Programme OPERA – ENTRETIENS

Entretien – santé n°21

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Responder: Gentlemen, are you ready? You've already ordered. Oh good, thank you.

Interviewer: Thank you very much. I'll just give you my card right now, and so we'll-- I'm a Professor at the French National School of Public Health. I know you have been to the OECD, in Paris?

Yes, I have.

Maybe you have heard about the Ecole-- what was it-- the Ecole Nationale de la Santa Publique? It's based in Rennes, Brittany.

No, I have not. So, you're in Rennes?

And in Paris. Just in Notre Dame-- (inaudible) from Notre Dame. I'm here because I'm a member of a research team, and we study healthcare reforms in the U.S. and in some European countries, like Spain, the U.K., France and Germany, so it's a very political science study, so we don't study the impact of healthcare reform on the population, but we study the ideas, so we try to explain where do the ideas come from, who were the actors involved in it, who were the influential actors, et cetera.

Interesting.

There was another question about change-- maybe change or not in the relationship between actors, is there more influent actors now than 20 years ago, et cetera. Our studies for '80s.

Sorry?

We study the reform since the '80s.

Have you talked to the people at OECD who know--

No.

Well, there's a woman, a French woman you should talk to who is an economist. Her name is Martine Durand.

Martine Durand?

Yeah. Tell her I sent you. She's very good. She also understands the United States better than most. I'll spell her last name, D-u-r-a-n-d, Durand.

(inaudible) last name.

There is also a woman who runs a think-tank who understands the market more than most people in France named Cecile Philippe, and if you send me an e-mail afterwards, I can send you these peoples'-- her e-mails, but it's Cecile Philippe, and I don't know where the Ls and the Ps are, but it's Philippe.

I don't either, I can't remember, too.

It's also the reverse, the French and the English are reversed.

And we try to meet a lot of people in the government, about 200 people in the U.S.

Whoa, boy.

But (inaudible) met 100 people in the Congress.

100?

Or from the HHS. That's why I wanted to see you, from think-tanks, and now I saw that you are now in the think-tanks?

In the what?

You work for a think-tank?

I don't work for it, but, yeah.

You don't?

I'm on the board of a think-tank.

Okay. So, my question-- may I ask you some questions, first, about your career, and could you explain to me what was your career, what was your differing positions, and how did you get it?

This-- probably typically American with an untypical career. I was a lawyer--

Unidentified Participant:(inaudible)?

That's all we want for now.

Unidentified Participant:Okay, I'll get the menus back.

Oh, good point.

Unidentified Participant:Sorry.

It's alright. I was a lawyer, and-- I am a lawyer, and in the 1970s, Nixon put price controls on the whole economy, you know about that, and healthcare was one of the last to come off price controls, so I filed a lawsuit against the government on behalf of some hospitals, then, eventually, the price controls went away, and I started working-- the people I was firing who were represented, wanted to change the system.

So, I started with a group of guys, and a group of hospitals, to work on ideas for changing the U.S. system. I was the main author of a bill that became known as the Gephardt-Stockman bill, which was the first bill in Congress-- it was the first effort to make a competitive system. Even back then, we knew it was going more regulatory, and this was a bill to make it more competitive.

Gephardt, the Majority Leader, G-e-p-h-a-r-d-t, hyphen, Stockman, who left and became Budget Director under Reagan in 1981. So, I did that for a number of years, and we never had success, and then I kept doing it, I was doing that bill and other regulatory-- fighting other regulatory things that came up, and in 2001, I went into the administration with Bush, and I was at HHS in Washington from 2001 through-- until the beginning of 2005, and I was at a policy office called ASPE. You've probably seen people at ASPE.

Then, in 2005, I went to Paris and was the health attaché to the U.S. mission to OECD, in English, and (inaudible).

Okay.

And there at OECD, I tried to suggest to the Europeans that you could do it-- you could have a market in healthcare. Europeans were not responsive-- were not-- although the Swedes occasionally got it, the Dutch occasionally got it, and some others, but they were-- this was all Health Ministers, and they were locked into their system, even as they saw the problems with the system.

Now, of course, you're here at the wonderfully ironic moment, the US thinks it's going more towards the Europeans, and the Europeans are trying to get out of their system and come back.

And (inaudible) talking about a group of guys fighting the regulations. It was a group-- a structured group, or was it informal, or--

That's a very good question. You know, we created a trade association, which is the way you do it here, and it was called the National Council of Community Hospitals. It has since run

out of money and disappeared, run out of money, and the people have gotten older, so history has passed it by, but, yeah, it was an interest group. It was an interest group.

It was a not-for-profit, it was not a trade association under tax law, because it was a think-tank, not-for-profit, with 501(c)3 status, and it had (inaudible) and not (inaudible), but it did a lot of work educating members of Congress.

(inaudible) and how did you arrive to the HHS? Why you?

Why me? In-- let me see, about 1996, the government set up a bipartisan committee-- you'll find this interesting, a bipartisan commission on the future of Medicare, and the chairman of it was-- I don't remember if it was-- Congressman Bill Thomas, who was Chairman of the Ways and Means Committee, and I was brought on as a special employee to work on it, and I'll tell you how that leads into it.

