Programme OPERA – ENTRETIENS

Entretien – santé n°28

Pour citer cet entretien : Guigner, Sebastien, Lepont, Ulrike, Entretien santé n°28, Programme OPERA (*Operationalizing Programmatic Elite Research in America*), dirigé par W. Genieys (ANR-08-BLAN-0032) (*insérer hyperlien*).

Interview with two actors (responder 1 & responder 2)
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Interviewer 2: **--for a long time. During your career, you were at MedPAC, you were since April?**

Responder 2: I finished in April, so I'm no longer at MedPAC, but the last six years at MedPAC.

Interviewer 2: **Yeah. Right, and you were also at the GAO?**

Responder 2: Right, for 11 years before that.

Interviewer 2: **Okay, so we would like, maybe-- can you maybe describe your job, your position now, and how you arrived here, in Health Forum?**

Responder 2: Well, actually, Judy should talk about the Forum. The Forum has been here for 38 years. Part of the reason I'm here is because I think of it as most like the GAO. One of the problems in the US system is that there is so much money that the people that are making it are always working for their interests and not for, you know, broader social goods, and I don't find it comfortable kind of advocating for someone to make money, and so the Forum is a nice place to be, and I think that-- it's not an advocate. It's nonpartisan, and that's also become sort of very, sort of unique these days. You probably have sort of been absorbing that.

I mean, in the United States, our political differences have become extreme, and in part, I think it's the fact that everything is covered on television, you know, all the time.

Interviewer 2: **Right.**

Responder 2: So, everything, you've-- you either blow it off as part of a news event or you put it into campaign commercials, and I don't know if you've seen some of our campaign commercials, but they can be very vicious.

Interviewer 2: Yes, some.

Responder 2: The other thing is that our campaigns last so long.

Responder 1: Two years.

Responder 2: Yeah, right. In fact-- people are running for office sort of all the time.

Responder 1: The day they get elected they start the next--

Responder 2: Right, they have to start raising money.

Interviewer 2: Right.

Responder 2: Recently, there was an article which will have no impact on the US about the British election, in the fact that, you know, a relatively short campaign, we anticipated it happening for a long time, have an election and, what, four days later you've got a new Prime Minister and Cabinet, whereas here, not only do we run elections all the time, but then we have an election, there's a couple of months before someone takes office, and right now, the Obama Administration has trouble getting people confirmed for their jobs.

So, we're now, what, 16 months into the administration and we still don't have someone to run the Medicare program.

Interviewer 2: Yes.

Responder 2: So, it's--

Interviewer 2: Yes.

Interviewer 1: Who did contact you to work in the Forum? Did you apply, or-- (inaudible).

Responder 2: What?

Responder 1: Because he is one of the smartest, most knowledgeable people in all of healthcare, he is a researcher by training and an economist, he knows both big-picture issues as well as going deep into how payment really operates. In the United States, we say care follows the dollar, and the delivery system is very strongly a reflection of the dollar flows, not the underlying burden of illness, not a reflection of the latest knowledge, for instance, we know chronic care is a bigger burden in some ways, we still have an acute care system.

We know prevention can work in some circumstances. Although it doesn't save money, it adds to quality of life, we don't do that because of (inaudible) recession, so Bill had worked as a researcher, had worked with foundations, and then headed the whole General Accounting Office-- it was called the General Accounting Office-- it's now the General Accountability--

Responder 2: Government Accountability--

Responder 1: Government Accountability Office, and he had, what, 200 people under you? Studying all the issues for the Congress. It was an organization that serves as what we call a legislative support agency, and it really is broader than that, because while it reports to the Congress, it also does management oversight over Executive Branch agencies. A lot of people don't know about that side of it, but they look at how well the government agencies are managing their programs, and give them advice on management, and he has been a member of many commissions.

One of them-- have you heard about MedPAC?

Interviewer 2: Yes, sure.

Responder 1: Well, he was Commissioner. He just had two terms. He has just finished. He is on the National Committee of Vital and Health Statistics, which oversees all the data collection. That's his second time there.

Responder 2: She used to be a member.

Responder 1: I was on it. I was there, too.

Interviewer 1: Had you met before Mr. Scanlon came here?

Responder 1: Oh, we've known each other since he was a researcher.

Responder 2: Right. I went to the first-- my first Forum meeting, I think in about 1976.

Responder 1: And we got started in '72, so we go back a long way.

Interviewer 1: From the beginning.

Responder 1: It is nice to work with somebody that you've known for a long time, that you admire, but you also have professional respect for.

Responder 2: And it's two ways. I admire Judy and the Forum, so it's a good opportunity for me. Maybe a couple of things about GAO which I think are important for you to know--

Interviewer 2: Yes, we were--

Responder 2: It's, as Judy said, it's what we call one of the support agencies, and it's working for the Congress, and it basically is working for both parties. It's not for the party that's in the majority, it's both parties, and so it will do reports at the request of either party, and its job is to just do the facts, not to try and support anybody's argument, or anybody's policy, and both parties recognize that there's a value in that, because if you've got this organization that you know isn't twisting things or slanting things to come to a sort of a conclusion, then when it's on your side, it's valuable, okay?

So, we used to say that we would, on a given day, make somebody mad and make somebody else happy, alright? But the people who were mad knew that maybe the next day or some later day, they would be pleased with what GAO said. That's why they support it.

The one important thing about doing that, besides sort of getting the facts right, is you can't answer questions that involve values. You can't say, you know, that these people are more deserving and therefore we have to do more for them. That' s a value question. What you have to deal with-- you have to sort of limit yourself with factual questions about, "if we don't serve these people, here's what's going to happen to them." Here's if-- if we don't kind of give them insurance, they are going to paying this much sort of out of their own incomes, or this is what their health consequences are going to be.

Responder 1: Or how it will hurt productivity.

Interviewer 2: Right.

Responder 2: Right. You can't say "it's wrong to let them spend this much out of their income," so we have to stick with that. GAO is the biggest of the support agencies. Have you been in touch with the Congressional Budget Office?

Interviewer 2: Yeah. Former people who worked there, but now it's kind of difficult to--

Responder 2: Yeah, no, they have been very busy, because, I mean, their role is to estimate costs of new sort of legislation, you know, what the spending impacts are going to be. GAO's, in a lot of ways, is to sort of both look at-- and doing research that will help design legislation, as well as look at what has been passed, and is already in law, and seeing how it's working, so that you can think about how to change it for the future.

So, it's-- so, I think CBO has maybe 30 to 40 people working in health, and GAO, because it's got a more-- there's more request for studies had over 200 working on--

Interviewer 2: **200?**

Responder 1: And the other thing is that while we have a civil service, it's not as trusted, and doesn't go up to the very highest levels, like in France or in Germany or in England. So that when a new party comes into power, they bring in a lot of people at the higher levels. They are called political appointees, in all the government agencies, and we have increased the number of people at the top level who are politicals-- we call them politicals.

So, that means that when a new administration comes in and they propose new rules, well, the bureaucracy swings like that. They still have to support the politicals up at the top, so it means that the agencies do become a bit more political, so when they propose changes, Congress may or may not take that as strongly as factual and more as political opinion. That's why they want much stronger Government Accountability Office, a Congressional Budget Office, even a Congressional Research Service in the Library of Congress, and then MedPAC.

And now, they are thinking of adding-- or they have put in legislation of two new groups, MacPAC is what it's called. It's not McDonald's, but it's the Medicaid Payment Advisory Commission, which looks at the Medicaid programs serving the poor.

