenue Service, *2010 Instructions for Form 990-PF*, p. 30, Paperwork Reduction Act Notice. Using the IRS's time calculations and estimated hourly preparer rates, the average cost of filing the return is $9,000. Costs for individual foundations, of course, vary widely, depending on their size and complexity of operations. With a $650 million endowment, The Commonwealth Fund, for example, spends about $18,000 in preparing its annual tax return. The author thanks Commonwealth Fund controller Jeffry Haber for these estimates and for his other contributions to this paper.

[4] See www.irs.gov/taxstats/charitablestats, IRS data files, average for the 1998–2008 filing years.

[5] Thomas A. Troyer, "The 1969 Private Foundation Law: Historical Perspective on Its Origins and Underpinnings," *Exempt Organization Tax Review*, Jan. 2000 27(1):52–65. This brief history of the evolution of Form 990-PF is based on Troyer's article and review of the archived 990-PF filings of The Commonwealth Fund. Another valuable historical perspective is in Paul Arnsberger et al., "A History of the Tax-Exempt Sector: An SOI Perspective," *Statistics of Income Bulletin,* Winter 2008, www.irs.gov/taxstats/charitablestats.

[6] Troyer dates the first 990 information return back to 1943, but the first filing of the 990 in the records of The Commonwealth Fund is for the 1940–41 fiscal year.

[7] Form 4720, much expanded, must still be filed by foundations to pay penalty taxes for self-dealing, failure to meet the payout requirement, excess business holdings, jeopardizing investments, and taxable expenditures.

[8] The requirement for detailed schedules on the sources of realized capital gains and losses has been dropped along the way, after proving to be of little value to regulators. Foundations were no longer required to file Form 990-AR after 1975.

[9] According to IRS data, the average payout of private foundations in 2007–08 was 7.9 percent, ranging from 27 percent for foundations with less than $1 million in net assets to 6.3 percent for foundations with $100 million or more in net assets. The payout rate is cyclical, rising in years of market decline, and falling somewhat in years of market upswing—but the average is routinely greater than the required minimum. See www.irs.gov/taxstats/charitablestats.

[10] Eleanor L. Brilliant, *Charity and Public Inquiry: A History of the Filer and Peterson Commissions* (Bloomington, Ind.: Indiana University Press, 2000).

[11] Arnsberger, "A History of the Tax-Exempt Sector," p. 133.

[12] Elizabeth T. Boris et al., *Foundation Expenses and Compensation: How Operating Characteristics Influence Spending* (Washington, D.C.: The Urban Institute, The Foundation Center, and Philanthropic Research, Inc., 2006).

[13] John E. Craig, "Rethinking the Management of Foundation Endowments," *The Commonwealth Fund 2009 Annual Report* (New York: The Commonwealth Fund, March 2010); and David F. Swenson, *Pioneering Portfolio Management: An Unconventional Approach to Institutional Investment* (New York: Free Press, 2009).

[14] Alan Leibman, "The Madoff Aftermath and Charities: The IRS Forms 990-PF of the Shapiro and Wilpon Foundations—a Contrast in Transparency—Installment 27," *White Collar Defense & Compliance*, Fox Rothschild, LLP, 6-1-10.

[15] In each case, the tax code terminology could be retained parenthetically following the plain language title.

[16] See www.foundationcenter.org/findfunders/statistics.

[17] *Strengthening Transparency, Governance Accountability of Charitable Organizations: a Final Report to Congress and the Nonprofit Sector*. June 2005. www.nonprofitpanel.org.

Conversation with Ana Thompson of the Charles and Helen Schwab Foundation and Gwen Sherman of the Bill and Melinda Gates Foundation, Jan. 14, 2011. Jody Blazek of Blazek and Vetterling LLP, a past chair of the American Institute of Certified Public Accountants' Tax-Exempt Organizations Resource Panel and member of its task forces on IRS Forms 990 and 1023, has provided expert advice to the group.

[18] The prototype also does not envision enabling foundations to meet the requirements for information on their charitable activities and grants with links to their Web sites and data submission to the Foundation Center.

[19] ABA Section of Taxation, Comments on Form 990-PF and Related Instructions, Sept. 28, 2010, American Bar Association (contact Victoria B. Bjorklund at vbjorklund@stblaw.com for more information); http://www.improveirs.org/annualreports/2008%20Recommendations%208-.5-2009.pdf/.

[20] Troyer, "The 1969 Private Foundation Law," p. 64.

[21] Losers under a switch to an assets tax would be foundations with large more-or-less permanently held holdings—especially in situations where such holdings have low dividends. Endowments with these characteristics produce little realized gains or income subject to the current tax on net investment income.

[22] *Investment Management Code of Conduct for Endowments, Foundations, and Charitable Organizations*, CFA Institute, Aug. 2010.

[23] The Foundation Center, www.glasspockets.org.

[24] John E. Craig, "The Commonwealth Fund Performance Scorecard," *The Commonwealth Fund 2006 Annual Report* (New York: The Commonwealth Fund, March 2007).

[25] The Fund's metric includes a 30th test of accountability not currently in Glasspockets: whether the foundation reports its endowment returns, compared to benchmarks, over multiple years.

[26] Brad Smith, "Foundations Need to Be More Transparent," PhilanTopic blog, www.foundationcenter.org, Jan. 26, 2010.

THE COMMONWEALTH FUND

2010 Annual Report

The Fund's Mission, Goals, and Strategy

The Fund's Board of Directors sets Fund strategy, monitors the foundation's performance, and contributes directly to its work in numerous ways. In November 2009, Chairman James Tallon (right) moderated a policy roundtable of Ministers of Health at the Fund's annual International Symposium in Washington, D.C. Jeanne Lambrew (left), director of the Office of Health Reform, U.S. Department of Health and Human Services, and Ab Klink (center), Minister of Health, Welfare and Sport, The Netherlands, were among those discussing the challenges all countries face in achieving high performance health systems and lessons from abroad from which the United States can benefit.

Photo by Paula Lerner

MISSION

The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy and practice is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

GOALS

The Fund's Board of Directors has identified the following goals to be pursued by the Fund over the next several years:

1. Achieve a high performance health system by 2020 that:

- focuses on population-based, high-quality patient-centered care and outcomes;
- fosters integrated, well-coordinated care across a continuum;
- ensures accessible and accountable systems of care for the entire population;
- mitigates rising health care costs, increases efficiency, and enhances value; and
- employs continuous improvement and innovation.

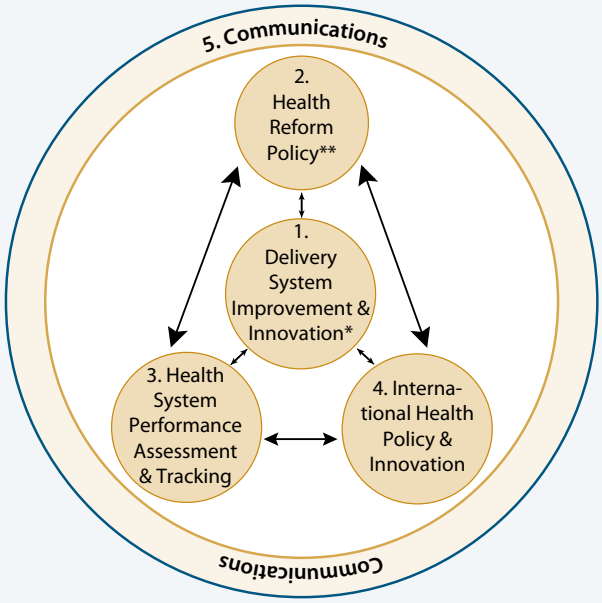
2. Accelerate the spread of high-performing community-oriented health systems, paying special attention to vulnerable populations.

STRATEGIES

To achieve these goals, the Fund pursues five integrated program strategies:

1. Identify, describe, assess, and help spread promising models of health care delivery system change that provide population-based, patient-centered, high-quality, integrated care. This strategy cuts across the continuum of care, including primary care medical homes linked to other community providers; acute, post-acute, and long-term care; care systems for vulnerable and special-need populations; and integrated care systems and accountable and coordinated care organizations.
2. Identify, develop, evaluate, and spread policy solutions that will expand access to affordable, high-quality, and high-value care for all—with special attention placed on vulnerable populations—and foster solutions for bending the cost curve.
3. Assess and track progress toward a high performance health system in order to identify top performance benchmarks, high-performing organizations, and best practices and tools, and to stimulate action to improve performance.
4. Translate and disseminate lessons from the international experience, with the aim of facilitating the spread of health system innovations.
5. Maintain and enhance the Fund's role in serving as a key resource to health system leaders and policy officials on reform implementation issues, and effectively communicate and disseminate the results produced by the Fund's grants and its research programs.

Exhibit 1. Commonwealth Fund Integrated Programs



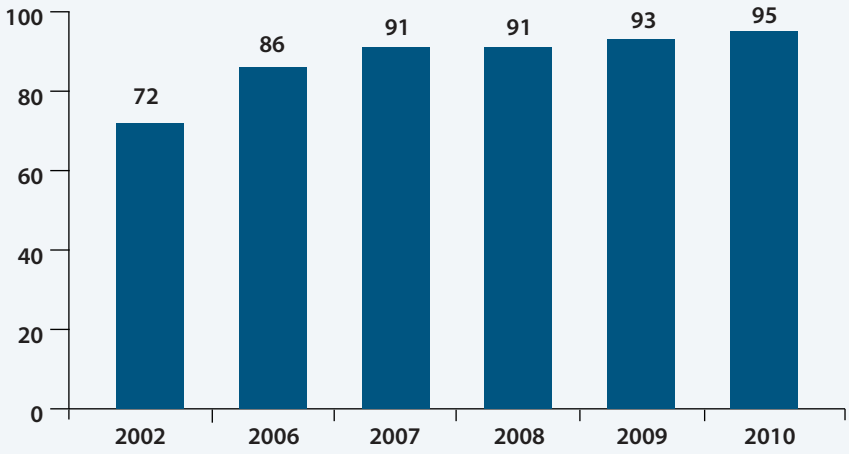
* Patient-Centered Coordinated Care; Health System Quality and Efficiency (including Long-Term Care Quality)

** Affordable Health Insurance; Payment and System Reform; Policy Development and Convening

The Fund's value-adding staff is central to executing these strategies successfully. The foundation combines the features of grantmaking and operating foundations—partnering closely with grantees to sponsor research and system innovations, but also conducting independent survey and health policy research and investing heavily in communicating the results of its work.

Exhibit 2. Commonwealth Fund's Performance Scorecard: Adding Value to the Work of Grantees

Percent of grantees saying staff contributions were "useful"–"extremely useful"



Source: 2002 Harris Interactive Survey and 2006–2010 Matthew Greenwald Commonwealth Fund Audience and Grantee Surveys.

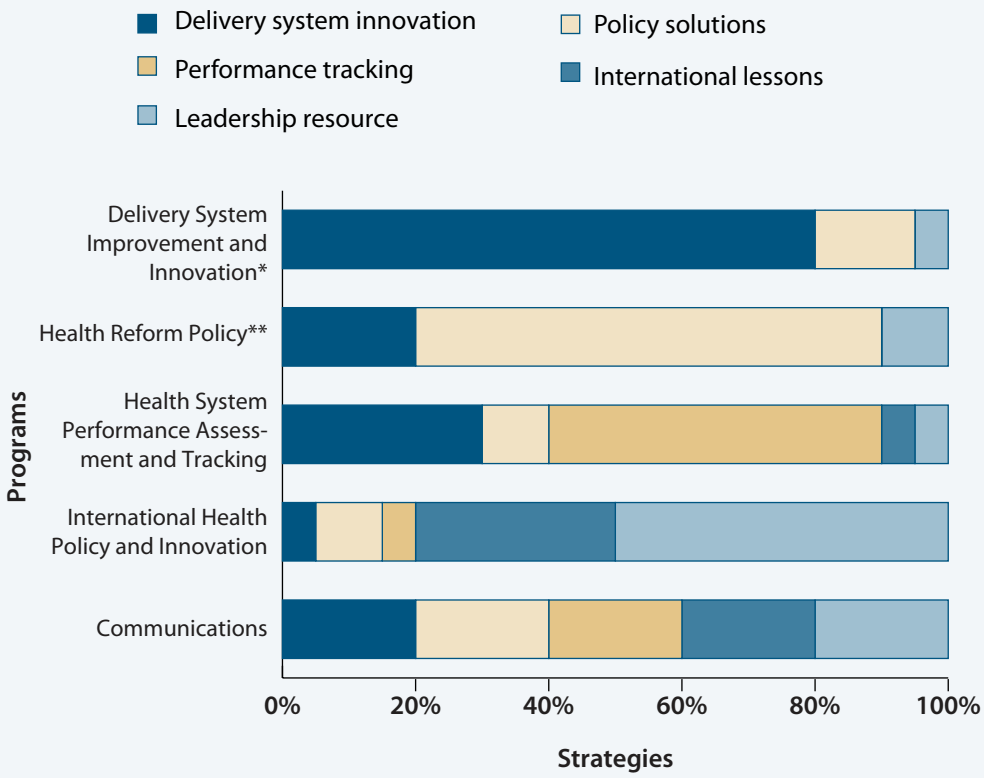
PROGRAMS

Each of the Fund's major programs contributes to the execution of the five strategies and involves inter-program collaborations.

The programs focusing on *Delivery System Improvement and Innovation* include:

- The **Health System Quality and Efficiency** program, the thrust of which is reducing hospital readmissions, through the State Action on Avoidable Rehospitalizations (STAAR) initiative and related work, and facilitating the development and spread of accountable coordinated care systems and measuring their performance. This program also continues the Fund's long-standing interest in improving the quality of nursing homes and long-term care services by supporting Advancing Excellence in America's Nursing Homes, a voluntary quality improvement collaborative, as well as Picker grants to support culture change in nursing homes and other long-term care service providers.
- The **Patient-Centered Coordinated Care** program, which includes a major safety-net medical home demonstration and evaluation involving community health centers and other clinics; evaluating primary care medical homes linked to other community providers; and facilitating spread of the medical home model of care. The program also supports the development of infrastructure, shared

Exhibit 3. Each of the Fund's Major Programs Contributes to the Execution of the Foundation's Five Strategies and Involves Inter-Program Collaborations



* Patient-Centered Coordinated Care; Health System Quality and Efficiency (including Long-Term Care Quality).
** Affordable Health Insurance; Payment and System Reform; Policy Development and Convening.

resources, and services to enable independent providers to improve their performance and coordinate their patients' care. A new initiative of the program is Community-Oriented Health Systems for Vulnerable Populations, which aims to identify high-performing safety-net organizations, analyze the financial and quality performance of safety-net clinics and hospitals, and develop strategies for promoting integrated health care services for vulnerable populations.

Numerous activities in these programs are state-focused.

The programs focused on *Health Reform Policy* include:

- The Commonwealth Fund **Commission on a High Performance Health System**, which has been in operation since 2005 and aims to contribute to the development of policy solutions to:
  - bend the health care cost curve;
  - spread high-performing accountable and coordinated health systems;
  - work toward universal health insurance coverage and comprehensive, affordable coverage for families and employers—advanced by the **Affordable Health Insurance** program;
  - enhance meaningful choice among community-oriented health plans;
  - restructure and sustain safety-net health systems;
  - through the **Payment and System Reform** program, support the development and assessment of payment innovation pilots and demonstrations, with a priority on multipayer initiatives; and align private sector and public program payment methods and rates.

- Through the **Federal Health Policy** program, the Fund sponsors briefings and dialogues for members of Congress and congressional and administration staff. The **State Health Policy and Practices** program further enhances the foundation's role of convening, promoting exchange, and disseminating information on health reform policy—at the federal, state, and sometimes regional levels.

- The **Health System Performance** program produces unique national and state scorecards on health system performance and is currently helping to develop local performance scorecards as well as a long-term care scorecard. The program also undertakes local market analysis of health insurers and providers and contributes to the Fund's other Web site, WhyNotTheBest.org, which offers easy access to data on hospitals and, eventually, will have data on accountable and coordinated care systems, primary care practices, and community health centers. As the 2010 Affordable Care Act takes effect, a program objective will be assessing delivery system change and the determinants of system performance. This work includes surveys tracking payment innovation, adoption of information technology, and trends in the organization of care, as well as national and international surveys tracking coverage, access, quality, and efficiency.

- The **International Health Policy and Innovation** program convenes policy officials and experts to learn from international innovations in the field. The program's activities include the following: an annual international symposium attended by health ministers and top policy officials from the industrialized world; annual multinational health care surveys; and the **Harkness Fellowships in Health Care Policy and Practice** program, in which Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Switzerland, and the United Kingdom participate. In addition, program staff and grantees produce a variety of publications, including issue briefs and case studies focused on innovative policies and practices identified through cross-national learning. Visitors to the Fund's International Health Policy Center, on www.commonwealthfund.org, can access a trove of international comparative data and analysis.
- The Fund's **Communications** program employs a variety of strategies—utilizing print, broadcast, online, and social media—to bring information on health reform and health system transformation to the attention of critical stakeholder groups, including policy officials and leaders in health care delivery. Recently, the Fund launched a new publications series analyzing the likely impact of health reform on key population groups and the health care delivery system, as well as a new media fellowship program, conducted by the Association of Health Care Journalists, to encourage in-depth reporting on issues related to health system performance and change.

MEASURING PROGRESS TOWARD A HIGH PERFORMANCE HEALTH SYSTEM

With the encouragement of its board, The Commonwealth Fund has identified measures that already exist or can be developed to track progress in achieving the objective of a high performance health system. These include evidence of the following:

- universal access to affordable, comprehensive insurance coverage;
- greater adoption of primary care medical homes as the standard of patient care;
- more patients receiving primary, acute, post-acute, and long-term care at benchmark-quality levels, and better coordination of these services across care settings;
- a greater proportion of physicians providing care in high-performing health systems, and a greater proportion of patients served by high-performing health systems;
- payment incentives that are aligned across payers and providers to enable and reward high-quality, coordinated care, and greater alignment of payment across public and private providers;
- health care spending growing at a rate equal to or below that of the gross domestic product (GDP) plus one percentage point;
- greater equity in access to high-quality care among population groups, and a narrowing of disparities in health and health care outcomes;
- a substantial and growing body of evidence for what constitutes and yields high performance, both within and across care settings; and

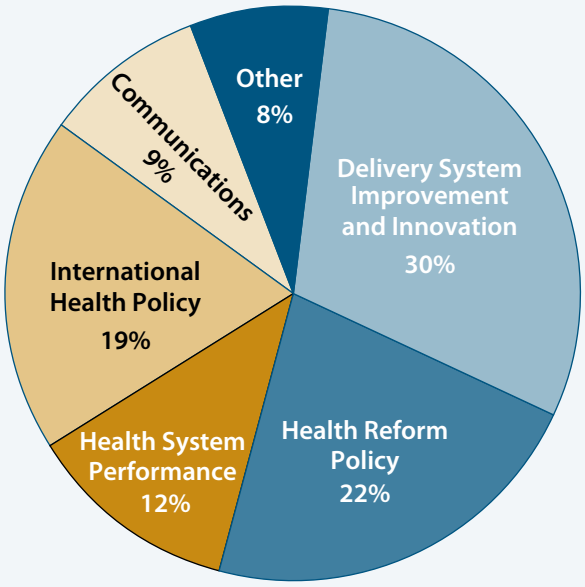
- effective leadership at the state and national levels, as well as collaboration among health system stakeholders, to achieve high performance health care.

RESOURCES AND THEIR MANAGEMENT

Over the five-year period 2010–15, the Fund expects to spend $146.6 million, strategically allocated across programs, toward implementing strategies and achieving goals—subject to the availability of funds from the foundation's endowment. The Fund's human resources are as important as its financial ones. They include highly productive professional staff based in the Fund's New York City headquarters and in its Washington, D.C., and Boston offices—as well as an outstanding constellation of advisors, including members of the Commission on a High Performance Health System, principal investigators on Fund grants, and members of the Fund's own Board of Directors.

Reflecting the foundation's value-added approach to grantmaking, approximately 37 percent of the total budget is devoted to intramural units engaged in research and program development, collaborations with grantees, and dissemination of program results to policymakers, health care leaders, researchers, and other influential audiences. The portion of the foundation's total budget devoted to administration is 5 percent.

Exhibit 4. In the 2010–15 Five-Year Extramural Program Budget, Funds Are Allocated Across Programs Strategically, and All Programs Will Contribute to the Pursuit of the Five Strategies



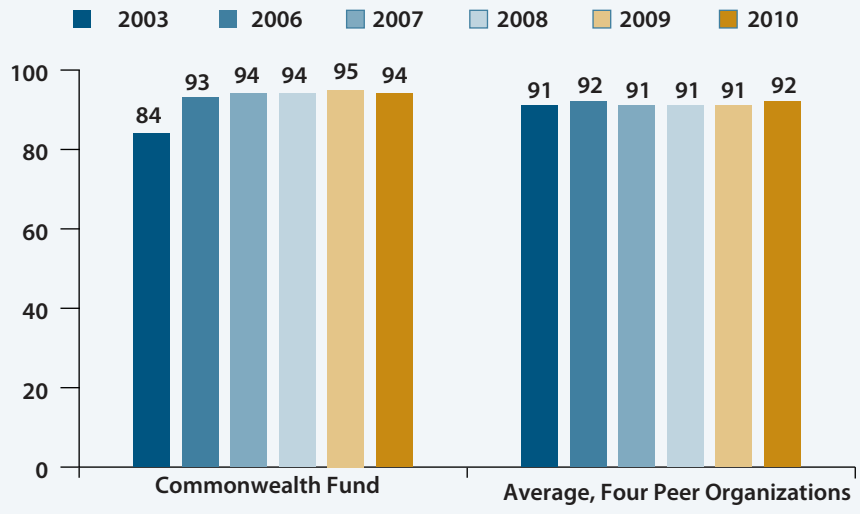
THE FOUNDATION'S PERFORMANCE

The Commonwealth Fund is one of only a handful of foundations that use a performance scorecard to provide their boards with a comprehensive annual assessment of the institution's overall performance and a means to spot weaknesses needing attention. The Fund's scorecard has 23 metrics, covering four dimensions: financial performance, audience impact, effectiveness of internal processes, and organizational capacities for learning and growth.

To help ensure a continued record of success and institutional vitality, the scorecard includes the objective of launching each year at least four new strategic initiatives that spur the foundation to take on new goals and strategies. The "stretch initiatives" for 2009–10 were as follows:

- assist the new administration and Congress in developing viable and effective health care reforms;
- expand the International Program in Health Policy and Innovation to additional European countries;
- partner with the National Business Coalition on Health on an electronic newsletter to aid employers committed to improving health care for their workforces;
- develop the capacity to estimate how payment reforms, including those involving the Medicare program, are likely to affect patients and the providers that serve them; and
- develop a strategy to assist states in advancing high performance health care.

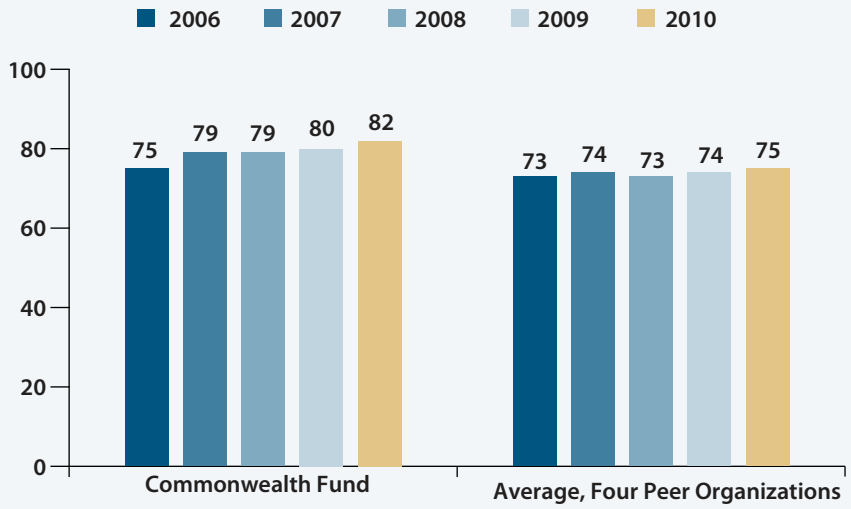
Exhibit 5. Commonwealth Fund's Performance Scorecard: Reaching Change Agents Effectively



Source: 2002 Harris Interactive Survey and 2006–2010 Matthew Greenwald Commonwealth Fund Audience and Grantee Surveys.

Exhibit 6. Commonwealth Fund's Performance Scorecard: Improving Health Care Access, Payment System, Quality, and Efficiency

Percent of Fund audience saying institution "effective"–"extremely effective" in improving health care access, quality and efficiency, and payment system



Note: "Payment system" added to questions in 2010 survey.
Source: 2006–2010 Matthew Greenwald Commonwealth Fund Audience and Grantee Surveys.

Exhibit 7. Commonwealth Fund's Performance Scorecard: Harvesting the Results of Grants and Research to Assure a Strong Flow of Information for Change Agents

Number of Fund publications

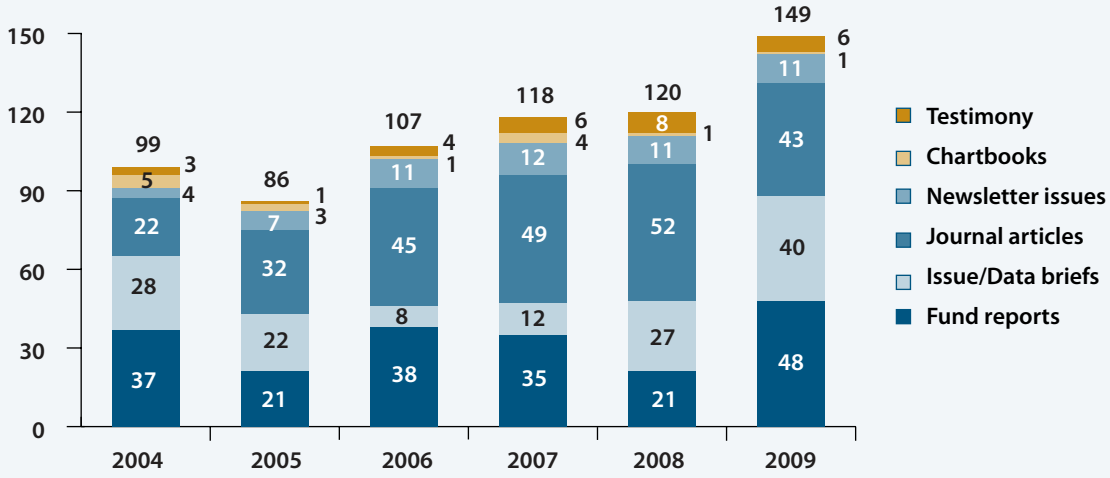
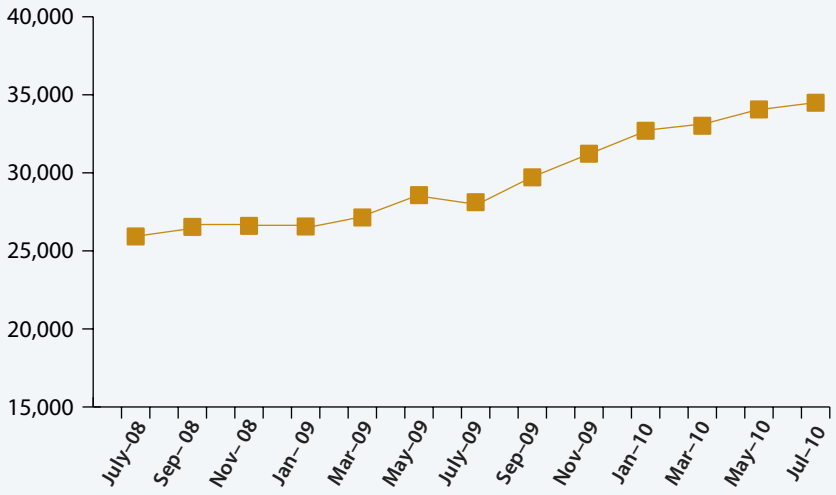


**Exhibit 8. Building a Large Influential Audience—
Commonwealth Fund Electronic Subscribers, July 2008–July 2010**



Note: Includes e-mail and RSS subscribers, Twitter and Facebook fans.

The Fund has made good progress on the first four of these initiatives. In pursuit of the last objective, the foundation will continue to avail itself of opportunities to help states undertake needed health care reforms.

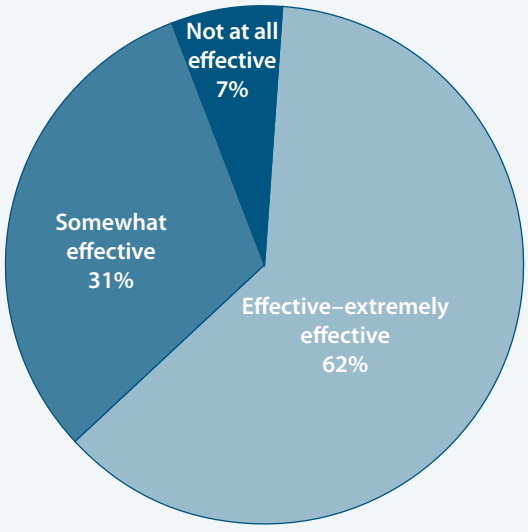
The Fund aims to be a learning organization, and consequently places a high value on assessments of its own performance. Each year, the Board of Directors commissions a thorough review of a major Fund program, with the goal of assessing its performance to date and drawing lessons to inform its future direction. In 2009–10, the Fund's Commission on a High Performance Health System was examined by Sheila Burke of Harvard University's Kennedy School of Government, Donald Berwick, M.D., former president of the Institute for Healthcare Improvement and current administrator of the Centers for Medicare and Medicaid Services, and journalist T.R. Reid.

The reviewers' overall conclusion was that the "Commission should continue to exist for a term of several years." Based on extensive interviews with health policy leaders, health system leaders, researchers, and journalists, they determined that "the information and analyses coming from the Commission process . . . provide American health care with an ongoing stream of publications and products that many influential leaders in American health care regard as valuable and unique." Findings of the review, highlights from which are listed below, were embraced by the Fund's Board in renewing the Commission's mandate for at least another three years.

- Almost all respondents were familiar with The Commonwealth Fund as an important asset in American health care, supplying copious information and analyses directly pertinent to the improvement of care, the reduction of cost, and the shape of health care reform.

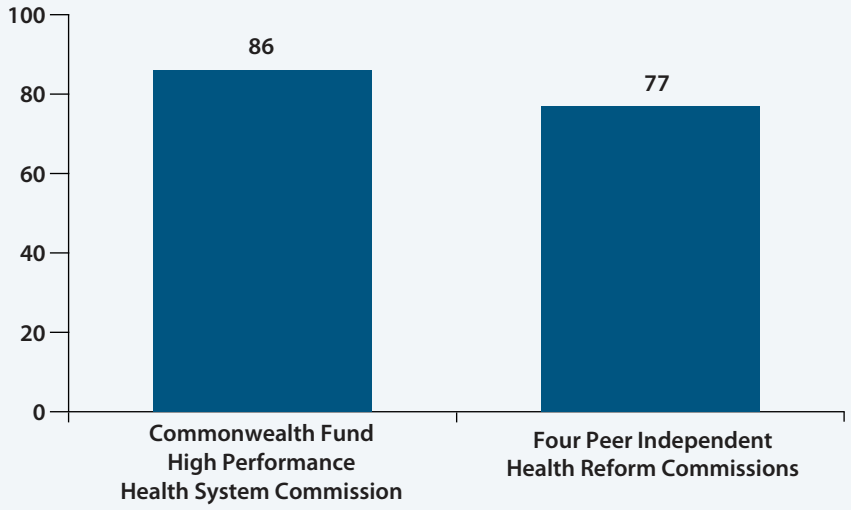
- Respondents viewed the Fund as especially strong in providing data, interpretive information, and policy guidance with respect to disparities, international comparisons, and possible options for reducing the increasing costs of health care.
- Overall, respondents most commonly mentioned the international comparative surveys and related reports from the Fund as the single most visible and helpful contribution. Close on its heels were the state report cards and a number of policy papers, especially *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*.
- Health care executives repeatedly mentioned internal use of the Fund's performance reports to stimulate interest among their clinicians and staff in improving clinical care quality and efficiency. Health care journalists uniformly seemed to consider Fund data to be the gold standard for comparative analysis.
- Health care executives, managers, association leaders, and academicians stressed the usefulness of the Fund's reports in their own speaking and teaching, both within and outside their organizations. Several commented on the ease with which Fund products—especially charts and graphs—could be downloaded and used.
- The majority of respondents regarded the Fund as having substantial impact on the health care reform debate—in many cases behind the scenes, mainly as a supplier of data and analyses on coverage, cost, and quality of care. One respondent, in specifically highlighting the importance of the Fund's international work, noted it was critical to the debate to point out that while the U.S. had much to be proud of, we spend twice what other advanced countries spend per capita, and much could be done to improve access and quality.