The interesting thing about this was, the understanding going at the beginning was that the Democrats and the Republicans would both go along with a proposal to basically voucherize Medicare. Do you know what that? Yeah, okay.

In the end, the Democrats didn't go along with it, and the belief was that they wanted to save a Medicare issue for Gore in the 2000 election, so the commission was not permitted, did not issue a report, because they couldn't get the necessary votes. Anyway, the Executive Director of that commission was a guy named Bobby Jindal. Does that mean anything to you?

Okay.

Bobby Jindal. J-i-n-d-a-l. He's Indian-- East Indian origin, but he's American. He's now the Governor of Louisiana, and he's the one who has been worried about the oil spill, but anyway, he-- so, he was appointed in 2000, 2001, after Bush finally won the election, to be the Assistant Secretary in charge of ASPE, and then he brought me in as someone who knew these issues.

So, you were a political appointee?

Yes. That's what I left Paris in January of '09, because I'm out.

You got replaced by a Democrat, or--

Okay.

What did you do when you were in the HHS? Did you arrive to push forward your ideas, or--

My responsibility was-- my main responsibility was at a particular agency, which was not health reform, it was-- but I tried-- this agency had no power to do anything, it could only issue grants, give money out to researchers, so I gave-- I got a number of projects going with academics, which was work that was related to reform.

I don't know how much you know what happened during Bush, but there was an effort that was led out of the White House to come up with a reform bill, and there was a guy named Rex Cowdry. Have you heard that name?

No.

Rex, like king, and then Cowdry, C-o-w-d-r-y, who was a psychiatrist who did (inaudible), and he was leading the effort out of the White House, and we came up with various proposals which would put a voucher-- which would give a tax credit to the poor to buy health insurance, which is the way we think we should go.

Remember, we never had the votes in Congress, because we barely had a majority-- we didn't even-- we had a majority in the Senate, and then Senator Jeffords switched parties, you don't remember that, but we lost the majority in the Senate, whether we had a majority or not, we didn't have a filibuster-proof number, so we could never get something like this through, the Democrats-- they wouldn't do it.

So, it never became a big, prime push, although the President was very good, in several speeches, in articulating this idea, but it was never a prime legislative push, because it couldn't, I mean, it was never going to go anywhere, and that's what the Democrats got that we never had, which was the-- for a brief period, they had the filibuster-proof vote in the Senate. Which is critical to this whole debate, that brief window that they had.

It's like the health savings account, or different?

Health savings accounts would have been consistent with it, but it was basically-- the answer is, you could have used the money to buy-- I can't-- we also, at the end of the term, Bush's term, changed it from-- I can't remember how this worked technically, but basically, you give the person money depending on their income, and they can use the money to buy insurance. Now, one of the insurance products that they could have bought would have been a high-deductible plan with an MSA.

But the point is that it was a-- they could buy into the insurance market. The reason it was a tax credit, actually, it was a voucher. The reason it was a tax credit, which is like a voucher, and it was refundable-- you know what the tax credit means? You get the money even if you don't owe any income tax. It was refundable, and-- for the very poor, refundable and prepaid, you put the money ahead of time so you could buy a policy for the year, but Bill Thomas, who was Chairman of the Ways and Means Committee, wanted to have control of the legislation, and-- to get it into the Ways and Means Committee, and not the Commerce Committee, it was turned into a-- crafted as a tax bill.

If it had been a voucher, it would have been just something that you pay out, it would have gone into the Commerce and whatever committee.

So, you mentioned that the OMB played an important role in this proposal?

Well, Rex Cowdry was in the White House, but he wasn't really in OMB, but yeah, OMB played some role, and that was Jim Capretta, have you heard of him?

No.

He was (inaudible)-- see, I left in '05, to go to Paris, and then there was another effort, so I don't know who was doing that effort.

And this idea for a sort of tax credit, does it come from the group you were involved in a few years ago?

They supported it. Actually, it's come-- I was a co-author of a book that we put out in 1992 or '93, with three other-- or three academics and me, where we-- there were two people that proposed it. There was Alain Enthoven-- do you know Alain Enthoven?

Remind me of--

Alain, which is A-l-a-i-n, Enthoven, I think like the city in Holland, because he is Dutch, about the same time, he and we came out with an idea. Alain Enthoven's idea was called "managed competition." Managed competition, to most of us-- it was like our idea, but it was more regulatory and more controlled. We think that managed competition is an oxymoron. You know oxymoron? Is that a French word?

It's the same.

The same word. To his credit, when Clinton tried his proposal in-- or Mrs. Clinton, in '93, they said that it was built on the ideas of Enthoven and managed competition, and he said no, he said it's more regulatory even than my ideas. Now, he didn't use the words "even mine," but that's the whole problem with managed competition.

Once you set up the structure, it inevitably turns into regulation. Anyway, so there was Alain Enthoven, and there was this book that was written by the four of us, and it was called Responsible National Health Insurance, and the lead author was Mark Pauly. Do you know-- have you run across Mark?

No.

Mark, M-a-r-k, P-a-u-l-y. He's a Professor at the University of Pennsylvania Wharton, and a leading academic on insurance.

And this book was published by which (inaudible)?

It was published by AEI.

AEI, which means?

