Policy Reports

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

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.

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 Gruber¹ 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 staff and 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 may be 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 struggle with is figuring 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.

Prepared for publication by:

Christina E. Folz,

Director of Communications, Academy Health

NOTES

1. Cutler D. and J. Gruber. "Does public insurance crowd out private insurance?" *Quarterly Journal of Economics*, 1996, Vol. 111, No. 2, pp. 391–430.
2. In August 2003, a new eligibility group was added: older workers receiving Alternative Trade Adjustment Assistance (ATAA).