Exhibit 9. Effectiveness of Commission on a High Performance Health System in Bringing About Improvements in Health Care Payment and Delivery Systems



These findings were supported by those of the Fund's own 2010 Audience and Grantee Survey and by confidential interviews with members of Congress or their staff conducted by Edward Howard of the Alliance for Health Reform.

Exhibit 10. Assessment of the Commission on a High Performance Health System's Impact on 2009–10 Health Care Reform Debate



Source: 2010 Mathew Greenwald Commonwealth Fund Audience and Grantee Survey (n=1,745, scale of 1, "very low" to 5, "very high").

The Commonwealth Fund's annual external program reviews, annual reports to the Board on the performance of all grants completed during the year, annual audience and grantee surveys, annual confidential surveys of Fund Board members, and periodic surveys of Fund staff—all of which contribute to the Fund's own annual performance scorecard—help to ensure a high level of accountability and institutional learning.

Health System Quality and Efficiency

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

HEALTH SYSTEM QUALITY AND EFFICIENCY

Program Goals

The Program on Health System Quality and Efficiency is a key part of The Commonwealth Fund's focus on delivery system improvement and innovation. The program's mission is to improve the quality and efficiency of health care in the United States, with special emphasis on fostering greater coordination and accountability among all entities involved in the delivery of health care.

The program is rooted in a model of change whereby improvements are most likely to occur when the need for change is understood, measured, and publicly recognized; when providers have the capacity to initiate and sustain change; and when appropriate incentives are in place. To that end, the program supports projects that:

- assess the capacity of organizations to provide coordinated and efficient population-based care, and help expand that capacity where necessary;

The program is led by Vice President
Anne-Marie J. Audet, M.D.

Cover: Evidence is emerging that several new technologies, including remote patient-monitoring devices, can significantly reduce the need for hospital readmissions and lower costs. One of the goals of the Program on Health System Quality and Efficiency is to generate information that will help providers and policymakers identify the best ways to incorporate these technologies into care redesign efforts, decide what to invest in, and implement the tools systemwide to reap their full benefit. Above, a Centura Health at Home staff member shows a patient how she can communicate with her caregivers any time of day by using a laptop and webcam.

Photo: Centura Health at Home

- foster the development and widespread adoption of standard measures for benchmarking the performance of health care organizations over time; and
- promote the use of incentives for improving quality and efficiency in health care.

The Issues

The quality and efficiency of American health care is not what it should be. While the basic skill and dedication of the nation's health care providers is not in question, there are nonetheless ample opportunities for improvement in quality, safety, coordination, and patient-centeredness throughout the health care system.

According to The Commonwealth Fund's 2008 National Scorecard on U.S. Health System Performance, up to 101,000 deaths could be prevented each year if the United States were able to raise standards of care to the benchmark levels achieved by the top-performing countries. The relatively poor performance of the U.S. health system, coupled with the nation's standing as the biggest spender on health care in the world, also suggests it is a highly inefficient one. Supporting efforts to increase the value obtained from our health care dollars is one of the Fund's chief goals.

Recent Projects

Redesigning Care for High Performance

Hospitalizations consume nearly one-third of the $2 trillion spent on health care in the United States. Many of these are readmissions for conditions that could have been prevented had proper discharge planning, education, and post-discharge support been provided for patients.

In May 2009, the Institute for Healthcare Improvement (IHI), with Commonwealth Fund support, initiated the first phase of the STate Action on Avoidable Rehospitalizations (STAAR), a multipronged effort to help hospitals improve their processes for transitioning discharged patients to other care settings. In addition to helping hospitals and other providers improve post-discharge support, multidisciplinary disease management, and patient education, STAAR is assisting state policymakers and other stakeholders in implementing systemic changes to sustain these improvements. These changes might take the form of requiring payers to track and report readmission rates, or trying out new

provider payment models that reward the coordination of patient services across the care continuum. Under the direction of IHI staff, the initiative has been launched in three states—Massachusetts, Michigan, and Washington.

A concurrent Fund-supported evaluation of STAAR by Pennsylvania State University's Dennis Scanlon, Ph.D., is assessing how well the interventions succeed in reducing hospital readmission rates. The results should hold interest for the Medicare program and other public and provider payers for whom reducing hospitalizations is a priority.

To help hospital leaders get started on a plan for reducing readmissions, a team of experts at the Health Research and Educational Trust (HRET) of the American Hospital Association produced the Health Care Leader Action Guide to Reduce Avoidable Readmissions. This easy-to-use resource outlines strategies that have been proven successful in reducing unplanned readmissions and helps hospitals estimate the level of effort required for them to implement the strategies. The guide was produced with support from both the John A. Hartford Foundation and The Commonwealth Fund.

Another major source of health care spending is the care provided to patients with chronic health conditions. Fund grantees Greg Pawlson, M.D., of the National Committee for Quality Assurance and Robert Berenson, M.D., of the Urban Institute conducted a survey of 31 health plans' organizational characteristics and activities to see how resource use in diabetes care corresponds with patient outcomes. Their findings, published in an article in the *American Journal of Medical Quality*, show that variation in the level of resources used to care for patients varied considerably more—by as much as three to five times—than the quality of care delivered. The findings suggest that efforts to make health care delivery more efficient do not require sacrificing the quality of patient care.

Meeting and Raising Benchmarks for Quality

At the end of 2008, the Fund launched a new benchmarking and quality improvement resource, the Web site WhyNotTheBest.org, which enables health care professionals to compare their organization's performance against a range of benchmarks and access case studies and improvement tools. This unique resource has since developed a wide following. Nearly 7,500 registrants—hospital executives, quality improvement professionals, medical directors, and others—now use the site to search for hospitals by name, region, and various

characteristics, choose from an array of performance benchmarks, and save reports for future visits. Here are just some of the performance data to be found on WhyNotTheBest.org:

- measures developed by the Hospital Quality Alliance to report how often hospitals follow recommended care processes for heart attack, heart failure, pneumonia, and surgical care improvement;
- findings from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which surveys recently discharged patients about important aspects of their hospital experience;
- Medicare data on heart attack, heart failure, and pneumonia patients who were readmitted to the hospital within 30 days of discharge, as well as risk-adjusted, 30-day mortality for these three conditions; and
- standardized rates for central line–associated bloodstream infections, an often deadly hospital-acquired complication.

WhyNotTheBest.org also has 38 case studies of high-performing hospitals and integrated delivery systems and 58 improvement tools. Site enhancements over the next year will add key measures obtained from new state all-patient data sources; these will include measures of prevention (e.g., follow-up for abnormal mammograms), measures related to safety (e.g., prevalence of deep-vein thrombosis), as well as sophisticated "maps" that provide a compelling overview of performance.

Assessing Providers' Capacity to Improve Care

For the nation's health care providers to attain performance benchmarks like those reported on WhyNotTheBest.org, they must have the capacity—the knowledge, infrastructure, and incentives—to do so. The first National Survey of Physician Organizations, conducted in 2000, found that most group practices were not taking advantage of evidence-based care management processes shown to improve treatment of patients with chronic illnesses—and that the lack of payment incentives and health information technology were partly to blame.

In 2006, Stephen Shortell, Ph.D., and his colleagues at the University of California, Berkeley, conducted the second round of the survey to assess progress made in chronic disease management. Results from the Commonwealth Fund–supported study, which was supported by the Fund and the Robert Wood Johnson Foundation, indicate that

between 2000 and 2006, the use of 17 chronic disease management processes—disease registries, patient reminders and other attributes associated with the medical home model of care—increased by 23 percent. Practices that participated in quality improvement activities and received financial rewards linked to quality were among those achieving the greatest increase in use. The study produced a number of peer-reviewed papers, including a September 2008 *Health Affairs* article.

Hospitals also need to make quality improvement a more integral component of their culture. A Fund-supported study led by Alan B. Cohen, Sc.D., of Boston University and colleagues surveyed top quality officers at 470 U.S. hospitals in 2006 to examine the extent to which hospitals are embracing the principles and methods of quality improvement, or QI. Cohen and his colleagues found that hospital executives, managers, and nurses are far more engaged in QI activities than physicians—a finding consistent with studies citing the lack of doctors' involvement in quality-focused activities as a barrier to improvement. Case studies of selected hospitals will shed light on what factors are driving variations in quality.

Disseminating Best Practices and Innovative Models

Accounting for more than half of all hospital admissions in the U.S., large multihospital systems play an important role in strengthening the quality and safety of patient care. With Fund support, a team led by HRET president and American Hospital Association senior vice president Maulik Joshi, Dr.P.H., identified the characteristics and practices of high-performing hospital systems and developed recommendations to help underperforming systems make necessary changes. The resulting publication, *A Guide to Achieving High Performance in Multi-Hospital Health Systems,* provides system leaders with nearly 20 best practices in four crucial areas: establishing a strategic plan, creating alignment between goals and incentives, leveraging data and measurement, and standardizing and spreading best practices across all member hospitals.

Conducting case studies of high-performing provider organizations is another way to educate health care stakeholders about best practices for managing chronic diseases, reducing hospitalizations, increasing patient satisfaction, and achieving other important performance goals. In addition to the case studies available on WhyNotTheBest.org, the Fund also has made available a series on organized delivery systems across the U.S. In a report synthesizing findings from the cases, Douglas McCarthy and colleagues explore

the attributes common to many of the standout organizations examined, including information continuity, a high level of patient engagement, an emphasis on coordinated care, team-oriented care delivery, continuous innovation and learning, and convenient access to care.

The Fund is also sponsoring two evaluations focusing on best practices in health care delivery. The first evaluation, led by Geoffrey Lamb, M.D., will examine the Wisconsin Collaborative for Healthcare Quality, one of the U.S. Department of Health and Human Services' designated Chartered Value Exchange Networks and a leader in public reporting and sharing of best practices. The other will study shared decision-making in primary care and specialty clinics that belong to the Group Health Cooperative's network in Washington State. Headed by David Arterburn, M.D., M.P.H., the project will assess the effectiveness of 12 patient-decision aids on the use of elective surgical procedures, total health care utilization, and total costs.

Future Directions

As the nation moves toward health care delivery systems that are accountable for the outcomes and health care costs of an assigned patient population, The Commonwealth Fund is sponsoring important work to realize this coordinated, patient-centered, efficient model of care. With Fund support, Elliott Fisher, M.D., and colleagues at the Dartmouth Institute and the Brookings Institution developed and piloted a "starter set" of health care claims–based measures that could be used to assess quality of care as well as determine payments to accountable care organization (ACO) providers and the shared savings for which they are eligible. In the project's second phase, the team will develop and test a more advanced set of measures with pilot sites, including clinical outcomes measures and patient-reported measures of care experience and health status.

Although the Affordable Care Act encourages the establishment of ACOs, it is not clear that health care providers are ready to participate in ACOs or will be able to develop the capabilities to do so. In the first study of its kind, researchers led by HRET's Maulik Joshi, Dr.P.H., will profile U.S. hospitals and health systems for their readiness to be accountable for the continuum of patient care, including their ability to manage financial risk, receive bundled payment, and calculate and distribute shared savings to providers. Meanwhile, Catherine DesRoches, Ph.D., of

Massachusetts General Hospital will lead a longitudinal national survey to learn about the organizational settings and local health care markets in which physicians practice, care coordination processes and relationships with other providers, forms of reimbursement, and use of health information technology to provide high-quality, coordinated, and efficient care.

Long-Term Care Quality Improvement

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

LONG-TERM CARE QUALITY IMPROVEMENT

Program Goals

The Picker/Commonwealth Fund Program on Long-Term Care Quality Improvement, part of the foundation's efforts in the field of delivery system improvement and innovation, aims to improve the quality of post-acute and long-term care services and supports, create linkages among them, and integrate this care with other health care services to serve patients better. Specifically, the program seeks to:

- identify, test, and spread measures, practices, models, and tools that will lead to person-centered, high-performing long-term care services;
- build strong networks among stakeholders to create a sense of common purpose and shared interest in improving performance;
- assess, track, and compare the elements of long-term care performance at the state and national levels; and
- ensure that long-term care is incorporated into payment, health information, and delivery system reforms.

The program is led by Vice President
Mary Jane Koren, M.D., M.P.H.

Cover: The quality of services provided by nursing homes, assisted-living facilities, home health agencies, and other long-term care providers is the chief concern of The Commonwealth Fund's Program on Long-Term Care Quality Improvement. As the nation's population continues to age, access to high-quality post-acute and long-term care services and supports is critical for patients trying to get well, stay well, and remain functional.

Photo: Visiting Nurse Service of New York

The Issues

As our population ages, an increasing number of people live with multiple chronic conditions, in addition to whatever acute conditions may arise. Advancing age can also take a toll on our ability to remain independent and often compromises our capacity to manage health care needs. Access to high-quality post-acute care and long-term care services and supports is therefore critical for patients trying to get well, stay well, and remain functional—especially for older adults who live alone.

Patients and their families know this, often from personal experience. Policymakers, on the other hand, have been slow to incorporate long-term care into plans for health system redesign. With the recent enactment of the Affordable Care Act, which included the Community Living Assistance Services and Supports (CLASS) Act, that seems to be changing. The Fund's Long-Term Care Quality Improvement program is poised to support efforts to implement successfully the long-term care reforms included in these laws and to assist nursing homes and other providers that are striving to improve their performance.

Recent Projects

Advancing Excellence in America's Nursing Homes

Advancing Excellence in America's Nursing Homes is a national, public–private quality improvement campaign begun in 2006 with support from The Commonwealth Fund and the Centers for Medicare and Medicaid Services (CMS) to help nursing homes become good places to live, work, and visit. Led by a steering committee representing all major organizations that have a stake in high-quality nursing home care, the campaign is unique in encouraging the participation of not only organizational providers but also the individuals who staff facilities and the consumers they serve. To participate, nursing homes must agree to work on at least three of eight quality-related issues, such as reducing staff turnover—a problem endemic within the industry—or improving pain management, and to set performance targets as well.

The campaign's Web site, www.nhqualitycampaign.org, is central to its work, providing a necessary tool for tracking improvement and comparing the performance of participating and nonparticipating facilities; serving as an efficient conduit for bringing evidence-based practices to the attention of nursing homes across the country; and giving consumers information they need to help them get good care in a nursing home.

Owing to its success in attracting participants—there are now more than 6,600 facilities, representing over 42 percent of all U.S. nursing homes—and in achieving measurable progress in meeting quality goals, the campaign has been extended beyond the original two-year commitment. In addition to updating the resources available on the Web site, in the past year new clinical goals have been added, such as improving advance care planning and staff satisfaction, and the metrics used to assess progress on organizational goals have been better defined.

Preserving Critical-Access Nursing Homes

The Commonwealth Fund's abiding interest in reducing disparities in health care for vulnerable populations has led to heightened attention on "safety net" health care providers. While the term typically refers to hospitals and primary care clinics, Brown University's Vincent Mor, Ph.D., and others have found a trend of nursing home closures in inner-city neighborhoods that points to the need to consider nursing homes as important elements of the safety-net system. Although the care provided by nursing homes in these communities is frequently of poor quality, these facilities are often the only source of post-acute and long-term care services that is accessible to residents.

With support from the Fund and CMS, a pilot project led by Carol Benner, national director of Advancing Excellence, is attempting to stabilize "critical access" nursing homes enough to forestall their closure and improve them sufficiently to warrant continued participation in the Medicare and Medicaid programs. The states of Georgia, Illinois, Indiana, and Ohio have been selected to test whether the Advancing Excellence campaign's state coalitions—know as Local Area Networks for Excellence, or LANEs—can build and sustain learning collaboratives among these nursing homes to improve organizational function, operational efficiency, and overall service delivery.

The Pioneer Network

In the vanguard of the nursing home "culture change" movement since 1997, the Pioneer Network reaches out to providers across the country that are seeking to become truly person-centered organizations. Pioneer, with support from The Commonwealth Fund, offers nursing homes training, practical tools, and access to a community of peers. Over the past year, CEO Bonnie Kantor, Sc.D., working closely with congressional staff and other federal policymakers, opened up exciting opportunities to spread person-centered care through the inclusion of specific language in the Affordable Care Act calling for a national demonstration of culture change projects. Other sections of the new law target workforce development, a critical concern for long-term care providers; allow for more creative use of civil monetary penalty funds; and encourage inclusion of incentives within payment reform efforts for delivering person-centered care.

In the coming year, the Pioneer Network will continue to work with policymakers to maximize the potential of these provisions to promote person-centered care in long-term care settings, as well as to address providers' concerns with the new changes.

Expanding Nursing Homes' Capacity to Improve Care

Just as health information technology (HIT) can improve the coordination of patient care in primary and acute care settings, it also has the potential to improve coordination in nursing homes, which increasingly serve patients that have been discharged from the hospital but are not yet ready to return home. Preliminary findings from a Fund-supported survey led by the University of Pittsburgh's Howard Degenholtz, Ph.D., suggest that nursing homes are considerably behind other health care sectors in the adoption of HIT systems, and that use is still largely confined to administrative functions like billing or submission of required resident assessment data to CMS. To help address this lag, a recently completed evaluation of New York State's nursing home HIT demonstration, jointly conducted by three separate research teams and cosponsored by the Fund and the

state legislature, has provided policymakers and providers with many insights about the process and timing of HIT implementation, incentives and costs, factors that facilitate or impede adoption, implications for nursing home staff, and outcomes for residents. A Fund case study by Shana Lieberman Klinger and Scott White discusses the findings in detail.

Fund support also enabled a team led by Joseph Ouslander, M.D., at Florida Atlantic University to develop INTERACT-II (Interventions to Reduce Acute Care Transfers), a set of clinical tools that assist nursing home staff in the early identification, assessment, communication, and documentation of acute changes in residents' health status. The goal is to help staff safely and appropriately manage acute illnesses in the nursing home, rather than automatically transferring residents to hospitals. The toolkit has been shared with the Institute for Healthcare Improvement's STate Action on Avoidable Rehospitalizations (STAAR), an initiative sponsored by the Fund.

Long-Term Care Scorecard

The Affordable Care Act and CLASS Act will greatly expand the availability of Medicaid community-based long-term services and provide states with financial incentives intended to forge a better balance between nursing home care and home- and community-based services. As states embark on this new era in long-term care, they will need the means to assess progress in expanding access to a range of affordable, high-quality long-term care services. Following on the success of the Fund's national and state health system scorecards, Susan Reinhard, R.N., Ph.D., and her team from AARP are working with Fund staff and the SCAN Foundation to develop a state performance scorecard focused on long-term care**.** Over the coming year, a set of long-term care performance indicators will be finalized, and state policymakers will be surveyed to supplement information obtained from publically available data sets. The scorecard will be ready for public release in the summer of 2011.

Future Directions

In addition to finalizing the Fund's new state scorecard on long-term care performance and continuing its support of the Pioneer Network to foster person-centered long-term care, the Long-Term Care Quality Improvement program is supporting a number of other projects. For example, Harvard Medical School's David Grabowski, M.D., has begun to explore the promise of telemedicine as a safe, cost-effective way to reduce hospitalizations of nursing home residents—which occur frequently and are often associated with negative health outcomes. Telemedicine allows nursing home staff to consult with off-site physicians, who can then assess residents' need for hospital care and recommend treatments that the home might be able to provide at lower cost.

Another project, meanwhile, is seeking to improve coordination of care between hospitals and home health care settings and reduce costly hospital readmissions. A team led by Penny Hollander Feldman, Ph.D., of the Visiting Nurse Service of New York will determine whether home health care agencies can effectively use the Care Transitions Measure, a brief patient questionnaire that was developed by Eric Coleman, M.D., with earlier Fund support to assess the adequacy of instructions that hospitals provide their patients prior to discharge, The study will test whether home health agencies and other post-acute care providers can use the tool to assess how well a hospital prepares patients for home care, predict the level of resources new patients will require, tailor services to patients' individual needs, and provide hospitals with feedback on their transitional care. The project team will also develop a version of the Care Transitions Measure capable of assessing how well home health care agencies prepare their patients for discharge.

Patient-Centered Coordinated Care

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

PATIENT-CENTERED COORDINATED CARE

Program Goals

In support of The Commonwealth Fund's efforts to promote delivery system improvement and innovation, the Program on Patient-Centered Coordinated Care sponsors activities aimed at improving the quality of primary health care in the United States, including efforts to make care more centered around the needs and preferences of patient and family. To achieve this mission, the program makes grants to:

- promote the collection and dissemination of information on patient-centered primary care, including patients' health care experience and physician office systems and practices associated with superior care experience, to facilitate quality improvement and strengthen primary care;
- facilitate the adoption of practices, models, and tools that can help primary care practices become more patient-centered and coordinate more closely with hospitals, specialists, and other public and private health care providers in their communities;

The program is led by Vice President
Melinda K. Abrams, M.S.

Cover: One of the goals of The Commonwealth Fund is to facilitate the adoption of practices, models, and tools that can help primary care practices coordinate their care more closely with hospitals, specialists, and other health care providers in their communities. Shown here are a nurse and patient at the Revere Family Health Center, a clinic in Revere, Massachusetts, that is striving to become a patient-centered medical home with the help of Qualis Health, a Seattle-based quality improvement organization that is leading the Fund's Safety-Net Medical Home Initiative.

Photo: Michael Malyszko

- inform the development of policies to encourage patient- and family-centered care in medical homes; and
- raise the performance of community health systems for vulnerable populations.

The Issues

As defined by the Institute of Medicine, patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families . . . to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care."

There is substantial evidence that health systems built upon a strong foundation of primary health care deliver higher-quality care overall, and at lower costs and with greater equity. Research also shows that patient-centered primary care is best delivered in a medical home—a primary care practice or health center that partners with its patients in providing enhanced access to clinicians, coordinating health care services, and engaging in continuous quality improvement.

Recent Projects

Testing and Evaluating the Patient-Centered Medical Home

In April 2008, The Commonwealth Fund launched the five-year Safety Net Medical Home Initiative to support the transformation of primary care clinics serving low-income and uninsured patients into patient-centered medical homes. Led by Jonathan Sugarman, M.D., president and CEO of Qualis Health, a nonprofit quality improvement organization based in Seattle, and Ed Wagner, M.D., of the MacColl Institute for Healthcare Innovation, the initiative involves 65 clinics in five states—Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania. The Qualis/MacColl team is providing technical assistance to local quality improvement organizations in the participating states that, in turn, are helping the clinics achieve benchmark levels of performance in quality and efficiency, patient experience, and clinical staff experience. Eight foundations have joined the Fund in support of the initiative (see table).

Commonwealth Fund–Supported Evaluations of Medical Home Initiativ

	Emblem Health New York	Rhode Island	Safety Net Medical Home Initiative CO, ID, MA, OR, PA	New
Number of practices	19	5	65	
Number of physicians	71	28	492	
Number of patients	28,000	27,000	554,570	10
Number of participating payers offering incentives	1	4	0	
Medicaid participating as a payer?	Yes	Yes	No	
Safety-net clinics included?	Yes	Yes	Yes	
Payment model	Monthly, per-patient care management fee; fee-for-service; pay-for-performance.	Monthly per- patient care management fee and fee-for-service.	N/A	Bi-yearly access impr perfo
Distinguishing characteristics	Randomized controlled trial. Financial bonus incorporates performance on patient experience surveys.	Multiple payers cover 67% of enrollees in state. State Medicaid (fee-for-service and managed care) is participating.	Fund's demonstration project. Exclusively safety-net clinics. Largest national safety-net initiative.	Part of healt effort, po Katrina. O clinics p
Principal investigator	Judith Fifield/University of Connecticut	Meredith Rosenthal/ Harvard University	Marshall Chin/ University of Chicago	Diane R University San F
Cofunding	Emblem Health paying for all data collection.	Participating payers supporting most data collection costs.	Eight cofunders: Colorado Health Foundation, Jewish Healthcare Foundation (Pittsburgh), Northwest Health Foundation (Portland, Ore.), Partners HealthCare (Boston), Blue Cross Blue Shield of Massachusetts Foundation, Blue Cross of Idaho, Boston Foundation, Beth Israel Deaconess Medical Center (Boston).	Federal gra some dat

ves

Orleans	Colorado; Ohio	Mid-Hudson Valley	Primary Care Global Fee Model Albany, N.Y.; Massachusetts	Pennsylvania Chronic Care Initiative
25	22–30	70	5	164
150	100	1,200	37	800
)3,000	60,000	1,000,000	62,500	625,000
1	Colorado: 7 Ohio: 3	6	6	11/12
No	Colorado: Yes Ohio: No	Yes	Yes	Yes
Yes	Colorado: Yes Ohio: No	Yes	Yes	No
grant award if roves; pay-for-ormance.	Monthly, per-patient care management fee; fee-for-service; pay-for-performance.	Annual pay-for-performance bonus only.	Risk-adjusted, comprehensive annual primary care fee.	2 different per-member, per-month management fee models; shared-savings model; and modest one-time grants to practices.
th care recovery ost-Hurricane nly safety-net articipating.	Multistate project. Several national health insurers working together to test new payment.	1 million enrollees. Assessing incremental effects of EHRs, pay-for-performance, medical home.	Unique payment model. High-performing practices participating.	Most extensive multipayer medical home demonstration program in the nation. Will compare results with CO, RI, and OH.
ittenhouse/ of California, Francisco	Meredith Rosenthal/ Harvard University	Lisa Kern/ Cornell University	David Bates/Brigham and Women's Hospital	Mark Friedberg/ RAND Corporation
ant supporting ta collection.	Colorado Trust	Grants from New York State Health Department ($1.9 million) supporting data collection, data aggregation, some personnel costs.	None	Cofunding expected from the Jewish Healthcare Foundation.

Under another Fund grant, Marshall Chin, M.D., and a team of researchers at the University of Chicago are evaluating whether the clinics participating in the effort do, in fact, become medical homes, how medical homes affect quality and efficiency, and what factors are associated with a clinic's successful implementation of this care model. The evaluation of the Qualis initiative is one of eight medical home evaluations that the Fund is supporting (see table). Using a variety of methods, the research teams are looking into whether participating primary care sites are able to make the changes necessary to function as medical homes, and to what extent sites receiving technical assistance and a revised reimbursement structure improve their performance on measures of quality, efficiency, patient experience, and clinician or staff satisfaction.

With such a large number of medical home pilots and evaluations, the Fund established the Patient-Centered Medical Home Evaluators' Collaborative, cochaired by Meredith Rosenthal, Ph.D., and Melinda Abrams, to align evaluation methods, share best practices, and exchange information on ways to improve evaluation designs. A key objective of the collaborative is to reach consensus on a standard, core set of outcome measures in each of the key areas under investigation, such as efficiency, clinical quality, and patient experience. In August 2010, Rosenthal and colleagues published an article in *Medical Care Research and Review* with their recommendations on how best to measure changes in efficiency in medical home evaluations.

Building Capacity for Delivering Patient-Centered Coordinated Care

The Commonwealth Fund also is supporting efforts to improve the process by which primary care practices gain recognition as medical homes. In 2006, the Fund supported the National Committee for Quality Assurance (NCQA) in its work with the nation's leading primary care specialty societies to develop criteria for assessing and recognizing practices as patient-centered medical homes. Since the standards were released in 2008, more than 5,000 physicians in 1,000 practices have been recognized as patient-centered medical homes. Under a subsequent grant, Sarah Scholle, Dr.P.H., and her colleagues at NCQA are developing and testing additional criteria for recognition based on patients' experience, including the quality of patient–clinician communication, patient self-management, and care coordination. The new medical home standards will be released in January 2011.

Access to primary care after regular physician office hours—on evenings, weekends, or holidays—is one of the defining features of a medical home. Although evidence shows that having access to after-hours care is associated with lower emergency department use and fewer unnecessary hospitalizations, only 29 percent of U.S. primary care physicians have arrangements for providing their patients with after-hours care. Ann S. O'Malley, M.D., of the Center for Studying Health System Change (HSC) is preparing case studies of primary care sites that either directly provide effective, efficient after-hours primary care or arrange the provision of such care with a patient's usual provider. Her research team is focusing on policies and practice characteristics that could facilitate replication of effective models. Another HSC team, led by Emily Carrier, M.D., is exploring how independent primary care practices develop and implement agreements with specialists, hospitals, and nursing homes to coordinate care for the patients they share. The findings could benefit accountable care organizations and bundled-payment systems that rely on well-coordinated care.

Improving Policy and Financing to Promote Patient-Centered Care

Thirty-seven states are developing patient-centered medical home programs for enrollees in Medicaid and the Children's Health Insurance Program. With Fund support, Neva Kaye and Mary Takach of the National Academy for State Health Policy (NASHP) are working with state Medicaid officials to assess options for helping primary care sites obtain recognition as medical homes, reimbursement and financing, and assistance with office redesign, as well as evaluating progress made by these sites. In 2008, NASHP provided technical assistance to Medicaid and state officials from Colorado, Idaho, Louisiana, Minnesota, Oklahoma, Oregon, New Hampshire, and Washington. Eight new states were selected in 2009—Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—to receive assistance on making the policy improvements necessary to implement medical homes for low-income beneficiaries. For more information about states' efforts to promote medical homes, use this interactive medical home map, or download this 2009 Commonwealth Fund/NASHP report.

To identify the most effective way to reimburse primary care providers who attain high performance, the Pennsylvania Chronic Care Initiative—the most extensive multipayer medical home demonstration program in the nation—is testing four different models for financially rewarding primary care sites that function as patient-centered medical homes. A Fund-supported team of RAND and Harvard University researchers headed by Mark W. Friedberg, M.D., is assessing the differential impact of these payment approaches—which range from per-member per-month care management fees to shared savings—on health care utilization, efficiency, cost, and quality of care.

In an article in *Health Affairs,* Katie Merrell of Social and Scientific Systems and Robert Berenson, M.D., of the Urban Institute examined the strengths and weaknesses of four medical home payment approaches: enhanced fee-for-service payments; the addition of codes for medical home activities within fee-for-service payments; per-patient-per-month medical home payments that augment fee-for-service; and comprehensive, risk-adjusted per-patient-per-month payments. The authors conclude that while there is no single best way to structure medical home payments, the many ongoing medical home evaluations will help policymakers understand the impact of different approaches.

Future Directions

The Affordable Care Act includes multiple provisions intended to strengthen primary care. To ensure successful implementation of health care delivery reform, the Fund's Patient-Centered Coordinated Care program will support projects in a number of areas:

- *Making medical homes successful.* Analyses will determine which medical home components are most highly associated with improvements in health care quality and efficiency. Additional research will examine effective ways to streamline and standardize implementation of medical homes in primary care sites.
- *Resource-sharing.* Because most smaller, independent primary care practices have difficulty offering the entire range of medical home services, many experts have proposed that groups of practices band together to share resources and personnel. The Fund will support projects to identify and analyze various models for sharing resources to help smaller practices function as medical homes.

