OPERA – fiche sociographique

http://en.wikipedia.org/wiki/Jeanne_Lambrew

Jeanne Lambrew is a United States professor of public affairs and health policy.

She has been named to serve in the Obama administration as Deputy Director of the new White House Office of Health Reform.

Jeanne Lambrew was named on *May 11, 2009 by newly confirmed Health and Human Services Secretary Kathleen Sebelius to the position of Director at The Department of Health and Human Services' Office of Health Reform*.[1]

Lambrew has been a leading health expert alternately in academic and government. Her research interests include the uninsured, long-term care, Medicaid and Medicare.

From 1997 to 2001, she helped analyze health issues and develop proposals as a program associate director at **the Office of Management and Budget and as the senior health analyst at the National Economic Council.**

She began as an assistant professor at Georgetown University.

She moved to the Department of Health and Human Services during the 1993-94 push for health care legislation, and she went on to coordinate budget proposal analysis in 1995.

She later worked at the George Washington School of Public Health and Health Services as an Associate Professor. She moved to the Lyndon Johnson School of Public Affairs at the University of Texas, where she has been an associate professor of public affairs.

She has also served as a Senior Fellow at Center for American Progress,[2] and she cowrote a book, *Critical: What We Can Do About the Healthcare Crisis*, with former Senate Majority Leader Tom Daschle.

At a press conference on December 11, 2008, President-elect Barack Obama announced that Lambrew would serve as Deputy Director of a newly created White House Office of Health Care Reform under Tom Daschle, who was also designated to serve as Secretary of Health and Human Services.[3] Due to Tom Daschle withdrawing from both positions over tax issues, Nancy-Ann Min DeParle was appointed Director. Under an executive order on April 11, 2009, Jeanne Lambrew was subsequently appointed the Director of the U.S. Department of Health and Human Services' Office of Health Reform, led by Kathleen Sebelius.

The Department's Office of Health Reform will work closely with the White House Office of Health Reform, headed by Nancy-Ann DeParle.[4]

During her time in the white house, Ms. Lambrew received confidential tax information from the IRS but was never prosecuted. [5]

http://www.americanprogress.org/events/2005/6/b593305ct927753.html

Medicaid

What's Driving Costs and What To Do About It

June 8, 2005

About This Event

Medicaid

Jeanne Lambrew is a *Senior Fellow at the Center for American Progress and an Associate*

Professor at George Washington University where she teaches health policy and conducts policy-relevant research on the uninsured, Medicaid, Medicare, and long-term care.

Lambrew worked on health policy at the White House from 1997 through 2001, as the Program Associate Director for health at the Office of Management and Budget (OMB) and as the Senior Health Analyst at the National Economic Council. In these roles, she helped coordinate health policy development, evaluated legislative proposals, and conducted and managed analyses and cost estimates with OMB, the Department of Health and Human Services, the Treasury Department, the Labor Department and other relevant agencies.

She was the White House lead on drafting and implementing the Children's Health Insurance Program and helped develop the president's Medicare reform plan, initiative on long-term care, and other health care proposals.

She also worked at the Department of Health and Human Services during the 1993-1994 health reform efforts, and coordinated analyses of budget proposals in 1995.

Prior to serving at the White House, Lambrew was an Assistant Professor of Public Policy at Georgetown University (1996).

She received **her masters** and ***Ph.D. from the Department of Health Policy, School of Public Health at the University of North Carolina at Chapel Hill*** and bachelor's degree from Amherst College.

http://www.forbes.com/sites/scottgottlieb/2013/03/11/whos-in-charge-of-implementing-obamacare-and-why-it-matters/

WHO'S IN CHARGE OF IMPLEMENTING OBAMACARE?

It's a relevant question now that the White House is finally releasing the pivotal regulations that outline the shape of the new insurance scheme.

I wrote more almost three years ago, in the New York Post, that many of the Obama Administration's economic centrists were leaving the White House. Left behind were some of the most progressive staffers. They would be the ones implementing the law.

That transition now seems to be complete. The few remaining centrists thinkers inside the White House, mostly scattered across the National Economic Council and Treasury, are gone – or largely marginalized when it comes to issues around implementation. **The people drafting and reviewing the regulations are mostly centered in the White House and its Domestic Policy Council — and they mostly work for Jeanne Lambrew.**

As I wrote three years ago in the New York Post, ***Obamacare was written to paper over an intellectual divide between White House economists and healthcare policy wonks like Lambrew.*** Some of the Obama economists wanted genuine competition to take root in the new federally managed insurance "exchanges." The policy crowd favored a one-sized government plan with tight federal regulation over benefits. The law itself didn't explicitly side with either school.

Unfortunately, the more moderate White House economists are now gone. The l***atest blow came when the widely admired and centrist health policy expert Liz Fowler left her position on the National Economic Council for the private sector.***

The Obama team's few remaining economic moderates – the ones who have a lot of experience in healthcare — all seem to be sitting out the details of Obamacare implementation and issuance of the law's many regulations. Otherwise, they are focused on other matters.

Normally, the Office of Management and Budget and the National Economic Council would be heavily engaged on the issuance of regulations tied to a major law like Obamacare. Not the Obama White House. The economists still play on the fiscal issues related to Medicare and Medicaid. But when it comes to Obamacare implementation, they are not calling the shots. ***The***

power is centered on Lambrew.

Yet key decisions are now being made that will profoundly shape the law and its new exchanges (and the contours of our healthcare system). Those who have a stake in the outcome should be mindful of how these decisions are being made.

Lambrew is a highly competent policymaker and power player with deep experience in healthcare. A former Senior Fellow at the Center for American Progress, she is also unabashedly liberal – often serving as the architect of her party's most progressive ideas on healthcare reform.

This is not a pejorative statement, by any means. One might suspect that Lambrew would proudly wear the label. And she's as deep a thinker as anyone who has worked in health policy.

In 2008, she co-wrote a book with Tom Daschle that outlined a lot of her thinking. My review of that book can be found here.

For conservative critics of Obamacare, who saw in the over-engineered law, the architecture for a liberal takeover of healthcare, this sort of outcome couldn't be worse. And it was entirely predictable.

