



The Commonwealth Fund 2009 ANNUAL REPORT

The Commonwealth Fund is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on 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.

The Commonwealth Fund 2009 Annual Report



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 2009 Annual Report offers highlights of the Fund's activities in the past year.

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Building a Foundation for Health Reform



President's Message
2009 Annual Report

Karen Davis
President

Preface

BUILDING A FOUNDATION FOR HEALTH REFORM

KAREN DAVIS, PRESIDENT
THE COMMONWEALTH FUND



The Commonwealth Fund marshaled its resources this year to produce timely and rigorous work that helped lay the groundwork for the historic Affordable Care Act, signed by President Obama in March 2010.

Anna Harkness founded The Commonwealth Fund in 1918 with the mandate to “do something for the welfare of mankind.” To that end, The Commonwealth Fund and its Commission on a High Performance Health System have become leading voices for reforming the U.S. health care system—to achieve insurance coverage for all, at reasonable cost, and to ensure that services are coordinated, patient-centered, and efficiently delivered. Long before health reform became a staple of national headlines, the Fund was working to provide much-needed data on the impact of spiraling health care costs on middle-class families, businesses, and government and proposing options for “bending the cost curve.” We also provided information on how the U.S. health system compares internationally—further evidence to build a compelling case for reform.

The Commission’s *2008 National Scorecard on U.S. Health System Performance*—the second one it has issued—showed that the nation was losing ground in health care. In nearly every category measured, the new scorecard found that the health system performed worse than it did in 2006—largely because of worsening access to care. Similarly,

Fund surveys comparing the U.S. to other industrialized nations repeatedly found that the U.S. falls far short of its peers in access, safety, and efficiency. And a highly publicized Fund-supported study released in 2008 found that the U.S. had dropped to last place, among 19 countries, on “mortality amenable to health care”—a measure of how well a health system prevents potentially avoidable deaths by ensuring that people receive timely, appropriate care for treatable conditions.

Commonwealth Fund professional staff, Commission members, and grantees also spent this critical period developing strategies to extend health insurance to all, improve care delivery, and reduce health care costs for government, employers, and individuals—approaches that ultimately helped shape the health reform legislation. As a result, we were in an ideal position to evaluate the reform proposals of the 2008 presidential candidates—and outline reform options for President Obama before he took office—drawing on such reports as *An Ambitious Agenda for the Next President* and *The 2008 Presidential Candidates’ Health Reform Proposals: Choices for America*.

Working toward solutions, the Fund also launched two multiyear quality improvement initiatives—one to develop patient-centered medical homes that redesign care to ensure 24/7 access to high-quality, coordinated primary care, and one to

reduce avoidable hospital readmissions—that have already helped turn these issues into national delivery system change movements. [The Safety Net Medical Home Initiative](#) aims to develop a replicable and sustainable implementation model for medical home transformation for health centers serving low-income populations. [The State Action on Avoidable Rehospitalizations](#) (STAAR) initiative, meanwhile, is a multipronged effort administered by the Institute for Healthcare Improvement to help hospitals improve their processes for transitioning discharged patients to other care settings. We also created [WhyNottheBest.org](#), a Web site that enables users to compare the performance of U.S. hospitals and other health care providers, and offers case studies and profiles of high-performing health care providers and best practices.

The following essays, published on the Commonwealth Fund’s Web site over a one-year period, each addressed one of the five strategies for a high performance health system laid out in the Commission’s report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, released in February 2009. Those strategies for comprehensive reform are:

- Affordable coverage for all.
- Align incentives with value and effective cost control.
- Accountable, accessible, patient-centered, and coordinated care.
- Aim high to improve quality, health outcomes, and efficiency.
- Accountable leadership and collaboration to set and achieve national goals.

The essay, “Insurance in Name Only,” discussed the need to improve coverage for the 25 million

Americans that Commonwealth Fund research has identified as being underinsured—meaning they have health coverage but still have medical expenses they cannot afford.

“Ensuring Accountability” reviewed an approach to realigning incentives for hospitals. Global fees, which cover a bundle of services for hospitalization and 30-day post-hospital care, can improve care, reduce complications, and generate savings. Another look at improving value, “Bending the Health Care Cost Curve: Lessons from the Past,” reviewed the history of failed voluntary industry efforts to contain health care costs, and showed why policymakers need to set health reform expenditure targets.

Other essays focused on the need to organize the delivery system so that providers can better offer patient-centered, coordinated care. “Delivering Change Through Health System Organization” discussed the six attributes of an ideal health care delivery system that have been identified by the Fund’s Commission and offered payment reform and other policy recommendations that would help the nation achieve it. “Can Patient-Centered Medical Homes Transform Health Care Delivery?” discussed how the medical home model can strengthen primary care. “Cooperative Health Care: The Way Forward?,” a timely response to a proposal floated in the Senate at a crucial moment in the health reform debate, highlighted the challenges cooperatives would face in the health care market and the need for a national authority that would provide support and set payment rates. Accompanying that essay were case studies of the two major health care cooperatives in the U.S.: Group Health Cooperative of Puget Sound, in Seattle, and HealthPartners, in Minnesota.

Evidence of poor health system performance, drawn from Fund-supported research, that underscored the need for reform was examined in “Headed

in the Wrong Direction: The 2008 National Scorecard on U.S. Health System Performance” and “Reducing Preventable Deaths Through Improved Health System Performance.”

“Health Information Technology: Key Lever in Health System Transformation” encouraged national policymakers to invest in health IT, as well as create standards and financial incentives to ensure providers will adopt and use health IT effectively.

“The Presidential Candidates’ Health Reform Plans: Important Choices for the Nation,” and “Health Reform in the New Era: Options for the Obama Administration” analyzed the health reform options before the country, while “Compassionate and Challenging Changes in Health Care” explained how reform would benefit patients and families, as

well as all stakeholders. Together, these essays provide a picture of the major health care issues of the year and the many ways that Fund research and analysis were used to support the nation’s drive toward comprehensive health reform.

For more than 90 years, The Commonwealth Fund’s role in health care has been to help establish a base of scientific evidence and work toward social progress by mobilizing talented people to transform health care organizations, collaborating with organizations that share its concerns, and practicing strategic communications to reach those in a position to effect change, particularly for society’s most vulnerable. We look forward to continuing our efforts to improve the health care system and the health and lives of all Americans.

A handwritten signature in black ink, reading "Karen Davis". The signature is written in a cursive, flowing style.

December 18, 2008

The Commonwealth Fund at 90

By Karen Davis

The 90th anniversary of the Commonwealth Fund serves as an occasion to reflect on the foundation's remarkable history and its role in supporting research and innovative practices that have driven improvements in the U.S. health care system for nearly a century. Anna Harkness founded the Commonwealth Fund in 1918 with the mandate to "do something for the welfare of mankind." Her son, Edward Stephen Harkness, was the Fund's first president, and he shared his mother's commitment to building a responsive and socially concerned philanthropy. The Fund's work has always focused on the challenges vulnerable populations face in receiving high-quality, safe, compassionate, coordinated, and efficiently delivered care.

Today, the foundation—along with the Commission on a High Performance Health System, which was established by the Fund in 2005—is a leading voice for reforming the U.S. health care system to achieve coverage for all, at reasonable cost, and with services that are coordinated, patient-centered, and efficiently delivered. Since its inception, the Fund has sought to bring the international experience to bear in efforts to achieve better value for the U.S. health care dollar. The foundation combines grantmaking with intramural research and communications to help inform the health care debate and improve the performance of health care delivery.

Advancing Public Health

In its early years, public health became a major focus of the foundation's philanthropy. In the 1920s, the new field of child guidance was developed and informed by the Commonwealth Fund to provide mental health services for children. The Fund supported the first fellowships in child psychiatry and established children's community clinics. Model public health clinics established by the Fund not only set standards for public health departments across the United States, but also spurred initiatives to reduce maternal and infant mortality.

In the 1930s, the rural hospital program helped to improve services in remote areas, paving the way for the passage of the Hospital Survey and Construction (Hill-Burton) Act of 1946 that brought federal funds to build and improve community hospitals. A 1933 Commonwealth Fund publication, *A Standard Classified Nomenclature of Disease*, brought a common terminology to medicine, allowing hospitals to more easily compile statistics and exchange information about the prevention and treatment of disease.

The Fund also advanced medical research in significant ways. Dr. George Papanicolaou's Fund-supported research in the 1940s led to the highly effective technique for detecting cervical cancer that became known as the Pap test. In the next decade, Fund support for research that refined cardiac catheterization as a diagnostic treatment for pulmonary heart disease resulted in the 1956 Nobel Prize for the physicians.

The Fund has similarly supported medical education over the years. The foundation was an early advocate of minority medical education through scholarships and grants, as well as funding for minority medical schools. In the 1960s, the

Fund supported the first training programs for physician assistants, nurse practitioners, and nurse midwives—establishing health professions that play a critical role in health care today.

In the 1970s, the Fund fostered the hospice care movement, pioneering sensitive care and support for the dying and their families through its support of the first modern hospice program, Hospice, Inc., in Connecticut. In the 1980s, it supported advanced nurse training, including business administration, to prepare nurses for positions of leadership responsibility.

Moving Toward a High Performance Health System

More recently, the Commonwealth Fund has developed pragmatic strategies for expanding health insurance to all. These approaches are designed to build on parts of our current system that work well—Medicare, the State Children’s Health Insurance Program, employer-based coverage, and the more recently established Massachusetts health insurance connector, which enables residents to purchase a affordable private or public coverage. Ideas proposed in Fund staff-authored *Health Affairs* articles, such as “Creating Consensus on Coverage Choices” and “Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance,” have been embraced and advanced by state and national policy leaders, including president-elect Barack Obama. Such publications spell out specific changes needed to improve health system performance and bring about universal coverage.

Through its surveys and analyses, the foundation and its Program on the Future of Health Insurance have led the field in defining gaps in insurance coverage and the concept of underinsurance. The Fund has also emerged as an evidence-based voice for preserving the role of employer-sponsored health insurance.

The Fund’s Program on Medicare’s Future provided original analysis and research that eventually helped inform the Medicare Part D prescription drug benefit. More recent Fund-supported Medicare research has looked at ways to protect access to care for vulnerable beneficiaries and

focused on the overpayment of Medicare Advantage plans and their record of performance.

The Commonwealth Fund’s Program on Health Care Quality Improvement and Efficiency has helped to promote the development and adoption of health care quality and efficiency measures and enhance the capacity of health care organizations to provide better care more efficiently.

The program has been a leading force in payment reform, supporting the development, testing, and evaluation of new payment approaches that align financial incentives of hospitals and physicians with quality and efficiency.

The Picker/Commonwealth Patient-Centered Care Program of the 1990s succeeded in making the patient experience a focus of medical care through the development of hospital patient surveys. Today, the Picker/Commonwealth Fund Program on Quality of Care for Frail Elders aims to transform the nation’s nursing homes and other long-term care facilities into resident-centered organizations that are good places to live and work and are capable of providing the highest-quality care.

The Patient-Centered Primary Care Program was launched in 2005 to encourage the redesign of primary care practices and health care systems around the needs of the patient. It is now supporting a number of evaluations of the medical home model.

The Fund’s Child Development and Preventive Care program has successfully supported states in improving the delivery of early child development services and building the capacity of Medicaid programs to deliver care that supports healthy mental development. As a result of the Fund’s work over the last decade, screening and referrals for developmental problems are now standard features of modern pediatric practice.

The Fund’s new state scorecard on health system performance and the State Quality Leadership Institute have helped trigger state policy officials’ interest in policy actions to improve quality and enhance value. Fund-sponsored evaluations of health reform in Massachusetts and Maine are now informing the national debate.

Commonwealth Fund-supported work has improved data collection and reporting on health disparities. It has also helped define and develop standards for cultural

competence. Today, the Program on Health Care Disparities aims to improve the performance of minority serving safety-net hospitals and ambulatory care providers. In addition, the Commonwealth/Harvard Minority Health Policy Fellowships, with 80 graduates, is producing a cadre of future leaders committed to addressing disparities in health care.

On the international level, the Fund's comparative data on health system performance has stimulated high-level thinking about methods to improve policies and practices in the U.S. and other industrialized countries. And the Harkness Fellowship in Health Policy has more than 100 international alumni who continue to serve as forces for health system change in their home countries.

Finally, through its Commission on a High Performance Health System, the Fund is supporting strategies for making the U.S. health system the best it can be, learning from best practices and outstanding performance within the U.S. and around the world. Its national and state scorecards are spurring improvements in health care providers and policy.

In this time of crisis and change, the Commonwealth Fund plans to continue its great tradition of service by supporting research and finding solutions that will move the U.S. ever closer to a high performance health system.

Insurance in Name Only

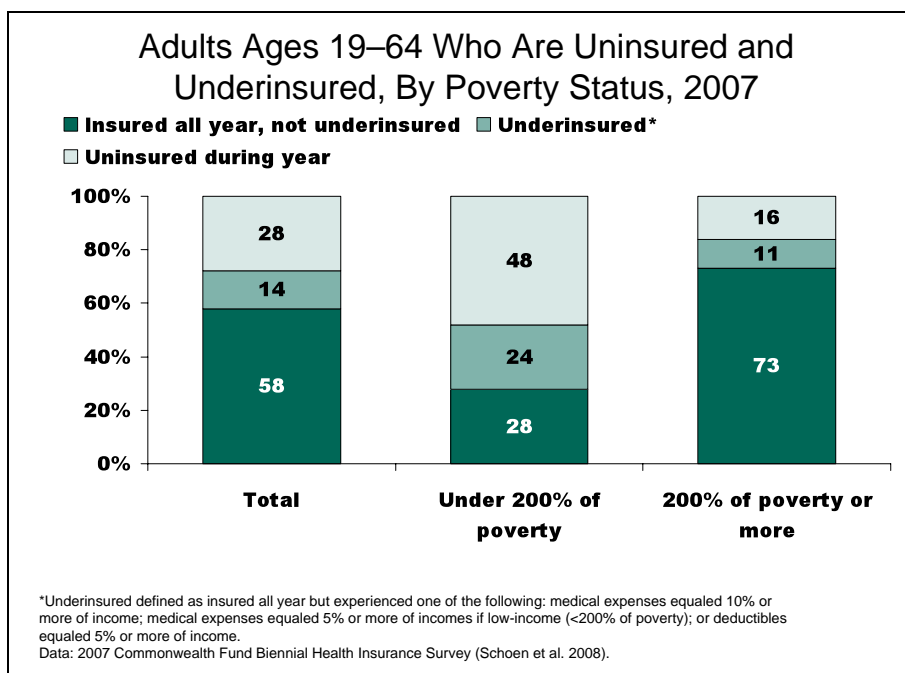
By Karen Davis

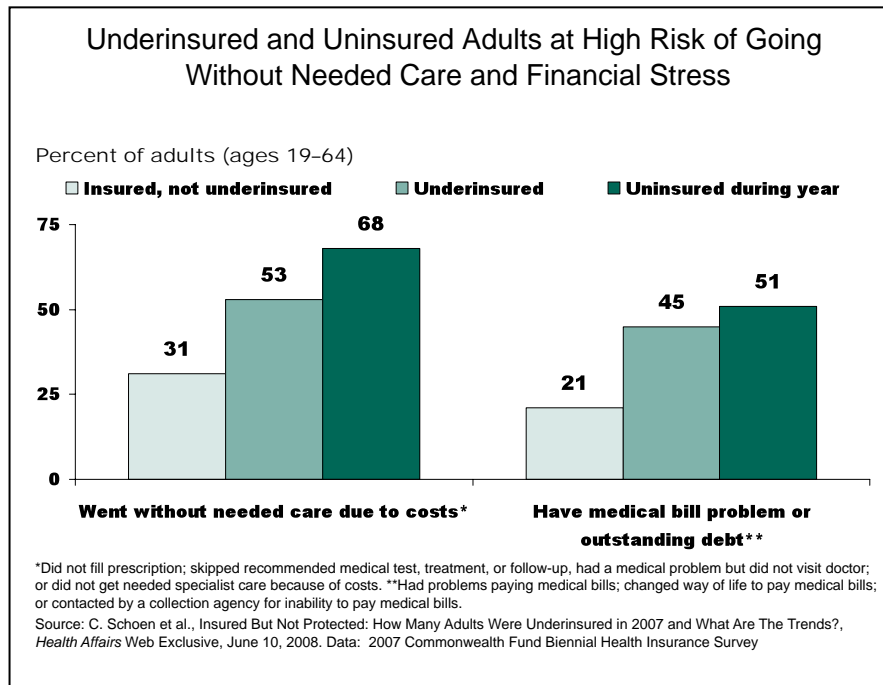
The purposes of health insurance are to ensure financial access to needed care and protect against financial hardship from medical bills. Unfortunately, for many of those with health insurance, neither purpose is fulfilled. A [Commonwealth Fund study](#) published earlier this month in *Health Affairs* showed that 25 million Americans are underinsured, meaning they have health coverage but still have medical expenses they cannot afford. The number of underinsured has risen by 60 percent since 2003. When added to those who are uninsured at some point during the year, 42 percent of all adults—and 72 percent of those with incomes below twice the poverty level—are inadequately or unstably insured.

Unaffordable Care

According to the study, people who don't have adequate coverage have many of the same experiences as the uninsured. More than half of the underinsured (53%) and two-thirds of the uninsured (68%) went without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment. Only 31 percent of insured adults went without such care. Forty-five percent of the underinsured had a medical bill problem or medical debt, compared with 51 percent of the uninsured and 21 percent of the insured.

The problem has quickly worked its way up the income ladder. Since 2003, rates of underinsurance have tripled among middle-income Americans, or families making more than \$40,000 per year.





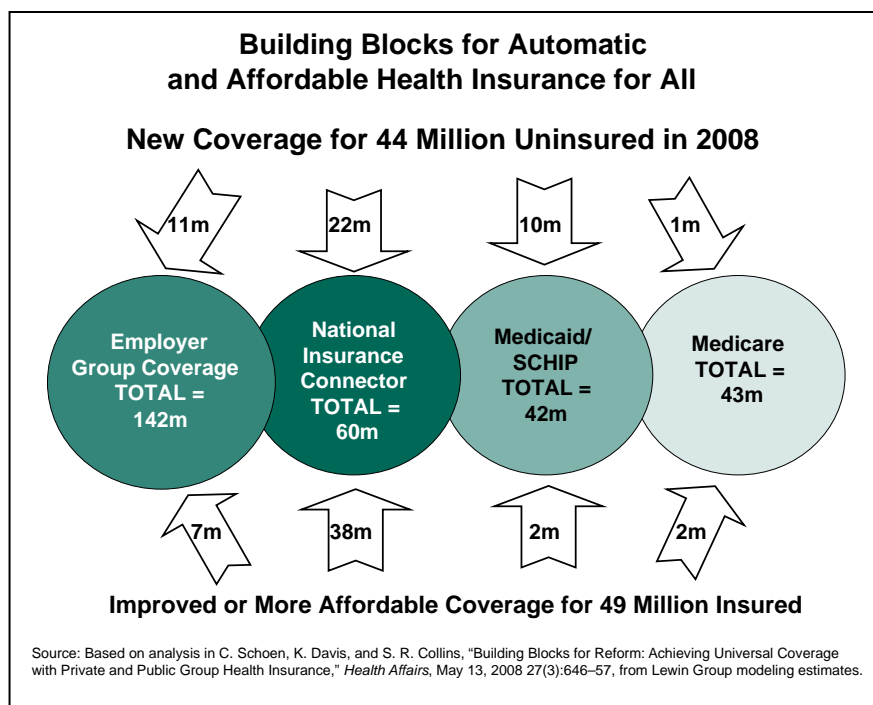
The study authors, the Commonwealth Fund’s Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty, conclude that a variety of factors related to insurance design are responsible for this growth. Health insurance premiums have risen at a much faster rate than wages. And because of rising costs, employers are often selecting plans for their employees with benefit limits, such as a set number of physician visits or restrictions on the total amount a plan will pay for medical care. Plans available through the individual insurance market are even more likely to have such restrictions. The underinsured also were far more likely to report having high deductibles: one-quarter had annual per-person deductibles of \$1,000 or more.

Well-Designed, Universal Coverage

The growing number of people with inadequate health insurance underscores the need for universal coverage that has comprehensive benefits. Such a system is feasible as spelled out in a “[Building Blocks](#)” framework described in another recent *Health Affairs* article, which I coauthored with Fund colleagues Cathy Schoen and Sara Collins. This framework sets forth a shared private–public solution that would benefit both the uninsured and the underinsured.

Under the *Building Blocks* framework, small businesses, the uninsured, and the self-employed could find coverage through a new national insurance connector that would offer a choice between a Medicare-like option with enhanced benefits, called Medicare Extra, and private plans. The premiums for Medicare Extra would be community-rated for everyone under age 60, estimated at \$259 per month for single premiums and \$702 per month for families in 2008.

These premiums would be 30 percent lower than those generally charged for employer-sponsored plans because of Medicare’s lower administrative costs and provider payment rates.



Other components of *Building Blocks* include: requiring that all individuals obtain health insurance, with automatic enrollment through the personal income tax system; a pay-or-play requirement for employers, who must cover their workers or contribute 7 percent of earnings up to \$1.25 per hour; and expansion of Medicaid and the State Children's Health Insurance Program (SCHIP) to cover all low-income adults and children below 150 percent of the federal poverty level. The plan also involves scaled tax credits to offset premiums that exceed 5 or 10 percent of one's income as well as several Medicare reforms, such as the elimination of the two-year waiting period for people with disabilities and the option for adults over age 60 to buy in to Medicare.

The plan would achieve near-universal coverage, with 99 percent of the population participating. Forty-four million uninsured people would find affordable coverage—from employers, the national insurance connector, Medicaid/

SCHIP, or Medicare. By building on the experience of Medicare and offering a Medicare Extra option to individuals and small firms, our plan would benefit the underinsured as well as those who are now paying much higher premiums. An estimated 49 million people would change coverage—finding lower premiums or better benefits through the insurance connector or public programs. By offering more choices, including the option of enrolling in public programs, all Americans would have the financial security that insurance is intended to provide.

We cannot accept a health care system in which 42 percent of Americans under age 65 are uninsured or underinsured. We must pursue a workable solution that mixes private and public coverage well before the majority of Americans find themselves with no coverage or coverage that has been chipped away until it no longer serves its purpose.

April 29, 2009

Ensuring Accountability: How a Global Fee Could Improve Hospital Care and Generate Savings

By Karen Davis and Kristof Stremikis

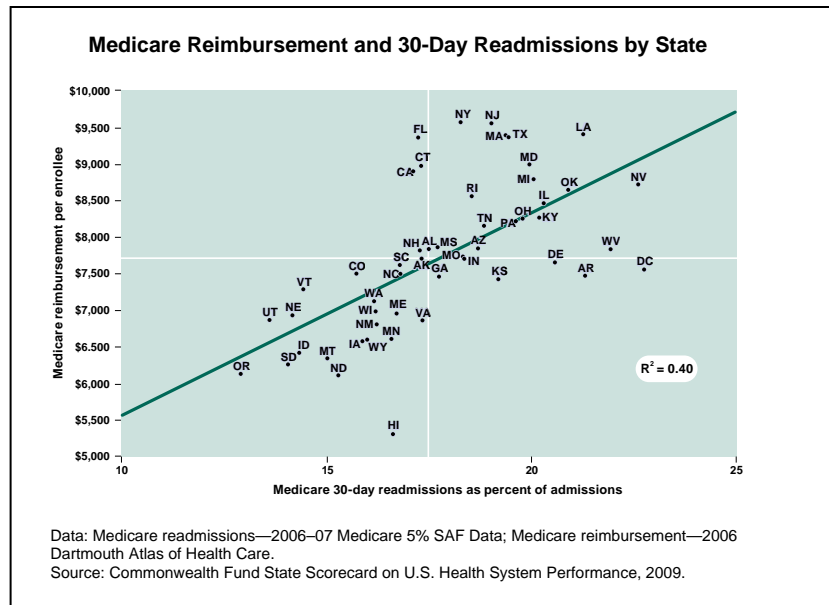
As U.S. federal policymakers embark on the much-needed expansion of our system of health insurance coverage, it is important to also examine how we organize and deliver health services. Looking closely at delivery will ensure both the best possible health outcomes for Americans and the most value for what we spend on health care.

