Changes in Health Care Financing and Organization

An RWJF national program

SUMMARY

For 25 years, *Changes in Health Care Financing and Organization* (HCFO) has supported investigator-initiated research to provide public- and private-sector decision-makers with timely information on the impact of reforms in the health care delivery and payment systems on access, quality, and cost.

Launched in 1989 by the Robert Wood Johnson Foundation (RWJF), the national program has been among the nation’s largest sources of private funding for policy-related health services research. From 1989 to early October 2014, under HCFO, RWJF awarded grants totaling $82.1 million for 333 health policy research projects.

CONTEXT

In the 1980s, before the program began, health care costs were on a steady rise. In response, both the public and private sectors experimented with new strategies for organizing and financing health care aimed at controlling costs. Perhaps most notable was the rapid expansion of health maintenance and managed-care organizations.

Many of these strategies entailed significant changes in the health care system. But what impact did they have on the quality of and access to care, as well as its cost? Private and public payers for health services—such as employers, unions, insurance companies, Medicare, and Medicaid—had limited capacity to answer that key question.

RWJF’s Interest in This Area

The mission of RWJF is to improve the health and health care of all Americans. How health care is delivered and paid for is central to that objective. Obtaining the best possible outcome and highest value for the nation’s health care dollars is one of RWJF’s areas of focus.
In 1982 the Foundation initiated *Demonstration and Research on Health Care Costs*—a $10.6 million grant program to stimulate development of cost-control measures. Reviewing the results five years later, staff determined the program was too narrow—that the studies it funded examined specific cost-saving interventions without considering broader policy implications.

As a result RWJF decided to develop a new, more broadly focused research program, this one aimed at researching and evaluating the impact of delivery system changes on the quality and access of care as well as cost.

Recognizing the integral relationship between the *financing* of health care and the *organization* of the delivery mechanism, RWJF designed the new initiative to stimulate examination of both. Authorized by the Board of Trustees in 1988, HCFO began the following year.

> “How you pay for health services has tremendous impact on access, quality, and cost. How you organize health services has a lot of impact on access, quality, and cost.”—Nancy Barrand

**THE PROGRAM**

HCFO—which continues to operate full tilt during its final year—solicits and funds projects that:

- Examine challenges and trends in health care financing and organization, with a focus on the impact on cost, quality, and access

- Evaluate specific new policies and approaches in health care financing and organization that have the potential to improve access to more-affordable and higher-quality health services

All projects must be timely and relevant to public- and private-sector decision making—advancing the body of evidence on health care services while informing policy debate. HCFO, says Barrand, “is very much tied into current policy—in terms of what is happening on Capitol Hill and within federal agencies, as well as in the industry and state government.”

HCFO also serves as an information bridge between researchers and decision-makers by bringing them together and keeping policymakers informed of investigators’ findings.
**Program Management**

*AcademyHealth*, a nonprofit health policy center in Washington, serves as the national program office. HCFO Deputy Director Bonnie J. Austin, JD, MPH, oversees the program.¹

A national advisory committee composed of researchers and policymakers provides overall guidance. (See Appendix 1 for a list of members.)

**Research Topics**

HCFO’s annual call for proposals suggests some two dozen broad areas of inquiry, which change from year to year based on input from outside experts. Researchers themselves choose their specific topics and approach.²

Program staff is particularly interested in research on changes in the health care market and the implications for purchasers of care, including the impact of the 2010 Affordable Care Act (ACA). For example, HCFO projects have examined:

- The impact of a provision in the ACA that penalizes hospitals for high rates of preventable readmissions among Medicare patients
- The effects of physician concentration, physician-hospital integration, and accountable care organizations—groups of providers who come together voluntarily to give coordinated care for their Medicare patients—on prices in commercial health care markets
- How consumers use information to make health-related decisions, and the impact of those decisions on costs
- Changes in the design of health insurance benefits, and the implications for consumers, employers, health plans, and providers

For links to profiles of five HCFO grantees and the research they pursued, see the Grantee Story List.

