Interview with Shelia Burke

Washington, D.C. on September 19, 2002
Interviewed by Edward Berkowitz

BERKOWITZ: September 19th and I am here in the Castle Building of Smithsonian Institution with Sheila Burke who is the undersecretary of the Smithsonian. And I wanted to ask you about your career before you were the undersecretary of the Smithsonian. And I know that you have a long association with Robert Dole.

BURKE: Yes.

BERKOWITZ: And I know he was involved in the Finance Committee, as were you. So I was wondering how that all started.

BURKE: Of course.

BERKOWITZ: How did you come to Washington?

BURKE: I came to Washington in 1977 and I was hired to be a legislative assistant for Dole. I had come to know people in Washington because I was working with the student nurses. I am a nurse by training and practice and had been quite active in the student association and had gone to work for them and handled student rights and government relations. They were concerned with issues like Title 7 funding and things of that nature. When approached about a job in Senator Dole's office, I was intrigued and interested in considering a change in jobs. At the same time, I was thinking about going home to California to graduate school but people here in D.C. that I had come to know said, "You ought to interview with Dole. He's looking for a health person." I had no clue who Dole was. I was born and raised in San Francisco, in a liberal Democratic family. No clue who he was, paid no particular attention to him. I generally voted Democratic in all elections, so he hadn't been someone I had really heard of in the past.

However, I thought it would be interesting to come to D.C. for a year. I came down from New York, I interviewed with him, and he said he didn't care if I was a Democrat or a Republican, he wanted somebody who had been a provider, who had actually taken care of patients.

At the time, he was a junior member of the Senate Finance Committee. Russell Long (D-Louisiana) was chairman. Carl Curtis (R-Nebraska) was the ranking Republican. Dole was about fourth down in seniority but he was

the—he was the ranking Republican on the health subcommittee with Herman Talmadge (D-Georgia) as the chairman.

At the time, I didn't know a great deal about the Medicare and Medicaid laws—hadn't been particularly involved. But Jim Mongan, a physician, was on the committee staff at the time. Senator Dole felt strongly that he wanted the Republicans similarly to have someone with a health background. As a side note, Jim, who became a good friend, is now the head of Partners, a major health plan in Massachusetts. He went on to do some wonderful things after he left the Committee. And so I went to work for Dole, given all of that, and remained with him for almost 20 years. I was on the personal staff with him for six months and he then surprisingly became the ranking Republican on the full committee because all the Senators senior to him—Cliff Hansen (R-Wyoming) and Carl Curtis—chose to retire.

And so he moved up to become the ranking Republican on the Senate Finance Committee, ultimately becoming chairman when the Senate went Republican. I began with Dole doing health policy and moved to the Finance Committee with him, ultimately becoming deputy staff director of Senate Finance, and ultimately oversaw the staff responsible for all the social welfare programs in the Committee's jurisdiction. But my primary interest and issues were largely Medicare, Medicaid, maternal and child health, all the health care financing issues. I went to the leader's office when he became leader in 1985 and became chief of staff in 1986 where I remained for 10 years until he left the Senate in 1996. I really had a great view of the Senate having served on a personal staff, a committee staff and then the leadership. So that's what got me there.

BERKOWITZ: And Dole was the head of the Finance Committee from 1981?

BURKE: That's correct. He became the ranking Republican in 1978 and then chairman when the Senate went Republican in 1981. That's exactly right.

BERKOWITZ: So from 1981–1985 you were on the majority staff of the Senate Finance Committee?

BURKE: Yes.

BERKOWITZ: Okay, let me ask you a question about that then. The other person I know that worked for Dole in this field is Carolyn Weaver.

BURKE: Yes. She handled Social Security. She would have joined Dole's staff after he went to Finance. And so it would have been—it would have been in the early '80s would be my guess when Carolyn came on board, because she was there when we did the 1983 Social Security reform.

BERKOWITZ: She strikes me as kind of a different person. I mean in the sense that she really is ideological and so on.

BURKE: And academic.

BERKOWITZ: So the Senator had both on his staff.

BURKE: He did. I perhaps was the most moderate of his staff. I was probably certainly the only Democrat at the time. Many of his other staff were in fact far more conservative. But it varied.

