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FEDERAL HEALTH POLICY: AN INTERVIEW WITH KATHLEEN SEBELIUS, 21ST SECRETARY, US DEPARTMENT OF HEALTH AND HUMAN SERVICES

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LIST OF PARTICIPANTS

KATHLEEN SEBELIUS
CEO, Sebelius Resources; 21st Secretary, US Department of Health and Human Services

JUDY WOODRUFF
Managing Editor and Anchor, "*PBS NewsHour*"

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FEDERAL HEALTH POLICY: AN INTERVIEW WITH KATHLEEN SEBELIUS, 21ST SECRETARY, US DEPARTMENT OF HEALTH AND HUMAN SERVICES

(3:30 p.m.)

MS. KATZ: Good afternoon, everybody. Could I ask those that are straggling in to come on in and take a seat? I am Ruth Katz, director of the Health, Medicine and Society Program here at the Aspen Institute, which is a co-producer of Spotlight Health. We are delighted to be back for a fourth year and we're delighted to have all of you here.

This is actually one of our very first sessions -- we don't officially start until five o'clock -- so we're delighted that all of you have come early for what we think is a very, very special session.

The interview is with the 21st secretary of Department of Health and Human Services, Kathleen Sebelius. And conducting the interview is actually someone who needs no introduction, Judy Woodruff, who is the managing editor and anchor of the *PBS NewsHour*. I just reminded Judy she has been here before. We missed you last year. It's great to have you back -- we're very excited and especially since this year Spotlight Health, in particular the Health, Medicine and Society Program is working very closely with the *NewsHour* on developing --

MS. WOODRUFF: That's right.

MS. KATZ: -- some programming through Spotlight Health that hopefully will appear on the *NewHour*. So thank you --

MS. WOODRUFF: Sure.

MS. KATZ: -- for being here. And with that, I will turn over the session to Judy Woodruff.

MS. WOODRUFF: Thank you, Ruth.

(Applause)

MS. WOODRUFF: I was just going to say the two women who actually need no introduction are Ruth Katz and Kathleen Sebelius.

MS. KATZ: Are they?

MS. WOODRUFF: We know who you guys are. And it's really a treat to be back at Aspen. As Ruth said, I did miss last year and I really did miss not being here. But it is great to be back at another Spotlight conference, where you bring together so many interesting and smart and the people who are really at the center of what's happening in this country and internationally when it comes to health issues.

And, you know, I have to hand it to the Aspen Institute, to Ruth -- I don't know whether we give you the credit. But the timing of today's session --

(Laughter)

MS. WOODRUFF: -- I'll give you credit. She stood up and said she planned it. But I mean what -- I can't think of any other day that would have been the right -- a better time to talk about the Affordable Care Act than the day that, as all of you know, the Senate Republicans did unveil their version of the overhaul of the Affordable Care Act a couple of months after the House passed its version.

So we now have a chance to compare the two and to talk about what they do versus what Obamacare. And who better -- speaking of who better and what better -- to talk about the Affordable Care Act than the woman who was at the center of debate and discussion and all the figuring out that took place when the Obama administration unveiled Obamacare and fought for it as it moved through the Congress and then was of course front and center as it became known as Obamacare was rolled out.

And that is of course Kathleen Sebelius. You all recognize her. She was the secretary of Health and Human Services from the beginning of the Obama

administration in 2009 through 2014. Before she served in the administration, she of course was governor of the state of Kansas for five years, six years --

MS. SEBELIUS: Six.

MS. WOODRUFF: -- before President Obama lured you to Washington. And as all of you know, she's the daughter -- I think you're the only governor ever to be elected governor who happened to also be the daughter of another governor --

MS. SEBELIUS: That's right.

MS. WOODRUFF: -- John Gilligan, the governor of Ohio. So with all that preface, you've had a chance to look. I don't know if you've seen all 160 pages of the Senate version, but, Kathleen Sebelius, what do you make of it?

MS. SEBELIUS: Well, I want to start by again thanking Ruth. Ruth does a spectacular job organizing a lot of health programs. And it's great to have a chance to discuss any issue with Judy Woodruff, who is one of my favorite people and also somebody who gives me the news on a nightly basis. So it's good to be with you, yes.

(Applause)

MS. SEBELIUS: Thank you all. I'd really like to start with -- and we can talk a little bit about how the Senate bill compares to the House bill, but I'd rather start with how the Senate bill compares to what was in place and still is in place. I need to remind people always that the law really still is the law.