- *Policy implementation.* The Affordable Care Act includes a number of provisions intended to reestablish primary care as the foundation of health care delivery in the United States. A Fund priority will be to share early lessons from the field with local, state, and federal policymakers to help them advance primary care and take full advantage of opportunities in the health reform law.
- *Improving care coordination.* Fund-supported work will help identify and assess promising models for improving information-sharing among primary care clinicians and specialists, hospitals, and other providers in both safety-net and commercial settings.
- *Community health systems for vulnerable populations.* Nearly 20 percent of the U.S. population relies on publicly funded health care provided by private practices and safety-net providers, including clinics, public and nonprofit hospitals, and local health departments. Many of these providers are struggling to sustain their operation while ensuring access to high-quality care. The Fund's new initiative on community health systems for vulnerable populations addresses these issues by promoting greater organization and integration among these safety-net providers. Efforts are likely to focus on: promoting resource-sharing among safety-net providers to improve clinical care and practice efficiency; consolidating and integrating safety-net providers into community-oriented care organizations; and advancing the ability of these providers to participate in health reform activities.

Fellowship in Minority Health Policy

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

FELLOWSHIP IN MINORITY HEALTH POLICY

Program Goals

Moving toward a high-performance health care system requires trained, dedicated physician leaders who can promote policies and practices that improve minority Americans' access to high-quality care. With the passage of the Affordable Care Act, it is more important than ever that minority health care needs be represented by well-trained clinician leaders as policies in the new law are implemented. Since 1996, the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has played an important role in developing such leaders.

The program is led by
Joan Reede, M.D., M.P.H., M.S., M.B.A.,
Dean for Diversity and Community
Partnership, Harvard Medical School.

Cover: Since 1996, the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has contributed to the effort to reduce pervasive racial and ethnic disparities in the U.S. by building a cadre of dedicated physicians trained to lead efforts to improve minority Americans' access to quality medical care. Shown here at a Fund orientation session are 2010–11 fellows Roy Wade, Jr., M.D., Ali Thomas, M.D., Mary Fleming, M.D., and Kamillah Wood, M.D.

Cover, group photo, and portraits: Martin Dixon

Based at Harvard Medical School under the direction of Joan Reede, M.D., M.P.H., M.S., M.B.A., the dean for diversity and community partnership, the year-long Fellowship offers intensive study in health policy, public health, and management for physicians with a commitment to changing the system to better serve vulnerable minority populations. Fellows also participate in leadership forums and seminars with nationally recognized leaders in minority health and public policy. Under the program, fellows complete academic work leading to a master's degree in public health at the Harvard School of Public Health.

As of July 2010, 92 Fellows have graduated since the program began. In 2010–11, seven physicians were selected as Minority Health Policy Fellows, including one who will be supported by a dedicated scholarship made possible through Harvard University.

For more information about the fellowship, visit the Minority Health Policy Fellowship page at www.commonwealthfund.org.

2010–11 Minority Health Policy Fellows

Dustyn Baker, M.D.

Internal Medicine Resident, University of Chicago Medical Center, Chicago, Ill.

Dr. Baker is currently completing her residency in internal medicine at the University of Chicago Medical Center. Her interest in public health policy led her to create the Chicago BREATHE project, whose mission was to increase health literacy related to asthma and medical adherence among the largely black population of South Chicago. Dr. Baker interned at the Department of Health and Human Services in Washington, D.C., as a program analyst after the passage of the Medicare Modernization Act. During that time, she was also selected as a government relations intern for the American Medical Association. She has also served as student advisor to the Board of Trustees of the University of North Carolina at Chapel Hill. Dr. Baker received her medical degree from Duke University Medical School in 2007.

Mary Fleming, M.D.

Post-Graduate Obstetrics and Gynecology Administrative Chief Resident, Meharry Medical College, Nashville, Tenn.

Currently the administrative chief resident in obstetrics and gynecology at Meharry Medical College, Dr. Fleming plans to pursue a career in public health. She was drawn to Meharry because of its unique Women's Center for Health Research, which is dedicated to eliminating health disparities. An externship at the Emma Goldman Clinic in Iowa City cemented her focus on women's health in the community. Dr. Fleming also participated in an epidemiology elective at the Centers for Disease Control and Prevention, working with staff to track the origin and spread of the avian flu, and she has held positions with the Student National Medical Association, Vanderbilt University Medical School Admission Committee, and the American College of Obstetrics and Gynecologists. Dr. Fleming received her medical degree from Vanderbilt University School of Medicine in 2006.

Ali Thomas, M.D.

Consultant in Internal Medicine, Group Health Permanente, Tacoma, Wash.

Dr. Thomas has been a consultant in internal medicine at Group Health Permanente since 2007. Previously, he was a resident at John H. Stroger, Jr., Hospital of Cook County in Chicago, and an intern in pediatrics and medicine at Rush University Medical Center, also in Chicago. His professional and volunteer endeavors have included work with the Health Care Disparities Solutions Support Group, the American College of Physicians, and the American Medical Students Association. Dr. Thomas received his medical degree from the University of Michigan in 2002, and completed his residency in internal medicine at Legacy Health Systems in Portland, Ore., in 2007.

Ashaunta Tumblin, M.D.

Pediatric Resident, Baylor College of Medicine, Houston, Texas

Dr. Tumblin is completing her pediatric residency at Baylor College of Medicine in Houston. She was a research fellow of the National Institutes of Health in 2005–06 and a Schweitzer Fellow at the Hospital of Dr. Albert Schweitzer in Lambaréné, Gabon, during the summer of 2006. It was this latter experience that solidified her commitment to clinical and research training geared toward informing policies that help meet the medical needs of minority populations. Through her ongoing work with the Student National Medical Association, she became involved with the Girls Achieving in Life Sciences (GALS) Program, partnering with a local community afterschool program to create a new GALS program for preadolescents. Dr. Tumblin graduated cum laude from Harvard Medical School in 2007.

Roy Wade, Jr., M.D., Ph.D.

Pediatric Resident, University of Virginia, Charlottesville, Va.

Dr. Wade, who is completing his residency in pediatrics at the University of Virginia, is interested in the intersection of health policy and preventive health. He believes that effective policy can only be attained through the acquisition and interpretation of accurate data that elucidates the mechanisms leading to poor health outcomes. Dr. Wade has been a volunteer physician at the University of Virginia Health System, the Charlotesville-Albermarle Health Department, the Charlottesville Free Clinic, and at the Boys and Girls Club. Among his honors, Dr. Wade received the Dean of the College Award for Service, the Merck Manual Award, and an Albert Schweitzer Fellowship while at Dartmouth. Most recently, he received the Janet Jeffries Award from the University of Virginia Health System. He received his medical degree in 2007 from Dartmouth Medical School and in 2002 earned a doctorate in molecular microbiology from the Georgia Institute of Technology.

Kamillah Wood, M.D.

Chief Resident in Pediatrics, Children's Hospital of Philadelphia, Philadelphia, Pa.

Dr. Wood is completing her pediatric residency at Children's Hospital of Philadelphia. She is also an instructor of pediatrics at the University of Pennsylvania School of Medicine. As chief resident, Dr. Wood has been engaged in the residency recruitment process and is committed to helping to create a diverse workforce that is reflective of the community it serves; to that end, she serves as co-president of the Children's Hospital of Philadelphia Multicultural Physician's Alliance. Previously, as an intern with the Federal Office of the American Academy of Pediatrics (AAP), she worked with the lobbyist on the health reform reconciliation bill, helping to understand its implications on health care coverage for children. Most recently, she joined the "Back to Sleep" campaign, a task force of the AAP's Pennsylvania chapter, which addresses sudden infant death syndrome. Her combined interest in adolescent medicine and climbing HIV rates within the adolescent

population led Dr. Wood to the People's Emergency Shelter in Philadelphia, where she conducted a teen group as part of an afterschool program. Dr Wood received her medical degree in 2006 from the George Washington University School of Medicine and Health Sciences, where she was a New Century Scholar.

Kimberly Cauley Narain, M.D. (California Endowment Scholar in Health Policy)
Primary Care Internal Medicine Resident, University of California, San Francisco, Ca.

A native of California, Dr. Narain most recently completed her residency in Primary Care Internal Medicine at the University of California, San Francisco. Interested in the structural and behavioral determinants of health and the translation of health services research into policy, Dr. Narain conducted research in the UCSF Department of Psychiatry on the association of bipolar affective disorder with HIV progression in an urban HIV clinic. In the summer of 2004, Dr. Narain served as a Photovoice Fellow for the Dekalb County (Georgia) board of health. Her community service efforts include working for four years in the Teen Services Center of Atlanta's Grady Memorial Hospital, as a group facilitator and lecturer on such topics as sexual health and reproductive anatomy. Dr. Narain received her medical degree from Morehouse School of Medicine in Atlanta, Georgia, in 2007, graduating summa cum laude, with honors in community and health service. In 2007, she was honored with the Louis W. Sullivan Academic Achievement Award.

Affordable Health Insurance

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

AFFORDABLE HEALTH INSURANCE

Program Goals

As part of The Commonwealth Fund's focus on health reform policy, the Program on Affordable Health Insurance envisions an equitable and efficient health insurance system that makes available to all Americans comprehensive, continuous, and affordable coverage.

- provide timely analysis of changes in private and public insurance coverage for people under age 65 and the impact of those changes on the number of people covered and the number of people who are underinsured;
- document the consequences of being uninsured and underinsured on people's access to needed care, share of income spent on health insurance and health care, problems paying medical bills and accumulation of medical debt, and health;
- inform federal and state policy makers and media about Affordable Care Act provisions and emerging regulations and implications for the coverage and affordability of coverage for families and employers;

The program is led by Vice President
Sara R. Collins, Ph.D.

Cover: Small business owners and their employees are one of the many groups that stand to benefit from the Affordable Care Act once it is fully implemented. Over the coming months and years, The Commonwealth Fund's Program on Affordable Health Insurance will be tracking the impact of the new law's coverage provisions and identifying issues that may need to be addressed as implementation proceeds.

Photo: Roger Carr

- inform successful implementation of reform through analysis of key provisions related to achieving universal, affordable, and comprehensive health insurance coverage;
- analyze and develop new policy options for coverage, as well as increase administrative efficiency to expand, stabilize, and improve the affordability of health insurance.

The Issues

The most recent Census Bureau data show that 50.7 million people lacked health insurance in 2009, an increase of 4.3 million over 2008. Moreover, in 2007 an additional 25 million nonelderly adults with health coverage had such high out-of-pocket costs relative to their income that they could be considered "underinsured"—an increase of 16 million people since 2003, according to Commonwealth Fund research. Both these trends have had serious consequences for U.S. families: an estimated 72 million adults under age 65, both with and without health care coverage, reported problems paying their medical bills in 2007, and 80 million reported a time when they did not get needed care because of the cost.

Fortunately, help is on the way. The Affordable Care Act (ACA) will significantly improve the affordability and comprehensiveness of nongroup health plans through new insurance market regulations, insurance exchanges, a new standard for health benefits, and sliding-scale premium and cost-sharing subsidies for families with low and moderate incomes, among other reforms. To ensure the law's effective implementation, policymakers will need information about the likely effects of the new reforms on the affordability and quality of coverage, and about aspects of the law that might require modification.

Recent Projects

Monitoring Health Insurance Reform

Beginning in 2007, The Commonwealth Fund published a series of reports on the health care reform proposals introduced in Congress, including a report examining in detail each bill's health insurance provisions. Authored by Fund staff, it provided information on the number of people who would likely gain health coverage under the proposals, the estimated insurance premium and out-of-pocket costs for families, the consequences for employers, and the reforms' potential to stimulate price competition and lower costs. In

2008, the Fund published two reports that analyzed the health reform proposals of the presidential candidates. And in 2009–10, the Fund released a series of reports and tables comparing the provisions of the Senate and House health reform bills. After the ACA was signed into law by President Obama, the Fund released a set of timelines outlining the provisions of the new law and their expected implementation; the timelines are now part of the Fund's online interactive Health Reform Resource Center.

The Fund's Affordable Health Insurance program is now closely monitoring the implementation of the new legislation's provisions and their impact on coverage, affordability, and access to care (see Future Directions for projects).

In July 2010, the Fund released the report *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, by Timothy Jost, J.D., of the Washington and Lee University School of Law. The centerpiece of the new law's private health insurance reforms, state-based exchanges are expected to play a major role in the purchase and sale of health coverage once they become fully operational in 2014. Jost discusses critical issues that federal and state policymakers will need to consider to ensure the exchanges are successfully implemented. He also examines how the ACA attempts to address these issues and identifies policy options that the states and the federal government might wish to pursue.

Tracking the Uninsured and Underinsured

In an issue brief published each May since 2003, The Commonwealth Fund has documented the crisis in health insurance coverage among U.S. adults ages 19 to 29—the age group with the largest number of uninsured. In the 2010 update, *Rite of Passage: Young Adults and the Affordable Care Act of 2010*, the authors reported continuing deterioration of coverage, as the number of uninsured young adults climbed to 13.7 million in 2008, up from 10.9 million in 2000.

But the analysis also showed how the new health reform law will provide significant help to this group, which will benefit from changes enabling young men and women to remain under their parents' coverage until age 26, enroll in Medicaid if their income is at or below 133 percent of the federal poverty level, and buy subsidized private coverage through the insurance exchanges. The Fund will continue to monitor young men and women's health coverage, focusing especially on the impact of the new federal reforms and additional measures taken by individual states to ensure health security for this vulnerable population.

Another recent Fund analysis, *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010*, concludes that health reform is likely to stabilize and reverse women's growing exposure to health care costs over the next decade. Up to 15 million adult women under age 65 could gain subsidized coverage under the law. In addition, 14.5 million women who are underinsured could benefit from provisions that improve coverage or reduce premiums. The publication is the first in a new series of Fund briefs examining the likely impact of the ACA on different groups of Americans—from young adults beginning their careers to older adults nearing retirement—as well as on employers and the health care system.

Another group of Americans for whom stable health coverage is rarely a guarantee is older adults in their 50s and 60s—those who are not yet eligible for Medicare. J. Michael McWilliams, M.D., Ph.D., and colleagues from Harvard Medical School have published several research papers in leading peer-reviewed journals on the use and costs of Medicare services; the health status of Medicare beneficiaries who were uninsured before gaining Medicare coverage at age 65; and the effects of Medicare coverage on disparities in controlling certain chronic diseases. Their most recent study, published in the *Annals of Internal Medicine* in October 2009, found that Medicare beneficiaries who were uninsured before gaining their benefits at age 65 cost the Medicare system substantially more—over $1,000 per year—than beneficiaries who were previously insured. The findings suggest that the ACA, by making affordable insurance coverage available to uninsured adults in late-middle age, could improve health outcomes while also reducing health care use and spending in Medicare.

Assessing the Affordability of Health Coverage

Employer-provided health benefits form the backbone of health insurance coverage in America. But recent trends paint a troubling picture for many U.S. workers and their families. In a June 2009 *Health Affairs* article, Commonwealth Fund grantee Jon Gabel of the National Opinion Research Center and colleagues found that the out-of-pocket expenses of enrollees in employer-sponsored health plans grew by more than one-third between 2004 and 2007. The analysis of medical claims and health benefits survey data revealed that the percentage of people with incomes at or above 200 percent of poverty whose expected out-of-pocket spending on premiums and medical services exceeded 10 percent of income—a measure of affordability—rose from 13 percent in 2004 to 18 percent in 2007. Those who were sicker and poorer were more often underinsured, the authors found.

Meanwhile, Commonwealth Fund researchers reported in a September 2009 issue brief that only 25 percent of workers in small firms had coverage through their own employers, compared with 74 percent of workers in large firms. Because there are few sources of affordable coverage outside the employer-based system, millions of employees in small businesses are uninsured or have inadequate health insurance.

Overall, the percentage of Americans facing a high burden of out-of-pocket health care expenses and insurance premiums continues to increase. Writing in *Health Affairs,* Fund grantee Peter J. Cunningham, Ph.D., of the Center for Studying Health System Change reported that in 2006, nearly one of five Americans—19 percent of the nonelderly population—lived in families spending more than 10 percent of before-tax income on health care, up from one of seven Americans in 2001. The study found that in all income brackets, people with private insurance experienced an increase in their health care–related financial burden between 2004 and 2006, with the greatest increase occurring among middle- and higher-income individuals. Cunningham also found substantial variation in out-of-pocket burdens across the states.

In a Fund issue brief published in 2009, Cunningham found that an alarmingly high proportion of adults with multiple chronic conditions had a high level of out-of-pocket expenses and premiums. Looking specifically at the nonelderly population, he found that for nearly 40 percent, such expenses exceeded 5 percent of their income for two consecutive years, compared with 14 percent of those who had no chronic conditions. Prescription drug spending accounted for more than half of the out-of-pocket spending by these individuals.

Examining Efficiency in Health Insurance

Administrative expenses are a major culprit in the growth of health care costs over the years. Physicians spend an average of 142 hours interacting with health insurance plans annually, at an estimated annual cost to physician practices of more than $68,000 per physician per year, according to a Fund-supported study in *Health Affairs* led by Lawrence Casalino, M.D., Ph.D., of Weill Cornell Medical College. Meanwhile, the costs of billing and insurance tasks in a large medical group practice consume more than $85,000 per full-time equivalent physician, or 10 percent of operating revenue, as determined by Harold Luft, Ph.D., of the University of California, San Francisco, and colleagues in another *Health Affairs* study.

A Fund issue brief from July 2009 showed how insurance market reforms similar to those included in the new health reform law could substantially lower such costs. The Fund's Sara Collins, Ph.D., found that as much as $265 billion could be saved over the period 2010 to 2020 if insurance companies reduced their marketing and underwriting, lowered the costs of claims administration, spent less time negotiating provider payment rates, and reduced or standardized commissions to insurance brokers.

High administrative costs are a central reason why the premiums and deductibles of health plans offered in the individual market are unaffordable for many adults. Fund researchers reported in *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* that between 2006 and 2009, nearly three-quarters of people who tried to buy coverage in the individual market never actually purchased a plan, either because they could not find one that fit their needs or they could afford, or because they were turned down because of a preexisting health condition—an insurance company practice now banned under health reform.

Future Directions

The Commonwealth Fund's Program on Affordable Health Insurance will monitor the impact of the Affordable Care Act on the nation's uninsured and underinsured and inform policymakers and federal officials about ways to ensure the reforms are as effective as they can be.

A number of projects are designed to inform policymakers and the public about health reform and to help ensure it accomplishes its goals. Timothy Jost, J.D., in collaboration with Mark Hall, J.D., of Wake Forest University, and Katherine Swartz, Ph.D., of the Harvard School of Public Health, will examine the creation of state insurance exchanges—which will allow individuals to shop for their health coverage—and inform state and federal officials, legislators, and regulators about ways to make them as effective as possible. The National Opinion Research Center's Jon Gabel, meanwhile, will be estimating the affordability of health plans that are offered through the exchanges, as well as the cost protection these plans provide.

Using "micro-simulation modeling," Harvard University's Jonathan Gruber, Ph.D., will analyze the cost and coverage implications of various policy options for helping states move forward on reform prior to 2014. The findings could aid the development of additional policies to provide relief for uninsured and underinsured families in the four-year period preceding full implementation of the Affordable Care Act. In addition, Gruber will gauge the level of affordability needed to achieve near-universal health coverage.

Pamela Farley Short, Ph.D., of Pennsylvania State University will estimate gaps in people's health coverage and the extent of churning in health plan enrollment over the 2004–2007 period; this research will yield baseline date for evaluating the capacity of health reform to address this problem. And Jean Hall, Ph.D., of the University of Kansas Center for Research will study the high-risk insurance pools created by the new law and offer recommendations to officials charged with their implementation.

Finally, throughout the implementation of the Affordable Care Act, The Commonwealth Fund will continue to report, through its *Realizing Health Reform's Potential* series, the law's impact on society, the economy, and the health care system.

Commission on a High Performance Health System

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Commission Goals

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's Board of Directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 17 members, a distinguished group of experts and leaders representing every sector of health care, as well as the state and federal policy arena, the business sector, professional societies, and academia, are charged with promoting a high-performing health system that provides all Americans with affordable access to high-quality, safe care while maximizing efficiency in its delivery and administration. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the young and the aged, and people in poor health.

The Commission's principal accomplishments have been to highlight specific areas where health system performance falls short of what is achievable, and

The Commission is chaired by James J. Mongan, M.D., a member of The Commonwealth Fund's Board of Directors. Fund staff members Stuart Guterman, Cathy Schoen, and Rachel Nuzum serve as executive director, research director, and senior policy director, respectively.

Cover: Since 2005, the Commonwealth Fund Commission on a High Performance Health System has highlighted areas of health care performance that fall short of achievable benchmarks, while making the case for comprehensive reform to expand insurance coverage, access to care, and ensure more effective, efficient, and equitable care. In this photo, clinicians at Revere Family Health Center in Revere, Massachusetts, review a patient's care plan. The clinic is currently taking steps to become a patient-centered medical home.
Photo: Michael Malyszko

to recommend practical, evidence-informed strategies for transforming the system. Many of the major ideas in the Affordable Care Act—among them, new insurance market regulations, requiring everybody to have coverage, providing premium and cost-sharing subsidies to low- and moderate-income families, and payment and delivery system reforms—were advanced by the Commission through the reports and statements it has issued over the past half-decade.

The Issues

The United States provides some of the best medical care in the world, yet a growing body of evidence indicates that our health care system comes up short in comparisons with other industrialized nations. Although health spending in the U.S. is significantly higher than in other advanced countries, we are the only such country that fails to guarantee universal health insurance, and millions of our citizens lack affordable access to primary and acute care. Moreover, the care that is provided is highly variable in quality and often delivered in a poorly coordinated fashion—driving up costs and putting patients at risk.

The Affordable Care Act seeks to address these problems. Over the next several years, the Commission will dedicate itself to monitoring the law's implementation and impact, and to recommending modifications that would make the reforms more effective.

Recent Projects

Tracking Health System Performance

In its first report, *Framework for a High Performance Health System for the United States*, published in 2006, the Commission traced the critical sources of health system failures and outlined a vision of a uniquely American, high performance system. Since that initial report, the Commission has issued two national and two state-level scorecards for the U.S. health system. These reports take a broad look at how well the health care system is doing, where improvements are needed, and what examples of good care exist that could serve as models for the rest of the country. They look at specific issues: Do people have access to the health care they need? Are they getting the highest-quality care? Are we spending money and using health care resources efficiently?

The 2008 edition of *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance* finds that in nearly every area of performance measured, the health system performed worse than it did in 2006, scoring just 65 out of 100 across 37 core

indicators—where 100 represents not necessarily what is ideal, but what has actually been achieved by the best performers. Despite some good news in the report—for example, performance on a key measure of patient safety, hospital-standardized mortality ratios, saw significant improvement—the U.S. health system continues to operate far below the performance of leading nations, states, delivery systems, and hospitals.

The State Scorecard, first published in 2007, offers a metric for evaluating individual states' health care systems on access, prevention and treatment quality, avoidable hospital use and costs, health outcomes, and equity—with the goal of spurring policymakers and private stakeholders to undertake efforts to improve their performance to benchmark levels and beyond. The second edition of *Aiming Higher: Results from a State Scorecard on Health System Performance* reports that the cost and quality of health care, as well as access to care and health outcomes, continue to vary widely among states. An interactive map that accompanies the report provides state-by-state comparisons, as well as estimates of lives and dollars saved if performance were brought up to benchmark levels.

Making the Case for Reform

The Commission believes that while ensuring that all Americans have health insurance is essential, doing so is alone not enough to drive the kind of reform our health system needs. In the 2007 report, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, the Commission discussed concrete goals—and the strategies for achieving them—that should be on the national health care agenda, including: guaranteeing affordable health insurance for all; containing growth in health care costs and reforming provider payment; fostering greater organization and integration of care delivery; speeding adoption of health IT, evidence-based medicine, and other infrastructure; and setting and meeting national goals through strong national leadership.

Later in 2007, in *A Roadmap to Health Insurance for All: Principles for Reform*, the Commission makes the case for achieving universal coverage by building on the current mix of private group plans and public programs—a course of action that would retain the best features of our current system while minimizing dislocation for Americans who currently have good insurance coverage.

The Commission also has issued a number of policy reports with specific recommendations for achieving higher system performance. The 2008 report, *Organizing the U.S. Health Care*

Delivery System for High Performance, points out the detrimental effects of fragmentation in the current system and offers recommendations for establishing greater coordination across health care providers and care settings. For example, the report recommends moving away from fee-for-service payments and toward bundled payment systems that reward coordinated, high-value care. As reported in a Commission data brief, eight of 10 U.S. adults believe the health system needs fundamental change or complete rebuilding, and most want their health care to be more patient-centered and integrated than it currently is.

Developing Policy Options

Certainly one of the most important reports published by the Commission is *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which lays out in detail federal options for both short- and long-term savings within the health care system. The Lewin Group modeled the likely effects of each option and estimated the five- and 10-year cumulative impact on total national health spending, as well as the effects across federal and state budgets, employers, and households. The analysis determines that if implemented along with universal health coverage, selected policy options could save $1.5 trillion in national health expenditures over 10 years, while also improving the value of care in terms of access, quality, and health care outcomes.

As the national health reform debate began taking shape in February 2009, the Commission released another groundbreaking report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*. The comprehensive insurance, payment, and system reforms described in the paper would guarantee affordable health insurance coverage, improve health outcomes, and slow the growth of health spending by $3 trillion by the end of the next decade, according to projections. Many of the policy options presented are similar to those included in the new health reform legislation.

Informing Policymakers

In addition to formulating policy improvement options and recommendations for health reform implementation, the Commission on a High Performance Health System works to engage and inform policymakers in the executive and legislative branches and key health care stakeholders. The Commission sponsors bipartisan briefings and meetings for members of Congress and their staff. Senior policy director Rachel Nuzum provides federal legislators and government officials with testimony and technical assistance as requested.

On the state side, Fund vice president Edward Schor, M.D., facilitates information-sharing among policymakers about state health reform efforts, as well as communication between state and federal officials.

The Washington-based Alliance for Health Reform receives support from the Fund to conduct the briefings and roundtable discussions, as well as an annual bipartisan congressional retreat and congressional staff retreat, which give members of Congress and their senior staff a unique opportunity for off-the-record discussion of pressing health policy issues.

Future Directions

Even with the passage of comprehensive health care reform, the work of the Commission on a High Performance Health System is far from complete. Over the coming months and years the Commission will: 1) inform implementation of the Affordable Care Act and assess its potential to move the U.S. on a path to a high performance health system; 2) help health care leaders and the American public understand the new legislation and what it means for them; and 3) lay the groundwork for future delivery system change and health policy action. In addition, the Commission will continue its efforts to assess national and state health system performance and to inform health policy at all levels.

Federal Health Policy

THE COMMONWEALTH FUND

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FEDERAL HEALTH POLICY

Program Goals

The Commonwealth Fund's Program on Federal Health Policy is designed to strengthen the link between the work of the foundation, including the Commission on a High Performance Health System, and the federal policy process. As a key component of the Fund's efforts around health reform, the program focuses on the identification, development, evaluation, and spread of policies that expand access to affordable, high-quality, and efficient care—particular for vulnerable populations—while reducing health spending growth. Specific activities include:

- producing written materials on timely issues relevant to federal policymakers and their staff, with particular emphasis on implementation of the health care reform legislation passed in 2010;
- fostering dialogue among policymakers, national stakeholders, and the research community on key health policy issues;
- convening federal policymakers and their staff, in both the executive and legislative branches, to discuss health policy concerns; and
- providing technical assistance and expert testimony on health policy, as requested by policymakers and their staff.

The program is led by Assistant Vice President
Rachel Nuzum, M.P.H.

Cover: One of the first health reform provisions to be implemented was the rule permitting young adults to remain on their parents' health plan until age 26. The Commonwealth Fund's extensive research into health coverage for this disproportionately uninsured group played a key role in the eventual adoption of the reform. As other parts of the Affordable Care Act are implemented, the Fund will continue to provide analysis, recommendations, and technical assistance to federal policymakers to ensure the goals of affordable, high-quality, and efficient care remain at the fore.

Photo: Blend Images

Recent Projects

Dialogues for Congressional and Administration Staff

A new Commonwealth Fund–sponsored series of off-the-record, invitation-only discussions provides a forum for senior congressional and administration staff to engage in dialogue with their peers and receive technical assistance from outside experts on key policy issues. In 2010, these events focus on topics related to the implementation of the Affordable Care Act, such as the establishment of the new Center for Medicare and Medicaid Innovation and the creation of federal regulations for implementing the new health insurance exchanges, which are required to be in operation by 2014.

Bipartisan Congressional Health Policy Conference for Members of Congress

A select group of members of the U.S. House of Representatives and Senate are invited each year to meet in an informal, off-the-record setting with a group of academics and health care practitioners from a variety of backgrounds to learn about and discuss health policy issues. Th e annual Bipartisan Congressional Health Policy Conference gives members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion, all in an environment free from partisan politics and media pressures. In addition to serving as an opportunity to reach one of the Fund's most influential audiences, it also helps build working relationships with members of Congress who can advance the Fund's mission to achieve a high performance health system.

Alliance for Health Reform Briefings and Roundtables

The health policy briefings and roundtables conducted jointly by the Alliance for Health Reform and The Commonwealth Fund are a valuable resource for congressional and agency staff, representatives of national organizations, the media, and other key stakeholders looking to stay abreast of the latest developments in health care policy. The briefings, which are held on Capitol Hill and open to the public, focus on timely health policy topics under discussion at the federal and state levels.

Bipartisan Health Policy Retreat for Senior Congressional Staff

At this annual conference, invited senior congressional staff and senior staff from congressional support agencies meet in an informal setting with leading academics and health care practitioners to learn about pertinent health policy issues, engage in open and off-the-record debate, and discover opportunities for bipartisan collaboration.

Future Directions

The Federal Health Policy program is currently focusing on issues surrounding implementation of the Affordable Care Act. In the coming months and years, it will furnish guidance and technical assistance to policymakers and congressional and administrative staff engaged in implementation, as well as identify areas that may require corrective action. The program will also provide federal policymakers with summaries of relevant research and analyses from the Fund, policy recommendations from the Commission on a High Performance Health System, and case studies of innovative policies and programs around the country.

State Health Policy and Practices

THE COMMONWEALTH FUND

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STATE HEALTH POLICY AND PRACTICES

Program Goals

As a component of The Commonwealth Fund's efforts on health reform policy, the Program on State Health Policy and Practices assists states that are seeking to implement policies and programs that help ensure access to affordable, accountable, high performance health systems. The program does this by:

- working with state-initiated public–private partnerships to develop the policies and infrastructure necessary to improve quality of care and ensure greater accountability for patient outcomes;
- fostering discussion among stakeholders and policymakers about ways to strengthen the health care safety net in vulnerable communities; and
- nationally disseminating lessons from states as they implement health care reform.

The program is led by Vice President
Edward L. Schor, M.D.

Cover: A physician with her young patient at Clearwater Valley Hospital in Orofino, Idaho, which is participating in a Commonwealth Fund initiative to transform community health centers in five states into patient-centered medical homes. The Fund's State Health Policy and Practices program was established to assist states with developing the infrastructure needed to improve health system performance, particularly for vulnerable populations.

Photo courtesy of Clearwater Valley Hospital, Qualis Health

The Issues

The passage of federal health reform legislation creates a host of opportunities for states to expand access to care, improve quality, and achieve greater efficiency in their health care systems. At the same time, today's difficult economic environment makes it more challenging for state leaders to find the resources to pursue their efforts. The Fund's State Health Policy and Practices program was established to assist states with developing the infrastructure needed to improve health system performance, as well as to help state leaders share information on the policy and practice innovations they are undertaking.