**Grant Size and Eligibility**

The program awards five to 20 new grants each year in two categories:

- **Small grants**, for projects requiring $100,000 or less and expected to take 12 months or less—typically analyses and case studies of the early impact of a new intervention

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¹ Although nominally deputy director, Austin has been in charge since 2009, when the director, Sharon B. Arnold, PhD, left the program. Arnold, who became director in 2005, was preceded in that position by Anne K. Gauthier, MS, director from 1992 to 2005, and W. David Helms, PhD, 1989 to 1992.

² The HCFO call for proposals is different than any other RWJF request for proposals in that it seeks investigator-initiated ideas instead of prescribing a set of topics on which proposals can be submitted.
• Large grants, for projects requiring more than $100,000 and expected to take longer than 12 months, usually up to three years

The program has been open to researchers from a wide range of disciplines, including economics, sociology, political science, public policy, public health, public administration, law, and business administration. Practitioners and public and private decision-makers working with researchers have been eligible to participate.

Applicants submit proposals through their home organizations, with public entities and nonprofits receiving preference. More than half of the grantees organizations have been universities; nonprofit research organizations have made up most of the rest.

Selecting the Grantees

Researchers can apply for grants at any time, and program staff reviews their proposals on a rolling basis. That’s a “lesson learned” from a 1982 RWJF demonstration program on controlling health care costs: potential applicants found a hard-and-fast application schedule a problem. Staff and reviewers judge proposals on their significance, uniqueness, and methodology, and the applicant’s experience and qualifications. Staff members provide guidance to prospective applicants on whether their research concept fits within the program’s purview, and the likely response of reviewers.

The application process differs by grant size. Applicants seeking more than $100,000 first submit a brief proposal outlining their project and then, if staff members respond favorably, a full proposal. Researchers requesting less than $100,000 submit just one application.

Staff members send each full proposal to at least two of the program’s 150 to 200 external reviewers scattered across government agencies and the private sector. Staff also gets advice from a retained expert in research methodology.3

In addition, the staff may consult with stakeholders on the real-world relevance of proposed research.

For example, says Barrand, if a potential project aims to focus on Medicaid, we may “get Medicaid experts to look at it and tell us: ‘This has already been done. This hasn’t been done…’ [or] ‘This would be very important if it were able to answer this question, not that one.’”

From 1989 to 2013, the program received some 1,600 brief proposals for large grants, and 840 full proposals for large and small grants. HCFO is highly selective: of 31 full proposals submitted in 2013, only six (19%) were funded. Once grantees are selected,

3 As of 2014, HCFO’s on-call expert methodologist was Stephen Zuckerman, PhD, co-director and senior fellow at the Urban Institute’s Health Policy Institute.
HCFO staff monitors their research progress and provides technical assistance, which includes helping them develop a plan to disseminate their findings.

**Special Solicitations**

In addition to this regular grantmaking process, the HCFO program office periodically conducts *special solicitations* targeting specified topics chosen by staff and the national advisory committee. For example, the program office issued a special solicitation in 2009 for research on the impact and challenges of Medicare’s Part D prescription drug benefit, to take advantage of newly released data. The solicitation drew 43 proposals, of which the program funded two.

RWJF also occasionally relies on the HCFO program office to handle special solicitations developed by Foundation staff. In 2013, for example, the program office managed a special RWJF solicitation on the impact of transparent health care pricing on consumers and providers.

**Program Evolution**

Early on, HCFO funded demonstration projects as well as research and analysis. For example, researchers used a $485,000 project in the 1990s to develop a mechanism for making the cost of health insurance for small employers in California more equitable. (Read the Program Results Report.) However, HCFO has not funded demonstration projects in recent years.

In 2011, as part of belt-tightening in response to the recession, RWJF reduced HCFO’s funding—to $5 million over three years, from $12 million for the previous three years. That spurred program staff to fund more small projects, and to cap most large ones at $250,000.