Today, U.S. health care delivery is disorganized and rife with examples of missed opportunities and waste. The high rate at which patients are readmitted to the hospital within 30 days of discharge is particularly alarming. Working within a payment system that doesn't encourage quality or efficiency, hospitals and post-acute providers often fail to properly coordinate services throughout the course of a patient's treatment and follow-up. This practice leads to hospital readmissions that are not only wasteful and costly but also potentially dangerous. To break this cycle, the U.S. needs to realign health care providers' financial incentives. Offering a "global fee" that covers a bundle of "best-practice" services for hospitalization and 30-day post-hospital care has great potential to improve care, reduce complications, and generate savings to finance health reform.

Evidence of Avoidable Complications and Costly Care

Hospital readmissions are a key indicator of overall health care quality. Commonwealth Fund-supported work has repeatedly demonstrated the troubling prevalence and costs of hospital readmissions in Medicare, as well as the wide variation in rates. A recent examination of fee-for-service claims data by Stephen Jencks, M.D., M.P.H., and colleagues found that one of five people with Medicare who was discharged from a hospital in 2003 and 2004 was readmitted within 30 days (Exhibit 1). While there is no doubt that some of these readmissions were unavoidable, it is likely that many could have been prevented with appropriate discharge planning, follow-up treatment, and post-acute care. In Dr. Jencks' study, half of the people who were hospitalized for reasons other than surgery were re-hospitalized without having seen an outpatient doctor for follow-up.

In its most recent national scorecard, the Commonwealth Fund Commission on a High Performance Health System found that the average 30-day hospital readmission rate for Medicare beneficiaries remained constant between 2003 and 2005, suggesting that we have not made needed improvements in post-acute care coordination and efficiency.



Realigning Incentives to Reward Efficiency and Increase Value

Recent proposals in President Obama’s budget blueprint, the Commonwealth Fund Commission’s *“Path”* report, and Senator Max Baucus’ white paper on health reform would realign financial incentives to encourage greater coordination by bundling hospital payments for inpatient care, as well as post-acute health services for a predetermined number of days following hospitalization. Under the [President’s proposal](#), bundled payments are combined with reduced reimbursements for hospitals with high rates of 30-day readmission. The Administration expects this combination of incentives and penalties to save \$8 billion through reduced readmissions and \$18 billion through increased efficiency in post-acute care, totaling \$26 billion in savings over the 10-year, 2010-2019 period.

The Commonwealth Fund Commission also recommends applying new payment methods to acute-care episodes to encourage hospitals and other providers to collaborate in developing the capacity to provide high-quality and efficient care for their patients. Offering a bundled acute-care payment (a global fee covering hospitalization and a specified set of services for 30 days following discharge) would give hospitals and other providers an opportunity to share the savings from their efforts to reduce complications of treatment and lower numbers of readmissions and would

allow them more flexibility in allocating their resources. Over time, spending would slow as efficiency savings were shared between Medicare and providers. The Lewin Group estimated that within the context of comprehensive insurance expansion and other system-wide reforms, the bundled payment approach proposed by the Commission would reduce national health expenditures by \$301 billion and save the federal government \$211 billion over the 11-year, 2010–2020 period.

Senator Baucus’ *“Call to Action”* on health reform includes a proposal for reducing hospital readmissions that utilizes global-care case rates and a phased strategy similar to the bundled payment approach outlined in the Medicare Payment Advisory Commission’s June 2008 Report to Congress. Both the Senator and MedPAC call for initially disclosing readmission rates and resource use only to hospitals and physicians, allowing providers to understand spending levels and improve performance before releasing such data to the public. The Senator further recommends reducing reimbursement to hospitals with high rates of readmission for a small number of conditions before expanding the program to include a full range of services. Finally, the proposal includes support for additional testing and implementation of bundled payment policies among participants in the Centers for Medicare and Medicaid Services Acute Care Episode demonstration.

Promising Interventions Already Underway

Evidence suggests that health care providers can follow a number of proven strategies to reduce hospital readmissions and increase efficiency. With support from the Commonwealth Fund, the Institute for Healthcare Improvement (IHI) recently completed a survey of the published evidence on effective interventions to reduce rehospitalizations and a compendium of 15 promising initiatives already underway. In their review of the literature, IHI identifies four common themes among successful interventions: 1) enhanced care and support during transitions; 2) improved patient education and self-management support; 3) multidisciplinary team management; and 4) patient-centered care planning at the end of life.

The IHI compendium includes four interventions with very strong clinical trial or program evaluation evidence, seven with very good evidence, and four that have potential but require additional data. For the interventions bolstered by very strong evidence, patient education, post-discharge care planning, and provider coordination were among the factors that contributed to reduced rates of rehospitalization. Initiating reminder calls for preventive care, empowering nurse practitioners to work as care managers, and utilizing multidisciplinary clinical teams were all effective components of programs with very good evidence of reducing hospital readmissions.

Through its health plan, Geisinger Health System, on whose board of directors I serve, has pioneered **testing payment** of a global fee for a basket of best-practice services for various surgical procedures and obstetrical care. Beginning in 2006, Geisinger used American Heart Association and American College of Cardiology guidelines for coronary artery bypass graft surgery (CABG) to develop and implement 40 verifiable best-practice steps in performing this procedure. It increased the proportion of patients receiving all 40 best-practice steps from 59 percent to 86 percent within three months, and then reached and maintained 100 percent performance, with few exceptions. Its Geisinger Health Plan offered a global fee “with a warranty” covering pre-operative, operative, post-operative, and rehabilitative services for 90 days post-discharge. Complications declined by 21 percent, readmissions declined by 44 percent, and the average length of stay declined by half a day. In short, this change in delivery and payment was a win-win: it improved

patient outcomes and reduced cost. Geisinger has subsequently extended this strategy to other areas, including hip replacement, cataract surgery, obesity surgery, and prenatal care and delivery of newborns.

A Win-Win

Offering a global fee for a package of best-practice services covering hospitalization and care for 30 days following discharge will reduce our overall hospital readmission rate, as well as the hospital and geographic variation in readmissions and post-acute-care spending. By realigning financial incentives to reward quality and efficiency, policymakers can eliminate the barriers to coordination among hospitals and post-acute providers built by the current fee-for-service payment system. Instead, providers will be encouraged to collaborate and rewarded for providing a continuum of care throughout the entire course of a patient’s treatment and follow-up.

This is indeed a win-win strategy. The current health reform debate calls for bold hospital payment reform to enable hospitals, physicians, and post-acute care providers to achieve the best possible outcomes for patients, hold providers accountable for improving care and realizing the potential savings, and reward providers for doing so. Medicare should quickly replace its current hospital payment system with a global fee including post-discharge care.

New health insurance plans developed as part of health reform to cover the uninsured should similarly be encouraged to adopt innovative payment methods. Hospitals should be permitted to keep a share of the savings as a reward for better care, but the net savings to the federal government should be dedicated to covering the uninsured. Such savings could increase the \$634 billion health reform reserve fund already proposed by the President over the 10-year period from 2010–2019 by more than \$100 billion.

These resources will help ensure that all Americans have a affordable health insurance coverage. Lower premiums would also ease financial burdens on employers by \$75 billion over 2010–2020. And premium savings for workers will provide financial relief in these difficult economic times. It is time to transform our current system of payment and delivery of health care into a system that not only provides better quality care but also bends the health-care cost curve.

May 26, 2009

Bending the Health Care Cost Curve: Lessons from the Past

By Karen Davis

In a May 11 letter to President Obama, the leaders of six health care organizations—the Advanced Medical Technology Association, the American Medical Association, America’s Health Insurance Plans, Pharmaceutical Research and Manufacturers of America, American Hospital Association, and Service Employees International Union—expressed their support for health reform, writing: “We will do our part to achieve your Administration’s goal of decreasing by 1.5 percentage points the annual health care spending growth rate—saving \$2 trillion or more.”

The organizations went on to say that they are developing consensus proposals on administrative simplification, standardization, and transparency; reducing overuse and underuse; encouraging coordinated care and adherence to evidence-based best practices and therapies; improvements in care delivery models, health information technology, workforce deployment and development; and regulatory reforms. The organizations also indicated that they support health promotion and disease prevention, including obesity prevention.

In response, a White House Fact Sheet stated that health care industry leaders “are proposing to take aggressive steps to cut health care costs that, if done in the context of comprehensive health reform, will reduce the annual health care spending growth rate by 1.5 percentage points for the next 10 years.” By the end of the week, the industry coalition clarified that they did not commit to a specific and immediate year-by-year target, though their statement did not retract their promise of \$2 trillion in savings over 10 years.

The back-and-forth between the government and industry signals the difficulty of developing, enacting, and implementing effective measures to bend the health care

cost curve. What should be clear, however, is that a strictly voluntary effort to slow the growth in costs is unlikely to be successful, and that health reform will need to incorporate legislative provisions and enforcement mechanisms to ensure that spending targets are met. The Medicare Trustees’ recent report that the Hospital Insurance Trust Fund will be exhausted in 2017 underscores the need to take effective action.

As we prepare health reform legislation, the history of failed voluntary health care efforts in other periods of crisis is instructive. President Nixon imposed wage and price controls on the nation’s economy in the wake of inflation triggered by the Vietnam War. Congressional legislative efforts to retain these controls in the health sector after the Executive Order expired were defeated when industry leaders pledged to control costs voluntarily. Similarly, President Carter’s proposed hospital cost-containment legislation was defeated with a promise from industry leaders that a “Voluntary Effort” would be sufficient to stem inflationary increases in hospital spending. An in-depth look at those prior efforts yields important lessons for the challenges ahead.

Voluntary Efforts: A Dismal History

From 1968 through 1970, when the overall inflation in the economy was 5.2 percent, Medicare hospital expenditures increased at an annualized rate of 18.1 percent, making health care costs an issue of intense concern. In 1971, President Nixon put a wage and price freeze on the entire economy, including the health sector, by [Executive Order](#). Later that year, the freeze was replaced by an initiative with specific inflation targets for each sector of the economy. By the following year, a ceiling of 5.5 percent on health care wage increases, 2.5 percent for non-labor costs, and 1.7 percent for new technology and services was imposed.

When the Executive Order expired in 1974, Congress sought to continue the health care cost controls legislatively.

The hospital industry strenuously opposed legislation and promised to control costs voluntarily. However, once the Economic Stabilization Program controls on the health sector were lifted, health expenditures increased rapidly.

When President Carter assumed office in January 1977, hospital expenses were increasing annually 8.7 percent faster than the overall inflation rate, posing a serious obstacle to his plans to balance the federal budget and expand health insurance coverage to the entire population. In February, Carter announced his intention to submit a major legislative proposal constraining the rate of increase in hospital costs, and as a new appointee at the Department of Health, Education, and Welfare, I was charged with developing the proposal. In April 1977, we submitted to Congress a plan to limit the rate of increase in hospital revenues for all patients to 3 percentage points over the overall inflation rate.

The major argument launched by the industry was that they could voluntarily contain costs without federal legislation. After extensive debate and Committee action, a bill passed the Senate in late 1978 that provided for a period of voluntary restraints on hospital cost growth, and a trigger initiating mandatory controls if the voluntary effort failed, but the session ended without action on the House floor. In 1979 at the behest of congressional leaders, the Carter administration introduced a new hospital cost-containment bill that contained a voluntary trigger, specifying that mandatory limits would only be imposed if national, state,

and individual hospital voluntary limits were not met, with limits set comparable to industry voluntary goals. The bill passed three major committees, but was defeated on the House floor in November 1979.

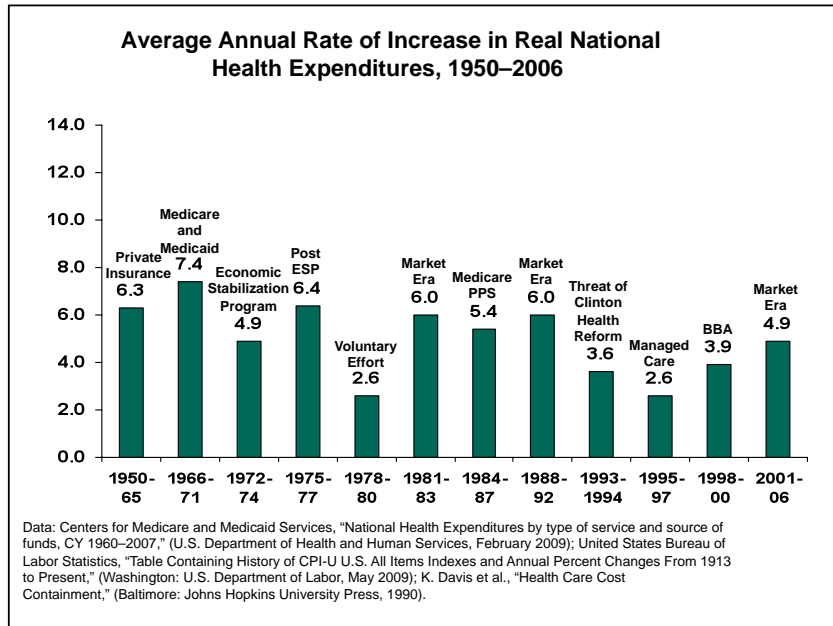
It was the launch of a formal Voluntary Effort created by a coalition of health care provider organizations (most notably the American Hospital Association, the Federation of American Hospitals, the American Medical Association, and Blue Cross/Blue Shield) that nailed the lid on the legislative option. The coalition set a 1978 goal of reducing the rate of increase by 2 percentage points below the 1977 rate of increase; that goal of 13.6 percent increase in 1978 was met. All subsequent goals, as well as goals related to holding down increases in the number of beds and employees, as well as increases in capital investment were substantially exceeded, leading to the end of the effort in 1981 and congressional hearings at which I testified that led to a new system of Medicare hospital payment.

The failure of the Voluntary Effort set the stage for enactment of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) that established a limit on the rate of increase in Medicare hospital payment rates based on a hospital market basket price index, plus 1 percent for new technology and services. The TEFRA legislation in turn paved the way for enactment of the Medicare hospital prospective payment system based on Diagnosis Related Groups (DRGs). Beginning in October 1, 1983, hospitals were paid a prospectively determined payment rate for each hospital patient, rather than its own costs. Payment rates were to

The Voluntary Effort: A Litany of Broken Promises

Annual Percent Increase in Hospital Expenses			
	Goal	Actual Performance	Promise
1978	13.6%	12.8%	Kept
1979	11.6	13.4	Broken
1980	11.9	16.8	Broken
1981	Below 16.8%	18.9*	Likely Broken

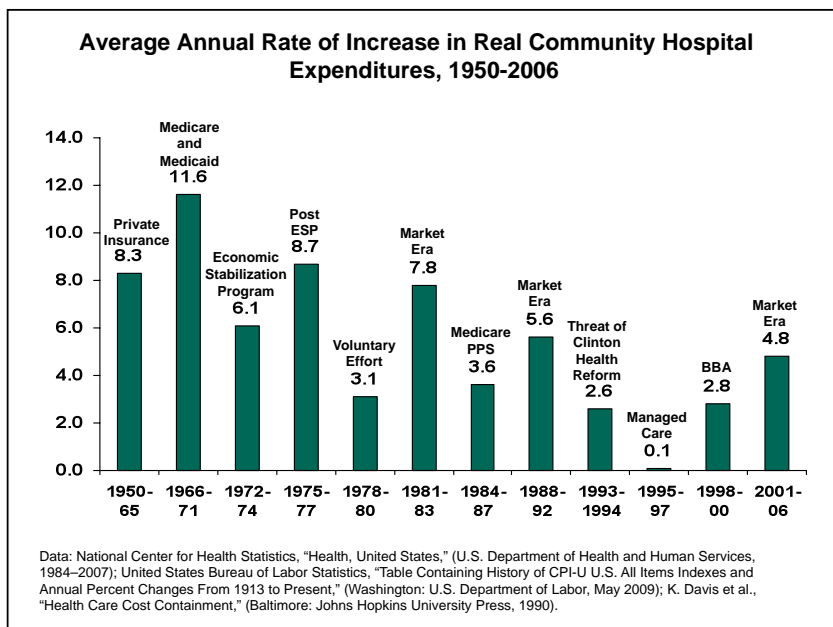
* January-August 1981
Source: K. Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort, testimony before House Energy and Commerce Committee, December 15, 1981.



increase each year at the rate of increase in the hospital market basket price index plus 1 percentage point. The legislation created the Prospective Payment Assessment Commission (now called the Medicare Payment Advisory Commission) to oversee the system and make recommendations to Congress. During periods when Congress has acted to limit increases in hospital payment rates, Medicare spending has slowed relative to private sector spending.

Lessons from Past Efforts to Control Costs

History is pertinent to today's health reform consideration. Industry leaders' response to federal consideration of mandatory controls has consistently been to promise voluntary efforts. Yet without an enforcement mechanism those promises have quickly evaporated as each individual provider independently pursues its own interests. But controls—whether crude controls like the Nixon wage and price controls and the TEFRA limits on Medicare hospital payment increases or more sophisticated approaches like



the Medicare DRG prospective payment legislation—have worked to slow increases.

To ensure the promised savings are realized, policymakers should consider incorporating into health reform expenditure targets that hold increases to **1.5 percentage points** below baseline projections. As several analysts have pointed out, reducing the annual growth rate in national health expenditures by 1.5 percent means that the entire health care industry can still expect sustained revenue increases over the coming decade. Moreover, if cost reduction

targets are incorporated into larger payment reform efforts that reward quality and value, ample opportunities for revenue growth will exist for efficient and innovative insurers and providers.

A commitment from business and industry to limit the unsustainable increases in health care is important as we work together to build a high-performance health system that works for all Americans. The President and Congress now need to follow up on this pledge with legislation that ensures the promise is kept.

August 14, 2008

Delivering Change Through Health System Organization

By Karen Davis

“Change” is on the minds of many Americans during this election cycle, and it is relevant to any discussion of the U.S. health care system as well. Our health care system must change: while we spend more than twice as much on health care as any other nation—over \$7,000 per capita in 2006—we do not, on the whole, get good value for our health care dollar. The U.S. falls short on many performance measures when compared with other countries, and there is tremendous unexplained variation in health care quality and costs across states and regions.

Americans are feeling firsthand the effects of this expensive, sometimes inadequate care. A survey of the public published this month conducted by Harris Interactive on behalf of the Commonwealth Fund’s Commission on a High Performance Health System found that eight of 10 respondents agree that the health system needs either fundamental change or complete rebuilding. Nine of 10 adults say it is very important for the 2008 presidential candidates to seek reforms that address health care quality, access, and costs.

Americans’ health care experiences offer further evidence of the need for change. Health care delivery in the United States is fraught with fragmentation at the national, state, community, and practice levels. There is no single national entity or set of policies guiding the overall organization of the health care system. Doctors and hospitals practicing in the same community and caring for the same patients are not “connected” to each other, and there is a critical shortage of primary care providers. And our current disjointed financing model—a mix of private insurers and public programs, each with its own set of rules and payment methods—further fragments the health care delivery system, contributing to waste and high administrative costs. Greater

organization is instrumental to ensure timely access to care, care coordination, and smooth flow of information among doctors and patients.

So what do I mean by an organized health care system? I mean a system that—at every point on the care continuum—makes it easy for patients and families to obtain the comprehensive, coordinated care they need. Second, but just as important, I mean a system that does everything it can to support physicians and other providers so they can deliver that excellent care.

As outlined in the Commission report published with the public views survey, *Organizing the U.S. Health Care Delivery System for High Performance*, an ideal health care delivery system that is truly patient-centered would have six key attributes:

1. Patients’ clinically relevant information is available to all providers at the point-of-care and to patients through electronic health record systems;
2. Patient care is coordinated among multiple providers and care transitions across settings are actively managed;
3. Providers (including nurses and the rest of the care team) both within and across settings have accountability to each other, review each other’s work, and work together to reliably deliver high-quality, high-value, care;
4. Patients have easy access to appropriate care and information, including 24-hours. There are multiple points of entry to the system, and the providers are culturally competent and responsive to the needs of the patient;

5. There is clear accountability for the total care of the patient; and
6. The system is continuously innovating and learning in order to improve the quality, value, and patient experience of health care delivery.

Any policies put in place to achieve these attributes should work for different kinds of organizations, from small practices and unrelated hospitals to fully integrated delivery systems. The authors of the report identify a combination of scalable policies that would be critical to achieving greater organization across a continuum of organizations. For example, payment reform—including the development of bundled payment systems that reward coordinated, high-value care rather than individual services—could range from blended fee-for-service and per-patient fees for primary care practices that act as medical homes to global fees for an acute hospitalization and follow-up care over 30 days. Such payment systems, along with paying providers for achieving certain levels of quality, would help coordinate the delivery of care.

Beyond payment reform, we need a center to evaluate the comparative effectiveness of drugs, devices, procedures, and we need to design health benefits around those recommendations. We also need to introduce an insurance connector to offer affordable choices to small employers and

individuals, including the option of purchasing coverage through a public plan using these new payment and benefit design principles. Most of all, we need national leadership among all stakeholders, including government, providers, employers, and consumers—real leadership that recognizes the value of public-private collaboration.

In the end, changes of the kind I've described will work only if physicians and other health care professionals see in them the opportunity to provide all of their patients with the best care possible. The reforms must support providers in improving the quality of care and realign financial incentives to reward high-quality, efficient care. This would include rewards for delivering better care and better outcomes, rather than simply providing more services, which is what the current, predominantly fee-for-service system rewards.

W. Edwards Deming, one of the fathers of quality improvement, once said, "It is not necessary to change. Survival is not mandatory." Yet, most of us have a fairly strong survival instinct, and most physicians and other health care providers are driven by a continual search for more effective ways to keep people healthy and care for the sick.

What is needed in the national debate is consensus that the status quo is no longer acceptable. Working together we can change course—and move the U.S. health system on a path to high performance.

March 27, 2009

Can Patient-Centered Medical Homes Transform Health Care Delivery?

By Melinda K. Abrams, Karen Davis, and Christine Haran

Now that President Obama has set aside \$634 billion in his budget for health reform, national policymakers need not only to outline overarching reform strategies but also consider how the system will work from the ground up. While much focus has been on how affordable coverage will be achieved, an equally important aspect of reform will be an overhaul in the delivery of care. This new delivery system must be built on a solid foundation of primary care.

Enter the medical home, a building block needed to ensure accessible, patient-centered, and coordinated primary care.

The medical home is an approach to primary care organized around the relationship between the patient and the personal clinician. First championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

Why the U.S. Needs Medical Homes

In 2007, four primary care specialty societies—representing more than 300,000 internists, family physicians, pediatricians, and osteopaths—agreed on the Joint Principles of the Patient-Centered Medical Home:

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and
- payment that recognized the added value provided to patients who have a patient-centered medical home.

Today, few Americans say they have a source of care with these features. In fact, the Fund’s *2008 National Scorecard on U.S. Health System Performance* found that only 65 percent of adults under age 65 reported that they have an accessible primary care provider; there were wide variations by race, income, and insurance status. Only half of the overall group said they had received all recommended screening and preventive care. Among adults who were uninsured all year, just 30 percent had received the appropriate preventive care. A 2008 Fund survey showed almost half of U.S. adults report a lack of care coordination, such as a specialist not receiving basic information from their primary care provider and vice versa, or never being called about test results. The Fund’s 2008 *Scorecard* shows that only a little more than half of all Americans report open and clear communication with their primary care clinician. When there is good communication, and care is delivered in a timely and coordinated manner, patients are more likely to adhere to treatment plans, fully participate in decisions, and receive better care overall.

Creating medical homes throughout the country will clearly require a significant restructuring of our existing health care delivery “system.” Whereas most doctors’ offices and hospitals are currently isolated from each other—electronically and otherwise—providing patients with around-the-clock access to coordinated care will require that providers are linked and working together. For example, small physicians’ offices could pool with other offices to provide regional urgent care centers that would be open from 5 p.m. to 9 a.m. Individual practices also will need support to redesign their practices or clinics as medical homes. A recent study of primary care practices in Massachusetts showed that many practices do not currently have the information systems, personnel, or continuous quality improvement initiatives in place to function as medical homes.