Recent Projects

Working with Public–Private Partnerships Providing Technical Assistance for Quality Improvement

In 2008, The Commonwealth Fund and AcademyHealth launched the State Quality Improvement Institute (SQII) to help states address some of the shortcomings in performance highlighted by the Fund's State Scorecard on Health System Performance. Nine states—Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington—were selected to participate in an intensive planning process and work with leading experts to improve care in three priority areas: delivery and financing system reform, chronic care and population health improvement, and data integration and transparency. SQII states have now begun the process of implementing action plans around specific evidence-based improvement strategies, among them: the implementation of medical homes and care coordination strategies, new community-based health initiatives for reducing chronic illness, chronic disease management programs to improve patient outcomes and avoid hospitalizations, and public reporting of health care quality data. A progress report covering the institute's first year is available on the AcademyHealth Web site.

Improving Care Coordination, Case Management, and Linkages to Community Services

The Assuring Better Child Health and Development (ABCD) initiative, supported by The Commonwealth Fund and led by the National Academy for State Health Policy (NASHP), has helped 25 states launch projects to promote the use of structured developmental screening by physician practices. As practitioners have stepped up their identification of young children with developmental concerns, however, they have been presented with a

new challenge: referring families to appropriate intervention services and coordinating their care with other developmental service providers. To address these issues, ABCD is currently engaging five states—Arkansas, Illinois, Minnesota, Oklahoma, and Oregon—in efforts to change their policies, develop programs, and work with physician practices to create the systemic changes needed for effective coordination and referral networks. NASHP is also continuing to support states' efforts to sustain their gains in developmental screening rates.

In an April 2009 NASHP/Commonwealth Fund report, authors Kay Johnson and Jill Rosenthal show how states can foster greater integration of services delivered by physician practices and community agencies. One of the strategies they describe is offering medical home providers financial incentives and other support for care planning and case management, electronic medical record systems, and individualized, patient-centered care plans.

Helping to Implement Reforms in Physician Practices

To help physician practices make the changes needed to improve quality and efficiency, the Fund is supporting the development of statewide, multi-stakeholder collaborations called "improvement partnerships." The Vermont Child Health Improvement Program (VCHIP), the first of these initiatives, is assisting public–private partnerships in 19 states. An online guide available on the VCHIP Web site provides state leaders in child health with step-by-step instructions on developing sustainable collaborations of public and private partners. Along with the American Academy of Pediatrics and the National Initiative for Children's Healthcare Quality, the Fund sponsored a September 2009 webinar in which representatives from three improvement partnerships described how their initiatives have improved care and informed state policy.

Promoting State and Federal Dialogue

Successful implementation of health care reform will require committed, informed leadership within each state. With Fund support, the National Academy for State Health Policy is testing a model for fostering dialogue between state and federal leaders on issues related to health system performance. An October 2009 meeting of state and federal leaders in Washington, D.C., focused on patient safety and nonpayment for adverse medical events. (See this NASHP report for more information.)

Disseminating Lessons Learned

Circulated to some 15,000 policymakers, researchers, administrators, and providers, the Commonwealth Fund e-newsletter States in Action: A Bimonthly Look at Innovations in Health Policy tracks and reports on promising state initiatives to improve health system performance. The newsletter, coproduced by Sharon Silow-Carroll and her team at Health Management Associates and Fund staff, will be an even more valuable resource to states in light of new federal policies requiring them to create, test, and implement innovative ways to deliver high-quality health care.

In 2009, the National Governors Association launched a $1.5 million national initiative, Rx for Health Reform: Affordable, Accessible, Accountable, to assist governors and other state leaders with developing the kind of coordinated, efficient health care systems envisioned by the Affordable Care Act. The Fund is providing support for a series of papers that analyze the law and its implications for states, informing state activities as the law's provisions are implemented. Paper topics include health insurance reform, changes to Medicaid, establishing state-based health insurance exchanges, and delivery system redesign.

While states have been regulating private health insurance companies and products for a century, state regulatory activity has not addressed insurers' obligations regarding health care affordability and cost-containment. A project undertaken by Michael Bailit of Bailit Health Purchasing, LLC, examined Rhode Island's innovative use of health insurance statutes and regulations to expand primary care capacity and change in the delivery of primary care services. A Fund issue brief provides details on the state's experience.

Future Directions

The State Health Policy and Practices program will continue to help states network practices and providers through shared resources and unified approaches to paying providers and improving quality of care. The program will also build on the Fund's experience with monitoring, evaluating, and reporting on health system innovation and performance. Grants will support projects that analyze states' capacity to adopt significant payment reform, integrate Medicaid into statewide reforms, and help state hospitals, physicians, and insurers work together. The program also will support technical assistance, such as case studies and meetings to inform state leaders about health care reform and help them share their experiences with federal policymakers.

For example, a grant led by Nikki Highsmith of the Center for Health Care Strategies is helping to advance primary care transformation in Medicaid. Already the nation's largest health coverage program, Medicaid will be greatly expanded by the new health reform law, and new ways are needed to improve the efficiency and effectiveness of the small primary care practices that provide much of the care for Medicaid patients, particularly in underserved areas. The project team has interviewed Medicaid leadership in several states to determine how they are supporting small practices and to identify funding strategies and potential partnerships.

The ABCD initiative, meanwhile, will continue to work with leaders from Arkansas, Illinois, Minnesota, Oklahoma, and Oregon to undertake policy reforms, develop programs, and collaborate with physician practices to create the systemic changes needed for effective coordination and referral networks for children with developmental problems.

Payment and System Reform

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PAYMENT AND SYSTEM REFORM

Program Goals

The Program on Payment and System Reform is a key component of The Commonwealth Fund's efforts to inform health reform policy. The program supports the analysis and development of payment policy options that include incentives to improve the effectiveness and efficiency of health care delivery while curbing growth in health spending. Activities sponsored by the program include:

- improving the existing payment structure to align incentives within payment systems and provide a base for more comprehensive payment reform;
- modeling the potential impact of alternative payment reform options in Medicare and throughout the health care system;
- using payment reform to encourage the development of new models of health care delivery that provide better, more coordinated care; and
- evaluating the potential of new health care payment and delivery models for broader application.

The program is led by Vice President Stuart Guterman.

Cover: The Commonwealth Fund's Program on Payment and System Reform is supporting an evaluation by University of Michigan researchers to assess the impact of a physician group incentive program implemented by Blue Cross Blue Shield of Michigan to incentivize providers to take joint responsibility for their patients' care. Shown here are a doctor and patient at the Ann Arbor Family Practice, one of the participating practices.

Photo: Dwight Cendrowski

The Issues

National spending on health care in the United States—which already has the most expensive health care system of any country in the world—is projected to almost double from $2.6 trillion in 2010 to $4.9 trillion, or 20 percent of the nation's gross domestic product, by 2020. Yet this high level of spending does not produce commensurate returns in health care access, outcomes, or value.

Critical to achieving an efficient, high-performing health system is payment reform. New approaches to paying for health care are needed so that health care providers are rewarded for providing high-value care rather than a high volume of services, and so that providers have incentives to work together to deliver more appropriate, coordinated, and effective care. In addition to its provisions for making health insurance coverage available to millions of uninsured Americans, the Affordable Care Act also establishes a foundation for identifying and developing new payment approaches. To aid this effort, policymakers will need information and analysis on the available alternatives, as well as their potential and actual impacts on health spending and quality.

Recent Projects

Developing and Evaluating New Payment Models

To compensate health care providers appropriately for the difficulty of managing the sickest and most challenging patients—and to avoid overcompensating for healthy ones—quality, cost, and other outcomes must be judged against appropriately risk-adjusted expectations that reflect the difficulty of achieving those outcomes. Under a grant to the University of Massachusetts Medical School, Arlene Ash, Ph.D., and colleagues are developing a practical and generalizable method for making risk-adjusted payments and for measuring and rewarding quality for groups of primary care providers that function as patient-centered medical homes. The project should also inform other efforts to distribute payments to groups of providers operating in a multipayer setting.

Having supported the evaluation of some of the first pay-for-performance programs in the nation, the Fund is turning to more sophisticated payment models, like the Alternative Quality Contract being implemented by Blue Cross Blue Shield of Massachusetts. Under this new system, the hospitals and physicians caring for a patient throughout the course of an illness are provided a monthly, risk-adjusted global payment that covers all services delivered; performance-based payments supplement the baseline payment. With Fund

support, Michael Chernew, Ph.D., of Harvard Medical School is assessing whether the new payment method improves the quality of patient care and controls costs.

Aligning financial incentives in health care was also the focus of a Fund-supported project led by Melanie Bella of the Center for Health Care Strategies, Inc. (CHCS). The researchers provided seven states with technical assistance in developing and implementing mechanisms to improve the alignment of conflicting incentives between Medicare and Medicaid in the treatment of "dual eligibles"—the more than 7 million Americans who are eligible for both programs owing to their costly and complex medical needs. Since the two programs were enacted in 1966, a lack of lack of coordination between them has often hindered these individuals' ability to access the full range of services they need. In addition to working with program staff in the seven states, the project has facilitated interaction across the states and among the relevant state and federal agencies. CHCS also produced a resource for states, Integrating Care for Dual Eligibles: An Online Toolkit, which is available on the CHCS Web site.

Modeling the Impact of New Reforms and Policy Options

Several Fund grants are modeling the potential impact of payment policy reforms. For example, Allen Dobson, Ph.D., of Dobson/DaVanzo & Associates is developing estimates of how hospital revenues in the post–health reform era could be affected by newly available payment from patients who previously had no insurance. The researchers are assessing the impact that different levels of payment have on total hospital revenues and net revenue margins for different types of hospitals across the country, and gauging the impact that alternative Medicare and Medicaid payments have on hospital margins. At the Center for Studying Health System Change, Fund support is helping a team led by James Reschovsky, Ph.D., in its effort to model the effects of proposals to change Medicare payment rates to encourage better care and slow cost growth.

The Affordable Care Act also contains several provisions designed to make private Medicare Advantage (MA) insurance plans more efficient and effective in providing Medicare beneficiaries with coordinated care. In addition to lowering reimbursement for MA plans so that per-beneficiary costs are more in line with traditional fee-for-service Medicare, it rewards plans that perform well on measures of quality and patient experience and strengthens protections for beneficiaries. Brian Biles, M.D., and his colleagues at The George Washington University's School of Public Health and Health Services are

analyzing the impact that the new policies have on these plans and their enrollees, and using information from past experiences with the MA program to draw implications on broader issues in the context of health reform, including the impact performance-based payment has in determining enrollment patterns and the performance of private plans in managed markets.

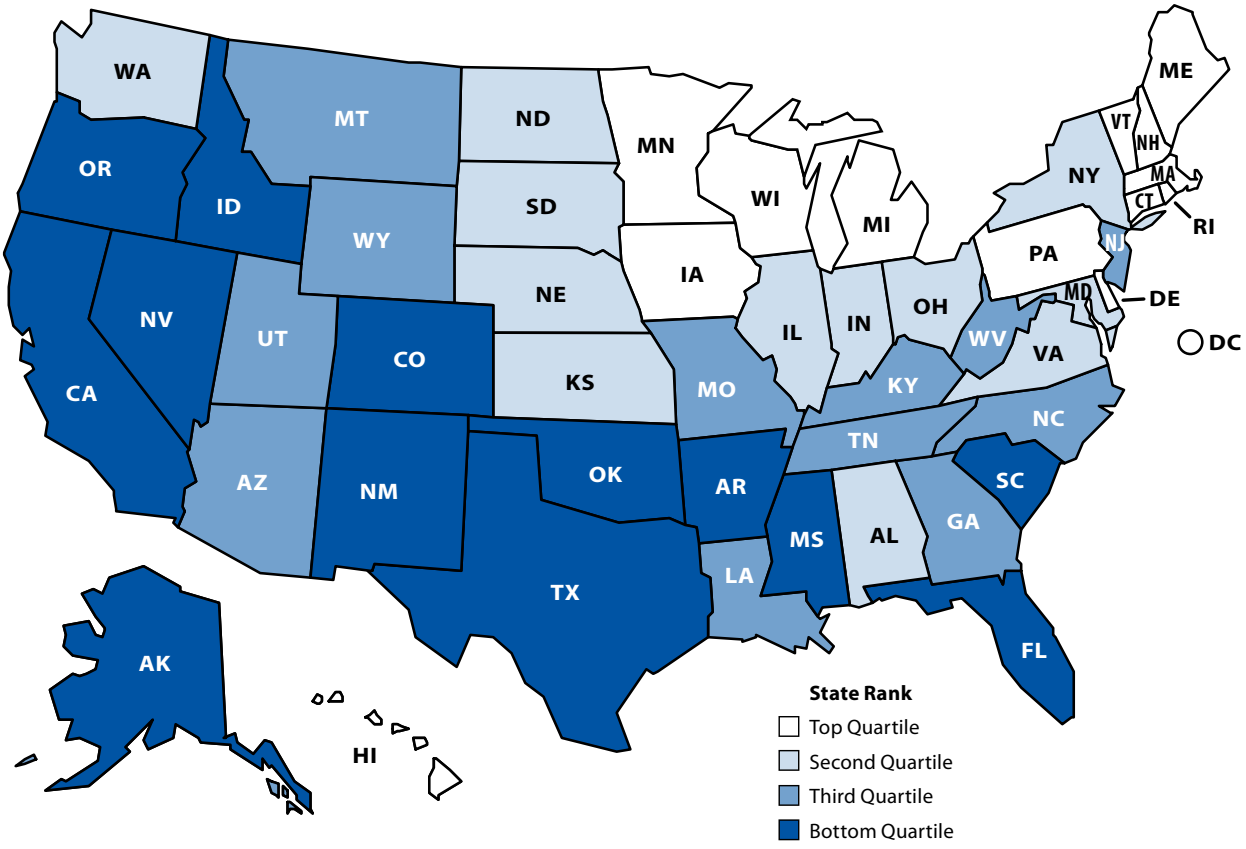
The Urban Institute's Stephen Zuckerman, Ph.D., and colleagues are collaborating with Fund staff and the Fund's Commission on a High Performance Health System to develop policy options to complement and build upon the Affordable Care Act's provisions for increasing quality and value in health care. In updating the Fund's 2007 report *Bending the Curve,* the research team will estimate the policies' potential impact, both individually and in combination, on national health spending over the next 10 years. Payment reform, quality improvement and patient safety, insurance market efficiency, and public health and prevention are possible areas of focus.

Understanding Geographic Variation in Health Care Costs

While it is well known that Medicare utilization and spending vary from region to region of the United States, patterns of use and spending in commercial insurance markets are not as well understood. Harvard Medical School's Michael Chernew, Ph.D., is examining geographic variation in commercial spending, adjusted for price differences, and the correlation between commercial and Medicare spending across hospital referral regions. With a better understanding of the factors related to geographic variation in health care use and spending in both the public and private sectors, policymakers will be better equipped to develop policies that constrain health spending and align payment incentives across the entire health system.

Future Directions

In the coming year, the Program on Payment and System Reform will further develop capacity to model the potential impact of health care payment and delivery reforms, including those in the Affordable Care Act, at both the health system and provider levels. The projects it supports will also identify ways to improve the process of rapid-cycle development, testing, and implementation of payment and system improvements, with which the new Center for Medicare and Medicaid Innovation Center is charged, and evaluate local initiatives designed to restructure payment incentives and improve health care delivery. For example, University of Michigan researchers led by Christy Lemak, Ph.D., will be evaluating a physician group incentive program implemented by Blue Cross Blue Shield of Michigan, in cooperation with the Michigan State Medical Society, to incentivize providers to work together in assuming joint responsibility for their patients' care. Among other changes, the study will document the impact on utilization, costs, quality, and relationships between physicians and payers.



Health System Performance Assessment and Tracking

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

HEALTH SYSTEM PERFOMANCE ASSESSMENT AND TRACKING

Program Goals

To advance its goal of a high performance U.S. health care system, The Commonwealth Fund gathers and disseminates evidence of excellence in health care from across the country and the world. This work is intended both to show what is possible and to stimulate health care providers, policymakers, and stakeholders to take action to improve performance in all facets of care.

The Fund's capacity for Health System Performance Assessment and Tracking enables it to:

- track and compare health system performance, by identifying benchmarks for patient care experiences, health outcomes, and cost that states, health care providers, and others can use to set improvement targets;
- assess trends in health insurance coverage, access to care, and patient-reported quality of care; and
- monitor public and private actions to transform health care delivery, including payment innovations, health information technology adoption, and the organization of care.

These activities are closely coordinated with Commonwealth Fund initiatives in the areas of Delivery System Innovation and Improvement, Health Reform Policy, and International Health Policy and Innovation.

The program is led by:

Senior Vice President for Policy, Research, and Evaluation Cathy Schoen

Assistant Vice President and Director of Survey Research and Evaluation Michelle M. Doty, Ph.D.

Senior Analyst and Project Director, Health System Scorecard and Research Project, David C. Radley, Ph.D., M.P.H.

Senior Research Adviser Douglas McCarthy, M.B.A.

Senior Research Associate, Health System Scorecard and Research Project, Sabrina K. H. How, M.P.A.

Research Associate, Health System Scorecard and Research Project, Ashley-Kay Fryer

Performance Assessment and Tracking Activities

Health System Performance Scorecards

Since 2006, The Commonwealth Fund and its Commission on a High Performance Health System have tracked the performance of U.S. health care through a series of national and state scorecards. The National Scorecard on U.S. Health System Performance (2006 and 2008) focuses on health care outcomes, quality, access, efficiency, and equity. The State Scorecard on Health System Performance (2007 and 2009) assesses states' performance on health care relative to achievable benchmarks for 38 indicators of access, quality, costs, and health outcomes. The upcoming Scorecard on Long-Term Care in the U.S. will report on care delivered by America's nursing homes, assisted-living facilities, home health agencies, and other long-term care providers. (For more information, see Picker/Commonwealth Fund Program on Long-Term Care Quality Improvement.)

WhyNotTheBest.org

The Fund's benchmarking and quality improvement Web site for health care providers, WhyNotTheBest.org, enables users to compare hospitals within and among states, read case studies of top performers and innovative programs, and access a variety of quality improvement resources.

Surveys

The Fund conducts a wide range of surveys, both in the United States and abroad, to monitor trends in health care access and quality, explore public views on health care matters, and assess the policy perspectives of health care leaders. Recent and ongoing surveys include:

- Commonwealth Fund Biennial Health Insurance Survey. Over the years, these surveys have produced a wealth of information about the extent and quality of health care coverage in the U.S. Topics covered in past surveys include: the stability and quality of adults' health insurance coverage, cost-related difficulties in accessing care, medical bill problems, and medical debt.

- Commonwealth Fund International Health Policy Survey (annual). Now including 11 industrialized countries, these annual surveys explore such topics as health system performance and responsiveness from the perspective of seriously ill adults and primary care physicians. Visit the Fund's online International Health Policy Center for more information.

- Commonwealth Fund Survey of Public Views of the U.S. Health Care System (2006 and 2008). The 2008 survey assessed the public's experiences and perspectives on the organization of the nation's health care system and ways to improve patient care.

- Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey (quarterly). Since 2004, these surveys have sampled key professional audiences about important health policy issues and options for addressing them. The four surveys in 2010 asked opinion leaders for their views on payment system reform, priorities for the Obama administration, slowing the growth of health care costs, and health reform legislation.

- Commonwealth Fund Survey of Young Adults (2009). Young adults ages 19 to 29 are one of the largest uninsured segments of the population. This nationally representative survey found that nearly half have gone without insurance at some time during the year.

- Commonwealth Fund National Survey of Federally Qualified Health Centers (2009). With the likely increase in demand for community health center services following enactment of health reform legislation, this survey explored these clinics' ability to provide access to care, coordinate care across settings, engage in quality improvement and reporting, adopt and use health information technology, and serve as patient-centered medical homes.

- Commonwealth Fund National Survey of Federally Qualified Health Centers. One of the many things Hurricane Katrina devastated when it hit New Orleans in 2005 was the city's health care system. To find out how well community clinics were serving their high-need populations, The Commonwealth Fund conducted interviews with patients at 27 clinics in 2009. The findings were encouraging.

To access all Commonwealth Fund surveys, visit Surveys at www.commonwealthfund.org.

Multinational Comparisons of Health System Data

Comparing the health care system in the United States with the systems of other industrialized countries reveals striking differences in spending, availability and use of services, and health outcomes. Each year, The Fund produces a chartbook depicting key health data for the 30 member nations of the Organization for Economic Cooperation and Development (OECD), as well as analyses based on those data. Visit the Fund's online International Health Policy Center for more information.

International Program in Health Policy and Innovation

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

INTERNATIONAL PROGRAM IN HEALTH POLICY AND INNOVATION

Program Goals

Sponsoring activities ranging from high-level international policy forums to the Harkness Fellowships and an annual health policy survey, The Commonwealth Fund's International Program in Health Policy and Innovation promotes cross-national learning by:

- sparking high-level creative thinking about health policy among industrialized countries;
- encouraging comparative research and collaboration among industrialized nations;
- building an international network of health care researchers devoted to policy; and
- showcasing international innovations in policy and practice that can inform U.S. health reform.

The program is led by Vice President
Robin Osborn, M.B.A.

Cover: The Harkness Fellowships in Health Care Policy and Practice are helping to fulfill the International Program's goal to build an global network of health care researchers devoted to policy. During the orientation for the 2010–11 fellowship class, Axel Mühlbacher (speaking), professor of health economics and health care management at Germany's University of Applied Sciences Neubrandenburg, and Jonny Taitz, assistant director of clinical operations and staff specialist pediatrician at Sydney Children's Hospital in Sydney, Australia, provide an overview of their countries' health care insurance, delivery, and financing systems.

Cover and group photo: Roger Carr

The Issue

Across the industrialized world, health care policymakers face mounting pressure to provide access to expensive new drugs and medical technologies, improve the quality and safety of care, and ensure that the care patients receive is responsive to their needs and preferences. Learning about other countries' approaches to attaining a high performance health care system—one that provides comprehensive health insurance coverage and delivers cost-effective, timely, high-quality health services—is of particular benefit to the United States, which continues to spend far more on health care per capita than any other nation and yet receives less in return than most.

Recent Projects

2009 International Symposium on Health Care Policy

For the past 12 years, The Commonwealth Fund has hosted an annual international health care policy symposium organized in collaboration with the leading U.S. health policy journal, *Health Affairs*. The 2009 symposium, held in November in Washington, D.C., brought together over 100 policy experts, including health ministers, senior government officials, and leading researchers from Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. U.S. Secretary of Health and Human Services Kathleen G. Sebelius kicked off the conference, which focused on building the infrastructure needed for a high performance health care system, particularly ways to address shared challenges and set priorities for reform.

A highlight of the symposium was the presentation of findings from the 2009 Commonwealth Fund International Health Policy Survey, the 12th in a series of cross-national surveys, by the Fund's Cathy Schoen and Robin Osborn. The survey compared the experiences of primary care physicians in Australia, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, the U.K., and the U.S. Published in

Health Affairs, the findings show the U.S. is an outlier on a number of key indicators. For example, U.S. physicians were the least likely to report having arrangements for patients to receive care after regular office hours, and among the least likely to use electronic health information technology or receive financial incentives for meeting care goals. U.S. physicians were also much more likely than their counterparts to report that the time they spend trying to get patients needed medications or treatment is a major problem, and that their patients have difficulty paying for care.

Harkness Fellowships in Health Care Policy and Practice

Targeted toward promising health care policy researchers and practitioners in eight countries, the Harkness Fellowships provide a unique opportunity to spend up to 12 months in the U.S. conducting a policy-oriented research study, gaining firsthand exposure to innovative models of health care delivery, and working with leading health policy experts. In 2009, Norway joined Australia, Canada, Germany, the Netherlands, New Zealand, Switzerland, and the U.K. as participants in the program.

Harkness alumni continue to generate important research based on their fellowship work and move into high-profile positions in their home countries. For example:

- Kalipso Chalkidou (U.K., 2007–08), Ruth Lopert (Australia, 2006–07), and colleagues identified international lessons for the U.S. in the field of comparative effectiveness research in a feature article in *Milbank Quarterly*.
- In an article in *Health Affairs,* Peter McNair (Australia, 2007–08) and colleagues studied the financial impact of the recently instituted Medicare policy of not paying to treat certain hospital-acquired conditions.
- In an article in *BMJ,* Harald Schmidt (U.K., 2009–10), Andreas Gerber (Germany, 2007–08), and Stephanie Stock (Germany, 2007–08) reviewed lessons from the German health system's financial incentives targeting individuals, which have been in place since 1989.

The 2010–11 Harkness Fellows represent a diversity of policy experiences and research interests. They include:

Iren Bischofberger (C.H.), Ph.D., M.Sc.N. (Switzerland)

Harkness/Careum Fellow
Program Director, Master of Science in Nursing by Applied Research
Project Director, Kalaidos Research, Kalaidos University of Applied Sciences

Project: Supporting Family Caregivers in Coordinating Care and Navigating the Health Care System
Placement: Visiting Nurse Service of New York
Mentors: Penny H. Feldman, Ph.D., Vice President, Research and Evaluation, and Director, Center for Home Care Policy and Research, Visiting Nurse Service of New York

Carol Levine, Director, Families and Health Care Project, United Hospital Fund

Berit Bringedal, **Ph.D.** (Norway)

Senior Researcher
The Research Institute
The Norwegian Medical Association

Project: Should Personal Responsibility for Health Count in the Prioritizing of Health Care Resources?
Placement: Harvard School of Public Health
Mentors: Norman Daniels, Ph.D., Mary B. Saltonstall Professor of Population Ethics, Harvard School of Public Health

James Sabin, M.D., Professor and Director, Harvard Pilgrim Health Care Ethics Program, Harvard Medical School

Martin Connor, Ph.D. (United Kingdom)

Program Director, Trafford Integrated Care Organization, Trafford PCT

Project: What Lessons Can Be Learned from the More Integrated Parts of the U.S. Health Care System, and How Could They Spread?
Placement: Stanford University
Mentors: Alan Garber, M.D., Ph.D., Professor, Stanford University

Stephen M. Shortell, Ph.D., Blue Cross of California Distinguished Professor of Health Policy and Management, and Dean, School of Public Health, University of California, Berkeley

Antoinette De Bont, Ph.D. (Netherlands)

Associate Professor
Institute for Health Policy and Management
Erasmus University

Project: Patient Safety in Primary Care
Placement: Kaiser Permanente
Mentor: Murray N. Ross, Ph.D., Vice President, Kaiser Foundation Health Plan, and Director, Kaiser Permanente Institute for Health Policy

Adam Elshaug, Ph.D. (Australia)

Hanson Fellow, Adelaide Health Technology Assessment (AHTA)
Senior Lecturer, Public Health, University of Adelaide

Project: Enhancing Priority Decision-Making in Comparative Effectiveness Research
Placement: Agency for Healthcare Research and Quality
Mentors: Carolyn Clancy, M.D., Director, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Jean Slutsky, PA, Director, Center for Outcomes and Evidence, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Sarah Garner, Ph.D. (United Kingdom)

Associate Director, Research and Development
National Institute for Health and Clinical Excellence (NICE)

Project: Value-Based Insurance Design: Low-Value Services
Placement: Tufts University
Mentors: Peter Neumann, Sc.D., Professor and Director, Center for Evaluation and Value and Risk in Health, Institute for Clinical Research and Health Policy Studies, Tufts Medical Center

Sean Tunis, M.D., Director, Center for Medical Technology Policy

Ruth Faden, Ph.D., Executive Director, Johns Hopkins Berman Institute of Bioethics and Philip Franklin Wagley Professor in Biomedical Ethics, Johns Hopkins Bloomberg School of Public Health

Alan Garber, M.D., Ph.D., Professor, Stanford University

Ansgar Gerhardus, Dr. med. (Germany)

Harkness/Robert Bosch Stiftung Fellow
Research Associate and Head
Working Group on Evidence-Based Public Health
University of Bielefeld

Project: The Potential Impact of Comparative Effectiveness Research on Health Care in the Context of Health Reform
Placement: University of California, San Francisco
Mentors: Lisa Bero, Ph.D., Professor, University of California, San Francisco

Carolyn Clancy, M.D., Director, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Diane Gray, M.B. B.S. (United Kingdom)

Director of Strategy and Planning, and Deputy Director of Public Health
Public Health and Strategic Planning, NHS Milton Keynes

Project: How Might Integrated Health Care Systems Increase Quality While Reducing Cost?
Placement: Weill-Cornell Medical College
Mentors: Lawrence P. Casalino, M.D., Ph.D., Chief, Division of Outcomes and Effectiveness Research, Weill Cornell Medical College

Benjamin K. Chu, M.D., MACP, President, Southern California Region, Kaiser Foundation Health Plan, Inc.

Ross Wilson, M.D., FRACP, Senior Assistant Vice President Quality, and Deputy Chief Medical Officer, New York City Health and Hospitals Corporation

Xander Koolman, Ph.D. (Netherlands)

Associate Professor
IPSE Studies
Faculty Technology, Policy and Management
Delft University of Technology

Project: Comparing the Massachusetts Model of Health Reform and the Dutch Health Reforms
Placement: Massachusetts Institute of Technology
Mentors: Jonathan Gruber, Ph.D., Professor of Economics, Massachusetts Institute of Economics

David Cutler, Ph.D., Eckstein Professor of Applied Economics, Harvard University

Sara Kreindler, D.Phil. (Canada)

Researcher, Research and Evaluation Unit
Winnipeg Regional Health Authority
Assistant Professor, Department of Community Health Sciences
University of Manitoba

Project: Social Processes in Implementing Accountable Care Organizations
Mentor: Elliott Fisher, M.D., Professor and Director, Center for Health Policy Research, Dartmouth Medical School

Axel Mühlbacher, Dr. rer. oec. (Germany)

Professor, Health Economics and Health Care Management
Hochschule Neubrandenburg

Project: Patient Priorities in Coordinated Care: A Discrete Choice Experiment to Identify Patients' Preferences
Placement: Duke University
Mentors: Peter Ubel, M.D., Professor, Fuqua School of Business, Duke University

Kevin Schulman, M.D., Professor, Duke Clinical Research Institute

Martina Roes, Ph.D. (Germany)

Harkness/B. Braun Stiftung Fellow
Professor, Institute for Quality and Case Management (IQC)
Hochschule Bremen

Project: Developing Outcome Indicators for Transitional Care for the Vulnerable/Chronically Ill Elderly
Placement: University of Pennsylvania School of Nursing
Mentor: Mary Naylor, Ph.D., FAAN, R.N., Professor, University of Pennsylvania, and Director, NewCourtland Center for Transitions and Health

Michael Schull, Dr.Med. (Canada)

Associate Professor and Director, Division of Emergency Medicine
University of Toronto
Senior Scientist, Institute for Clinical Evaluative Sciences (ICES)

Project: Hospitalization and ER Use in Networked and Integrated Primary Care Systems
Mentor: Elliott Fisher, M.D., Professor and Director, Center for Health Policy Research, Dartmouth Medical School

Emma Stanton, B.M., MRCPsych (United Kingdom)

Clinical Adviser to the Chief Medical Officer
Department of Health, England

Project: Understanding What Constitutes "Value" in Mental Health Care
Placement: Partners Community HealthCare
Mentors: Thomas H. Lee, M.D., CEO, Partners Community HealthCare

Elliott Fisher, M.D., Professor and Director, Center for Health Policy Research, Dartmouth Medical School

David Goodman, M.D., Professor and Director, Center for Health Policy Research, Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Medical School

Richard Bohmer, M.B.Ch.B., Professor, Harvard Business School

Jonny Taitz, **M.B.Ch.B., FRACP, FCP (SA)** (Australia)

Consultant Pediatrician
Assistant Director, Clinical Operations
Sydney Children's Hospital, Randwick

Project: Engaging Clinicians in Health Care Reform
Placement: Partners Community Health Care
Mentors: Thomas H. Lee, M.D., CEO, Partners Community HealthCare

Thomas D. Sequist, M.D., Assistant Professor, Harvard Medical School

Robyn Whittaker (N.Z.), M.B.Ch.B. (New Zealand)

Program Leader, Health Technology Research
Clinical Trials Research Unit
University of Auckland School of Population Health

Project: Changing the Course: The Future of Mobile Health Information Technology Initiatives
Placement: Health Resources and Services Administration
Mentor: Kyu Rhee, M.D., FAAP, FACP, Chief Public Health Officer, Health Resources and Services Administration, U.S. Department of Health and Human Services

To learn more about the Harkness Fellowships, visit http://www.commonwealthfund.org/Fellowships/Harkness-Fellowships.aspx.