When I first went on his personal staff, there was a woman who handled welfare and food stamps for him who ultimately helped negotiate the original food stamps legislation with Senator McGovern (D-South Dakota). Mary Wheat. So Mary was from Kansas, a wonderful woman and also something of a moderate. Dole has a history of having kind of a mixed staff, which I think is to his credit.

I mean, I think he surrounded himself with people of lots of different backgrounds, which was quite good. But you're absolutely right. Carolyn and I were certainly ideologically very different and had very different backgrounds. She was clearly an academic where I was trained as a nurse.

BERKOWITZ: And Dole also has a reputation of being a very competent senator with a competent staff.

BURKE: He is.

BERKOWITZ: And I know in 1983 he was actually on the Social Security rescue commission.

BURKE: Yes, he was.

BERKOWITZ: —that did the Social Security reform and was considered a very key player by the White House and by the House leadership.

BURKE: Well, he and Moynihan I think at the end of the day, you know, I think both had an enormous impact on what we were able to do. And I think it was because of their standing with their colleagues that people were able to ultimately work out an agreement.

BERKOWITZ: And I know that Robert Ball has a lot of respect for Dole.

BURKE: Yes, yes.

BERKOWITZ: Which is not true of all Republicans.

BURKE: Dole certainly held Bob Ball in high regard. There are a lot of, I think, good feelings between the two of them.

BERKOWITZ: So I know you were involved in DRG legislation—

BURKE: Yes.

BERKOWITZ: —which was part of the package in 1983 for the Social Security reform.

BURKE: Yes.

BERKOWITZ: Do you have any memories of the start of Diagnosis Related Groups that come to mind?

BURKE: Oh, vivid.

BERKOWITZ: One of the questions, of course, is how it got to be put onto that legislation.

BURKE: We were driven by what vehicles were available. I mean, one of the challenges for Finance was always waiting for a tax vehicle or waiting for some vehicle out of the House that would allow us to move these things forward. The Medicare program began to experience difficulties almost right after it was created in terms of far exceeding anyone's expectations in utilization and cost. And so even as early as '67 and '68 we began to see some real tensions around the financing of the program.

One of the things certainly that we began to see in the late '70s was this rapid escalation in health care costs. And there was a real interest, particularly on the hospital side, because that was the biggest piece of the program, trying to get a handle on what we ought to be doing. The program had been historically based on a sort of Blue Cross/Blue Shield model or Aetna model, which essentially involved having us pay costs. And what we began to see was, not surprisingly, behaviors that reflected the fact that the more you did, the more you got reimbursed. There were also huge variations in cost depending on where you were in the country. We began to look seriously at ways of paying that created incentives for cost reductions and created uniformity based on what you were doing, rather than where you were.

There were real issues around whether or not this formula, this essentially 300+—or whatever it was categories, would allow us to begin to get some control on what was a serious cost issue but also this increasing awareness of the disparity, the differences in care between the different parts of the country. The work that Jack Wennberg had done out at Dartmouth and a

variety of others had begun to look at ways to begin to address these issues. We had already moved from cost-based reimbursement to the 223 system which paid people basically on the size of the institution.

The question was whether we could begin to translate this experience into something different. The sense was the DRGs held the promise of beginning to put some discipline into the program and also allowed us to begin to look at things in a more consistent way. So that was what got us to moving in that direction. Having said that, it was not a simple process. I mean, there were an enormous range of issues that had to be dealt with, not the least of which were the beginning of an understanding of the differences in institutional settings and what impact that had on utilization, what you could distinguish between a teaching hospital and a non-teaching hospital and how you looked at outliers.

When you looked at behaviors, where were the extremes? It's sort of the low end and the high end. How did you adjust for those? Originally we constructed both a cost and a day outlier so that you had some way to deal with the fact that there were some cases that were just, you know way out of sync. The acknowledgment of the graduate medical education issues, the fact that it presented and resulted in additional costs because of the presence of interns, and the acknowledgment that that was something we felt was important for us to continue to finance through Medicare. So all of those things began to spill out of the conversations around DRGs. There were all the sort of weird little, you know, carve-outs. You know, you wanted to carve out a particular county or how accurately we were in being able adjust for labor costs, you know, what were the input prices? And today many of the same questions remain. I sit on MEDPAC and we are still struggling to try and figure out what it is that we know and whether we can do a better job and refine it. But it was the earliest attempt to try and get at volume as well as cost issues.

BERKOWITZ: MEDPAC stands for—?

BURKE: The Medicare Payment Advisory Commission.

