Programme OPERA – ENTRETIENS

Entretien – santé n°7

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Interviewer 1: --can give you a few words about our studies. Our study, in fact, there's only one. So, we study healthcare reforms in the U.S. And the EU, since the '80s, the beginning of the '80s, and we, in particular, study where do ideas come from, what are the actors involved in, and what were the impact of the reforms on politics and power in healthcare field. So, that's, in a few words, our study.

Responder: That's an ambitious task.

Interviewer 2: Yeah, very ambitious.

Interviewer 1: Yes, it is, but we are five researchers on study, and we have three years to do this, so--

And what's the purpose of this study? What are you hoping to accomplish?

Interviewer 2: We are trying to do a comparison with the EU, and to understand the evolution of the state of the federal and state programs in the field of health sector, so, yeah.

Interviewer 1: It's just to better understand healthcare reforms, and maybe to anticipate the next evolutions.

So, when you say the EU, of course, the EU is made up of different countries--

Interviewer 2: Exactly.

--with very different policies, so they're not uniform, and are you trying to compare that to what we do here state-by-state, as well as on a federal level?

Interviewer 1: No, it's more federal level, and in Europe, it's only a few countries, like France, the U.K., Germany, Spain, I think, and now, in the U.S., it's only at the federal level

At the federal level.

Interviewer 1: --but maybe we will study some states, if there is--.

Okay, you're not looking at the states, because health policy in this country operates at both the federal and the state level, and particularly with the Medicaid program. Are you familiar with the Medicaid program?

Interviewer 2: Yeah.

Although-- it's a federal/state partnership, and there are federal rules, but then each state has a lot of discretion in terms of how they implement it, so we really have healthcare going on at both the federal and the state level.

Interviewer 2: Yes, right.

Interviewer 1: Excuse me. Maybe we begin in asking you about your career. Could you tell us a bit about your career? Who are you--

Who am I? I actually, back in 1977, went back to Columbia University, where I had gotten a Master's degree before that, and I got a Master's in Social Work, and then an MBA, and as a result of that, I was recommended for what was then called the Presidential Management Intern program, it's now called the Presidential Management Fellowship program, and it was a special program where people who were selected came to Washington, interviewed with the various agencies, and were offered positions on a two-year internship basis, which then could be converted to permanent federal positions.

So, I interviewed with a lot of agencies, and ended up being offered a position at the Office of Personnel Management, and that agency actually-- it's the federal human resources agency, so it does all the human resources policy, including all the federal benefits policy, and so I ended up in the benefits area, and that was in 1979, so it was about 30 years ago, and just over time, became the administrator of the Federal Employees Health Benefits program, which actually provides health insurance for about 8 million people, including federal employees and their dependents and retirees and so on.

Also did a little work with the federal retirement programs, and I was the person who actually brought the FSA program to federal employees, the Federal Savings Accounts, and the long-term care programs, so I did a lot of work in the benefits area, but primarily in the FEHB program, so my focus was really on acting as a purchaser for a government agency purchasing insurance coverage in the private sector, because that's how the FEHB program operates.

The government actually just contracts with a bunch of insurers to offer coverage under the program, and so in 19-- in, actually, 2004, Mark McClellan, who had just become administrator of CMS, called me about two days after he was confirmed and said, “Would you consider coming to CMS to help me implement the Medicare Advantage Act?” The Medicare Modernization Act, actually, which introduced the prescription drug program to Medicare.

Medicare, up until that point, never had a prescription drug benefit, and so that was a brand-new program, and it was scheduled to become effective January 1, 2006, so this was, you know, around, I don't know, August or September of 2004, and this was when CMS was starting to gear up, and so, after a lot of discussion, I did agree to come here and work with Mark and others to bring up that program, and ended up as head of the Center, which actually administers both the Medicare Advantage program and the prescription drug program, and that's different than fee-for-service Medicare, which is a whole separate area.

What I was involved in, again, and that was why Mark so much wanted me to come, was purchasing insurance from private insurers to actually implement a government program, and I did that both for the Medicare Advantage program-- and stop me if you don't know what I'm talking about, because you may not.

Interviewer 1: No, it's okay.