While the medical home is not a “magic bullet” that will provide an immediate return on the investment, studies have demonstrated tangible benefits, including improved quality, lower costs, and fewer disparities in care.

Medical homes are associated with better preventive care and improved chronic disease management (chronic diseases are a major source of high health care costs). Forty-two percent of people with a medical home have regular blood pressure checks, for example, compared with 20 percent without a regular source of care or medical home, according to the Fund’s [2006 Health Care Quality Survey](#). Furthermore, patients with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care provider, and fewer medical errors. The quality survey also showed that medical homes do not just improve, but actually eliminate, disparities in getting needed medical care.

Medical homes also produce efficiencies. U.S. adults with medical homes were less likely to have medical reports unavailable during a visit or to have to undergo duplicative tests, according to the Fund’s latest [international survey](#). A Fund case study of a system of opening medical homes, the MeritCare System in [North Dakota](#), demonstrated that pilot programs addressing the management of chronic diseases such as diabetes and asthma resulted in substantive costs savings.

Ongoing Fund-supported demonstration and evaluation projects, including a new initiative to transform safety-net clinics into patient-centered medical homes, will generate more information about the value of medical homes and how to turn practices into medical homes. Additionally, several ongoing rigorous evaluations of medical home demonstrations will help determine if they improve quality and slow the rate of health care expenditures. The evaluations vary considerably, from a randomized, controlled trial with one commercial payer to multistate, multipayer efforts that involve national health plans collaborating with the Medicaid program to support new reimbursement and delivery models for medical homes. All of the studies will examine the impact of the medical home on clinical quality, patient experiences, clinician/staff experiences, and health system costs. A Patient-Centered Medical Home Evaluators’ Collaborative is under way to encourage investigators to work

together to reach consensus on a core set of standardized measures that will facilitate cross-study comparisons.

Measuring Medical Homes

Developing metrics to recognize and monitor medical homes is an ongoing process that was kicked off by the National Committee for Quality Assurance (NCQA) in 2007. According to NCQA’s national measures, to qualify as a patient-centered medical home a practice must demonstrate proficiency in at least five of the following 10 areas:

- written standards for patient access and patient communication;
- use of data to show they are meeting this standard;
- use of paper-based or electronic charting tools to organize clinical information;
- use of data to identify patients with important diagnoses and conditions;
- adoption and implementation of evidence-based guidelines for three conditions;
- active support of patient self-management;
- tracking system to test and identify abnormal results;
- tracking referrals with paper-based or electronic system;
- measurement of clinical and/or service performance by physician or across a practice; and
- reporting performance across the practice or by physician.

These measures, which were created in collaboration with the four primary care specialty societies, offer an excellent starting point in the process of developing comprehensive medical home standards. With Fund support, NCQA continues to develop and test additional measures that would make the standards more patient-centered and inform future iterations of the measurement set. Areas under development include excellence in patient experience, shared decision-making, family and community involvement, coordination of primary care and specialty physicians, functioning of the staff as a team, and services to address limited English proficiency.

Another key aspect of the medical home model is reforming physician payment to strengthen and reward primary care. Current reimbursement is biased in favor of procedures, such as surgery or imaging, and does not adequately pay for time spent with patients to take their medical history or follow up after the appointment. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure, and care coordination. Rather than following a strictly fee-for-service model, purchasers in the Bridges to Excellence Medical Home Initiative, for example, will pay primary care physicians \$125 a patient if they meet medical home metrics and chronic care guidelines. In the Medicare Medical Home demonstration planned by the Centers for Medicare and Medicaid Services (CMS), physician practices will receive a risk-adjusted monthly care management fee that, on average, ranges from \$40.40 to \$51.70 per member per month, depending on the capacity and infrastructure of the physician practice. Such financial support should help bolster the field of primary care as well as improve care. Today, primary care physicians are undercompensated relative to specialists.

Encouraging the adoption of medical homes in small practices and large systems will require national cooperation and federal support for infrastructure, such as health information technology and health information exchanges. With better information technology, practices will have enhanced capacity to summarize the needs of their patients, identify patients who are overdue for appointments, obtain feedback from patients through e-mail and Web portals, or review test results remotely. However, technology is just a tool, and unless the information generated is used to better meet the needs or preferences of patients, it is a disruption that does not improve care.

Multipayer, public-private demonstrations—and there are several getting started—will offer the best glimpse at how practices and patients respond to the medical home. According to a survey by the National Academy for State Health Policy, 31 states are exploring the medical home

concept for their Medicaid enrollees. To build more robust experiments, CMS should join commercial and Medicaid payers in these demonstrations.

Getting on the Path to High Performance

The patient-centered medical home can play an integral role in improving quality in the health care system. But we must pursue a number of policies simultaneously.

The Commonwealth Fund's Commission on a High Performance Health System has outlined **five strategies** for high performance:

- extending affordable health insurance to all;
- organizing care to ensure accessible, patient-centered, coordinated care;
- aligning financial incentives to enhance value and achieve savings;
- meeting and raising benchmarks for high-quality, efficient care; and
- ensuring accountable national leadership and public/private collaboration.

The Commission envisions a care system where patients have personal providers who know them, serve as advocates to help them get needed care, help coordinate care, and are accountable for the best possible health outcomes and prudent use of resources. Toward this end, the Commission recommends the following policies:

- **New Per-Patient Medical Home Payment**
Qualified providers who elect to participate in the program would receive a per-member, per-month medical home fee, in addition to all currently covered fee-for-service payments. The amount of the per-member, per-month payment would vary depending on the severity of illness of the enrolled patient.
- **Qualifications for Medical Home Status**
To qualify for participation in the program and for the medical home payment, primary care providers

would need sufficient capacity. Qualifying factors would include:

- providing enhanced access (e.g., 24-hour coverage, timely appointments);
- using information technology to improve patient care (e.g., electronic health records with registries, reminders, e-prescribing, and clinical decision support);
- offering care management and care coordination services; and
- reporting quality and patient experience measures.

- **Incentives for Patients**

Positive incentives would be provided to encourage patients to enroll and designate a primary care practice. Beneficiaries would receive a discount on their premiums, have their deductibles waived, or enjoy lower cost-sharing for primary care as an incentive to designate a primary care medical home.

- **Incentives for Providers**

Physicians would also participate in the incentive program, under which savings in total health spending for enrolled groups would be shared by patients, providers, and payers. Participating providers could receive their share of savings as year-end bonuses based on their performance as judged by clinical quality and patient experience. Evaluation measures might include, for example, the proportion of patients who are up-to-date with recommended preventive services and percentage of patients with chronic conditions who are adequately controlled.

This year we have a historic opportunity to fundamentally change health care in the United States. We hope our country will seize this chance to improve access and care, and lower costs, so that the health system will work well for everyone for generations to come.

Cooperative Health Care: The Way Forward?

By Karen Davis

As part of the health reform debate, Senator Kent Conrad (D-ND) has proposed forming nonprofit cooperatives to provide health insurance coverage at low cost. While the details are still being fleshed out, an examination of the history of cooperative health care—which has often also featured an integrated care delivery system—reveals some important lessons that apply to the current policy discussion.

Three major takeaways are:

1. Local cooperative health organizations can and do provide top-quality integrated, coordinated care, but they have faced formidable obstacles in their formation, operation, and growth.
2. A national organization with authority to purchase health care at reasonable rates is integral to controlling costs successfully.
3. Transforming health care delivery in the United States into a mission-driven, patient-centered, value-enhancing system of care will require incentives for physicians to practice in health care organizations that are accountable to patients and consumers, as well as disincentives for continuing our current fragmented fee-for-service system.

History of Health Cooperatives

According to sociologist and writer Paul Starr, the first health care cooperative was formed in 1929 by Dr. Michael Shadid in Elk City, Oklahoma—my home state. This pioneer faced immense obstacles, including opposition from the county medical society. Nonetheless, with the help of the populist Oklahoma Farmers' Union, he succeeded in securing a loan to build a hospital and creating a prepaid insurance plan. Dr. Shadid's philosophy was that the government's role was to subsidize the poor's enrollment fees. Consumers would

manage the business operations, but doctors would remain in control of the professional aspects of care.

Dr. Shadid's success inspired others to form regional health cooperatives that provide networks of health care plans and providers. Indeed, the two most successful modern examples of cooperative health systems are HealthPartners, based in the Twin Cities of Minnesota, and the Seattle-based Group Health Cooperative. Both of these consumer-governed health care organizations serve more than 500,000 members in a wide geographic region. Along with insurance, they directly provide health care services through a nonprofit integrated delivery system that owns its own hospitals and has its own dedicated multispecialty physician group providing integrated, coordinated care of high quality while making prudent use of resources. Although both organizations have encountered obstacles throughout their 50-plus-year histories—among them, the opposition of organized medicine and internal tensions between physicians and consumer-governed boards—they exist today as examples of health care organizations that deliver high-value care. New case studies of the two organizations, now available on the Commonwealth Fund Web site, offer insight into their strategies.

There is no question that these shining examples of cooperative health represent a model for the financing and delivery of health care, as do similar nonprofit—though not consumer-governed—integrated delivery systems, such as Geisinger Health System, Intermountain Healthcare, and Kaiser Permanente. The question is: What would it take to go from our current system of health care to a national delivery system that has the mission, values, capacity, and operational systems and strategies of these organizations?

e cooperative landscape is certainly littered with failures. Group Health Association in Washington, D.C., for example, failed in the early 1990s after intense conflicts between consumer-led management and the medical group. Another large cooperative, Group Health Inc. (GHI), in New York City, is preparing to convert to for-profit status. Surrounded by a marketplace that provides substantial rewards to for-profit insurance and fee-for-service care, these organizations have moved away from the original consumer-led governance structure and mission.

is cooperative health care experience—both successful and unsuccessful—underscores the difficulty of reconciling the public’s desire for low-cost, high-quality care with physicians’ desire for professional autonomy and control of health resources. It is also difficult to maintain the ideals of consumer-governed health care in the face of a marketplace that rewards volume over value. There are even legal obstacles, erected by those favoring the current marketplace incentives. In response to the development of cooperatives owned by their members/patients, a number of states enacted laws that make it illegal for a physician to be employed by a nonphysician, effectively precluding cooperative health plans.

e key to the success of cooperatives in other sectors of the economy has been the ability to leverage purchasing power to obtain lower rates—for electricity, as an example. Rural electricity cooperatives took root during the Great Depression following establishment of the Tennessee Valley Authority (TVA) Act in May 1933. This act authorized the TVA board to construct transmission lines to serve “farms and small villages that are not otherwise supplied with electricity at reasonable rates.” The idea of providing federal assistance to accomplish rural electrification gained ground rapidly when President Roosevelt took office in 1933 and launched his New Deal programs. On May 11, 1935, Roosevelt signed Executive Order No. 7037, establishing the Rural Electrification Administration (REA). A year later the Rural Electrification Act was passed, and the lending program that became the REA got under way.

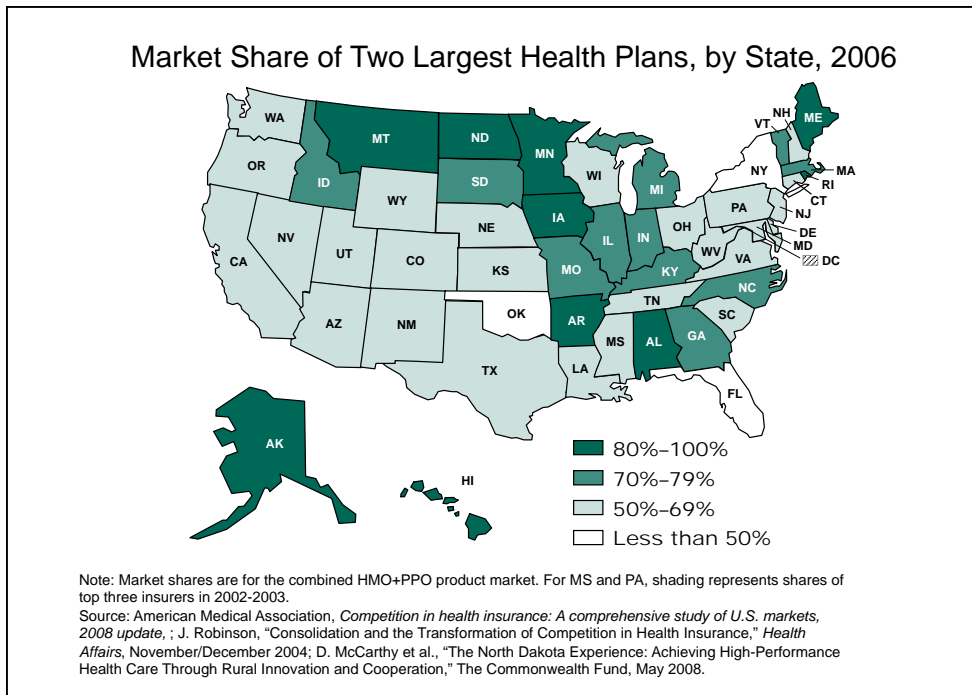
Most rural electrification is the product of locally owned rural electric cooperatives that got their start by borrowing funds from REA to build lines and provide service on a nonprofit basis. Today the REA is the Rural Utilities Service

and is part of the U.S. Department of Agriculture. An important part of the history of electric cooperatives has been the development of power marketing agencies (PMAs). In 1937, the federal government established the first PMA, the Bonneville Power Administration. The government proceeded to form four more PMAs to market the power generated at 133 federal dams across the country. The federal law that governs PMAs gives preference in the sale of power at cost to public bodies and electric cooperatives. The availability of low-cost power to electric cooperatives has promoted economic development and has offset the cost of serving sparsely populated areas.

For cooperative health care to slow the growth in health care costs and achieve savings, a cooperative insurance organization would need the authority to purchase care on favorable terms. This might be accomplished by guaranteeing that the cooperative health plan can obtain the lowest price charged to the most favored customer. Today, commercial insurers dominate the market in most geographic areas, and, with the exception of three states, the two largest health insurance plans in each state account for 50 percent or more of all private insurance enrollment.

ese plans use their purchasing clout to obtain discounted rates in negotiations with local health care providers. In local markets where there are dominant health care providers, hospitals and other providers are able to push back and demand higher rates. But while multiple negotiations among multiple insurers and multiple providers consume significant administrative costs, the result is not a competitive market price applicable to all customers, but rather favorable rates for the most powerful participants in the negotiations.

Another way to leverage purchasing would be to have a national cooperative organization negotiate provider prices on behalf of all customers. This is the model used by Germany’s “sickness funds.” These membership cooperatives, which have consumer boards, conduct negotiations with their regional counterpart provider organizations on behalf of all patients for standard health benefits. In the U.S., such a process could be entrusted to a national “Health Value Authority” and applied to all health plans participating in an insurance exchange. A nonprofit, consumer-driven entity acting in the public interest would then manage payment and delivery system reform, rather than leave such



reforms to the market powers of insurers or providers in a given geographic area or to a political process influenced by special interests.

Transforming American Health Care

Two different strategies for revamping the health insurance system have now been proposed by members of Congress: a cooperative strategy and a public insurance plan. A cooperative health strategy could establish a national cooperative organization to transform insurance provision and support the development of local cooperative health care delivery systems. A national organization, such as a Health Value Authority, could provide a variety of supporting functions, such as making grants and loans to start local cooperative health care delivery systems and providing actuarial technical assistance and other needed support. Such a national organization could also be given the authority to negotiate provider payment rates and methods on behalf of all insurers—public and private—and eliminate the administrative waste now generated by thousands of individual-provider price negotiations. In addition, it could institute new methods of payment, changing the marketplace from one that competes on providing greater volume of services to one that rewards better outcomes for patients and more prudent use of resources. National

authority might be needed to override state laws that restrict cooperative health care delivery systems or cooperative health insurance products.

is strategy would break new ground and lead to a health system that provides high-quality, high-value care. The role of insurance would be to pool risk broadly and restructure local competitive markets so as to align incentives with the provision of high-value care. The long history of establishing local cooperative health care delivery systems certainly raises awareness about how quickly such change could be effected. And the responsibilities, authority, and structure of a national Health Value Authority would require careful thought, time, and expertise to develop and implement.

The second option is to create a new public health insurance plan, offered by the U.S. Department of Health and Human Services (HHS), that adopts new value-based payment methods, builds on the current Medicare network of hospitals and physicians, and competes with private insurers within a national health insurance exchange. Even subject to the same rules as private insurers regarding benefits, coverage, and other standards, such a plan could offer a premium that is 15 to 25 percent lower than premiums now offered in the individual and small business market, depending upon

whether providers are paid at Medicare levels or at some midpoint between commercial and Medicare levels.

HHS could also be given the authority to modify rates for individual services. This might involve reducing rates for overpriced services, which have contributed to the enormous growth in volume of services documented by the Dartmouth Atlas and, more recently, by Atul Gawande in his influential *New Yorker* article. Savings from reducing prices for overpriced services could be shared between the federal budget and a bonus pool for high-performing providers.

Payment rates under the public health insurance plan could also be made available to private plans, with the same carrots and sticks for physicians to participate in the network. Competition between a public plan and private plans featuring a level playing field for provider payment could achieve significant economies both initially and over time, yielding up to \$3 trillion in health system savings between 2010 and 2020.

Under such reform, most providers would continue to experience rising revenues, albeit at a slower rate. Covering the uninsured generates new revenues for providers and improved benefits reduce bad debts. If a public plan paid providers at a point midway between Medicare and commercial rates, physician revenue would grow on average at an annual rate of 4.3 percent over the 2010–2020 period and hospital revenue would grow at an annual rate of 5.3 percent—well within the growth rate promised by an industry coalition in a letter to President Obama.

A People-Centered, Value-Enhancing Health System

As President Lincoln emphasized in his Gettysburg Address, the U.S. is guided by the philosophy of “government of the people, by the people, and for the people.” What is needed in health care is a similar philosophy: a health system that is truly for the people. Redesigning health care so that it puts people front and center and ensures that care is patient-centered, accessible, and coordinated should be the fundamental goals of health reform.

Ultimately, it is the public that pays for health care, whether through the direct costs of premiums and health services, forgone wages from rising premiums in employer-sponsored health plans, or higher taxes to support Medicare, Medicaid, and other public health programs. Health reform needs to ensure accountability and value for the resources that are entrusted to health care organizations and providers for the care of patients.

Two choices have been put on the table—a cooperative health care system designed and governed by consumers, and a public health insurance plan designed and offered by government acting in the public interest. Both could work if they are given sufficient authority to act in the public interest. Adopting a new cooperative health system would be difficult, and its long-term impact and sustainability would be uncertain. Still, both alternatives embrace a philosophy of people-centered health care and both are worthy of debate and consideration. Incorporating elements of both into health reform may well point the way forward.

July 17, 2008

Headed in the Wrong Direction: The 2008 National Scorecard on U.S. Health System Performance

By Karen Davis

Belief in economic and scientific progress is deeply engrained in the American way of life. As residents of a “can do” nation, Americans expect that our children will be better off than their parents, and that scientific breakthroughs will eventually conquer disease. Evidence that health care in this country is slipping backward is, therefore, deeply troubling.

Despite the best efforts of millions of talented and dedicated health care professionals, the Commonwealth Fund’s latest Commission on a High Performance Health System *National Scorecard on U.S. Health System Performance* demonstrates that, in fact, we are losing ground. The first *Scorecard* was published in 2006. The new *Scorecard*, published this month, finds disturbing evidence that the health system is on the wrong track. In nearly every category measured, the health system performs worse than two years ago—scoring just 65 out of 100 across 37 indicators, where 100 represents not what is ideal but what has actually been achieved in some places for some groups of people.

The *Scorecard* takes a broad look at how well the U.S. 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. It looks at specific issues: Do people have access to the health care they need? Are they getting the highest-quality care, and are we spending money and using health care resources efficiently?

One of the primary reasons for the system’s poor performance is worsening access to care. In 2007, more than 75 million adults—42 percent of all adults ages 19 to 64—were either uninsured or underinsured during the year, up from 35 percent in 2003. This means that millions of Americans are unable to get the care they need.

The *Scorecard* also found evidence that the billions spent on U.S. health care—far more than any other industrialized country—are often squandered on administrative costs, inefficient systems, wasteful care, or treatment of preventable conditions.

The U.S. also failed to keep up with advances in health outcomes, falling from 15th to 19th among industrialized nations in terms of the number of premature deaths that could potentially have been prevented by timely access to care.

The good news? There have been some gains in the quality of care. Performance on a key measure of patient safety—hospital standardized mortality ratios, which were targeted in the Institute for Healthcare Improvement’s “100,000 Lives campaign”—improved significantly, by 19 percent from 2000–2002 to 2004–2006. Moreover, hospitals are increasingly meeting evidence-based treatment guidelines, for which data are collected and reported on a Medicare Web site. Rates of control of two common chronic conditions, diabetes and high blood pressure, also have improved significantly. These measures are publicly reported by health plans, and physician groups are increasingly rewarded for improving treatment of these conditions. So improvement is possible, but it takes leadership, concerted action, and monitoring of progress.

If the U.S. health system achieved benchmark levels of performance, there would be real benefits in terms of health, patient experiences, and savings. For example:

- thirty-seven million more adults would have an accessible primary care provider, and 70 million more

adults would receive all recommended preventive care.

- 100,000 fewer people would die from causes that could have been prevented by good care.
- The Medicare program could potentially save at least \$12 billion a year by reducing readmissions or reducing hospitalizations for preventable conditions.
- If we could lower the administrative costs of health insurance to the level found in Germany, which like the U.S. has a blended public-private health system, we could save \$51 billion a year. Reaching levels

achieved in the best performing countries would save an estimated \$102 billion per year.

These and other findings make a compelling case for change in the way U.S. health care is financed, organized, and delivered. A new Presidential administration in 2009 will provide a historic opportunity to change direction. A comprehensive strategy that simultaneously aims to ensure health insurance for all, improve quality, and achieve greater efficiency is needed to close gaps in performance. The goal should be a 2010 *National Scorecard* that lives up to the best of what is possible with American ingenuity and the considerable resources invested in our health sector.

October 9, 2008

Reducing Preventable Deaths Through Improved Health System Performance

By Stephen C. Schoenbaum, M.D., M.P.H.

In its initial [Framework Statement](#), the Commonwealth Fund Commission on a High Performance Health System stated that “a high performance health care system is one that has the overarching mission to help everyone live as long, healthy, and productive lives as possible....” But research from the Commonwealth Fund and others shows that the U.S. is not reducing its rate of “mortality amenable to health care”—or potentially preventable deaths—as quickly as other industrialized nations. And some recent studies point to shocking declines in the U.S. on a related measure, life expectancy, as well as rises in infant mortality rates.

Poor performance on these measures points, in large part, to flawed preventive care that fails to identify underlying conditions, such as hypertension, that can lead to potentially fatal diseases or to help people living with chronic disease stay as healthy as possible. For example, Fund research has found that, as of 2005, adults in the U.S. received only half of the recommended screening and preventive care for their age group.