After laws get passed, the principals in an administration move on (especially in a second term). **The implementation work is left to the policy wonks. Those wonks tend to be a party's true believers, representing the ideological wings of their political parties.** ***Lambrew is deeply progressive, and will hew in that direction at the many regulatory decision points that the law leaves murky.***

The only difference in this White House is how little influence the economists seem to have. **And how successful Lambrew has been at consolidating her power.**

Observers were surprised when the Obama team didn't slow down implementation of some of the law's insurance market regulations (like aged based rating). These regulations are going to cause insurance rates to spike this fall. ***If you followed Lambrew's body of intellectual work, you might have had some forewarning that these regulations would get implemented on time, and with no frills. Provisions like these have been a central feature of her past proposals for healthcare reform***.

It's worth looking back at her rich body of intellectual work. It's perhaps the best guide to how future decisions are going to get made.

Lambrew and her team will massage the law's vague language to exert greater control over the law and the healthcare sector – and will bring about their clearly defined vision for medicine.

This political reality, more than the statutory language of the law itself, is likely to define Obamacare – and our health insurance — for many years to come.

http://www.nytimes.com/2010/04/19/health/policy/19health.html?_r=0

Obama Health Team Turns to Carrying Out Law

By ROBERT PEAR

Published: April 18, 2010

WASHINGTON — The success of the new health care law depends to a large degree on a handful of Obama administration officials, who are scrambling to make the transition from waging political war on Capitol Hill to managing one of the most profound changes in social policy in generations.

Jeanne M. Lambrew, an idealistic veteran of the Clinton White House, is carrying out provisions of the law aimed at expanding coverage.

Jeanne M. Lambrew

When President Bill Clinton's plan for universal health insurance collapsed in 1994, many Democrats, exhausted and disillusioned, turned to other issues. Ms. Lambrew never wavered. She kept plugging away at efforts to expand coverage.

In Mr. Clinton's second term, she worked at the White House, as senior health analyst at the National Economic Council and as an associate director of the Office of Management and Budget. In those roles, she was an architect of the Children's Health Insurance Program.

During the Bush administration, Ms. Lambrew refined her ideas as a senior fellow at the Center for American Progress, a sort of government in exile for liberal policy experts. She became an associate professor at the University of Texas and collaborated with former Senator Tom Daschle on a book that laid out many ideas incorporated in the new health care law.

Ms. Lambrew is leading efforts to expand coverage as director of the Office of Health Reform established by Ms. Sebelius. Ms. Lambrew is racing to meet a deadline set by the new law: Within 90 days, every state must have an insurance pool where uninsured people with medical problems can buy coverage at reduced rates.

Even people who disagree with her politics say Ms. Lambrew is a pragmatist, focused on results, not ideological purity.

Ms. Lambrew picked up her interest in health care from her father, Dr. Costas T. Lambrew, a cardiologist in Maine; her mother, Patricia, a nurse; and her maternal grandfather, Dr. James Travers, a family doctor in New York.

While working at academic medical centers, her father said, "I ran clinics for people who could not afford private care."

In 2003, Ms. Lambrew helped local officials overhaul the health care system in Maine, her home state. "Jeanne has a passion for the uninsured," said Trish Riley, director of the Office of Health Policy and Finance in Maine.

http://www.kaiserhealthnews.org/general-pages/players/lambrew.aspx
The Players

By Kate Steadman

'The Players' is a series of *Kaiser Health News* profiles highlighting the key roles of certain individuals in the current health reform debate. Each profile provides a brief bio, whether the player was involved in President Clinton's attempts to overhaul health care in 1993-1994 and how their participation could shape today's negotiations. This list is in alphabetical order

ON y trouve NAnCY ANN De Parle, Karren Ingani, Chris Jennings, Chip Kahn III, Pter Orszag, Larry Summers + des élus.

JEANNE LAMBREW DIRECTOR, HEALTH AND HUMAN SERVICES OFFICE OF HEALTH REFORM **Education**: B.A., Amherst College; M.A., Ph.D. in health policy, University of North Carolina, Chapel Hill.

Career Path:

After finishing her Ph.D., Lambrew worked as a special assistant at HHS under the first term of the Clinton administration. During Clinton's second term, she served as health policy associate

director for the Office of Management and Budget and as a senior health analyst for the National Economic Council. Lambrew was a lead creator and implementer of the State Children's Health Insurance Program during that time. Lambrew later was a fellow for the Center for American Progress and a professor at both the George Washington University School of Public Health and Health Services and the University of Texas LBJ School of Public Affairs.

Role in Health Care Reform, 1993-1994:

Lambrew was a special assistant coordinating Medicaid and state research at HHS and helped with the President's legislation.

Why She's a Player Now:

Lambrew, who is known for having an expansive knowledge of health policy, was originally set to be deputy director of the White House Office of Health Reform under former Sen. Tom Daschle, D-S.D. After Daschle withdrew his nomination, President Obama selected Lambrew to head the HHS reform office. As director, Lambrew will use her experience with past reform efforts to help craft and implement overhaul legislation.

Quote: "If you really believe in competition why not give the public plan a chance." (*CQ Healthbeat*, Feb. 2, 2009.)

http://prospect.org/article/health-care-heavyweights

THE AMERICAN PROSPECT

Health Care Heavyweights

EZRA KLEIN

DECEMBER 11, 2008

By appointing Tom Daschle and Jeanne Lambrew, Obama isn't just signaling that he is serious about health care, he's putting it in the hands of people who will get it done.

There's an old saying in Washington: "Personnel is destiny."

In 1993, President Bill Clinton sealed the destiny of his health-reform plan when he chose his wife, Hillary Clinton, to head the effort, and his old friend, management consultant Ira Magaziner, to serve as her deputy.

Neither of the two had lived long in Washington nor had either worked in Congress.

Neither possessed standing relationships with powerful legislators or a deep understanding of the federal bureaucracy. But they had something else: undeniable brilliance. Tremendous analytical horsepower. They would -- President Clinton thought -- approach the policy problem with an outsider's perspective and synthesize dazzling new ideas and tested old concepts.