In collaboration with the Australian Department of Health and Ageing, the Fund also offers the Australian–American Health Policy Fellowship, a "reverse Harkness Fellowship" designed to enable midcareer U.S. policy researchers or practitioners to spend six to 10 months in Australia conducting research and gaining an understanding of that country's health care system.

International Meeting on Quality of Health Care

Since 1999, The Commonwealth Fund and The Nuffield Trust have sponsored annual symposia that brought together senior government officials, leading health researchers, and practitioners from the United States and the United Kingdom, for an exchange on quality improvement policies and strategies. The 10th conference in this series, held in July 2009 at Pennyhill Park, England, explored provider payment policies and care integration. Since its inception, this meeting has underpinned a cross-national collaboration on quality led in the U.S. by Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), and in the U.K. by Sir Liam Donaldson, former chief medical officer for England's Department of Health.

Capitol Hill Briefings

In 2009, the Fund and the Alliance for Health Reform cosponsored two Capitol Hill briefings on international health reform, attended by congressional staff, policymakers, and journalists. One examined the role of comparative effectiveness research in health care decision-making and featured the directors of national institutes for comparative effectiveness in England, Germany, France, and Australia. The second briefing highlighted actions taken by independent quasi-governmental authorities in Germany, the Netherlands and France to control costs and enhance value in health care.

Forum on Using Electronic Medical Record Databases for Outcomes Research

A forum held at the Institute of Medicine in March 2010 and cosponsored by the Fund and the Joseph H. Kanter Family Foundation examined experiences in the U.S. and abroad with using electronic medical records as a data source to conduct comparative effectiveness research. Attended by senior government officials and leading experts from the U.S., Denmark, Germany, Norway, and the U.K., the meeting was organized in collaboration with AHRQ and the federal Office of the National Coordinator for Health Information Technology.

Commonwealth Fund/Change Foundation Meeting on Primary Care

The first in a series of meetings with policymakers and leading experts from Canada and the U.S. took place in New York City in March 2010. Themes for the panels and discussion were assessing and comparing the current state of primary care in both countries, the obstacles to change, and strategies to achieve high-performing primary care systems, with a particular emphasis on information technology and care integration.

Partnerships with International Foundations

The Fund has established more than 20 partnerships with health ministries and outstanding international organizations working to improve health system performance.

Country	**Partner Organization:** ***International Survey***	**Partner Organization:** ***Harkness Fellowships***
Australia	Bureau of Health Information Australian Quality and Safety Commission	
Canada	Health Council of Canada Ontario Health Quality Council Québec's Commissioner of Health and Welfare	Canadian Health Services Research Foundation
France	National Health Authority (HAS) National Fund for Health Insurance for Employees (CNAM)	
Germany	Institute for Quality and Efficiency in Health Care (IQWiG)	B. Braun Foundation Robert Bosch Foundation
Italy	Italian Association of Primary Care Doctors	
Netherlands	Ministry for Health, Welfare, and Sport Scientific Institute for Quality of Healthcare (IQ Healthcare)	Ministry for Health, Welfare, and Sport
Norway	Knowledge Centre for Health	Research Council of Norway
Sweden	Ministry of Health and Social Affairs	
Switzerland	Federal Office of Public Health;	Careum Foundation
United Kingdom	Health Foundation	Nuffield Trust NHS National Institute for Health Research/SDO

Future Directions

The 2010 International Health Policy Survey will assess health care system performance from the perspective of the general population. Conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.S., and the U.K., the study will include questions about health care access and coordination, care for chronic conditions, and inefficiencies in the health system. Survey findings will be released at the Fund's 13th annual International Symposium on Health Care Policy in November 2010.

Most of the International Program's unrestricted grant money is for small grants up to $50,000 and for issue briefs and case studies. Topics of particular interest include health care delivery system integration; patient-centered primary care models; governance structures for ensuring quality, cost-containment, and competition; and comparative pricing utilization for pharmaceuticals, medical imaging, and medical devices.

THE COMMONWEALTH FUND

2010 Annual Report

Treasurer's Report

THE COMMONWEALTH FUND

2010 Annual Report

Treasurer's Report

John E. Craig, Jr.

The investment committee of the Fund's board of directors is responsible for the effective and prudent investment of the endowment, a task essential to ensuring a stable source of funds for programs and the foundation's perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and chief operating officer/treasurer, who, with the assistance of consultants from Cambridge Associates, is also responsible for researching investment strategy questions to be addressed by the committee. The committee meets at least three times a year to review the performance of the endowment and individual managers, reassess the allocation of the endowment among asset classes and managers and make changes as appropriate, deliberate investment issues affecting the management of the endowment, and consider new undertakings.

In the fiscal year ending June 30, 2010, the value of the Fund's endowment began to recover from the losses arising from the major global financial crisis and stock market crash of 2008–09 (Exhibit 1). The market value of endowment assets rose from $503 million at the depth of the market crisis in March 2009, to $550 million at the beginning of the fiscal year, to $598 million on June 30, 2010. At the same time, the foundation expended $33.8 million during the year in pursuit of its mission of advancing a high performance health system (Exhibit 2).

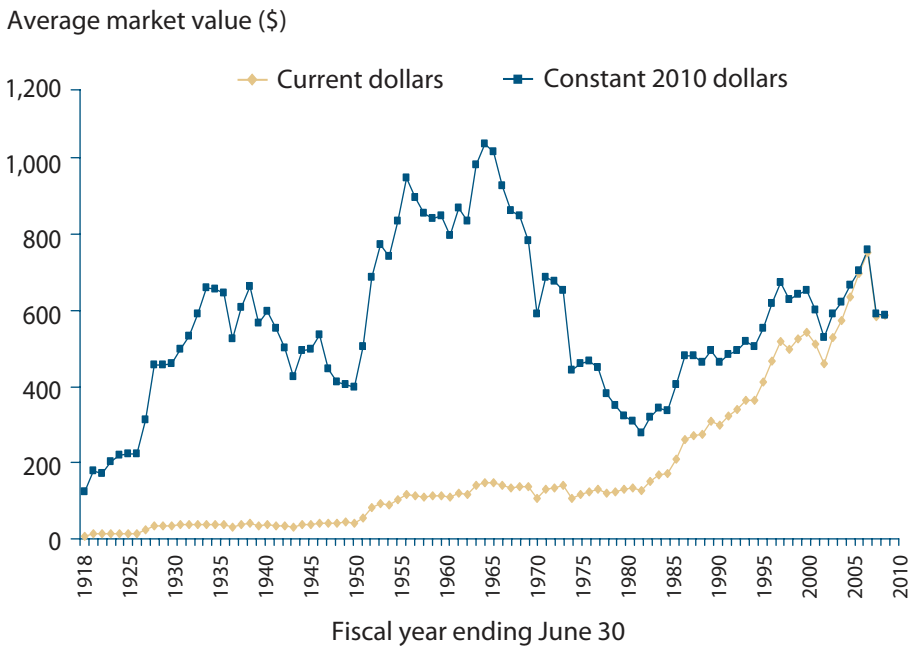
The net return on the Fund's endowment over the 12 months ending June 30, 2010, was 14.0 percent (Exhibit 3). Because of the defensive asset class allocation of the endowment, it underperformed the market benchmark during the year (14.0% vs. 15.9%). But the foundation's average annual returns through June 30, 2010, for the last three-, five-, seven-, and 10-year periods are well above those of the market benchmark.

The performance of the Fund's endowment is also quite competitive with that of peer institutions (Exhibit 4). For example, in the 12 months ending June 30, 2010, the Fund's return of 14.0 percent was well above that of the median return (12.3%) of 82 peer endowments with assets between $500

About the cover: The Investment Committee of The Commonwealth Fund's Board of Directors oversees the management of the foundation's endowment. Chaired by William Yun (top photo), the committee makes the asset class and manager allocation decisions that are key to ensuring strong endowment performance. Robert Pozen is among the committee members bringing their expertise to bear on promoting the Fund's fiscal health. The foundation delegates the actual investment of assets to external managers, such as TIFF, whose president and chief investment officer is Larry Lebowitz (bottom photo). Management of most of the foundation's hedge fund portfolio is outsourced to TIFF, where Nina Scherago is deputy chief investment officer and in charge of the organization's hedge fund investment pools.

Photos by Roger Carr.

Exhibit 1. The Commonwealth Fund's endowment, in millions, 1918–2010

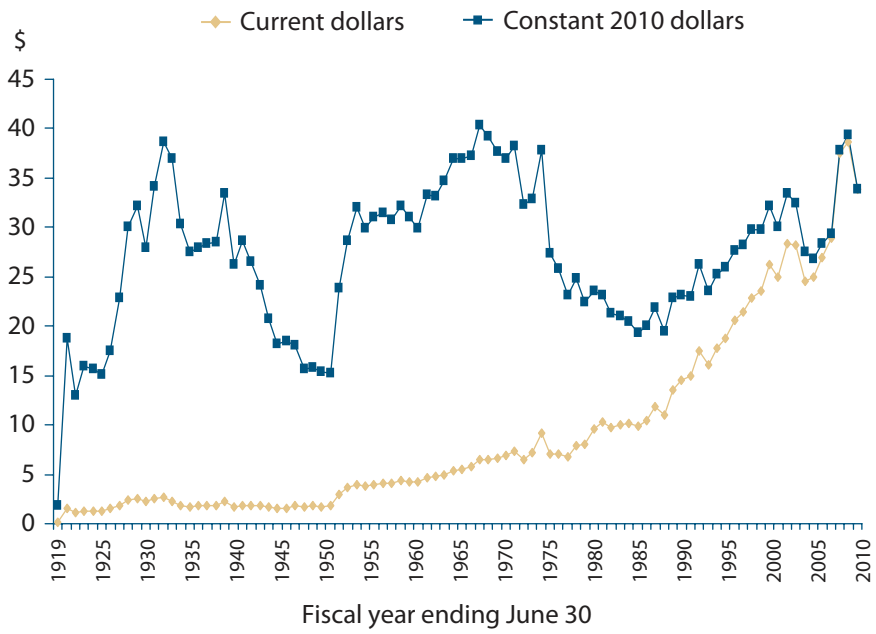


million and $1 billion. This year's return was also well above that of many very large leading university endowments. Over longer periods, the return of the Fund's endowment, as of June 30, 2010, was also significantly better than that of peer endowments—for example, over the last 10 years, the Fund's average annual return was 5.6 percent, while the median peer institution's return was 3.8 percent.

The salient features of the Fund's current investment strategy are summarized in Exhibit 5. Key among these are an overall target commitment of 88 percent of the portfolio to equities (publicly traded and private) and 12 percent to fixed-income securities; a 20 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent to 10 percent allocation to emerging markets; assignment of responsibility for 20 percent of the endowment to marketable alternative equity (hedge fund) managers; a 10 percent commitment to nonmarketable alternative equities (venture capital and private equities); and an 18 percent allocation to inflation hedges, including oil and gas, commodities, gold, and TIPS.

The board's investment committee has recently devoted particular attention to restructuring the management of the fixed-income portfolio. Aimed at preventing a repeat of the 2008–09 failure of the fixed-income portfolio to provide the expected protection in periods of financial market crisis, the committee has reduced the extent to which it delegates to managers the responsibility for determining the allocation of the portfolio among different types of fixed-income securities. As a result, 42 percent of the fixed-income portfolio is now invested in a passive U.S. government intermediate-term bond portfolio, while another 20 percent is similarly indexed, but with the manager employing a variety of strategies to increase returns by exploiting inefficiencies in fixed-income markets. The committee continues to employ a global fixed-income manager (23% of the fixed-income allocation) and another 8

Exhibit 2. The Commonwealth Fund's annual spending, in millions, 1919–2010: Total spending of $840 million over 91 years, or $2.5 billion in constant 2010 dollars



percent of the fixed income portfolio is allocated to an emerging markets short-term debt and currency manager—the remaining 7 percent being in cash reserves.

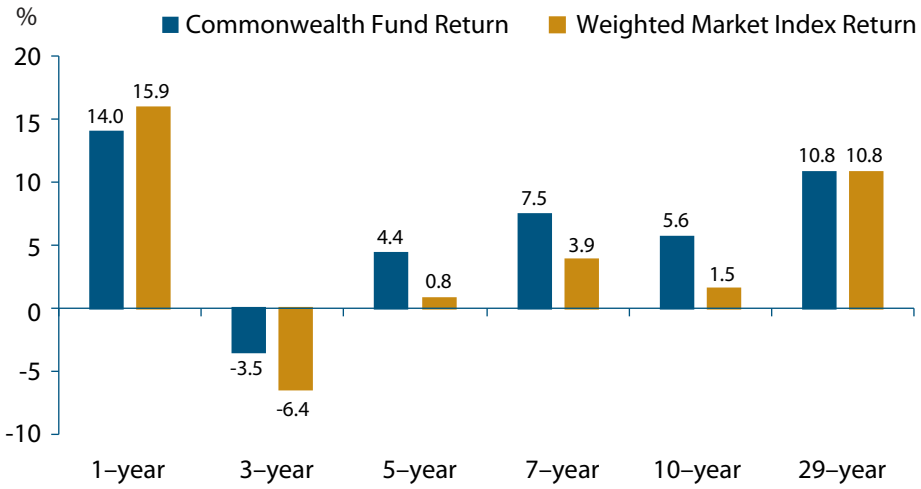
The committee periodically reviews asset class allocation targets and the permissible ranges of variation around them. Except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

Three considerations determine the Fund's annual spending policy: the aim of providing a reliable flow of funds for programs; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year.

Like most other institutions whose sole source of income is their endowment, the Fund has continued to adjust spending plans to the new realities resulting from the recent financial crisis (Exhibit 6). Following a 15 percent reduction in the Fund's budget in 2009–10, the board of directors approved a further 10 percent reduction in the 2010–11 fiscal year, lowering the total for the year to $31.3 million. In order to reduce the spending rate to the long-term target of 5.4 percent of the endowment—and barring a major rebound in the market value of the endowment—we expect further reductions in the budget over the next two fiscal years of 6 percent and 2 percent. The budget should ultimately stabilize at around $28.5 million (its level preceding the global asset price bubble that led to the 2008–09 financial crisis), and then grow with inflation.

As a value-adding foundation, the Fund seeks to achieve an optimal balance between its grantmaking and intramural research, communications, and program management activities, while minimizing purely administrative costs. Recognizing that data

Exhibit 3. Because of the defensive asset class allocation of the Fund's endowment, it underperformed the market benchmark over the 12 months ending June 30, 2010, but average annual returns through June 30, 2010, for the last 3-, 5-, 7-, and 10-year periods are well above those of the market benchmark.

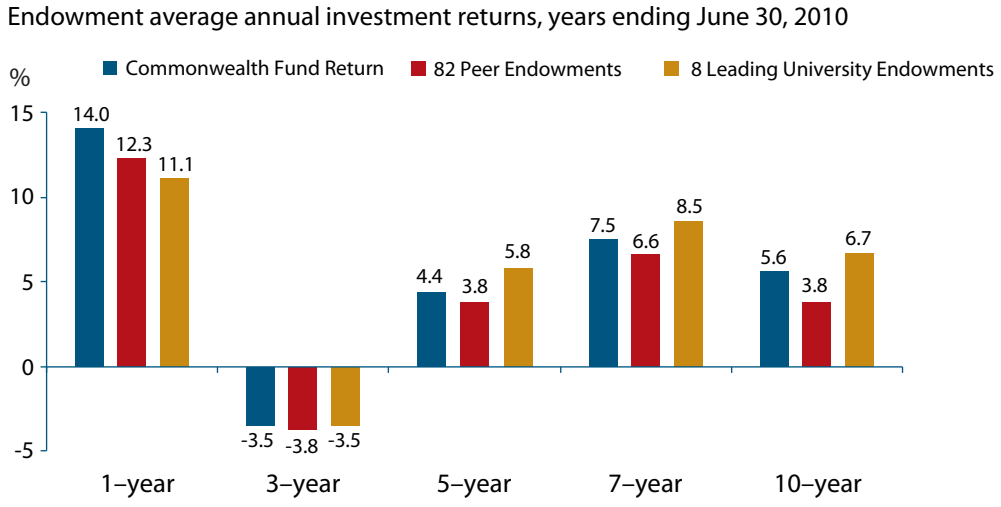


on expenditures reported in the Internal Revenue Service 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in Exhibit 7 sorts out the foundation's 2009–10 expenditures according to four categories recommended by the Foundation Financial Officers Group: direct public-benefit activities (extramural grants and intramurally conducted programs, such as research, communications, and fellowships); grantmaking activities, including grants management; general and administrative activities; and intramural investment management. In 2009–10, the Fund's total direct public-benefit activities accounted for 85 percent of its annual expenditures. Value-adding oversight of grants took up 9 percent of the Fund's budget, and the intramural costs of managing the endowment, 1 percent. Appropriately defined, the Fund's administrative costs amounted to 5 percent of its budget.

Throughout the recent belt-tightening, Fund staff have demonstrated creativity in achieving cost savings and reordering spending priorities to maximize the impact of the foundation's resources. As painful as the budget reductions have been, given the still-subdued inflation within the U.S. economy, the Fund is fortunate that it continues to have the resources needed to maintain its role in helping inform the health policy debate and promote a high performance health system.

Since at least the 2001 Enron scandal, all American institutions have become more attuned to the possible risks they face, and that sensitivity has risen markedly since the 2008–09 financial crisis. Private foundations learned during the financial crisis that the unusual comfort zone that their endowments normally provide them can be unexpectedly and rapidly eroded by global financial forces. The Madoff scandal of 2008 provided another wake-up call to private foundations about the risks that can go undetected in the management of their endowments if investment and audit committees are not

Exhibit 4. The Commonwealth Fund's returns are very competitive with those of peer foundations and universities/colleges.



Source: Peer Endowment comparisons provided by Cambridge Associates

experienced, alert, adequately staffed, and committed to best endowment management practices.

In an environment of heightened awareness of, and concern about, risk, many nonprofits and foundations have assigned increased responsibility to board audit committees and staff to regularly undertake thorough reassessments of potential risks. The aim is to develop countermeasures to control risk and therefore reduce or prevent harm from negative events. The Commonwealth Fund instituted in 2006 an Enterprise Risk Management (ERM) tool that has helped it better assess risks and identify areas requiring the most attention.

As shown in Exhibit 8, the Fund's ERM tool assesses the potential risk of negative events and their potential severity in 16 domains:

- A catastrophic loss in the market value of the endowment;
- A terrorist event impairing the viability of New York City as the Fund's headquarters;
- Legislation adversely affecting private foundations' business model, or their ability to help inform public policy debate;
- Activities undercutting the Fund's standing as a nonpartisan organization;
- The strength of the foundation's board and executive leadership;
- The quality of the Fund's research and publications, on which the organization's reputation largely depends;
- Compliance with IRS regulations on such issues as conflicts of interest;
- The functionality of the Fund's landmark New York headquarters building;
- Compliance with tax payment requirements and myriad federal and state regulatory filings;
- The safekeeping of securities composing the foundation's $645 million[1] endowment;

[1] As of November 30, 2010.

Exhibit 5. The Commonwealth Fund's endowment management strategy

	Allocation on September 30, 2010	Long-term target	Permissible range
Total endowment	100%	100%	
Asset Class			
Total Equity	83%	88%	75%–90%
U.S. equity marketable securities	17%	20%	15%–30%
Non-U.S. equity marketable securities	19%	20%	15%–30%
Marketable alternative equity	18%	20%	15%–30%
Non-marketable alternative equity	12%	10%	5%–15%
Inflation hedges	17%	18%	5%–20%
Fixed Income	17%	12%	10%–25%

- The strength and vitality of Fund grants programs;
- Conduct of the Fund's staff or board;
- Financial fraud;
- Compliance with a very large number of human resources regulations;
- Malfeasance by a grantee; and
- Failure of funded projects.

Since its development, this tool has been continually improved. Today, the foundation's independent auditor and a substantial number of the Fund's Board, management, and staff—each with different vantage points—participate in an annual exercise in which they are asked to assess independently the potential for a negative event, and such event's potential severity, across all 16 domains. The scoring is done confidentially, on a scale of –2 (very low risk/severity) to +2 (very high risk/severity), and the scores are averaged to produce an overall assessment.[2]

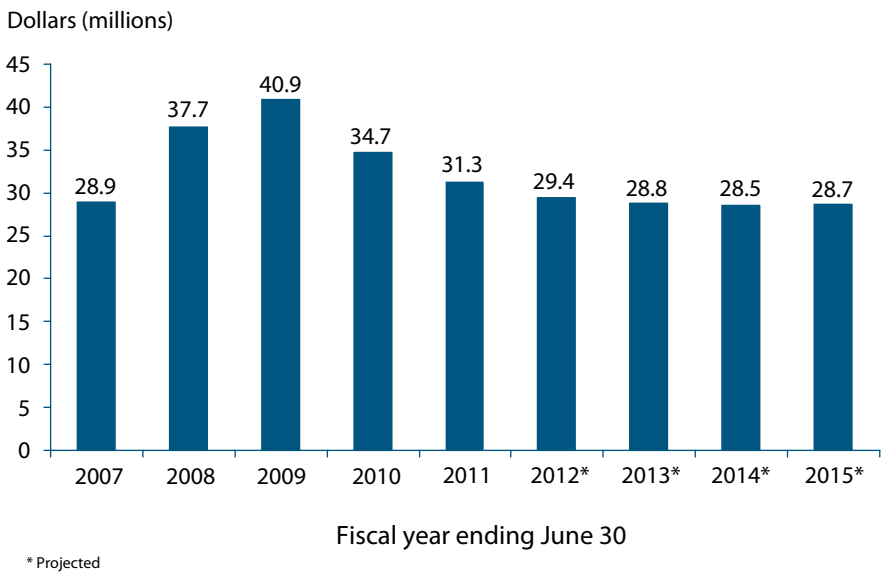
[2] Other points along the scale can be properly translated as follows: –1 = low; 0 = moderate; +1 = high.

The June 2010 ERM analysis reveals that none of the domains for the Fund is accorded both a high impact and high risk (probability of occurrence) rating. The domains with greatest potential impact ratings (1.0 or greater) are as follows: a catastrophic loss of endowment market value; a terrorist attack on New York; activities that undercut the Fund's nonpartisan standing; adverse legislative/regulatory actions against foundations; and diminished performance of the Fund's leadership. The domains "publications/research damaging the Fund's reputation for high-quality and reliable work" and "IRS regulatory compliance" also received severity scores approaching 1.

None of the domains has a risk rating of "high" or "very high," and only "project failure" (a grantee's failure to produce expected deliverables) has a risk assessment approaching "moderate." While the impact severity of an endowment-threatening event is rated the highest, the risk of a catastrophic loss in market value is rated as "moderate–low."

The Fund's Investment Committee seeks to control endowment risk through a clearly

Exhibit 6. As a result of the 2008–09 financial markets crisis, the Fund's budget will return to approximately its pre-asset-bubble level of $29 million annually.



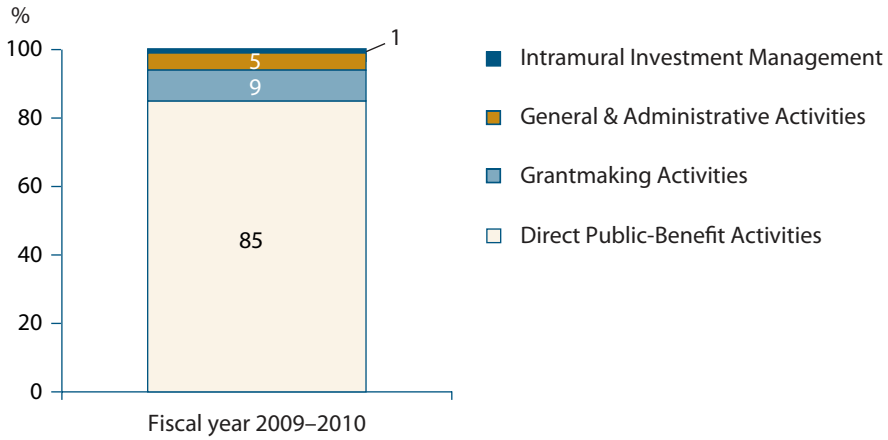
articulated investment policy statement, diversification, and strong oversight of investment strategy, including use of a top-ranked endowment management adviser, Cambridge Associates. Mitigation of the impact of a potential terrorist event affecting New York is attempted through a detailed Business Continuity Plan that is updated annually and shared with key staff and Board members, and includes backup offices in other cities and regions.

Management seeks to control the "partisanship" risk through careful review of publications, clear policies for staff regarding types of events in which they may participate, written guidelines for interaction with members of Congress and presidential candidates, and education of staff on prohibited lobbying activities. Staff responsible for monitoring adherence to guidelines and providing guidance are the Fund's executive vice president/COO, its senior policy director, and its president. The Fund's success in attracting both Republicans and Democrats to its annual Bipartisan Congressional Retreat for discussion of health policy issues has helped control this risk, by establishing working relationships that cross party lines. The attendance of Board members at this event, as well as other major events like the Fund's International Symposium on Health Care Policy, is also helpful in monitoring this risk.

On the regulatory risk front, management is quite active in identifying and advocating best practices in the foundation sector, and the Fund's work with legislators on health care reform has heightened bipartisan appreciation of the unique role that foundations play in informing debate on public policies and advancing social improvements. The close ties that have been developed with members of Congress on both sides of the aisle also help to reduce the risk of legislation or regulations that might impair the foundation's business model or programmatic strategy.

The Fund's Board has a strong Governance and Nominating Committee and Executive and Finance Committee, which, along with the rest of the Board, are responsible for ensuring effective leadership at the Fund. Measures to control the risk of

Exhibit 7. The Fund's total direct public benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 85 percent of its annual expenditures. Value-adding oversight of grants takes up 9 percent of the Fund's budget.



diminished leadership capacity include the following: annual Board reviews of the performance of the Fund's president and executive vice president/COO, the Board's annual participation in the Center for Effective Philanthropy's Survey of Foundation Trustees, annual external reviews of major programs, the Fund's own performance scorecard (encompassing annual audience and grantee survey findings), and the attentiveness of the chairman of the Board and Board committee chairs.

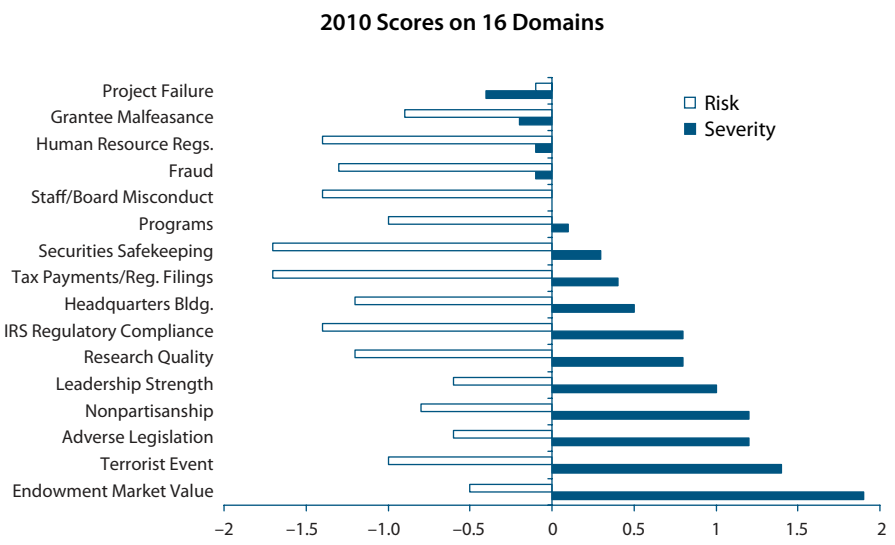
The risk of publishing research of questionable quality is regarded as low (score of –1.2), given the internal and external pre-publication review processes that the Fund employs and the strong professional standards of staff. Risk of conflict-of-interest policy and other IRS regulatory violations is also regarded as low, given the high level of integrity of Fund Board members and staff and an enforced conflict-of-interest policy.

The Fund's system for vetting proposals and its strong professional staff help control the risk of project or program disappointments. An annual report to the Board on completed grants provides feedback on the extent to which projects are executed successfully, as well as lessons learned in the selection and management of grantees. Review each year by the Board and an external expert of a Fund program, annual meetings of the chairman with each program officer and with management to discuss program strategy, and Board meetings' focus on discussion of Fund strategy all help control the risk of program failure and enhance the potential of success. Attendance by Board members at key Fund-sponsored events also helps in assessing the effectiveness of program strategies.

Management seeks to control the risk of capital loss and business interruption arising from damage to the foundation's headquarters building at One East 75th Street in New York through a high level of maintenance, replacement-cost insurance coverage, and an up-to-date business continuity plan.

The Fund's Enterprise Risk Management tool reveals that, while important, most of the traditional points of risk focus—projects, grantee malfeasance, regulatory filing requirements, routine financial fraud—are unlikely to effect lasting, significant damage on the organization should

Exhibit 8. Commonwealth Fund Enterprise Risk Management Assessment



they occur. Greater potential for major harm lies in domains where risk is more difficult to control and may go undetected, to the point where improvised controls are too late in preventing significant harm. Foundations that do not pay sufficient attention to the management of their endowment, the legislative and regulatory environment in which they operate, the performance of their board and management, and the quality of the work they generate do so at considerable risk to their effectiveness, vitality, and longevity.

