# Programme OPERA – ENTRETIENS

## Entretien – santé n°47

Pour citer cet entretien : Lepont, Ulrike, Entretien santé n°47, Programme OPERA (*Operationalizing Programmatic Elite Research in America*), dirigé par W. Genieys (ANR-08-BLAN-0032) (*insérer hyperlien*).

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Responder: My name is Gail Wilensky and I am senior fellow at project Hope, in a National Health Education Foundation. I think you have already spoken to John McMowood. The fellow position is an under-defined position. Basically, it reflects that I do not have an operating position in the organization. In the 1980s, I was here as a vice-president and directed, there is a senor for health policy affairs, and I was an administrative official in the organization. When I returned, after my three years in the first Bush administration, I didn't want to continue that. And they created this position for me, which allows me to do what I want. I don't have any obligation particularly to the Foundation and it allows me to do what is my interest, to work with the Congress. Since this period, in 1993, I have been in a number of commissions, a number of non-profits boards, and it gives me a lot of freedom to speak and write as I wish. It's an attachment to an organization but usually when you see someone as a fellow, it means he doesn't have real obligations. It's really nice for us!

**Interviewer: Yes, I read in testimony that you presented in Congress that you introduced yourself as an independent consultant, and not as representative of an organization…**

It's very important that I do that because my views are my views and, in the US, we have these non profit foundations, with the 305© status the ARS which restraints what they can do regarding to political activities. And because we are a Charity here, I am also very cautious that my views cannot be attributed to the Foundation because, if not, people could become angry. Sometimes, when I go to television during a political period, I ask them to identify me as a former head of Medicare or a Republican adviser, rather than fellow at Hope; if I think that what I will be saying might be regarding as too political and therefore offend some contributors. So I try to keep that very clear.

**So, what's the advantage for the Hope project to have you here?**

Before the Congress, I am a known entity and whenever I think it's to their advantage, I always identify myself as a Project Hope fellow; so if I am doing interviews in radio or television, or being quoted in newspapers, or testify: groups pay public relation to get their name out. There is a little of that. And for some project, I help them. That big stack of papers was abstract for an issue that health affairs is going to publish and therefore, in comparative effectiveness, which is an area that I work in, I am helping them review papers and selecting

the papers to be… So, I do things! I try to help them to raise money sometimes. But mostly, I do my own things and what I give them in return is publicity. I don't know if French corporations or foundations do that, but it's a very nice arrangement.

**We were very interesting about your different position and about gathering information about these positions. For instance, you were head of HCFA: so, what was your role, and what did you support at this time, which kind of reform?**

You know that HCFA is now CMS; So the basic operation of CMS or HCFA is to direct the Medicare and Medicaid programs. That is your fundamental obligation. The major function of any of the regulatory agency in government is regulations that implement changes in the law passed in Congress. And to be responsible for the operational running of these very large programs. They're different because Medicare is a federal program, so it's a direct responsibility of the operation of the programs. Medicaid is a state program with federal oversight; so the relationship of the agency to the program is different. It is making sure that the states are doing what they are supposed to do, that there are state plans that they need to file with the agency, explaining when they're making changes, going through a very structural process. So, the activity tends to be a little different. At any time that the agency would have a very change in the law, it's responsible for implementing. Whenever the get around to conforming a new had???, even now in the Obama administration where there is no administrator yet - … had been named but it's early in the process – which is amazing, you know, it is so long what is going on… He will have an enormous amount of work because of the new legislation. He would probably have more responsibility in terms of the rules and regulations that need to be written and implemented than any previous administrators.

When I was there, they have just passed the Resource Value Scale, which was the new way to pay physicians. So, one of the big responsibility was to make sure that the arborvious???? was finished because it was not complete. When the law was passed, there was a lot of work that needed to be happen. Was it directly the agency responsibility? But it needed to happen because you couldn't implement something, if it was not finished. And then, writing the regulation to implement this new way of paying was a major responsibility. There are a lot of interests in funding and financing of Medicaid. There were some concerns about whether states were avoiding paying their share of Medicaid by using some created financing, voluntary donations and providers taxes. We were concerned and our focus was trying to come up with regulation that would prevent some of these activities. And then, there were a lot of concerns about how clinical labs were up reading. Legislation called clear the Clinical Labs Act but there were some difficulties in regulation and controversial, and that was the big area we focused when I was there. In addition, and it tends to very with Republican and Democratic administrations and then within those Democratic administrations – so, a generalization, but, more or less true – Democrats historically have been much more interested in health care policy. And, in addition to the obvious focus on the Congress and the White House, there have tended to be many people who are experts in various aspects of health financing, of health organizations that are parts of the administration.