Interviewer 2: **Yeah, for Medicaid.**

Responder 1: And it would work, supposedly, with MedPAC, but there's IPAB, and tell me what that is--

Responder 2: Independent Payment Advisory Board, and that's

Responder 1: Board.

Responder 2: And that's in the health reform law.

Responder 1: And that one's problematical because it has 17--

Responder 2: 15.

Responder 1: 15 full-time people, but only the same level of staff as MedPAC, and a lot of people think it will be revised before it actually gets funded. It is supposed to come up with suggestions that the Congress can't override

unless they explicitly pass the law. It's supposed to be like what they call a base-closing law.

In our country, we have military bases in all the states. That's because there's a lot of money that goes along with a military base, and when you say you want to close on, members of Congress don't want them closed because that's (inaudible), so they had to form a base-closing commission that took over from the Congress to decide what bases would be closed, and it becomes a model for doing other things, like, where the Congress has to accept their decisions unless they specifically vote to override, and it's harder to do.

Interviewer 2: **That's to provide cover for members of Congress.**

Responder 1: Right, exactly. Very smart.

Responder 2: Exactly.

Responder 1: I love it-- you even have the right lingo, "provide cover." Yeah, you got it.

Interviewer 2: **IPAB is made for that?**

Responder 1: Yeah. Exactly. MedPAC has, for years, come up with suggestions about how to improve efficiency and quality and reduce costs, and the Congress sort of says, "Oh, that's nice, but that would mean less money for my people, less money for my doctors, my hospitals, my drug supply people, my nursing homes, my home health agencies."

Responder 2: Right. Well, one of the things, you know, that the providers, I think, the physicians and the hospitals and the other kinds of healthcare providers do is, they make it seem risky for the Congress to cut costs, because they always-- it's always "if we don't have this much money, we're not going to be able to provide services," and so--

Interviewer 2: **Right.**

Responder 2: So, if you're a member of Congress, you worry about-- if that ever came true, being blamed for it, so they have-- the provider groups are very good at trying to build sort of a belief that any kind of cut is going to compromise services, and they are-- they will use patients. They are effective in terms of getting patients to complain about potential cuts.

I mean, we did one report about how much we were overpaying for cancer drugs, and all the cancer patient lobbies were against making changes, because they were going to be deprived of these drugs, and the reality was, we were paying a huge amount more than was necessary, and the Congress, every now and then, the Congress does have sort of reason or-- and enough will to make a change, so in 2003,

they made the change, there was significant cuts in the price of many, many drugs, and there hasn't been any access problem at all, so that's the kind of thing that this IPAB, if it works, it could make a cut, and then everybody will discover that, tomorrow, we still get services.

Responder 1: We have more than enough money. We just spend it poorly, and richly.

Responder 2: Yeah.

Interviewer 2: Yeah, sure.

Responder 1: We spend it making people rich.

Interviewer 1: During the last 20 years, have you seen an evolution in the power of providers' groups? Are they more powerful groups or less powerful?

Responder 1: Oh, incredible. When this program started, we had about 5 or 10 maybe very strong associations, the American Hospital Association, the American Medical Association, the Blue Cross/Blue Shield Association. Over the years, within the physician groups alone, we now have the College of Surgeons, the College of Physicians, the College of Ophthalmology, the radiologists, the cardiologists, the pediatricians, the family practice. All of them have huge staffs and spend a lot of money.

Within the hospitals, we have the for-profit hospitals and the non-profit. We have the metro hospitals, we have the disproportionate share safety-net hospitals. We have the Children's Hospitals, we have the specialty hospitals, long-term care hospitals. Within the insurance world, it's now blues and non-profit insurers associations of community health plans. We have an association of Medicaid-based health plans.

We have the American-- the Association of Health Insurance plans. There, they have gotten bigger, and there's a lot of overlap. But, on the one hand, you see within our delivery structure, market-- what we call market consolidation, and you go into a certain area, and there are only three or four insurers, maybe three or four big hospital systems, certain large physician groups, and they are at stalemate, and it's very-- they don't negotiate, they just sort of say "I'm going to-- this is what I will charge, this is what you will pay," and they pass it across to the (inaudible).

So, on the one hand, you have consolidation, and on the other hand, you have proliferation of all these groups, which clogs the airwaves, which allows people to spend money in a variety of ways. We have what we call "Disease of the Month Club," so we have the cancer

groups, and the Multiple Myeloma Society, the Alzheimer's groups, we have many cancer groups, etc. We have cancer research groups that compete with each other. We have the Heart Association, we have the Diabetes Association, and they are good groups, in some ways.

They are funded, by the most part, not by the patients, but by the drug companies.

Interviewer 2: **Really?**

Responder 1: They are an opportunity for the drug companies to look at working with the doctors in that organization to help them make money, to protect the patient, and to deliver the best to the patient, but there are real conflicts of interest in that, and it's become big business to lobby on healthcare, big business. A lot of money gets spent.

So, when we have fights about medical malpractice and you have the tort lawyers on one side and the physician groups on the other. One time, I asked a group of very senior people, should we be doing more meetings on malpractice, and they said, "Oh, don't bother, we're not going to take that up, because we make too much money. Every year, the doctors give a lot of money and the lawyers give a lot of money. If we solve the problem, we wouldn't get as much campaign money." It's one of the biggest reasons that doctors and lawyers give money in healthcare.

Responder 2: There's two parts to lobbying. One part is making your argument, and the other is making campaign contributions, and since campaigns are so expensive, it's-- we had a friend who ran for Congress, you know, think of it as a little race, okay? Just one seat in the House, spent about $2 million.

Interviewer 2: **Really?**

Responder 1: And she spent over half her time calling people to raise money, begging for money.

Responder 2: Yeah, so you've got races in big states, campaigns in big states that cost millions and millions of dollars, so it really matters.

Responder 1: And the money, in a way, cancels things out.

Interviewer 2: **That's true.**

Responder 1: I mean, it ups the ante, we say, but you can't show the $2 million campaign versus the $10 million campaign is all that much different, except that we have made it the norm. It is almost a barrier to entry, like franchises. Unless you could get enough money to run, you're leaving it-- it makes it easier for the income (inaudible) to run.

Or, the other way is, we get groups of individuals and companies that support somebody at a local level. They run them for County Commission, Mayor, County Mission, State Legislator, then they come and run for office in Washington, and it won't be the same group of individuals who run the small syndicate to support the (inaudible), and that's not talked about very much at all, but you can trace that.

Interviewer 2: **That's really interesting, the fact that even if everybody is conscious that there's a problem, there's nowhere to fix it, because the system like that, working by campaign contributions, and--**

Responder 1: And the latest is, we have so many millionaires, billionaires running for office, so Meg Whitman, the woman who founded for eBay, the woman who did World Wrestling--

Responder 2: World Wrestling Federation, you know about that?

Responder 1: World Wrestling Federation, she's running.

Interviewer 2: **Interesting.**

Responder 2: It's--

Responder 1: In Connecticut.

Responder 2: Right, she's running in Connecticut for the Senate, right.

Responder 1: So, when you have $20 million of your own money to put in, or $40 million, I mean--

Responder 2: Or the Mayor of New York. I mean, there were stories in the press, after he won--

Responder 1: Bloomberg--

Responder 2: In the recent election, of how much he spent per vote, because he spent--

Responder 1: $78 million, right?

Responder 2: $78 million, yeah, some huge number, out of his own pocket, because he's so wealthy.

Responder 1: Some huge number.

Responder 2: So, it's-- one of the things that-- since you're interested in reform, I mean, one of the lobby's sort of principal positions is, "don't change the status quo," because, essentially, we're making so much money on

it, so that's kind of one thread that you'll see a lot of when you see what their positions are.