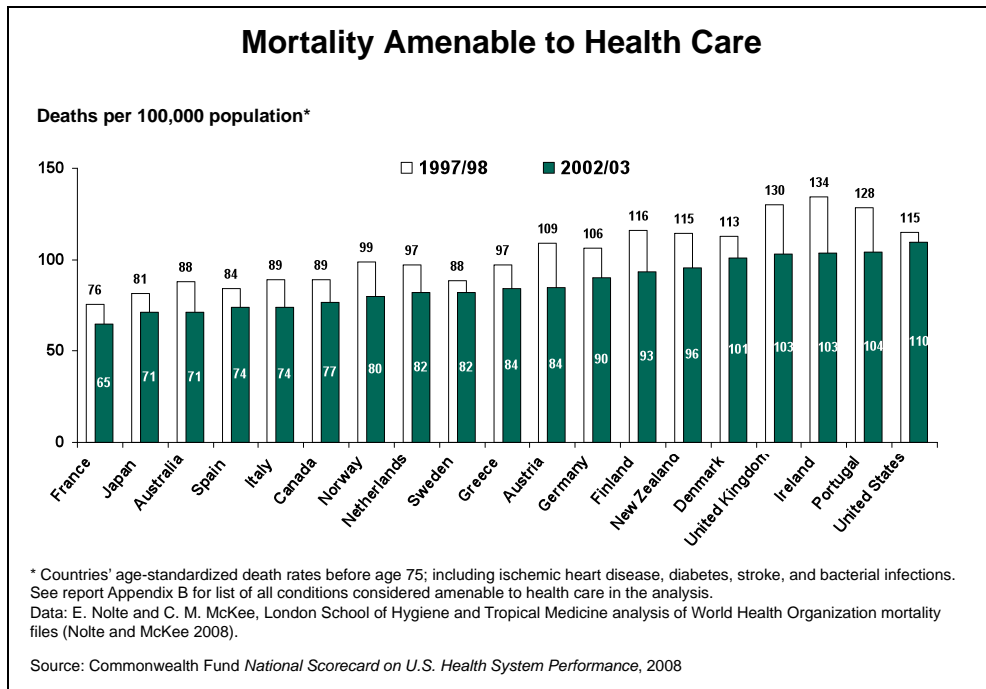
Understanding the Differences in Rates of Preventable Deaths

On average across Organization for Economic Cooperation and Development (OECD) countries, mortality amenable to health care comprises about 23 percent of total mortality for men under age 75 and 32 percent of total mortality in women in this age group. It is a worthy target for reduction. Because of its significance, mortality amenable to health care was one of the measures of long, healthy, and productive lives used in the Commission’s [2006](#) and [2008 National Scorecards](#) on health system performance.

As Ellen Nolte, Ph.D., and C. Martin McKee, M.D., D.Sc., of the London School of Hygiene and Tropical Medicine reported in a [Fund-supported study](#) in *Health Affairs*, mortality amenable to health care in the U.S. dropped from 115 to 110 per 100,000 between 1997–1998 and 2002–2003. But the decline in other countries over the same period was greater—and the U.S. went from 15th to 19th in relative position among 19 developed countries in the OECD.

Within the U.S., there is tremendous variation on this measure. The Commonwealth Fund’s [State Scorecard](#) revealed that, while some states have achieved results better than the top countries, others have results that are significantly worse than the national average.

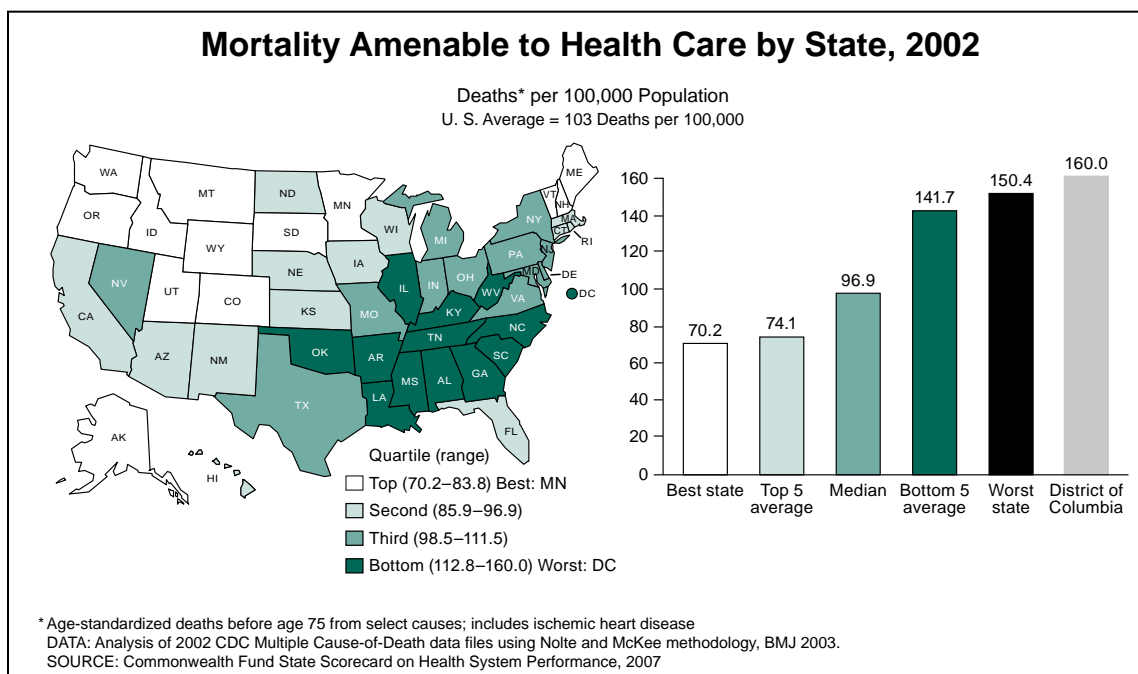
Many people believe that differences in mortality rates simply reflect differences among the populations of countries or states, such as genetics or diet and lifestyle. Indeed, there is little question that measures of overall mortality are heavily influenced by factors other than health care. But the researchers measuring mortality amenable to health care minimize the influence of these factors by setting age limits. The measure includes only deaths under age 75, and is further restricted to deaths at younger ages for specific conditions, such as under age 50 for diabetes, 45 for leukemia, and 15 for conditions such as whooping cough. Researchers also adjust for the inability of medicine to prevent all deaths from certain conditions. For example, since evidence suggests that only up to half of premature deaths from ischemic heart disease (IHD) can potentially be eliminated by health care, the measure includes only half of the IHD deaths.



e measure may still reflect factors other than health care differences. But that said, the death rate from amenable causes among women under age 75 in 2002–2003 was 96.41 per 100,000 in the U.S., versus 68.15 in Canada and 57.40 in France. It appears that this is not the best we can do.

The Role of Disparities

Recent articles have drawn attention to other variations in mortality data within the U.S., in particular data on life expectancy that show increasing inequality among socioeconomic groups and geographic regions. The reasons for the inequality in life expectancy are not clear, though factors such as higher smoking and obesity rates, which



contribute to chronic disease, have been cited. An [April 2008 study](#) on cross-county mortality disparities in the U.S. found that increasingly poor life expectancy in certain counties in the Deep South and Appalachia was caused by increasingly higher mortality from lung cancer, chronic obstructive pulmonary disease, and diabetes, among other non-communicable diseases. Christopher Murray, a coauthor of the study and director of the Institute for Health Metrics and Evaluation at the University of Washington, told the *Wall Street Journal* that, because chronic diseases are often preventable, this finding was both discouraging and encouraging.

Additionally, Centers for Disease Control and Prevention data reveal that the nearly decade-long decline in U.S. infant mortality rates has now stalled, a reflection of poor early prenatal care, among other problems. Most recent infant mortality rates are a little higher than in the past, and African-American newborns are 2.4 times as likely to die as white infants. While the link between race and infant mortality has not been established with certainty, poverty, poor access to health care, and dietary differences are likely to contribute.

A Need for High Performance

The data cited here underscore the need to implement health reform in the U.S. so that all Americans can have excellent access to excellent care.

The Commonwealth Fund's Commission on a High Performance Health System has developed five [key strategies](#) for achieving broad performance improvement:

1. Extend affordable health insurance to all.
2. Align financial incentives to enhance value and achieve savings.
3. Organize the health care system around the patient to ensure that care is accessible and coordinated.
4. Meet and raise benchmarks for high-quality, accessible care
5. Ensure accountable national leadership and public/private collaboration.

First, we should make affordable care available to all by maintaining the employer-based system, as well as expanding public programs and offering health insurance through a national health insurance exchange. It is critical that Americans' health insurance be comprehensive, covering all necessary care, including preventive care, with little or no cost-sharing with individuals.

We also must reform our payment system, as fee-for-service incentives reward more services and not necessarily better care. Good preventive care, for example, requires not just a screening test, but also services that are not currently reimbursed such as outreach and follow-up when a test is positive.

Outreach and follow-up care are facilitated when patients have a medical home that serves as a regular source of care and coordinates care for people. Medical homes that are paid per patient can encourage preventive care by sending electronic reminders of screening visits—reminding patients that it's time for their cholesterol check, for example. We also should strengthen the quality of care offered by providers, particularly safety net providers, by ensuring they meet benchmark goals of performance.

Finally, national leadership is needed not only to establish prevention guidelines but to implement them better, develop incentives for creating and sustaining medical homes, and support better care with infrastructure such as health information technology. At that point, we can see whether we are able to catch up to the other industrialized countries that have long since passed us by in terms of outcomes such as amenable mortality, life expectancy, and infant mortality. Our poor performance on these measures should urge us to start work to improve health system performance as soon as possible.

January 26, 2009

Health Information Technology: Key Lever in Health System Transformation

By Karen Davis and Kristof Stremikis

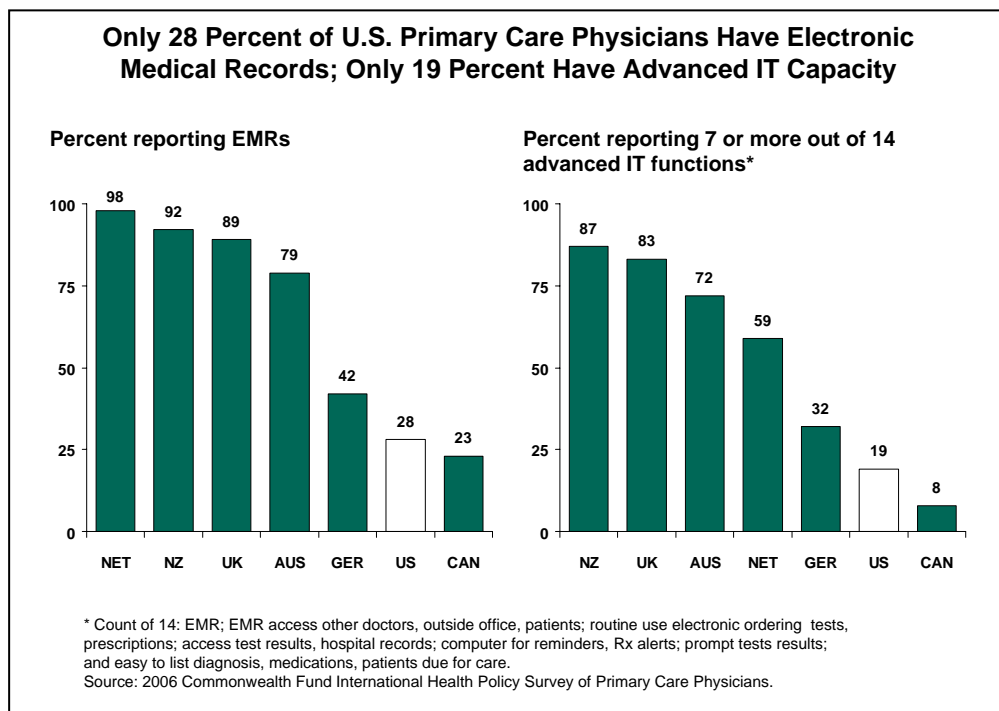
As President Obama and the new Congress embark on an ambitious agenda to reform the American health care system, the need to develop a national policy to encourage the spread of health information technology (IT) is resurfacing as a key issue. The health care proposals from both the Obama–Biden campaign and Senator Max Baucus (D–Mont.) call for expansion of health IT as a means of facilitating quality reporting and improvement activities, empowering individual patients, and expanding provider access to evidence and clinical decision-support tools. More recently, significant investment in national IT infrastructure was put forward as an integral component of the economic stimulus bill, which aims to expand employment while increasing efficiency and lowering costs in the long run.

Still, modern IT is not a panacea for all that ails health care in this country. Data from high-performance health systems within the United States and throughout the broader international community show that **investments in health IT** must be supported by other actions, including financial incentives to make a provider case for adoption and use, and standards set by government. IT investments must also be coupled with strong commitments to performance improvement.

The Evidence Base and Business Case for Health Information Technology

U.S. health providers have been slow to adopt health IT, in part, because of concerns about its value and the costs of implementation. Analysis of the [2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians](#) demonstrates that the United States has fallen far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on a number of measures related to the utilization of health IT. The contrast between the United States and the Netherlands is particularly stark, with 98 percent of Dutch primary care physicians reporting the use of electronic medical records compared with only 28 percent of their American counterparts. This general pattern persists when examining the prevalence of other IT functions such as electronic prescribing, decision support, and computerized access to test results.

Evidence from the literature demonstrates that investments in health information technology show substantial promise for improving the quality of care that patients receive. Recent analysis of the 2006 Commonwealth Fund Survey of Primary Care Physicians that Commonwealth Fund colleagues and I published recently in the professional journal *Health Policy* confirms that advances in information technology are making it easier for physicians to provide coordinated, high-quality care by streamlining many crucial tasks, including sending patient reminders, creating disease registries, prescribing and refilling medications, and viewing lab results. Doctors with a high level of health IT functionality were also more likely to think the health system works well and be satisfied with the practice of



medicine. In addition, [Fund-sponsored work](#) led by Ruben Amarasingham, M.D., M.B.A., of the University of Texas Southwestern Medical Center has shown that hospitals with more advanced information technology capacity have fewer complications and decreased mortality rates.

Several studies have also suggested that a business case can be made for the adoption of health IT, both at the facility level and within the health system as a whole. Amarasingham and his colleagues' findings importantly show that utilizing IT to automate test results, order entry, and decision support was not only associated with better quality but also lower average adjusted costs for hospital admissions and lower mean hospital costs for a variety of clinical conditions, including heart failure and coronary artery bypass grafting. Computerized decision support was particularly effective at generating savings. Higher degrees of decision support automation were associated with lower average adjusted costs of \$538 for all conditions. If these reductions were realized among the 37 million hospital admissions in the United States in 2005, facilities across the country would stand to save almost \$20 billion a year.

The Commonwealth Fund report, *Bending the Curve*, put the aggregate system-wide savings of promoting health information technology at \$88 billion over 10 years. The authors estimated that the cost reductions would result from a lower rate of medical errors, more efficient use of

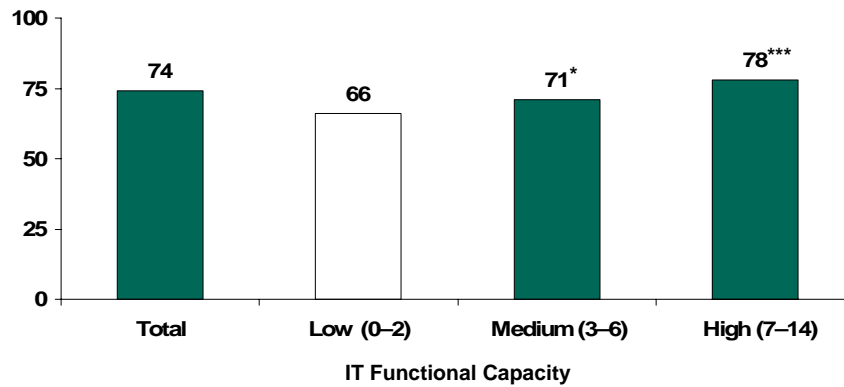
diagnostic testing, more effective drug utilization, and decreased provider costs, among other improvements. Additional savings would likely flow from better care coordination among multiple providers—and improved chronic care management—that would lead to a decrease in provider utilization and better health outcomes. Financial benefits accrue to all payers, with investments in health IT estimated to result in substantial cumulative net savings to all levels of government and households over 10 years and cumulative savings to private insurers after 11 years.

Health Information Technology in High Performance Health Systems

While technology has the potential to improve care, save lives, and reduce cost, data from high performance health systems within the United States and the broader international community show that investments in health IT must be made in conjunction with performance improvement activities. [Analysis of Geisinger Health System](#), a nonprofit integrated delivery network in Pennsylvania on whose board of directors I serve, shows that information technology is a crucial component of that organization's efforts to empower consumers and enhance value. Use of electronic health records within Geisinger's *ProvenHealth Navigator* medical home initiative improved quality while decreasing costs by 4 percent per enrollee during the first phase of implementation. Similarly, utilization of health IT

Physicians with Advanced IT Capacity in Seven Nations Are More Likely to Report Being Well-Prepared to Provide Optimal Care for Patients with Chronic Conditions

Percent of physicians who feel well-prepared to provide optimal care for patients with multiple chronic conditions



Note: Adjusted percentages based on logit models; Difference from practice with low IT capacity is statistically significant: *** p<0.001, * p<0.05.
 Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
 Source: K. Davis, M. M. Doty, K. Shea, and K. Stremikis, "Health Information Technology and Physician Perceptions of Quality of Care and Satisfaction," *Health Policy* (published online Nov. 25, 2008, in advance of print).

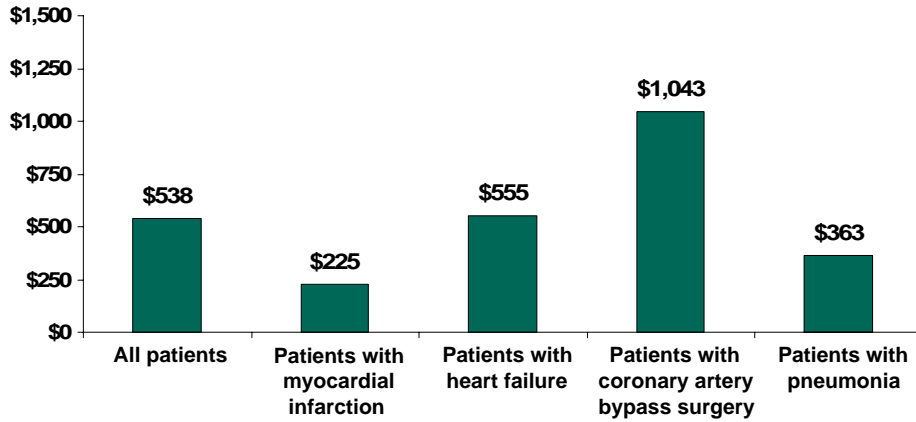
in Geisinger's *ProvenCare* acute episodic payment program helped decrease readmission rates by 5 percent, while the rate among the Medicare control population increased.

Geisinger's experience shows that realizing the full benefit of electronic health records requires a strategy that leverages technological innovation while simultaneously realigning provider incentives and encouraging greater organization of care delivery. This approach parallels that employed by Kaiser Permanente (KP), where investment in health IT was done concurrent to key changes in care process design and the introduction of a performance-based, patient-centered culture. As a result of these initiatives, more than 2.4 million KP members are now able to check lab results, access health information, and send secure messages to their doctor online. Integrating this functionality with KP's *HealthConnect* inpatient and outpatient care delivery systems has driven higher quality and better clinical outcomes.

The promulgation of health IT and the establishment of national information exchanges are also key components of high-performance health systems in Denmark and the Netherlands. Upwards of 99 percent of Danish primary care physicians now use electronic health records and e-prescribing. All prescriptions, lab tests, and hospital discharge letters flow through a single electronic portal accessible to patients—and with the permission of patients—to physicians and home health nurses involved in the patients' care. A 10-country study shows the importance of financial incentives, delivery system organization, a standards-setting organization, and peer influence in achieving and sustaining near-universal levels of participation in Denmark. Meanwhile, government funding, an electronic billing mandate, and accreditation of vendor systems all contributed to similar levels of health IT adoption in the Netherlands.

Hospitals with Automated Clinical Decision Support Generate Savings

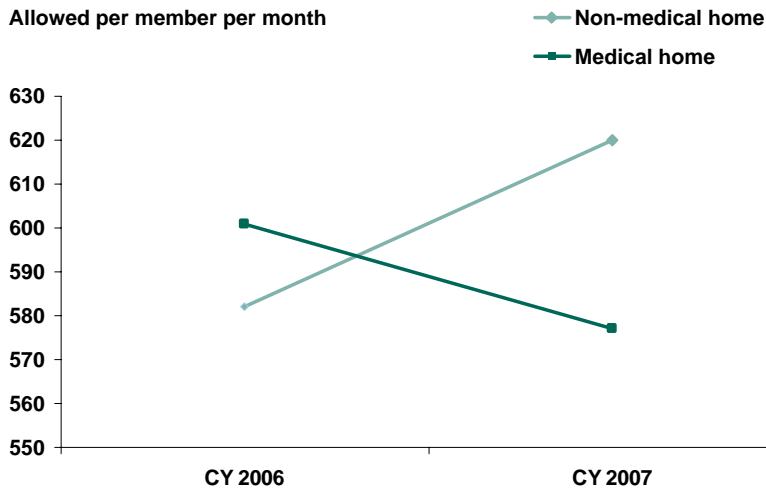
Mean adjusted hospital savings per hospitalization*



* Adjusted for patient complication risk; patient mortality risk; and hospital size, total margin, and ownership. Savings associated with a 10-point increase in Clinical Information Technology Assessment Tool subdomain score.
 Source: R. Amarasingham, L. Plantinga, M. Diener-West et al., "Clinical Information Technologies and Inpatient Outcomes: A Multiple Hospital Study," *Archives of Internal Medicine*, Jan. 26, 2009 169(2):108-14.

Geisinger Medical Home Pilot Sites Reduce Medical Cost by Four Percent in First Year

Allowed per member per month



Source: G. Steele, "Geisinger Quality—Striving for Perfection," Presentation to The Commonwealth Fund Bipartisan Congressional Health Policy Conference, Jan. 10, 2009.

Advancing the Health Information Technology Policy Agenda

President Obama and Congress must draw on the data and lessons from high-performance health systems as they design policies to encourage the spread of health information technology. Not only does the country need to implement health IT within the context of broader quality improvement, international and domestic experience show that concerted federal action is needed to encourage the spread of health information technology and ensure a substantial return on investment. In a new Commonwealth Fund [policy perspective](#), David Blumenthal, M.D., of the Massachusetts General Hospital proposes five important strategies for federal leaders to consider:

- The federal government should provide financial assistance to safety-net providers and small physician practices without the resources to purchase and implement health IT systems.
- Federal financial support is needed to design and implement information exchange networks in local communities.

- The federal government should support research to improve the capabilities of health IT and further evaluate its effects on health care costs and quality.
- Federal leaders must enact payment reform initiatives that encourage adoption of IT and improve health system performance.
- National regulations and standards are needed to ensure privacy and enhance certification, improving both doctor and patient confidence in the security of electronic medical records and the utility of a national network.

Just as investment in railroads, air traffic control, and interstate highways facilitated economic development and national prosperity in the 20th century, so too will the spread of health IT and the development of a national health information network bring long-run benefits and gains to the nation in the 21st century. It is crucial that our federal leadership move now to harness the power of information technology and put the nation on a path to high performance.

September 16, 2008

The Presidential Candidates' Health Reform Plans: Important Choices for the Nation

By Karen Davis

The presidential candidates have responded to Americans' deep-seated concern about the shortcomings of the U.S. health system with two very different health reform proposals. A new series of articles published on the Web site of the health policy journal *Health Affairs* provides important analyses of the health plans of Senators Obama and McCain that merit close examination. As the articles reveal, the candidates are far apart on what they perceive to be the root causes of system failure and on their overall strategy for fixing a broken sector that consumes 16 percent of the gross domestic product, yet leaves 46 million uninsured and another 25 million working-age adults underinsured.

The September 16 online issue of *Health Affairs* includes a [critique](#) of Senator Obama's health reform plan by Joseph Antos and colleagues, a [critique](#) of Senator McCain's plan by Thomas Buchmueller and colleagues, and an [article](#) by Mark V. Pauly that explores how the candidates' proposals might be combined in a single compromise package.

I believe the kind of scrutiny of both plans that is seen in the *Health Affairs* articles is positive—so that when the public has made its choice, the winning candidate can put his team to work, using the best information available on what reforms are most likely to promote a high performance health system.

Correcting a Cost Estimate

In the interest of helping inform the debate, colleagues at the Commonwealth Fund and I developed a framework for a comprehensive approach to health care reform that is laid out in "[Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance](#)," published in *Health Affairs* in their May/June 2008 issue.

To support their argument that Senator Obama's plan is too costly, the critique by Joseph Antos and colleagues cites the estimated costs of the *Building Blocks* proposal, which has several features in common with Senator Obama's plan. However, Senator Obama's proposal differs in important respects—for example, it does not require adults to have insurance and it has not specified the level of income-related premium subsidies or income eligibility levels for Medicaid and the State Children's Health Insurance Program (SCHIP).