BERKOWITZ: Okay. So it was all very technical, this stuff about DRGs—

BURKE: Yes, yes.

BERKOWITZ: —and so on. At what level did someone like Senator Dole engage this discussion?

BURKE: Well, the members at the time were less involved in what is in fact a remarkably technical issue—they were really more involved in setting the

basic policies and examining the impact of any shift in payments. It was a conceptual argument in the sense that they wanted to try to get a handle on costs, and they wanted to make more sense out of how we paid. Why should it cost you differently and why should length of stay be different in Los Angeles than it is in Chicago or Miami or New York?

So the members really looked at it at that level, whereas the staff were buried in the unbelievable details. Brian Luce, who was at the department at the time, was critical to our efforts and I remember fondly to this day the hours we spent at the Finance Committee around the table with bags of M&Ms as we tried to figure out all these weird little things. Like: What do you do about carve-outs? What do you do about lengths of stay? What do you do about hospitals that are atypical in your service mix, rehab hospitals, for example, children's hospitals? Of course, the decision was to pull them out. But all of those things had to be done and much of it was done with the members having a great say conceptually but with the staff really having to sort out the details. Now, that has begun to change and you see members getting more involved in sort of the minutiae, you know, carving out particular hospitals, districts, all those kinds of issues. But as a general matter, the interesting [thing] about Finance is that they are confronted with extraordinarily complicated topics from tax to trade and Social Security to Medicare. And the social welfare stuff is sometimes a little overwhelming in the sense of their not particularly wanting to get involved in the minutiae. They just want to know how it's going to work and who is it going to affect.

BERKOWITZ: And it's also not clear to me that there's an obvious Republican and Democratic point. I can see that there would be a point of view—

BURKE: There wasn't. And it's a very interesting point that you raise. There is to the extent that you get into the big fights over social welfare financing and things of that nature where you do have ideological differences. But when it comes down to sort of the figuring out many of these kinds of issues that faced us regarding how to pay for services, it is rare that it is a partisan issue. Now, drug coverage, though, in the current debate is obviously one issue that has become highly politicized. But as a general matter, we found that the staffs worked very closely both on a bicameral as well as a bipartisan basis, where you were sort of given a puzzle and the issue is to solve the puzzle. Everybody would sit around and solve the puzzle. You didn't have the kind of politics of R's and D's that you would see around Medicaid or welfare or some of the other issues.

BERKOWITZ: And Social Security.

BURKE: Social Security is known as the 3rd rail of politics. Battles over funding and benefits certainly get partisan at times.

BERKOWITZ: Right. So let me get then to this other thing I have been asked to look into a little bit, which is the Medicare Catastrophic Coverage Act of 1988. By then you were not at Finance, right?

BURKE: I was the chief of staff to the majority leader.

BERKOWITZ: But you must have heard buzz about this.

BURKE: Oh, Dole was still on the Finance Committee, as was Senator Mitchell (D-Maine), the Democrats leader. Dole and Mitchell were both sitting on the committee and they were both leaders. And so it wasn't that we heard inklings, we were smack in the middle of it.

BERKOWITZ: And who had your job on the Finance Committee at that point?

BURKE: Probably—that's a good question. Ed Mihalski or Julie James. I don't recall who it was, actually.

BERKOWITZ: And this would have been after 1986.

BURKE: This was '88'.

BERKOWITZ: So the Republicans are a minority now.

BURKE: Julie James might have been there. Ed Mihalski replaced me at Finance when Packwood became chair and then ranking. So it would have been Packwood, so it probably was—Julie James, Ed Mihalski would be my guess.

BERKOWITZ: And how does Ed Mihalski spell his name?

BURKE: M-I-H-A-L-S-K-I. He's currently at Lilly. Ed was my deputy. And so when Dole went to the leadership, Packwood became chair or ranking and Ed remained and ultimately became staff director and did the health stuff. Julie James was there. I don't honestly remember who specifically in '88, but those people were likely involved.

BERKOWITZ: So in 1988 as this catastrophic legislation takes shape, it starts out, as far as I understand, in the Reagan administration.

BURKE: Yes, it does. Secretary Otis Bowen and his assistant Tom Burke.

BERKOWITZ: Is Otis Bowen alive, by the way?

BURKE: I don't know, actually. It's a good question. I don't have a clue.

BERKOWITZ: You haven't seen him?