Another one is that they do also pursue their own narrow special interest. They will want something to change that benefits their little group, and that's-- and if you're a paid lobbyist, and you're going back to the members of your association, you know, the doctors or the hospitals or whatever, you want to say you won.

You want to say, "here are my victories," and the two victories are "we didn't change anything," or, "I got you this." Okay, this new thing, and if you look at our legislation over the years, well you can't-- it's hard to see the no change, obviously, because that doesn't get into law, but the little things that are-- embedded in our bills, are little provisions that benefit very, very few people, and those are the result of lobbying.

And you'll end up with people in the Congress that, in some ways, become the advocate for a-- you know, a single member becomes the advocate for a particular interest. I mean, it could be-- I mean, one of the groups that ended up getting multiple reports done by MedPAC and by GAO, were people called First Assistants at Surgery, and these are nurses who assist at surgery, but they're not paid by the hospital, they're paid independently-- they want to be paid independently, okay? They want to be able to bill the insurance company, or, actually, bill Medicare independently.

Interviewer 2: **Okay. Not to be attached to a hospital?**

Responder 2: Not to be attached to a hospital, right. So, they had someone in Congress that was very interested, got support from them, and they wanted-- they had asked GAO for a study, they asked MedPAC for a study, so they haven't gotten this independence yet, but they won't stop working on it, I mean, that's kind of what-- that's the kind of thing that you'll see happen.

You'll have other things that are strange-- there's-- in one of the bills over the last ten years, there was a provision that said, "Here's how much we're going to pay for a certain kind of x-ray film," and it was because the manufacturer lobbied for a special price for their film. So, it gets down to very narrow sort of details, but that's what lobbying is about, you can get a victory of one sort or another, so, but--

Interviewer 2: **And you were working at the GAO during major reforms, in-- during the Clinton attempt, and then Balanced Budget, the Medicare Modernization Act. What would you-- how would you evaluate the impact of the GAO during this reform? Maybe impact of reports, of analysis from this bipartisan and very objective perspective?**

Responder 2: Well, I think with Clinton Health Reform, GAO didn't actually have much of a role. It was actually the Congressional Budget Office that was, in terms of support agencies, that had the bigger impact, and that was primarily over the whole question of costs, and one of the things about Clinton Health Reform was that there was a hope for cost control, but, I mean, again, there's a question of kind of whether the mechanism or the policies they have were actually going to gain sort of control over cost, and CBO said no, and I think that was probably a significant thing in terms of ending it.

The Balanced Budget Act, in some ways, there's kind of a history of GAO reports, multiple GAO reports, as well as reports coming from before MedPAC, there were two other commissions, there was the Physician Payment Review Commission, and the Prospective Payment Assessment Commission, which dealt with hospitals.

They all said, "We can save money by revising our payment systems," and so you had those reports that had been done in the past, and some of those kinds of things got incorporated into the Balanced Budget Act. I mean, there was-- we're paying too much for home healthcare, we're paying too much for skilled nursing facility care, we're paying sort of managed care plans too much, and the Balanced Budget Act sort of had provisions to deal sort of with all of those kinds of things.

Then, sort of, the-- to go to the Medicare Modernization Act, the Balanced Budget Act, in some ways, set up the Medicare Modernization Act, because the Balanced Budget Act included a provision that said we should have a provision to look at the future of Medicare, okay? And it was, in some ways, the intent was to look at how do we pay for Medicare, but one of the big things that came out of that commission was, we have no drug coverage in Medicare, and so for, I guess between 1998 and 2003, there was a big focus on we don't have any drug coverage in Medicare.

There was-- we did a number of reports about drug coverage, and, you know, the problems of Medicare. I mean, there are other problems with Medicare besides the lack of drug coverage, but that was the piece that got fixed in the Medicare Modernization Act, and so there's-- you know, again, in feeding the Congress or giving the Congress information to think about a drugs benefit, the-- there is GAO work on that.

We also did-- I mean, the Balanced Budget Act involved a lot of cutbacks, or cuts in programs, or payments, but it also created the Children's Health Insurance Program, and one of the reports that we did in-- while they were debating the Balanced Budget Act was to tell them about how many uninsured poor children there were. So, I mean, I don't know want to claim credit, but it was the kind of information that they had-- Senator Dodd, who was one of the principal movers

behind the Children's Health Insurance Program, and we did that work for him.

Interviewer 2: **Okay.**

Responder 2: So, when they are considering legislation like this, there was either some old GAO reports that probably were relevant, or they would ask for information that would support-- I mean, that would deal with what they were interested in.

There's other GAO work which never is in a report which also we were doing, like, in the Balanced Budget Act, one of the things that they were interested in doing was trying to revise the Medicaid formula, how the money is shared between state and federal governments, and we did all kinds of work on that for them. It was never in a report, it was all just for the Congress, and the same thing happens on kind of smaller legislation when we've had recessions, and the states have a loss of revenue, and if Congress wants to increase the revenue going to the states, they would ask for estimates of how much money would go to each state, because, again, sort of-- if you're coming from a state and you're a member of the Senate or a member of the House, you want to say how much money you brought home.

So, that would also go on behind the scenes, to give them information and such.

Responder 1: Generally, what you see is, when you want to add something, you use this information. It's harder to take something away, and GAO shows both sides. It can't force them to accept things, so we're still struggling with how we're going to pay for all this entitlement.

I mean, what's happening in Greece and other European countries is happening here, we just don't want to admit it. It's happening in many of our states, which are broke. Not all, but money, and we're going to have to figure out what do we want to pay for and how much do we want to pay for healthcare as opposed to education.

Interviewer 2: **Right.**

Responder 2: One of the things that has been written about the health reform this year is that we're paying for it with Medicare, sort of-- we're cutting Medicare to pay for health reform. Well, the reality is that the changes in Medicare, almost all the things that MedPAC or GAO has said you should do for years. They've said you're paying too much, you know, you can get the same service for less, so why not pay less for that service, okay?

So, these are the kinds of things that have been around, sort of have been recommendations that have been around for years. It took an

interest in having money to cover more people with insurance to get those kinds of things adopted, you know, and so it's kind of a mistake to say we're using Medicare to pay for insurance reform, when we actually should have been saying, well, we made the changes in Medicare that should have been done, and now we feel wealthier and we can actually cover the uninsured.

So, that-- we've had-- and this is in the provider's interest, probably, behind some of this, we've had, instead, we've had Medicare beneficiary organizations, some of them are sort of hard to see who really belongs to them, saying, you know, you're robbing the Medicare program. I mean, they even take film from World War 2 and say "We served you, what are you doing to us, you're depriving us of our Medicare program," and, I mean, that's the kind of passion that they try to generate.

Responder 1: And the other part is that people with money, many of whom give campaign contributions, also recognize that the health of our economy is, in large part, due to the amount of money in healthcare, so if you look at some of these stock portfolios, many, many companies are doing well with their healthcare products or subsidiaries. If you cut back, people are worried, "Oh, my stocks will go down in value."

So, older people don't want to see changes to a Medicare program they have come to love. They believe their doctors, "Oh, this will hurt quality, this will hurt access." They don't want to see their stock portfolios go down, because they live on the strength of that income. So, it's a double-edged sword.

Children have less capacity or-- and we spend a whole lot less on kids. We do well by kids because, you know, they're cute, and, right? But we really don't do as well by them. We are not investing in our children, overall, the way we say we should to build a productive economy and sustain it. We are spending a lot on our older generation, and not as efficiently as we could. I really don't mind some imbalance. After all, people have worked hard, but it would be nice if we spent it more efficiently.