The authors' assertion that the *Building Blocks* plan would increase spending by \$162 billion if it were operating in 2008 is misleading. The actual net cost to the federal budget in the article is \$82 billion in 2008, after allowing for the recapture of funds now subsidizing care of the uninsured, employer contributions to coverage of workers, and assessments on providers that offset their enhanced payments for care of the uninsured and Medicaid beneficiaries. An accompanying [issue brief](#) notes how even this cost could be further reduced to \$31 billion in 2008 by adopting a series of provider payment and health system reforms that have been supported, in principle, by both Senator McCain and Senator Obama. As a result, the nation could actually *save* \$1.6 trillion over 10 years if health expansions are coupled with efforts to reform how the United States pays for health care, invest in better information systems, and adopt initiatives to improve public health. The debate is not furthered by implying that coverage for all Americans is unaffordable. If properly designed, universal coverage could improve overall performance of the health system, enhance value for what we are spending, and assure access to health care for all.

The Underlying Differences

Despite the general nature of the health proposals advanced by the candidates, the *Health Affairs* articles shed light on the issues underlying this debate: how health insurance coverage would be changed, how coverage would be made affordable, and how the delivery of health care services would be affected.

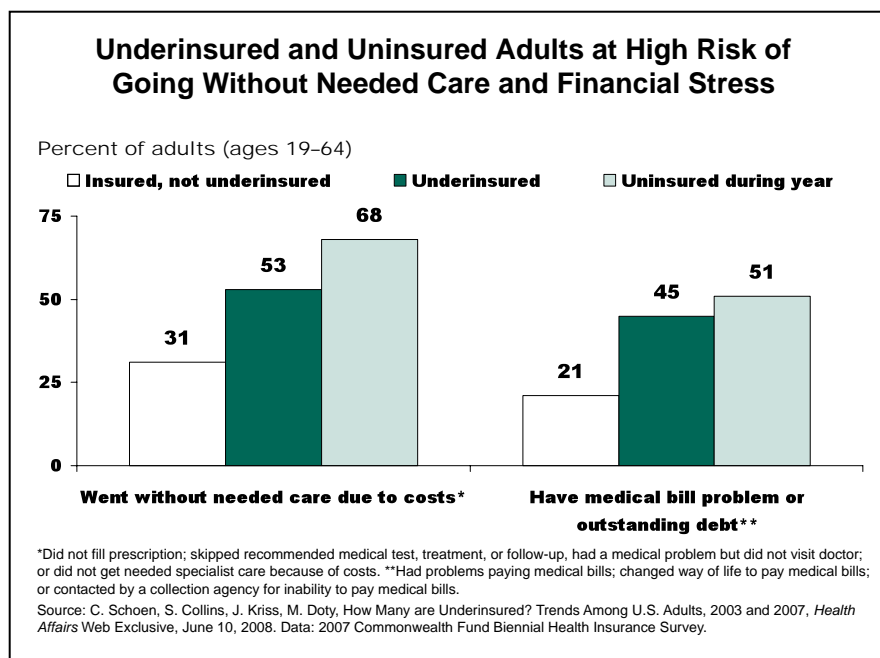
Senator McCain would provide refundable tax credits for the purchase of health insurance coverage—\$2,500 for individuals and \$5,000 for families. He would also count employer premiums for health insurance as taxable income to families. As a result, some people would pay less than they now pay, and some would pay more. Buchmueller and colleagues estimate that roughly 20 million would lose employer coverage and 21 million would buy individual coverage—for a net reduction in the uninsured of one million. Over time, the numbers of uninsured would grow because the tax credit is indexed to general inflation rather than rising health care costs. Buchmueller’s estimates are consistent with recent estimates from the [Tax Policy Center](#) at the Brookings Institution and Urban Institute.

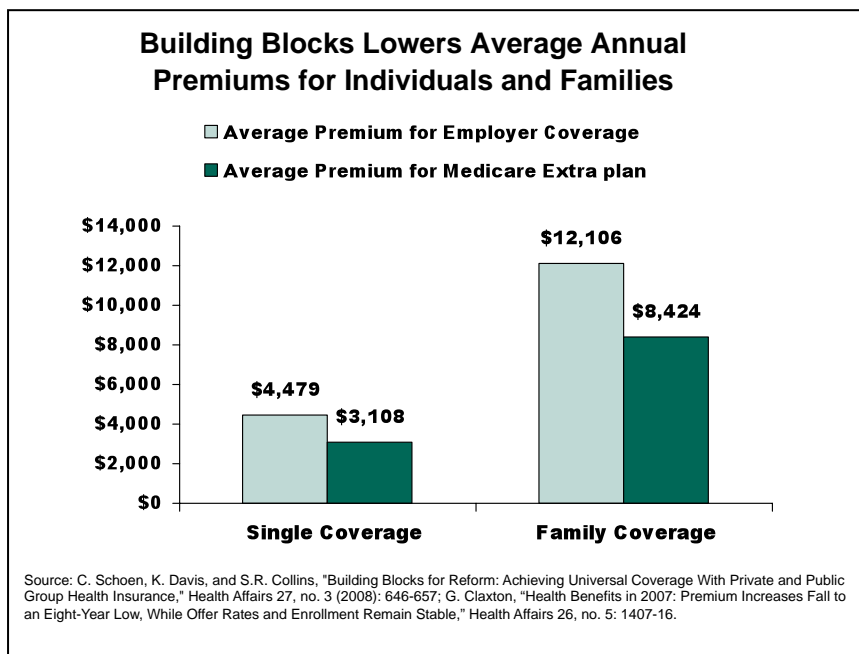
By contrast, Senator Obama would provide income-related premium assistance to lower- and middle-income families—although the exact amounts are not specified—and expand coverage under Medicaid and the SCHIP. The Tax Policy Center makes a number of assumptions about these specifics and estimates his plan would cut the number of uninsured roughly in half.

Our *Building Blocks* proposal, which includes a mandate that everyone have health insurance, expands SCHIP to adults and children with incomes below 150 percent of the poverty level, and ensures that no one pays a premium in excess of five percent of income for those in the lowest tax brackets or 10 percent of income in the higher tax brackets. As a result, it covers an estimated 44 million uninsured out of an estimated 48 million uninsured in 2008. Even without setting system reform savings, \$82 billion in federal budget outlays is an important investment in healthier children and workers, and key to ensuring financial security from medical bills for all families.

The *Health Affairs* articles also make clear the strategy each candidate would use to make coverage more affordable. Senator McCain would deregulate the health insurance market and permit individuals to purchase coverage in any state. Obama would provide a larger number of choices and include the option to select cheaper plans with more limited benefits. However, Buchmueller and colleagues point out that Senator McCain’s approach could undermine consumer protections and state laws designed to provide a minimum level of coverage—as insurers are likely to charter in states where regulations are scarce, as credit card companies do now.

Senator McCain’s philosophy is that consumers making cost-conscious choices would buy policies with leaner benefits. Higher out-of-pocket costs would also lead patients not to seek care for minor conditions. Antos and his coauthors say that the standard for benefits in





Senator Obama’s federal plan—now modeled on the plan available to members of Congress—should be reduced in order to hold down the costs of premiums and federal subsidies. But a skimpier plan is not the answer. A recent Commonwealth Fund report found that low- and even middle-income families are already experiencing difficulty paying medical bills and those with accumulated medical debt are rising. In 2005, 34 percent of adults ages 18 to 64 said they had trouble paying medical bills or had accrued medical debt; by 2007, 41 percent of adults reported such problems.

Buchmueller and colleagues also note that coverage in the individual market typically costs \$2000 more than employer coverage offering the same benefits. Pauly argues that many working families may prefer to keep coverage from employers, which generally has lower administrative costs, and suggests a compromise plan that would retain employer coverage but cap the amount of the premium excluded from income taxes.

Senator Obama has a different strategy for making coverage affordable. He would offer a public plan as well as private insurance plans through a national health insurance exchange and set rules for the sale of private insurance—such as requiring private insurance to cover healthy and

sick enrollees on the same basis. Private plans would have a maximum ceiling on the share of premium for administrative costs and profits. Antos and colleagues, however, suggest that greater government regulation of insurers could have undesirable consequences and stifle innovation. They are also concerned that increased insurance regulation coupled with the creation of a “fallback” National Health Plan would undermine the employer market. But this has not happened in Massachusetts, which has expanded employer coverage and restrained premium growth since enacting health reform.

Offering small businesses and those without access to employer coverage the option of buying a public plan modeled on Medicare is an intermediate approach. If the government can provide better coverage at lower cost, it would attract employers and the uninsured. Our *Building Blocks* proposal, which like Senator Obama’s proposal includes a public plan option, found that actuarial premiums for families in the public plan option were 30 percent below premiums now typical in the employer-sponsored insurance market. Such competition could induce private insurers to compete on quality and efficiency—for example by using networks of hospitals and physicians that provide superior care at lower cost.

Changing the Health System

While the candidates differ markedly on their approach to health insurance coverage, as Mark Pauly describes in his *Health Affairs* article, there are promising features in both McCain and Obama's plans; both would expand the use of health information technology, expand research on the comparative effectiveness of different prescription drugs, devices, and procedures, and support disease management programs. In addition, both Senator McCain and Senator Obama would allow importation of prescription drugs, reducing the costs of drugs.

Most importantly, both Senator McCain and Senator Obama support ensuring that Americans have access to a physician practice or clinic that serves as a medical home that is accessible to patients 24/7. Almost **three in four Americans** have problems with access to primary care on nights and weekends and even getting an appointment or phone call returned during the day. A medical home would also help patients navigate a complex health care system and be accountable for providing preventive care and chronic disease management. The Commonwealth Fund Commission on a High Performance Health System national scorecard finds that today, only half of Americans are up-to-date with preventive care and millions more do not have their chronic conditions adequately controlled.

To help make the system more responsive to patients, both presidential candidates would change the way doctors and

hospitals are paid to reward those that achieve excellence in care and keep patients healthy and out of the hospital, while cutting out unnecessary services that waste dollars and patients' time. A recent **Commonwealth Fund survey** of the public found that a third had experienced duplicate tests or doctors recommended services or treatment that were of little health benefit.

is is the most important aspect of the reform proposals—but one which has received very little attention. The *Health Affairs* authors are skeptical about magic “silver bullets” that will solve our cost problem, improve quality, and reduce medical errors. But other countries have succeeded in getting better outcomes at lower cost. Candidates should be pressed for more details on how they propose to put the U.S. on the road to a high performance health system—and what approaches now in practice in parts of the U.S. or around the world are workable options for the U.S. as a whole.

The *Health Affairs* articles do highlight some common ground in candidates' aspirations to improve the efficiency of the system and the quality of care. Our hope is that, post-election the focus will turn as quickly as possible to building concretely on the areas of agreement and work from there to achieve the health system reform that the country needs so desperately. We cannot afford to continue on our current course, and indeed must change direction to ensure affordable health care for all Americans.

November 7, 2008

Health Reform in the New Era: Options for the Obama Administration

By Karen Davis

After a long campaign season, and in the middle of an economic crisis, the American public has elected a new President and the 111th Congress. President-elect Obama and Congress will be juggling many competing priorities in 2009, including a historic window of opportunity for health reform.

The public and health care opinion leaders have called for an overhaul of the health care system. The President-elect campaigned on an ambitious health reform agenda—and he has often talked about the stories he heard on the campaign trail about ordinary Americans' struggles with the health care system, as well as his own family's health care experiences. The new President will be assisted in his reform efforts by the new composition of Congress—many members of which also made health care a key message in their campaigns.

The health care system is in crisis. John F. Kennedy, in a speech he gave nearly 50 years ago, noted that when written in Chinese, the word “crisis” is composed of two characters—one representing danger, the other representing opportunity. Perhaps never in our nation's history has this duality been more apparent than in our current quandaries.

In 2007, the number of uninsured stood at 46 million, up 20 percent from 2000. And the number of underinsured—people with health insurance that fails to provide access to care or financial protection—jumped 60 percent over four years, to 25 million in 2007. Today, people are even more worried about keeping their jobs and their health coverage, and are increasingly concerned about their debt, including medical debt. The Commonwealth Fund 2007 Biennial Health Insurance Survey found that about two-thirds of U.S. working-age adults, or 116 million people, struggled to pay medical bills or pay off medical debt, went without needed

care because of cost, were uninsured for a time during the year, or were underinsured.

While President-elect Obama has set forth the substance of his health reform agenda, he has not yet revealed his overarching strategy or precisely when and how he would move on health reform, but there are a number of courses of action open to his Administration.

Defer legislative action while pursuing administrative changes.

One option would be to postpone legislative action on health reform while tackling other immediate priorities such as the economy, energy, and Iraq. In the meantime, he could begin a process for gathering input and forging consensus by setting up a Congressional working group or Commission charged with soliciting views from the public, experts, and health care stakeholders, and then developing recommendations for the Administration. The Administration could simultaneously focus on a number of administrative changes that are possible through Executive Order, rule-making, and administrative actions. For example, it could make use of the rule-making authority to support state efforts to maintain and improve Medicaid/State Children's Health Insurance Program (SCHIP) coverage.

The advantage of this strategy is that it permits time to sort through difficult issues and find areas of consensus, while addressing other urgent policy priorities. But it also gives opposition time to build.

Make a down payment. At the Democratic Convention, Representative Rahm Emanuel (D-IL), the newly designated Obama White House chief of staff, said the incoming President would need to make a “down payment” on health reform, with the promise of more action to come. So another option would be to show quick action on part of the health reform agenda by enacting a few measures that would garner bipartisan support. This could include,

for example, reauthorization and adequate funding for the SCHIP and building health measures, such as an increase in federal matching funds for Medicaid, into any economic stimulus package. While this approach could have quick results, the major disadvantage is that it postpones fundamental reform, while likely surfacing many of the familiar ideological divides over private insurance and the expansion of public programs.

Use the states as laboratories. If the Administration believes that there is not sufficient consensus to enact health reform at the federal level, the new President might seek funding to permit five to ten states to move forward and test alternative approaches. Such a strategy already has strong bipartisan support. The advantage of this strategy would be the opportunity to learn from testing new approaches on a broad scale. However, a state-based approach to reform means that there will likely be wide variations in insurance coverage, effectiveness, and efficiency—a problem that has plagued the Medicaid program.

Initiate incremental steps in the context of a long-range vision. An alternative that would retain a strong role for the federal government in shaping health reform would be to set forth a long-range vision accompanied by a request for legislative action on some initial reforms. These first reforms could include not only the reauthorization of SCHIP and enactment of health information technology legislation, but other measures aimed at slowing the growth in health care costs such as the creation of a comparative effectiveness institute. The legislation could also authorize the planning and implementation of a national health insurance exchange to offer public and private health plans to small businesses and individuals, as well as a health board to oversee rapid experimentation with and diffusion of payment innovations in Medicare.

Seek a single legislative package with sequenced phases. Another possibility is to include building blocks for reform in a single legislative package that authorizes the flexible roll

out of reforms over a six-to-eight year period. A first phase could include the steps outlined above to slow the growth in health care costs and cover low-income children, but with a commitment and the legislative authority to phase in coverage for all. After covering low-income children, subsequent phases could, for example, eliminate the two-year waiting period for coverage of the disabled under Medicare and gradually providing premium assistance for low- and middle-income families to purchase coverage through the health insurance exchange. This approach has the advantage of generating savings in early phases and ensuring those health system reform savings are dedicated to coverage expansions, that sufficient planning is given to implementation of more complex provisions, and that politically popular as well as difficult reforms are considered in their totality and early-on, when the new Administration and Congress have the requisite political capital. Such a sequenced approach to health reform could put the U.S. on a firm path to a high performance health system, yielding better access to care, improved quality, and greater efficiency.

Take early action on comprehensive reform. Finally, president-elect Obama could move swiftly to enact comprehensive health reform in a single legislative package while he has the political capital garnered in a major election victory. If leaders in Congress, such as Senator Kennedy, have a legislative package ready to go, it could be introduced immediately and folded into a major omnibus budget reconciliation act. This would be a bold stroke—one appropriate to the seriousness of the crisis in the health care system and the even more challenging fiscal problems ahead as the baby boom generation reaches retirement.

Windows of opportunity for real health reform do not stay open for long. While the challenge is daunting and the stakes are high, it is imperative that our new federal leadership moves swiftly to change direction and put the U.S. health system on the path to high performance.

February 25, 2009

Compassionate and Challenging Changes in Health Care

By Karen Davis

Last night, President Obama reaffirmed that comprehensive health reform is urgently needed to spark economic recovery, ensure all Americans are able to get the care they need, and lay the foundation for slowing the growth in health care costs. With a recognition that our country's health care and economic fate are intertwined, the president and the 111th Congress have already taken several significant steps toward ensuring affordable health coverage for millions of families and bending the curve of the country's spending on health. Reauthorization of the Children's Health Insurance Program (CHIP) and the passage of an economic stimulus package with health provisions to invest in information technology and research on the effectiveness of medications, devices, and health services represent important down payments on more fundamental change and far-reaching reform.

The president has said that the stories he heard on the campaign trail about people struggling with health care touched his heart. Tragically, there are countless stories of Americans whose lives could have been saved or disabilities averted if they had been able to afford high-quality medical care. In a recent *New Yorker* article, Atul Gawande, M.D., wrote that instances of cruelty in the health care system triggered health reform in many other countries. We may have reached the point where Americans can no longer tolerate the lack of compassion too often faced by those who are sick and unable to pay for care. As a result, many Americans are now willing to think seriously about reforms that will lead to excellent and affordable health care for all.

In response to the health and economic crisis facing the country, the Commonwealth Fund Commission on a High

Performance Health System has issued a report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, that provides a strategy for achieving long-term health security and fiscal responsibility.

The Commission lays out a framework for responsible and effective use of federal money that ensures funds go to improve access to care, provide savings to families and businesses, and improve the quality and efficiency of care. These reforms will guarantee affordable coverage for all, improve health outcomes, and slow health spending growth by \$3 trillion over the next decade. If enacted now, these early investments will pay significant dividends, with coverage, payment, and system reform savings projected to offset the increase in annual federal spending for affordable coverage expansion by 2020.

Compassionate Changes

The Commission's report makes a compelling case for compassionate change in our health system. Most importantly, these reforms would make the health care system work better for patients and families.

Coverage and Care for All

The *Path* proposal would extend affordable health insurance to everyone. The number of uninsured—now at 46 million and projected to rise to 61 million in 2020—would instead fall to an estimated 4 million, or about 1 percent of the U.S. population. Even hard-to-reach individuals would likely qualify for free or low-cost coverage if they became ill and sought health care. An estimated 100,000 lives could be saved through the coverage and system reforms included in the *Path* framework.

Affordable Premiums

The *Path* proposal's approach to coverage builds on what works best in our public-private insurance system. A national health insurance exchange offering a public plan option and a variety of private plans would ensure that everyone has access to an affordable coverage. Income-related premium help would be available to make sure that individuals and families in the lowest tax bracket spend no more than 5 percent of income on premiums, and that people in middle-income tax brackets pay no more than 10 percent of income on premiums. For the many Americans facing job insecurity, the insurance exchange would provide a stable and portable source of an affordable coverage.

The plan also calls for opening up Medicaid and CHIP to people with incomes below 150 percent of the federal poverty level (under \$33,000 for family of four). Those who currently have insurance coverage could keep it.

No Discrimination Against the Sick

Under the *Path* proposal, insurance plans could no longer turn people away because they have an existing medical condition or are considered to be at high risk for one. Nor would individuals with health conditions be charged higher premiums than healthy people. As a result, people in poor health who can no longer work—who today have few prospects of retaining or obtaining coverage—would no longer fear being without access to insurance coverage and care.

Protection from Ruinous Medical Expenses

The public plan offered through the national health insurance exchange would establish a minimum standard benefit package based on the standard option available to members of Congress and federal employees. Employer plans and plans offered through the exchange would be required to meet this standard of coverage. Deductibles would be \$250 per person or \$500 per family rather than the \$2,000 to \$10,000 deductibles found in some health insurance policies today. Preventive services and services required for treatment of chronic conditions would be covered in full.

Family Savings

The average family would save \$1,140 in 2010 under the plan, thanks to reforms that reduce administrative costs and promote efficiency in the health care system, as well as those that guarantee financial protection from health care bills. By 2020, the average family would save \$2,314 annually, with families of all income levels spending less due to slower cost growth. These dollars would provide substantial relief to families that are now financially strapped because of medical bills and often have to choose between medical care and other basic necessities.

Challenging Changes

While health care providers, employers, taxpayers—and insurers and the health industry—would benefit in important ways, the *Path* framework includes several significant challenges and important decisions for the country to make as it moves down the path to high performance.

Health Care Providers

The most important benefit for physicians is that health insurance for all would help them deliver the care their patients need. No longer would nearly 40 percent of adults under age 65 say they do not obtain needed care because of cost. No longer would patients fail to fill a prescription or take it as indicated, fail to receive a mammogram or colonoscopy or see a specialist, or fail to come back for follow-up care because of trouble paying medical bills.

To help physicians deliver care in a way that works for patients, the *Path* proposal makes changes in the way health care is organized and the way hospitals and doctors are paid. All patients would be encouraged to enroll with a physician or nurse practitioner practice that meets the standards of a “patient-centered medical home” that makes care available 24/7. Such practices would be expected to be accountable for ensuring that their patients get all recommended care by using information technology and office systems to remind patients about preventive care and assisting them with obtaining needed specialty care.

ese practices would be rewarded with an extra “medical home” fee paid by insurers and public programs, as well as extra bonuses for high performance in preventive care and chronic care management. Physicians would be encouraged to practice in more integrated delivery systems or virtual networks, working with other physicians, nurses, pharmacists, and other health professionals in a team approach to ensure coordination of care and shared accountability for health outcomes. This is a major change from our current isolated solo or small physician practice style of care, and will require not just funding but technical assistance and infrastructure support. To support provider groups as they reorganize—a challenging task even for large providers—the government should fund regional or state health information exchange networks, facilities that offer after-hours care to patients from different practices, case management help, and more.

Likewise, hospitals would be accountable not only for care during the hospital stay but follow-up care for 30 days following discharge, with incentives to improve transitions in care, reduce complications, and coordinate care as patients go back home or to rehabilitation facilities or other post-acute care. Hospitals would be rewarded for reducing complications and assisting patients with recovery, as well as ensuring that post-acute services are tailored to patients’ needs. To carry out this role, hospitals would need to modernize their information systems and participate in health information exchange networks that ensure prompt information about hospital and emergency room care gets back to patients’ primary care physicians.

Providers who accept accountability for patient health outcomes and prudent use of resources would be rewarded.

Those who provide unnecessary, duplicative, or avoidable services would face revenue losses and would need to improve their processes of care and reposition their business operations.

Health expenditures would grow at 5.5 percent annually under the proposed policies, compared with 6.7 percent under current projections. A phased approach to payment reform will give providers time to prepare for the new payment methods and allow Medicare to develop appropriate rates, methods, and administrative structures that will support greater care coordination.

Employers

Along with households and governments, employers are expected to be part of the solution to gaps in coverage, variable quality, and high costs. All employers would be required to either provide health insurance that meets minimum standards to their employees or contribute 7 percent of worker earnings, up to \$1.25 an hour, toward a coverage fund for employees.

While costs will initially increase for employers who do not currently shoulder some of the responsibility for providing coverage, businesses of all sizes stand to gain under the *Path* framework. Reforms will slow the rise in premiums with net cumulative employer savings of \$231 billion over the period from 2010 to 2020.

Taxpayers

The net effect of the *Path* proposal could result in higher federal taxes and lower state and local taxes. The Commission did not recommend specific federal tax changes but noted revenues that could be generated, if necessary, through taxes on health insurance, health care, luxury goods, or incomes of \$200,000 or more. Indeed, the *Path* proposal requires initial federal investments and sources of long-term financing to achieve maximum system savings. Taxes on harmful health products, including sugared soft drinks, calorie-dense foods, tobacco products, and alcoholic beverages are included; a portion of these revenues would be shared with state and local governments to launch obesity and smoking cessation initiatives.