American Enterprise Institute. There was a whole community of people who believed and still believe that that's the way to go. There are people at AEI, there are people at Heritage, and then Galen, in the Consensus Group got started-- do you know about them?

I read it on your webpage.

They got started in 1993 in reaction to the Clinton bill, so all the groups said "We have to get together."

Are you talking about the Consensus Group or another group?

Which-- the Consensus Group or the which--

(inaudible)

(inaudible)?

Hamilton. H-a-m-i-l-t-o-n, because Ann Agnew, who--

Yeah, I know Ann.

She told me that she was a member of a group called Hamilton, and thinking about a (inaudible)

Hamilton, like the Secretary of the Treasury? H-a-m-i-l-t-o-n?

I think so. No?

She may have been in a different group. I didn't know about that. There were lots of different people who--

Okay, so the Consensus Group was a reaction to Clinton's proposal?

It was a reaction to Clinton's proposal and an effort to get all of these different think-tanks that had-- they all had different views but, at the core, they had common views, and the whole point of the Consensus Group was to emphasize where they agreed, which was the critical (inaudible). The rest, the non-agreement was on basically design details, but the agreement was on the core that you needed to fix the tax code, which we talked about, and we didn't want to go the Clinton regulatory way.

I don't know if you know the tax code regulations on this. One of the main problems with the U.S. system, besides all of the other problems, but on the financing side, is that one of the ways that we subsidize purchase of insurance is through the tax exclusion. The tax exclusion, if you are an employee, and the work-- and the employer pays you wages, you have to pay taxes on those wages.

If the employer buys health insurance for you, although that is compensation for labor, because of historical quirks going back to World War II, and price controls during World War II, that is tax free to you. So, it is better to take money in health insurance than in cash, and that has built up the employer-based system for good and for bad.

The problem is, the benefit-- the more income you make, the greater is the benefit, and the more insurance you buy, the greater is the benefit. So, the guys in the middle, the guys in the middle, who are self-employed, don't get this benefit, and the poor don't get this benefit, and our group doesn't think that's right.

It costs-- it's an exclusion both on the federal and the state levels, and Social Security taxes. It costs-- on the federal level, it costs $200 billion a year is what the exclusion costs. That's a lot of money, even now.

Some Republicans don't want to change the exclusion because they would see it-- get rid of it-- what we suggested was, eliminate the exclusion and substitute it with an income-related tax credit, so that-- they saw it as a tax increase, as you're raising the tax on people for whom you take-- if you take away the exclusion from someone, and the credit is less than the exclusion, you're raising the taxes.

So, some Republicans are very nervous about it. McCain, in his recent campaign, tried to articulate this on the exclusion. Now, I think-- and Obama criticized him for it, that the healthcare bill that came out, the reform bill, I don't know-- you probably don't have to get into this detail. It's wrong. It takes the idea of getting rid of the exclusion and does it wrong. It puts a so-called Cadillac Tax. Have you heard of the Cadillac Tax?

The Cadillac Tax is supposed to be a more politically acceptable way of doing the exclusion. It doesn't because of a whole variety of reasons, but that's where they tried to tie it-- Obama tried to tie it to McCain, the Cadillac Tax. It is that fear.

So, anyway, those are the ideas, it was-- it wasn't just one, it was a whole movement, and it still is, of Heritage, Bob Moffat and Stewart Butler, AEI, Bob Belms, and (inaudible) development went into Galen, and then the people were writing on it. John Goodman wrote on it, Mike Tanner wrote on it, this book that I told you about wrote on it, so there was a whole--

So, it still exists?

It what?

This group still exists?

The Consensus Group still exists.

And who is leading it?

Grace-Marie Turner.

Oh, she is at the Galen.

Yes, that's one of Galen's activities.

So, and I still read on the Internet that you drafted the first bill for (inaudible) in Congress, but which one was--

That was the Gephardt-Stockman bill that I told you about.

With whom did you draft this?

I drafted it myself. Well, I drafted it, and I got help from one guy, Don Moran, who worked on the Medicaid parts of it, but it was a constant back-and-forth with Dick Gephardt himself, so it wasn't just me drafting it, but I was giving him ideas, and so he was the one who decided what went into that bill, and the brought Stockman on, and just to show you, Stockman was on the bill, and then we had a new Congress after the 1980 election, where Reagan won, and Stockman was appointed budget director, and there was a gap between the new Congress and the new President.

Congress comes in on January 3 or something, a new President is January 20th, but Stockman insisted on putting the bill in again in that interim, because he wanted to show his support for it, even though-- even as he was going into the administration.

And, when drafting this bill, later in your work in the HHS, did you consult any academics, for instance?

When I was at HHS, I didn't have the lead on developing their proposal. As I said, Rex Cowdry did, and Jim Capretta. Did they consult with-- I can assure you they consulted with the academics. You know, I wasn't there, I didn't see them doing the consulting, but yes, that's the way it would work.

But at this point, the academics and the policy people all pretty much knew the same thing, so I'm not sure how much they needed the academics. The main problem was always trying to figure out how much it costs, and OMB can do that without academics.

If you were-- who was appointed to the OMB? What kind of profile? What is the kind of profile that people have at the OMB? Are they lawyers, economists, politicians?