Interviewer 1: Is this the position of the National Health Policy Forum, that you've seen now?

Responder 1: We can't take a position other than to sort of laugh at things, and we make people step back and try to think about what they're hearing. We do meetings, we write papers that explain how the law works, we also take them on site visits to see how the law plays out and how federal law dovetails with state law and local law, and how the programs operate, and how it affects the patient, their family, the community, and all the players in it.

I mean, for every nasty thing you want to say about rich doctors, there are some very good, very poor doctors. It's not like it's all black and white. We have doctors who make $1 million a year over-treating some people, and we have other doctors who are taking care of very poor people who don't follow instructions and may not even be able to read properly, and they don't get much money in that area where they practice. It's the unevenness that we try to talk about, and the efficiency.

We really do try to say, "okay, here's how the incentive structures work." Do those incentive structures get what we say we want? How would you change them? What would be the intended consequences, what might be the unintended consequences? So, we're a sort of place where people can come together, ruminate, talk to each other, check their perceptions and their vision, you know, recalibrate how you're looking at things, how you're hearing things.

Interviewer 1: **And as far as the GAO, do you think that the Forum has had an impact on health reforms?**

Responder 1: Well, people tell us that we are the place they go to think. Most of the time, they are running so fast they don't think, they just respond, and the Forum is a safe haven. We work very closely with the four legislative support agencies, so, years ago, people in the Congress asked us to run, every time there's a new administration, we run a major workshop to explain to the new people what is Medicare, what is Medicaid, what is CHIP, how do these programs operate, what is prospective payment versus (inaudible), excuse me, administrative pricing versus prospective payment in full (inaudible), and we run it, but we use the people from GAO, CBO, CRS, MedPAC, as the faculty.

So, they look at us as a translation mechanism and something interstitial. Sort of a public utility, in a way, but we're very, very small. We're 16 full-time equivalents, counting support staff. We're tiny, but we're additive, we hope, and if we do our job well, we make other people look good. That's our goal.

Interviewer 2: **So, okay, all of the ideas that are discussed are discussed by experts from these four support agencies?**

Responder 1: And others. We bring in people from all around the country to talk at our meetings. Health services researchers-- mostly, though, we don't use academics any more. We really, more often, get to people in the field, the more thoughtful people, and we try to do a balanced presentation so that both sides can represent it. We don't do the far extremes, because that only pits one against the other, and it polarizes. What we want is to show-- okay, what are the biggest issues that we have to grapple with? What are the areas where we can see each others' side and make some headway.

Interviewer 2: **Okay, so, you are a place where options that will not be partisan--**

Responder 1: We try hard not to. I mean, sometimes people come and they speak in a partisan manner, but we try to tell them ahead of time, "Don't do that. You'll make an enemy."

Responder 2: And there also may be somebody else, I mean, it's a workshop, there's three speakers, there will be somebody else that says the opposing side.

Interviewer 2: **Okay, so that's not building a common option that could be--**

Responder 1: We do not, however, try to reach consensus. We leave that to the parties to work on behind the scenes, although, during health reform, we did do several series of meetings on the medical home, care coordination, comparative effectiveness, and on individual insurance market reforms, and we had very small groups of people, sometimes 75 in a room, sometimes 25 in a room, and they told us later that we were the last place where the House and the Senate, the Republicans and the Democrats and the different committees would all sit in the same room together, because then it broke down.

Interviewer 2: **This is really interesting, what--**

Responder 1: And then they went back into their, you know, two fighting bulls, you know, coming together. So, and now we're trying to go back to saying, "Okay, not everybody agrees with the bill that was passed. Not everything that got discussed even got included. Some good ideas didn't get into the final version. How are we going to make the best of this?"

And we know that there will be some people in the room who want to defeat this bill over time and overturn it, and we know that some people want to make it even stronger, more single-payer, more Medicare for all. I don't think there's much chance of that in this environment.

Interviewer 2: **Sure. In terms of the public that goes to this workshop or meetings, who is coming, and--**

Responder 1: Only government people. Some limited number of interest groups. Many of our meetings-- no press ever. No press. Have you heard of the Alliance for Health Reform? Have you heard about that?

Interviewer 2: **Right.**

Responder 1: That's really for the press. It's all televised. It started out to be a program to help educate the press, and it has a lot of interns and younger people. We tend to-- we have no press, and we tend to get

more in detail, so they will do a meeting on the big picture, and they will do talking heads, as we call them, the politics of the issue. We go deep into policy, and we complement each other.

Interviewer 1: **Is it a place where actors negotiate acts?**

Responder 1: Well, some people will go out in the hallway, but generally, you come, you talk about things. There are some negotiations going on, but--

Responder 2: Yeah, think of it-- it's not formal negotiations, but it certainly sets up sort of-- (inaudible) discussions, and unlike the-- what you see on the television with-- when the members are leading in the Congress, I mean, this is-- you can have both Republicans and Democrats having a much calmer discussion, sort of, in one of these meetings, and then they can-- they know what they disagree about, but then they also discover what they agree on.

Interviewer 2: **For instance, just an example, would you have people from Grassley's staff working with Baucus staff and getting to know each other better?**

Responder 1: Oh, they already know each other very well.

Interviewer 2: **Maybe true.**

Responder 1: But they will use the meeting as an opportunity to see how the issue is unfolding, how people are feeling about it, to test the waters. We have one of the Grassley people at a meeting ten days ago, and he had told us privately some things and how he was teasing, saying, you know, "two years from now, we're going to have her job," because of the changes-- but he said it publicly in our meeting, and people go, "whoa, that's what the Republicans are thinking," and it caused quite a stir.

But, there is concern behind the scenes about what happens if the House turns more Republican, or even the Senate, and, god forbid both, then you'd have a Democratic White House Administration and a Republican Congress, and we've lived through that before. Actually, it has worked sometimes not so bad.

Interviewer 2: **Yeah, in 2003 and 2004.**

Responder 1: You're good. Yeah, but it's never happened in this environment where the Democrats are more left today than they were before, and there's-- the Republicans are much more right, and there's really no overlap in the middle. A lot of the political analysis says that there used to be conservative Democrats and more moderate Republicans, and they would overlap. Not any more.

They don't-- in some ways, they don't know how to talk to each other.

Responder 2: One of the things for future reforms is, this is a big question, is how the Senate will work, because if you look at the Medicare Modernization Act in 2003, and there had to be Democrats that voted for it because there weren't 60 Republicans in the Senate, and so there were times when there were key votes, and the Democrats supported it, and they were key to it becoming law. This time around, there was a very strange set of circumstances that led to having 60 Democrats for a while and then 59, and so it's become-- it became the norm at this moment that 60 votes is what it takes for everything.

Well, if that continues to be the case you know, we're going to have to find some way to get people to bust party lines, because it's not-- it's going to be very unlikely that 60 votes are going to be in one party at some point in the future, so, it hasn't been true very often in the past, so it's kind of a rare thing. It didn't last long, and we have to figure out how we operate without it.

Interviewer 2: Yes.

Responder 1: And the other thing is that while the Republicans, for years, have talked about containing costs, now they are disavowing some of the things that they've said for 20 years because they don't want to alienate the interest groups. So, they have suddenly gotten very weak in the knees, as we put it. It's going to be very interesting. So, on the one hand, they complain "we don't want big government," but when the time comes to make the government more efficient, they're not there.

And I can say this. I worked in a Republican office, but I worked for a Vermont Republican who, today, would be a Democrat, and he was in the middle, he was a consensus-builder. And my husband worked for a Kennedy. We can work together. I wasn't married to him, then. That's very hard to do now.