And at the end of 2016 -- and I start there because it begins to get murkier as the Trump administration moves into office. But at the end of 2016, here's what we knew: 20 million Americans had new health insurance coverage either through Medicaid expansion or the marketplaces. We know our uninsured rate in the United States of America had never been lower. It was below 9 percent. We never reached that point before.

Health inflation during those six-and-a-half years -- from the time the president signed the law in April of 2010 until the end of 2016, health inflation rose at the slowest pace ever documented in the nation's history, so we were actually seeing a much slower rise in Medicare, in Medicaid and in the private insurance market. It was going up at a slower pace. And patient safety was beginning to show some real signs of improvement. Hospital readmissions were falling, patient safety was improving. So there were some signs on the horizon that things were actually really getting better.

We then fast forward to the Senate version of dismantling the law that helped to make a lot of that framework possible. And I would say that the Senate version may be less awful than the House version, but it's awful. I start from that premise.

We don't know how many people will be uninsured by the Senate version because the Congressional Budget Office, the CBO, hasn't scored it yet, but it will be millions of people who are likely to lose coverage both with seizing Medicaid expansion -- so there are millions of people in that population, the lowest income, childless adults who got coverage under the plan in 31 states -- but also because the subsidies are lower and because they don't take into account age with as much care and the insurance companies can charge somebody over 55 times what they can charge a young American and those folks are likely to have preexisting conditions -- it will get more expensive.

There is -- we know that the bill will give flexibility -- whatever that means -- to states -- and I was an insurance commissioner at one point, so I kind of know this drill -- but to states to roll back essential health benefits. So we may have plans that are offered without mental health coverage again, without maternity coverage again. And what that really means is that people who need that care will be paying for it out-of-pocket or not getting it at all. It doesn't mean that those needs go away, it's just that the federal government won't pay for them.

And I think as terrifying as all the pieces are to the Affordable Care Act and the individuals, that is 20 million people who will -- higher cost many of them will lose their coverage, won't have the benefits they need for their health care is really in both the House and the Senate bill an assault for the first time in 52 years in the underlying Medicaid program. And I don't think this has really gotten enough attention.

So Medicaid is now the largest insurance program in this country. About 72 million people are Medicaid. And those people look like this: 10 million disabled children and adults. Medicaid is the largest payer for nursing home care and most of those folks are poor elderly, frail elderly who are in nursing homes. Medicaid pays for half of the births in this country, so 50 percent of the children born their parents actually are on Medicaid coverage and that's who pays the hospital bills and pays for coverage. And a number of pregnant women and 40 percent of our children are on Medicaid.

You can't cut that program by 25 percent, as is proposed in both the House and Senate version, without cutting benefits to some of those folks. The dollars just don't go around. And no state in the country has enough money to make up that difference.

So we're really looking at both people -- some of the 20 million new population and some of the expanded Medicaid, but also serious cuts over the next 10 years in benefits to that underlying Medicaid program. I think the Senate pushes the pain a little further down the road --

MS. WOODRUFF: Right.

MS. SEBELIUS: -- but the pain actually is worse in the Senate plan. They cut more out of the underlying Medicaid program than even the House suggested.

MS. WOODRUFF: Well, let's stop and talk about --

MS. SEBELIUS: Other than that, it's great.

(Laughter)

MS. WOODRUFF: Well, let's stop and talk about it. You said you didn't necessarily want to talk about the difference between the two, but Republicans are talking about it. They're saying what's coming out of the Senate is a more, in so many words, humane version, because, for example, on Medicaid, yes, there are cuts, but they're stretching them out. They are basically saying the phase out or phase down of Medicare is going to be drawn out over more years, people are going to have more time to adjust to it, and compared to the House version, this is a more forgiving arrangement.

MS. SEBELIUS: Well, again, we're talking about -- I think it's really important that there are two Medicaid populations. So the underlying Medicaid program has always covered pregnant women, lower-income kids, disabled adults and kids, poor seniors, home health care for frail elderly so they could actually get health service. That's getting cut.

The additional cuts are the expanded populations. So one of the things that the Affordable Care Act did was --

MS. WOODRUFF: You're referring to states were allowed to --

MS. SEBELIUS: Correct.

MS. WOODRUFF: -- expanded Medicare and some did and some didn't.