They did, but unmitigated disaster resulted. Clinton and Magaziner built a policy of exquisite delicacy and undeniable innovation, ***pairing managed care with managed competition to construct an elegant hybrid structure where the public sector and the private sector*** would toil in productive cooperation. ***The legislation stretched past 1,000 pages, was nearly impossible to explain, and lacked the support of either the relevant legislators or the American public.***

Yesterday, in Chicago, Illinois, Barack Obama named the personnel for his own health-reform effort. Tom Daschle, the former majority leader of the United States Senate, will serve as both secretary of Health and Human Services and as director of the newly constituted White House Office of Health Reform. Jeanne Lambrew, the former top health-care staffer for the National Economic Council and the Office of Management and Budget, will serve as his deputy. Their presence ensures that Obama's effort to reform health care will follow a very different path than that of his Democratic predecessor.

The mistakes of the 1994 health-care reform were predictable the moment Magaziner was unveiled as its architect. ***Peter Gosselin, writing in The Boston Globe, noted Magaziner's tendency to produce "mammoth policy studies conducted under the auspices of big bi-partisan commissions that don't just make recommendations, but come up with entirely new language for talking about problems."*** This has since become the standard explanation for what doomed the Clinton plan. The lumbering, bureaucratic approach produced a proposal few understood and none desired. But Gosselin wasn't writing a postmortem. He wasn't even writing about the health-care battle. He was profiling Magaziner in November of 1992, before Magaziner had any involvement in health-care at all.

Hillary Clinton, meanwhile, created a different set of problems. Whip smart and a tireless campaigner, her presence atop the effort was meant to signal its importance to the president. But she also had a chilling effect on the administration's deliberative process. You can tell the president's health-care adviser that he's full of shit. You can't say that to the president's wife. And so few did. As discussion inevitably turned to disagreement, the process sprung a thousand leaks. Better to let the president know your objections through an anonymous quotation on the front page of the *The New York Times* than risk angering his life partner.

Clinton and Magaziner's blind spots converged in the process that led to the Clinton administration's plan. ***The initial phases of that process are now famous: 30 working groups involving more than 500 people, most of them policy wonks.*** What followed might have made for a good Brookings conference, but it did not result in sound legislation. Eventually, the sprawling structure was dissolved, and a smaller executive committee built the actual bill. Procedurally, that made sense to Clinton and Magaziner. The point was sound and comprehensive legislation, and that required experts gathered in a room. Politically, it made no sense at all.

The executive committee, after all, didn't have any votes in Congress. Members of Congress had votes in Congress. And the bill wasn't constructed with their involvement, and so few of them understood its eventual shape, much less felt personally invested in its success. "I was the biggest mistake of the Clinton health-care bill," says Sara Rosenbaum, who sat in a hotel room with other policy experts and drafted the legislation. "It was a terrible error to have the president doing what Congress was supposed to do. It was a misuse of the relationship between the legislative branch and the executive branch.

By sending a 1,300-page bill, you're writing a detailed blueprint for the policy rather than using the congressional process to create a consensus." Clinton and Magaziner did not know Congress, and so they did not build legislation that worked in Congress. They saw the policy problem more clearly than the political problem. ***Arguably, they solved the former. But in failing to solve the political problem, their policy was stillborn.***

You can't pass health-care reform without understanding Congress anymore than you can win a race without knowing the route. Congress is where health-care reform happens. If you don't have the votes, you don't have reform. And so Barack Obama and Joe Biden -- the first dual-senator ticket to win since John F. Kennedy and Lyndon Johnson -- asked former Senate Majority Leader Tom Daschle to serve as secretary of Health and Human Services.

But, as Mike Allen reported, Daschle "did not want to be HHS secretary -- or at least was lukewarm on it -- unless he was given a health-czar role." Health and Human Services is an administrative position with a heavy load of bureaucratic responsibility. The agency's leader must oversee the National Institute of Health, the Center for Disease Control and Prevention, the Food and Drug Administration, the Indian Health Service, and dozens more. Worse, it's far from the Oval Office. There's no guarantee of regular contact with the president. Donna Shalala, secretary of Health and Human Services during the 1994 health-reform fight was a peripheral player at best.

Negotiations produced a new White House agency named the Office of Health Reform, which Daschle will also direct. ***Daschle chose for his deputy Jeanne Lambrew, a longtime government health expert, survivor of the 1990s battles, and Daschle confidante (they even***

co-authored a book together: Critical: What We Can Do About the Health-Care Crisis). "This is a way for Daschle to institutionalize his pre-eminence," **says Len Nichols**, director of the New America Foundation's health-policy program, "so when he's on the Hill, he's speaking for health reform. It's a reaction to the Clinton structure and shows the world he's in the White House on a daily basis."

If the Office of Health Reform is Daschle's reaction to the marginalization of Shalala, Daschle is Obama's effort to inoculate his administration against the personnel mistakes of Bill Clinton. Magaziner and Clinton may have known policy. ***But Tom Daschle knows legislative politics.***

Daschle first came to the Senate in 1973, as a staffer for the eccentric Sen. James Abourezk of South Dakota. He won his first race for Congress in 1978. He was elected to the Senate in 1986 and became Senate minority leader in 1994 -- at the age of 47. "It turned out that beneath the 'Leave It to Beaver' exterior was a little bit of Machiavelli," marveled George Stephanopoulos.

It was a difficult time. 1994 was, for Democrats, their party's nadir. The midterm elections had been a historic massacre. The party lost 54 seats in the House and eight in the Senate. The proximate cause, at least in part, was the catastrophic failure of Bill Clinton's health-reform effort.