And other part of the HHC, the Clinton administration, you had a lot of centers of expertise in the department and various individuals in the White House who were knowledgeable and recognized in various aspects of health care policy and financing. That tends to be less true for the Republican administration; the implication for me when I was there was that there not many people in other parts of HHS, White House or OMB, who had a very well developed

background in health care financing or policy. So, what it meant was that I was involved in many areas that's said if conform ????their administrators would not probably be involved in because they are so many other people in the administration with expertise. I became much more involved with some of the key things in health care reform that Dictor Helman who was director of OMB was put together to represent White House activity in the first Bush Administration. And I was called for discussions before the Congress as the administrator of HCFA; in part because the person who was the assistant secretary for planning and evaluation – it is the policy at the secretary office -, his expertise was disability and incomes policy but not health care policy.
*(Le telephone sonne; X s'enquiert de savoir sis a secrétaire va prendre le coup de fil)*

Because he was not an expert of health policy, I tended to do more testimony on broad health policy – not, everything, but much more than if I had been in a Democratic administration. In the Clinton area, they had several people, Judy Feder was a deputy assistant, secretary Ken ….?? was involved, Len Nichols was overhead of OMB, there were a lot… Alice Rivlin who was the head of OMB has some knowledge of health care. It tends to be a large of centers of expertise in Democratic administration. You see it now, they tend to trip over each other sometimes in attention of who really represents the administration as the most polled; so you have people in HHS, but you have Nancy de Parle in the White House and you have also Hillary Summers and Peter Orszag. They have too many, a lot of experts and Republican administrations tend to have a scarcity. For me it was a very good opportunity because there went very people around; there were people, the secretary was a well-regarded physician, a head of a medical school; so he was well recognized but he didn't have a health financing background. And it was true in most places of the administration. They didn't have this packet of expertise. So, it was excellent for me but probably not as good for the administration.

**So, you worked on the Favorated Project**

I worked on the Favorated Project in addition to be responsible for Medicaid and Medicare.

**Which projects in particular?**

The biggest was the first Bush administration: put together a health care reform proposal which was released very early in 1992. The work on that had started in early summer of 1991. I was working in a group that included Tom Sculley who was at the OMB at that time and Dick …???, several other people worked on this. Just around the time that it was going released, I changed job and went from my physicians Medicare and Medicaid HCFA administrator to be the president senior health and welfare advisor. Which I actually was not happy to do; I was happy running Medicare and Medicaid; but Clinton Idor??? who was the senior most policy advisor of the president had – previously the secretary of agriculture and the US trade representative – gone to the White House to be the domestic policy advisor, but it-s basically the senior counselor of the president, he wanted to have a person for health care going on the election year. And he persuaded me to leave my position and to go.

**Was it a good experience?**

It was!... It was not… When you are in a position like that, you are staff. I would report to Clinton but effectively directly to the president because when I would go brief the president, he would frequently not come with me. He's a very secured individual and I admitted to come because I like people like Tom, who is quite young. I was in my 40s, I have already been elected member in the Institute of Medicine which is a national Academy of science for health care and medicine. So, I was a known senior voice in this area and he had wanted to have someone like that. But, when you're staff, it's different than when you have your own operations. And, I prefer having my own operation. I actually had to be cost, into leaving. I declined twice when he approached me and said "brother, stay where I was and raise some concern I have in making a move", which he resolved and finally I decided "it's an offer, I shouldn't refuse." And it turned to be a very good experience, different.

**Why?**

Because you're not running; you're in activity but you're involved in all the senior level meetings, national security meetings in the White House. And when the president was being interviewed, I had been requested also on welfare because I had spent some time very early in my career on welfare issue; so I still had some interest. So when the president was being interviewed on issues, including health and welfare, or traveling, I went with him. That was very interesting.

**When you were adviser of the president, where did you get your expertise, information, reports? Did you ask the administration or other organizations?**

Both. You first turn typically to HHS and OMB. You are a part of the administration, and you want to know what positions have been developed – because it is a peculiar time when you're getting ready to go into an election circle – and also, because we had now spent the last months developing the health care reform proposal, a lot of what I was doing was trying to help organize the material or questions about thing would work under this proposal and I did a lot of interviews with the media. The type of position that I had allowed – there are certain positions in the White House that are more restricted between doing something which could be regarded as political or just doing your job. The job that I had, didn't have as much sensibility around that distinction. So, it allowed me to be involved both in supporting the president when he was out, doing campaign – very interesting because I am not primarily political. The main area was to fill in many of the issues raised in the health care reform proposal, to work on some of the background documents that would explain how it would really functions, how the high risk pool would function… and also other issues that would be related. Again, unlike some of the other people in the administration, I had health policy research background. When I needed information, I had a broad reach. Some of the few political appointees that I know, who have spent seven years in what is now called "AHCRQ", the Agency for Quality Research and Help, or something, Agency for Health care research and Quality; its previous name, twice before has been the Nationel Center for health Services Research (and then it became HCPR and then AHCRQ).

I was there co-directing the first of the big expenditure survey called the Expenditure Medical Survey, now called MAPS. It had a big impact in two ways. When I went to BDC Adminsitrator, I knew how the department worked: I knew the relationship between the publical service and the agency supporting the secretary, and HCFA, because I had been around for a long time as an active researcher. And I also had a good knowledge of the senior

researchers, health service researchers, in the government and of course outside the government, because, you know, we were publishing, generating all of the data. We had a lot of interactions with all the economists and sociologists and some of the political scientist. Especially on health care because we had all this big data that we had developed. It meant that both when I was in HCFA and when I was in the White House, I had a very wide, good … that I could call in for information.