As designed, federal government net outlays would increase by \$593 billion over the 2010–2020 period and state and local government net outlays would decline by \$1.034 trillion. Other design choices—such as increasing premiums paid by states to buy public coverage for the low-income elderly and disabled—could shift more of the savings to the federal government.

Deficit financing in the early years can be justified as part of an economic recovery program because expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Making important investments in coverage, payment, and delivery reform now will reap savings in the long term. These actions, taken together, have the potential

to bend the curve of our unsustainable spending on health and generate systemwide savings of \$3 trillion over 10 years.

Insurers

Perhaps the most challenging change is the proposed shift in the role of private insurers. Insurers would be required to provide coverage to all—healthy and sick alike—on the same terms. In addition, they would need to compete with a public plan that would be offered to all individuals and employers at a premium at least 20 percent lower than current premiums in the individual and small-business market.

To compete against a public plan with lower administrative costs and greater leverage over provider prices, private plans would need to bring added value, improved quality, and greater efficiency through tools available to them, such as selection of provider networks, utilization management, and benefit design. Some private insurers may adopt the public pay innovations in payment—as they earlier adopted Medicare payment methods. This would provide even greater impetus to delivery system changes to improve quality and efficiency.

The public plan option is key to system savings. The *Path* report shows that \$0.8 trillion would be saved by the coverage, payment, and system reforms without a public plan option, while \$3 trillion would be saved with a public plan. The public plan is critical to lower administrative costs and ensure that savings from payment reform are passed on to employers and workers.

Under the *Path* proposal, an estimated 108 million Americans would retain private coverage, compared with the 178 million now covered by private plans. The net “loss” of private coverage is based on the assumption that private insurers will not alter their business operations to compete effectively with the public plan—an assumption that may well be proven wrong. Moreover, like Medicare, the public plan would contract with private insurers to administer claims for the 106 million people enrolled through the public plan, which would be a major expansion of the administered services business.

Integrated delivery systems that are able to provide higher quality care more efficiently—through their own hospitals and physician group practices—would experience a major expansion of enrollment, with over 50 million enrolled in such systems of care. Private insurers that are not linked to integrated delivery systems may try to emulate some of practices that lead organized care systems to achieve savings, such as funding nurses in physician practices to help patients with chronic conditions.

Health Industry

Any reform with the potential for \$3 trillion in savings in a sector of the economy that is otherwise expected to spend \$42 trillion represents a major shift to stakeholders. Pharmaceutical companies, for example, could expect to be paid lower prices for many of their medications as the government becomes a more active purchaser of prescription drugs. In addition, research on comparative effectiveness may find that certain new drugs do not offer added benefits, making public programs and insurers unlikely to pay more for the new drugs.

There are also business opportunities for the health industry. The uninsured will be able to afford needed medications. Currently only 40 percent of adults with hypertension, for example, have that condition controlled. New information systems and incentives for chronic care management could lead to a major increase in use of effective medications.

The almost universal adoption of information technology and health information exchange networks envisioned by the *Path* report—and given an important jumpstart by the economic stimulus legislation—will also provide business opportunities for the health industry. Accelerating the adoption and use of effective health information technology—with the capacity for decision support and information exchange across care sites—is required to bring about needed change in our care delivery system.

These investments will yield significant returns. The *Path* report estimates total system savings of \$261 billion over 2010–2020 from increased use of health information

technology, and \$634 billion in savings from comparative effectiveness research and its application to health insurance benefit, coverage, and payment decisions. Rather than denying patients effective care, utilizing value-based benefit design based on comparative effectiveness research will facilitate the use of safe, clinically proven care within the system and provide the information needed to improve value.

Health Security and Long-Term Fiscal Responsibility: A 2020 Vision

Although politically difficult, there is an urgent need to move in new directions. The comprehensive reforms proposed by the Commission will spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure that all Americans are able to get the care they need and deserve. The cost of inaction is high. The nation needs national leadership and public-private sector collaboration to forge consensus to move in positive directions. With both an historic political opportunity and a clear path toward a high performance health system that works for all Americans, the time has come to take bold steps to ensure the health and economic security of this and future generations.



RETHINKING THE MANAGEMENT OF FOUNDATION ENDOWMENTS



Executive Vice President and COO's Report
2009 Annual Report

RETHINKING THE MANAGEMENT OF FOUNDATION ENDOWMENTS

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As the implications of the 2008–09 financial crisis for the world economy and markets have become clearer, many foundation executives and investment committees are reassessing their approach to endowment management. This essay reports on the effects of the recent turmoil on foundation endowments thus far, and offers lessons from the crisis and earlier ones that could help boards and investment committees responsible for foundation endowments avoid mistakes going forward. The essay concludes with an analysis of alternative models available to foundations for managing their endowments, highlighting the strengths and weaknesses of each and providing recommendations on preferred models.

A Bear Stock Market of Epic Proportions: The Impact on Private Foundations

The bear market in stocks that began in October of 2007 and apparently bottomed in early March 2009 constituted the second most severe crash in stock prices on record—exceeded only by the September 1929 to June 1932 crash that ushered in the global Great Depression (Exhibit 1). Tellingly, the recent market decline exceeded by substantial margins any of

the bear market declines that the current generation of endowment managers had experienced in their careers.

As a result of the market crash of 2008–09, the returns of most foundation endowments in the fiscal year ending on June 30, 2009, were severely negative: the average for 420 university and foundation endowments tracked by Cambridge Associates was –19.1 percent for the year (Exhibit 2). The crash has changed the financial landscape for foundations: most are now faced with three-, five-, and 10-year average annual returns well below the 5-percent-plus-inflation rate needed to ensure perpetuity.

Prior to the recent market crash, large foundation endowments with sophisticated investment strategies, patterned on those of major university endowments like Yale's, outperformed smaller endowments with more conservative investment strategies.¹ Because all asset classes except U.S. government bonds joined in the 2008–09 market rout, the risk-reducing benefits of diversification expected of the Yale endowment management model disappeared during the recent financial crisis—with the result that larger endowments uncharacteristically performed no better than smaller ones over the last year, and many did worse (Exhibit 3).

Cover: Robert C. Pozen, chair of MFS Investment Management, and William Y. Yun, executive vice president of Alternative Investments for Franklin Templeton Investments, are members of the Fund's Investment Committee, which Mr. Yun chairs. The Investment Committee, supported by the Fund's executive vice president-COO and Cambridge Associates consultants, oversees the management of the foundation's endowment, including determining the allocation among asset classes and selection of investment managers and closely monitoring investment performance. Photo: Martin Dixon.

Exhibit 1. The 2007–08 bear market in U.S. stocks was the second-most severe since 1929.

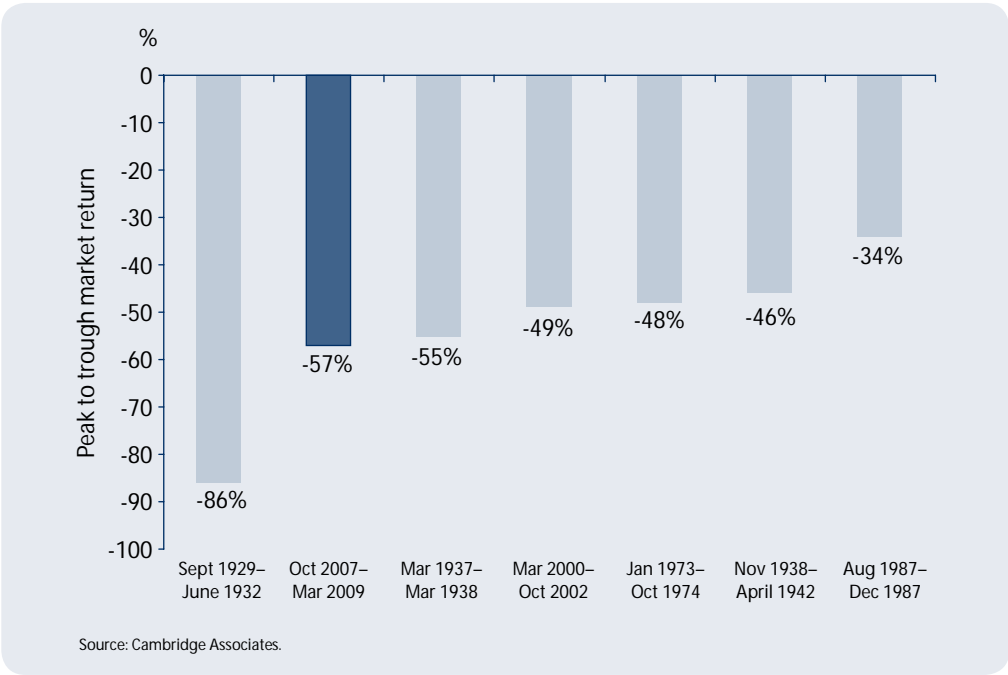
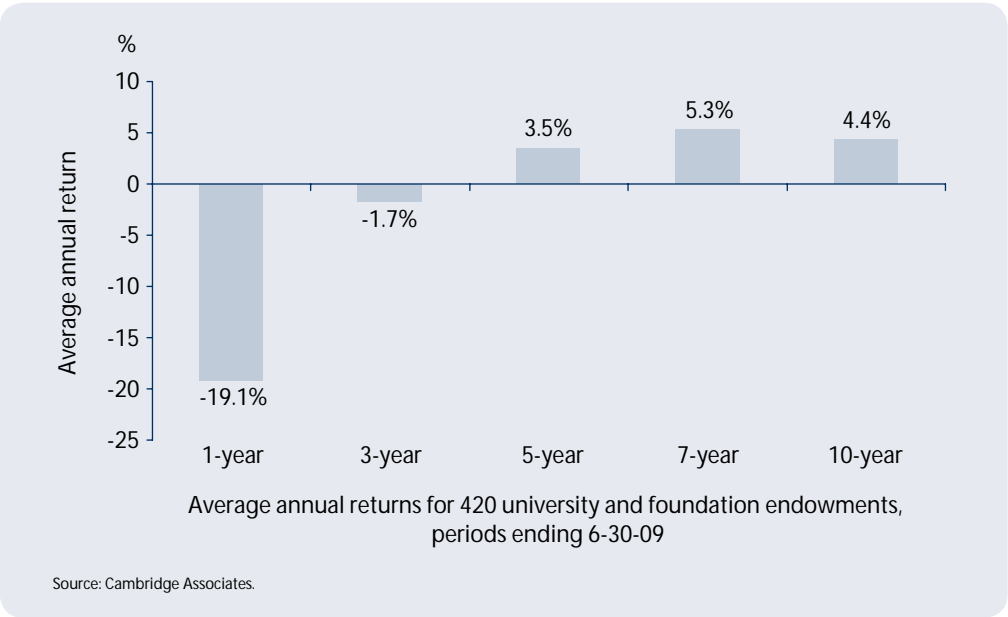


Exhibit 2. In the July 1, 2008–June 30, 2009 fiscal year, university and foundation endowments suffered severely negative returns, pulling down their long-term average annual returns to levels insufficient to cover both inflation and the 5 percent payout required of foundations.



Following the market crash, private foundation assets have likely declined by over 20 percent (Exhibit 4). March 2009 survey results reported by the Council on Foundations reveal that three-quarters of foundations experienced asset declines of 25 percent or more in 2008, and 47 percent reported a drop in endowment market value of 30 percent or more.² Since many foundations base their spending on the lagged three-year rolling average market value of their endowment, the immediate impact of the market crash on giving has been muted thus far. Even so, the Council on Foundations survey revealed that 48 percent of foundations reported plans to reduce the value of their total grantmaking by 10 percent or more in 2009. Sixty percent of responding foundations reported cutting their operating budgets in 2009, and 45 percent implemented salary freezes.

Will the 2009 Market Rally Last?

Along with other investors, foundation managers have been heartened by the global market rally that took off in early March 2009 (Exhibit 5). As impressive as the bounce-back returns have been thus far, however, they have not been sufficient to restore much of the wealth lost in the crash: the value of a dollar invested in U.S. stocks at the October 2007 peak was still worth only 70 cents (before inflation) on December 31, 2009. More worrisome, the history of stock market episodes following major financial system crises is marked by bear market rallies that raise hopes, dashed by subsequent corrections—as exemplified by the 2010 stock market correction that began on January 19 and pushed down U.S. stocks by 6.5 percent by February 12.³ Further, there is widespread agreement that the rally to date has been concentrated in speculative, lower-quality stocks and based on the expansion of price/earnings ratios, rather than sustainable increases in corporate earnings.

Exhibit 3. In 2008–09, the endowments of very large foundations uncharacteristically did not outperform those of small foundations.

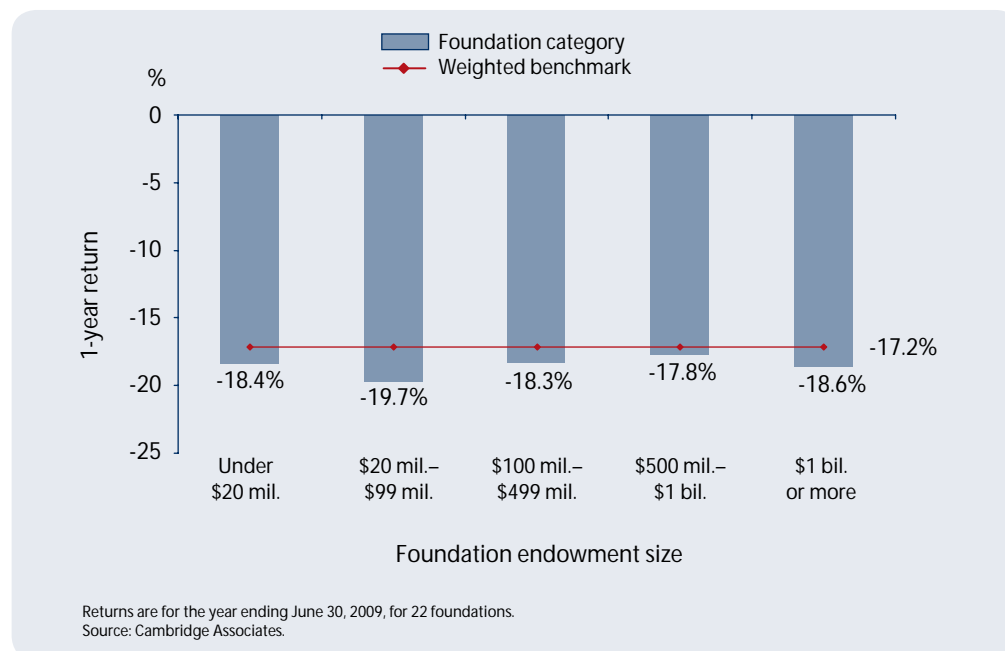


Exhibit 4. As a result of the 2008–09 market crash, total private foundation assets have likely declined by more than 20 percent.

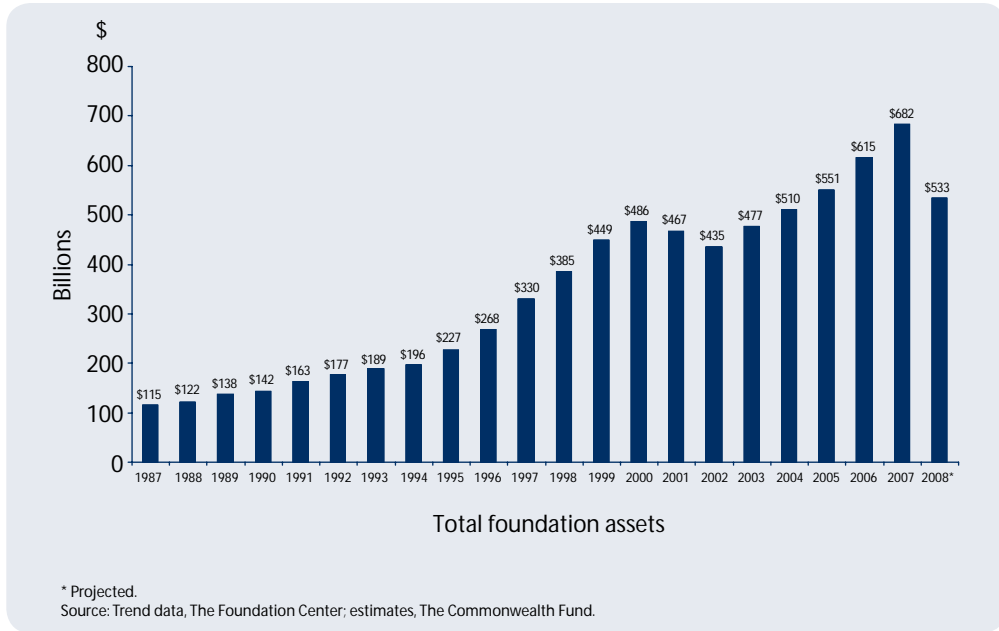
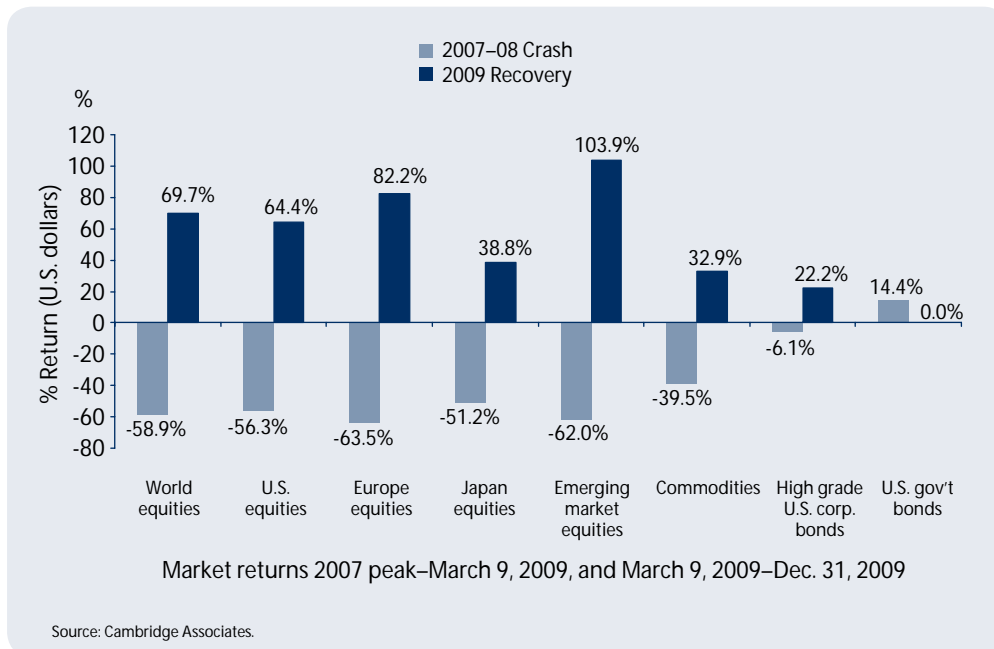


Exhibit 5. The post-crash recovery—will it last?



Thus, venerable investors like Jeremy Grantham of the investment management firm GMO predict modest investment returns over the next seven years, especially in the United States: as of December 2009, the predicted average annual real return for large-capitalization U.S. stocks is about 1.3 percent, and that for small capitalization U.S. stocks, 0.5 percent (Exhibit 6). Grantham does hold out the possibility that these returns might be increased by skilled active managers, but the probability of achieving better returns depends crucially on whether the fault lines in the global financial system that caused the crash are being properly fixed, and on the prospects for the revival of economic activity.

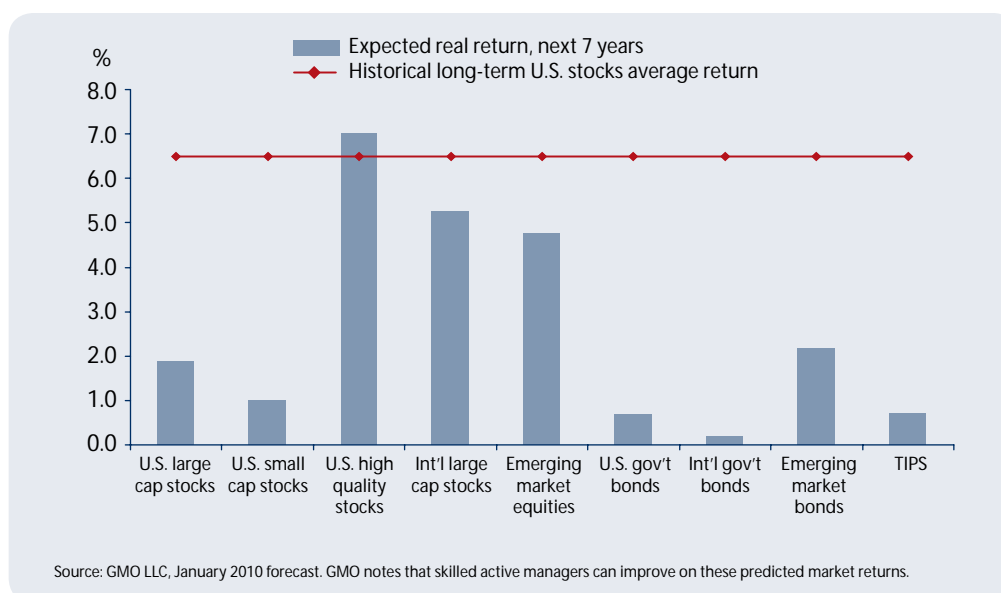
Lessons from the Financial Crisis and Progress Toward Financial System Reform

Among the best of the numerous books analyzing the causes of the crisis in the financial markets is one written by Robert Pozen, chairman of MFS Investment Management and member of The Commonwealth Fund's board of directors and its investment

committee. In *Too Big To Save?*, Pozen describes how the Federal Reserve set interest rates too low from 2001 through 2006, leading dollar investors across the world to search for higher yields from mortgage-backed securities than obtainable with U.S. Treasuries.⁴ This global demand, given lax regulation of many mortgage lenders and excessive leverage allowed in Wall Street banks, drove housing prices to bubble heights. Pozen documents how the spread of new financial instruments such as collateralized debt obligations and credit default swaps introduced unappreciated major risks into the financial system, a problem compounded by the trading of such securities outside regulated exchanges and by the conflicted position of credit-rating agencies, whose compensation depended on favorable ratings for securities they were supposed to score objectively.

In his book, Pozen proposes a wide array of system reforms that he sees as key to putting the U.S. and global financial system on a firm footing for economic stability and growth. A number of these proposals are included in the financial system reform

Exhibit 6. Many analysts predict quite modest inflation-adjusted returns on equities over the next seven years, with the result that foundations will be challenged in meeting their objective of 5 percent annually.



legislation that is now being debated in Congress. In the debate, there is wide agreement on the need for the following reforms: a systemic risk monitor, higher capital requirements for financial institutions, more transparent and better organized markets for financial derivatives, as well as expansion of the federal government's resolution authority to cover insolvent nonbank financial firms. Passage of reform legislation, however, has been delayed by major points of disagreement, including the following: the scope of the Federal Reserve's authority, the proper agency for regulating consumer financial products, and the supervisory framework for mega-financial institutions in the system—how to insure their accountability and define a contained, low-cost role for government when they get into trouble.

Along with all Americans, foundation endowment managers have a great deal riding on the outcome of the ongoing financial system reform debate in Congress. The above-noted modest investment returns forecast for the next seven years are predicated on at least a modest economic recovery and average annual inflation of 2.5 percent. However, as documented by Carmen M. Reinhart and Kenneth S. Rogoff in a recently published landmark study of financial crises, the typical aftermath of a major bank-centered financial crisis involves a protracted period of falling GDP, often lasting two years or more.⁵ In their review of eight centuries of financial crises, with special focus on those in this century, these scholars label the current turmoil as the "Second Great Contraction," ranking just below the one that produced the Great Depression. Thus, there is substantial risk that the nation may face slow growth and high unemployment for an extended period. This risk puts a premium on getting financial system reforms "right," and in place as soon as possible. As Rogoff notes, "If we don't re-regulate the

banking system properly, we'll either get very slow growth from overregulation, or another financial crisis in just 10 to 15 years."⁶

Added to these risks are those posed by the state of U.S. finances—the level of government debt and persistent international balance of payments (current account) deficits that threaten long-term growth and stability. As Alice Rivlin, former vice chair of the Federal Reserve and founding director of the Congressional Budget Office, argues, "[T]he biggest economic challenge for 2010 is enacting credible future deficit reduction without derailing the fragile recovery."⁷

Avoiding Mistakes

In his book, Pozen lays out the mistakes made by many modelers responsible for the introduction of the complex financial instruments, such as mortgage-backed securities and credit default swaps, that played key roles in bringing the financial system to its knees in 2008.⁸ Reinhart and Rogoff similarly identify recurring fallacies and lessons to be drawn from the history of financial crises. These two bodies of work can help foundations avoid mistakes in managing their endowments.