BURKE: No, no, not in years. I don't think I have seen him since he left.

BERKOWITZ: When he left Washington he kind of left Washington.

BURKE: Yes.

BERKOWITZ: I see.

BURKE: Yes.

BERKOWITZ: And Tom Burke is dead.

BURKE: Is he?

BERKOWITZ: I think so.

BURKE: I don't know, actually.

BERKOWITZ: Maybe I'm just assuming but I think. At any rate, what kind of stuff were you picking up about this?

BURKE: Well, health care was not high on the Reagan agenda. I mean, it was a topic that they didn't have any particular interest in getting in the middle of. And there was some sensitivity on, I think, Republicans' parts that it really was second tier in terms of the White House. I think they were tied up at the time—and I may have my dates off a little bit—but I think they were—Iran-Contra was maybe around that time, so they were certainly distracted. And I think Bowen had decided this was going to be kind of his issue. He described at the time the history his wife had had and the challenges they had had in terms of her illness. He kind of took the bull by the horns without any great interest or involvement on the part of the White House, at least that's how it's reported, and he decided to kind of move this forward. And no one sort of checked him in the sense of saying no. And then what occurred was what you would have expected to have occurred, which is the opportunity presented itself for a Medicare bill with a lot of things that had been sort of held in abeyance and waiting for an opportunity.

BERKOWITZ: It's like 1983 again.

BURKE: Exactly. And it just became something of a free for all in terms of everyone trying to get involved and get a piece of the action. There then, as you might imagine, ensued a whole series of negotiations over what people

would support. And everyone took the opportunity to add on the things that they cared most deeply about.

There was also, of course, all the issues around financing and how one would add a new benefit. And, you know, when the White House finally got involved the sort of sensitivity to what this would do in terms of the trust fund, but also in terms of finances generally. And so we began with these sort of convoluted series of attempts to try and create a financing mechanism. In retrospect, the mistakes that were made across the board are legendary in terms of judgment calls—who was involved, who wasn't, the AARP getting involved and kind of buying in and, not bringing anybody with them, the Roosevelt group that sort of came up out of nowhere and this became their cause celebre. But it was clearly originally initiated by Otis Bowen and largely ignored in the Reagan White House and spun out of control pretty quickly.

BERKOWITZ: How did Dole feel about the sort of Christmas tree aspect of the bill?

BURKE: Well, it wasn't terribly unusual and we tended to find this kind of thing with Medicare.

BERKOWITZ: That was 1988.

BURKE: Yes.

BERKOWITZ: So it was worse than 1983 in the sense it was an election year.

BURKE: Again, you had come to kind of expect that around these issues. We had begun sort of looking at and experiencing, you know, what started out as TEFRA and DEFRA and then OBRA and then COBRA, and then you had this whole series of reconciliation bills, so this lumping together of all sorts of stuff. And really during that period of time most Medicare legislation had been reconciliation-related, so everything was sort of constructed around the budget. This was the first sort of break loose is my sort of vague recollection. And so everybody saw it as a shot at, you know, moving ahead on their agenda.

BERKOWITZ: Was prescription drugs on Senator Dole's agenda or something he proposed?

BURKE: It was an issue that people had raised. And obviously it had been of concern even then in terms of the exposure of the elderly. And we began to see the pattern of their out-of-pocket expenses being driven largely by

pharmaceuticals except where they were covered by Medicaid. You knew this was a big issue.

It was also an issue, even at the time, that we all struggled with in terms of cost. And even then, the inability to do any reasonable cost estimates with any kind of predictability of what the actual utilization would be had everybody terrified in terms of what the exposure was to be. It's certainly one that, we struggle with even today trying to figure out how the hell will this—much will it really cost? What will people do? How do you finance it? What do you do with the Medicare program generally?

BERKOWITZ: What is your feeling about the CBO (Congressional Budget Office) in debates like this? Do you think they were partisan in the sense that it makes a difference that the Democrats were in control and that changed estimates.

BURKE: At the time?

BERKOWITZ: If the Republicans had been in control, estimates would have been different. Or is that not true?

BURKE: You know, I think it ebbs and flows. It depends on the leadership at OMB, or CBO rather. You know, I think there have been times when they have been more partisan than others. There are a lot of people who think that CBO was unreasonable—was unfair during health care reform. I think Bob did exactly what he should have done. I think people worked damned hard at being—at being balanced. You know, it would be too simple to simply blame it on partisan politics. I just don't believe that. I mean, I think there are fundamental differences in estimating and fundamental differences in philosophy about utilization and all the things that impact on cost estimates.