**Who were the main persons that you would call in?**

It's a long time ago! Well, probably, when I was in the White House, the first person I would call in were the people I worked with in HCFA: who knew the policy issues – because Medicare and Medicaid is so much of it. But I also would contact the people in SB, the Assistant secretary for Planning and Evaluation, but I can't remember who I called, … was the assistant secretary but he wasn't the health person. So I probably would have talked whoever the health deputy was, but I can't remember who he was. And again, I would have reached back people I knew in CMS bar they knew the data. So I would have contacted both the senior level but also colleagues who work on the data and analyses.

**For you, it was more important to get data or formal information than to get ideas? For instance, did you have contact with the Heritage Foundation?**

No, I don't remember. Since that, I had a lot of contact with AEI, Heritage Foundation, and Brookings. When I was there, it was more the internal people and the people I had broad in. There was a small group of people I used to talked, mainly when I was in HCFA, some policy ideas, my kitchen cabinet. There were five or six people who I knew for many years and I was comfortable with, and, I though, would be good advisers; who were knowledgeable but have a good political sense. It was one of the things that you're kinley aware when you are in this position: There are political positions. You need to balance the policy issue with what would be possible politically both within the administration, but more important, within the Congress. And this was especially important for me because the Congress was Democrat, both Houses. It was something that I thought would be acceptable to the Republican White House and the administration but also to the Congress, independent that it was something primarily for show; something you thought might be possible to happen. You do both when you are in a political position.

**Was it in that sense that you developed the health care reform in 1991?**

It was done… The issue was obviously an important issue. It had been very frustrating to the secretary suddenly and to me that it took until the third year to push this issue forward. The answer was both. A number of us and this was an area which the secretary didn't have background for very passionate about, for pushing as a cabinet member the importance for coming forward, expanding coverage and reforming health care. So, I mean, I thing there was a large agreement among the knowledgeable that it was a serious issue, that needed to be dealt with, but it's also a very political issue. It was real. The frustration is that it took so long to get it to rise to the level of preeminence that automatically it did. Unfortunately, by the time, it was very upfront and the policy decade. It was very late and it made it hard to have taken. with the same seriousness by the public that it would have come earlier. …..Happens, it's because it was serious competing issues. It was coming up with the Budget Act in 1990 and a lot of focus in particularly, with OMB had been on the Budget Act and getting the Tax

Agreement, then …….. was a very big issue in 1991; the president had very it was its first job not surprisingly a lot of focus. So it was, when that … really resulted, it was about health care.
And especially because health care costs passed in 1999, it had been everything had happened and again, social security and health care are typically regarded as Democrat issues and defense and economic policies are more Republican issues and there's truth to that that it affects how administrations run this area. But it's not to suggest that they shift their position true. It came up, it was regarded as important by OMB and … in particular the domestic where the administration I served. That is not always true. Who takes this importance of OMB in the second Bush administration was very different than in his father administration.

**Less important…**

Much less important.

**I would have question on the reforms. You are the main advocate, and that was you accepted to be the adviser of the president.**

We say in English, an offer you can't refuse… Someone very senior had me lead to do that. It was a different experience. I got know the president in a way I didn't because I spent more time with him. I experienced to be in the White House, at a reasonable senior level, as deputy assistant to the president. But in health care I was the most senior person.

**What was your relationship with Congress during developing this…**

I had a very interesting and good relationship with Congress because of my background. Because I had worked with Congress as a technical expert, before I was a political appointee. One of the wonderful statement that came up in my hearings, my confirmational hearings – I can't remember who introduced me, but whoever. The Republican side – because I am from the District of Columbia which normally doesn't have a senator - , to the finance committee; the said: "The Bush administration regards me as theirs, but the Finance Committee regards me as theirs because they've known and worked with me earlier". So it was very nice and I had a very good relationship with Congress, especially the Democrats, because I had been a technical expert and testified a number of occasions before I was a political appointee. The Finance Committee and Ways and Means Committee are relevant Committees for health care, the Labor and health Committee for public Health: I had known the seniors, I had started to testify around 1982 or 1983; at the time they had no ideas about what my political party was; it wasn't relevant. In fact, most Congressional staff said me "I didn't know that you were Republican". I said "I am a good economist and you trust my empirical analysis, you shouldn't know what my political party is, because if not, I am not a good political analyst." I don't think they regarded that way but I regarded that as a great compliment that they didn't know my political leaning, and I am not a very political partisan person. It meant that I had a very strong relationship both with the Democrats and the Republicans.