**PROGRAM RESULTS**

HCFO staff cited these results to RWJF:

- **From 1989 to early October 2014, under HCFO, RWJF awarded 333 grants for research projects that totaled $82.1 million.** Of those:
  - 91 were for small research projects: grants totaled $6.9 million
  - 242 were for large research projects: grants totaled $75.2 million

Of those, 12 projects were active as of early October 2014 with one expected to run into 2016.
• The projects produced findings relevant to policymakers and health care practitioners. HCFO staff cited these recent projects as influential:

— *Cost and Efficiency in Treating High-Cost Medicare Beneficiaries: The Role of Physician Practice and Health System Factors*

James D. Reschovsky, PhD, of the Center for Studying Health System Change, and colleagues examined key physician practice and market characteristics that may contribute to high costs and inefficient care in the Medicare program.

The study, published in 2013, provided an alternate explanation for the geographic variation in Medicare spending and generated widespread attention in the health services research community, according to HCFO staff.

— *Analyzing the Impact of Fair-Pricing Regulations and Government Subsidies on the Cost of Hospital Services for the Uninsured*

Glenn Melnick, PhD, of the University of Southern California, examined how the state’s 2006 Hospital Fair Pricing Act affected hospital prices for uninsured patients, and how hospitals nationally are likely to respond to similar requirements in the Affordable Care Act.

The law requires hospitals to develop financial assistance policies that make care more affordable to the uninsured. Melnick found that 97 percent of hospitals in the state reported offering free care to uninsured patients with incomes at or below 100 percent of the federal poverty level.

Melnick, the recipient of multiple HCFO grants, published his findings in *Health Affairs* (32[6]: 1101-1108, June 2013) and presented them to the U.S. House Ways and Means Committee. (Also read a Grantee Story of Melnick.)

— *Impact of a Tiered Physician Network on Consumer Behavior*

Meredith B. Rosenthal, PhD, and Anna Sinaiko, PhD, of Harvard School of Public Health assessed the impact on consumer behavior of a system in which patients pay different cost-sharing rates for providers in different tiers, determined by the cost and quality of their care.

Rather than moving patients to the “best” performers, tiering appeared to affect mostly consumers choosing new physicians, and physicians in the lower-end (least-preferred) tiers. Sinaiko briefed staff of the U.S. Senate Finance Committee and the Pennsylvania state legislature on the study’s findings and implications.

For reports on earlier HCFO research of note, see the Project List. For a synopsis of all HCFO projects since the early 1990s, see Awarded Grants on the program website.
Most grantees published their findings in peer-reviewed journals. In 2013, for example, grantees published 16 articles. For a complete list, see Grantee Publications on the HCFO website.

HCFO staff used face-to-face gatherings and electronic communications to inform public- and private-sector decision-makers about research findings that could affect health care cost, quality, and access. Early on, HCFO staff sponsored large policy conferences in Washington—two a year at first, and then one. But as more organizations convened such conferences, HCFO shifted to other formats, including:

Meetings and Briefings

— **Small working meetings.** Program staff members periodically convene some 30-40 stakeholders to analyze specific challenges and developments in health care and identify needed research.

  - In 2012, for example, a meeting focused on implementing a provision of the Affordable Care Act requiring Medicare to develop a mechanism (known as the *physician payment modifier*) for paying doctors based on the quality and cost of their care. Economists, researchers, analysts, and federal officials participated in a moderated discussion on the needed mechanism, including cost and quality measures.

  - In 2013, a meeting focused on the provision requiring Medicare to cut payments to hospitals with excess readmissions. Participants concluded that the program was spurring hospitals to be more efficient, but that it needed refining to improve its effectiveness and equity.

— **Grantee briefings.** These sessions allow HCFO researchers to vet their findings before publication with stakeholders from federal agencies and the nonprofit sector. For example, one of two briefings in 2013 featured researchers who had studied how changes in payment for inpatient services under the Affordable Care Act could affect Medicare savings.

— **Webinars.** Each year HCFO staff members conduct a number of online seminars on developments and tools in health care research. The webinars are posted on the AcademyHealth website (specifically, in the *Methods, Data,* and *Policy Topics* sections of the *Professional Development Catalogue.* (See the *Bibliography* for a list of webinars.) The four webinars in 2013 included:

  - **One** that disseminated best practices in using new information on hospital prices for inpatient procedures. The Centers for Medicare & Medicaid Services collaborated on the webinar.

