

# Health Reform on the Horizon

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

**J**eanne Lambrew, PhD, 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 per-



sistence 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



**Jeanne Lambrew, PhD**

Since 2001, Jeanne Lambrew, PhD, has been an associate professor at George Washington University's Department of Health Policy, Washington, DC. She will be joining the faculty of the Lyndon B. Johnson School of Public Affairs at the University of Texas in the fall of 2007. She served at the White House in the late 1990s as program associate director for health at the Office of Management and Budget and as senior health analyst at the National Economic Council. In these roles, she helped to coordinate federal policy development, evaluate legislative proposals, and manage cost estimates with multiple agencies. The State Children's Health Insurance Program, the Medicare reform plan developed under President Clinton, and the federal long-term-care initiative all bear the stamp of her influence.

In addition to her teaching and research responsibilities at George Washington, Lambrew is a senior fellow at the Center for American Progress, a nonpartisan research and educational institute working for a progressive policy agenda. She has frequently testified on Capitol Hill, most recently on children's health, before the House Committee on Energy and Commerce.

Lambrew earned her master's and doctoral degrees from the University of North Carolina at Chapel Hill, School of Public Health, Department of Health Policy. Her bachelor's degree is from Amherst College in Massachusetts.

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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 health 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. ■