All of the above, really. You're talking about the political appointees.

No, no, in the OMB?

Yeah.

Because there are also political appointees there?

Yes. Just a few.

Are there career people and political--

Yes, yes. And also got involved in this was Treasury. There was a woman at the Treasury whose name I can't remember, who has been working on this, doing the technical issues, (inaudible) operational, and I simply can't remember her name.

So, when you were in the HHS, the government passed an important bill in healthcare, on--

Medicare.

Yeah, Medicare. Did the HHS play a role in that?

Yes, oh yeah. Not me, it was a different office, but yes, indeed, yes. But it's really back and forth, or it was with this recent bill. It's a joint effort between the administration and Congress when they're in the same party, when the administration party controls the Congress, when it controls the Committee.

I ask you the question because a lot of people, it is well-known that when Bill Clinton proposed his reform, he didn't consult the HHS, didn't consult the Congress either, but he did it by himself.

Right. Hillary had all her groups that she brought in. That was a highly unique-- that's not usually the way it works. Obama-- on this health reform bill, HHS was actually not much involved. They took people and put them in the White House, so it was mainly-- well, it was people in Congress, and it was people in the White House. It wasn't HHS, exactly, but people-- different presidents do it different ways for how they want to get their group together. It was-- I mean, in the White House, for Obama, you had Nancy Ann Min-DeParle, and you also had Jeanne Lambrew.

I've heard about her.

She's critical.

So, how do you explain that Bush did give more importance to the HHS than the Democrats did?

Why did Bush give more--

Or did he?

Yeah, on the health reform-- on the Medicare bill, he did. I don't know if it's more or less than Obama, because they haven't done Medicare. I mean, the health reform bill, I would not say that-- I don't think that HHS did lead that. It was this guy in the White House in OMB, that's how (inaudible), and--

So why, in one case, (inaudible) because it was more technical and one is more political?

No, these things are not that rational. It's just where people are and who they feel comfortable with and--

Unidentified Participant:I couldn't figure out if I'd given you the check or not.

Maybe you were hoping for more.

Unidentified Participant:No, I thought I had brought-- see, it's too early for me. I knew I had brought some checks around, and I was saying, did I bring it, or--

I see you're starting later in the morning in the summer.

Unidentified Participant:I don't like it, because I have to come in an hour earlier.

Well, you lose breakfast.

Unidentified Participant:See, the breakfast people come in at 8:00. Now they come in at 10:00, and I was in at 11:00 before, so now we all come in at 10:00, it's like nobody's happy.

I don't think you can-- I don't think-- there's certainly not an institutional answer to the question, and I think it's always much more informal-- it's just the way the relationships develop on who is going to do it.

Some people told me (inaudible) the team that the Republicans have maybe less expertise on healthcare, and so they rely on the HHS more than the Democrats?

No, no. This business about less expertise is-- the Democrats spend their life, their professional life administering government programs, so they develop, well, what is-- for one thing, the Democrats have been in control of Congress for most of this time, except 1995, so they have been in charge of all of these programs in Congress, so they have developed that expertise there.

Secondly, they administered and are the grantees of a lot of the money from a lot of these programs. Republicans don't think the government should play such a large role in healthcare, and they, therefore, have not-- very few Republicans have built up a career administering these programs. There are some, but very few. There are some at the state level, particularly, because they have to, they have to administer Medicaid.

So, the knowledge is actually different. Yeah, the Democrats have greater knowledge-- there are more Democrats who have greater knowledge of the details of the current regulatory system, but they actually have less knowledge of how the healthcare system actually works in the real world, because they have never been-- never been, fewer of them have ever been in the real world, and that is actually one of the problems that is going to reveal itself with the Obama bill, because it makes-- it creates programs and creates concepts and makes people-- it makes people do things that it wants, which are very difficult in the real world, and for which there is going to be a rebellion in the real world.

So, that's a cliché that's much too--

Maybe it's just political argument to say, "We Democrats have more expertise than--"

Well, if they're saying that, it depends on what you mean by healthcare. I mean, they have more experience in running Medicaid programs and writing Medicaid statutes, but that doesn't mean they have more knowledge about healthcare. That's the whole disconnect.

We have a-- there is no question that Republicans have fewer people-- this is another complaint, the academic world is controlled by the liberals, who do not place-- it's much easier for these Democrats, when they get out of power, to get a job in the university than it is for a pro-market Republican. There is a clear ideological and personal, because they all know each other, personal bias. So, the universities are in the control of the liberals.

How do you explain this?

What?

How do you explain that?

How do I explain that. I think it's a deeper, sociological question. These are people from the 1960s, liberals from the 1960s who (inaudible) into academia, and have no worked their way up to the top of the departments and the top of the universities. I don't know why. Universities-- I don't know. I think it's true all around the world, tend to attract and favor statist solutions, in a liberal, U.S. context, this all goes back to the progressive, here. They think that-- and Obama does, too, they think that a few wise experts can run these programs, as do some people in France.

That's what-- that's the point, because we are (inaudible) for French--

You what?

The results of the study for France now, we get our response to our questions from France, and we saw that healthcare reform, for 20 or 30 years in France was really promoted by a very small group of actors inside the administration, career people only, and they disseminate ideas and have specific strategies to promote their ideas, so that's why we try to compare it with the U.S., and it's different.