  - **Another in which** an HCFO-funded researcher joined other experts in discussing the Massachusetts Health Connector, the state’s health insurance
exchange for individuals and small businesses, and the implications for other states that are developing such exchanges.

Other Electronic Communications

HCFO staff also reached policymakers and practitioners through a range of products disseminated through the program website or by email, including:

— **Findings Briefs**, which summarize specific challenges and related results from HCFO-supported research. One of six briefs published in 2013, for example, described the impact of changes in the Medicare reimbursement rate—the same study featured in a grantee briefing session that year.

— **Study Snapshots**, begun in 2012 to give policymakers a one-page description of an HCFO study, including the research question, findings, and policy implications. HCFO issued five snapshots in 2013—one on Melnick’s study of California’s fair-pricing law.

— **Policy Briefs**, which provide an in-depth analysis of health care challenges and developments, often informed by an HCFO meeting or research. For example, a 16-page issue brief posted in 2012 reported on the HCFO working meeting on the Medicare physician payment modifier, including the consensus that emerged from the session.

— **HCFO e-newsletters**, which the program began distributing in 2003 to some 7,000 individuals, summarize health care challenges and related HCFO research and profile selected grantees.

  The 10 newsletters in 2013, for example, included an article exploring the extent to which cost influences treatment choices by prostate cancer patients. Another article profiled Andrew Ryan, PhD, an associate professor at Weill Cornell Medical College studying the early effects on hospitals of Medicare’s value-based purchasing program.

— **Other website features**, including **Hot Topics and Research Headlines**. Program staff also launched a Twitter account in 2010.

  For a full list of these products, see the Publications section of the program website.

**EVALUATION FINDINGS**

RWJF and HCFO staff have contracted for several evaluations of the program, including, most recently, an informal assessment in 2013.
1995 and 2002 Assessments

In 1995, RWJF funded the Barrents Group to evaluate the program’s first six years. The evaluators reported that HCFO was efficiently run and well regarded by the research and policy communities. (See the Program Results Report on that evaluation.)

In 2002, to inform the program’s reauthorization, RWJF commissioned an evaluation by a team at Georgetown University’s Institute for Health Care Research and Policy led by John F. Hoadley, PhD. The team reported that researchers and policymakers saw the program “as making significant contributions to policy-relevant literature through both the published results of grant-supported research and the synthesis and summary reports prepared by HCFO staff.”

2010 Assessment

In 2010, the HCFO program office engaged Hoadley to assess the program a second time. Hoadley, himself a HCFO grantee, interviewed researchers, staff in Congress and at federal agencies, advisory committee members, and HCFO staff. Hoadley reported that respondents:

- Viewed findings from HCFO projects as timely, relevant, and nonpartisan
- Valued HCFO's focus on policy
- Praised the application process, including open solicitations, assistance from HCFO staff, and quick turnaround on proposals
- Viewed the special solicitations as focusing valuable attention on neglected areas and evolving disciplines. However, they voiced concern about crowding out investigator-initiated projects.
- Valued grantee briefings sessions the most among HCFO's dissemination strategies, citing the unique opportunity for researchers and policymakers to talk about findings and their implications
- Said “HCFO helps to enhance the Foundation's reputation as an honest broker at the frontier of health policy research.” The program “is seen as less ideological relative to other private foundation funding sources, including some of the RWJF initiatives.”

Although all three evaluations were positive, they recommended some changes in HCFO operations. For information on resulting modifications to the program, see Appendix 2.

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4 ID# 27137 ($98,391, April 15, 1995 to February 9, 1996).
5 ID# 44971 ($92,417, February to July 2002). The institute has since been renamed the Health Policy Institute.
2013 Informal Assessment

In 2013, HCFO staff interviewed 26 individuals—including federal policymakers, researchers, health insurance executives, current and former grantees, and members of the national advisory committee—about the program. It was, says RWJF’s Barrand, an unscientific assessment—a “crowdsourcing evaluation”—to prepare for the program’s reauthorization, scheduled for 2014.