2010 Annual Report

Independent Auditors' Report Financial Statements

Years Ended June 30, 2010 and 2009

2010 Annual Report

Independent Auditors' Report

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2010 and 2009 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2010 and 2009 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Owen J. Flanagan & Co.
October 28, 2010

THE COMMONWEALTH FUND
STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2010 AND 2009

	2010	2009
ASSETS		
CASH	$ 1,300,500	$ 57,383
INVESTMENTS - At fair value (Notes 1 and 2)	597,134,926	550,723,964
INTEREST AND DIVIDENDS RECEIVABLE	74,177	115,532
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	492,525	318,256
TAXES REFUNDABLE	609,945	1,813,852
PREPAID INSURANCE AND OTHER ASSETS	324,088	—
LANDMARK PROPERTY AT 1 EAST 75TH STREET -		
At appraised value during 1953, the date of donation	275,000	275,000
FURNITURE, EQUIPMENT AND BUILDING IMPROVEMENTS -		
At cost, net of accumulated depreciation of $1,848,540 at		
June 30, 2010 and $1,562,304 at June 30, 2009 (Note 1)	4,313,804	4,452,579
TOTAL ASSETS	$604,524,965	$557,756,566
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 1,362,171	$ 1,098,700
Program authorizations payable (Note 3)	24,418,124	19,321,512
Accrued postretirement benefits (Note 4)	4,539,962	2,194,182
Deferred tax liability (Note 5)	1,339,221	454,039
Total liabilities	31,659,478	23,068,433
NET ASSETS:		
Unrestricted	572,865,487	534,688,133
Total net assets	572,865,487	534,688,133
TOTAL LIABILITIES AND NET ASSETS	$604,524,965	$557,756,566

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2010 AND 2009

	2010	2009
REVENUES AND SUPPORT:		
Interest and dividends	$ 7,876,340	$ 8,559,797
Contribution and other revenue	43,645	100,623
Total revenues and support	7,919,985	8,660,420
EXPENSES:		
Program authorizations and operating program	31,612,976	36,300,670
General administration	1,869,540	1,923,564
Investment management	3,670,564	4,064,044
Taxes (Note 5)	1,199,562	(2,453,030)
Retirement and other postretirement (Note 4)	2,809,234	225,365
Total expenses	41,161,876	40,060,613
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS (LOSSES)	(33,241,891)	(31,400,193)
NET INVESTMENT GAINS (LOSSES):		
Net realized gains (losses) on investments	27,160,110	(39,475,243)
Change in unrealized appreciation of investments	44,259,135	(124,996,796)
Total net investment gains (losses)	71,419,245	(164,472,039)
CHANGES IN UNRESTRICTED NET ASSETS	38,177,354	(195,872,232)
Net assets, beginning of year	534,688,133	730,560,365
Net assets, end of year	$572,865,487	$534,688,133

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2010 AND 2009

	2010	2009
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$ 38,177,354	$(195,872,232)
Net investment (gains) losses	(71,419,245)	164,472,039
Depreciation expense and retirement of assets	286,236	331,384
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	41,355	18,287
Decrease (increase) in taxes refundable - net	1,203,907	(804,703)
Decrease (increase) in proceeds receivable from securities sales - net	(174,269)	42,624
Decrease (increase) in prepaid insurance and other assets	(324,088)	23,908
Decrease in recoverable grants	—	59,665
Increase (decrease) in accounts payable and accrued expenses	263,471	(25,051)
Increase in program authorizations payable	5,096,612	1,295,363
Increase in accrued post retirement benefits	2,345,780	—
Increase (decrease) in deferred tax liability	885,182	(2,499,935)
Net cash used in operating activities	(23,617,705)	(32,958,651)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(147,461)	(458,164)
Purchase of investments	(125,170,744)	(192,409,526)
Proceeds from the sale of investments	150,179,027	225,555,617
Net cash provided by investing activities	24,860,822	32,687,927
NET INCREASE (DECREASE) IN CASH	1,243,117	(270,724)
CASH, BEGINNING OF YEAR	57,383	328,107
CASH, END OF YEAR	$1,300,500	$57,383
SUPPLEMENTAL INFORMATION:		
Taxes paid: excise and unrelated business income	—	$ 800,000

See notes to financial statements.

THE COMMONWEALTH FUND

Notes to Financial Statements

Years Ended June 30, 2010 and 2009

1. Summary of Significant Accounting Policies

The Commonwealth Fund (the "Fund") is a private foundation supporting independent research on health and social issues.

a. *Investments* - Investments in equity securities with readily determinable fair values and all investments in debt securities are carried at fair value, which approximates market value. Assets with limited marketability, such as alternative asset limited partnerships, are stated at the Fund's equity interest in the underlying net assets of the partnerships, which are stated at fair value as reported by the partnerships. Realized gains and losses on dispositions of investments are determined on the following bases: FIFO for actively managed equity and fixed income, average cost for commingled mutual funds, and specific identification basis for alternative assets.

   The Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

b. *Fixed Assets* - Furniture, equipment, and building improvements are capitalized at cost and depreciated using the straight-line method over their estimated useful lives.

c. *Contributions, Promises to Give, and Net Assets Classifications* - Contributions received and made, including unconditional promises to give, are recognized in the period incurred. The Fund reports contributions as restricted if received with a donor stipulation that limits the use of the donated assets. Unconditional promises to give for future periods are presented as program authorizations payable on the statement of financial position at fair values, which includes a discount for present value.

d. *Use of Estimates* - The preparation of financial statements in conformity with generally accepted accounting principles requires the Fund's management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of additions to and deductions from the statement of activities. The calculation of the present value of program authorizations payable, present value of accumulated postretirement benefits, deferred Federal excise taxes and the depreciable lives of fixed assets requires the significant use of estimates. Actual results could differ from those estimates.

e. *Cash* – Cash consists of all checking accounts and petty cash.

At times the Fund's cash exceeds federally insured limits. This risk is managed by using only large, established financial institutions.

2. Investments

Investments at June 30, 2010 and 2009 comprised the following:

	2010		2009	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$ 80,387,617	$ 83,534,330	$ 85,442,087	$ 99,162,268
Non - U.S. Equities	104,167,492	91,678,376	107,737,667	96,747,215
Fixed income	94,489,324	87,488,048	94,977,480	88,848,667
Short-term	15,087,701	15,087,701	8,709,505	8,856,065
Marketable alternative equity	134,247,901	79,872,435	107,017,384	70,265,832
Nonmarketable alternative equity	61,307,334	67,855,885	53,148,235	63,393,994
Inflation hedge	107,447,557	104,657,084	93,691,606	100,747,993
	$597,134,926	$530,173,859	$550,723,964	$528,022,034

At June 30, 2010, the Fund had total unexpended investment commitments of approximately $81.6 million ($52.4 million in non-marketable alternative equity and $29.2 million in inflation hedge).

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. At June 30, 2010 and 2009, the Fund had no outstanding derivative positions.

Fair value of an investment is the amount that would be received to sell the investment in an orderly transaction between market participants at the measurement date.

Accounting guidance establishes a hierarchal disclosure framework which prioritizes and ranks the level of market price observability used in measuring investments at fair value. Market price observability is impacted by a number of factors, including type of investment and the characteristics specific to the investment. Investments with readily available active quoted prices or for which fair value can be measured from actively quoted prices generally will have a higher degree of market price observability and a lesser degree of judgment used in measuring fair value.

Investments measured and reported at fair value are classified and disclosed in one of the following categories.

Level 1 Inputs – Quoted prices in active markets for identical investments. In the case of funds, a reported NAV and full liquidity.

Level 2 Inputs – Other significant observable inputs (including quoted prices for similar investments, interest rates, etc.). Hedge funds with reported NAV are included in this category.

Level 3 Inputs – Prices determined using significant unobservable inputs. Unobservable inputs reflect the Fund's own assumptions about the factors market participants would use in pricing an investment and would be based on the best information available. Investments included in this category generally include private equity, venture capital, real estate, natural resources, gas and oil, and hedge fund investments with limited liquidity.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an investment's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Investments are categorized as follows:

	2010			
	Total	**Level 1**	**Level 2**	**Level 3**
U.S. Equities	$ 80,387,617	$ 80,387,617		
Non - U.S. Equities	104,167,492	104,167,492		
Fixed income	94,489,324	71,273,790	$ 23,215,534	
Short-term	15,087,701	15,087,701		
Marketable alternative equity	134,247,901	5,156,944	128,978,131	$ 112,826
Nonmarketable alternative equity	61,307,334			61,307,334
Inflation hedge	107,447,557	72,369,988		35,077,569
	$597,134,926	$348,443,532	$152,193,665	$96,497,729

	2009			
	Total	**Level 1**	**Level 2**	**Level 3**
U.S. Equities	$ 85,442,087	$ 85,442,087		
Non - U.S. Equities	107,737,667	107,737,667		
Fixed income	94,977,480	75,607,046	$ 19,370,434	
Short-term	8,709,505	8,709,505		
Marketable alternative equity	107,017,384	8,222,153	98,711,013	$ 84,218
Nonmarketable alternative equity	53,148,235			53,148,235
Inflation hedge	93,691,606	64,605,178		29,086,428
	$550,723,964	$350,323,636	$118,081,447	$82,318,881

The change in Level 3 assets is as follows:

	Marketable Alt. Equity	**Nonmarketable Alt. Equity**	**Inflation Hedge**	**Total**
Balance, July 1, 2009	$ 84,218	$53,148,235	$29,086,428	$82,318,881
Investment return	(19,179)	3,284,876	2,127,443	5,393,140
Purchases and redemptions - net	(853,681)	4,874,223	3,863,698	7,884,240
Transfers between levels	901,468			901,468
	$112,826	$61,307,334	$35,077,569	$96,497,729

3. Program Authorizations Payable

At June 30, 2010, program authorizations scheduled for payment at later dates were as follows:

July 1, 2010 through June 30, 2011	$19,642,086
July 1, 2011 through June 30, 2012	4,655,488
Thereafter	245,026
Gross program authorizations scheduled for payment at a later date	24,542,600
Less adjustment to present value	124,476
Program authorizations payable	$24,418,124

A discount rate of 2.67% was used to determine the present value of the program authorizations payable at June 30, 2010.

4. Retirement And Other Postretirement Benefits

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 17% and 16% of the participants' compensation for the years ended June 30, 2010 and 2009. Pension expense under this plan was approximately $983,000 and $1,082,000 for the years ended June 30, 2010 and 2009, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

Effective July 9, 2002, the Fund established a Section 457 Plan for certain employees that provides for unfunded benefits with employer contributions made within the legal limits provided for under Federal law.

The Fund provides postretirement medical insurance coverage for retirees who meet the eligibility criteria. The postretirement medical plan, which is measured as of the end of each fiscal year, is an unfunded plan, with 100% of the benefits paid by the Fund on a pay-as-you-go basis. Such payments approximated $118,000 and $103,000 for each of the years ended June 30, 2010 and 2009.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2011 are expected to be approximately $203,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2010 and 2009 is as follows:

	2010	2009
Benefit obligation at June 30	$4,539,962	$2,194,182
Fair value of plan assets at June 30	—	—
Status - unfunded	4,539,962	2,194,182
Actuarial loss	—	—
Accrued benefit cost recognized	$4,539,962	$2,194,182
Net periodic expense	$2,463,956	$102,759
Employer contribution	$118,176	$102,759

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2010	2009
Discount rate	2.70%	4.51%
Health care cost trend rates – Initial	7.3%	7.3%
Health care cost trend rates – Ultimate	7.1%	7.1%

At June 30, 2010, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2011	$203,000
Year ended June 30, 2012	$208,000
Year ended June 30, 2013	$237,000
Year ended June 30, 2014	$177,000
Year ended June 30, 2015	$263,622
Five years ended June 30, 2020	$1,306,000

5. Tax Status

The Fund is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code, but is subject to a 1% or 2% (depending if certain criteria are met) Federal excise tax on net investment income. For the years ended June 30, 2010 and 2009, that excise tax rate was 1%. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, The Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2010, distributions approximating $6.9 million are required to be made by June 30, 2011 to satisfy the minimum requirements of approximately $30.2 million for the year ended June 30, 2010.

In the Statements of Financial Position, the deferred tax liability of $1,339,221 and $454,039 at

June 30, 2010 and 2009, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2010 and 2009, the tax provision was as follows:

	2010	2009
Excise taxes - current	$ 314,380	$ 46,905
Excise taxes - deferred	885,182	(2,499,935)
Unrelated business income taxes - current	—	—
Total Taxes	$1,199,562	$(2,453,030)

6. Fair Value of Financial Instruments

The estimated fair value amounts have been determined by the Fund, using available market information and appropriate valuation methodologies. However, considerable judgment is necessarily required in interpreting market data to develop the estimates of fair value. Accordingly, the estimates presented herein are not necessarily indicative of the amounts that the Fund could realize in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

All Financial Instruments Other Than Investments - The carrying amounts of these items are a reasonable estimate of their fair value.

Investments - For marketable securities held as investments, fair value equals quoted market price, if available. If a quoted market price is not available, fair value is estimated using quoted market price for similar securities. For alternative asset limited partnerships held as investments, fair value is estimated using private valuations of the securities or properties held in these partnerships. The carrying amount of these items is a reasonable estimate of their fair value. For futures and foreign exchange forward contracts, the fair value equals the quoted market price.

7. Contributions Received

In fiscal years 1987 and 1988, the Fund received a total of $15,415,804 as a grant from the James Picker Foundation, with an agreement that a designated portion of the Fund's grants be identified as "Picker Program Grants by The Commonwealth Fund." The Fund fulfills this obligation by making Picker Program Grants devoted to specific themes approved by the Fund's Board of Directors. For the years ended June 30, 2010 and 2009, Picker program grants totaled approximately $1,960,000 and $1,802,000, respectively.

In April 1996, the Fund received The Health Services Improvement Fund, Inc.'s ("HSIF") assets and liabilities, $1,721,016 and $57,198, respectively, resulting in a $1,663,818 increase in net assets. In accordance with the terms of an agreement with HSIF, this contribution enables the Fund to make Commonwealth Fund/HSIF grants to improve health care coverage, access, and quality in the New York City greater metropolitan region. During the years ended June 30, 2010 and 2009, grants in the amount of $414,000 and $300,000 were awarded.

During the year ended June 30, 2002, the Fund received a bequest of $3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. An additional amount of $100,000 was received during the year ended June 30, 2004. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by the gift be designated "Frances Cooke Macgregor" grants. During the years ended June 30, 2010 and 2009, the Frances Cooke Macgregor grants totaled approximately $350,000 and $372,000, respectively.

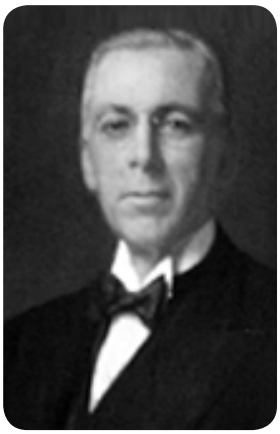
8. Uncertain Tax Position

The Fund has not entered into any uncertain tax positions that would require financial statement recognition. The Fund is no longer subject to audits by the applicable taxing jurisdiction for periods prior to June 30, 2007.

9. Subsequent Events

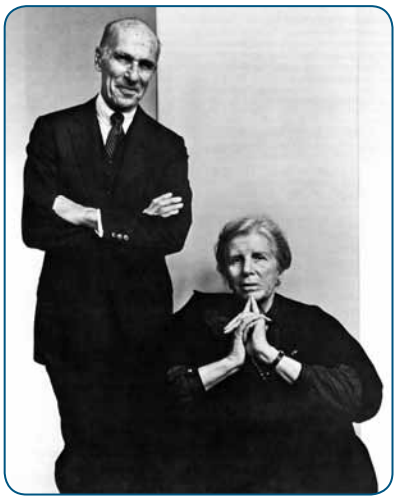
In connection with the preparation of the financial statements, the Fund evaluated subsequent events after the statement of financial position date of June 30, 2010 through November 8, 2010, which was the date the financial statements were available to be issued.

Founders and Benefactors



Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company. After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly $10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge. Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.



Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the $15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.

THE COMMONWEALTH FUND

2010 Annual Report

Directors and Staff

Commonwealth Fund chairman James R. Tallon, Jr. (speaking) discusses future strategic directions for the foundation's grantmaking programs with Fund staff Edward Schor, M.D., Mary Jane Koren, M.D., Anne-Marie J. Audet, M.D., and Melinda Abrams.

Photo by Leland Bobbé

The Commonwealth Fund's Board of Directors has fiduciary responsibility for the foundation and is charged with ensuring its accountability and effective pursuit of mission. Throughout the foundation's history, its Board has been a policy-setting body, with responsibility for overseeing the overall mission, hiring and assessing the performance of the president–chief executive officer, advising on and approving program strategies, approving spending policy (including allocations of resources among programs and between extramural and intramural work, the Fund's annual budget, and Board-level grants), guiding the management of the Fund's endowment, and assessing the performance of the institution.

At its July 13, 2010, meeting, the Board elected Julio Frenk, M.D., to the Commonwealth Fund Board, with his first five-year term to begin in April 2011. Dr. Frenk is dean of the Harvard School of Public Health and T & G Angelopoulos Professor of Public Health and International Development, a joint position at the John F. Kennedy School of Government and the Harvard School of Public Health.

An eminent authority on global health, Dr. Frenk served as Mexico's minister of health from 2000 to 2006 and was the founding director-general of the National Institute of Public Health, one of the leading institutions of health education and research in the developing world. During his tenure as minister, a program of comprehensive national health insurance—Seguro Popular—was introduced to expand access to health care for tens of millions of previously uninsured Mexicans. Dr. Frenk also served at the World Health Organization (WHO) as executive director in charge of Evidence and Information for Policy, the first-ever unit explicitly charged with developing a scientific foundation for health policy to achieve better outcomes.

Most recently, Dr. Frenk served as a senior fellow in the global health program of the Bill & Melinda Gates Foundation and as president of the Carso Health Institute in Mexico City. He chairs the boards of the Institute for Health Metrics and Evaluation, at the University of Washington, and the Partnership for Maternal, Newborn and Child Health. Highly regarded for his tireless efforts to eliminate health disparities and encourage policymakers and practitioners to put a greater focus on evidence-based decision-making, Dr. Frenk received the Clinton Global Citizen Award in September 2008.

Dr. Frenk holds a medical degree from the National University of Mexico, as well as three advanced degrees from the University of Michigan: a master of public health, a master of arts in sociology, and a doctorate in medical care organization and sociology.

As noted by the Fund's chairman, James R. Tallon, Jr., Dr. Frenk's global health experience, combined with his practical knowledge about what it takes to reform health care systems based on the best available research, will be invaluable assets to the Fund and its work.

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[1] June 30, 2010

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Georgette Lawlor, *Program Associate, Patient-Centered Coordinated Care*

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Michelle G. Ries, *Senior Program Associate, Management and Marketing, International Health Policy and Innovation*

Gabrielle Ritaccio, *Program Assistant*, *Health System Improvement and Efficiency*

David Squires, *Program Associate, Research and Programs, International Health Policy and Innovation*

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2 August 31, 2010

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Shelford Thompson, *Building Manager*
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Matthew E. Johnson, *Dining Room Manager*
Edwin Antonio Burke, *Assistant Dining Room Manager*

Health System Performance Assessment and Tracking Unit, based at the Institute for Healthcare Improvement in Boston, Mass.

David C. Radley, *Senior Analyst and Project Manager, National and State Scorecard Project*
Sabrina K. H. How, *Senior Research Associate, National and State Scorecard Project*
Ashley-Kay Fryer, *Research Associate, National and State Scorecard Project*

White & Case, Counsel
Owen J. Flanagan and Company, Auditors

2010 Annual Report

Grants Approved, 2009–10

DELIVERY SYSTEM INNOVATION AND IMPROVEMENT

Health System Quality and Efficiency

Regents of the University of California

$259,756

Assessing Models for Health Information Technology Regional Extension Centers

The Health Information Technology for Economic and Clinical Health (HITECH) Act authorized $36 billion for health information technology (IT) spending through 2016. HITECH will help fund regional extension centers, which supply physician practices and other providers with technical and change-management services to help them adopt and use health IT effectively. The New York City Primary Care Information Project, the Massachusetts eHealth Collaborative, and programs of some private independent practice associations and hospital-affiliated medical groups are already providing IT services to affiliated solo and small practices, which are especially in need of them. This project will assess how these programs are organized and run, which services they provide and at what cost, and what challenges they face. The answers to these questions will aid in the implementation of regional extension centers and associated federal regulations nationwide.

Robert H. Miller, Ph.D.
Professor of Health Economics
Institute for Health & Aging
3333 California Street, Suite 340
San Francisco, CA 94118
(415) 476-8568
robert.miller@ucsf.edu

Trustees of Dartmouth College

$309,257

Developing and Piloting Standardized Measures to Assess the Performance of Accountable Care Organizations, Phase 1

Many experts believe that controlling health care spending and improving quality of care will depend in part on the advent of accountable care organizations (ACOs)—groups of hospitals, primary care physicians, specialists, and other providers that are collectively responsible for patient outcomes and the prudent stewardship of medical resources.

Although interest in ACOs has grown rapidly—even attracting the attention of Congress—widespread implementation of the ACO model in a multipayer environment faces numerous barriers. Working with three pilot sites in Arizona, Kentucky, and Virginia, this project—part of a much larger joint undertaking of Dartmouth Medical School and the Brookings Institution to advance this model—will develop and test a "starter set" of performance measures to assess the performance of ACOs and guide the evolution and refinement of this promising innovation in health care delivery.

Elliott S. Fisher, M.D.
Director, Center for Population Health
Dartmouth Institute for Health Policy and Clinical Practice
35 Centerra Parkway
Lebanon, NH 03766
(603) 653-0803
elliott.fisher@dartmouth.edu

President and Fellows of Harvard College

$419,289

Evaluating the Global Payment Model Developed by Blue Cross Blue Shield of Massachusetts

Among the variety of provider payment reform options that have been proposed, the Alternative Quality Contract (AQC), developed by Blue Cross Blue Shield of Massachusetts, holds special promise to improve quality and efficiency, in part because of its use of incentives. The contract provides the hospitals and physicians caring for a patient over an episode of care with a monthly, risk-adjusted global payment that covers all services delivered. This baseline payment is supplemented with substantial performance-based payments linked to nationally recognized quality measures. Pilot-testing with medical groups began in January 2009, and thus far seven care delivery organizations have agreed to participate in the AQC. This project will assess whether the new payment method improves the quality of patient care and controls costs, and whether it can serve as a model for other health plans.

Michael Chernew, Ph.D.
Professor
Department of Health Care Policy
180 Longwood Avenue, Suite 207-B
Boston, MA 02115
(617) 432-0174
chernew@hcp.med.harvard.edu

Institute for Safe Medication Practices

$195,074

Assessing the State of Safe Medication Practices in U.S. Hospitals: A Five-Year Follow-Up Survey

While the decade following release of the Institute of Medicine report To Err Is Human witnessed significant movement on the patient safety front, the extent to which hospitals have adopted safer practices is unknown. With Commonwealth Fund support, the Institute for Safe Medication Practices surveyed U.S. hospitals in 2000 and again in 2004, with findings revealing significant opportunities for hospitals to improve systems and processes for reducing medication errors. Six years later, another survey of U.S. hospitals is needed to guide renewed national efforts to

improve safety. This project will update the instrument used for the earlier assessments and then resurvey all U.S. hospitals, identifying areas where progress has been made and gaps remain. The findings will guide efforts to redesign care delivery processes and inform the Office of the National Coordinator of Health Information Technology as it disseminates tools to improve safety.

Allen J. Vaida, Pharm.D.
Executive Vice President
200 Lakeside Drive, Suite 200
Horsham, PA 19044
(215) 947-7797
avaida@ismp.org

Massachusetts General Hospital

$349,996

Developing and Testing a Set of Measures to Assess Safety in High-Risk Intensive Care Units

Frances Cooke Macgregor Grant

Despite progress in measuring the safety of health care delivery, health executives, clinicians, managers, and policymakers still lack valid outcome indicators to benchmark safety across institutions or regions and to track whether safety is improving over time. This project will build on an earlier Commonwealth Fund grant that identified the most frequent and severe medical complications in hospital intensive care units (ICUs), where the risk of medical error is particularly high. The investigative team will develop specifications for a set of ICU safety indicators, validate the indicators, and test them in two hospitals. The new ICU measures will be of great value to organizations concerned with patient safety, like the National Quality Forum, Agency for Healthcare Research and Quality, and Joint Commission, and could be used to assess progress in safety improvement nationwide.

Elizabeth Martinez, M.D.
Associate Anesthetist
55 Fruit Street, WHT-3
Boston, MA 02114
(617) 643-7031
emartinez10@partners.org

National Committee for Quality Assurance

$178,649

Developing an Approach for Measuring and Monitoring Care Coordination for Vulnerable Children

Having well-coordinated health care is particularly important for patients with multifaceted needs, such as children who have developmental problems. Building on previous Commonwealth Fund-sponsored work on care coordination, the project team will develop an approach to measuring the structure, processes, and outcomes of care coordination for vulnerable children, emphasizing coordination between medical and nonmedical service providers. The researchers will conduct their activities in collaboration with the Fund's current Assuring Better Child Health and Development (ABCD) initiative, which works with state Medicaid programs. It is expected that the new approach will also be applicable to other vulnerable patient populations in need of high-quality care coordination.

Sarah Hudson Scholle, Dr.P.H.
Assistant Vice President, Research
1100 13th Street NW, Suite 1000
Washington, DC 20005
(202) 955-1726
scholle@ncqa.org

University of Oregon

$172,914

Assessing the Role of Patient Self-Management in Improving Health Care Delivery

With recent studies showing that patients who are more involved in their care have better heath outcomes and use less costly services, there is a growing recognition that clinicians need to engage their patients more in the care process. This project will identify specific behaviors of clinicians that are linked to higher levels of patient engagement, improved health outcomes, and more-efficient physician practices. Focusing on practices affiliated with Fairview Health Systems in Minnesota, the research team will compare data on health care utilization and outcomes with data obtained from the Clinician Support for Patient Activation Measure, which assesses how well doctors and nurses impart their patients with the knowledge, skills, and confidence necessary for care self-management. Project findings will inform strategies to improve the quality and efficiency of clinical practice.

Judith H. Hibbard, Dr.P.H.
Professor
5293 University of Oregon
Eugene, OR 97403
(541) 346-0695
jhibbard@uoregon.edu

Pennsylvania State University

$240,754

Diffusing Health Information Technology in Rural Areas Through Hospital-to-Hospital Partnerships

Rural hospitals face a high hurdle in acquiring sophisticated health information technologies (HIT) while also remaining financially viable. One way for these institutions to address the challenge is to outsource the design and maintenance of HIT infrastructure not to traditional vendors, but to a larger, more technologically advanced hospital in their region. The viability of this hospital-to-hospital HIT partnership model, which has been used with success in a rural region of Pennsylvania, will be the focus of a three-state survey of rural hospitals. Project staff also will conduct case studies of three rural hospitals that have partnered with a regional hospital to identify factors that lead to success and examine the impact on patient care, the economic benefits, and the challenges involved. As the federal government takes steps to diffuse HIT nationwide, the findings of this project will inform the Office of the National Coordinator for Health Information Technology about innovative approaches.

Madhu Reddy, Ph.D.
Assistant Professor, Information Sciences and Technology
321 J IST Building

University Park, PA 16802
(814) 863-6316
mxr49@psu.edu

Pennsylvania State University
$523,843
Evaluating the State Action to Avoid Rehospitalizations Initiative, Phase 1
In May 2009, the first phase of the Institute for Healthcare Improvement's State Action to Avoid Rehospitalizations (STAAR) initiative was officially launched in Massachusetts, Michigan, and Washington. Over the course of this Commonwealth Fund-sponsored initiative, a number of strategies will be implemented, from redesigning care processes at hospitals and other community-based providers to reforming payment policies and regulations. This grant will support a rigorous evaluation of STAAR to assess how well these interventions—and the initiative overall—succeed in reducing hospital readmission rates. In particular, the findings will help identify effective interventions that should be scaled up, as well as those activities that may require modification. The evaluation results will be of interest to national leaders, health care systems, the Medicare program, and other payers for whom reducing rehospitalizations is a priority.
Dennis P. Scanlon, Ph.D.
Associate Professor
504 Donald Ford Building
University Park, PA 16802
(814) 865-1925
dxs62@psu.edu

Public Health Institute
$296,093
Reducing Hospital Readmissions Through Innovative Technologies That Improve Care Coordination
Evidence is emerging that several new technologies, including remote patient-monitoring devices, medication optimization systems, and tools that improve caregiver-to-caregiver and caregiver-to-patient communications, can significantly reduce the need for hospital readmissions and lower costs by enabling a greater level of care coordination and integration. However, providers and researchers lack sufficient information about the best ways to incorporate these technologies into care redesign efforts, what to invest in and when, and how to implement the tools systemwide in order to reap their full benefit. This project will develop case studies, working papers, and tools based on different types of organizations that have successfully implemented these technologies. The findings will assist care delivery systems, community partnerships, and national organizations in efforts to improve care coordination and reduce avoidable hospital readmissions.
Carmen Nevarez, M.D.
Vice President for External Relations and Preventive Medicine Advisor
555 12th Street, 10th Floor
Oakland, CA 94607

(510) 285-5500
crnevarez@phi.org

University of Washington

$359,183

Assessing Organizational Characteristics for Effective Patient-Centered Health System Reform and Innovation

Recent legislative initiatives in the state of Washington present an opportunity to explore how different types of health care organizations respond to delivery and payment system reforms, and what impact these reforms have on costs and quality of care. This project will document how five organizations selected for their diversity in culture, organizational structure, delivery system integration, and market environment respond to three innovations being implemented throughout that state: 1) the patient-centered medical home; 2) shared patient–physician decision-making; and 3) experimentation by individual purchasers with new methods for paying primary care providers. This work will inform policymakers, health care leaders, and others in their efforts to reform health care delivery at the organizational, state, and national levels.

Douglas A. Conrad, Ph.D.
Professor
Box 357660
Seattle, WA 98195
(206) 616-2923
dconrad@u.washington.edu

Yale University

$203,185

Identifying Evidence-Based Approaches to Reducing Mortality for Patients Hospitalized with Heart Attack

Despite a decade of efforts aimed at improving care for heart attack patients, a twofold difference in hospital mortality rates persists between the highest- and lowest-performing institutions. Very little is known about what distinguishes hospitals that have low mortality rates. This project will contribute to a larger three-year initiative funded in part by the Agency for Healthcare Research and Quality and the United Health Foundation to test ways in which hospitals can reduce deaths from heart attack. The investigators will visit selected hospitals and interview hospital personnel to guide the development of a survey of 350 randomly selected hospitals, the findings of which will be used to determine the hospital structures, processes, and features that are associated with exceptional outcomes.

Elizabeth H. Bradley, Ph.D.
Professor of Public Health
Yale School of Medicine
60 College Street, Room 300A
New Haven, CT 06511
(203) 785-2937
elizabeth.bradley@yale.edu

Small Grants—Health System Quality and Efficiency

Beth Israel Deaconess Medical Center, Inc.

$14,850

Commonwealth Fund Issue Brief—End of Life Care in Massachusetts State Health Reform: Lessons for National and State Health Reform Efforts

Lachlan Forrow, M.D.
Director, Ethics and Palliative Care Programs
Chair, Massachusetts Expert Panel on End of Life Care
330 Brookline Avenue, YA-111
Boston, MA 02215
(617) 667-3095
lforrow@bidmc.harvard.edu

Brandeis University

$15,000

The XVII Princeton Conference: Examining End of Life Care—Creating Sensible Public Policies for Patients, Providers, and Payers

Stuart H. Altman, Ph.D.
Professor & Chairperson, Council on Health Care Economics and Policy
The Florence Heller Graduate School
Institute for Health Policy - MS035
P.O. Box 549110
Waltham, MA 02454
(781) 736-3803
altman@brandeis.edu

The Brookings Institution

$33,000

From Concept to Reality: Exploring Approaches to Legal, Contractual, Payment, Measurement Issues Required to Implement Accountable Care Organizations: A One-Day Roundtable Multi-Stakeholder Meeting

Mark B. McClellan, M.D., Ph.D.
Director, Engleberg Center for Health Care Reform
Senior Fellow, Economic Studies
1775 Massachusetts Avenue NW
Washington, DC 20036
(202) 741-6567
mmcclellan@brookings.edu

Foundation for the eHealth Initiative

$50,000

Creating a National Progress Report on eHealth Initiatives

Jennifer Covich Bordenick

Chief Operating Officer & Interim Chief Executive Officer

818 Connecticut Avenue NW, Suite 500

Washington, DC 20006

(202) 624-3288

jennifer.covich@ehealthitiative.org

Group Health Cooperative

$35,709

Identifying Best Practices for Efficient Electronic Consultation Between Primary and Specialty Care Providers

Edward H. Wagner, M.D.

Director, McColl Institute for Healthcare Innovation

Group Health Research Institute

1730 Minor Avenue, Suite 1600

Seattle, WA 98101

(206) 287-2877

wagner.e@ghc.org

Institute for Healthcare Improvement

$43,087

A Conference to Advance the State of the Science and Practice on Scale-Up and Spread of Effective Health Programs

C. Joseph McCannon

Vice President and IHI Lead Faculty on Spread & Large-Scale Change

20 University Road, 7th Floor

Cambridge, MA 02138

(617) 359-6320

jmccannon@ihi.org

The Texas A&M University System Health Science Center Research Foundation

$47,522

Evaluating the Impact of Expanding a Salary-Based Network of Physicians by Contracting with Fee-for-Service Out-of-Network Physicians: The Scott & White Experience

Thomas R. Miller, Ph.D.