1. *Simple extrapolations of the past are dangerous.* Pozen cautions that "the differences between past and future trend lines can be as important as the similarities." For example, given the gravity of the current financial crisis, foundations should be careful about assuming that the historical average of market returns will prevail over the next several years.
2. *Be patient in riding out financial bubbles.* As Pozen reminds us, investment bubbles can last for years, but economic fundamentals

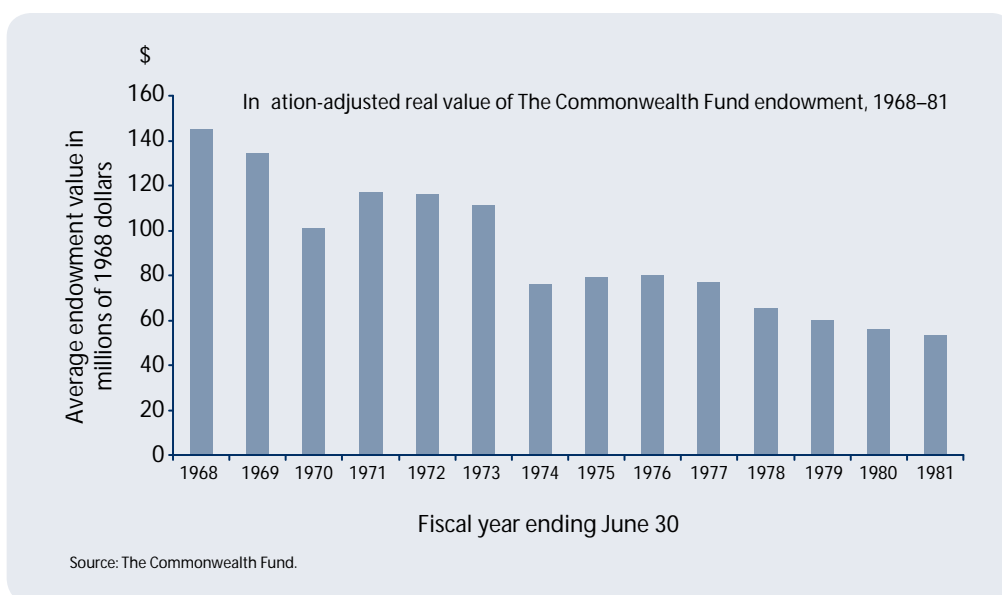
ultimately win out. In safeguarding against bubbles, foundations should base their budgeting and investment strategies on what they perceive to be long-term realities. As Jeremy Grantham points out, this means in practice that in a financial bubble like that of 2003–08, perpetual foundations should allow their spending rate (spending as a percentage of endowment average market value) to fall—thereby setting aside “fat years” funds for use in the lean years that are inevitably to come.⁹ More difficult, of course, is sticking to fundamentally sound investment strategies that produce below-benchmark returns in periods of market excess. As Pozen concludes, “the timing of the burst of any bubble is impossible to predict, so be very patient.”

3. “The frequency of extreme events is greater than people think,” to quote Pozen again. Major global banking crises have occurred, on average, every 12 years since 1900, as Reinhart and Rogoff document, and

every 11 years since 1945. For perpetual foundations, the occurrence within a 40-year period of two endowment-shaking crises like the financial crisis and oil shock-induced stagflation of the 1970s (when, as shown in Exhibit 7, it was not unusual for the inflation-adjusted market value of foundation endowments to decline by 60 percent) and the 2008 global financial disorder indicates that such crises are not “black swan” events. Foundation managers would be wise to heed Pozen’s advice: pay more attention to low-probability events and hedge or insure against them if possible.

4. Beware of the “It is Time Is Different Syndrome.” As Reinhart and Rogoff describe, the thinking of the mid-2000s in the U.S. was “Everything is fine because of globalization, the technology boom, our superior financial system, our better understanding of monetary policy, and the phenomenon of securitized debt.” In their research covering multiple centuries, these

Exhibit 7. The real value of a typical U.S. foundation’s endowment declined by over 60 percent in the financial and stagflation crises of the late 1960s and 1970s.



authors find similar thinking preceded virtually every financial crisis. Foundation managers should conclude that the siren call of “It Is Time Is Different” is a sure signal to lower the risk profile of the endowment.

5. *Be knowledgeable of the predictors of financial crisis.* Reinhart and Rogo present a convincing body of evidence that markedly rising asset prices (particularly housing bubbles), slowing real economic activity, large current account deficits, and sustained debt build-ups (public or private) generally precede a financial crisis. Attention to such systemic risk measures can help foundations position their endowments to better weather financial crises.

6. *Understand how the origins of a financial crisis can greatly affect the depth and duration of its impact on economies and markets.* Reinhart and Rogo’s research informs us that bubbles are far more dangerous when they are fueled by debt, as was the case with the global housing bubble of the early-to-mid-2000s.

Their study reveals that global financial crises arising from excess leverage are typically followed by very severe, multiyear slowdowns in economic activity accompanied by high unemployment. Just as such crises produce major bear markets in stocks, so they entail bear market rallies followed by resumed slumps. Endowment managers ignore this pattern at considerable risk.

7. *Ignore liquidity risk at your peril.* With their deep endowment pockets and significant fixed-income holdings, foundations generally do not worry much about liquidity. But with increasing commitments to private equity

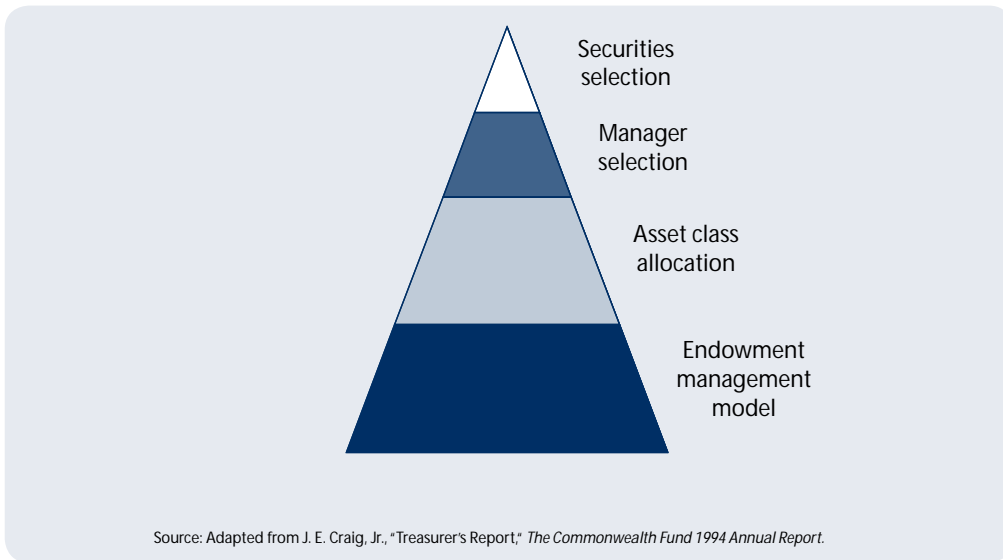
and hedge fund partnerships, liquidity risk was already a real concern for many endowments before the recent financial crisis. The crisis demonstrated that this risk rises significantly as leverage increases within the financial system. Thus, foundations should keep necessary reserves on hand and take increasing care that they are cautiously invested as financial storms gather. As yields fall on short-term investments, foundations will be lured to higher-yielding alternative products, but the risks and liquidity profiles of such products require very close examination. In light of recent experience, a number of foundations have taken out lines of credit, and more should consider doing so.

8. *Be ready to question the experts.* Adapting Pozen’s advice on how banks and investment firms should manage their expert modelers, a primary role of a foundation’s investment committee is to understand the limitations of the foundation’s financial staff, consultants, and investment managers. Committee members should ask questions that push the so-called experts to explore fully the risks involved in each strategy and the assumptions underlying any quantitative model.

Managing Foundation Endowments

The uncertainties arising from the 2008–09 market crash, the Second Great Contraction, the path of financial system reform, and the need to put the U.S. financial house in order mean that foundations face more challenges in managing their endowments than at any time since the interrelated monetary system crises of the late 1960s and the oil-shock-induced stagflation of the mid-1970s. In response to their

Exhibit 8. The management model of a foundation endowment ranks with asset class allocation as a key determinant of long-term performance.



disappointing investment performance over the last several years, a number of foundations have already overhauled their approach to managing their endowment. The remainder of this essay will address options available to others that have misgivings about the suitability of their current model.

By the early 1980s, foundation managers, their investment consultants, and academic researchers had come to recognize that decisions regarding asset class allocation generally have greater impact on investment performance than does the choice of investment managers or individual securities—important as the latter two components of endowment management are. The widely used pyramid shown in Exhibit 8 reflects this consensus, indicating that the most important function of endowment fiduciaries is to determine the asset class allocation appropriate to current market circumstances, then to select investment managers best suited to implement the allocation decision—leaving the task of portfolio construction to full-time investment professionals.

While the literature on endowment management is replete with research and advice on asset class

allocation, the manager selection process, and of course the selection of securities for different types of portfolios, it is remarkably silent on the makeup of the base of the endowment performance pyramid: the endowment management model specifying the role of investment committees, internal financial/investment staff, investment consultants, and external entities assigned with responsibility for making asset allocation and manager decisions.¹⁰ Reflecting the bias of the research literature, foundation investment committees spend most of their time on investment strategy, when it is often the case that as much attention needs to be given to discussion of the ideal management model for making the most of the endowment.

The universe of private foundations is far more diverse than that of colleges and universities, comprising some 29,000 organizations in 2008 that range in size from tiny foundations with assets of less than \$100,000 to the Bill and Melinda Gates Foundation, with assets of \$38 billion. As shown in Exhibit 9, the distribution of foundation assets is heavily concentrated in some 300 organizations with

assets of \$250 million or more, but even within this group, the size range is enormous. This diversity, as well as the uniqueness of each foundation's mission, culture, and history, makes it difficult to develop general lessons on how best to structure the management of an endowment. Even so, it is hoped that the following analysis will help fill an important gap affecting the performance of the foundation sector.

Foundation Endowment Management Models

The schematic in Exhibit 10 presents five basic models available to foundations for managing their endowments and the approximate level of delegation of authority by investment committees that goes with each. As the chart indicates, the delegation level for each model ranges substantially from foundation to foundation.

- Solo investment committee model.** In this common approach, typically employed by very small foundations but also by many small and even midsize ones, the investment committee of the board has virtually all strategic and operational responsibility for the endowment—working with little or no internal staff or consultant support, although generally delegating portfolio management to a brokerage firm, mutual funds, or external investment managers (typically using commingled funds shared with other investors).
- Investment committee-investment consultant model.** As foundation size and investment strategy complexity increase, many investment committees recognize the need for an investment consultant to help inform and guide their decisions, and sometimes to help implement them. The amount of responsibility

Exhibit 9. The distribution of foundation assets is heavily concentrated in some 300 foundations with assets of \$250 million or more.

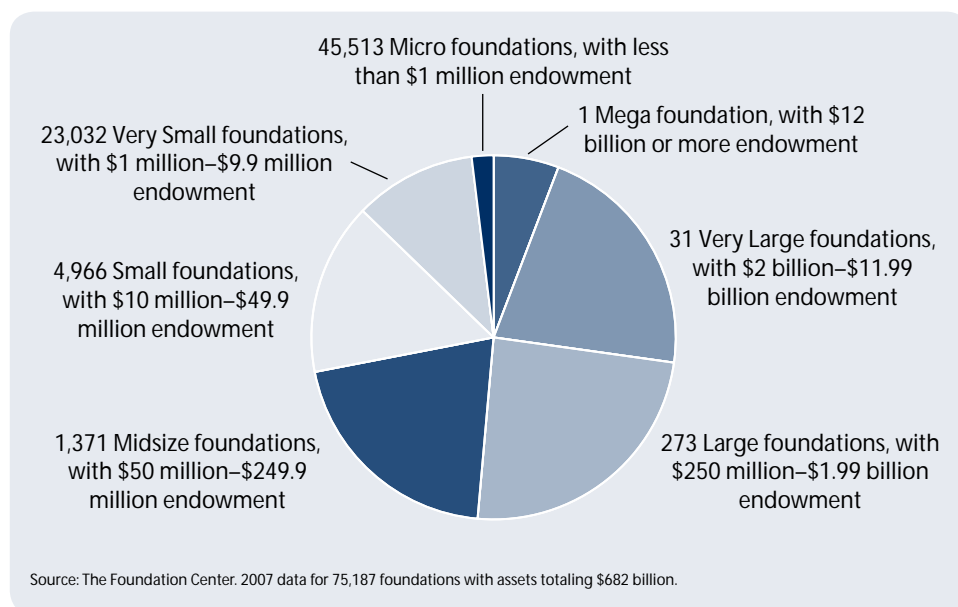


Exhibit 10. The larger the foundation, the more responsibility investment committees must delegate to consultants, internal chief investment officers, or outsourced CIOs.

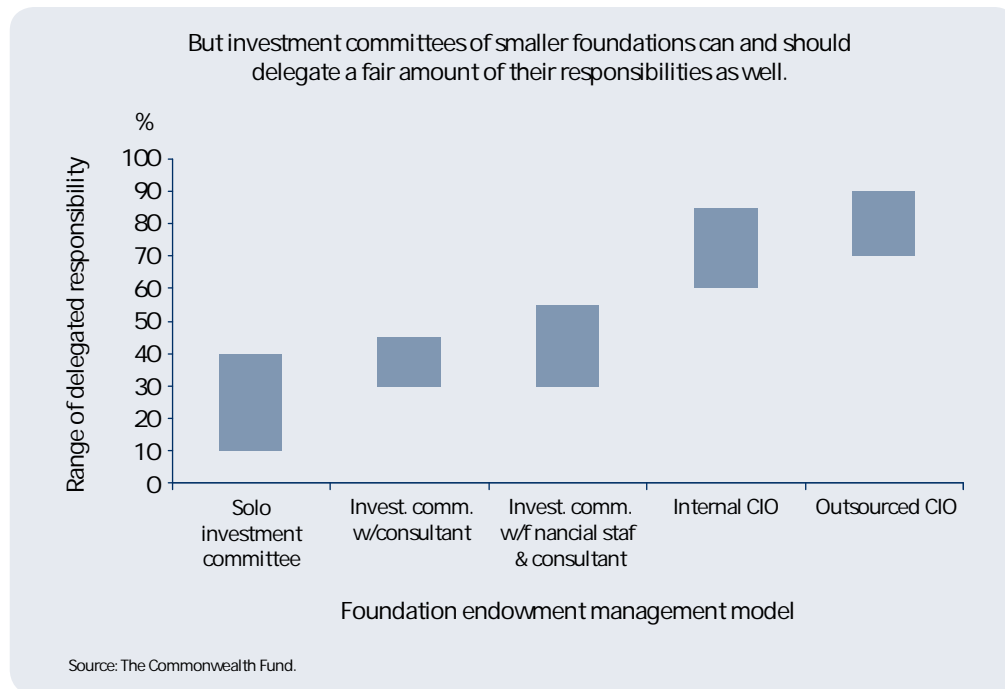


Exhibit 11. Over the last 25 years, larger private foundations have increasingly diversified their endowment portfolios, substantially increasing allocations to a variety of equity markets and reducing fixed income allocations.

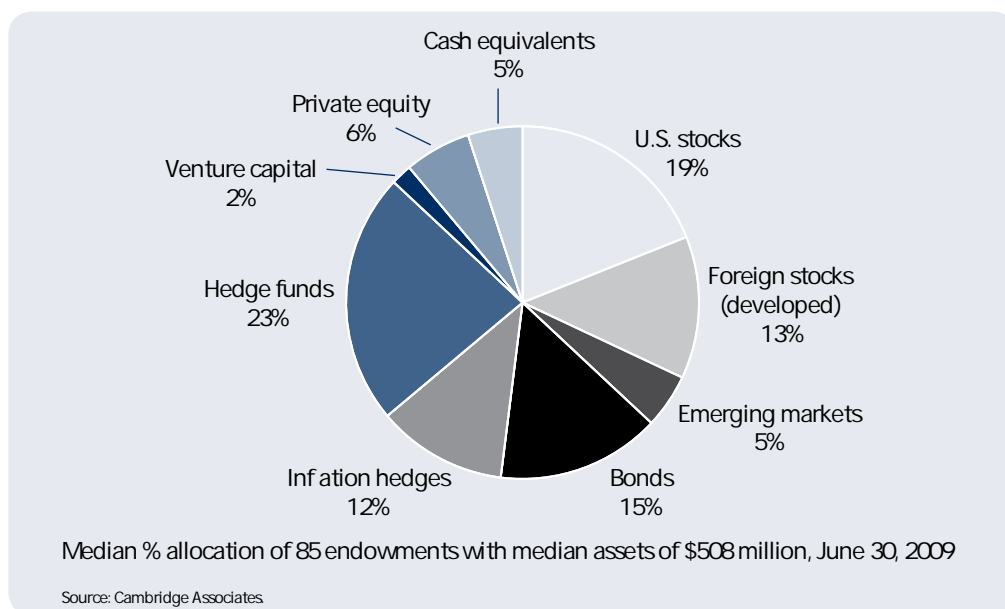
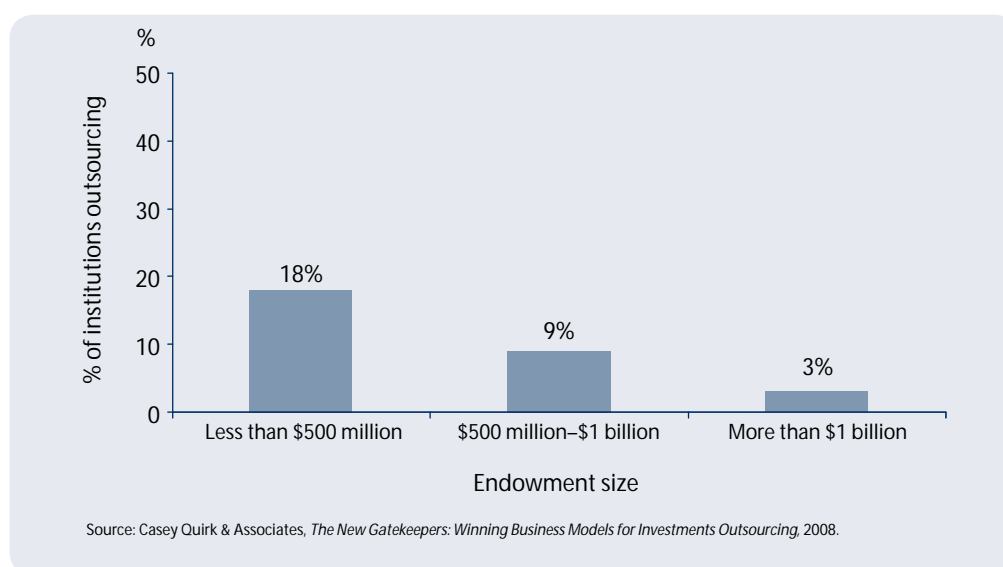


Exhibit 12. Increasingly, nonprofits are fully outsourcing the management of their endowments.



delegated by the committee ranges significantly under this model, depending on the capacities and preferences of the committee and the ability and services offered by the consultant.

- Investment committee-internal financial staff-investment consultant model.** Any foundation with assets of \$250 million or more is likely to pursue the sophisticated diversified investment strategy shown in Exhibit 11. Under these circumstances, the day-to-day responsibilities of managing the endowment require qualified staff; moreover, barring an investment committee member with the time, inclination, and expertise for working closely with the consultant on strategic and operational issues like manager searches, a professional staff member is needed to ensure best use of the time and skills of the consultant and committee members. Thus, this model entails still higher de facto (if not formal) levels of responsibility delegation by the investment committee.
- Internal CIO model.** Once a foundation reaches the \$2 billion or so level in endowment

assets, it becomes economic and feasible for it to hire a full-time, highly trained, experienced chief investment officer (CIO) and recruit a sizeable, dedicated professional investment team, compensated at the necessary competitive levels.¹¹ As described by Lawrence E. Kochard and Cathleen M. Ritterreiser, a number of very large foundations including the Carnegie Corporation and William and Flora Hewlett Foundation use this model and have achieved considerable success.¹²

- Outsourced-CIO (O-CIO) model.** Given the shortcomings of the solo investment committee, committee-consultant, and committee-financial staff-consultant models discussed below, the trend in recent years is for foundations with under \$2 billion dollars in assets to fully outsource the management of their endowment to a firm that essentially offers a packaged set of services comparable to those that very large foundations obtain with an in-house CIO (Exhibit 12). The O-CIO firm—the best being the creation of a stellar former CIO

of a large university endowment or pension fund—assumes most of the responsibility for managing the endowment. While the amount of delegated authority varies from foundation to foundation, most investment committees using this model have an essentially advisory role and, beyond consultation on broad strategy, leave decisions on managers and tactical moves to the O-CIO. The spectrum of actual services offered by O-CIOs is wide, ranging from somewhat customized portfolios to one-size-fits-all proprietary portfolios.¹³

Small foundations are leading the trend toward the O-CIO model, but foundations in the \$250 million to \$2 billion range are also attracted to it—in large part because of their increased use of “alternative” investments like hedge funds, private equity, venture capital, real estate, and timberland, and the difficulties of identifying and gaining access to top-ranked managers of this type on their own. Contributing to the trend also is the disappointment of many midsize and large foundations with their existing investment committee- or consultant-driven management model in the recent financial crisis.¹⁴ Foundations that have gone this route include the Rockefeller Brothers Fund, Colonial Williamsburg Foundation, John A. Hartford Foundation, Teagle Foundation, and Chichester DuPont Foundation.

It should be noted that the universe of firms offering the O-CIO model is diverse. While firms established by distinguished former CIOs of large university endowment or pension funds attract the most attention, many traditional investment consultants now offer such services (partly out of competitive necessity). Additionally, some traditional top-ranked balanced managers serve as O-CIOs to institutions like the Greenwall Foundation, although

their products do not include alternative investments. Some offices of wealthy families also offer O-CIO services to selected clients other than the founding family, and, of course, banks have for years performed this function for foundations organized as trusts.

The strengths and weaknesses of each of these models are summarized in Exhibits 13a and 13b. The primary strength of the solo investment committee model is that it leaves, in theory, no doubt regarding where accountability for the management of the endowment lies. All too often, however, foundations employing this model shy away from the investments performance tracking that would help tell them how well their investment committee is functioning. Even when a record of below-market performance is clear, some boards are unwilling to hold the investment committee accountable for it. Small and even midsize foundations can find it difficult to attract board members with sufficient investment experience and expertise and the time or inclination to fully direct their skills to management of the endowment. Further, committee members are likely to develop a very limited set of investment managers from which to choose and may favor those they know—with attendant potential conflicts of interest. Indeed, board member conflicts of interest in the management of endowments arise all too frequently, and require firm attention by board and audit committee chairs.

Even with effective leadership, investment committees operating alone are sometimes challenged in reaching consensus and taking action, or fall into the trap of “group think.” Under these circumstances, most small foundations using this model are best off employing only mutual funds, with a strong bias toward low-cost mutual fund indexes. Even so, the

Exhibit 13a. The *strengths* of foundation endowment management models.