This assessment revealed that respondents “understand the process of how we vet these grants and the objectivity of the research being done, which affects how they look at the results and value of the program,” Barrand notes. “What we’ve done is build a quality brand for the research that comes out of HCFO.”

LESSONS LEARNED

1. Documenting a direct link between research findings and policy change is difficult. One of HCFO’s main challenges has been to show that funded research has an impact on policymaking. As Barrand puts it, “It’s not like the [Affordable Care Act] is passed and it has footnotes: ‘This was based on an HCFO study.’”

   Part of the difficulty, says Deputy Program Director Austin, is that findings from HCFO-funded research often contribute to a large body of evidence that informs policy. Years can also elapse before a published study percolates up and affects policy.

2. Take steps to document impact. To help show the program’s policy relevance, HCFO staff asked researchers to notify them of inquiries from public- and private-sector decision-makers. Thus, for example, the program office knew that the Government Accountability Office had asked for information from an HCFO-funded study of Medicare spending.

   HCFO also asks researchers to note their funding source in published articles. However, not all comply, nor do all journals allow such a citation, making it difficult to track some HCFO-supported articles and the attention they receive. (Deputy Director/Austin; Program Officer/Barrand)

3. An efficient, supportive process for reviewing grants helps produce good projects. HCFO’s approach of providing feedback during the grant application process, and of requiring brief proposals before complete ones for larger projects, produces high-quality proposals. Applicants also appreciate the assistance. (Deputy Director/ Austin; Program Officers/Barrand, Quinn)

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6 Although not a footnote in the statute, program staff cites a reference by Solicitor General Donald B. Verrilli, Jr., to HCFO-supported research during oral arguments before the Supreme Court on the Affordable Care Act in 2012. Countering a point by Justice Scalia, Verrilli cited findings from a 2002–03 study of the New Jersey insurance market funded by the Commonwealth Fund and RWJF through HCFO.
4. **Open solicitations yield timely projects.** Allowing researchers to apply for HCFO funding when they need it rather than according to a specified timetable allows them to propose more timely ideas. (Program Officer/Barrand)

5. **Use external reviewers to bolster a program’s relevance and visibility.** By relying on a network of outside experts to review proposals, HCFO expanded its reach into the policymaking and research communities while building the staff’s understanding of health policy. (Program Officer/Barrand)

6. **Ask policymakers about the research they need.** By consulting with policymakers on research gaps, program staff helped ensure that the results of funded research would be relevant to the real world. (Deputy Director/Austin; Program Officer/Barrand)

7. **Create structured, comfortable venues for policymakers and researchers to discuss their findings.** HCFO's grantee briefings sessions allow policymakers to ask questions they might not in large public settings, and enable researchers to explore the implications of their findings. (Deputy Director/Austin; Program Officers/Barrand, Quinn)

**WINDING DOWN THE PROGRAM**

In early 2014, RWJF announced an overall restructuring of its grantmaking to focus on building a Culture of Health. This included phasing out a number of long-running initiatives, HCFO among them. The decision reflected no dissatisfaction with the program or its management, says RWJF’s Quinn. Rather, RWJF aims to create a broader program to include research not only on health care financing and management but on the social determinants of health, such as poverty, education, and housing.

Program staff will continue to evaluate project proposals until HCFO ends in February 2015.

In August 2014, RWJF was preparing to issue a call for proposals from organizations interested in managing the new research program, expected to begin in March 2015. While more broadly focused than HCFO, RWJF expects the new program to continue to emphasize investigator-initiated projects and open solicitations.
APPENDIX 1

HCFO National Advisory Committee, 2014

Mark Peterson, PhD, Chair
Professor of Public Policy, Political Science, and Law
Luskin School of Public Affairs
University of California, Los Angeles
Los Angeles, Calif.

Lynn Blewett, PhD
Professor, Health Policy and Management
Director, State Health Access Data Assistance Center
University of Minnesota School of Public Health
Minneapolis, Minn.

Melinda Buntin, PhD
Chair, Department of Health Policy
Vanderbilt University School of Medicine
Nashville, Tenn.