One of the things which was very interesting that I would go to a group that Newt Gingrich had put together and I was there when I was working in the White House, so he could say "we have someone of the White House", there was some tension between this group and the White House - I think they didn't regard them as conservative enough – so, in any case some tension but I was invited because I had helped this group before I worked in the

administration at all member of Congress. I am always regarded as a public policy analyst ; I help anybody who asks me. Republicans, Democrats. Sometimes, I will explicitly tell the person that I am glad to help you things through your policy and what it would take to make it happen but I am not personally support what you are applicating because I don't assume that; because I help the, I don't necessarily support them. I regard it as the appropriate role for a public policy analyst and I have worked for very different groups. Typically not for liberal Democrats, but some of the more business-oriented Democrats or some of the Democrats I had long relationship with ; and with the ……. of Republicans. Some of the fiscal Conservatives, because I tend to be a limited government and more fiscally conservative person. So, sometimes, I would be person regarded as quite conservative, but, in the US, there are there are some people who are tagged as conservative but there are actually only social conservative and spending and taxes are coming, there're not conservative at all; and some people who might not be social conservative, but when it comes to government activity and policy, are quite conservative. I tend to be more with the business-oriented or conservative Democrats because they would read what I wrote or said and it would be more comfortable. But I also will help people who are more radical if they want my assistance.

**Again about this reform: you wrote a draft, who wrote it? Was it more administrative or…?**

We produced it all together with the whole administration. It was the Bush administration health care reform proposal, it was developing by the administration and it was primarily OMB and the White House with some HHS support. And advocated by the president. As he wanted 1992, then it would have taken a different life because then it would have got transmeted over really to the Congress as a serious proposal for a new administration, a second Bush administration going forward. But it was developed by the administration in the middle of 1993, meaning by definition that a legislative activity …….

**To be introduced by members?**

Yes

**Ok, that makes sense.**

They were working both with the Senate and the House of Representatives, Duran Burger and Gramm Barison. Gramm was the head of .. Committee and Republican health subcommittee. Duran Burger had been very active in the Finance committee of the Minesota. So, they were involved in it but it was primarily the creation of the Bush administration.
And Dick.., and Tom Scanlon. And people he was comfortable with. He was the domestic person of the administration. He was not an easy man but an incredibly smart individual who unfortunately died one year ago.

**You said that when you are in very high level position, you have to balance between your political views and what is politically feasible. Could you give examples of this difficulty?**

They tend to be very provoquial to the moment ant to the issue in terms of how you look at. What would give the problem resolved, and solve a political issue, which is depending on where you are, either it may be your Republican base, it may be the people that you are trying

to reach out to drink campaign, or it may be the people in the Congress who either support or not support what your views are. I give you some interviewed issues, a couple of the broader issues because I can't remember some of the specific I experienced. Two areas that would came up frequently in Medicare and Medicaid related issues were "could you tolerate some reductions in the increased payments to hospitals". It was the balancing act between homw much would they accept and how much would they be hewup with public but then going on because it was actually reasonable. This kind of balancing axe, - and number of that is so small in terms of saving that we are talking about. Then it was reductions of 5 billons dollars in terms of possible as regarded, people dying in the street. And at the end, the proposal that you would support, the Congress pushed back, didn't have anything to say and it changed of that. Concerning what I mentioned above, whether states conserved or shared their money for the Medicaid match, there ware a lot of concern that states were moving money around in voluntary donation skim; basically the way that worked. They would get the hospitals – thout should be the main receipion of the Medicaid money – to make voluntary donation to the state to . put on the match. The match is 90% for the status. The money . The states would give back the donations and then have the new money. So basically the only new money was coming from the federal money as opposed to additional. This was an area where some regulation had been proposed and they blocked them, the Congress can do. Tom Scolley who were in OMB when I was in HCFA mainly supported the White House, mainly the chief of staff. When it worked with individual members of Congress to try to draft legislation that they would not back.
That is something that costs a lot of special deals to give extra time to certain states, to leap down states where they were but to stop any further match. But some states have been quite heavily involved. And so it was trying to put a limit on what had already happened and not become bigger. And so on, it means at a very little scale compared to what is going on with a very large legislation, you need to get support, so you need to figure out what you can offer without giving yourself in so much trouble. It is a messy process and you have to concentrate and judge whether at the end what you're doing is basically what havy even if there is something that you agree that you don't like. But usually, there are limits. You know, you can …. We are trying to get back but not too much. It's of course unfair, but you work in a world that …. Sometimes, when you're crafting a position, both parties have their major base to keep happy, and then they want to reach to the largest group they can to indicate and understand their concerns. So they can influence the legislation all together, but it's especially influential as you sell it as a package. In our reform, the focusing on mainly the uninsured who are poor and low-income and doing very little for those who are upper-middle and upper-class. But that's partly a budget issue, and partly a policy issue. There are clearly differences among the two parties in terms of how much government …, how much regulation put on, whether at the federal level, versus the states level; but a lot of concerned that were raised when I was in the White House, about whether or not things should be shifting away from states' control or federal control in terms of insurance reforms. And practice issues, which is typically a state issue and regarded as a serious impediment but concerned about taking this over as a federal function because it is traditionally a state function. Nobody in the Congress would push back, not necessarily because they disagree with the policy but because they are concerned by the shift by the federal government.