The Medicare Advantage program is an opportunity that seniors have, instead of being in regular fee-for-service Medicare, to actually buy a health insurance plan, and have their coverage, you know, through a private insurer, and the prescription drug program is run entirely through private insurers.

So, that was the piece that I administered through, actually, last March, when the Obama Administration came-- I'm a career federal employee, so I'm a civil servant. The position that I was in is more typically headed by a political appointee, so when the Obama Administration came here, they wanted a political attaché in that position, so I was assigned out of it, and in fact, you've come in at an interesting time. I have just actually signed an agreement with a private consulting firm, and so I'm going to retire at the end of June and go out and work in the private sector, so--

Interviewer 2: Okay, okay.

Interviewer 1: To do what?

I'm going to be part of the health team at Booz Allen Hamilton, and hopefully continue to work on healthcare reform, which is what I'm very much interested in, but in a whole different capacity, so it's an exciting opportunity, and very few people actually know about it at this point, but I've just exactly now signed the agreement.

Interviewer 2: Okay.

So, this will be-- June will be my last month as a public employee, and starting July 2nd, I'm off to another job.

Interviewer 2: Okay.

Interviewer 1: So, we will come back in August to interview you as a private--

I was going to say, probably that would be good, because I'm going to be a lot freer to talk then.

Interviewer 2: Okay.

Interviewer 1: So, may I ask you, how did you meet Mr. McClellan?

So, I had actually spoken with him on the phone. When he came-- he had been in the federal government in various capacities before he was chosen as CMS Administrator, and do you know about Mark McClellan?

Interviewer 2: Yeah.

I mean, he is both an MD and a PhD in economics, so he's a very unusual person, to say the least.

He was head of the FDA before he became head of CMS, and he-- before that, he was the President's economic advisor on healthcare, and in that capacity, he came to OPM, you know, to just learn more about the Federal Employees Health Benefits program and how that worked, and so that's how he knew of me, from my work through the Federal Employee program, and he felt that that was the closest example of what he wanted to do, you know, in terms of implementing the MMA.

Interviewer 2: So, when was this?

In 2004.

Interviewer 2: Okay.

So, I actually got here in October of 2004. People here were already writing regulations. The MMA passed in December of 2003, so between that time and when I got here, they had done a lot of drafting of regulations and so on. It took, let's see, well, they had exactly two years to implement the program, and that may seem like a long time, but it really isn't, and we're looking at the same situation now with the Affordability Act. People think that 2014 is a long way away, but it really isn't. There's an awful lot that has to be done between now and then.

Interviewer 2: Why did you want to work for the federal administration? Did you have special motives, or--

You mean back in 1979?

Interviewer 2: Yeah.

I had always-- well, pretty much always, worked in the public sector. Before that, before I went back to Columbia and got the two degrees, I worked in drug education and prevention programs, so I worked for both the New York City Board of Education and the Nassau County Drug Abuse Commission in drug education and prevention programs.

So, I've sort of always been in the healthcare field, and I was just-- it's just always been my interest. When I was at Columbia, when I was taking the MBA, I was actually offered an internship with Mobil, Mobil Oil at that time, and I thought about it really a great deal, and it

just kind of wasn't my thing, I guess. The public sector had-- was just my primary interest and it always was.

Interviewer 2: Do you--

Interviewer 1: I can. Did you have a question, or--

Interviewer 2: No, no, that's fine.

Interviewer 1: So, during your career as-- a career (inaudible), did you have any specific policy or specific ideas that you wanted to push forward during your (inaudible) career?

Yeah, I had a very consistent value, and actually, it's interesting, I-- you know, when I first came here, we had lengthy discussions with the people in the office and the actuaries in terms of setting up policy and dealing with the health insurance companies, and, you know, as I explained to them, and it was very helpful in our working together, my perspective was always that I was a purchaser, and when I was at OPM, I spent a lot of time meeting with other large employer purchases, because I always felt that my job was to get the best possible deal I could for my customers, and my customers were both the people who were going in-- covered by the insurance, and the taxpayers who were basically going to pay the bill.

So, I just treated it always in my relationship with the industry as-- I was just another large purchaser, and I wanted, you know, obviously, I wanted to pay the right price for the coverage, I wanted the best possible service, I wanted the best possible benefits I could buy, you know, for the money that the taxpayers were spending, and that the beneficiaries were going to receive.