It was clearly a big issue at the time in terms of how people cost things out between CBO and HHS (the Department of Health and Human Services). But, you know, as a general matter I think they do try to be honest. There are exceptions to that we could all find. But I don't—I don't instinctively think they are, you know, the cause of all evil.

BERKOWITZ: So basically people just don't know what's going to happen when there's a prescription drug benefit put in?

BURKE: No, no. You don't know today.

BERKOWITZ: Right.

BURKE: I mean, we're spending huge amounts of time and assets trying to figure it out and the cost estimates are—you know, today it's 300, tomorrow it's 600.

BERKOWITZ: Right. A little bit like the disability rolls, isn't it?

BURKE: Yes

BERKOWITZ: Very volatile and affected by lots of things you can't predict.

BURKE: You just don't know what kind of demands you're going to create. There's just no way to know with any real certainty.

BERKOWITZ: Right. Let me try one more idea on you. Then I'll ask you about the repeal. One thing that occurred to me is that this was a field of very technical—as you say, it was all done in these reconciliation acts, very hard to explain.

BURKE: Uh-huh.

BERKOWITZ: And they would say things like we want to get at this to be so that they are getting, you know, so much here, so much there, so much in academic...

BURKE: Right.

BERKOWITZ: But when the actual legislation, quite complex to get—

BURKE: Right.

BERKOWITZ: —at that idea so that when they started tinkering with the financing for this catastrophic thing, it was in that tradition. It was looking at numbers and spreadsheets and therefore, their political sensibilities were dulled in some sense.

BURKE: Yes, in some sense. I mean, I can also give you examples. I remember vividly the conversation before the Finance Committee about the coverage of mycotic toenails, which the members became quite involved in.

BERKOWITZ: Really?

BURKE: So it really—I mean, we can all think of ridiculous examples. In the context of catastrophic, the members really were looking at the big picture issues. And, you know, they were certainly sensitive to wanting to go home with having done something, having moved something ahead. A number of them were concerned about the increasing concerns about the elderly and

out-of-pocket expenses and being impoverished. So I think it's not that they were uncaring about the broad question or picture. But they did tend not to get involved in the minutiae to a large extent, although there were members who did.

The exceptions are people like Dave Durenberger, who used to throw himself into minutiae, you know. So there are exceptions to that rule. But as a general matter, the members look at these in sort of broad context. Does it do something for my constituents? How much is it going to cost? Can we afford it? And then they basically say work out how you're going to finance it. The concept though that the members did agree to, which was critical in catastrophic, was that it would be a shared financing, that it was not going to be a new entitlement in the sense of a fully financed federal benefit. And that was a conscious decision. So they didn't come upon that as a surprise. I mean, they didn't suddenly wake up and go, "Oh, my gosh. There's a premium involved here?" I mean, that was clearly a policy decision. So—and that's generally how it goes, or did at least when I was there, was you would get a policy direction and then you would be sent off to try and figure out how to achieve it.

BERKOWITZ: But is there a difference in the sense that if you do a DRG formula you are going to have quick feed-back from the health care providers but whereas with something like the Catastrophic Act the situation is a little more diffuse?

BURKE: Well, it is and it isn't. We found out pretty quickly that it wasn't, that Roosevelt was able to successfully get everybody to be terrified about what their exposure would be. We found with health care reform that, you know, the Harry and Louise stirred up everybody's anxieties about what they were going to lose.

So, you know, members do follow those kinds of things. And notwithstanding the minutiae of how you draft it, they followed the sort of general trends and—

BERKOWITZ: I guess the point I was kind of probing here is that for something like whether there should be a DRG for rehabilitation you can talk to people inside the Beltway and so on. Whereas in this case, as with general health care, when it's a big diffuse thing, it's going to affect both sides. There's not that same communication.

BURKE: Yes. That's correct.

BERKOWITZ: It's not so discrete.

BURKE: There isn't the clarity.

BERKOWITZ: Yes.

BURKE: There isn't the kind of clarity in people's views. And it was clear that this was quite diffuse in terms of people's knowledge and understanding. Obviously, in retrospect we realized that there was no real comprehension of what was occurring. It's much more difficult to get a consensus around what it is that people want you to do.