The political systems are different, but it's actually the reverse here. Whether it's-- this country is basically split right down-- in this case, the country was split right down the middle on whether you want more government control or more individual control. Obama, because of a strange, unusual congruence of circumstances, one. He went, we think, too far to the left, and the people are now seeing what the consequences are, and we think the people now turned more the other direction, because they see what it means.

My point was that in either direction, it really comes from-- comes up-- it really does come up here from what people-- not government, but people, think, and then government's effort to not translate, but to capture what they think the people want. The Democrats, in passing the Obama bill, think that they are doing what their people want. So, it isn't just a few guys in the government who-- in this case, they are imposing it, but they are imposing it because they think-- it has been 100 years of rhetoric on the Left, that this is what they wanted, and so they think they are doing what the people want, at least what their people want.

So, it's just the reverse (inaudible), but both sides have this whole network of people who are thinking on these ideas, and then these same people go into the government. All of the Obama people were people in the think-tank and the academic community, just as our people were when we went in.

And there is probably more-- in one career, in your career, for instance, you have more change in just one year of your life than most people.

Much more back-and-forth and (inaudible). Much more than (inaudible). France has a much more disciplined and much more honest, you know, civil service that actually administers things than we do. We've got a much more chaotic, diffuse, flexible, open, chaos.

And when you were in the HHS, did you have any problems or not with the civil servants?

No, in fact, the civil servants were wonderful, at least the ones I knew were wonderful. They were willing to do the things we wanted to do, and they got-- I think they appreciated the interchange with us. I think they were glad we were there, it was kind of a new, intellectual ferment that they hadn't had before.

Even when they are Democrats?

Oh, yeah, even when they are Democrats.

So they are honest here, too?

I wasn't thinking dishonest, I was thinking more some people who were administering programs like offshore drilling, and I don't think that would ever happen. I think that's a perfect example of how-- the way that that was regulated, I don't think would ever happen in France. It would be much more professional and honest. I don't think (inaudible) the bribes and the incompetence.

But if you read the stories about the Katrina spill and read about MMS, you will be-- there is a Rolling Stone article on MMS which you would find very interesting, and I would wager that that would never happen in France.

What is the MMS?

It's-- actually, if you Google Rolling Stone and MMS, you'll get it, but it's Minerals Management Service, I guess, I don't know, Minerals Management, something, within the Department of the Interior.

Okay.

It's worth reading as a political science example of how things can really go wrong, if it's true. I think it is true.

And you could talk to me about the opposition between more or less government, federal government, but what is the importance of states in this process of reform? Do they just follow, or are they more proactive, or--

Well, the way we would do it, the states would have much more influence than the way Obama is doing it. The Obama bill-- the role of the states under the Obama bill is really interesting, because the states are unhappy, and angry at the expenses they are going to be forced to take, including Medicaid and state-- and having state exchanges, but they didn't speak up.

The Democratic governors-- the Republican governors spoke up, but nobody wanted to listen. The Democratic governors did not speak up, and we just think-- we think they were just going along because-- to be part of the team. One of the-- what country is it-- Germany, you know, the upper House of the Parliament in Germany is elected by the state, by the (inaudible). In the U.S. the Senate used to be elected by the states, until 1920 or something, and-- as part of the progressive movement, because the Senators were being bought. The Senators were bribing legislators, so they changed it so the Senators are now directly elected by the people.

Therefore, the role of the state-- the defense of the interest of the states went way down. In Germany, because they were strongly represented, and if we-- anyway, so that's-- that has changed the dynamic, but the states-- beyond the Medicaid and beyond the exchanges, there are all kinds of things in this bill the states are going to have to do which is going to cost them money, and many times, they are going to have to do it under federal rules.

For instance, price controls, premium controls, some states have them, some don't. The Feds are going to give money to the states to do premium controls. They are telling the states-- they are telling the exchanges, which are state-run or state-based, that they have to consider unreasonable increases in premiums when they decide whether or not to let an insurance company into an exchange. There is a whole series of these things, and the relationship between the state and the Feds is going to be very confused.

But during the past 20 or 30 years, would you say that the states are more and more under federal control at this point?

Yes.

There is still a lot of autonomy?

Remember, a lot of-- I can't remember the percentage, but 50% or something of U.S. spending-- health spending is Medicare, which is federal, and then you have Medicaid, and Medicaid is supposed to be a state-federal partnership, but the states-- if the states want to get the money, they've got to do what the Feds say, so, again, there's another constant source of tension with the-- but the Feds have to have the (inaudible).

Other healthcare-- on private healthcare, the states have been the regulators, except for, and this is really confusing, and we can't get into it, but there's a federal law on the responsibilities of employers when they give insurance, ERISA, and that has been very lightly used. Leaving that aside, the states have been the ones to control-- to regulate insurance companies, individual and small-market insurance companies, and that's all changed by this law.

Because all of the regulation on how the insurance is to be operated is going to come out of the Feds. We-- I'll give you another example of how it's really screwed up. There is something called NAIC, the National Association of Insurance Commissioners. This is the state insurance commissioners who get together, like a club, and they issue-- they try to work out problems among the states and issue model-- basically, model regulations and model provisions which states can either accept or not accept, but it gives them a beginning.