So, that was, you know, basically my philosophy, and it carried over from the federal program, from the federal employee program to the Medicare program.

Interviewer 2: Okay.

And it's-- it's interesting, because I truly believe, and I don't think we're there yet, that if healthcare reform is going to succeed, that's the approach that is going to have to evolve, it's not the approach now, and it has to move in that direction, because they're really-- in order for this new program to succeed, there has to be a good working relationship between the government and the states as purchasers, and the industry-- the insurance industry that's going to provide the coverage.

So, hopefully, in the next couple of years, as we're working towards full implementation, we'll get closer to that good working relationship.

Interviewer 2: Okay. So, you developed a kind of expectance in the relation with the providers and with the industries, so were you sometimes asked by other people, by politicians or by political (inaudible) for this knowledge about-- these skills about the industries, the producers, the--

Yeah, actually, while I was still at OPM, I testified several times about how the FEHB program worked, and how that might be helpful in looking at the Medicare program, and

worked a lot with Congressional staff, as well, so that's very typical, and the relationship between the federal agencies and Congress, people like me do a lot of briefings with Congressional staff, and we've always-- and still do, I mean, as politically-charged as the environment is now, we've always briefed people from both parties, staff from both parties, and-- on a bipartisan basis, and typically, that's the way it's supposed to work.

Federal agencies are supposed to deal with staff from both sides of the aisle, and do, in fact, so that goes on all the time. There are special briefings on discreet subjects and so on. And I have also been asked to testify several times, and have done that as well.

Interviewer 2: Of the people who asked you (inaudible) to testify?

Well, the request to formally testify is different from the informal staff briefings. A request to testify, most typically, comes to the agency, and then the agency designates who they want to appear. It happens occasionally, but not so often, that a specific person will be requested, and actually, it's at the agency's discretion unless you're subpoenaed, which doesn't happen very often, so who testifies is really, you know, the request comes from the Congressperson or committee chair to have somebody from the agency testify, then the agency decides, based on the nature of the hearing, who they feel the best person would be to do that.

And the same thing, actually, with the informal staff briefings. Every agency has an Office of Congressional Relations or Legislative Affairs. Each agency may have a different name for it, but there is a liaison office in every agency between the agency and the Hill, and it's that office, basically, that arranges briefings and responds to requests for briefings and so on.

Interviewer 2: Okay.

But every agency really bends over backwards to respond to those requests, because it's very, very important in every agency that people on the Hill committees that have jurisdiction over that agency's policies and programs be as knowledgeable as possible and understand, as best as you can explain it, what's happening and why things are happening, because, again, you just always want a good working relationship, so briefing Hill staff is part of creating a good working relationship.

Interviewer 1: Do you also brief people in the think tanks, or lobbies, or--

That's an interesting question. People from any organization, really, it's very open and very collaborative in the sense that virtually anybody can ask for an appointment, you know, just as you did, really, to come and meet people in an agency, and typically, it's more-- when that happens, it's more the people coming in want to present positions and ideas to the agency staff rather than the other way around.

When people request a meeting with agency personnel, they have some issue that they are interested in or concerned about, or some position that they are advocating for, and so they want to come and make their views known, and in a sense, it's lobbying, but, you know, that's what they're doing. They're coming to put forward, you know, their position, and agency people listen and take into consideration. There's typically no commitment one way or the other, they-- and you may have people coming and lobbying for opposing positions, so it's just, again, a way of gathering information, and there are many ways that agencies do that.

Are you familiar with the whole regulatory system, how that works?

Interviewer 1: More or less, yes.

So, I mean, again, every time an agency publishes regulations, there's a period of public comment, and everybody is free to comment, both organizations and individuals, to comment on regulations, and agencies literally take all those comments into account, and that's why there's a time-gap between when a regulation may be published or proposed, and before it actually goes final, and staff is literally sifting through, and there could be hundreds and hundreds of comments on a proposed regulation, and the staff literally sifts through every single comment and they categorize them, because, you know, typically, they will fall into various categories, and so they categorize all the comments into the various categories and then there is a lot of internal discussion within the agency in terms of what these comments tell us and what ultimate impact they will have on the final regulation.