In those dark days, when Democrats were supposed to get rolled by a newly assertive Republican majority, Daschle showed a surprising talent for caucus management and parliamentary maneuvering. "In his three years as Minority Leader, Daschle has never failed to get forty-one votes to block the Republicans when he's decided to make the effort to do so," wrote Joe Klein in a 1997 *New Yorker* profile that examined Daschle's unexpected success at navigating the traditionally fractious Democratic coalition. "The counting of noses and the winning of votes is one of the more elusive political arts," Klein continued. "It happens one on one, in private. It requires skills too subtle for most politicians -- notably, the divining of individual temperaments." He went on to quote Chris Dodd, who had challenged Daschle for the position. "I'd like to think I would have done a good job as leader," said Dodd. "But, boy, Tom certainly does have a talent for this."

It's that talent -- the talent for counting noses and winning votes and understanding temperaments -- that Obama will now be relying on. Daschle can recite the pet issues of individual senators and the unseen constituent crosscurrents that shape their decisions. Personnel is destiny, and if policy wonks give you a process tightly focused on the concerns of experts, former legislators are likely to give you a process that's intensely sensitive to the needs of congressmen. And congressmen, after all, are the ones who will decide whether policy becomes law.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361018/

Health Serv Res. Jun 2004; 39(3): 433–444.

Health Policy Roundtable Panel Discussion: Translating Health Insurance Studies into Policy Proposals

Abstract

Researchers often wonder whether and how their studies are translated into policy or practice. AcademyHealth convened a roundtable of experts at the organization's 2003 Annual Research Meeting in Nashville to discuss how research on health insurance enters the policy process. The participants drew on their experience at the state, federal, and local levels to suggest ways that policy researchers can maximize the likelihood that their work will be used by decision-makers. The following report is based on the transcript from this 90-minute discussion; it captures the panel's answers to a series of questions posed by session-chair, Sherry Glied.

Go to:

A brief description of the participants

Chair: **Sherry Glied, Ph.D.**, is professor and chair of the Department of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Glied conducts research on health insurance reform. She worked as a senior economist for the Council of Economic Advisers in the Administrations of George H.W. Bush and Bill Clinton.

Panelists: **Kathryn Haslanger, M.S., J.D.**, is vice president at the United Hospital Fund in New York. Dr. Haslanger analyzes health insurance programs and other aspects of the health care system in New York City. She has held senior positions in city government.

Richard Kronick, Ph.D., is professor in the Department of Family Preventive Medicine at the University of California at San Diego's Research and Policy Center. Dr. Kronick helped develop the managed competition aspect of the health reform plan for the Clinton Administration.

Jeanne Lambrew, Ph.D., is associate professor of health policy at George Washington University. Throughout the Clinton Administration, Dr. Lambrew worked in various capacities in the Department of Health and Human Services, the Office of Management and Budget, and at the National Economic Council.

JoAnn Lamphere, Dr.P.H., is senior manager in health care finance at The Lewin Group, Inc. Dr. Lamphere worked with the Treasury Department and the Internal Revenue Service to develop and implement a health coverage tax credit program which was enacted in the Trade Act of 2002.

Sherry Glied: Please give an example of health services research that has substantially changed health insurance policy in the United States.

Richard Kronick: I conducted some analyses in the mid-1990s that evaluated patterns of expenditures among Medicaid recipients with disabilities. The results suggested that among Medicaid beneficiaries who are disabled, high-cost users in one year tended to remain high-cost users the next year—much more so than was observed in the general population or among Medicare beneficiaries.

This work resonated with teaching hospitals that were serving people with disabilities under capitated contracts with Medicaid. It helped them to push Medicaid agencies to adopt diagnostically adjusted payment systems for people with disabilities. When these analyses were first published, there were no state Medicaid programs making health-based payments to HMOs; now there are about a dozen.

Another example of research that has informed policy dates back to 1985, when I worked for Michael Dukakis. He was governor of Massachusetts at the time, and his administration had proposed legislation to create a bad debt/free care pool to change the way that state hospitals get reimbursed. The idea was to remove the competitive disadvantage associated with hospitals that serve uninsured people. When the bill was introduced into the legislature, some representatives from western Massachusetts expressed concern that the proposal would cause their hospitals' money to be redistributed into Boston. Hospitals and employers from western Massachusetts were similarly apprehensive.

We conducted an analysis that demonstrated that, contrary to those fears, the bill would not cause any net redistribution of money from western Massachusetts into the Boston area. The findings gave legislators from the western part of the state the reassurance they needed to vote for the bill—and it was enacted.

Jeanne Lambrew: When I went to the White House National Economic Council in 1997, I went primarily to work on children's health issues. This was around the time that creating a children's health insurance program became a priority for the Clinton administration. As the in-house person who knew research and was familiar with this topic, I was asked to find relevant evidence to guide development of the proposal.

It was surprisingly difficult to find any research that had been designed to answer the simple question: Does health insurance matter for children? Fortunately, I was able to ask for new

analysis from the National Center for Health Statistics and draw on state-level research from Florida and New York suggesting that children who have health insurance are more active in school, for example, and more likely to participate in sports. In the end, we were able to piece together enough information to justify the proposal.

On the other hand, there was one piece of research that had a huge effect on the debates surrounding children's coverage. David Cutler and Jonathan Gruber[1] suggested that Medicaid expansions during the late 1980s and early 1990s had, to some extent, “crowded-out,” or replaced, private coverage. Conservative groups such as the National Center for Policy Analysis and the Heritage Foundation used those results to argue that extending coverage to children was a bad idea because it would only substitute for private coverage. The Congressional Budget Office argued that the findings implied that the bill to create the State Children's Health Insurance Program (SCHIP) may cost more money and cover fewer uninsured than had been anticipated.

Finally, the research influenced the ultimate design and implementation of the law. For example, SCHIP had a six-month waiting period built into it so that children could not transition immediately from private to public coverage. It also focused on children from families whose incomes were below 200 percent of the federal poverty level, because, based on the research, we knew that crowd-out occurred most often with higher-income families that are eligible for private coverage. The Cutler and Gruber study is proof that one study can change policy.

Kathryn Haslanger: I have two stories from New York. In the mid-1990s, we conducted a very simple analysis—a straightforward slicing and dicing of the Current Population Survey and the Contingent Workers Survey—that showed that New York was falling below the rest of the country on some important measures of health insurance coverage. We found that people were playing by the rules and still losing. Although New Yorkers were working hard and trying to be independent, many had low-wage jobs in small firms that did not offer coverage.