**Did you also have contact with the stakeholders?**

Always. I give you an example that I had when I was the HCFA administrator. Prospective payment system (the DRJ system), it was always supposed to include both capital and

upreading expenditure. But earlier, it included upreading expenditure only and we were supposed to expand to the capital hospital payment. Twice the expansion had been proposed and twice the Hospital association, which didn't want the expansion, got track the legislation. When I was there, I decided to try again. So, initially, I invited the representatives of the major stakeholders, the public hospitals, the non-for-profit, the for-profit hospitals, some of the big state hospital associations, like the Great New York Hospital association, very powerful, and other to come in with me and to tell me the issues that they're the most concerned about. When you're having this position, you're constantly reaching out. When I was trying to implement the Right and Value scale, and to get ready to putting out the proposal, I met regularly with the American Medical Association, but more with all the specialty associations, American college for radiology, Surgeons, and American college for ophthalmology… When they asked me to come to speak at their annual meetings, I would frequently do that. So you do both, you bring the men, I had a physician who was a dean at a medical school, who was my medical adviser, so she could be my bridge to this group. I absolutely had contact with these groups. Ones are your supporters, and ones are not.

**So, you did the negotiation…**

You listen, you try to craft the rule, and the answer is no: you don't negotiate. Because they don't have decision-making power. There are other people you have to negotiate with. You listen and you try to put something together that reflects their concerns and that you think it's appropriate. When you go to the congress, you maybe negotiate with. You can say: "here are the people I met with, here are the issues they raised and here is how I try to take account of their concerns but to get the job done. When you're negotiating, you're only negotiating with the Congress.

**Is it still important for you, as senior fellow, independent to the government, to have contacts with stakeholders to frame your positions and to be relevant?**

Yes, but in a much less formal way. I don't so much reach out. They try typically reach in, I mean, they want to talk to me because they knew that I speak with members of Congress or administration, Republican and Democrat; and I do a lot of speaking. Some are paid and a lot of it are not paid. So I am constantly out and about, I am a good observer and a good listener; so I am always interested in questions and answers questions when I speak because I want to hear people I am concerned about, and their issues. I do it but it's only for me. So people reach out to me, come into to speak with me. But I am doing a lot of that reach when I am traveling. Sometimes I might make an effort when I am curious about a particular group. I might call somebody who I know is involved in them.
When people are developing policy, it depends on how much they know, how much their reach they use and what they are doing their reach for. In terms of broad policies, there are many options. When you worked in this area for very long, you don't need a particular commission to know the options. You know the options. Options are the same option for 20 years! At the big level. Now, there would be little options on how you actually make that happened. When I call somebody who is in an insurance commission or in a state, who runs an hospital, about a very specific option on how it really works. But, in terms of basic policy choices, you know what they are. If you don't know the issues, if you are a political appinttee and that you don't know the health care issues, or that ii is not your area of expertise, that's another question. Then you need people who can lay out : "here are the issues, the pros, the cons, who supports this, who supports the others". But if you know the area you don't need

that. Then it become – when you get down to the detailed issues – who's ware, how can you do that actually makes happen, how much give do you have, who is supporting in one way or if you choose another way, and it goes down to this kind of trade-off.

You may get ideas from creative people, people I reached out to ask them to talk to me at seven o'clock in night : "I am thinking about an issue, what do you think about this?" But then you have to digest it. Does it make any sense in your environment? Does it make any political sense? And sometimes, you invite people in because it's politically helpful. I had a very opendoor policy when I was HCFA administrator. People who represented any organization and people who big gourps, even if they are single groups, could mome in with me at seven O'clock in the sunday night or … If they want to talk to me, I would listen to them. Because meech of Medicaid and Medicare is so big that people that they feel that they have a chance to have their say. I did a lot of speech and traveling to get people views and ideas. But I wouldn't go to Massachusetts unless the president would ask me to go their because I had two children in college in Massachusetts; I was very careful because I have lived in Washington a long time and I would not accept a speaking engagement a Monday or Friday unless the secretary of White House would ask me to do it. I didn't want that somebody could say: "She accepts this speech, so she can visit her children in the week end." John Senunu basically got pushed of being chief of staff because of trouble abuses and the assistant secretary, Janet Holder, who were the head of aging when I was there or at the end of the year, had got a lot of troubles on this issue. When you're in a position which creates a lot of potential animosity, you have to be very careful. And, when you run Medicare and Medicaid, it's always getting somebody mad. Some spier, some senior, I mean, it's the nature of what you're doing.

**My question was just about the most action you did. You have been adviser of John McCain. And I was also wondering if you have been involved in the current health care reform…**

Indirectly. Mostly through the Senate. Max Baucus had put together three big breafings for its entire Finance Committee last year, and I was in the third. It was in May 2009. There were four hours sessions. They were wonderful. It was terrific because they were very helpen, they were no-opening statements among the people; it was only a panel of ten or twelve experts and we answered questions of the whole committee. I did that plus – I mean, when people call me, this is partly, I don't pick up the phone and call the members of Congress or administration, Republican or Democrats; and haven't since I left. The reason is that I don't do any lobbying, and I don't want anybody to think that I am lobbying them. So, my assumption has been: I am here, they know I here, I go through some periods where I am much more active than others and I really assume that some people she can help us. So they call me and some other see me testifying. …… and then something happen and get back in you mind, you made right something that could picked off.