Tanisha Carino, PhD
Senior Vice President
Avalere Health LLC
Washington, D.C.

Robert M. Crane, MBA, MPA
Senior Adviser
Kaiser Permanente
Encinitas, Calif.

Phil Ellis, PhD
Principal Analyst
Congressional Budget Office
Washington, D.C.

Anne K. Gauthier, MS
Senior Program Director
National Academy for State Health Policy
Washington, D.C.

Jack L. Hadley, PhD
Associate Dean for Finance and Planning
Professor and Senior Health Services Researcher
College of Health and Human Services
George Mason University
Fairfax, Va.

Jim S. Hahn
Health Economist
Congressional Research Service
Washington, D.C.

Edward H. Livingston, MD
Deputy Editor
Journal of the American Medical Association
Chicago, Ill.

Mark V. Pauly, PhD
Professor/Chair of Health Care Systems
Wharton School
University of Pennsylvania

John Pilotte
Director
Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services
Baltimore, Md.

Katherine Swartz, PhD
Professor, Department of Health Policy and Management
School of Public Health
Harvard University
Boston, Mass.

Herbert Wong, PhD
Senior Economist
Agency for Healthcare Research and Quality
Rockville, Md.
APPENDIX 2

Program Modifications Resulting From Two Evaluations

As an outgrowth of the Barents’ 1995 evaluation:

- HCFO issued additional targeted solicitations to stimulate proposals addressing issues of particular importance.
- HCFO placed greater emphasis on framing the policy implications of research findings, and disseminating those findings to a broader audience.
- RWJF appointed a new national advisory committee that included leading researchers across a range of disciplines as well as policy leaders from the public and private sectors.

In response to Hoadley’s 2002 evaluation, HCFO staff:

- Revised the program website to provide easier access to HCFO products, and more information on publications produced by researchers
- Began disseminating HCFO News and Progress, a monthly e-newsletter with information on program activities and publications, summaries of key aspects of policy issues, and biographical sketches of selected grantees and their expertise
- Increased its emphasis on branding HCFO

Following Hoadley’s 2010 evaluation, HCFO staff:

- Developed a comprehensive communications plan, including the launch of social media tools
- Increased the program’s reach by developing the one-page Study Snapshot, which is disseminated electronically to a diverse list of policymakers
- Started connecting HCFO researchers directly with policymakers by arranging briefings at policymakers’ offices
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Articles

HCFO grantees have published scores of articles. For a list, an abstract of each article, and sometimes the full article, see Grantee Publications on the HCFO website.

Reports

HCFO staff has published numerous briefs, reports, and other products on challenges, developments, and findings in health care policy. See the Publications section of the HCFO website.

Communication or Promotion

What’s New with HCFO. E-newsletter published most months since March 2003 and sent to some 7,000 individuals. Washington: AcademyHealth. Available online.


Webinars. Washington: AcademyHealth. The following webinars are available on the AcademyHealth website:

- Leveraging Mobile Health (mHealth) Solutions for Health Services Research (HSR) Session 1
- Leveraging Mobile Health (mHealth) Solutions for Health Services Research (HSR) Session 2
- Leveraging Mobile Health (mHealth) Solutions for Health Services Research (HSR) Session 3
- Leveraging Mobile Health (mHealth) Solutions for Health Services Research (HSR) Session 4
- New Hospital Pricing Data: What It Says, What It Means
- Using the American Community Survey (ACS) for Health Services Research: Opportunities, Best Practices and Expert Advice
- Getting and Using Medicare Data: What I Wish I Had Known Before I Started My Research
- The Health and Retirement Study: The Best Data Resource You're Not Using
- Getting and Using the Medicare Current Beneficiary Survey (MCBS) for Health Services Research: Guidance from the Experts
• Examining Employers' Use of Massachusetts' Health Insurance Exchange to Inform
  Best Strategies Nationally Under the Affordable Care Act

GRANTEE STORY LIST

These Grantee Stories introduce five HCFO researchers and their HCFO projects

**Linda J. Blumberg, PhD**
Senior Fellow
Urban Institute
Washington, D.C.

**R. Adams Dudley, MD, MBA**
Assistant Professor of Medicine and Health Policy
Institute for Health Policy Studies
University of California, San Francisco,
San Francisco, Calif.