As a result of this study—as well as a large statewide media buy-in—we passed a Medicaid extension. Like many states' programs, ours expanded coverage for parents and children. But it also included singles and childless couples, and that was particularly important. The expansion was part of a multi-dimensional strategy to increase coverage for low-wage workers; it also included an intervention in which the state worked with small firms to help them provide insurance.

My second story is about the temporary disaster-relief Medicaid program, which was implemented in the wake of the September 11, 2001, attacks on the World Trade Center. It is an interesting example of how policy can change overnight. Following the attacks, New York City lost its computer systems that linked it to state Medicaid information systems. Consequently, officials lost their ability to determine eligibility and track information about Medicaid recipients in New York City. The state stepped in and quickly developed a 1-page application that could be handled in a 10-minute interview. The streamlined process, which was implemented within 13 days of the attacks, gave beneficiaries in one day access to four months of Medicaid insurance (which was later extended to nine months).

Following implementation of the new system, enrollment skyrocketed. Between September 24, 2001, and January 31, 2002, more than 340,000 people signed up for Medicaid. Officials were concerned that the high enrollment was due to fraud. In other words, they feared that people were taking advantage of the new system by misrepresenting their eligibility status.

To find out if this was the case, we did surveys of people at application sites and conducted a series of focus groups. It turned out that the post-9/11 enrollment surge was indeed a result of the temporary enrollment system, but fraud had nothing to do with it. Rather, the simplified process had encouraged eligible individuals to enroll who had been dissuaded from doing so in the past due to administrative barriers. Thanks to the on-the-spot research we conducted, we now have a new perception of our program that we can hopefully build on in better economic times.

JoAnn Lamphere: For a long time, many respected researchers and analysts have been promoting the use of tax credits as a means of expanding opportunities for individuals to purchase health insurance, particularly in the individual market. They supported this idea based on economic theory and their research findings. Several embraced the goal of promoting choice in the health insurance market and decreasing the cost of premiums. Experts generally agree, for example, that employer-sponsored insurance is not adequate for covering individuals in many sectors of the economy.

The Trade Act of 2002, which was signed into law in August 2002, established the nation's first tax-credit program for the purchase of private health insurance. The tax-credits are available for two groups of workers (nearly 200,000 people)—individuals aged 55 and over receiving pensions through the Pension Benefit Guarantee Corporation and displaced workers who are certified to receive trade adjustment assistance (TAA) through their state workforce agencies2.

It is interesting to speculate about why experts' theories and Congressional staffers' assumptions about individual tax credits converged when they did and were subsequently incorporated into this legislation. However, looking at the Trade Act a year later, it is not clear whether the Act's numerous statutory objectives and requirements can be achieved simultaneously and efficiently. The tax-credit program is an enormously complex undertaking that involves collaboration among numerous federal and state agencies and many different private-sector entities including health plans, third-party administrators, and banks. I think the next step for researchers is to look at how well this program is working and conduct analyses to suggest mid-course corrections so that this legislation can reach its full potential.

Sherry Glied: What features make research relevant to the policy process?

Kathryn Haslanger: Two things immediately come to mind. First, research must be timely in order to be relevant. Researchers must have the foresight to think about what might be coming on the policy horizon. They need to anticipate the next generation of research questions to be answered and be able to target studies and secure funding to address those topics as they emerge.

Second, the information researchers provide must be seen as being needed by policy makers. So often, people respond to research results with the somewhat cynical question:: "Who cares?" Policy analysts should think about whether they are providing useful information that can help policymakers to make decisions, whether they be budgetary, political, or programmatic decisions.

Jeanne Lambrew: In order to determine what makes research relevant, we need to think about how health policy is shaped. The people who actually make broad policy decisions—such as members of Congress, the President, and state legislators—probably do not read research and policy journals regularly. They often learn about research through the media, so the question becomes: How can researchers most effectively get the word out about the results of their studies to this audience?

In order to get press coverage, research probably has to have drama. In other words, it needs to show that the scope of a problem is bigger than we previously thought, or it should be directly relevant to a policy that is currently under debate.

Researchers should also bear in mind that federal and state governments are composed of many different agencies that have myriad deputies, assistants, and policy relevant staffand these are the people behind the scenes who are working with top decision-makers to formulate policy. A lot of researchers go into those jobs and they are the individuals who are more likely to read and understand our research. Developing and nurturing connections with these folks may help policy analysts get their work recognized.

Finally, because policy is driven by cost considerations, researchers should strive to get their studies on the desks of those who use research to make financial assumptions about how policies will work. Especially in this current environment of fiscal stress, the Congressional Budget Office (CBO) and the Office of Management and Budget call the shots in many, many

ways.

Kathryn Haslanger: I would like to add two observations to Jeanne's comments. In order for research to be relevant, there has to be space available in the policy debate for information. Some debates are so overwhelmed by ideology and the agendas of well-funded interest groups that it is really hard to make the case for information—no matter how clear and targeted the message or how timely it is.

Second, there are many people at the state level, within the federal administration, and in relevant interest groups with whom researchers can communicate directly. Policy analysts should act as a research bureau for these individuals when they need information. That means they must be willing to quickly return their calls and answer questions about their work. Researchers should check in with them frequently and ask them what is coming up, what is on their minds, and what they think will happen next.

Richard Kronick: We have all heard the mantra that the message needs to be simple, and that is certainly an important part of making research relevant. The message should also be targeted to the likely audience. Some research is used primarily by interest groups in an attempt to persuade politicians to support their position; other studies are used by politicians who have taken a position and want evidence to justify it in the face of opposition.

Sherry Glied: What can researchers and policy analysts do to anticipate where the next health policy question will come from?

Jeanne Lambrew: If policy analysts want to see what is coming, they should just open the newspaper. Researchers tend to think that it is too late for them to address issues that are in the news right now, but in reality these debates go on for years. I wish that, in 2000, when Congress began looking at major bills to reform Medicare, investigators had decided to focus on specific aspects of that legislation and how it would work. Three years later, we are in a situation where there has not been a lot of analysis informing the new Medicare prescription drug plan. Granted, it is difficult to research policies that are brand new or evolving—because researchers need to find ways to study something that has never been done before—but with a little creativity it can be done.