Assistant Professor

Department of Health Policy and Management

School of Rural Public Health

TAMU 1266 Room 306

College Station, TX 77843
(979) 458-0831
trmiller@srph.tamhsc.edu

Patient-Centered Coordinated Care

Center for Studying Health System Change
$163,970
Examining Effective Practices and Policies for Facilitating After-Hours Care
One of the hallmarks of the patient-centered medical home is access to primary care after regular office hours—on evenings, weekends, and holidays. Having this enhanced access has been shown to reduce unnecessary emergency department use, which in turn leads to lower health care costs. In the United States, however, only 29 percent of primary care physicians report that their practice makes arrangements to see patients after hours. This project will study primary care sites in this country and possibly abroad that either directly provide effective, efficient after-hours care primary care or coordinate such care with a patient's usual primary care provider. Through case studies and interviews, project staff will identify the factors associated with successfully providing such care, particularly focusing on policies and practice characteristics that could facilitate replication of effective models.
Ann S. O'Malley, M.D.
Senior Health Researcher
600 Maryland Avenue SW, Suite 550
Washington, DC 20024
(202) 554-7569
aomalley@hschange.org

Center for Studying Health System Change
$179,897
Using Care Coordination Agreements in Primary Care
One tool that holds promise to improve the coordination of patients' health care is the "care coordination agreement"—a formal, written arrangement between clinicians that defines responsibilities for the coordination of a patient's care. Emerging evidence suggests that these agreements improve timely access to specialty care services, speed feedback to primary care providers about their patients' hospital stays, and improve discharge planning. This project will support research into how independent primary care practices construct and implement care coordination agreements and how useful they find them to be when collaborating with specialty care practices, hospitals, home health agencies, and nursing homes. The findings will help providers use these agreements more effectively and could facilitate implementation of accountable care organizations and bundled payment systems that rely on well-coordinated care.
Hoangmai H. Pham, M.D.
Senior Health Researcher
600 Maryland Avenue SW, Suite 550
Washington, DC 20024

(202) 554-7571
mpham@hschange.org

University of Chicago

$1,500,000

Evaluation of The Commonwealth Fund's Safety-Net Medical Home Initiative, Phase 2

In April 2008, The Commonwealth Fund launched a five-year initiative to transform 68 safety-net clinics in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania into patient-centered medical homes. A team at the University of Chicago has begun to monitor the clinics' transformation and will soon be evaluating the effectiveness of this ambitious initiative by comparing the new medical homes' performance on clinical quality, patient experience, clinician experience, cost savings, and efficiency with that of other health centers. In the evaluation's first year, the researchers administered and analyzed the baseline survey of clinic directors, initiated analysis of Medicaid claims data to assess baseline quality and efficiency, and worked closely with the Fund and the initiative's leadership to ensure that the evaluation is feasible and coordinated with program implementation. To ensure timely dissemination of findings, the evaluation team, beginning as early as 2010, will begin publishing baseline results. Over the course of the study, the team also will prepare case studies of successful clinic strategies, policy briefs, and journal articles aimed at policymakers and health center leaders.

Marshall Chin, M.D.
Professor and Associate Chief of General Internal Medicine
5841 South Maryland Avenue, MC 2007
Chicago, IL 60637
(773) 702-4769
mchin@medicine.bsd.uchicago.edu

The George Washington University

$285,949

Promoting High Performance Safety-Net Health Systems: Learning from Existing Models

The economic recession has increased the number of people relying on publicly funded health care while it has decreased the revenue states have available to support that care. Caught in the squeeze, safety-net providers are being forced to do more with less, potentially limiting patients' access and compromising quality. Public and critical-access hospitals and community health centers that operate within integrated systems appear best-equipped to handle the needs of vulnerable patients efficiently. To guide subsequent efforts to promote system integration, this project will examine the degree to which safety-net providers are part of larger systems of care, identify examples of different approaches to integration, and analyze policies that would facilitate greater integration.

Leighton Ku, Ph.D.
Professor, Department of Health Policy
School of Public Health
2021 K Street NW, Suite 800
Washington, DC 20006

(202) 416-0479
lku@gwu.edu

National Committee for Quality Assurance

$298,011

Using Patient Feedback in the Certification of Primary Care Practices as Medical Homes

With Commonwealth Fund support, the National Committee for Quality Assurance (NCQA) has developed measures to recognize practices as medical homes. These widely used metrics, however, rely exclusively on practice features—patient registries, protocols, and electronic health record systems—and do not take into account patients' feedback. To reflect the experiences of patients with their physician practice, the baseline qualification criteria must incorporate results from patient surveys. In consultation with a panel of physician leaders, purchasers, patients, and policy experts, the NCQA team will work to address methodological challenges related to questionnaire design, data collection, sampling techniques, and scoring so that patient survey data can be added to the metrics used for certifying physician practices as patient-centered medical homes.

Sarah Hudson Scholle, Dr.P.H.
Assistant Vice President, Research
1100 13th Street NW, Suite 1000
Washington, DC 20005
(202) 955-1726
scholle@ncqa.org

Qualis Health

$1,499,965

Transforming Safety-Net Clinics into Patient-Centered Medical Homes, Year 3

In April 2008, The Commonwealth Fund launched a five-year initiative to help safety-net primary care clinics become patient-centered medical homes and achieve benchmark levels of performance in clinical quality, efficiency, and patient experience. Sixty-five clinics in five states—Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania—were selected to participate. In the past year, a team at Qualis Health and the MacColl Institute for Healthcare Innovation has engaged clinics and local process-improvement organizations (regional coordinating centers) in the five states to begin the work of practice transformation. In the year ahead, the Qualis/MacColl team will: 1) provide direct consultation to clinics and create implementation guides to help them improve access, coordinate care, and engage patients better; 2) help several participating clinics achieve National Committee for Quality Assurance recognition as medical homes; and 3) continue to promote a 'learning laboratory' for the five states through peer-to-peer events. The University of Chicago's Marshall Chin, M.D., M.P.H., is currently working with the project team to evaluate the safety-net medical home initiative.

Jonathan R. Sugarman, M.D.
President and Chief Executive Officer
10700 Meridian Avenue N, Suite 100
Seattle, WA 98133

(206) 288-2300
jonathans@qualishealth.org

RAND Corporation
$496,162
Evaluating Models of Medical Home Payment Within the Pennsylvania Chronic Care Initiative
The Pennsylvania Chronic Care Initiative, the most extensive multipayer medical home demonstration program in the nation, is testing the effectiveness of four models for financially rewarding primary care sites that function as patient-centered medical homes. RAND and Harvard researchers will assess the differential impact of these payment approaches—which range from per-member per-month care management fees to "shared savings" to one-time grants—on health care utilization, efficiency, cost, and quality of care. In addition, the team will compare the results in Pennsylvania with those from the Colorado, Ohio, and Rhode Island medical home initiatives, which the researchers are evaluating under other Fund grants.
Mark W. Friedberg, M.D.
Associate Natural Scientist
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407
(310) 393-0411
mfriedbe@rand.org

Small Grants—Patient-Centered Coordinated Care

Brandeis University
$22,000
Foundations and Healthcare Reform
Claudia Jacobs
Director of Capacity Building
Sillerman Center for the Advancement of Philanthropy
415 South Street, MS 035
Waltham, MA 02454
(781) 736-3806
cjacobs@brandeis.edu

Texas Health Institute
$15,000
Seventh National Conference on Quality Health Care for Culturally Diverse Populations
Dennis P. Andrulis, Ph.D.
Senior Research Scientist
8501 N. MoPac Expressway, Suite 300

Austin, TX 78759
(512) 279-3917
dandrulis@texashealthinstitute.org

Picker/Commonwealth Fund Long-Term Care Quality Improvement Program

AARP Foundation
$70,140
The Commonwealth Fund State Long-Term Care Scorecard, Phase 1: Laying the Foundation
Picker Program Grant
Long-term care, which encompasses a wide range of services, from home care to nursing homes, is largely paid for by Medicaid—making it an extremely important issue for states. Having established the need for and feasibility of creating a state long-term care scorecard, the project team will take the first steps in developing one. With input from a national advisory committee, the investigators will: 1) describe what a high-performing long-term care system would look like; 2) develop a conceptual framework for the scorecard and identify and define the indicators needed to assess current performance; and 3) begin development of a survey that will be used to fill gaps in existing data sets.
Susan Reinhard, Ph.D.
Senior Vice President, Public Policy
601 E Street NW
Washington, DC 20049
(202) 434-3841
sreinhard@aarp.org

American Association of Homes and Services for the Aging
$897,969
Advancing Excellence in America's Nursing Homes, Year 3
Picker Program Grant
Advancing Excellence in America's Nursing Homes, a three-year-old national effort supported in large part by The Commonwealth Fund, continues to demonstrate results in improving the quality of life and care for nursing home residents. Nearly half of all facilities in the country now participate in the campaign, and there have been more than two years of steady progress toward its clinical quality goals. Fund grants support a two-person staff that coordinates activities, assists state networks and workgroups, and oversees the production of educational resources. The Centers for Medicare and Medicaid Services also lends support and, in the next year, plans to support efforts to raise the campaign's national visibility. The next phase of activities will include: recruiting new participants; rolling out new and revised goals; building up the capacity of state networks; producing new online informational resources; executing a communications plan; and testing an awards program.
William L. Minnix, Jr., D.Min.
President and CEO
2519 Connecticut Avenue NW
Washington, DC 20008

(202) 508-9426
lminnix@aahsa.org

President and Fellows of Harvard College
$131,131
Evaluating the Potential of Telemedicine to Reduce Hospitalizations of Nursing Home Residents
Picker Program Grant
Many costly hospitalizations of frail elders could be avoided if appropriate care were available in nursing homes. This study will test the promise of telemedicine to help nursing home staff consult with off-site physicians more easily. With the ability to see residents who are in another location, physicians could assess their need for hospital care or recommend treatments that the nursing home would be able to provide. Building on other Commonwealth Fund-supported work to decrease unnecessary hospital transfers of nursing home residents, the project will inform policymakers about a potentially cost-effective way to safely reduce avoidable hospitalizations for a vulnerable group.
David C. Grabowski, Ph.D.
Associate Professor of Health Care Policy
Department of Health Care Policy
Harvard Medical School
180 Longwood Avenue
Boston, MA 02115
(617) 432-3369
grabowski@hcp.med.harvard.edu

Pioneer Network in Culture Change
$195,470
The Pioneer Network: Advancing Culture Change in Nursing Homes, Year 5
Picker Program Grant
Building on its prior work on behalf of nursing homes in the vanguard of culture change, the Pioneer Network is now reaching out to a broad audience of policymakers, regulators, and professionals as it tries to galvanize the majority of homes still sitting on the sidelines. Building on last year's Fund-supported work, the project team will undertake a number of activities, including: four case studies of nursing homes that have undergone culture change; an examination of a Colorado pay-for-performance demonstration that uses culture change markers to trigger higher payment rates; the development of food safety and dining requirements that meet residents' needs; and an analysis of the national impact culture change has had on quality and cost outcomes.
Bonnie S. Kantor, Sc.D.
Executive Director
P.O. Box 18648
Rochester, NY 14618
(585) 271-7570
bonnie.kantor@pioneernetwork.net

Visiting Nurse Service of New York

$414,107

Using the Care Transitions Measure in Home Care Settings to Improve Outcomes and Reduce Hospital Readmissions

Health Services Improvement Fund Grant

Picker Program Grant

The Care Transitions Measure was developed with earlier Commonwealth Fund support to assess the adequacy of instructions that hospitals provide their patients prior to discharge. This brief questionnaire for patients will now be tested to see whether home health care agencies and other post-acute care providers can use it to: 1) assess how well a hospital prepares patients for home care; 2) predict the level of care resources new patients will require; 3) tailor services to patients' individual needs; and 4) provide hospitals with feedback on their transitional care. The project team will also develop a version of the Care Transitions Measure capable of assessing how well home health care agencies prepare their patients for discharge. The findings will aid efforts to reduce avoidable rehospitalizations and rein in spiraling costs.

Penny Hollander Feldman, Ph.D.
Senior Vice President for Research & Evaluation
Director, Center for Home Care Policy and Research
107 East 70th Street, 3rd Floor
New York, NY 10021
(212) 609-1530
pfeldman@vnsny.org

Small Grants—Picker/Commonwealth Fund Long-Term Care Quality Improvement Program

Brown University

$41,683

Updating Nursing Home Hospitalization Scorecard Measures and Adding Selected Quality Indicators

Picker Program Grant

Vincent Mor, Ph.D.
Professor & Chair, Department of Community Health
121 South Main Street
Providence, RI 02912
(401) 863-2959
vincent_mor@brown.edu

Massachusetts Department of Public Health
$47,500
Improving Care Transitions Among Skilled Nursing Facilities, Hospitals, and the Community: A State's Strategy
Picker Program Grant
Alice Bonner, Ph.D.
Director, Bureau of Health Care Safety and Quality
99 Chauncy Street, 11th Floor
Boston, MA 02111
(617) 753-8100
alice.bonner@state.ma.us

National Senior Citizens Law Center
$20,000
Medicaid Assisted Living Study: A Communications Plan
Picker Program Grant
Eric Carlson
Directing Attorney, Long-Term Care Project
3435 Wilshire Boulevard, Suite 2860
Los Angeles, CA 90010
(213) 674-2813
ecarlson@nsclc.org

University of North Carolina at Chapel Hill
$49,487
Improving Psychosocial Care for Nursing Home Residents: Optimizing the Utility of the New Minimum Data Set 3.0
Picker Program Grant
Sheryl Zimmerman, Ph.D.
Professor and Director of Aging Research
Sheps Center for Health Services Research
725 Martin Luther King Jr. Boulevard, Campus Box 7590
Chapel Hill, NC 27599
(919) 966-7111
sheryl_zimmerman@unc.edu

Planetree, Inc.
$49,864
Developing Systems to Support Person-Centered Care: Optimizing Planetree's Continuing Care Designation Criteria and Measurement Strategies
Picker Program Grant
Heidi Gil

Senior Director of Continuing Care
130 Division Street
Derby, CT 06418
(203) 732-1381
hgil@planetree.org

The Board of Regents of the University of Wisconsin System
$42,344
Development of a Practicum Site Quality Profile for Long Term Care Administration Programs
Picker Program Grant
Douglas Olson, Ph.D.
Director, Center for Health and Aging Services Excellence
University of Wisconsin-Eau Claire
Eau Claire, WI 54702
(715) 836-5067
olsondou@uwec.edu

HEALTH REFORM POLICY

Affordable Health Insurance

Trustees of Columbia University in the City of New York
$47,820
Contributing to Health Care Reform: Analysis of National Data Sets
From the very start of the current historic debate over health care reform, The Commonwealth Fund has produced timely, targeted analyses that have informed policy development. With the passage of a reform package likely, there will be a need for additional analyses to track the effect of the new policies on U.S. families' access to affordable health insurance and health care, and to identify areas for improvement. To help generate these reports, researchers at Columbia University will provide computer programming and analysis of important federal data sets on behalf of the Fund and its grantees, the Commission on a High Performance Health System, and policymakers.
Bhaven Sampat, Ph.D.
Assistant Professor
Department of Health Policy and Management
600 West 168th Street, Room 604
New York, NY 10032
(212) 305-7293
bns3@columbia.edu

The George Washington University

$115,000

Analysis of the Affordable Care Act of 2010

The landmark health reform law, the Affordable Care Act, promises to expand access to comprehensive health insurance for approximately 32 million people and help transform the way health care is delivered in the United States. In the wake of the law's passage, The Commonwealth Fund has emerged as a key resource to policy makers, the press, and the public on the provisions in the law through a set of detailed health reform timelines on coverage, delivery system reform, and revenue provisions posted on its Web site. The Fund plans to enhance the timelines with an interactive Web-based design that will merge the timelines into one. To ensure accuracy and provide greater depth, this project team of legal experts will conduct a thorough review of the law's provisions in key areas important to the Fund—coverage, payment and delivery system reform, cost-containment, and revenue sources. In addition to support for the enhanced reform timeline, this analysis will also serve as an important resource for staff and the Commission on a High Performance Health System in responding to the needs of federal and state policy makers and regulators, grant development, grantee papers, and staff-led policy briefs and reports on key implementation issues.

Katie B. Horton
Research Professor
Center for Health Policy Research, Department of Health Policy
School of Public Health and Health Services
2121 K Street NW, Suite 200
Ashburn, VA 20147
(202) 994-4129
katie.horton@gwumc.edu

President and Directors of Georgetown College

$84,943

Massachusetts Health Insurance Reform: Promise and Results

While there has been a considerable amount of research on the effects of the Massachusetts' reform on coverage and access to care, there has been little work on its effects on insurance markets, including the diversification of risk pools and the cost of premiums. This project will consist of an actuarial analysis of the Massachusetts reform law using claims data from commercial carriers. The project team will investigate the effects of the reform law on premiums, risk pooling, and risk selection by health plans. Their finding will help inform federal and state policy makers and regulators about key issues in implementation of the Affordable Care Act, particularly with respect to the state-based exchanges, including decisions about merging the individual and small group markets, standards for qualified health plans and the essential benefit standard, the individual mandate, the potential effect of the catastrophic health plan option on risk selection, and the affordability of premiums over time.

Ryung Suh, M.D.
Research Assistant Professor
3700 Reservoir Road NW, St. Mary's Hall 238
Washington, DC 20057

(202) 297-2444
suhr@georgetown.edu

University of Kansas Center for Research, Inc.
$99,704
Evaluating High-Risk Pools as a Health Insurance Option for People with Preexisting Conditions
The new health reform law includes a transitional national high-risk pool that will go into effect 90 days from the date of the bill's enactment and continue until new insurance exchanges are implemented in 2014. The high-risk pool will provide basic coverage for people turned down in the individual insurance market because of health problems. Much is unknown about how the high-risk pool will be administered and marketed, who will enroll in it, how much it will cost enrollees and taxpayers, and whether the coverage will meet people's needs. This project will conduct an immediate study of the new law's high-risk-pool provisions, identifying implementation issues and providing policy recommendations to federal and state officials charged with implementation.
Jean Hall, Ph.D.
Associate Research Professor
Division of Adult Studies
Joseph R. Pearson Hall
1122 West Campus Road, Room 517
Lawrence, KS 66045
(785) 864-7083
jhall@ku.edu

National Opinion Research Center
$325,912
Comparing Employer and Nongroup Health Plans Against the Health Reform Benefit Standard
Compared with health insurance sold in the individual market, employer-based group health plans provide enrollees with far greater protection from out-of-pocket expenses, and at much lower cost. The new reform legislation contains a number of provisions that will greatly improve the affordability and comprehensiveness of nongroup health plans. This project will estimate the affordability, out-of-pocket costs, and actuarial value of plans that will be available through insurance exchanges, and then compare the results with existing group and nongroup plans. In addition, the investigators will attempt to develop a more efficient mechanism for reining in high-cost plans that provide rich benefits than the excise tax that will take effect in 2018.
Jon R. Gabel
Senior Fellow
4350 East-West Highway, Suite 800
Bethesda, MD 20814
(301) 634-9313
gabel-jon@norc.org

Pennsylvania State University

$353,822

Analyzing Policy Options for Improving the Stability of Health Insurance Coverage

Eighty-five million people were without health insurance coverage at some point between 1996 and 1999, according to a 2002 study supported by The Commonwealth Fund. Instability, or churning, in health plan enrollment was highest among people with low and moderate incomes, as they gained and lost their eligibility for public insurance or moved in and out of private coverage. This project will update estimates of gaps in coverage and churning in insurance enrollment in the United States over the 2004–07 period, to provide policymakers with a baseline for evaluating the capacity of health reform to address the problem. The researchers also will offer solutions for minimizing gaps in coverage that might occur during the implementation of reform.

Pamela Farley Short, Ph.D.
Director, Center for Health Care and Policy Research
504 Donald Ford Building
University Park, PA 16802
(814) 863-8786
pxs46@psu.edu

Washington and Lee University

$299,539

Implementing Health Insurance Exchanges: What Are the Keys to Success?

Health insurance exchanges are a central feature of the new health care reform legislation. As regulated marketplaces facilitating health plan selection, insurance exchanges could help achieve several objectives of health reform: creating broad and diverse risk pools, reducing plan administrative costs, increasing transparency in plan choice, regulating premium growth, encouraging innovation in benefit design, and providing a new foothold in the market for innovative plans. Whether the exchanges are effective will depend on several factors, including how they are implemented and how they are received in the marketplace. This project will conduct real-time analysis of exchange implementation, helping state and federal officials, legislators, and regulators understand the reasons for success or failure and ways exchanges might be improved.

Timothy Jost
Robert L. Willett Family Professor of Law
1370 Lincolnshire Drive
Harrisonburg, VA 22802
(540) 464-2524
jostt@wlu.edu

Small Grants—Affordable Health Insurance

Education & Research Fund of the Employee Benefit Research Institute

$46,000

2011 Sustaining Membership in the Employee Benefit Research Institute Education and Research Fund; Support of the

Annual Health Confidence Survey and the Consumer Engagement in Health Care Survey
Paul Fronstin, Ph.D.
Director, Health Research and Education Program
1100 13th Street NW, Suite 878
Washington, DC 20005
(202) 775-6352
fronstin@ebri.org

The George Washington University
$45,952
Assessing State Health Insurance Laws in the Context of the Essential Benefits Provision of the Patient Protection and Affordable Care Act
Sara Rosenbaum
Hirsh Professor and Chair, Department of Health Policy
2021 K Street NW, Suite 800
Washington, DC 20006
(202) 994-4232
sarar@gwu.edu

Princeton Survey Research Associates International
$36,400
The Commonwealth Fund 2010 Health Insurance Survey—Additional Funding for Cell Phone Sampling
Mary E. McIntosh, Ph.D.
Principal, President
1211 Connecticut Avenue NW, Suite 305
Washington, DC 20036
(202) 293-4710
mary.mcintosh@psra.com

Payment and System Reform

University of Massachusetts Medical School
$339,535
Developing a Risk-Adjustment Model for Paying Patient-Centered Medical Home Practices
Using health care claims data, this project will develop a practical and generalizable approach for making risk-adjusted payments, and for measuring and rewarding quality for groups of primary care providers that function as patient-centered medical homes. The research team will devise approaches to paying medical home practices appropriately for their patient case mix and incorporate incentives to achieve efficient, high-quality care. In addition, the team will investigate how the patient-centered medical home can be implemented in a multipayer setting marked by a diversity of health plan types with their own payment methods and cost-sharing arrangements.

Arlene S. Ash, Ph.D.
Professor, Department of Quantitative Health Sciences
55 Lake Avenue North
Worcester, MA 01655
(508) 856-8999
arlene.ash@umassmed.edu

Regents of the University of Michigan
$405,868
Evaluating Blue Cross Blue Shield of Michigan's Physician Group Incentive Program
To encourage providers to work together to assume joint responsibility for their patients' care, Blue Cross Blue Shield of Michigan, in cooperation with the Michigan State Medical Society, has implemented a physician group incentive program (PGIP). Groups of physicians are evaluated on population-based cost and quality measures and provided incentives through a pay-for-performance program. For physicians to be financially successful, they have to join together, using the patient-centered medical home model, to achieve high performance on cost and quality. This project will document: 1) how the PGIP was developed and implemented; 2) the change in participating physician groups' organizational structures and systems of care; 3) the effect on providers' perceptions regarding practice transformation, costs, and quality; and 4) the impact on utilization, costs, quality, and relationships between physicians and payers.
Christy Lemak, Ph.D.
Associate Professor
M3116 SPH II
1415 Washington Heights
Ann Arbor, MI 48109
(734) 936-1311
chrislem@umich.edu

Urban Institute
$347,378
Updating The Commonwealth Fund's Bending the Curve *Report*
Published by The Commonwealth Fund in 2007, Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending estimated the national health spending impact of 15 policy options for improving both the effectiveness and efficiency of care. Several of the options in the report found their way into the health reform bill that was just enacted. With the passage of comprehensive reform, an Urban Institute team will work with Fund staff to update Bending the Curve and develop new policy options, with input from the Commission on a High Performance Health System, that would complement and build upon the new law's provisions for maximizing quality and value in health care. The updated report will also feature estimates of the policies' potential impact on national health spending over the next 10 years. Payment reform, quality improvement and patient safety, insurance market efficiency, and public health and prevention are anticipated areas of focus.
Stephen Zuckerman, Ph.D.
Senior Fellow

2100 M Street NW
Washington, DC 20037
(202) 261-5679
szuckerman@urban.org

Small Grants—Payment and System Reform

AcademyHealth
$45,000
Colloquium on Group Employed Models in an Era of Healthcare Reform
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

AcademyHealth
$48,257
Developing New Methods for Designing and Evaluating Emerging Payment System Reform Demonstration and Pilot Projects: Anticipating the Challenges
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

Center for Health Care Strategies, Inc.
$14,422
Analysis of Alternative Models to Integrate Care for Dual Eligibles
Melanie Bella
Senior Vice President
200 American Metro Boulevard, Suite 119
Hamilton, NJ 08619
(609) 528-8400
mbella@chcs.org

Jewish Healthcare Foundation of Pittsburgh
$22,733
Supporting Co-Evolution of Payment and Delivery System Reforms
Harold D. Miller
Executive Director
Center for Healthcare Quality and Payment Reform
320 Fort Duquesne Boulevard, Suite 20-J
Pittsburgh, PA 15222
(412) 803-3650
miller.harold@gmail.com

Massachusetts Medical Society
$38,300
Toward a Shared Vision of Payment Reform
Elaine Kirshenbaum
Vice President of Policy, Planning, and Member Services
Waltham Woods Corporate Center
860 Winter Street
Waltham, MA 02451
(718) 434-7223
ekirshenbaum@mms.org

Urban Institute
$50,000
Preparing for a 2010 Update of the Bending the Curve *Report*
Stephen Zuckerman, Ph.D.
Senior Fellow
2100 M Street NW
Washington, DC 20037
(202) 261-5679
szuckerman@urban.org

Federal Health Policy

Alliance for Health Reform
$338,278
Commonwealth Fund Bipartisan Congressional Retreat, 2010
The Fund's annual Bipartisan Congressional Retreat offers members of Congress the opportunity to engage in substantive dialogue about timely health policy issues in a nonpartisan, off-the-record setting. Given the intense legislative activity surrounding health reform, the retreat will enable participants to take stock of legislative

accomplishments, examine areas that presented both political and policy challenges, discuss implementation of enacted reforms, and review lessons learned. To bolster participation and post-meeting follow-up, the Alliance for Health Reform will hold special briefings for members and congressional staff.

Edward F. Howard
Executive Vice President
1444 Eye Street NW, Suite 910
Washington, DC 20005
(202) 789-2300
edhoward@allhealth.org

Alliance for Health Reform

$380,664

Toward a High Performance Health System: Informing Health Policy Leaders on Key Issues, 2009–10

Alliance for Health Reform briefings are a valuable resource for congressional staff and journalists seeking the latest health policy information and analysis. In the coming year, the Alliance will conduct seven Commonwealth Fund-sponsored briefings or roundtables on Capitol Hill. The sessions will focus on topics most relevant to policymakers and will depend largely on how health reform progresses through the remainder of 2009. The annual Congressional Staff Retreat, meanwhile, provides an opportunity for up to 100 senior health staff from both parties to engage in an informal, off-the-record exchange of ideas. This grant also provides support for meetings of the Fund's Commission on a High Performance Health System.

Edward F. Howard
Executive Vice President
1444 Eye Street NW, Suite 910
Washington, DC 20005
(202) 789-2300
edhoward@allhealth.org

Harris Interactive, Inc.

$67,000

Health Care Opinion Leaders Survey, Year 5

In 2007, The Commonwealth Fund, in collaboration with Modern Healthcare magazine, relaunched its quarterly series of online surveys of health care opinion leaders. The surveys, conducted by Harris Interactive, ask experts about a range of health policy issues and the options for addressing them. The results are published in the print and online editions of Modern Healthcare and on the Fund Web site, along with original commentaries by top policy experts. For each survey, the Fund also publishes a data brief providing analysis of the key findings and their relevance to current policy debates. Building on the project's success to date—in bringing health policy leaders' views to bear on the health reform debate, generating extensive coverage of survey results, and informing other research—the Fund will support an additional year of quarterly surveys that will cover major issues closely aligned with the work of the Fund and its Commission on a High Performance Health System.

Roz Pierson, Ph.D.

Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
(301) 502-9018
rpierson@harrisinteractive.com

Small Grants—Federal Health Policy

Center for American Progress
$30,000
Strategic Planning and Coordination to Assist Health Reform Implementation
Melanie Nathanson
Managing Director
The Glover Park Group
1025 F Street NW, 9th Floor
Washington, DC 20004
(202) 337-0808
mnathanson@gloverparkgroup.com

Johns Hopkins University
$50,000
Updating National Health Care Scorecard Data and Assessing Methods for Adjusting Medicare Costs and Defining Hospital Readmissions
Gerard F. Anderson, Ph.D.
Professor and Director
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
(410) 955-3241
ganderso@jhsph.edu

RAND Europe Cambrdge Limited
$17,020
Updating International Trends in Mortality Amenable to Health Care, 2007–08
Ellen Nolte, Ph.D.
Director, Health and Healthcare
Westbrook Centre, Milton Road
Cambridge CB4 1YG
United Kingdom

+44 0 1223 353329
enolte@rand.org

State Health Policy and Practices

Center for Health Policy Development

$395,961

Advancing State Health System Performance: New State Roles

Even while the President and Congress pursue comprehensive national health reform, states can play important roles in expanding insurance coverage, improving quality of care, and controlling costs—both individually and in partnership with the federal government. This project will examine provider payment and delivery system innovations taking place throughout the states and identify those that hold the most promise for achieving high-value care. Former Commonwealth Fund assistant vice president Anne Gauthier will undertake case studies of Minnesota and Massachusetts' payment reform initiatives and prepare three reports describing current and future state roles in strengthening primary care, and improving delivery of chronic care, establishing health insurance exchanges, and implementing national reforms related to provider payment, delivery of services, and quality of care. She will also present her findings through presentations to state and national audiences.

Anne K. Gauthier
Senior Fellow
1233 20th Street NW, Suite 303
Washington, DC 20036
(202) 507-7586
agauthier@nashp.org

Center for Health Policy Development

$373,174

ABCD III: Improving Care Coordination, Case Management and Linkages to Support Healthy Child Development, Year 2

The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) program is helping states recognize that improving young children's developmental and health outcomes demands systemic linkages between primary care practices and other health services and community resources. Five states are now collaborating to develop sustainable models of community-based care coordination services and supports for child health care practices. In year 2 of this three-year project, states will test their implementation plans in selected communities, build the case for policy changes, and develop the capacity to spread effective care coordination models to other communities.

Neva Kaye
Senior Program Director
National Academy for State Health Policy
10 Free Street, 2nd Floor
Portland, ME 04101
(207) 874-6524
nkaye@nashp.org

$220,000

Authorization to Support the Initiative in Five States

The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) program is helping states recognize that improving young children's developmental and health outcomes demands systemic linkages between primary care practices and other health services and community resources. Five states are now collaborating to develop sustainable models of community-based care coordination services and supports for child health care practices. In year 2 of this three-year project, states will test their implementation plans in selected communities, build the case for policy changes, and develop the capacity to spread effective care coordination models to other communities.

Health Management Associates, Inc.

$113,846

States in Action Newsletter: Six Issues for 2010–11

Since 2005, The Commonwealth Fund, through its now-bimonthly newsletter States in Action, has identified and reported on successful state health care policy and program initiatives to an audience of approximately 15,000 policymakers, researchers, administrators, and providers. The newsletter will have an even more important role to play in the coming year, as states meet new demands and opportunities related to national health reform and federal grant programs. With new policies requiring states to create, test, and implement innovative ways to deliver high-quality health care, States in Action will provide a valuable service in disseminating information about these initiatives nationally. This grant supports six new issues of the newsletter for 2010–11.