Interestingly, Mark Hayes, who works for Senator Grassley, his wife works for Chris Jennings, who had been in the Clinton White House, so they are a bipartisan couple.

Interviewer 2: Oh, okay.

Responder 1: So, there are some.

Interviewer 2: So, it's like there is this huge political battle and divide, but behind that, some options, and the people, the experts, are--

Responder 1: Not quite as ideological. We know that we will work on the substance and then it will pass to the political phase, so you have the Senate-- it started with a bipartisan bill, Baucus and Grassley, and it got pretty far.

The House didn't have-- its bill was not bipartisan ever, and then negotiations started.

There were a lot of things that the House and the Senate had worked out which never went to conference, and then when Senator Reid started the final version, it was pure horse trading, it was not built on substance. It was pure vote-getting. "I'll give you this if you give me that," and some of the things that that horse-trading produced, there are provisions in the bill that aren't even synchronous with each other. They don't conform either with each other or with the current law, and they need to be worked out, and they don't represent good policy.

But, okay, you've read about Senator Ben Nelson wanting to have a special exemption from Medicaid, his state would get paid more than everyone else for the rest of eternity. That was so egregious he had to disavow it, but there was a lot of stuff like that.

I think some of this happens in other countries as well, but it's not usually as bold and audacious.

Interviewer 2: **No.**

Responder 1: And you have a stronger sense of solidarity.

Interviewer 2: **For now.**

Interviewer 1: **We had.**

Interviewer 2: **We had, yes. Were.**

Responder 1: Yeah, it's a little-- it's interesting. I don't know what's going to happen with the current market, and--

Interviewer 2: **We were discussing that just the other day.**

Responder 1: You know, when people are threatened-- it's hard to be magnanimous. We spent, you know, how many years for the euro to take hold, what was it, ten years before the euro even came into existence, before the market (inaudible), and now--

Responder 2: It's hard to undo things.

Responder 1: So it will, you know, we'll see.

Responder 2: In difficult times, they sometimes pass. I mean, you live through them, and this is the case where the bill that has passed, and I think people understand that it's now law here, and it's going to-- you can't really just say that we're going to totally just eliminate it, and so how do you

make the best of it, depending upon your perspective, and so that's what will happen.

Responder 1: Let's be very clear. This bill passed because $1 trillion was put on the table, and if they didn't pass that bill, that $1 trillion would have been spent on defense or deficit reduction, and the doctors and the hospitals and the drug companies and everybody else behind the scenes said "We don't like this bill, but we're all going to get something out of it."

Interviewer 2: So, it was bargains?

Responder 1: Oh yeah, it was a grand bargain behind the scenes, and we heard, just before Christmas, where it looked terrible at that time, a friend of mine in the drug industry said "It's going to pass," and I said, "Are you kidding? It looks terrible." "It's going to pass." I said, "Oh, you want that trillion dollars," and all he would do was go-- and it was all he could do to break out laughing.

Interviewer 2: A pragmatic approach.

Responder 1: Okay, do they want to give that up? They will argue about it, they will fund people to run against it, but they're not going to overturn it. They may change how it operates. They will, in fact, try to do all those special provisions that let this group or that group or the other have a bigger slice of the pie, but they don't want to overturn it.

Interviewer 1: Maybe you could ask--

Responder 1: You've got a set of questions we're probably not getting through it.

Interviewer 1: So, I'm going to-- I have a quick question-- how do you rate the relative importance of key actors-- institutional actors, or maybe individual actors in the healthcare field? Who is important in this field, in your view, and who is less important? I mean, Congress or maybe the White House, or federal administrations?

Interviewer 2: The evolution?

Responder 1: Well, at different times, different players count more, okay? So, during ordinary times, the interest groups and the Executive Branch, they putter along, and they know each other, and they work together fairly well. As problems build, some of the other interest groups can come into play. I think there has been growth in the number of consumer groups saying "This system isn't working." It's a very acute-care system. We do need more attention to chronic care. We could improve what we call the medical home and patient-centeredness. Respect for the patient and information.

Those things have come about by the advocacy organizations. Certainly for the drug benefit, a lot had to do with the older, AARP, wanting a drug benefit. Well, they wanted it for their patients, but they also wanted to sell drug coverage and insurance plans.

A President can be very important when something is coming to fruition, and where there's real legislation pending, and there were some people who felt that Obama left too much to the horse trading too long and might have gotten a better bill if he had stepped in sooner. I'm not sure I know the answer to that. No matter what you do, there's always, 24 hours later, or-- second guessing.

If you look at the field, when I started, there were certain towering people, individuals, who were really talking health reform. Jim Salmons, at the AMA, Alex McMahon at the AHA, Walt McNerney at the Blue Cross, John Nowells (ph). There were named individuals who used to speak and talk about things. Most of them were doctors. That's changed.

There are a few physician leaders now, Glenn Steele, Ed Geisinger. Fewer people know who leads MAYO or the Cleveland Clinic. There are some people who look at Karen Davis at Commonwealth or Drew Altman at Kaiser, but they know-- it's not as individuals much-- individuals anymore. It's big, organized interests taken over from the individuals, I think, and it's just a huge population of interests.

What is it--

Responder 2: I think, I mean, there's also members of Congress that have been incredibly important. The (inaudible) Act of 1981, when you had the Reagan Administration and they were cutting the budget, Congressman Waxman introduced changes in long-term care that totally changed what we did-- what we do. Sort of, I mean, up to that point, the state Medicaid programs were all about nursing homes.

They have since become sort of about home care as well as nursing homes. In the late '80s, he was the one that got provisions in to extend eligibility for children and pregnant women, so it was a huge expansion of Medicaid at the time, and, I mean, he played sort of, I mean, in this reform effort, kind of when the Democrats are under control, a key sort of compartment.

When the Republicans were in charge, Bill Thomas who was first the Health Subcommittee Chairman for (inaudible), was key. I mean, he was a major force behind the Balanced Budget Act. He was on the bipartisan Commission on the Future of Medicaid, you know, the co-chair with Senator Breaux, and then, you know, in terms of writing the Medicare Modernization Act.

So, I mean, these kinds of people have made a huge difference, at times, and in this bill, I would also kind of give incredible credit to Grassley and Baucus, and particularly Baucus. I think, in October of 2008, his document call to action kind of sets a framework that is very sort of much followed in terms of what the bill includes, and Grassley and Baucus have worked together well sort of over the years on, I mean, between the Medicare Modernization Act and the Health Reform Act, it's kind of-- the bills are smaller, but they're still important, and they have done all kinds of things together in terms of dealing with the health agenda.

You know about our problem with physician payment in Medicare?

Interviewer 2: **Yes.**

Responder 2: Okay, because what that does is, it almost means that every year there has to be a Medicare bill, and so a Medicare bill that fixes the physician payment, you know, eliminates the reduction in fees, but there is also budget rules that say that you have to find some way to quote "pay for it," and so it has other provisions in it, and so those other provisions involve little parts of health reform of the type, and so we're going to have another bill at some point, because there is now in place the 21% cut to physicians, and so we will have a bill that eliminates that cut and does something else, though "something else" is to be determined, but-- next year, we'll have-- I mean, well, if they come up with a change to the last 18 months or two years or three years, then they'll feel good, okay, but--

Responder 1: They're saying five years, but I don't think they can pick it.

Responder 2: Then they will have to be back there, and they will have to do this again, because the cuts are in law. I mean, this is a quirky, this is a strange thing about our budget laws, and so they have to deal with it.

So, in each one of these little reforms, there is a couple of members of Congress that are key to sort of making this happen.