This bill has-- there has been a great controversy over the medical loss ratio part of the bill, and what goes into the calculation of this bill gives authority-- let me go back. It directs the

NAIC to develop definitions for the MLR provision, and then it's got a very ambiguous phrase, "Subject to HHS certification." We don't know what that means. We don't know if that means the HHS could disapprove or what. But, again, it's going to the commissioners, which really means the professional bureaucracy that works for the NAIC.

So, is that state? Is that federal? Don't know yet.

Don't know yet.

But it's a federal requirement. That's the point.

So, the federal government sets more and more general framework and economic pressure on states to do what they want to do?

Yes. Is the federal-- yes. Yes. Mainly, because they control the dollars and the state-- the Feds have one advantage which is that they can print money and borrow money, and most states have to run a balanced budget, so they have what seems to be a bottomless pit of money, but it, of course, isn't.

Could we say that this is a process, a linear process of increase of federal control, or is it back and forth, and-- when Bush was President, (inaudible) then the federal government went back?

Rather than linear, I think-- until there is a revolution, the process is more one of an upward ratchet, because you never-- even under Bush, the way Bush was able to give some authority back to the states was because the law, especially in Medicaid, permitted waivers of certain requirements when requested by the states. So, the states came in with a whole bunch of requests, and Bush granted-- the administration granted them.

But the basic law is never-- was never turned back, and so if-- you can call it linear, you can call it-- it is linear towards more control, but it's a little bit more like a ratchet, because it comes back a little bit and then it goes back up. It's-- until people revolt, that's the tendency, and that's what's going to be an issue with this election and the election in 2012. It's hard, it's really hard to turn it back.

And you tried to introduce it in a form in (inaudible) in a campaign for 2012, this issue?

Which campaign?

Senate or Congress in 2012?

Oh, well, 2010.

This year? When you renew the Congress?

Yes, this fall. This fall, all of the Congress gets elected, and one-third of the Senate, and this issue is not going to come up this way, but it's going to come up because the people-- this goes to Tea Party and a whole bunch of other things, there are people mad about a lot of things, one of which is the healthcare bill, and that's going to be an issue is-- it's going to be

part of a much bigger issue of federal control in this, and spending in this election, and then, what's going to happen, there's no question there will be a more conservative Congress elected. It may not be Republican-controlled, but it will be more conservative.

So, then there's going to be fighting over the next two years over the implementation of the healthcare bill, and then Obama is going to try to use it as a-- it will be one of the major issues in 2012.

As he himself said, when we were going into the election-- not the election, but the passage of the bill, he said the-- well, we'll take it to the people. We'll let the people decide. That's what elections are for, and that's what he said. Unless he gets smart and, because he's got a more conservative congress, turns, but I don't think he will.

And Galen is-- it's the Galen Institute?

Galen.

Galen. What's the strategy to promote more market in healthcare?

Yes, I mean, Galen doesn't do political activities, because it's a think-tank, but the strategy is to keep-- of Galen and everybody else, is to keep pointing out all of the problems of the healthcare bill. There are just so many, we are just going to be explaining them, and we are going to be watching the implementation, like the MLR, which is coming up soon, like the question of what's grandfathered. There are a whole bunch of tough questions.

We will be fighting about it for--

Will they organize a seminar, conference--

Right. Seminars, articles, kind of shorter than articles, you know, blog-type things, seminars, yes, and Grace-Marie does a lot on the radio, and she knows-- OpEds is the other thing, OpEds in the Washington Examiner or the Wall Street Journal. The media-- the mainstream media tend not to want to run those, so we have to run them in other places.

Okay. I'm sorry, it's not very organized. It's back and forth.

I understand. The whole topic is.

Come back to when you were at the HHS system, at the HHS, did you concretely change something? A policy? What were your results?

What were my results. That's a very good question. There was one bill that was our result. It was actually supported, in the beginning by Senator Kennedy, and I worked very hard on this bill, and when it actually, finally, got passed, after I went to Paris, but I was very active in getting it right, and that was the Patient Safety Bill, which-- I always worked on malpractice reform, and that's the whole point.

The Safety Bill was an effort to set up a structure so that people, doctors, and hospitals could report errors to a central-- not central, but to an organization so that that organization could

use it to make recommendations on how to improve quality, but the point was that hospitals and doctors would not have this information used against them in a lawsuit, and that was very contentious.

Senator Kennedy had been originally behind the original version of it, so that was one thing that we got done. We did a lot of work on malpractice reform, to try to reduce litigation, never could get it through Congress, could get it through the House, and I worked very much on this, could get it through the House, because we controlled the House, but could not get it through the Senate, back to the same problem.

Then-- I'm trying to think of other issues. Those were the two main ones I worked on, and then we did a lot of studies, as I said, on how the individual insurance market worked, and then there is something called Cash-- a very good program called Cash and Counseling, which was actually done-- supported by Robert Wood Johnson and the government, and was done in Arkansas, with Huckabee, Governor Huckabee, which gave disabled people who were going to have a personal attendant, but it gave them money, and they could use the money any way they wanted to buy-- to choose their own attendant, to buy things like a dishwasher or a microwave instead of the government doing it by providing the service for them.