Right now, I have been spending some time working with some of the Republicans in the Senate on comparative effectiveness, which have been a very strong passionate mind. A number of republican who have trashed this idea mistakenly, they don't understand, or they are looking at quick political stakes. I have been spending time mostly with their staff that I occasionally know because again, I have been around for a long time. I have an opportunity to explain them why it should be regarded as consistent, why it's easy done. More than many – because I try to tell them: "ok, there is the political time, when it's politically useful to trash

something, or you think it would …..something that you object to, and there is another period where it happens or it doesn't. Because the problems are still up there. I have done much less with the House. They have been; three years ago, 2006 and 7, I was doing much more with the House. Because I am more passiviness, a lot depend on who's the staff drives, who testify, who comes and bring their members. It may be who happens to think that he would be a good voice. In the last year, what I have done the most is explain issues to the media because media have known somebody who is reasonably balanced, impartial and reasonable. I had a lot of cost from newspapers, I did a lot of NPR, public radio, public television, number fax. I am surprinsingly amused that Fox called me because I am pretty moderate for some of the people that they have on, and especially during the health care reform period. I decided that I wasn't interested in a lobbying related significantal approach. It seemed clear that we were not getting on with resolving these problems, we needed to get the best bill we could through to the Congress and go back and fix it. That happened. There are a lot of things I don't like about it, but it would do a reasonable job if it could do expand coverage among the people eventually. That's something which needed to happen and that why I …. The other things.

**I read that you are very involved in the issue of increasing medical efficiency. Did you try to push in this direction?**

Yes, and it has been critical by a little in this health care reform package. I was on the Hill yesterday doing a – I would say close but I don't think it's the right term – mostly CMS and representatives, members of Congress invited in a little meeting to discuss the innovative medical payments in health care reform. An then there was a larger meeting which was on Cspan, it was web, postcast whatever, the audience that this health care reform had yesterday probably getting on the web. It would be post to next day – talking about innovation and payment. What I have been trying to do is to get a better perspective about what would need to happen in order to go to this whole process. The innovations rely on this pylets. That makes sense because we don't have to make the changes that we generally need to happen: get away from fee-for-service payments, for many billion items, position bill 8000 different causes under Medicare. There are very little alignment between hospitals and physicians, and other providers' health care. We pay for more and more complex, we don't pay for good outcomes, or good health. And so trying to help reorganize the delivery of health care by driving changes in payments policy is an important issue, but we don't know exactly how to make that happen. So doing pylets and demonstrations is a good idea but we need to be realistic about how tough it's going to be to automatically drive the change that we need to have. It takes time, it takes constant vigilance, we have to decide when the data is good enough. You have to except a lot of push back, a lot of specialists find that they are getting shade up by these delivery innovation. We have too many of them and too many high tech centers. We need to understand that the first we are waiting from them is " to provide my patient the best quality health care". That will gonna be their line. It gonna be unconnient to say "it's not the case"(1'10'35). That means setting up infrastructure that can be credible, that provide good or better quality, not best quality – I recognize, some of my colleagues are making statements at the OMB the way understanding the saving. They're crazy. They're just… "What planet are you living on?" Not that we could delivery health care much cheaper. Everybody understand that. The question is "what the likelihood", "what is going to happen in the five next years". And the answer is zero. I think the likelihood in the second five years is small. And that means that, if you're really aggressive, start getting this pylet?……..going in 2011 or 2012 makes the …. You have to make one. Things won't go exactly like people planned because the never do. Make the changes you need on order to make them right, figure ou "here are the

ideas and they seem good ideas", scale the map and see what is going to happen if you double or triple them in a very big country, finding what works, and not only works in a little point, in Arizona but works in Los Angeles, or Miami… Not so easy.
Then try to scale it out, and then decide what you want to do and go on to what you want. We are seing that in the second five years of this coming decade, I'll be pleasantly surprised; by the five years after that, if we are seing that we are not, we will have to find something else. But it's just recognizing that the earliest any of this is 2016 to 2020. Then it will be try to drive successfully the changes that we three years. There have been many good ideas, and now there are a group practice demo in a panels that were open speaking to this congressional staff people in CMS; people before that is the head of the Beelings clinic, his name is Doctor NcGorders, good guy and we wrote an article together. This group practice demo is by CMS to reward large group practices that need a good quality level and good efficiency level, so very good. But, look back to what happened. The idea in this demonstration starting in 2001 or 2002; the actual are picken out around 2003 or 2004 because it takes time to get this good idea into a request for this proposal, get the bill and blabla. It started technically in 2005. You had ten of – if you want to who products this – ten groups that . At the University of Michigan, Medical center, you have tis Beeling Clinic, Mentanic Group which have formed in 1993 and had ten years to get going. It's an interesting group of academic , delivery centers, it's a very nice. Only two of ten stars were able to …. The other eight , they just getting enough to qualify to the saving. It's not to say "it is not a success", it is now 2010! And it started in 2001. And now? Now nothing. They the second three years. It is to think : we are decade out! And we would have to figure out what do we learn from that? Again, it is to try to get in perspective. I am nothing, but a realist. And I think it's a terrible mistake to sed up for expectation. Congress has enough trouble keeping its attention for any period. There are a lot of dyslestic in the Congress; I mean, the focus on something and they often something off. It is a real mistake to read them to expect that it is a quick fix. You would be able to actually see nationally changes in budget and window. It means, in the ten years of the outset, and probably in the first five years, what seems attractive enough to get players interested in participating and to get seniors interested in participated. One of the big issues is that most of the pressure is on the providers; but you also need to have the patients interested in participate in . You can just legislate the train – basically, we do that – people are widely concerned that – think a little about legislative really big changes in approach Medicare that affect 7 millions people. Trying at first is not a bad idea, but figuring out that you try is actually working and that it would work nationally is tough. We will see how this process is playing out. I am not critical that you're doing out in the stage way – nothing with a…… reform, it was a easy trade that institutions that follow base medical engaged major savety engaged by the institute of Medicine. Protected against suit and criminal negative…….But the Democrats and trailholders the are a long term coalition and they just don't want to figure out. Physicians and hospitals that have to do few things with no ability protection.