Responder 1: They say that when the Balanced Budget Act that was written, there might have been 10 members of Congress who really knew what was in the bill.

Interviewer 2: **10? Who was--**

Responder 1: Who really knew what was in it, and the rest went along because their staff said "this is okay." And for MMA, they said it was 5, right?

Interviewer 2: **5?**

Responder 1: So, who knows. The bigger the bill, the fewer the number who really can read through all of it and understand what it's going to be, and you trust the Chairman of the Committee that proposes it to have the staff to work it through. You may argue about bits and pieces so that you get a certain provision added or changed, but really, a lot of the hard work comes down to the key staff who work on this.

So, you look at Baucus' key person, who is Liz Fowler, is a PhD and a lawyer. You look at Mark Hayes, he is a pharmacist and a lawyer. In the House, you look at Waxman's people, many of whom he called back from 30, 35 years ago, some who have been with him the whole time. He never lets anybody go.

Interviewer 2: They are really loyal to him.

Responder 1: Yes, and he has people. One of his people is the number two at HHS, and another person is the number two at the Food and Drug Administration. He has people.

Responder 2: Part of it is the fact that the head of Congressional liaisons with the White House is a former Waxman staffer--

Responder 1: Congressional representative, oh, this is--

Interviewer 2: Phil Schiliro?

Responder 2: Phil Schiliro, yes.

Responder 1: Phil Schiliro, and Childress is back.

Interviewer 2: No, he was on the Health Committee?

Responder 1: He went up to the Health Committee, and so these people, they circulate.

Interviewer 2: And it was Waxman people?

Responder 1: Well, Childress was only Kennedy-- no, he had worked--

Responder 2: I don't know.

Responder 1: I don't know who else he worked for, I'll have to look him up, because some people have worked both the House and the Senate.

Interviewer 2: Okay, and this is--

Responder 2: We're citing the examples of people who have been around for a long time, but we have another problem which is that a lot of people aren't around for a long time, and so the-- I mean, say, 20 years ago, or--

people would have been in the Congress working as staff for 15 or 20 years, now, five or ten, maybe, stretching it, and part of it is that the job has become so intense.

It used to be that the Congress would finish its work, say, early October and go away and come back, you know, at the end of January, and you had, like, three or four months to recover and to plan for the next year. Lately, they seem to meet 12 months a year, and while-- the bill was passed on Christmas Eve, right? So, it's kind of-- and they had off Christmas Day, and the next-- what was it, the next-- Christmas was on a Saturday, so they had off until kind of Monday to kind of go back and then go back to work.

So, it's-- you have no life if you're working for--

Responder 1: And even when Congress is out of session, they are still holding hearings. They will hold hearings-- field hearings out in the states.

Responder 2: There's no time off.

Responder 1: So, Waxman's staff, there's a woman there, Karen's on Medicare, so she's in her 60s, late 60s, and she and Ammie Schneider, both in their 60s, they were running the old people ragged. They would be there at 6:00 in the morning until 11:00 at night. And the young people are saying, "If they're going to be here, I've got to be here."

Interviewer 2: Wow.

Responder 1: So, people do make a big difference, there's no doubt about it, but there's not the big-name people always. Yes, key members of Congress play a very important role. Specter's loss will be important, because he has been sometimes a swing vote. He has been very supportive, chair of some other things. But, we'll see.

Interviewer 2: Sure.

Responder 1: It's just going to be a very interesting time.

Responder 2: And then the other thing is that then there are-- besides sort of what happens in terms of the elections, I mean, there are big decisions that are made. I mean, the whole discussion about Obama deciding that they were going to make health a major priority, because they could have decided not to. They could have decided, "Well, we've got this huge recession, we're just going to deal with the recession." We passed close to $1 trillion bailout, or anti-recession bill, and we need to make that work. We need to get the administration going, and instead, they said, "Okay, we're going to take on health, too," and they said the same thing with the Clinton Administration, deciding, "Okay, we're going to do this," and those are big decisions.

It's kind of hard to know what made them decide this, but once they do, everything's going.

Interviewer 2: **Right.**

Responder 1: Not everyone's comfortable with that, because some people, Democrats feel that he made this decision for him and the country, and he had four years-- three years after it has passed, whereas in the House, the Democrats feel, it's going to cause some of them to lose.

So, they feel that the President made a decision that will hurt some of them. They will lose office, and, on the other hand, morally, it was the right decision. Also, as a way of containing costs, it's probably the right decision, as long as you don't have more universal coverage. You can't really control costs, because you can always charge the other guy to make up the difference.

So, you know, these are not easy answers. Congress, you know, in the House it's every two years. In the Senate it's only every six, for the President, every four.

Responder 2: But if you're an unfortunate Senator, this is your year, I mean, I think one of the examples would be Senator Lincoln from Arkansas. They're going to have a run-off in her primary, and if there hadn't been health reform, who knows if she would have just had an easy election.

Interviewer 2: **Right.**

Responder 1: And Mitch McConnell made it through two years ago by the skin of his teeth. I don't think in this move he would have made it through.

Responder 2: Against the incumbent, yeah, it seems relatively bipartisan, right? If Paul had been running against him.

Interviewer 2: **Okay.**

Interviewer 1: **And what about in the FHA? You didn't speak out about the Health Administration.**

Responder 1: Do you mean like Berwick?

Interviewer 1: **Like--**

Responder 1: Don Berwick becoming head of CMS?

Interviewer 1: **Yes.**

Responder 1: It's hard to know. They're not going to-- I don't think they will let a vote happen before the election. They will just delay it and delay it and delay it.

Responder 2: One of the things that-- and, there are GAO reports about this, that we've talked about, is that the amount of people and other resources to run the programs is not sufficient, and you-- I mean, it goes to two things. One is to kind of just doing what you're trying to do with current policy, and we're actually-- the Forum is doing a site visit to Miami in two weeks, and a big part of Miami, which is the highest-priced area of the country, is fraud, people not providing services, but billing the program and getting paid.

And a part of why that exists is that we just don't have the resources, the people to go and find out what's fraudulent and what's not. I mean, there is so little money that's used to pay for claims, that all the claims are paid-- virtually all, 99% of them are paid electronically. They come in as a computer record, the check is written and sent back, and nobody ever looks at sort of the medical record and says, "Okay, this person really needed the service, and we can see that they got the service," so there's that kind of a problem.

The second deficit that that creates is one in terms of being able to design innovations that might make your payment policies better, might make it so that you have a better ability to look at the services you're paying for. They work so hard to kind of keep the thing going on a daily basis, they can't think ahead. They can't think for the future, and so this has been true, now, for close to 30 years. I mean, it started, I think, with the Reagan Administration, that basically said we needed a smaller government.

So, they shrunk some of the resources. The amount of money going into research and development and evaluations demonstrations became much smaller, and it has never been increased that much. I mean, even under the Clinton Administration it didn't grow back to its old levels.

So, that's a real handicap, and so when we talk about these things, there is policy being made, it is partly the White House, it is partly Health and Human Services, it is partly Congress, but then to make policy work well, you've got to have good administration. You've got to have people that can actually sort of make this sort of operational.

And the-- this bill, if you look at it, it's more of an outline than a set of instructions. I mean, you'll-- someone should take, in a pdf file, how many times it says "the Secretary shall," which is kind of a short way of saying "we don't know what we're doing here, so we're going to let HHS figure it out," but there's nobody-- I shouldn't say nobody, but there's just not enough people at HHS to figure out the answers to all these questions, okay?