And invariably, the final regulation will change from the composed regulation based on the comments. I can't think of a single instance where that doesn't happen, because you always learn something from the comments, and they're always really taken into consideration.

Interviewer 1: And inside the agency, is there a sort of common worldview of healthcare, or is there very different forms of view inside the--

Well, the administration really sets the policy, and that's the way our government works, and that's why we have political appointees in every agency. The political appointees set the policy. They represent the administration, whoever that administration may be. It is really the job of career civil servants to then implement the policy that comes down from the Congress and the administration, so people don't typically have very different opinions at the policy level.

The differences in opinion among civil servants will typically be more operational.

Interviewer 1: Like implementation?

Yeah, implementation, What's the best way to implement this, how can we do it most effectively? And there can be considerable disagreement, you know, around the operational issues. But the policy is basically set, and there are opportunities where career people can weigh in on policy, but not in terms of making policy. The way that happens is, when a policy has not yet been decided, typically career people write what we call options papers, and you write an options paper and it presents the various options, and there may or may not be a recommendation, but then that's presented, ultimately, to the various people in the hierarchy, and ultimately, if it's a significant decision, it's not even decided exclusively at the agency level, it goes to OMB, and OMB has a major voice in representing the administration on policy decisions.

So, the way people weigh in is typically through drafting options papers, and that's the opportunity, really, to put forward various options, but the decisions are not really made by career people.

Interviewer 1: Do you have examples of option papers that had an influence on some policies?

Well, there were many, many options papers that were written when we were writing the regulations to implement the MMA. The way things work, typically, statutes give kind of broad parameters. They are never very, very specific. Occasionally, but not typically, so what the statute says is kind of up here, and then it's up to the agency in writing the implementing regulations to spell out in greater detail how the statute is going to be implemented, and so the options papers-- when I got here in October of 2004, there was a governance council, and that governance council consisted of representatives of CMS, of HHS, the Department, the OMB the White House, everybody was on that committee-- everybody was represented on that governance council, and that council would meet typically once a week, and options papers were discussed, and then a decision would be made based on the recommendation, if there was one. They might agree to the recommendation or disagree, or whatever, but they then gave direction to the people writing the regulations who then went back, and then the regulation would, in fact, reflect the decisions of that group.

So, you know, there were many, many of those, and I'm not going to remember any specific one right now, but there were probably dozens and dozens of options papers written and discussed at the governance council.

Interviewer 2: Okay, and in this process, where did you find your information? Did you find them inside the agency, or outside?

Both, and that, you know, was basically up to the staff people who were writing the options papers, to get more as much information as they felt they needed. So, depending on the subject. I mean, for example, when we were working on the prescription drug program, we had a tremendous amount of input from doctors, from pharmacists, from the pharmaceutical industry, from consumer advocates, you know, people who-- from-- there are associations that represent every disease group you can think of, and so all of those people had tremendous interest, and they had positions.

So, yeah, I mean, we talked to all of those people and collected information from all of those sources. It was very important in figuring out how to implement that program. I mean, what was happening was, probably the biggest thing that was happening was, millions of people who were getting their prescription drug coverage through the Medicaid program, that is, through the various state programs, were all moved into the federal program, and I'm talking about, like, 6 million people, so that was a lot of people.

So, there was a tremendous amount of research in terms of what those people's needs were, you know, what, typically, their disease categories were, what their prescription drug usage was, and how best to implement the program so that when those people-- you know, it was an overnight transition, December 31st of 2005, they were getting their drugs through the Medicaid program, January 1st, 2006, they were getting their drugs through a totally different program.

The biggest concern we had in implementation was-- and this is very complicated, because remember the program was implemented through private insurance. So, each of those people had to be in a private prescription drug plan, and the records, what plan they were in and so

on, all had to be available, and the concern was, if people went to the drugstore on January 1 of 2006, could they get their medications?

I mean, that was an absolutely life-or-death issue, because you had people who were seriously ill, and they couldn't possibly have any gap in their prescription drug coverage. It was absolutely a life-and-death-- you had all kinds of failsafe systems in place to make sure that people-- that nobody would be in a coverage gap, that everybody was guaranteed that they would get whatever prescription they needed the first day that the program started.