Solo Investment Committee	Investment Committee-Consultant	Investment Committee-Consultant-Internal Sta	Internal CIO & Dedicated Investment Sta	Outsourced CIO
<p>Committee exercises full responsibility for the endowment—no question of where accountability lies, provided performance is tracked and board holds committee accountable</p>	<p>Consultant brings:</p> <ul style="list-style-type: none"> • Advice on asset allocation based on wide range of contacts and experience • Strong financial research base • Information on and access to a wide range of investment managers, including managers of nontraditional alternatives like hedge funds and venture capital • Independent voice, helping build consensus, avoid conflicts of interest 	<ul style="list-style-type: none"> • More effective use of consultant, customization of services to foundation's particular needs • Better oversight of investment managers and endowment operations • More accountability • More safeguards regarding conflicts of interest • More integration of investment mission with program mission 	<ul style="list-style-type: none"> • Full and measurable accountability for management of the endowment • High level of internal investment experience, expertise, and research capacity • Capacity to identify and gain access to top-ranked managers, especially to nontraditional alternatives and rising-star managers • Undivided loyalty of CIO to the foundation • Potential contributions of CIO to foundation's program strategy (investment insights) 	<ul style="list-style-type: none"> • Potential solution to "missing chief investment officer" problem for foundations with assets <\$2 billion • Full and measurable accountability for management of the endowment • High level of investment experience and expertise • Pre-hiring investment track record • Capacity to identify and gain access to top-ranked managers, especially to alternatives and rising-star managers • Proactive, rather than passive advice • Performance fees • Limited number of clients, low conflict-of-interest risk with O-CIO, if not also an investment consultant

weaknesses of the solo investment committee model are such that it is prone to being suboptimal.

Adding a qualified investment consultant to the investment committee model helps address many of these issues, but not all. The chief weakness of the investment-committee-with-consultant model is that responsibility for decision-making is muddled, and it is difficult for the board to hold either the committee or consultant accountable if things go wrong. While investment consultants bring research, experience, and contacts that are extremely valuable in building

consensus, setting strategy, and hiring and firing managers, they can be more passive in providing advice than is desirable. Additionally, the quality of investment consulting firms can range widely, as can the value-adding capacity of any single consultant within even a strong firm.

There are other weaknesses as well. First, the performance record of investment consultants is reputational, not statistical, which presents a challenge in the hiring decision.¹⁵ Second, consultants have many clients competing for their best ideas and

Exhibit 13b. The *weaknesses* of foundation endowment management models.

Solo Investment Committee	Investment Committee-Consultant	Investment Committee-Consultant-Internal Sta	Internal CIO & Dedicated Investment Sta	Outsourced CIO
<ul style="list-style-type: none"> Challenges in recruiting members with sufficient investment experience and ability to commit required time and attention Significant conflicts of interest risk Potential board reluctance to hold committee accountable Challenges of achieving consensus while avoiding “group think” No investment research capacity Limited capacity for identifying and gaining access to top-ranked managers—especially managers of alternatives and rising stars 	<ul style="list-style-type: none"> Accountability weakened by diffusion of responsibility and resulting difficulties regarding performance attribution In hiring a consultant, reliance on references unsubstantiated by verifiable track records Variable quality of individual consultants within a firm Competition among many clients for consultant’s attention and firm’s best ideas and access to best managers—significant consultant conflicts of interest risk Can be passive in offering advice—when conviction is needed Unlikely to identify or propose innovative rising-star managers Effective management of consultant can be an issue 	<ul style="list-style-type: none"> Weaknesses of Investment Committee-Consultant model mitigated, but not eliminated, and performance of model depends heavily on ability of internal financial staff to add value Given multiple responsibilities and compensation issues, difficulties of attracting staff able to add value Competing responsibilities of internal financial staff, limiting their ability to add value to investment process 	<ul style="list-style-type: none"> Economic only for foundations with \$2 billion or more endowment Challenges of recruiting and retaining star CIO, compensation issues Potential oversight issues Potential culture conflicts between program and investments staffs 	<ul style="list-style-type: none"> Key person risk Possible limits on customization of strategy/services to individual foundation needs Significant conflicts of interest risk for O-CIO, if also an investment consultant Adequacy of oversight by foundation investment committee Limited number of truly able O-CIO firms available, and limitations on their client capacity Concern that outsourcers will, over time, add clients beyond optimal level

access to the best firms in their pools of investment managers. Third, consultants are unlikely to recommend partially tested, rising-star managers or cutting-edge products—although achieving above-market performance virtually depends on beating other investors to new investment approaches. Finally, as with any consultant, investment consultants provide their best work through a strong working relationship with, and guidance from the client; yet many investment committee chairs lack the time required to provide such guidance.¹⁶

Foundations with assets of roughly \$150 million or more find it economic to seek to enrich the potential of the investment committee-consultant model by assigning a qualified foundation staff member responsibility for managing the consultant and orchestrating investment committee meetings. With the right experience, training, and judgment, an internal chief financial officer can greatly strengthen the committee's ability to make the most of the investment consultant's skills, ward against any problematic conflicts of interest, ensure firmer daily oversight of endowment operations and their integration with the foundation's operating needs, and bring helpful investment insights to program strategy and grantmaking. Even so, while accountability can be enhanced by the addition of qualified staff, it remains an issue. More seriously, staff in these roles typically have multiple and substantial other responsibilities within the foundation, and may lack either or both the time or expertise to produce all the benefits of this approach. Foundations employing this model, moreover, often face a major challenge in identifying and adequately compensating a staff person able to meet the many demands of the assigned role.

The vitally missing piece in the first three models is a chief investment officer—a role which should arguably be assigned, at least *de facto*, to someone in

any organization totally dependent on an endowment for income. Well executed, the internal CIO model addresses most of the shortcomings of the first three models. Besides being unaffordable for all but about 30 of the largest private foundations, however, the chief weaknesses of this approach are the challenges of recruiting and retaining a highly qualified CIO, particularly given the compensation such individuals draw in other settings.¹⁷ While CIOs can add value to the foundation's programs, culture clashes between programmatic and investment staffs do arise, and the foundation needs to take care that the values of the foundation and the CIO are fully aligned, and that the strong personality that is typically a CIO trait fits into the foundation's management structure.

Like the internal CIO model, the outsourced-CIO model also addresses most of the weaknesses of alternative management approaches. The constraint here is the number of highly qualified individuals and firms to which such responsibility can be safely delegated. As predicted in a study by Casey Quirk and Associates, many former large university or pension fund heads will set themselves up as O-CIOs in the coming years—but not all will be true investment stars.¹⁸ The ability of the largest group of entrants into this business—established investment consultants—to deliver high-quality O-CIO services stands a substantial risk of being compromised by their responsibilities to existing consulting clients and their questionable ability to attract truly outstanding investment professionals. There are also concerns that while existing O-CIO firms restrict the number of clients to the small number needed to ensure above-market returns, they will be pressured over time to grow the firm beyond an asset level that is optimal for clients.

Other issues with O-CIO firms include the extent to which they can customize services to the needs of individual foundations and the extent to which an investment committee feels it has adequate oversight of the O-CIO. Among the best of existing O-CIOs, any shortcomings on these issues are more than offset by their skills and thus performance. The remaining risk, “key person,” is thus the primary one—the viability and strength of the firm should it lose its star CIO. This risk is real, as most outstanding O-CIO firms are small. At the same time, given the newness of this model, few such firms are likely to face a transition in leadership for the foreseeable future.

To sum up, the three existing endowment management models used by most foundations—solo investment committee, investment committee with consultant, and investment committee with consultant and limited financial staff—all have serious limitations that make it unlikely that they will produce, over the long term, returns greater than those of the market and present considerable risk of generating below-market returns. Yet very few foundations are likely to be able to pursue the two alternative models, because of the economic infeasibility of the CIO approach for most foundations and the limited availability and capacity constraints of truly outstanding firms able to serve as outsourced CIOs.

Fortunately, The Investment Fund for Foundations (TIFF) was established in 1991 to help overcome many of the shortcomings of the principal endowment management models available to most foundations. Patterned after the CommonFund, which was established for educational institutions in 1971, TIFF enables foundation and other nonprofit investment committees to get out of the business of identifying and selecting managers by offering pooled funds invested by teams of multiple managers hired

by the TIFF board.¹⁹ The range of products offered by TIFF is wide—from mutual funds for conventional U.S. equities, international equities, and bonds, to hedge fund, private equity, and natural-resources investment pools. In addition, TIFF’s Multi-Asset Fund provides foundations an efficient vehicle for fully outsourcing the management of the endowment. While not offering investment consulting services, TIFF staff does help educate foundation trustees on asset class allocation and other investment issues. Operating as a nonprofit cooperative and with a highly trained and experienced staff and board, including some of the most respected endowment and pension fund CIOs in the country, TIFF avoids many of the pitfalls, articulated so well by Yale University’s David Swensen, of management approaches dominated by for-profit fund-of-fund managers, consultants, and inadequately equipped investment committees.²⁰

Given the strengths and weaknesses of this array of approaches for managing foundation endowments, the following recommendations seem appropriate:

- Foundations with assets of \$2 billion or more will generally be best off by hiring a highly qualified chief investment officer, supported by a sizeable dedicated internal investments staff.
- For other foundations, particularly those with assets in the range of \$500 million to under \$2 billion or so, identifying an outstanding outsourced-CIO firm is the preferable approach. Foundations with assets of \$20 million–\$50 million are also prime candidates for this approach, as their size is well suited for rounding out an O-CIO’s portfolio of clients.

The limited supply and capacity of outstanding O-CIO managers, however, means that relatively few foundations will actually be able to successfully execute this model.

- Great care, obviously, must be taken in selecting an O-CIO, with respect not only to their qualifications but also to potential conflicts of interest involving board members. Given the amount of delegation of board responsibilities involved, any conflicts of interest should be avoided, and most committees would benefit from using a consultant to professionalize the search for, and screening of, candidates. The obvious conflicts of interest that investment consultants face in simultaneously serving traditional and O-CIO clients lead to the conclusion that, with rare exceptions, the O-CIO responsibility should not be delegated to consultants. As with any investment manager, the performance of an O-CIO should be judged over a market cycle.
- Foundations with assets under \$2 billion that are unable or disinclined to outsource should make the most of the investment committee-consultant-internal financial staff model by taking maximum advantage of the products offered by TIFF or other nonprofit fund-of-fund managers.
- Foundations with less than \$100 million in assets may not be able to retain internal staff capable of adding value to the investment committee's work, but only the smallest foundations (assets of \$20 million or less) can justify, for economic reasons, going without the benefits of an investment consultant. Smaller foundations that choose not to use an investment consultant should make all the more use of TIFF by taking full advantage of the investment educational services and advice that it offers.

Making the Most of Investment Consultants

Since most foundation investment committees should supplement their skills with those of an investment consultant, it is well to consider guidelines for selecting and using such consultants effectively. As Robert Marchesi has written, there are more than 100 investment consulting firms in the United States, and the scope and quality of their services vary enormously.²¹

In selecting a consultant, the first task of an investment committee is to define the level of services it needs to address gaps in the committee's capacities. Most committees need a significant number of services from their consultant, including investment research, investment strategy, manager searches and selection, and regular consultation with the committee and internal staff. If the foundation lacks internally or through its securities custodian the ability to measure and report investment performance, this service should also be sought from the consultant.

Exhibits 14a and 14b summarize desirable and undesirable traits to look for when selecting an investment consultant for a foundation endowment. A strong weight should be placed on the consultant team's investment experience and training, but equally important is the firm's business structure, with particular attention to conflicts of interest. The investment committee should probe to see if the consultant is honest about its own strengths and weaknesses, and whether it is willing to recommend competitors (e.g., TIFF or low-cost index funds) when they offer superior products. As the Madoff scandal of 2008 demonstrates, the investment consultant should be able to explain the investment strategy of any firm in its stable of managers, and should demonstrate deep knowledge of each firm's business. Regardless of recommendations from the consultant's existing clients, a foundation investment

Exhibit 14a. Selecting an endowment investments consultant—essential traits.

<ul style="list-style-type: none"> • Firm is independent, with no ownership conflicts. • Firm displays high level of integrity and appreciation of conflicts of interest that arise regularly in investing. • Firm recognizes its limitations—does not, for example, offer O-CIO services that it is poorly equipped to provide. • The lead consultant offered by the firm is skilled and experienced, and interacts well with investment committee members and staff. • The lead consultant is backed up by a deep team of researchers and investment professionals with a wide range of contacts in the investment manager business. • Lead consultant advises with conviction, strengthening committee's decision-making process. • Firm is transparent on the investment managers with which it works and is able to fully document and explain any recommended manager's investment strategy, performance, and risks. 	<ul style="list-style-type: none"> • Firm has a range of investment manager types in its stable—with respect to size, investment style, age, risk/reward profile—and has a record of identifying promising new managers and recommending them for clients' consideration when appropriate. • If the foundation is large enough to invest in the "alternatives" areas, the consulting firm has demonstrated capacity to identify top-ranked managers of this type and gain access to them for its clients. • Firm is willing to recommend TIFF and other nonpro fit pooled fund products, as well as low-cost index funds when these can serve the client best. • The foundation will be an important client to the consulting firm, ranking high in its pecking order for recommending clients to leading investment managers. • Firm and proposed lead consultant produce multiple strong client references. • Firm offers a competitive fee structure, with no imbedded conflicts of interest.
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Exhibit 14b. Selecting an endowment investments consultant—traits to be avoided.

<ul style="list-style-type: none"> • Firm owned by a larger business selling investment products posing conflicts of interest. • Firm has a record of involvement in conflicts of interest, questionable practices. • Firm is essentially a "feeder" for large investment managers, mainly serving to steer clients to established managers. • Firm offers services—e.g., O-CIO, that it is ill-equipped to provide. • Firm's team has questionable investment training and experience. • Concern that the proposed lead consultant may not be their best, or that interactions with the lead consultant could prove problematic. • Lead consultant is passive in giving advice, weakening committee decision-making process. • Firm is secretive regarding its investment manager pool and is unable to document and explain some managers' strategy, performance, and risks. 	<ul style="list-style-type: none"> • Firm is so small that it is likely to offer the same set of investment managers to all clients, and be limited in its ability to identify and recruit promising new managers to its stable. • Firm is unable to identify and gain access to leading managers in important areas in which the foundation wishes to invest. • Firm is unwilling to recommend TIFF or other nonpro fit pooled funds or low-cost index funds when appropriate, instead offering up inferior products for its own business reasons. • The foundation will be a marginal client for the firm, unlikely to receive "preferred customer" attention in opening doors to skilled investment managers. • Client references on the firm or proposed lead consultant are limited and inconclusive. • Firm has noncompetitive fee structure or fee arrangements posing potential conflicts of interest.
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committee and staff should focus on the ability of the lead consultant to meet the particular needs of the foundation and on the personal chemistry that emerges in the screening process.

Consultants, in general, are no better than the individual directing the use of their services, and this rule applies equally in the endowment management business. Thus, investment committees should lay out clearly in the foundation's investment policy statement the division of responsibilities among committee members, any internal staff, and the consultant, and assign a specific committee member or staff person with responsibility for guiding the consultant's work. The foundation person charged with this responsibility should have available the time needed to advise and direct the consultant effectively. To play this role well, the committee member (usually the chair) or staff member should be well informed about the foundation's overall financial picture and program objectives and skilled in using the consultant's services to advance effective committee decision-making.

Just as most foundations judge the performance of their investment managers over a market cycle, so should the performance of the investment consultant be reviewed periodically—about every five years. Such reviews are best carried out in the context of considering a small number of alternative consultant firms, as the strengths and weaknesses of the existing consultant are more clearly illuminated by comparisons with other firms.

Conclusion

Every crisis presents opportunity, and many foundations should at this time take a hard look at their basic structure for managing their endowment. In doing so, they should aim for accountability on the part of each major player sharing responsibility for the endowment, and for a management model likely to make the most of their resources while protecting against major risks. In a period of great uncertainty, foundations should give heightened attention to the composition of their investment committees and to the skills and time priorities of members. They should also reassess the extent to which their investment committee is adequately staffed to do its job, and whether external resources need to be tapped to ensure strong endowment management.

NOTES

- ¹ John E. Craig, Jr., "New Financial Realities: The Response of Private Foundations," *The Commonwealth Fund 2008 Annual Report* (New York: The Commonwealth Fund, March 2009).
- ² Council on Foundations, *Foundations Respond to the Needs of Families Even as Their Assets Have Declined*, May 6, 2009, www.cof.org/economicdownturn.
- ³ Cambridge Associates, "Living on Borrowed Time? Dissecting the Current Equity Market Rally," Sept. 2009.
- ⁴ Robert Pozen, *Too Big To Save? How to Fix the Financial System* (Hoboken, N.J.: John Wiley & Sons, Inc., 2010).
- ⁵ Carmen M. Reinhart and Kenneth S. Rogoff, *This Time Is Different: Eight Centuries of Financial Folly* (Princeton, N.J.: Princeton University Press, 2009). Ms. Reinhart is professor of economics at the University of Maryland; Mr. Rogoff is the Thomas D. Cabot Professor of Public Policy and professor of economics at Harvard University.
- ⁶ "After the Bailouts, Washington's the Boss," *Wall Street Journal*, Dec. 28, 2009.
- ⁷ Alice M. Rivlin, "U.S. Debt Scolds Can't Be Ignored Much Longer," Bloomberg, Jan. 6, 2010.
- ⁸ Pozen, *Too Big To Save?* 2010, pp. 82–94.
- ⁹ Jeremy Grantham, "Just Desserts and Markets Being Silly Again," *GMO Quarterly Letter*, Oct. 2009. Although the Internal Revenue Service requires private foundations to distribute 5 percent of their endowments annually, in practice the payout rules enable foundations to meet the requirement over a period of years. This makes Grantham's advice practicable, and it is heeded implicitly by the many foundations that base their annual payout on a lagging three-year (or longer) average endowment market value.
- ¹⁰ The definitive book on endowment management, David F. Swensen's *Pioneering Portfolio Management* (Free Press, 2009), for example, focuses on the circumstances of very large universities, which are able to afford and recruit internal professional investment staffs that assume responsibility for management of the endowment.
- ¹¹ Dennis R. Hammond, "Choosing the Best Investment Management Structure: Use of Consultants to Drive the Investment Process," Hammond Associates, Foundation Financial Officers Group meeting, Sept. 27, 2007.
- ¹² Lawrence E. Kochard and Cathleen M. Rittereiser, *Foundation and Endowment Investing* (Hoboken, N.J.: John Wiley & Sons, Inc., 2008).
- ¹³ Casey Quirk & Associates, *The New Gatekeepers: Winning Business Models for Investments Outsourcing*, Dec. 2008. Lawrence Kochard and Cathleen Rittereiser describe the business models and investment strategies of such leading O-CIO firms as Investure and Morgan Creek Capital in Kochard and Rittereiser, *Foundation and Endowment Investing*.
- ¹⁴ Cambridge Associates: "'Fiduciary Fatigue' CIO Outsourcing: Leaner Times Increase Demand, and Raise New Questions," 2009.
- ¹⁵ Investment consultants should be able to produce the "blinded" investment performance records of their clients, but only in the limited number of cases where consultant firms have virtually total responsibility for the endowment can they attribute the extent to which the record reflects their decisions, as opposed to those of the investment committee or internal staff.

- ¹⁶ Many foundation investment committees reject the idea of retaining a consultant because of the cost. In fact, the fees of most such firms, measured as a percentage of the market value of the endowment, are quite reasonable. Reflecting the economies of scale enjoyed by larger foundations, standard investment consultant fees range from approximately 60 basis points on the endowment market value for a foundation with a \$20 million endowment, to 8 basis points for one with a \$250 million endowment, to 6 basis points for a foundation with a \$500 million endowment. Given that most foundations have only one source of income, and are typically otherwise dependent on volunteer trustee services for overseeing the endowment, they are well advised to spend at least these levels of resources to enhance their endowment management capacities.
- ¹⁷ A novel approach to solving this problem is provided by three Indianapolis foundations that recently jointly together to hire an experienced CIO to manage the three endowments. The foundations have combined assets of around \$1 billion, and they share the costs of the CIO office.
- ¹⁸ Casey Quirk & Associates, *The New Gatekeepers*, 2008.
- ¹⁹ Over the years, the CommonFund and TIFF have opened their doors to other nonprofits, and both now serve both educational organizations and foundations.
- ²⁰ Swensen, *Pioneering Portfolio Management*, 2009, pp. 309–12. The author of this essay is a member of the board of the TIFF Education Foundation, but not of TIFF Advisory Services or TIFF Investments Program, the investments arms of the TIFF organization.
- ²¹ Robert F. Marchesi, DeMarche Associates, www.demarche.com.



2009 Annual Report

The Fund's Mission, Goals, and Strategy



Commonwealth Fund chair James R. Tallon, Jr., president of the United Hospital Fund, and Board member Cristine Russell, reporter.
Photo: Martin Dixon.

The Fund's Mission, Goals, and Strategy

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.

GOALS

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

Move the United States toward a high-performing health care system that achieves better access, improved quality, and greater efficiency, and focuses particularly on the most vulnerable due to income, inadequate insurance, minority status, health, or age.

- This overarching goal is being advanced through the Fund's Commission on a High Performance Health System, which is charged

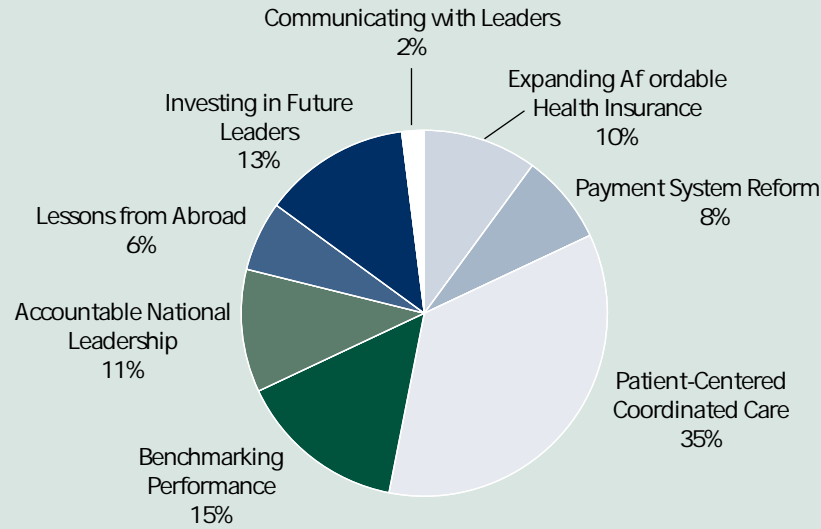
with setting and tracking national and state performance targets, developing policy options, and disseminating innovative practice changes that would improve the functioning of the U.S. health system. The Fund's grantmaking programs support and enhance the Commission's work.

Achieve an efficiently run health insurance system that makes available to all Americans comprehensive, affordable coverage.

In support of this vision, the Program on Affordable Health Insurance seeks to:

- provide timely analysis of changes in private and public insurance coverage for people under age 65, as well as the impact on the number of people covered and the quality of coverage;
- document the consequences of being uninsured and underinsured on people's health, finances, and productivity; and
- analyze and develop policy options to expand, stabilize, and improve the affordability of health insurance coverage, as well as increase its administrative efficiency.

Exhibit 1. The Fund's grants programs, in concert, pursue eight strategies for promoting a high performance health care system.



Allocation of grants from July 2005 through November 2009

Help public and private insurers, especially Medicare, be an innovative leader in coverage, quality, and value improvements.

To this end, the Program on Payment System Reform supports analysis and the development of policy options to curb spending growth and improve the way health care is provided. Areas of interest include:

- changing existing payment systems to improve the alignment of incentives to promote better quality and efficiency and to provide a base for more comprehensive payment reform;
- modeling and analyzing the potential impact of alternative options for payment reform in Medicare and throughout the health system;
- reforming provider payment to encourage the development of new models of health care delivery that provide better and more coordinated care; and
- using comparative effectiveness research to support better decision-making by providers, payers, and patients.

Improve the quality and promote the efficiency of health care services.

The Program on Quality Improvement and Efficiency is based on the premise that 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. The program supports projects that:

- promote the development and widespread adoption of measures of health care quality and efficiency;
- assess and enhance the capacity of health care organizations to provide better care more efficiently; and
- promote the development and adoption of payment and incentive models that encourage health care providers to improve quality and efficiency.