Highly complex, because of how it interacts with the wage-- with the employment taxes, so just don't get into it. So, we had to work all sorts of things out with the IRS, but this started under Clinton, under Clinton, and we did a lot to advance it, and it's still going. It's in the Obama bill, too.

What else did we do? Let me see, malpractice, patient safety, I guess those are the two main things. I was only there for three years.

That's already-- that's a lot. So, in a way-- you tried, personally, your ideas, to introduce more market, a regulated market, but (inaudible) market, but in a way, you introduced also more government, for instance, with the Patient Safety Bill?

No, well, I mean, any time the government acts, it's more government, but this was actually a way-- you call that more government, but I call it less government, because it's an effort to create-- to support these private-- these organizations are private, they are voluntarily set up by hospitals and other people in the hospitals, and to avoid that information getting into the medical malpractice system, which is government, by the way. Medical malpractice is run by the government, called courts, but it-- no, that's not government.

I mean, it's government because-- when the government tries to counteract something else that the government does, that's less government, because those are private safety organizations getting more data. The whole effort on the malpractice reform was to, more generally than just this bill, was to get people paid to have a law that would encourage people to settle malpractice cases quickly and get them their economic loss more quickly and, at the same time, avoid the length and trauma and the big judgments for non-economic damages, which is what's in the courts.

So that was an effort to create private settlements and avoid-- and actually, there was a very successful pilot program on a version of this which was run by HHS on claims that are filed

against HHS for malpractice under community health services or Indian health, or other places where HHS is actually a defendant.

I don't know if you are aware of the extent of the problem we have with malpractice litigation, but it's enormous, because we spend all this money, and then a few guys get a huge judgment, and then the lawyers get a huge judgment, and then most people get nothing, so it's all arbitrary, slow, and expensive.

So, no, I don't think that what we did was more government.

So you can sleep well tonight.

Right, I have no problem.

So, some problems inside the HHS were pilots, sort of models, like this one, like what you were just talking about, but did you investigate programs in states to find some models for different operations? Did you, in the HHS?

I can't give you any specifics, but the answer is yes. A lot of the money that went into research (inaudible) research was doing studies on what different studies were doing, like on this Cash and Counseling, there were a whole bunch of states that were doing it, there were different ways of doing it, so we did refinance studies, so, yes, a lot is-- a lot of effort went into seeing what the states--

So, in a way, it's like bottom-up and top-down?

Yes, exactly, at the same time.

And how did you choose the people to do the research?

The contracting process at HHS is very complex.

Specified by law, or--

Well, there's a universe of people who you have to deal with except in certain circumstances, and I don't think we did too many competitive contracts, but we took people who we thought-- you know, there were a lot of people who have spent a lot of their career doing these studies, so we used these people. We did a study with-- on medical malpractice-- on medical licensure boards, and I cannot remember-- I cannot remember exactly what we did, but it was the effectiveness of medical licensure boards in promoting quality.

That study was done by a guy at Brookings. Urban. Brookings. Either Urban or Bookings, I can't remember which. Urban. There's a stable of people who do this work.

And it's always the same terms?

Yeah, I think the Democrats may use different people. It's-- I guess I shouldn't-- there is a stable of institutions. The people are different. You get different people at the institutions who you think may understand what you want to investigate better than somebody else. The-

- well, they just announced yesterday $25 million in grants for medical malpractice reforms which really aren't-- I'm sorry, not medical malpractice-- how to improve quality, but it's related to medical malpractice. I didn't know any of the people who they used in this study.

Because they're the from the other side?

Because they're from the other side. Usually, I know the people on the other side. I didn't even know these at all, so-- and I know most of the team on the other side.

This is maybe the last question, because we've been very long, and-- who, in your career, has been maybe the most important people you meet for your own career? Or maybe there are several that are important for your career?

Well, you have to remember I was a lawyer, just a normal lawyer doing legal work, so I had that whole career, and then I had the policy part afterwards, and (inaudible). I would have to say, collectively, it's the guys-- it's the guys at AEI, Heritage. Pauly, the academics, Grace Marie, Bob Helms, Mark Pauly, Joe (inaudible), (inaudible). It's Nina O, she's at Heritage. That whole group of people. There's no one guy or girl. I have not had a mentor.

Not a particular mentor, but maybe someone who pushed you or promoted you, or-- but where do you meet Madame Agnew?

Who?

Ann Agnew?

Ann Agnew. I got my job at HHS, and I then learned how the process worked at HHS, and Ann was the funnel for everything that comes out of HHS, and I did not know her before, but I-- but she was the one who had to get-- if you were objecting to something that somebody else was doing, or if somebody was objecting to what you were doing, she would send it around to 20 different agencies, and she would get the comments together, and she would get the people together to discuss it.

She had a great job-- she did a great job in making the institution, making the agency-- everybody participated. They didn't make the decisions, but at least everything that they had to say came to the Secretary or whoever else was making the decision. I don't think they've kept that same process now.