**Maybe it was difficult for the Congress to pass a bill against the insurance and the physicians and hospitals?**

There was no problem doing against the insurance because the insurance were made the bad guys. So you could do enough against the insurance. The physicians and hospital are tougher they have supporters, the hospitals are in between. The doctors are terrible politically. They just don't. They just don't know how to organize.
The made a lot of voice in the US but they got nothing. They are very bad in terms of political strategy. The lawyer of hospitals are good, the drugs company are media. They're not very

smart in how effective they are. The doc are worse; and I tell them when I speak to them all the time. You wait and help them to desperate and then you don't understand why people don't help you as opposed constantly keep in touch with your representatives about important issues to you. Being small supporters, 300-500 dollars to be booster of their member booster club. It's not a lot of money.

**What you said that interests me a lot is that you didn't adopt this blow out position; you are working on this reform and changing it.**

Because there are real problems up there. I want to make them better. I don't want a political office, so I can say what I believe and sometimes I think I make my Republican friends mad. I didn't join them, I didn't sign anything, I didn't speak for them. Because I think the Republicans had too many opportunities and time to fix these issues, and they didn't. Now we shouldn't be surprised when Democrats have the opportunity that they are trying – I criticized and I continue to criticized what I think are mistakes but I wasn't interested in lobbying grenade. In 1990s I did invilenty as much as I could to help destroy the Hillary Security Act, I think it was bad legislation bad politically, bad substantively, and I though there were enough time that better legislation could be proposed; but here we are now 17 years later and it was time to get something done.

**And they are more focus on individual also; we were speaking about that because people who were supporting the individual mandate were more the republicans and now Democrats are supporting this position.**

More than I have in the past.

**How do you understand this change?**

They are more verbally than in reality for them more that I have been. So, it's like, you have to have an insurance – what I support – but then, and I am serious about it, the penalties are trivial modest and way down the road. I think they were reflecting some concern expressed by the American public. But not a lot, this is why there were a lot of push back going on, because they are concerned by how have been spent and the role of government. There were individual responsibility but the expanding role of government and especially the federal government in this legislation is enormous. But, it can be changed! My advice is stop saying repeal, just say revise or refine. First of all, it start to happen; it's not the right message. There are some phenomenon about covering people and I have been pleading with the Republicans to bring every body in the public life in Medicaid something like Medicaid, some low income support program. They're technically poor, they're uninsured, it's the third of the uninsured population: who ask who gonna pay for them. And if you bring up to a %, your talking about 40% of the uninsured. And if you, you're talking about the 60% of the uninsured. So, we shouldn't to have to fight about those. We speak about the very poor or the near poor. We need to help them to have a coverage. Just have to decide how much and how. And that's really why it was time to fix this problem. That why I made it cery clear when people asked me that I wouldn't be part of these people who just tried to destroy it when they are on the table. You had too many opportunities and you didn't do enough. So, get this time and we'll go fix it.

**What was your position for the other reform, the MMA and BBA?**

I was actually in the most uneasy about the BBA, about the children health insurance expansion act for expansion to children above the 20% of poverty line. Because, we were not meaning what we were saying about these children. At the time, we had no support for many people who have low poverty and having support for children who are 30% above the poverty line, that's make no sense! I decided that children are not the right cible of an insurance coverage. They are a part of their families. With the MMA, I was very disappointed. Not because the expansion wasn't important, it was an interesting way to do it. There were no attempt to get fiscal solvency move in the right direction for Medicare. In fact, it's just added another unfunded piece. So it took a program which was already completely insolvent and add a new huge instability. I thought it was grossly irresponsible and I was very disappointed they didn't use this fiscal mechanism to give financial stability into the program. It was the less … that they had. Now it's so stick. Which of course never made policy sense. It's just a budget issue. And it also made it hard for Republicans to be very credible. They proposed this new legislation when they have just passed this Drug benefit which was just completely unpaid for. I mean, what they said was right but it's like who are you to say and why people should take you seriously. What I say is that they paid the automatically political price. And Democrats should have to listen to that! The House is very left to center, and not reflecting in my view the American population and they will pay a big price for that.