MS. SEBELIUS: Thirty one states, half of them Republican governors, took advantage of a plan that said if someone lives in your state and is below 130 percent of poverty, they are eligible for Medicaid and actually offered the most generous federal state match ever seen in this country. Hundred percent would be paid by the federal government for the first three years and gradually reduced, never lower than a 90/10 match.

So that population gets entirely phased out.

They will no longer be eligible. They will not unless the state funds it with 100 percent state dollars and comes with a regular match. But in addition, the underlying program gets cut, because that's where the money is.

For the Republican, both the House and the Senate plan, this is not necessarily helping the federal deficit. It's not going into the Treasury. That $600 billion cut in Medicaid is going to be used to pay for the tax cuts that are just behind the curtain and on the horizon for the wealthiest Americans and the largest corporations.

MS. WOODRUFF: And that is something that we -- at least my understanding is that that is -- that remains in --

MS. SEBELIUS: Correct.

MS. WOODRUFF: -- the Senate plan as it was -- it is in the Senate plan and it was in the House plan. And that's a --

MS. SEBELIUS: So that's where the money goes. It --

MS. WOODRUFF: It was a tax increase that was part of Obamacare on individuals over a certain income bracket.

MS. SEBELIUS: To pay for healthcare.

MS. WOODRUFF: Right, for healthcare.

MS. SEBELIUS: To pay for individuals and instead it's going to go --

MS. WOODRUFF: But again, another -- but back on the Medicaid question.

MS. SEBELIUS: Okay.

MS. WOODRUFF: What Republicans are saying is that, you know, "We hear you, but we have a fundamentally

different way of looking at this because we think Medicaid is unsustainable the way it is. It costs too much. It has exploded in terms of the price tag for the federal government, for the state governments. And we want to put it on a sustainable course so that it's around for years and years to come. And we can't do it the way it is now." They also have created -- and I don't have the name of it in front of me, but a fund with tens of billions of dollars which would be part of taking care of those people who frankly get left out by these Medicaid changes.

MS. SEBELIUS: Well, I would respond that as taxpayers -- I think there is great support I know in my conservative state of Kansas and I think it's pretty much there across the country that Americans believe we need to provide a health safety net, a framework where the most vulnerable, oldest, poorest, sickest members of our communities actually don't fall through the cracks, don't die in their beds at home, don't -- so what the federal -- what the Republicans are proposing -- and again, this has never been proposed. But they proposed this on Medicare also, if you remember.

MS. WOODRUFF: Right.

MS. SEBELIUS: But the outcry of the public was strong enough that they're now saying, okay, we'll just focus on Medicaid. They say this isn't sustainable. And one of my questions is: What happens to those populations? They're still going to be there. They're going to be poor seniors in nursing homes. There are going to be people who need opioid treatment and mental health treatment, who then end up in jails and under bridges. This just shifts the cost to states and on down to local governments and it will leave people without coverage and without care.

In the opioid situation -- we just finished a two day meeting here in Aspen -- a three day meeting that former Secretary Tommy Thompson and I chair and we focused on some ideas around opioids. The money in the special funds is a fraction of the coverage that people now have for mental health and substance abuse. You can't cut that coverage and then say we'll have a little pot of $2 dollars. It's currently about $180 billion dollars --

MS. WOODRUFF: Right.

MS. SEBELIUS: -- in services that are available.

MS. WOODRUFF: So you're saying when the Republicans say we're creating this fund over here to help individuals who are -- or just are going to be left out --

MS. SEBELIUS: Right.

MS. WOODRUFF: -- in the coverage gaps --

MS. SEBELIUS: It's nowhere nearly enough. And I would finally say that Medicaid is actually the single most efficient insurance program, a broad set of benefits at the cheapest price of any, much cheaper than commercial insurance, much cheaper than Medicare. The reason the costs have grown is more people are now eligible.

MS. WOODRUFF: But is it sustainable? Republicans say -- many -- most Republicans say it isn't.

MS. SEBELIUS: Well, sustainable to what? Am I willing to pay my taxes and have it support Medicaid? You bet. Again, I would just suggest that the $660 billion that they want to take out of Medicaid won't pay for the deficit, it won't be sent to states, it won't take care of these individuals -- it will be for tax cuts for the wealthiest.

So do we have the money to make sure that people don't fall through the cracks? Yes. This is really a choice.

MS. WOODRUFF: It's so easy to get into the weeds on this subject and we're trying to sort of skirt on the edges of the flower garden here. But another question that has to do with how the Republican version treats those who are most in need are these subsidies to individuals who need help --

MS. SEBELIUS: Yeah.