Sharon Silow-Carroll
Principal
1133 Avenue of the Americas, Suite 2810
New York, NY 10036
(212) 575-5929
ssilowcarroll@healthmanagement.com

National Association of Health Data Organizations

$146,034

Opportunities to Improve Cost Performance: A State Resource Center

States need access to health care data on all their residents to improve health system performance with respect to access, quality, efficiency, and cost. Because of practical and policy barriers, only a few states have made substantial progress toward creating and using all-payer claims databases that would provide such information. The leading organizations in this field, the National Association of Health Data Organizations and the Regional All-Payer Health Information Council, will collaborate on the creation of a best-practices guide, along with other materials, to help states solve the technical and other issues that are currently hampering the development of these important repositories of health care quality and cost data.

Denise Love
Executive Director
448 East 400 South, Suite 301
Salt Lake City, UT 84111

(801) 532-2262
dlove@nahdo.org

National Governors Association Center for Best Practices
$200,000
Supporting the National Governors Association's Rx for Health Reform Initiative
State leaders have a keen interest in initiating and implementing health care reform, but to succeed in their efforts they need assistance from one another and from experts. The National Governors Association (NGA) is launching a year-long initiative to provide governors and other state leaders with guidance on health policy decisions, options for implementing reforms, and technical assistance in building coordinated, strategic programs. For its initiative, the NGA is seeking support to develop a set of publications on insurance reform and regulation, Medicaid expansion, and state governance of health care around which much of the initiative's participatory activities will be centered. This project provides an opportunity for the Fund not only to provide useful information to state leaders, but also to collaborate with a key partner on improving the performance of state health systems.
Kathleen Nolan
Division Director, Health
444 North Capital Street, Suite 267
Washington, DC 20001
(202) 624-7872
knolan@nga.org

Small Grants—State Health Policy and Practices

AcademyHealth
$25,000
Support for the 2010 Activities of AcademyHealth's State Health Research and Policy Interest Group
Enrique Martinez-Vidal
Vice President
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6729
enrique.martinez-vidal@academyhealth.org

Association of Maternal and Child Health Programs
$25,000
Optimizing Health Care Reform to Advance Shared Resources Among Systems Serving Maternal and Child Health Populations
Michelle Alletto
Associate Director, Public Policy and Government Affairs
2030 M Street NW, Suite 350
Washington, DC 20036
(202) 775-0436
malletto@amchp.org

Michael C. Barth
$40,000
An Examination of Self-Funded Healthy Steps Sites: How and Why They Continue
Michael C. Barth, Ph.D.
3818 Military Road NW
Washington, DC 20015
(202) 262-7889
mcb1mcb@gmail.com

Center for Health Care Strategies, Inc.
$49,713
Advancing Primary Care Transformation in Medicaid
Nikki Highsmith
Senior Vice President of Programs
200 American Metro Boulevard, Suite 119
Hamilton, NJ 08619
(609) 528-8400
nhighsmith@chcs.org

Center for Health Care Strategies, Inc.
$29,756
Providing Shared Practice Supports in Medicaid
Nikki Highsmith
Senior Vice President of Programs
200 American Metro Boulevard, Suite 119
Hamilton, NJ 08619
(609) 528-8400
nhighsmith@chcs.org

Center for Health Policy Development
$49,886.00
Improving State Medicaid EPSDT Program Management and Policy
Neva Kaye
Senior Program Director
National Academy for State Health Policy
10 Free Street, 2nd Floor
Portland, ME 04101
(207) 874-6524
nkaye@nashp.org

Center for Health Policy Development
$48,594
State Strategies to Use Federally Qualified Health Centers as Community Utilities to Support Medical Homes for Vulnerable Populations
Neva Kaye
Senior Program Director
National Academy for State Health Policy
10 Free Street, 2nd Floor
Portland, ME 04101
(207) 874-6524
nkaye@nashp.org

Greater New York Hospital Association
$1,200
21st Annual Symposium on Health Care Services in New York: Research and Practice
Tim Johnson
Executive Director
555 West 57th Street, 15th Floor
New York, NY 10019
(212) 506-5420
tjohnson@gnyha.org

Health Management Associates, Inc.
$49,816
Analyzing 'Systemness' in Low- and High-Performing States
Sharon Silow-Carroll
Principal
1133 Avenue of the Americas, Suite 2810
New York, NY 10036
(212) 575-5929
ssilowcarroll@healthmanagement.com

Issues Research, Inc.
$19,249
Analysis of Rhode Island Quality Institute Model
Deborah Chase
Health Care Policy Consultant
7408 Byron Place
Clayton, MO 63105
(314) 757-1694
dchase@goinet.com

Johnson Group Consulting, Inc.
$13,663
Helping States Address Women's Health Through Medicaid
Kay A. Johnson
President
175 Red Pine Road
Hinesburg, VT 05461
(802) 482-3005
kay.johnson@johnsongci.com

National Association of Health Data Organizations
$49,999
Advancing State Health Care Data Reporting Initiatives: Hospital Readmissions Reporting and All-Payer Claims Database Applications
Denise Love
Executive Director
448 East 400 South, Suite 301
Salt Lake City, UT 84111
(801) 532-2262
dlove@nahdo.org

HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING

Institute for Healthcare Improvement

$531,999

Support for a Research Unit to Update the Health System Scorecards and Analyze Local Variations in Performance

The national and state scorecards issued by The Commonwealth Fund Commission on a High Performance Health System have focused attention on deficiencies in U.S. health care and helped health care leaders and policymakers identify opportunities for improvement. Several states, in fact, have adopted core scorecard measures to help them track performance and target reforms. This grant will support a research unit that will produce the third editions of the national and state scorecards as well as profile health care performance across large metropolitan and non-metropolitan areas. The research unit, which will be overseen by Cathy Schoen, also will compile information on delivery system organization and insurance market characteristics and examine their relationship with geographic variations in costs and outcomes. In addition to the scorecards, the team will prepare issue briefs on topics of national and state interest, provide data and research support for case studies, and develop policy options for slowing the growth in health care costs.

Donald Goldmann, M.D.
Senior Vice President
20 University Road, 7th Floor
Cambridge, MA 02138
(617) 301-4800
dgoldmann@ihi.org

IPRO, Inc.

$465,000

WhyNotTheBest.org: A Web Resource for Quality Improvement, Year 3

Under two previous Board grants, The Commonwealth Fund developed a Web site, WhyNotTheBest.org, to enable health care professionals to compare their organization's performance against a range of benchmarks, read case studies of high-performers, and download tools they can use to measure and improve their organizations' performance. In 2009, WhyNotTheBest.org underwent further development, with the addition of new data sets, new ways to search and compare hospitals, and a refined user interface. This grant will support plans for hosting and maintaining the site, updating data sets, and making design and development changes as needed.

Jaz-Michael King
Senior Director, eServices and Health Care Transparency
1979 Marcus Avenue, Suite 105
Lake Success, NY 11042
(516) 326-7767
jmking@ipro.us

IPRO, Inc.

$407,752

Innovative Measurement and Performance Improvement Resources for WhyNotTheBest.org

Three previous Commonwealth Fund grants supported development of the basic infrastructure and platform for WhyNotTheBest.org, the Fund's performance benchmarking and quality improvement resource. The goal for the next phase is to build a more comprehensive profile of hospital performance and explore the feasibility of profiling health plan quality as well. IPRO will work with Fund staff to add key measures obtained from new state all-patient data sources, and the team will also create sophisticated 'dashboards' that provide a compelling picture of performance. The proposed expansion of data, reporting capacity, and improvement resources will enable WhyNotTheBest.org to continue serving as a unique and rich resource for performance improvement in health care delivery.

Jaz-Michael King
Senior Director, eServices and Health Care Transparency
1979 Marcus Avenue, Suite 105
Lake Success, NY 11042
(516) 326-7767
jmking@ipro.us

Issues Research, Inc.

$318,520

Research and Technical Assistance in Support of a High Performance Health System, Year 4

One way in which The Commonwealth Fund seeks to stimulate higher performance throughout the U.S. health system is by educating stakeholders about the nature and scope of current performance deficits, the implications for the health and well-being of Americans, and promising approaches for surmounting these challenges. This requires the continuing development of innovative information resources, something which Doug McCarthy and his firm, Issues Research, Inc., have been providing the Fund over the last three years. Under this proposal, the Issues Research team will continue to provide research and writing services in support of the national health system scorecard, data and issue briefs, case studies of high-performing organizations and health system innovations, WhyNotTheBest.org, and the Quality Matters and States in Action newsletters.

Douglas McCarthy
President
1099 Main Street, Suite 305
Durango, CO 81301
(970) 259-7961
dmccarthy@issuesresearch.com

Pear Tree Communications, Inc.

$165,000

WhyNotTheBest.org: A Web Resource for Quality Improvement, Year 3

Under two previous Board grants, The Commonwealth Fund developed a Web site, WhyNotTheBest.org, to enable health care professionals to compare their organization's performance against a range of benchmarks,

read case studies of high-performers, and download tools they can use to measure and improve their organizations' performance. In 2009, WhyNotTheBest.org underwent further development, with the addition of new data sets, new ways to search and compare hospitals, and a refined user interface. This grant will support plans for hosting and maintaining the site, updating data sets, and making design and development changes as needed.

Martha Hostetter
Partner
3035 Lincoln Boulevard
Cleveland Heights, OH 44118
(216) 262-0717
mh@cmwf.org

INTERNATIONAL PROGRAM IN HEALTH POLICY AND INNOVATION

The Commonwealth Fund
$341,000
International Symposium on Health Care Policy, Fall 2010
The Fund's 13th International Symposium on Health Care Policy will examine the major health care reforms industrialized nations have undertaken to attain higher performance in health care, the strategies that underpin reforms, and the choices made in sequencing them. Of particular interest are the governance structures that facilitate national policy leadership and the infrastructure investments that countries have made to ensure access, achieve benchmark-level quality, improve coordination, and increase efficiency. In bringing together leading policymakers and researchers from 11 nations, the symposium will highlight for U.S. policymakers the approaches that other health systems have employed to ensure high-level performance and sustainability. To reach a Washington policy audience, The Commonwealth Fund and the Alliance for Health Reform will also cosponsor a briefing on Capitol Hill to showcase international reforms relevant to the United States. The journal Health Affairs will consider online publication of papers commissioned for the symposium.

Robin Osborn
Vice President & Director, International Health Policy & Innovation
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$75,000
Commonwealth Fund/Nuffield Trust International Conference on Health Care Quality Improvement, 2010
Since 1999, The Commonwealth Fund and The Nuffield Trust have sponsored annual symposia that have brought together senior government officials, leading health researchers, and practitioners from the United States and the United Kingdom for an exchange of quality improvement policies and strategies. The forums provide a unique

opportunity for senior policymakers in the two countries to forge relationships, a venue to showcase innovations in quality improvement, and a means of facilitating discussion about what works and what does not in the quality arena. The agenda for the 11th conference will reflect the two nations' mutual challenge of improving quality of care while demonstrating "value for money." The strategies to be examined will include: comparative and cost-effectiveness research, health information technology, payment reform, and the redesign of care delivery processes.
Robin Osborn
Vice President & Director, International Health Policy & Innovation
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$1,682,500
Harkness Fellowships in Health Care Policy and Practice, 2011–12
Support for a 14th class of Harkness Fellows in Health Care Policy and Practice will allow the Fund to continue development of promising policy researchers and practitioners from Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Switzerland, and the United Kingdom. Building on the partnership model that has enabled the European expansion of the Harkness Fellowships, sponsorship will be sought for a second Scandinavian fellow, as well as a French Harkness Fellowship, in 2011. The Fund launched a Harkness Alumni Network in 2010 and will organize a policy forum in 2011 that brings together Harkness alumni and policymakers around reform issues relevant to the U.S. In June 2010, the Fund also will publish a 10-year review of the Harkness Fellowships.
Robin Osborn
Vice President & Director, International Health Policy & Innovation
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

Harris Interactive, Inc.
$407,800
International Health Policy Survey, 2010
The 2010 International Health Policy Survey, the 13th in an annual series commissioned by The Commonwealth Fund, will assess public perceptions of health system performance and responsiveness in 11 countries. The survey will ask about access to care, cost, comparative effectiveness, and quality of care received, and the analysis of results will focus on the extent to which variations reflect differences in each nation's system of care delivery and insurance coverage. The findings, to be released at the 2010 International Symposium, should generate substantial interest among health ministers, policymakers, researchers, and the media, and will also inform the work of the Fund's Commission on a High Performance Health System. A paper discussing the survey results will be submitted to Health Affairs.
Roz Pierson, Ph.D.

Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
(301) 502-9018
rpierson@harrisinteractive.com

Johns Hopkins University
$61,000
Cross-National Comparisons of Health Systems Quality Data, 2010
Comparisons of the U.S. health care system with those of other industrialized countries reveal striking differences in spending, the availability and use of services, and health outcomes. This project will produce the 12th paper in an annual series of Commonwealth Fund-supported analyses of key health data for the 30 member-nations of the Organization for Economic Cooperation and Development (OECD). The authors will provide an update of overall trends in the performance of health systems, with an emphasis on measures of efficiency. Findings will be presented at the Fund's October 2010 International Symposium on Health Care Policy and submitted to the journal Health Affairs for publication. In addition, Fund staff will prepare a companion data brief and update the OECD data chartpack that is currently posted on the Fund's Web site—a resource for journalists, policymakers, and researchers.
Gerard F. Anderson, Ph.D.
Professor and Director
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
(410) 955-3241
ganderso@jhsph.edu

London School of Economics and Political Science
$199,650
International Lessons on Health Reform: Learning From the Experiences of European Nations, Year 2
The current drive for health reform presents a unique opportunity to highlight for U.S. policymakers the valuable lessons learned by other industrialized nations in the areas of health system governance, infrastructure investment, innovation, and cost control. Project staff will establish an advisory group of international experts to identify and compare best practices within the diverse health systems of Denmark, England, France, Germany, and the Netherlands and assess lessons from them for the United States. A set of papers commissioned for the project will form the content for the 2010 International Symposium on Health Care Policy; these will later be submitted to Health Affairs. To reach policy leaders in Washington, the Fund and the Alliance for Health Reform will organize a Capitol Hill briefing on the project's findings.
Elias Mossialos, Ph.D.
Director, LSE Health
LSE Health and Social Care, J413

Cowdray House
Houghton Street
London WC2A 2AE
United Kingdom
44 20 7955 7564
e.a.mossialos@lse.ac.uk

Urban Institute
$125,000
Enhancing the International Program's Communications and Publications Capacity, Year 2
To strengthen the impact of the Fund's international program and spark creative health policy thinking in the United States, an external contractor will work with Fund staff to produce a series of issue briefs highlighting innovations in health policy and practice from abroad that might be transferable to the U.S. Given the recent heightened interest in other nations' health systems, these publications will provide a much-needed vehicle for bringing fresh ideas tried in other countries to the attention of U.S. policymakers, journalists, and researchers. The contractor will serve as the series' coeditor, helping to identify salient topics and working with international authors to present information in an accessible format.
Bradford H. Gray, Ph.D.
Senior Fellow
2100 M Street, NW
Washington, DC 20037
(202) 261-5342
bgray@urban.org

Small Grants—International Program in Health Policy and Innovation

University of British Columbia
$49,198
Pharmaceutical Policy: Global Trends, Challenges, and Innovations
Steven G. Morgan, Ph.D.
Associate Professor and Associate Director
Centre for Health Services and Policy Research
201-2206 East Mall
Vancouver, British Columbia V6T 1Z3
Canada
(604) 822 7012
morgan@chspr.ubc.ca

Regents of the University of California
$49,999

A U.S.–U.K. Comparison of Trends in Quality and Disparities in Diabetes Management
Dean Schillinger, M.D.
Professor of Medicine in Residence
San Francisco General Hospital
1001 Potrero Avenue, Ward 13
San Francisco, CA 94110
(415) 206-8940
dschillinger@medsfgh.ucsf.edu

University Hospital of Cologne
$50,000
Patient-Related Outcomes Survey in German Disease Management Programs
Stephanie Stock, M.D., Ph.D.
Health Economist
Institute of Health Economics and Clinical Epidemiology
Gleueler Street 176-178
Cologne 50935
Germany
00 49 221 4679 134
stephanie.stock@uk-koeln.de

Knowledge Networks, Inc.
$8,500
Testing a Panel-Approach to General U.S. Population Surveys
Jordon Peugh
Vice President for Health Care and Policy Research
440 Park Avenue South, 6th Floor
New York, NY 10016
(646) 742-5334
jpeugh@knowlegdenetworks.com

Knowledge Networks, Inc.
$50,000
Assessing the Spread of the Chronic Care Model and Patient-Centered Care: An On-Line Survey of Adults with Chronic Conditions
Jordon Peugh
Vice President for Health Care and Policy Research
440 Park Avenue South, 6th Floor
New York, NY 10016

(646) 742-5334
jpeugh@knowlegdenetworks.com

London School of Economics and Political Science
$49,600
Analysis of Prescription Drug Prices in the United States and Europe
Elias Mossialos, Ph.D.
Director, LSE Health
LSE Health and Social Care, J413
Cowdray House
Houghton Street
London WC2A 2AE
United Kingdom
44-20-7955-7564
e.a.mossialos@lse.ac.uk

National Academy of Sciences
$40,000
Commonwealth Fund/Joseph H. Kanter Family Foundation International Roundtable on Electronic Medical Records and Outcomes Research
J. Michael McGinnis, M.D.
Senior Scholar
500 5th Street NW, Keck 849
Washington, DC 20001
(202) 334-3963
mmcginnis@nas.edu

Scientific Institute for Quality of Healthcare
$21,102
Expansion of 2010 Commonwealth Fund International Health Policy Survey to Include the Netherlands
Richard Grol, Ph.D.
Head of the Center for Quality of Care Research
Raboud University Nijmegen Medical Centre
P.O. Box 9101 114
Nijmegen 6500 HB
The Netherlands
+31 24 361 5302
r.grol@kwazo.umcn.nl

Scientific Institute for Quality of Healthcare

$5,000

Dutch Harkness Fellowships Marketing Event at the Scientific Institute for Quality of Healthcare Annual Conference

Richard Grol, Ph.D.
Head of the Center for Quality of Care Research
Raboud University Nijmegen Medical Centre
P.O. Box 9101 114
Nijmegen 6500 HB
The Netherlands
+31 24 361 5302
r.grol@kwazo.umcn.nl

OTHER CONTINUING PROGRAMS

Fellowship in Minority Health Policy

President and Fellows of Harvard College

$800,000

The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2010–11

Reducing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physicians who can lead efforts to improve minority Americans' access to quality medical services. The Fellowship in Minority Health Policy has played an important role in addressing this need. During the year-long program at Harvard University, physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues. Fellows also participate in special program activities. Since 1996, 67 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, program staff will select a 15th group of at least four fellows, provide current fellows with an enriched course of study and career development, and conduct evaluation activities.

Joan Y. Reede, M.D.
Dean for Diversity and Community Partnership
Minority Faculty Development
164 Longwood Avenue, Room 210
Boston, MA 02115
(617) 432-2413
joan_reede@hms.harvard.edu

Academic Pediatric Association

$160,206

Promoting Delivery of Preventive Services to Children and Families: APA Young Investigator Awards, Phase 2

While preventive services are a critical component of high-quality health care, research into effective preventive services for children is seriously lacking. Over the past two years, the Academic Pediatric Association (APA) has initiated a Young Investigator Awards program to identify and support six promising researchers working in the field of child development and preventive care. The APA will continue this program in 2010 and 2011 by selecting six new young investigators pursuing research projects in preventive health care for children. In addition to financial support, the researchers will receive mentoring, networking opportunities, and a forum to present their findings and receive feedback from peers.

Cynthia S. Minkovitz, M.D.
Associate Professor & Director of the Women's and Children's Health Policy Center
Department of Population, Family and Reproductive Health
Johns Hopkins Bloomberg School of Public Health
615 N. Broadway, E4636
Baltimore, MD 21205
(410) 614-5106
cminkovi@jhsph.edu

COMMUNICATIONS

Burness Communications

$230,000

Enhancing The Commonwealth Fund's Capacity to Reach Change Agents and Inform Public Discourse

The Commonwealth Fund's communications department partners with several firms to disseminate its sponsored research and analysis to the public, to policymakers, and to other health system stakeholders. Most notable among these firms are Burness Communications, a media and public relations company; Velir Studios, a Web site developer; and Datapipe, a global information technology company that provides the Fund's Web hosting services. This authorization will support the Fund's partnerships with these three firms during fiscal year 2009–10.

Bethanne Fox
Senior Associate
7910 Woodmont Avenue, Suite 700
Bethesda, MD 20814
(301) 576-6359
bfox@burnesscommunications.com

Center for Excellence in Health Care Journalism

$200,000

Association of Health Care Journalists Media Fellowships in Health System Performance

As budgets for many news organizations shrink, the number of journalists well schooled in critical areas related to health system performance is on a steep decline. This project seeks to mitigate the problem by supporting excellent journalists in their pursuit of deeper understanding of the U.S. health system and examples of innovation and high

performance. The four fellows selected in each of the program's first two years will produce a package or series of in-depth stories, for publication in various media formats, examining issues related to health system performance.
Len Bruzzese
Executive Director
10 Neff Hall
Columbia, MO 65211
(573) 884-5606
bruzzesel@missouri.edu

DataPipe, Inc.
$75,000
Enhancing The Commonwealth Fund's Capacity to Reach Change Agents and Inform Public Discourse
The Commonwealth Fund's communications department partners with several firms to disseminate its sponsored research and analysis to the public, to policymakers, and to other health system stakeholders. Most notable among these firms are Burness Communications, a media and public relations company; Velir Studios, a Web site developer; and Datapipe, a global information technology company that provides the Fund's Web hosting services. This authorization will support the Fund's partnerships with these three firms during fiscal year 2009–10.
Bill Dolan
Vice President, Sales
10 Exchange Place, Suite 1200
Jersey City, NJ 07302
(201) 792-1918
bdolan@datapipe.com

Velir Studios, Inc.
$110,000
Enhancing The Commonwealth Fund's Capacity to Reach Change Agents and Inform Public Discourse
The Commonwealth Fund's communications department partners with several firms to disseminate its sponsored research and analysis to the public, to policymakers, and to other health system stakeholders. Most notable among these firms are Burness Communications, a media and public relations company; Velir Studios, a Web site developer; and Datapipe, a global information technology company that provides the Fund's Web hosting services. This authorization will support the Fund's partnerships with these three firms during fiscal year 2009–10.
Mark Gregor
President
212 Elm Street, Suite 401
Somerville, MA 02144
(617) 491-6900
mark.gregor@velir.com

Velir Studios, Inc.
$140,250
Creating State and International Data Centers for The Commonwealth Fund Web Site
In an effort to make Commonwealth Fund data more accessible and useful for visitors to the Fund's Web site, the Fund's Communications Department is working with Velir Studios, a Web developer, to create two online "data centers"—one focusing on states and one on industrialized nations. These resources will enable online visitors and researchers to access the Fund's trove of data on health system performance throughout the United States and around the world, and to browse, compile, and download this information for use in their own work. The new data centers are not only likely to increase traffic to commonwealthfund.org, but they will help position the Fund as a leading resource for easily accessible, up-to-date comparative information on health system performance.
Mark Gregor
President
212 Elm Street, Suite 401
Somerville, MA 02144
(617) 491-6900
mark.gregor@velir.com

Small Grants—Communications

Center for Excellence in Health Care Journalism
$30,000
Support for the Association of Health Care Journalists' Annual Conference and Rural Health Journalism Workshop
Len Bruzzese
Executive Director
10 Neff Hall
Columbia, MO 65211
(573) 884-5606
bruzzesel@missouri.edu

Trustees of Columbia University in the City of New York
$28,000
2010 Educational Health Care Insert in Columbia Journalism Review
Louisa Kearney
Advertising Director
2950 Broadway
New York, NY 10027
(212) 883-2828
ldkpub@aol.com

National Business Coalition on Health

$49,257

"Purchasing High Performance" Newsletter

Andrew Webber

President and CEO

1015 18th Street NW, Suite 730

Washington, DC 20036

(202) 775-9300

awebber@nbch.org

Rocky Mountain Public Broadcasting Network, Inc.

$50,000

"Small Town, Big Surprise," A One-Hour News Documentary Film

Lisa Hartman

Producer, Photopia Productions

2233 South Jackson Street

Denver, CO 80210

(303) 639-5722

lisa@photopiaproductions.com

Society of American Business Editors and Writers, Inc.

$15,000

The Society of American Business Editors and Writers' 2010 Annual Conference & Web-Based Trainings for Journalists

Warren Watson

Executive Director

555 North Central Avenue, Suite 416

Phoenix, AZ 85004

(602) 496-5186

watson@sabew.org

Other—Organizations Working with Foundations and Institutional Support

AcademyHealth
$158,119
Rent and Services for the Fund's Washington, DC Office
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

AcademyHealth
$15,000
General Support
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

The Center for Effective Philanthropy
$5,000
General Support
Phil Buchanan
Executive Director
675 Massachusetts Avenue, 7th Floor
Cambridge, MA 02139
(617) 492-0800
philb@effectivephilanthropy.org

Citizens Budget Commission, Inc.
$2,000
Citizens Budget Commission 2010 Annual Dinner
Carol B. Kellermann
President
One Penn Plaza, Suite 640
New York, NY 10119
(212) 279-2605
ckellermann@cbcny.org

The Commonwealth Fund
$30,000
Grantee, Audience, Staff, and Board Surveys to Support The Commonwealth Fund Performance Scorecard
Andrea C. Landes
Assistant Vice President & Director of Grants Management
1 East 75th Street
New York, NY 10021
(212) 606-3844
acl@cmwf.org

The Communications Network
$3,500
General Support
Bruce S. Tratchenberg
Executive Director
1755 Park Street, Suite 260
Naperville, IL 60563
(630) 364-1575
bruce@comnetwork.org

Joan and Sanford I. Weill Medical College of Cornell University
$5,000
2009 David Rogers Health Policy Colloquium
Oliver T. Fein, M.D.
Professor of Clinical Public Health
505 East 70th Street
Helmsley Tower, 4th Floor
New York, NY 10021
(212) 746-9663
ofein@med.cornell.edu

Foundation Center
$15,000
General Support
Bradford K. Smith
President
79 Fifth Avenue
New York, NY 10003
(212) 620-4230
bks@fdncenter.org

Grantmakers in Aging, Inc.
$6,500
General Support
Carol A. Farquhar
Executive Director
7333 Paragon Road, Suite 220
Dayton, OH 45459
(937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health
$15,000
General Support
Lauren J. LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue NW, Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Grantmakers In Health
$5,000
The Grantmakers In Health Fall Forum on Women's Health
Lauren J. LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue NW, Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Grants Managers Network, Inc.
$2,000
General Support
Michelle L. Greanias
Executive Director
1101 14th Street NW, Suite 420
Washington, DC 20005
(202) 329-7670
mgreanias@gmnetwork.org

Health Services Research Association of Australia & New Zealand
$1,500
General Support
Jackie Cumming, Ph.D.
President
PO Box 123
Sydney, NSW 2007
Australia
+61 02 9514 4723
jackie.cumming@vuw.ac.nz

Independent Sector
$12,500
General Support
Diana Aviv
President and Chief Executive Officer
1602 L Street NW, Suite 900
Washington, DC 20036
(202) 467-6100
diana@independentsector.org

International Society for Quality in Health Care, Inc.
$1,000
General Support
Roisin Boland
Chief Executive Officer
2 Parnell Square East
Dublin 1
Ireland
+353 1 871 7049
rboland@isqua.org

Medicare Rights Center, Inc.
$5,000
Medicare Rights Center 20th Anniversary Gala
Joseph Baker
President
520 Eighth Avenue, North Wing, 3rd Floor
New York, NY 10018
(212) 869-3850
info@medicarerights.org

National Committee for Quality Assurance
$5,000
NCQA's Health Quality Awards 2010
Margaret E. O'Kane
President
1100 13th Street NW, Suite 1000
Washington, DC 20005
(202) 955-3500
okane@ncqa.org

New York Academy of Medicine
$6,000
New York Academy of Medicine 2010 Gala
Jo Ivey Boufford, M.D.
President
1216 Fifth Avenue
New York, NY 10029
(212) 822-7201
jboufford@nyam.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Michael E. Clark
President
1350 Broadway, Suite 1801
New York, NY 10018
(212) 502-4191
mclark@npccny.org

Nonprofit Coordinating Committee of New York
$25,000
Nonprofit Coordinating Committee of New York's 25th Anniversary Awards Dinner
Michael E. Clark
President
1350 Broadway, Suite 1801
New York, NY 10018
(212) 502-4191
mclark@npccny.org

Philanthropy New York
$15,100
General Support
Ronna D. Brown
President
79 Fifth Avenue, Fourth Floor
New York, NY 10003
(212) 714-0699
rbrown@philanthropynewyork.org

Primary Care Development Corporation
$6,000
Primary Care Development Corporation 2010 Spring Gala
Ronda Kotelchuck
Executive Director
22 Cortlandt Street, 12th Floor
New York, NY 10007
(212) 437-3917
rkotelchuck@pcdcny.org

Rockefeller Archive Center
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Year 14
This grant will support the transfer, processing, and storage of additional Commonwealth Fund materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985. Under new leadership, the Center is moving ahead to ensure state-of-the-art archiving, including ultimately, electronic storage. It continues to be an important research center on the history of philanthropy.
Lee R. Hiltzik, Ph.D.
Assistant Director and Head of Donor Relations and Collection Development
15 Dayton Avenue
Sleepy Hollow, NY 10591
(914) 366-6345
lhiltzik@rockarch.org

United Hospital Fund of New York
$8,500
2009 United Hospital Fund Gala
James R. Tallon, Jr.
President
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
jtallon@uhfnyc.org

SUMMATION OF PROGRAM AUTHORIZATIONS

Year ended June 30, 2010	Major Program Grants	Small Grants Fund Grants	Total Authorizations
Program Grants Approved			
Delivery System Innovation and Improvement	$9,289,201	$527,632	$9,816,833
Health System Quality and Efficiency (See Note 1)	$3,156,430	$239,859	$3,396,289
Patient-Centered Coordianted Care	$4,423,954	$37,000	$4,460,954
Picker/Commonwealth Long-Term Care Quality Improvement Program (See Notes 2 and 3)	$1,708,817	$250,773	$1,959,590
Health Reform Policy	$5,119,081	$845,960	$5,965,041
Affordable Health Insurance	$1,236,740	$128,352	$1,365,092
Payment and System Reform	$1,092,781	$218,712	$1,311,493
Federal Health Policy	$1,260,545	$97,020	$1,357,565
State Health Policy and Practices	$1,529,015	$401,876	$1,930,891
Health System Peformance Assessment and Tracking	$1,888,271		$1,888,271
International Program in Health Policy and Innovation	$2,891,950	$323,399	$3,215,349
Other Continuing Programs	$960,206		$960,206
Communications	$755,250	$172,257	$927,507
Other -- Organizations Working with Foundations and Institutional Support	$375,219	$174,000	$549,219
Total Program Grants Approved	$21,279,178	$2,043,248	$23,322,426
Grants Matching Gifts by Directors and Staff			$467,367
Program Authorizations Cancelled or Refunded and Royalties Received			($736,071)
Total Program Authorizations			$23,053,722

NOTES: (1) Frances Cooke Macgregor Award of $349,996 in 2009-10.

(2) Picker Program Grants totalled $1,959,590 in 2009-10.

(3) Health Services Improvement Award of $414,107 in 2009-10.

1 East 75th Street
New York, NY 10021
Tel: 212.606.3800

THE COMMONWEALTH FUND

1150 17th Street NW
Suite 600
Washington, DC 20036
Tel: 202.292.6700