So, it was a huge effort, and it took tremendous collaboration with, as I said, various consumer groups, people who were-- there are people out in the community who work with people in various disease categories, and so on, so it was absolutely critical to work with all those groups, to work with the pharmaceutical industry, and with the local pharmacists, the retail pharmacists, because they were, you know, the public face.

So, all of that was absolutely critical in working through the implementation of that program. Nothing happens in isolation, and nothing happens just within a federal agency. Everything really depends on outreach beyond the federal agency into the world of the public.

Interviewer 2: And did you work sometimes with think tanks?

We did, to some degree, yes, and in truth, think tanks came in for meetings, and yes, we met with various think tanks. The way we work with think tanks is really in terms of what you might be thinking about legislatively for the future, you know, how can your programs be improved, and typically, that comes down to, possibly, changes in legislation or changes in regulation, and so, yeah, think tanks can provide a lot of data. Think tanks do research, and the government contracts with think tanks to do certain research projects. CMS has done some of that, other parts of HHS probably do more of it, you know, AHRQ and organizations like that contract with think tanks a great deal.

Others do granting, they have granting relationships where they give grants to think tanks to do research work for them, so, yes, a lot of that goes on.

Interviewer 2: How do you explain that the government today uses more of the work of think tanks than before?

Well, I don't know that they do. I mean--

Interviewer 2: Because, in the '70s times or in the '60s, there were not so many think tanks, so we can guess that-- but, and today, there are more and more think tanks, so do you think that the government uses more of them, or--

Well, tell me what you mean by "think tanks." I'm taking it broadly as "research organizations," and there are many, many research organizations, and, well, I mean, I can give you a perfectly good example of-- many, many researchers were interested in the Medicaid prescription drug data, and so we went through a whole process here of developing regulations that would make that data available on request, and we have very strict requirements, particularly around patient privacy, for example.

So, any time we release data to a think tank or to any research organization, we have to be absolutely guaranteed that no individual's privacy will be violated, because that is the primary governing rule, that individual privacy is protected, and so organizations that request data from us basically sign agreements that say exactly how they're going to use the data and spell out what the restrictions are, and the restrictions are always around privacy issues and making sure that privacy is protected.

So, we have that in place, and we've always provided data to research organizations on request. This Administration is more open and transparent than others have been in the past, and so more and more data is now just being put out on the websites, and available. It's just there, so that it doesn't-- you don't need to even go through the same request process. So, there has been a big movement just in the last year or so of putting more data out. The concern among staff-- you know, it has always been a concern among staff of-- the staff has no problem of making the data available, the staff just wants to make sure that it's used properly so it isn't misinterpreted, because if you have people who don't understand the data and don't use it properly, then writing reports and issuing press releases, coming to conclusions that may not be accurate, and that may, in fact, be counter-productive in the sense of, you know, may scare people or give them information that's not helpful. That's a concern.

So, there is always the tension between putting as much data as possible out there for anyone who wants to, to use, and making sure that it doesn't get used in such a way that people will be disadvantaged.

So, I mean, when you talk about now and the '70s, you're talking about two different worlds. I mean, we didn't have computers in the '70s, we didn't have the tons and tons of data that we have now. I mean, we collect data on absolutely everything. None of that was available in the '70s. I mean, there was no way that you could really collect that much information without the electronic, you know, capabilities that we have now. So, it's a totally different world.

Interviewer 1: Were there other evolutions since the '70s for the federal administration in its impact on the insurance and health policies? How did the federal administration evolve since the '70s?

Well, that's a really interesting question. The Medicare program was enacted, you know, in 1965, I believe. It covered fewer people, it was-- the whole-- the whole healthcare system was totally different in the '70s. I mean, it's-- it was a whole different world. What happened really was-- I mean, do you know the whole history of health insurance in the United States, and how it started with Blue Cross and, you know, the hospital program?

Interviewer 1: Yes.

It was-- people originally had insurance-- it was catastrophic insurance, it was meant to cover major medical expenses. Nobody had insurance for doctor's visits or for, you know, getting a prescription at a pharmacy. It started out really protecting you, you know, if you had a major hospital bill, and that's how health insurance really started. In the '70s, the HMO Act was enacted, and are you familiar with that?