Another example is the Family Opportunity Act, which has also been kicking around Congress for years. The legislation would help families who have children with disabilities be able to return to work without disqualifying their children from Medicaid. The bill has a lot of co-sponsors but, to date, it has not been passed. I think young researchers could still make valuable contributions in this area.

One example of research that has successfully contributed to the next policy frontier is the body of evidence highlighting the importance of covering parents through SCHIP. Researchers at the Urban Institute have studied how this not only improves health of the parents but also aids access and coverage for their children. A number of proposals to address this problem are still in play in Congress.

Sherry Glied: Can you think of examples of times when you would have liked to have more research to drive a decision, and policy analysts did not have anything for you?

Richard Kronick: As Jeanne mentioned, at the time when SCHIP was being developed, there was a dearth of information on the effects of coverage on health and productivity. I would argue that we still do not know much about that. For the most part, the research base just is not there, and that is a big part of the reason why we continue to debate the merits of universal coverage. We have many numbers about the financial effects of coverage on those who have to pay for it, and the distribution of the financing burden, but we know distressingly little about the influence that coverage has on people's lives.

JoAnn Lamphere: Before the tax-credit program was enacted, I wish that more administrative information had been available to answer the question: What will it take to make this program work from an operational perspective? As I mentioned earlier, the program is complex and involves collaboration among federal and state agencies on multiple levels.

There are a number of areas where it is not clear how different agencies can and should communicate essential transactional information to one another or to beneficiaries. For example, the program is grappling with privacy concerns and data transactions. At both the federal and state levels, numerous laws are in place to guarantee privacy and safeguard medical records and taxpayer information, and yet many agencies need to share information in order to make the program work and depend on each other for accurate data.

Sherry Glied: Can you think of examples of times when answers from research were available, but they did not get incorporated into the policy process?

Kathryn Haslanger: As I read the headlines about states' problems with Medicaid spending, I am a little distressed about the reemergence of the "Pac-Man" image, i.e., the concept that states are carelessly spending on Medicaid in the wake of a fiscal crisis. This idea has been resurrected despite the good work that the Kaiser Commission and others have done to illustrate the predictable nature of Medicaid budget problems in the wake of a recession: When people lose jobs, more individuals become eligible for Medicaid, and state revenues tank because the economy is tanking.

Although accurate information is out there, it does not always seem to penetrate the public consciousness. In this case, part of the reason is that "Pac-Man" may be easier for people to understand than the cyclical nature of state Medicaid programs. "Pac-Man" is a sound bite, and the media covers sound bites.

Sherry Glied: Some of the panelists' remarks suggest that policy analysis maybe most useful when there is a constituency waiting for certain results to further their agendas. Do you agree?

Kathryn Haslanger: Not necessarily. Sometimes an analysis can prevent advocates or other constituencies from doing something really ill-advised. For example, in New York, we were able to keep substantial benefit cuts off the table in what was a pretty tough budget year. We accomplished that by getting inside of policy discussions. We made people understand that widespread benefit cuts would not make a difference considering that only 30 percent of beneficiaries were responsible for 70 percent of Medicaid expenditures. If information is presented in a clear and compelling way, it can give people pause and prevent them from taking action that may have been harmful.

Jeanne Lambrew: In some cases, studies can come from out of the blue and stimulate change. Compelling results are not always something that people are anticipating. For example, a few years ago, The Institute of Medicine (IOM) produced a report that, by synthesizing existing data, documented that 98,000 people are killed from medical errors each year. Within days, President Clinton announced a series of actions that his administration was planning to take to address this problem.

Richard Kronick: Jeanne's story of the IOM report is a wonderful window into the importance of communicating results in an effective way. That report was based on studies that were published 10 years ago in *The New England Journal of Medicine*, and received very little attention at that time. By putting together a body of evidence, the report got noticed. It is not just that the report found receptive constituencies, but also that it led to a fundamental change in the way people view the U.S. health care system.

Question (from the audience): When it comes to expanding coverage, we seem to have some nearly intractable federalism issues. Given that state and federal governments are each looking to the other to assume responsibility for the uninsured, is it politically viable to continue to research coverage expansions?

Jeanne Lambrew: Let's not forget that there are some national level debates during the upcoming election year that will continue to encourage consideration of universal coverage.

It is a great question, though, because there has always been criticism of incrementalism. Does it make sense to focus on small policies that can make a difference in the interim, or should policy analysts concentrate on larger reforms? I think there is plenty of room for both on researchers' agendas.

JoAnn Lamphere: I think we need to make the case about health insurance in new ways. Apparently many elected officials are not necessarily concerned about whether insurance matters in terms of health. What may matter more to them are the links between insurance and labor market behavior, or between insurance and developing communities. How does coverage affect productivity? What are the implications of insurance on spending in other parts of the health care system?

Kathryn Haslanger: We cannot just talk about coverage. We also need to discuss delivery service reform. It is time to do serious research to figure out how to change the current system, where people with complicated chronic conditions are being treated body part by body part.

Sherry Glied: How can researchers know whether to disseminate their findings rapidly on the Web, or more slowly through traditional peer-reviewed journals?

Jeanne Lambrew: It is hard to say. Researchers need to continually monitor their work against what is going on in the health policy world. They may find themselves in the midst of writing a paper when, all of the sudden, something happens that makes the findings immediately relevant, and they need to change their dissemination strategy.

Right now, I am working on a paper about Medicaid block grants that started when the block-grant debate was raging, shortly after the President issued a proposal to form a task force to consider this concept. The idea was to provide analysis to inform the debate on Medicaid reform. Well, the task force was recently disbanded, and we decided instead to go the peer-review route.

Richard Kronick: Your dissemination strategy really depends on your goals. If researchers want to effect near-term change on a piece of legislation, they obviously want to move quickly. But sometimes investigators want to change the way that we collectively think about a problem in order to drive policy change; for that, they may want to take their time and really hone their message.