BERKOWITZ: Right. And so how did you begin to hear about concerns over the Catastrophic Act—this is now 1989, I guess—after late 1988. Did you begin to get letters in Senator Dole's office?

BURKE: Yes, we did slowly begin to get some letters. It was really the members themselves that began to hear it when they went home. John McCain (R-Arizona) obviously was critical in that. And really, it is McCain who began to stir the fires and who had heard from his constituents. And we began to hear from constituents as well as the news went out about what was going on and the fact that there was going to be a cost. AARP hadn't really inoculated us. I mean, they hadn't gotten their troops all signed up. So it was that you began to see an action, you know, sort of the dance of legislation that the public sort of responded, and said, "What is this?" And it was the absence of clarity, the absence of information that helped bring it down. We hadn't bought in key constituencies and that let the Roosevelt group basically drive the agenda.

BERKOWITZ: And you are talking about James Roosevelt—

BURKE: Yes.

BERKOWITZ: —and his organization—

BURKE: Yes.

BERKOWITZ: —to save Social Security or whatever it was called.

BURKE: Whatever it was at the time, right. Martha McSteen was involved.

BERKOWITZ: And she must have been somebody that Senator Dole knew or had known when she was Commissioner of Social Security.

BURKE: Very well. You bet.

BERKOWITZ: And was not considered a kook.

BURKE: No, no, no, not at all. I mean, these guys were all caught by surprise at the vehemence of the response. I mean, you know, the sort of vision we all had of (Congressman Dan) Rostenkowski being chased down the street.

BERKOWITZ: I think it was August of 1989

BURKE: Yes. It was just horrible. Nobody wanted to have that happen when they were home greeting constituents. What you began to hear as early as that spring was that things were beginning to heat up. And McCain and others were really beginning to push hard to try and deal with it.

BERKOWITZ: So did the leadership make an explicit decision: Okay, we're going to let this thing go? Or was there a period of saying, well, no, why don't we try to finesse it, save it in some way or—

BURKE: You mean when the ultimate vote was taken?

BERKOWITZ: As this thing played it out over 1989 there were a couple of kind of iterations of it.

BURKE: Yes, there were.

BERKOWITZ: Perhaps some people thought that maybe we should change the financing.

BURKE: I think early on there were attempts to try and keep it alive, but the view was that it really would help some people, that it was salvageable. It became clear over time that it just wasn't, that we weren't going to be able to work out anything with McCain that he was satisfied with or that the groups were satisfied with in terms of an alternative financing. But it clearly built up over time, and it was in some ways not unlike health care reform in that having delivered the message and having done so on a fairly free and open environment in the sense that the proponents weren't positioned to really deal with the opponents' statements, claims, public relations, and were caught basically on a reactive mode rather than having anticipated it and sort of laid the groundwork for people to accept this method of financing in exchange for a benefit. You had a scenario where essentially we were playing catch-up. You know, they were out there. They had delivered the message. And people's instincts were to believe the message that they were going to be disadvantaged.

BERKOWITZ: If the timing had been different and instead of President Bush there was President Reagan still, would that have changed things? Would the White House have then said, "No, we've got to keep this. We did this"?

BURKE: No, I'm not sure it would have. I think the White House at that point would have loved to have gotten rid of it as well. Certainly it wasn't Bush's problem when Bush came. I mean, it was something that had begun in the Reagan administration. I don't think you can assume that because it was a transition to Bush that it was disadvantaged. I don't think we know the answer to that. But it certainly wasn't on Bush's list.

BERKOWITZ: So let me ask you one last question. You had been in these high-level meetings on Medicare policy and in Washington things more generally. Do people talk about this still, say, "Gee, this catastrophic shows we can't do X or Y or Z?"

BURKE: Oh, yes. It has a tail that's unbelievable. Not as strong as it once was, and part of it's kind of been replaced by health care reform. It became the new disaster. But catastrophic is still regarded with some awe because of the speed with which the reversal occurred. I mean, Christ, it takes us that long to pass a bill, let alone to pass it and reverse it. It's just unheard of, the complete absence of a strategy that would have anticipated and dealt with the issues that arose.
There are still lessons that catastrophic taught us. But I think health care reform is probably the more recent example of a similar kind of response .

BERKOWITZ: Good. Thank you very much.

BURKE: You're very welcome.

###