I mean, that was really the beginning of a whole different approach, which was much more comprehensive, which wanted to manage healthcare and coordinate healthcare in a way that had never been done before, but again, what the HMO Act did was encourage the emergence of private insurers who provided these services. They were not ever provided directly by the government.

So, you had, I mean, just hundreds and hundreds of HMOs emerge, and employers purchased insurance from them, the government did, I mean, I did at OPM for the Federal Employee program, and then you had the whole backlash against it because people didn't really like having their care coordinated. What you had, typically, was quote "gatekeepers," then you had to go to a primary care physician who basically managed your care, and you couldn't get to a specialist without a referral, and so on, and there was a huge backlash against it, and it really kind of fell out of favor, and after that, you had the growth of the PPOs, the Preferred Provider Organizations, which are basically network providers that can go to be a network provider, and pay lower out-of-pocket costs, but they offer people outside of the network at a slightly higher cost, and they don't need referrals and so on.

So, there has been a whole evolution, and none of that has really been dictated by the government. I mean, that has been a private insurance movement. The government basically-- just a few pieces of major legislation. The Federal Employee program came about prior to Medicare, was in existence before the Medicare program, and then the Medicare program was enacted, then the HMO Act was enacted, then the MMA was enacted. These are the major milestones in terms of federal legislation, and now, finally, this new Affordable Care Act.

So, there haven't been that many, really, major federal programs or federal legislative initiatives that have dictated the way healthcare is managed in this country. Medicare is huge, and was huge, because it covered so many people, and because it is more regulated than any other program. Its rates are highly regulated in terms of what providers can be paid, and there are big, huge issues around that.

So, it has had a big influence on the market. In many ways, private employers look to what Medicare does in terms of coverage, so when the Medicare program makes coverage determinations, private employers will very often follow and adopt the same guidelines and so on, so it has a huge, huge influence. There's just no question.

But until the MMA came along, between Medicare and the MMA, the only major legislative initiative was the HMO Act.

Interviewer 1: But, so, what was the evolution of the agencies? The federal agencies? Do they have more power or more impact on policies or implementation, or---

Well, that's hard to say, and it varies from one administration to another, so it's not a straight line, you know, different administrations have had a different perspective on what the federal role should be, and that's basically-- that's how this government works, and I think that's probably how governments work everywhere.

So, I can't say it's a straight line, but, again, as the world changes, federal policy changes. There is clearly so much more information available now, and so much more information out there in a very public way, and, you know, just recently, looking at all of the social media,

and just the fact that if somebody posts something on Facebook, millions and millions of people are becoming aware of it.

So, federal agencies, I think, are reacting more and more to all the information that's out there and what the public response is, and it just seems obvious to me, I don't deal with it directly, but, for example, the FDA has become, I think, much more assertive in its role in terms of protecting people against, you know, food poisoning.

The various incidents that there have been-- there's an alfalfa salmonella incident that's going on right now, but those things are public in the way they never used to be, because everybody goes on the Internet and the information is available instantly to millions and millions of people, so you get more of a push on federal agencies to say, "Well, why aren't we doing something about that?"

So, as the society evolves, as the electronic media evolve, as the-- more people are more tuned in to more and more sources of information, that has an impact on federal agencies, and how they respond, what the expectations are.

Interviewer 1: I was asking the question because we met last week with someone that told us that the federal administration had more power on decision-making in the '80s than now.

In what area?

Interviewer 1: In what area? Someone from the HFCA. We don't speak about the specific area.

I don't know what to make of it. I don't know what they're talking about, so, without knowing more specifically what they had in mind, I don't know what-- I have no idea.

Interviewer 1: The idea was that the White House decides on health more than the (inaudible).

Oh, okay, I see what they're saying. They're saying that they think that there's more control from the White House. Well, that's interesting. Again, that varies from one administration to another. In my experience, it really-- the difference has been what program I was dealing with. In the Federal Employees program, for example, both the White House took much less of a direct interest in that program, so OPM, the agency, had a lot more autonomy, because it was a smaller program, there's less money involved, and so on.

The Medicare program is always very political, very visible, and nothing happens in the Medicare program without approval from OMB, and OMB is the voice of the White House, so, I mean, that's basically the way it happens. Every regulation is approved by OMB. Although our regulations are approved by OMB at FEHB as well, but there's just less visibility, because it's a smaller program.