Sherry Glied: Statistics and numbers play an important role in shaping policy. Does policy analysis without numbers matter? What do researchers gain and lose by quantifying?

JoAnn Lamphere: One of the things that researchers strugglewithisfiguring out what the “right number” is in a given debate, and how to get that number used. Policy analysts need to make their estimates based on the best available data, given a great deal of uncertainty about what is behind the current numbers and what the future holds in terms of the economy, etc. They must try to tease out what could reasonably be accomplished through a given program in the context of a changing environment and many unknowns.

Jeanne Lambrew: People underestimate the importance of numbers in health policy. My example is the current prescription drug debate. It began with a number—$400 billion, the amount of money dedicated to financing the plan over the next ten years. People think that that figure was based on analysis, but it was really just a number that fit into the budget resolution. The current Medicare drug plan was built around that number.

Thus, it was the CBO's assumptions that shaped the policy details, since Congress has had to back into a policy using its assumptions to meet the budget limit. Numerous assumptions are needed to determine a drug benefit's costs. For example, the CBO made precise estimates for the number of retirees that will be dropped from their retiree health benefits due to the drug benefits, and it incorporated into their financing the hypothesis that drug prices will rise once catastrophic care is covered for seniors. Even the decision to use a private risk-based system was partly based on an assumption the CBO made that private plans would produce deeper discounts than a non-risk-based system.

The point is that few of these assumptions are based on much actual research. There is a strong need for health services researchers to produce work that informs cost estimators like those made by the CBO and to review and refine their assumptions.

Sherry Glied: Do you have any final thoughts on what policy analysts should do in order to make their research useful to policy makers?

Kathryn Haslanger: Researchers need to cultivate relationships with policymakers and their constituents. They should try to understand the cycle of their work, the culture that they are working in, and the demands they face. I recommend bringing them into analyses at an early stage—so they understand from the beginning how problems are being defined—and working with them to shape a range of solutions.

Jeanne Lambrew: Researchers should not shy away from the media, and they should not be afraid of using other outlets besides journals to broadcast their research, including Web-based reports, conferences, and congressional briefings. They need to know what their question is and be able to articulate it in one sentence. Most important, they must be able to explain clearly why their research matters—even if there are caveats, even if caution is warranted.

http://www.chausa.org/publications/health-progress/article/may-june-2007/press-conference---health-reform-on-the-horizon

Press Conference - Health Reform on the Horizon

May-June 2007

A White House Veteran Shares Her Insights on the Future of Health Care Reform

Jeanne Lambrew, Ph.D., is an associate professor at George Washington University's Department of Health Policy and a senior fellow at the Center for American Progress. Her years of policy work at the White House and experience testifying on health reform issues on Capitol Hill give her a unique platform from which to discuss current efforts and the extended outlook for health care reform in the United States.

HP: What initially drew you to the world of health policy? In an arena that sometimes looks bleak, what keeps you hopeful?

Lambrew: I come from a family of health care providers. My parents, several aunts, an uncle, and a grandfather have all delivered care in some setting. As such, I grew up listening to debates about health care. Most of these debates were about the gaps and breakdowns in the system. So, when I was contemplating what to do, I was drawn to policy.

I went to graduate school and defended my dissertation the day after President Clinton delivered his health reform plan to a joint session of Congress. I moved to Washington the next week and joined the Clinton administration to try to pass that plan. So, my first formative policy experience was certainly exciting, but also chaotic and marked by the deep disappointment of the last great health reform debate.

But in the wake of that defeat, I had the chance to be involved in some small but significant success. In 1995, I contributed to the analyses of what a Medicaid block grant would mean for vulnerable populations, helping to defeat that proposal. In 1997, I took a position at the National Economic Council to help develop, draft, and implement the State Children's Health Insurance Program (SCHIP). And throughout President Clinton's second term, we worked on legislative, regulatory, and "bully pulpit" initiatives to improve and expand health coverage. I can honestly say that I left the White House less cynical about politics than when I went in. Public policy can and has made a real difference in people's lives.

Now, working in a university and for a think tank, my hope is drawn from the growing support for policy solutions to the health system problems. I see this in my students who are driven to learn how to improve health through policy domestically and globally. At the think tank — the Center for American Progress — we have made gains in leveraging leadership through ideas and education. So, while my personal persistence comes from my experience and beliefs, my professional optimism rests on what feels like a rising tide of support for comprehensive health

reform.

HP: Overall, how do you view the prospects for comprehensive health reform? Many say the environment for change is riper than it has been in 15 years. Do you agree?

Lambrew: Some flaws in our health system are slow burning and old. The problem of the uninsured, while worsening, has always been a black mark on our nation. For the past several decades, the U.S. spending has been higher and growing faster than that of peer nations. And quality of care is more sporadic than it should be. However, several new developments are catalyzing discussion and, potentially, action.

The supply side of the system has consolidated. A few large hospital chains and insurance companies have emerged and dominate the market. This makes it harder for purchasers, even large employers, to contain costs. Employers are despairing as a result. Job coverage is eroding, and those with that coverage often feel that they are paying more for less. Another reason for less employer coverage is the shifting U.S. economy. The typical 40-year-old today has already held 11 jobs, making it difficult to tie health insurance to one's employment. Lastly, the growing epidemic of chronic disease makes early and aggressive health care more important than ever. These developments, I believe, are putting health reform in the daily news and near the top of the political agenda. I agree that the environment is ripe for reform, but as we learned the hard way, the presence of the right circumstances and even the right ideas do not guarantee that change will occur.

For this to happen, I believe that we need the confluence of three things. The first is broad-based support and agreement over the goal. Payers, providers, patients, and the public must agree that, as a nation, we should provide quality, affordable health coverage for all. This agreement, backed by pressure, will set the table for the discussion. Second, once the table is set, the door must be locked and a clock must be ticking for a compromise to emerge. Without an action-forcing event, we'll spend another 15 years talking about the crisis. And, third, it will take skilled and committed leadership from the president and Congress. Changing the health system is the equivalent of overhauling the economy of major nations. It will take flexibility, determination, and, most of all, conviction.