And some of them, it's not a question of having people come into a room and sit down and saying "let's have a discussion of this and let's come up with an answer," you need to do real research. You can say, "Well, if we do this this way, what are the consequences going to be," and the answer would be "We don't know, because we've never ever done anything even close to that before."

So, you need research. You need demonstrations and times to test out new ideas, and that has not been going on, and the bill actually, in some ways, it reflects frustration. People are sort of mad that it hasn't been going on, and so they want it to happen immediately, but it can't, and as you do your research, you can't-- you know, nobody can-- you feel it would be very unfair if somebody said "give me the answer now."

Interviewer 2: **Sure.**

Responder 2: But it's like-- that's what the bill kind of says. It says "we're tired of waiting, we have to have it now, and that's not going to happen." So-- Judy mentioned earlier, we talked a little bit about this independent payment advisory board. It could be a good idea, but it has to have the staff to do the research to give it good ideas and to be able to defend the ideas that they're going to propose.

Instead, it's going to have a staff of about 25 people to deal with this huge program, and that's no bigger than the MedPAC staff. It's 15 members of the board and 10 members of staff. It's almost-- not quite one-to-one, but it's close.

Responder 1: The Federal Reserve, which it's sometimes modeled after has seven full-time governors, and--

Responder 2: A research staff of about 400.

Interviewer 2: **Fair enough.**

Responder 1: And it has exemptions from the pay scale so that they can get-- they can pay people better. They have much better computer systems than any other agency government. HHS got $1 billion to implement this whole bill. That's the same amount that they got just to implement the drug benefit.

Interviewer 2: **That's nothing.**

Responder 1: It's nothing. It's nothing.

Responder 2: The $1 billion for the drug benefit was probably the underpayment. I mean, you talk to the people that worked there then, they donated a lot of time. They worked many hours that they never got paid for, so

that's the way-- it's happening now. It's unfortunately the way, in some ways, we do government, and there's one image of government which is that government workers don't work hard, and the reality is that there's that set of government, and then the other government that works on policy that works incredibly hard.

So, they come in at 6:00 in the morning and they go home at 11:00 at night.

Responder 1: And they're there on the weekends.

Responder 2: And they're there on the weekends, and that's what we have, and we suffer because we don't invest in enough resources, because we don't get the good, new ideas to change things.

Interviewer 1: Would you say now that the HHS is important for the implementation of the bills, but not (inaudible) during the negotiation process?

Responder 1: They are there, but they don't play as big a role as they used to. When I started in the '70s, it was the administration that would come up with the new bills, they would give the proposals to somebody in the Congress to introduce. It is rare, now, for the administration to come up with new proposals. They will modify proposals that are under discussion, but a lot of bills actually get written by Congressional staff and interest groups, and then the administration comments and makes changes.

One of the problems during health reform was they were there, but there were no leaders in place, and they were not as forceful. A lot of the young people who were having to review the provisions didn't-- have never managed these programs. There had been a lot of turnover, so John Blum, who used to work for Baucus in Senate finance and then was a consultant, and had worked a lot on Medicaid, was trying, personally, to review a lot of provisions, but he had never run Medicare, he had never gotten a regulation through the process.

A regulation can take two, three, four years, ten years to get out. He's never been through that yet.

Interviewer 2: And he is--

Responder 1: He is one of the five Deputy Administrators, and he's wonderful, he's just wonderful, it's no reflection on him. It's just that it takes a long time to learn these processes. There is a woman now who has come in-- - there is now five associate-- Deputy Associate Administrators, or whatever, and now there's a woman who is the number two in CMS, she came from Virginia, her name is Marilyn Tavenner, and we hear

she's an excellent manager, but they need a leader, because a leader can speak out, and argue for staff, and can do this.

Interviewer 2: **(inaudible)**

Responder 1: But-- even that's hard for a leader to do, because, really, the Office of Management and Budget tells you whether you can ask for more staff and (inaudible), but she's doing the best she can, and they're doing the best they can, but if-- it reflects some glitches in our system which people use to their advantage.

Interviewer 2: **Right. Was it on purpose that there is no administrator of the CMS during the whole process?**

Responder 1: They decided not to do it because it would become one more point of contention. It was a political decision. They thought they were choosing someone who could get through the process. They wanted Glen Steele, originally, from Geisinger, but he turned them down, three times, and-- because he didn't want to be in this political fishbowl, and-- among other things, and he didn't want to report to a Committee, Kathleen Sebelius, at the White House.

So, then they chose Berwick, and they were on-again, off-again with him, and now they finally put his name forward, but you can see how they're using him as a foil for the bill and running against him, and they are accusing him of being a rationer and this and that.

And, you know, he is a really thoughtful, articulate position. He has done a lot to improve quality, but the truth is, he has never managed a government agency, and a lot of people internally like him, but they don't think he knows what the day-to-day job is, of developing regulations and fighting the interest groups, and so they are saying, "Well, he will be the titular head, but a lot of the hard negotiation will be done by Nancy-Ann and her staff, who have been here previously, and they stayed on at the White House."

And then the structure of governing will change, so you have things like CMS reporting to Sebelius, the whole department, but jointly, always having to clear things through the White House, Nancy-Ann and her staff, and the Office of Management and Budget, Peter Orszag and his staff.

So, one of the reasons we had to meet with you early is, we're going over to the White House to meet with Nancy-Ann's number two and Peter Orszag's number two. They're friends of ours, and even we can't figure it out, because the structure changes with every administration, and part of the structure is what's on the organization chart. You hear the term "org chart," so you see the boxes and who reports to whom.

But personalities count. Long-term relationships count, and somebody may have the job, but if you know this person over here, you're also going to connect.

Interviewer 2: **Right.**

Responder 1: That relationship.

Responder 2: Yeah, and in thinking about reforms, a lot of these things, they develop over time, and there's multiple people involved in different times. You know, if you go to the Medicare Modernization Act and the drug benefits. I mean, in some ways, it has some link to the bipartisan commission, not just to say we need a drug benefit, but in terms of Bill Thomas, and an interest in saying I want private plans to essentially administer the Medicare program, I want them to bid in a competitive situation, so I save money through competition, just the way the market would work. So, I mean, he had those ideas there in the bill.

The structure of the benefit, which included sort of paying people for their first dollar's worth of drugs, having a donut hole, you know, the gap, and then catastrophic, actually has roots in the Clinton Administration, who initially proposed a catastrophic drug benefit, and then got some pushback on that, because it said, you know, only a few people are going to get this benefit, and so they said, "Okay, we'll have some first-dollar coverage, but we'll have the gap before they get to catastrophic."

So, I mean, ideas kind of-- they surface and they're just around. This reform bill, you can find elements of it in bills that Republicans and Democrats introduced over the last six or seven years, and then when we still had a Republican president in the Bush Administration, we have-- Baucus puts out his document in October of 2008 which, I mean, combines a lot of different elements, and, as I said, sort of becomes, in some ways, an outline for a lot of what we have here now, but you also have the campaigns outlining this kind of thing.

So, it's like-- everybody is involved. There's a question, which may or may not be important, which is who was in the room at any particular point in time, because even if some people are not in the room, they may have influenced things by floating something, and then that becomes the basis for what people are thinking at a given moment.

So, it's-- I think that the people in HHS are definitely part of this, but the role-- the kind of formal roles, they change sort of depending upon administrations, they change sort of upon a given sort of moment in the negotiation process, etc. And you remember, Obama tried to say "I want the White House and HHS to work almost as one because I want Tom Daschle to be the Secretary of HHS and to be the Head of my White House Office Health," but then when Daschle had to drop out, it

became, "Okay, well, I'm going to have a White House Office on Health, and who's going to be running it? Nancy-Ann, and then I'm going to have to find a Secretary for HHS, and we ended up with Kathleen Sebelius." So, we have two different people in the jobs.