**Glenn A. Melnick, PhD**
Professor
School of Policy, Planning, and Development
University of Southern California
Los Angeles, Calif.

**Len M. Nichols, PhD**
Director
Health Policy Program
New America Foundation
Washington, D.C.

**Katherine Swartz, PhD**
Professor of Health Policy and Economics
School of Public Health
Harvard University
Boston, Mass.
PROJECT LIST

RWJF’s Program Results Reporting Unit produced and posted more than 50 Program Results Reports on noteworthy HCFO projects that were funded from fall 1991 through spring 2007. The date with each report is the posted date on www.rwjf.org. All HCFO-funded projects are described on the HCFO website at www.hcfo.org.

Demonstrations

● Nursing Home Patients Fare Better With On-Staff Primary Care Providers (Grant ID# 20039, January 2001)
● Large Employers Evaluate Risk-Adjustment Tools for Purchasing Health Insurance (Grant ID# 22538, January 2001)
● Washington State Develops and Tests New Predictor of Patient's Health Needs (Grant ID# 23352, etc., January 2001)
● Examining the Impact of Global Budgets on Health Care Costs (Grant ID# 24231, August 2003)
● California Finds a Prescription to Make Health Insurance Premiums Equitable (Grant ID# 26226, January 2001)

Evaluations

● Abolition of State-Regulated Hospital Payment Rates Has Minor Impact (Grant ID# 23465, January 2001)
● Business Coalitions Face Challenges as Purchasers of Quality Low-Cost Health Care (Grant ID# 26940, January 2001)
● California's Shift to Medicaid Managed Care Doesn't Save Money or Improve Outcomes (Grant ID# 49006, etc., October 2005)
● Case Studies of Five Regional Public Health Structures—How They Contribute to Public Health Preparedness (Grant ID# 56470, May 2009)
● Health Plans Try to Boost Their Grades on Plan Report Cards (Grant ID# 29202, August 2003)
● HMOs in California Decrease Use of Inpatient Care by Medicare Enrollees (Grant ID# 41289, August 2008)
● In Competitive Markets, Price, Not Quality, Guides Health Plans' Choices (Grant ID# 24328, August 2003)
● Increased Access to Medicaid Had Little Effect on Pregnancy Care or Outcome (Grant ID# 19672, etc., January 2001)
• Insurance Premiums Decline in States Capping Malpractice Payouts, Alabama University Study Finds (Grant ID# 50298, December 2007)

• It's All in the Family: How Baby Boomers Will Meet Their Long-Term Care Needs (Grant ID# 49919, July 2008)

• Researchers Find that Physicians Provide the Same Level of Care Even After Their Compensation Method Changes (Grant ID# 34281, August 2003)

• Revised Medigap Policies Helped Consumers Purchase Insurance (Grant ID# PC258, January 2001)

• State Laws That Provide Parity for Mental Health Care Benefit Children and Ease Families' Financial Burden (Grant ID# 56465, February 2008)

• Study Looks at Factors That Determine Physician Participation in Medicaid (Grant ID# 44126, January 2008)

• Study of Federal Health Tax Credit Program Finds It Expensive and Complicated (Grant ID# 50263, July 2008)

• Study Shows Physician Gatekeeping May Help Lower Costs, But Questions Remain About Physician and Patient Satisfaction (Grant ID# 24831, August 2003)

• Study Shows Physician Profiling Software Can Rank the Cost-Effectiveness of Some Specialties (Grant ID# 48779, December 2007)

• Who Was Insured and How—1996–2000 (Grant ID# 49257, July 2008)

Research

• Contrary to Fears, the Newly Insured Did Not Use More Services Than Others (Grant ID# 18294, etc., January 2001)

• Conversion of Hospitals from Nonprofit to For-Profit Can Offer Community Benefits (Grant ID# 32501, January 2001)