HP: Will most health reform activity continue at the state level, or will the federal government soon become the locus of activity?

Lambrew: Leaders in states are doing what they must: helping those in need. Their moral courage should be applauded, as should their ideas. We have seen innovative purchasing pools created in Massachusetts and Maine, aggressive cost control in California, and a number of states have decided that the budget cost of expanding coverage generates health savings that are worth the investment.

Few believe, however, that we can create a seamless, efficient, and universal health care system from a patchwork of 50 state programs. Some states simply are too small to use their leverage to get better outcomes from the system. States are also no longer the boundaries for most businesses in an increasingly global economy. Moreover, what states really need to expand coverage is assistance for those who can't afford it. It is hard to imagine Congress allocating big blocks of funding to a few states to cover all their residents rather than small amounts to all states to cover the most vulnerable. As such, I believe that we should view state initiatives not as the solution but as a signal that it's time for national health reform.

HP: With SCHIP reauthorization up for renewal this year, are you optimistic that this program will provide a viable safety net for uninsured children in the U.S.? What do you believe will be the biggest issue that will surface during the reauthorization debate?

Lambrew: I am optimistic about SCHIP reauthorization. The same federal-state, bipartisan support for children's coverage that created the program exists today. In fact, I believe that this support is stronger a decade later, given the program's success. SCHIP has cut the rate of uninsured, low-income children by a third, and improved access to care.

That said, this success has been marred by the need for Congress to fix federal funding problems

six times in its brief history. This is not just because the original bill lacked adequate funding, which it did. It is also because we have not been able to figure out how to target its capped funding to the states that need it. I'd argue that this is not just because we haven't tried hard enough. It is because health care is inherently unpredictable. Demographic changes, medical advances, and changing patterns of coverage make health cost predictions less reliable than weather forecasts.

Good ideas exist on overcoming this problem. They generally involve adding flexibility to the financing formula to adjust for success in enrollment. The bipartisan Healthy Kids Act, for example, does not limit federal matching payments when state costs are higher than their allotment due to successful outreach. I am optimistic that Congress will not just extend SCHIP, but will improve it to make the Federal government true partners in outreach.

HP: What role can, or should, hospitals play in the reform debate? What unique voice might Catholic health care organizations bring?

Lambrew: Hospitals have a special place in this nation, and because of this, a special power. They are the place that people trust when faced with the most fundamental threats of injury, disease, or death. And it is the hospitals that experience the flaws, complexity, and gaps in the health system on a daily basis. This gives them a voice that is unique in the health care debate. The challenge is using that voice effectively. As crisis managers, hospitals often make the immediate problems the focus of advocacy — the level of Medicare payments or the regulations relating to safety. Such problems are clearly important but are like leaks in a crumbling dam. Hospitals should apply the same vigorous advocacy they used for short-term fixes to help advance a systemic solution to our nation's health care problems.

Catholic hospitals could be at the forefront of creating the climate for change. Many of our policy advances had their origins in communities of faith. By mission, Catholic providers care for the most vulnerable, people whose illness or circumstances constrain their participation in policy change. They can, and probably should, represent these people when decisions about hospitals' policy priorities are being vetted. In addition, Catholic health care organizations lack the conflict that sometimes occurs between profit and practice. Hospitals gain from providing more care, sometimes inappropriate care, and care only when a person is seriously sick rather than before then. Such financial incentives are less important when there is no shareholder demanding returns. This frees Catholic health systems to support aggressive efficiency and quality initiatives that are essential to health reform. In fact, I'd argue that such systems not only have the freedom but obligation to do so, since their "shareholders" are Catholics like me whose faith demands action.

HP: Finding ways to cover 47 million uninsured people is obviously the greatest health policy challenge we face. From your perspective, what are the other top-tier challenges?

Lambrew: There's no doubt that expanding coverage for all is the top priority, but coverage must be improved as well. One area for improvement is disease prevention. Chronic and preventable diseases now account for most deaths and costs in the system. Chronic illness has driven virtually all of Medicare's cost growth in recent years. And, due to the childhood obesity epidemic, the next generation of children may have shorter life expectancy than their parents. Much of these lost lives and needless costs are preventable. John Podesta, president of the Center for American Progress, and I have developed an idea for a "Wellness Trust" that would carve preventive services out of the existing health insurance system and pay for high-priority services centrally. The trust would employ innovative and effective systems for delivering them and align payments with priorities. The trust would be the primary payer for prevention priorities for all Americans, irrespective of insurance status. It would be integrated with the rest of the health care system through an electronic health record. The trust is one of many ideas on how to promote wellness. But small changes that merely jam prevention into an already stressed medical environment simply may not work.

HP: Medicaid is a critical safety net program for low-income populations. What changes are necessary for that program to be sustained? How might Medicaid reform fit in with

other health reform activity?

Lambrew: I think that sustaining Medicaid begins with setting the record straight. Medicaid is no more expensive than any other heath insurance program. In fact, its level of spending and spending growth per capita are relatively low — even, perhaps, too low in some instances. A recent article by Rick Kronick and David Rousseau ("Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," Health Affairs, February 23, 2007) found that projections of Medicaid spending are not excessive compared to economic growth. So the challenge to Medicaid is less its overall costs than the cost it places on states and families. States with high need typically have low revenue, making it hard for them to fill in program gaps and keep pace with cost growth. As for families, once in Medicaid, the cost of care is no longer a barrier. However, getting in is difficult for poor parents and nearly impossible for adults without children. For both of these reasons, the best way to make Medicaid sustainable is to pass comprehensive, national reform. Without it, Medicaid will always serve as that safety net that struggles with the weight of caring for people falling through the cracks.

Medicaid would play an essential role in a reformed system. The need for it would persist. Low-income people would still require direct assistance to pay for premiums and cost sharing. People with special health needs would still need additional benefits not typically covered by private insurers. There is no single answer on how Medicaid would fit into a comprehensive health plan, but the bottom line is that it is essential and should be supported, regardless.