I think, in terms of doing some of this with HHS and Kathleen, the fact that she didn't come until July or August made a big difference, because Nancy-Ann had already been over there in the White House for six months.

Responder 1: And Daschle was still around. Although he didn't have the title, he was sitting there.

Interviewer 2: Oh, really?

Responder 1: Yeah.

Interviewer 2: He was in every meeting of the healthcare?

Responder 1: Supposedly.

Interviewer 2: That's interesting.

Responder 1: He's still around.

Interviewer 2: He is in the private--

Responder 1: Yeah, a law firm.

Interviewer 2: Okay.

Responder 1: But he's still around.

Responder 2: But in Washington, there's always conversations that go on between private citizens and public people. I mean, that's probably true in every country, right? So--

Interviewer 2: Maybe less.

Responder 2: Maybe less, okay.

Interviewer 2: And what about the role of Hillary Clinton? Was she around, or--

Responder 1: She changed a lot from the time of HillaryCare. When she became a Senator, she started out-- people felt that she was arrogant, very smart, arrogant, and her staff was arrogant, and there was an element of HillaryCare that they brought with them, and over time, she modulated, and her staff got better, I think, and even during the campaign, she actually said some things that I think were quite strong.

She said we do not want to have more universal coverage if it's only an entitlement to a dysfunctional system. We have to change how the system functions as well, and she was much more thoughtful and careful about that, but she didn't make healthcare the only issue she ran on, and then she's out of the discussion, really, because of being in state.

She's still involved in global health issues, but only to a small degree.

Interviewer 2: **Right.**

Responder 1: But, some of the people who have worked with her have moved on to really important positions, and I don't know-- she might have been-- you know, if she had become President, she might have been so bruised by the '93 experience that she wouldn't put healthcare first.

Responder 2: Well, with the recession, I mean, it would have been-- nobody would have faulted her for saying we have to deal with the recession. That needs to be our primary focus, I mean, it was ambitious to take on both the recession and healthcare reform, and while-- you know, they also tried to do something about climate change, and now we're trying to do something about financial regulation, so they have been ambitious, there's no question.

Responder 1: But they always thought healthcare would also be a jobs bill. They thought that doing health insurance expansions would create more jobs and help those with jobs keep their jobs.

Interviewer 2: **Right, but that was--**

Responder 1: So, there's the surface, and then there's the other parts that you have to evaluate, too.

Interviewer 2: **Sure. Since you have a meeting, we--**

Responder 2: Yeah, we have to go.

Interviewer 2: **Maybe two quick questions, if you don't mind?**

Responder 2: Sure.

Interviewer 2: **About your personal background. Maybe, also, describe your experience.**

Responder 1: I am really a (inaudible). My undergraduate degree is sociology, I worked four years for IBM on computer-assisted instruction and medical information systems, at a very early stage. I then went to the

Senate as a legislative aid. I was going to law school at night, and so I became a legislative aid in the Senate.

Interviewer 2: **Which Senator?**

Responder 1: Senator Winston Prouty, from Vermont. Nobody ever knew his name, because he was in the shadow of somebody very famous, named George Aiken, and then I went to work for Elliot Richardson, at HHS. But when I was in the Senate, I was one of the few legislative aids--well, I was one of the few female legislative aids. I was one of the few aids who actually had worked in the industry, and then I went to HHS, so for a while, I was one of the few people who had both legislative branch and executive branch experience, and then when we started this program, I was asked just to help out with, and then two more competent people weren't very popular, and I got the job by default, and I've been doing it ever since.

Because I had run users groups for IBM, I would have 40 deans of schools of education, 40 medical center directors in a room, teaching them what is a computer, and how can it be applied, and how can you change the way you do business because you now have a computer to do all the processing.

I was really very imbued with what we now called knowledge management, about how do you do in-service learning? IBM is one of the most famous countries in the company for in-service education at different levels, from their marketing classes to their systems engineering classes to the high level senior management, getting time off to take the whole summer off to learn, so I applied those principles at the Forum, and they served us well.

But, I never was an expert on healthcare. I had to learn it all on the job. I don't even like it when people look at the record of our meetings those first two years, because I didn't know what the heck I was doing.

But you learn as you go, on-the-job training, still learning, and the secret is, you hire people as your associates, and get people who are smarter than you are, who know more than you do, and you create a team, and we represent both a team here, but we also look at our participants as part of the team.

They-- a lot of them know more than we know about individual issues, and we try to get them to help us, too, or get experts in the field to be helping us. We can call almost anybody and say, "We're studying this issue, can you help us," and they say, "Oh, sure," because it's for the common good.

But Bill is much more important.

Responder 2: I don't know about that. I was trained as an economist, and worked as a researcher from healthcare-- did some early work in other fields, but worked in healthcare from '75 to 1993, first at the Urban Institute, and then Georgetown, in the medical school, and did mostly work on payment policies, and a lot of it on nursing homes and long-term care, and as a researcher, you do sort of a very narrow topic, and it's what you do.

So, then I went to GAO, which was a very interesting experience. We referred to it as like being in graduate school for 11 years, because there's these 200 plus people that are doing reports on everything in healthcare, and my job was to be involved in every one of those reports, and to read them and to kind of make minor contributions to them, but it was really like a learning experience, and so with GAO, it was Medicare, Medicaid, the Children's Health Insurance Program, private insurance, the Veteran's Program, the Defense Department program, the delivery side, you know, quality of life, you know, sort of quality of nursing homes, the supply of physicians, the supply of hospitals.

I mean, it was just kind of-- so it was like being in school, and it was great, so I did that, and then since leaving GAO, I've been out six years now. I continued a bit of that with the Medicare Payment Advisory Commission because, there again, it's got a staff of really good people, and they're generating reports and you are, as a commissioner, getting the benefit of reading reports about all of these different topics, and the National Committee on Vital Health Statistics is a different one. That's an advisory committee to Health and Human Services, and get sort of more information sort of there.

So, it's kind of-- and then the Forum is another educational opportunity for me, so I've been in school, now, since '93.

Responder 1: I checked, we are still on, so-- we could have gotten canceled at the last minute.

Responder 2: Okay, thank you.

Responder 1: We were going to be seeing Liz Fowler one day, and it was four days before-- four different appointments before we got to see her, because every time, something would come up. But we understand, they're our friends.

Interviewer 2: Okay, you're friends, cool.

Responder 1: You had one more question, but I hope it wasn't a long one.

Interviewer 2: No, it was just about maybe you would recommend us some people that would be helpful for our research to meet with?

Responder 1: And you're here until June--

Interviewer 1: Mid-June. 17th of June.

Interviewer 2: And I'm leaving tomorrow, but Sebastian will be here.

Responder 1: Oh, you leave tomorrow?

Interviewer 2: Unfortunately. I'm so sad.

Responder 1: Okay, let us think about that. If you could get to see somebody at CBO, that would be great. I don't know if Holly or somebody in (inaudible) could do that. Have you met Mark Miller or anybody at MedPAC?

Interviewer 1: (inaudible)

Interviewer 2: I met him about two years ago, so-- it was before the reform, so maybe you could go again.

Responder 2: And Bruce (inaudible), who just retired from GAO would probably be a good person to talk to.

Interviewer 2: Right, yes.

Responder 1: Let us think about that. We'll call you.

Interviewer 1: Yes, I will contact you.

Interviewer 2: Thank you so much.

Responder 2: Sure. You're welcome.

Responder 1: That's great.