MS. WOODRUFF: -- and which is what Obamacare was originally all about. What the Senate has done in its version is essentially go back to the Obama formula of saying the subsidies will be governed by income level rather than by age. The House version had changed that. So again, without getting into the weeds, isn't this at least a move in a direction that is more acceptable to you and the others here?

MS. SEBELIUS: Well, again, there are two funding streams for individuals. So let's back up a step to the sort of high level. Who is in these marketplaces? These are folks who do not have affordable coverage in their workplace, so their employer is not paying a share of their insurance. They either don't get offered it at all or can't afford what's in the employer workplace. And they don't qualify for a Medicare program or a Medicaid program. So they're really out there trying to pay 100 percent of their health insurance premiums.

So the framework of the Affordable Care Act said: "Okay, below certain incomes since your employer isn't paying a share the federal government through a tax credit will help pay for your insurance." And it was a sliding scale. And it was based really on a number of factors. It was based on your income, which is a big factor. It was based on the cost of healthcare in your area of the country. Florida and California happened to be much more expensive than Minnesota, for instance. So there was some variation --- based on your family size some variation.

So again, what the Republicans have said is in the Senate: "We will go back to an income-based subsidy."

MS. WOODRUFF: Right.

MS. SEBELIUS: "We're going to cut it off at a lower income level." So they take the top tier of people income and say they don't get subsidies at all. So they cut a portion of the population. They also have said for the lowest income people, there was additional help paying for out-of-pocket costs and expenses, these so-called subsidies, the tax subsidies. They said we'll pay those

for two years in the Senate version. The House didn't say anything about them. The Senate says we'll pay them for two years. But who knows what happens after two years. So you're talking about again the lowest income seniors more likely to have a preexisting condition who now can be charged five times what a younger individual pays in a health plan.

So this help from the Senate side is very short-lived and will not cover I would suggest what is going to be a dramatic jump in costs. It's better than the House, which said, "We really don't care what your income is. We'll give you some help if you're a bit older than if you're younger." But nowhere -- again, it will not allow the same group of people to be able to afford the coverage that they have.

MS. WOODRUFF: I want to remind everybody we're going to give you all a chance to ask questions for about the last I guess 20 minutes of our session. But the reason, Kathleen Sebelius, we're having these conversations in the first place, the reason the Republicans have been so bent on changing the healthcare law is frankly because it never achieved a -- it's now today more popular than it was frankly at any time since it was enacted into law. Everybody acknowledges there were problems with it. So to go back --

MS. SEBELIUS: There's that website thing.

MS. WOODRUFF: And there was that website thing.

(Laughter)

MS. SEBELIUS: That did get fixed.

MS. WOODRUFF: But there were problems with it from the beginning. And you and I have had this conversation earlier today: the premiums have gone up. A number of health insurance companies have just exited the market. We know a few others are looking at coming in. But -- there has been churn, there has been turmoil. And a lot of it in my personal opinion has to do with people -- the difficulty in understanding it. It has been so

complicated from day one and hard for people to get their arms around and understand until it hits them personally, and then when they have a bad experience, whether it's a higher co-pay or a higher insurance premium. What could have been done differently in the beginning to avoid this or to avoid at least some of this turmoil?

MS. SEBELIUS: Well, it's a great question. And there are some things about the framework of the bill that could have been written differently. Should the subsidies have hit at a different level? Probably. Should they be more graduated? Because there were either people in or then flat out that caused a problem. I do think some of the churn is part of this marketplace. This market is a churning market. People are in and out. They may have a job, lose a job, be switching jobs, come out of college, whatever else. So there's always going to be some churn.

One of the big changes is really having a package of benefits that every plan had to offer. And while it's complicated, I got to tell you having been an insurance commissioner, been on the other end of the phone with people trying to figure out what in the world they were buying when they were trying to buy coverage for themselves, what in the world they were looking at with 26 pages of fine print that may or may not have caveats in it that took their doctor out and took their medication out. This was a plan where people knew if you bought health insurance it had these features in it and every plan had to have the features in it. That raised the cost --

MS. WOODRUFF: Right.

MS. SEBELIUS: -- for some folks who wanted skinny plans, but it was finally a health insurance package that if you got sick you didn't go bankrupt. If you got sick, you actually had care. If you needed depression screening, you had it.