**You may not have time but we were also very interested in the McCain campaign**

I was part of the small group of people who worked for him. It was a very serious issue. There were a few parts that went quite sort out. And they needed to be some structured by insurance. So a loosely regulated by insurance exchange would have make a huge difference. But of course, as you know, it's like "of course you can have that". It was really changing the tax treatment and have a very sizeable refundable credit to be used and taking on the other issues that were raised improving (overwelhming) payment, improving information. It was probably fortunate that nobody focused on the costs which over time would have been not right because of how the credit was indexed. The first five years would have been quite substantial. I didn't have any trouble being a very vocable advocate in the free camp speaker because the basic of the proposal was good. I thought it was justifiable, good policy and it gave me a chance to say: "don't tell me that Republicans don't have any good health care ideas!". They do! They don't often embrace them, they're not passionate enough in driving them but it's not the problem not having good ideas. It needed to have organized place to buy insurance ; they really didn't taken a lot of create ….. they just want to do it because the health insurance exchange was regarded as too regulatory. And potentially, it's really regulatory, but it's not necessarily regulatory. You can have states organized assurance exchange which are just places to go buy insurance and get information.

**Who worked with you?**

Doug Holtz-Eakin. That is essentially the reason I joined. He was his general domestic adviser. Tom Miller at AEI. A guy of the university of Chicago, Thoutsen? – I have to go and look - , a physician from Texas and congressman, Charlie something… You go on line and get this I am sure. Or talk to Doug Holtz-Eakin. I am sure he agrees to see you, he's a very nice person. I didn't know McCain that well and I advised the …….person during the

Primary. As I said, I am not an exclusive person, so I talked to Journalist/Julian East people; I didn't talk to Bob Romney people……. But I like Doug Holtz-Eaken a lot. He has been the CBO director and on the details, he was very helpful.

**Were there other Republicans supporting these ideas; Was Hotz-Eakin supporting these ideas?**

Changing the tax treatment has been more Republican than Democrat. It's really more about: how sizeable are the refund? Talking about refundable tax credit. Your not serious if you don't…You have to do something for low income people. What I would be congratulate income, but you have to be careful marginal tax rate; not too many . Changing the tax treatment, that was proposed by Bush 43, initially to have the same tax deduction for everybody and then he indicated his willing to credit deduction. But again, there are lots of good ideas, I advised during the early part of the campaign in 2000 and I was regularly included in meetings in the White House for policy issues you know, six or seven people with the president. It's just the passion. It's not enough to have the president supporting something. It need to embrace them, and talk about it, and drive – because you can see how hard it is to get something done. Even as important health care is to the Democrats, they struggle merely/moderly to the last minute to actually make it because it is tough, it's controversial, there are different views. If you don't have a president embracing with passion, every weaking moment. That what Republicans haven't been able to do; and McCain didn't do it either.

**George Bush was involved in health care modernization.**

He was, at the end. He spent more probably than others, but not in the broader health care reform.

**What do you think about the idea of Medical Saving Account / Health Saving Account?**

It's not the salvation of our system. I like it because I like making people getting involved in the decision-process making. I like people to think about the fact that their quality very used; they should care; and the best way to have that is to have a shake of money, which is theirs. I think people get completely crazy about this, on the right and on the left. On the right, people think that as long as we have Medical Saving Account, there will be no problem, but it's like no no, the really spending is this little group of people who are very sick. Or people on the left who think that is it only …….. It's ok to have them thinking about what there are doing. Again, can preventive care that you think is well supportive it's necessarily well supported. I think it's a good idea. I think it gets people on the good frame of mind; and then maybe when the get very sick, remembering questions they should ask and they should care about. I like it for that reason. It wouldn't solve our problem. It would help us to have a better frame; it's nothing else. People who say it is, just don't know, they don't understand health care.

I hope it was helpful.
There are only a relatively small number who have been involved as policy people. I have been involved with the businesses involved because I sed on some corporate boards. I have been involved in a lot of non-for-profit, so I look at that way, being in government; so I was probably one of the few people who were actually civil servant. It gave me a less gendes view of the people who work in government as being serious people. There are a lot of skills/ – like

every places – but there are a lot of serious committed, hard working people to do that and who could earn more money than that.

**Do you think they have increased their expertise now? There more people advising?**

Yes, but it's still quite small. If you look at the vast number of health policy people, I would say, 90% of them are Democrats. There might be a small exaggeration, but not too much.

**The supply for health care expert has increased or?**

The supply has been bigger than the demand for a long time. In economics particularly. Because it's a kind of funny of/upshoo, in economics; It's not a real specialty in economics. The way labor or public finances, there are health economics but people like me, I never took a question to health economics. I talk them at university, but they don't exist. I came up with public finance. Most of the older health economics are either public finance or labor. Some now are training young economists. It's 17% of our economy; of course, it's a lot of demand. And a very big political issue as well, and very challenging technical issue, in terms of how to get this problem solved. So I am not really surprised there are more people that going.

X montre les photos exposées dans son bureau, dans le bureau de G Bush Junior, lui serrant la main dans une cérémonie.

He is a bad politician but he is a really nice person. They are wonderful reminders. ……Goerge Collar who I worked very closely with, because he was the head of the Subcommittee in the Finance committee, which was responsible for Medicare when I was HCFA administrator. So, he and I had a very good working together.