When you talk about the Medicare program, it's probably one of the most highly-political, highly-visible programs in the country. So, again, it really depends on who is on staff in the White House. This administration has certainly had a huge interest because, almost from day

one, they wanted to move healthcare reform, and yes, they have been very, very much involved, because everything they did was gearing up to trying to pass the legislation.

Interviewer 2: What's the impact of this involvement on your agency?

Well, again, decisions-- I think-- it's not as extreme as whoever you're talking to says. Under the previous administration, we always had so-called "principal's meetings." In other words, the people at CMS, which was my agency, before we moved forward with anything of any significance, met with representatives from the Department, and needed to get the Department's approval before it moved to OMB, and then needed to get OMB's approval.

So, those procedures were-- have always been in place. They're not new with this administration, they have been in place for as long as I have been in the federal government. Every administration wants to, from a policy perspective, have some control over how the agencies, which are part of the Executive Branch, function. So, it's not as extreme as you're hearing.

On the other hand, because of gearing up for healthcare reform, there are committees at the White House itself in this administration that didn't exist before, but they were really much more related to the legislation, and getting the legislation enacted, and now getting the legislation implemented, so, yeah, I mean, it was just tremendous, tremendous activity. Much, much more, even, than with the MMA, because the Medicare Modernization Act was, again, still limited to Medicare, and although that's very big, it's not as big as national healthcare reform, so what this administration is undertaking is just much, much bigger, and has much broader reach, so, yes, much, much more politically involved.

Interviewer 1: And is there a difference in your day-to-day work when there is a Republican government or a Democrat one. Can we make a generalization about that?

You can probably-- again, it's just a weighing in the balance. Republican administrations, you know, at least the Reagan Administration, it's hard to say, there were big differences between the Reagan Administration and the first Bush Administration, for example, and they were both Republican administrations, but--

Interviewer 1: In what ways?

Just different relative to the point-- at the time I wasn't at HHS, but just in terms of the approach to federal employees and benefits for federal employees, there was a huge difference. The Reagan Administration was-- let's say this tactfully, less concerned about the interest of federal employees. Reagan kind of ran as an anti-government president. His approach was less government, government is the enemy, and so that had an impact on the attitude toward federal employees.

The first President Bush, although he was a Republican, had a totally different attitude. He had been a career federal service person, he ran the CIA, and his appointees just worked much more collaboratively with the federal employees. They just tried a whole different attitude. They weren't anti-government, and so although they were both Republican administrations, working with them was very different.

The Clinton Administration, again, I mean, I was on Hillary Clinton's original healthcare reform task force back in '93. You know, they made the big effort to try to do national health reform, and it, of course, failed, so after that, it just all sort of died, but it was kind of-- there were not major differences between the first Bush Administration and the Clinton Administration, it was a pretty smooth transition.

The second Bush Administration they passed the MMA and that was a major political controversy. I think, probably, the goals were similar in terms of giving more benefits to Medicare beneficiaries, particularly prescription drug benefits. The disagreement, always, between the parties, is what's the best way to do that. The Democrats would have had a single, national program that looked more like Medicare, and the Republicans wanted a private-sector program, and that's what they enacted, so that coverage under the Medicare prescription drug program is all through private insurers, rather than a single-payer government agency like Medicare.

So, you know, there are just those differences-- philosophical differences as you go from one administration to another. Both administrations, the Bush Administration and this administration have listened to consumers, but I would say that probably more weight is given to the consumer perspective in the Obama Administration. Probably more weight is given to the industry's perspective in the Bush Administration.

So, you know, what happens within the agency reflects the philosophy of what the parties are and which party happens to be in power.

Interviewer 1: Yeah, because I met someone yesterday morning, and he told me that when the government is Democrat, your government can come with a lot of experts and relation in the academic sense, but-- and when the Republican is in place-- are in place, they not have so many experts, so they rely more on the (inaudible) than the Democrats.

I'm not sure that's true. I am really not. You know, everybody sees things from their own perspective, and I'm really not sure that's true. I think that's-- that's really an interesting comment. Certainly, if you look at Mark McClellan, he was a highly recognized academician, and had all kinds of contacts with people in the academic world, and was highly respected in that world, so, you know, and he was the administrator of CMS under a Republican administration.