But it was-- actually, HHS, from what I understand, especially with Ann, had a kind of uniquely well-organized system. You know, the HHS-- not only do you have a lot of different agencies, you've got some with their own budgets and their own people, like FDA and CDC and NIH, who have a lot of money and a lot of power, and you've got to bring them all together and bring--

And you have had some opposition with other agencies?

Oh, yeah. Sure.

On budget, or--

Budget or everything. CMS-- CMS would suggest some regulations, and we at ASPE would say, "No, we think that's unnecessary, wrong, or too regulatory." My favorite, actually, just to-- at one point, it's a very technical question, so I've now forgotten, but it had to do with reimbursement of specialty hospitals, and they said, "We'll put a--" they had a new idea, which we didn't like for various reasons, and they said, "We'll put a moratorium on this idea, and after the moratorium is over, we'll collect the amounts, we'll make effective-- what was suspended during the moratorium." And we said, "That's not a moratorium."

There were lots of disagreements, even among people who were on the same team, which is good. That's good. I don't know--

I'm sorry, I said this was the last question, but did you have a relationship with the White House directly?

Now?

No, no, when you were-- maybe now, but--

No, no, no, no, none now.

But when you were in the Department?

Did I have a relationship-- most of the time no, but sometimes yes. I would talk to people in the White House.

When you were negotiating bills, and at the end of the process?

It wasn't that structured. We would have meetings at the White House-- I had a meeting at the White House on information technology. That was the other thing I should have mentioned, I did a lot of work on the effort toward electronic health record, when it started. We had meetings at the White House, because they wanted to do something I didn't think could be done, for practical reasons. I had one situation where I-- since they saw something I had written, which was inconsistent, they thought, with something they were saying to the Hill, so we changed the wording a little bit.

So, they knew what was going on, and we had occasional, but I was one step down, so-- Bobby Jindal may have had more contacts with the White House, and certainly the Secretary and Ann had more contacts, and we had to get regulations through OMB, which is the White House, there was OMB, and then there were people-- the White House, actually what OMB was doing.

Right, okay. OMB looks very important here.

It is, it is. Every-- this has been true for 50 years. In fact, there have been times when people within the Department didn't want something to be done and it was done by the Department, but then OMB would stop it. I have no specific examples, but I know that's accurate. OMB is very powerful.

I'll try to meet some people there.

I don't know who's there now. That's back to-- you should meet with Jim Capretta, if you have time, because he was at OMB. He was the PAD. Principal Assistant Deputy for healthcare.

Okay. Did not know PAD. Okay, I'll stop here.

Okay.

Thank you so much.

I look forward. I want to see what you write. Obviously it's going to be in French.

And in English, but you just have to be a little bit patient, because the study is supposed to end in 2012.

What?

Our study is supposed to end in 2012. It's a big report, but there will be probably some shorter articles published before, in academic journals-- before the big report for the French government, because the money comes from the French government.

So they want to see some results.

Yes.

I would love to see what you-- you should-- one thing-- when you use the word "reforms," Europeans tend to use the word "reform" for smaller changes than we do. When the Europeans reform their healthcare system, it's usually not a big deal, some little change which we would not call a reform, so the word has slightly different tones, and Martine-- you really should talk to Martine, because Martine and I have talked about writing a book comparing the U.S. and the French healthcare systems, because actually, especially now, the French healthcare system probably has more market in it than we would under the new bill that goes into effect.

Well, you've got ways that people-- you want another one, or do you want to-- in France, you can pay, like England, you can pay to get out of the system, to get out of National-- here, if you're under Medicare and, I think, after-- if this new system goes into effect, more people-- you can't get out of the system, because a doctor-- you can't jump the queue. A doctor who is doing Medicare patients cannot price-- has to charge what Medicare says if he's going to take any Medicare patients.

In England, I know you can-- a specialist can see you in the government hospital, he can charge you separately.

I think in France, too.

And in France, too. But I-- on the other hand, one of the-- we have something called the Stark Law, which is that doctors are not supposed to be referring to clinics unless they have an interest. In France, I had a bad foot, and I went to the orthopedic guy. He wasn't allowed to have an x-ray machine, so I had to wait five days and walk down to another place to get an x-ray, because the guild-- the radiology guild, here, at least, the guys can own all kinds of equipment. Talking about coordination of care, that's just crazy.

Anyway, the differences are fascinating, and the similarities-- so the book, Martine and I have talked about writing and haven't done yet. We may do it after the study, let me know.

Who knows, maybe. Maybe we can get some contract (inaudible).

And get an American to do the American and a-- do it.

No, no, I--

[crosstalk]

The budget for this is very sparse.

[crosstalk]

It's getting more and more expense for you.

Here?

Yes. You noticed?

You're right. The (inaudible) took over.

Used to be it was a real cheap thing.

It's maybe better for our economy, I think.

If you're an exporter, yes.

It was too high.

The problem I have is that I can't go to Italy or someplace and get things cheaper. I want to get rid of the euro so I can have competitive currencies, like they used to have.

Maybe it will come back?

Maybe.

Who knows. So, I just want to thank you, (inaudible), as they will be published. Maybe you read French?

I read some French. I can get--

I can send you an article, it's only about the French case, and it has already been published. I think there was an English version. I'll check. It's (inaudible) now. Hope it worked.

Who knows what it's got?