• Cost-Utility Analysis Has Potential to Measure the Value of Public Health Systems (Grant ID# 56782, August 2008)

• Doctors’ Dilemma: How Health Care Financing Shapes Service (Grant ID# 28525, August 2003)

• Do State Health Insurance Risk Pools Make a Difference? (Grant ID# 19190, January 2001)

• Fine-Tuning Drugs to Match Our Genes—What Are the Implications for Health Care Costs and Treatments? (Grant ID# 50400, July 2008)
• Health Purchasing Coalitions Struggle to Gain Bargaining Clout: Small Size and Lack of Support From Health Plans Are Factors (Grant ID# 35044, August 2003)

• HMO Mergers Cut Premiums in Only Most Competitive Markets (Grant ID# 23271, January 2001)

• HMOs Make Good Bedfellows with Mid-Cost, Higher Quality Hospitals, but Not with Teaching or For-Profit Hospitals (Grant ID# 29388, January 2001)

• HMOs Surpass Traditional Insurance in Eliminating Some Disparities (Grant ID# 38088, December 2006)

• Hospital Expenditures Largest Culprit in Rising Health Care Costs (Grant ID# 18289, etc., January 2001)

• Hospital Mergers Affect Consumers: Higher Premium Costs, More Uninsured (Grant ID# 50491, July 2008)

• Hospital Mergers Do Not Always Save Money or Reduce Inefficiencies (Grant ID# 29909, August 2003)

• Laws that Limit Providers and Limit Patient Choice May Have Limited Effects (Grant ID# 29014, January 2001)

• Managed Care Policies Limit the Diffusion of Medical Technology (Grant ID# 28072, January 2001)

• Market-Based Strategy Helps Charitable California Hospital Chain Reorganize and Reverse Financial Losses—While Maintaining Its Mission (Grant ID# 46649, January 2008)

• Measures of Access to Health Care Need for Hispanics to Reflect Cultural Differences (Grant ID# 36333, August 2003)

• Medical Directors Often Apply Different Definitions of "Medical Necessity" (Grant ID# 39396, August 2003)

• Most HMOs Use Drug Formularies to Influence Prescribing Behavior of Docs (Grant ID# 24271, January 2001)

• Most State Governments Offer Choice of Health Plans, but do not Standardize Benefit Packages Survey Finds (Grant ID# 23270, January 2001)

• New Jersey's 1993 Reform of Individual Insurance Market Gets High Marks (Grant ID# 34320, etc., January 2001)

• No Quality Differences in Medicare Diabetes Care: Managed Care or Fee-for-Service (Grant ID# 44201, October 2005)
- Nurse Practitioners Can Expand Roles in Collaborative Care Units (Grant ID# 20553, January 2001)

- Physician Compensation Method Does Not Affect Patient Treatment (Grant ID# 38154, etc., July 2008)

- Physicians Among the Chief Drivers of High Drug Costs (Grant ID# 23654, January 2001)

- Preferred Provider Organizations—Are They Better at Keeping Health Costs Down? (Grant ID# 20040, January 2001)

- Prescription Coverage Caps Leave Elderly Scrambling for Needed Meds (Grant ID# 37380, August 2003)

- Researchers Explore Patterns of Individual Health Insurance Coverage (Grant ID# 43650, November 2007)

- Researchers Find That Individual Rather Than Community-Level Factors Affect Minorities' Purchase of Health Insurance (Grant ID# 36332, December 2006)

- Researchers Statistically Analyze Market Entry and Costs of New Medicare Prescription (Grant ID# 51151, March 2008)

- Should Government Encourage Use of Market Forces in Spreading Health Insurance Risks? (Grant ID# 26052, January 2001)

- State-Run Rx Programs for Low-Income Seniors in Illinois and Wisconsin Show How Differences in Coverage Affect Enrollment, Rx Use and Spending (Grant ID# 50507, March 2008)

- With Hospitals, It's Survival of the Fattest, Not the Fittest (Grant ID# 28054, January 2001)

- Working as if One's Health Depended Upon It (Grant ID# 29201, August 2003)