I think that there's no question -- there is no mandate in the bill that says insurance companies have to sell a product.

MS. WOODRUFF: Right.

MS. SEBELIUS: So could we have done more along the way to encourage more insurers? Probably. And the reinsurance pool that was there -- I know this is very -- I'm sure all of you read insurance manuals on a regular basis and are fascinated by this. But what the reinsurance pool did is basically say, for the first couple of years nobody knows, everybody's bidding blind. They don't know what rates to charge and they don't know who their customers are going to be because there's no trend line in this market. So there should be a pool saying, "At the end of the day if you, Judy Woodruff, running the Blue Cross plan have many more old and sick patients than I do in my health plan, we're going to help you with some additional resources. You shouldn't get punished as a company. We want you to stay in the market."

The Republicans took away that money year one. And I would just remind folks -- I know I get a little bit defensive about this, but there was a declaration the day that the president signed this law that -- first of all, 27 attorneys general all with Republican governors sued the administration saying the law was unconstitutional. There was a declaration by Congress that they were going to do everything they possibly could to defund and dismantle this law. And I think it has been under assault.

So the notion that somehow this fear of Republicans is new is just not accurate. It has been a war for seven years with a lot of misinformation, a lot of -- states that --- we're all in Colorado. We're in a great all-in state. The governor said, "I want this to work. I'm going to run a state exchange. I'm going to expand Medicaid. We're going to give information to our consumers about how to use it. We're going to have our public health people reaching out." Colorado has done extremely well and had a lot of robust sign up.

Other states where the governor blocked it -- I mean, Florida passed a law that enrolling individuals, trying to find people to say you qualify for healthcare, you have a subsidy, this would be your first time -- it

was illegal to use public property to enroll people for health insurance --

MS. WOODRUFF: Yeah.

MS. SEBELIUS: -- just to give you a sense of the hostility in some areas.

MS. WOODRUFF: There were clearly roadblocks. One other thing before I go back to a broader question about what else could have been done. Was it made just too hard to -- was there not enough incentive to get young people to sign on? I mean, that's one of the things Republicans are pointing to today that we've come up with some devices, measures that we think will get more young people to sign up. Hasn't that been a problem from the beginning?

MS. SEBELIUS: Well, it has been a problem, but here's the bottom line issue. If you take young Americans -- so the plan said young adults could stay in their parents' plan till 27, right? And that was very successful. About 4 million people took advantage of that right away and are still in their --

MS. WOODRUFF: And the Republicans have now adopted.

MS. SEBELIUS: They seem to love that piece. So we're really talking about then over 27 years old.

MS. WOODRUFF: Right.

MS. SEBELIUS: And you either have a risk pool that's balanced, so you have some people who are sicker and older and some people who are younger and healthier, or you divide it up. Can I sell a cheap insurance product to a 28-year-old man who will not get pregnant and who is healthy? You bet -- you know, $4.45, on your way. That really isn't putting a risk pool together and it doesn't help kind of balance the cost. And that guy who often thinks that's all he needs, if he rips his ACL in a basketball game, if he has a ski accident here in Colorado, he may be looking at medical bankruptcy, he may

be looking at unpaid medical bills because he will not have the coverage he actually needs.

What the Republicans are talking about is going back to those days, segregating out the young healthy, saying, "We'll offer you cheap coverage." But I would just suggest in the long run that doesn't do a lot.

MS. WOODRUFF: What do you make of President Trump's comments? I mean, on the campaign trail I mean what was --

MS. SEBELIUS: What do I make of President Trump?

(Laughter)

MS. WOODRUFF: On this particular --

MS. SEBELIUS: We're in a pub like setting.

(Laughter)

MS. WOODRUFF: So during the campaign, he talked about ripping it up. "We're going to completely undo Obamacare; it's terrible," on and on. Since he's been in office, he said, "We want it" -- "but we do want to cover everyone." He said, "We need" -- just this week I think he said, "We need a healthcare plan with heart." He said the House bill was too mean. What do you -- how do you process all that?

(Laughter)

MS. SEBELIUS: I try to processes as little as possible and I drink heavily on those days.

(Laughter)

MS. SEBELIUS: He also said on the campaign trail, "I will not touch Medicaid," let's remember that, Medicare or social security. But Medicaid was one of the promises he made. "I'm different than all the other Republicans. I won't do this." He had a rose garden

party for the authors and the champions of the House bill celebrating what a great bill it was -- only to turn around and call it mean.