So, I think what people are telling you is that's there particular, individual experience, and I don't think that it would be wise to generalize, and say that the whole government operates the way that person happened to have experienced it.

Interviewer 2: You said at the beginning that Mark McClellan was very interested in the Federal Employees program?

Yes, because he saw it as a model for the way that the prescription drug program would operate, because it was a program where the federal government contracted with private insurers in order to provide the coverage.

Interviewer 2: I think other people have been very interested in this program, for (inaudible).

Which program?

Interviewer 2: The Federal Employees--

Yes, it has always been held up as a model, yes, absolutely.

Interviewer 2: So, are you often being asked by other people about this program, since you know it very well, I guess--

Yeah, I mean, I'm asked by reporters about it, I've been asked by Congress about it, been asked by various individuals and done briefings and so on, but the idea, really, and again, even in the-- back to the Hillary Clinton health reform task force, it was considered something of a model even then, even though, under the thinking of that group, it was going to go away, they were going to abolish the program, interestingly enough, originally, because they-- it was just their opinion that there was no way that you could tell the general public that the President and members of Congress and federal employees were going to have a different kind of health coverage than they were going to have.

So, there was a sense that, from a political perspective, the program had to be abolished, but Congress didn't agree, so that wasn't going to happen. Yeah, I mean, because the tension, as I'm sure you know, is between the people who would like to see a single-payer type of approach, as some European countries have, certainly not all, and the kind of approach that the FEHB program is really a model for, which is a government program, but a program where the government actually contracts with private insurers to provide the services.

So, the people who prefer that model always point to the Federal Employee program, and say, well, "That's really the way it should work," and that's based on the assumption that, because there is competition in the program, because federal employees can choose among many different providers, that that helps to keep rates competitive, premiums competitive and benefits competitive and so forth.

Interviewer 1: Well, I'm okay.

Interviewer 2: Yeah, I have a question, maybe a very general question, but, I was wondering-- it's a question about the political appointees. So, because I think that now the-- when the administration changes, the political appointees also go to other organizations outside the (inaudible) from (inaudible), and I was wondering, how did they do before, in the '60s or in the '70s when there were not so many organizations? Where did they go?

Or, they also-- there have always been lobbyists, and there has always been law firms. Many people, many political appointees, and certainly many Congressional staff are lawyers, and members of Congress are lawyers, and so they just been to law firms, and there have always been lobbying firms in Washington, so, I guess, you know, it's an interesting question, and I truly don't know what happened in the '60s or '70s, I wasn't in a position to know.

I find it amusing now, because my own perception now is, nobody ever leaves Washington, so, if people are out of office because they don't get re-elected or they don't get re-appointed

because of a change of party, probably-- I mean, obviously, some people leave, but the vast majority of people, yes, just get absorbed into the Washington establishment, and I'm sure, and I don't have the data, I'm sure you can find it, the number of organizations of-- and it's not just think tanks, it's-- there are firms that are dedicated exclusively to lobbying, and there are many, many law firms that are dedicated to both practicing law and lobbying, and probably those numbers, over the years, have grown. I'm sure they have.

I'm sure there is data somewhere that could probably give you information. So, I don't know, maybe in the '60s or '70s, more people went home, so I don't know.

Interviewer 1: Just, maybe, last question, very last one, so, now, you know, you know our questions. Who do you think we should contact?

Well, have you-- you've been talking to people in other agencies in HHS?

Interviewer 1: Some agencies like the HFCA, the (inaudible), trying to remember. Very few people in the department.

I think you probably should talk to other agencies within HHS and-- there is AHRQ, there is NIH, there is CDC, there is HRSA--

Interviewer 1: This is HRSA, where we are today.

So, there are many agencies within the Department. There's the FDA. Most of them are probably in the Rockville area. They seem to be situated pretty much in that area. They will have different perspectives. They have different missions, and they will have different perspectives, and it would probably be interesting to talk to people in those different agencies.

Interviewer 2: Okay.

Interviewer 1: Okay, so thank you very much for your time.

Interviewer 2: Thank you very much.

(inaudible).