And I have no idea. I mean, he said: "What I think should happen is everybody should have insurance. It should be cheaper and better." I'm for that. I mean, I'm all in. And President Obama said on a number of occasions he's always in. So that is not what either the House or the Senate has proposed. I would suggest that many people -- most people unless you're young and healthy will pay more under either the House or the Senate plan. Their out-of-pocket costs will go up, not down, for either the House or the Senate bill. Many people will not have the benefits they need, which means they either go without service or are really looking at serious medical bills in either the House or Senate bill. And there's nothing really to lower costs at all for anyone.

So I have no idea why either the House or Senate bill fits with what the president has said or whether he has any idea what's in either the House or Senate bill.

MS. WOODRUFF: We're now hearing more conversation from the other end of the spectrum about: "Hey, it's time to go to single payer." And, you know, we know that was part of the conversation early in the Obama administration. How do you see that? Do you think there's any realistic possibility that this country would move in that direction given what we've been through?

MS. SEBELIUS: You know, if you could start all over again, I don't think anybody would build the kind of platform that we have in America for health insurance. Having said that, we have 180 million people who get their coverage through their workplace. You would think that what Obamacare did was dismantled that. It did not. It was dealing with about 8 million or 9 million people who were in this individual market, a small slice. Fifty three million in Medicare; 70 million in Medicaid; 180 million employer health. This is a tiny fraction of the market and you would think the world is coming to an end.

So could we get to a single payer? I don't know

how. Does it make a lot more sense? You bet.

MS. WOODRUFF: Do you --

MS. SEBELIUS: And Medicare is a single payer plan. I love the people. And I've been in a number of health meetings where somebody in a crowd -- this was early on when we were trying to pass the bill and doing town hall meetings all over the place. And, you know, people literally would say to me, "Honey, I hate this measure you're talking about, but you all make sure to keep your hands off my Medicare and keep government out of my Medicare." And I would -- I didn't share with them that I actually ran the Medicare program.

(Laughter)

MS. SEBELIUS: And we were all over it and we were the single payer for Medicare. But there is still -- I mean, people are very happy with Medicare and it is a single payer program.

MS. WOODRUFF: What do you think realistically are the prospects for getting the cost of healthcare down?

MS. SEBELIUS: There is some progress being made. We need to make a whole lot more progress. And my concern is not just the overall cost and again it's not insurance. It's the cost. We pay more for everything in America, everything that is done. But we don't get a very good bang for our buck. We have health statistics that don't look very good compared to all of our competitive nations.

And just let me go back to the opioid discussion for just a minute because I found this fascinating. So we were looking at a variety of countries where everybody they have universal health coverage -- we're talking about Western Europe primarily -- universal health coverage, basically free medication. The United States of America prescribes probably four times as many opioids as any country on earth. We have a far higher problem with addiction, with whatever. And yet the report back from patients on pain and chronic illness and dealing with

those situations is a much higher patient satisfaction in countries which have a far lower level of prescribing.

We do more diagnostic tests. We do more operations. We have more hospital days. We pay more to -- I mean -- so we pay a lot of money for things that may or may not add at all to patient wellbeing or health and wellbeing in the long run. And our mortality rate is lower than many of our competitive nations.

So we have a lot of challenges -- it isn't like we're paying more and then we have these dazzling results. We're paying more and have very mediocre results.

MS. WOODRUFF: Now, that comes across as something that's very difficult to go back and undo.

MS. SEBELIUS: Well, it's difficult. So the federal government, again, for the first time is moving Medicare, which is a large payer of drugs in hospital services and doctor visits, into more of what I call a value-based payment: looking at outcomes, paying not just for the number of things that you do, but what actually happens to you, are you improving, is your care improving. That has I think a pretty significant impact on protocol and on people getting the right care at the right time. That's a help.

We got to do a whole lot more in prevention too. Our chronic disease rate is high. Putting more time and effort and frankly money into smoking cessation and into work around obesity would lower a lot of disease platforms in this country. But all of that really requires more time, more attention, more money and more care. And I'm not sure that's the direction we're moving.

MS. WOODRUFF: In a few more minutes I am going to turn to all of you, so be thinking of tough questions for Secretary Sebelius. But at this point what sectors in the healthcare universe could be helpful in figuring out some of these problems, especially is it hospitals, is it physicians, is it pharmaceuticals, is it all of the above? I mean, who -- where does -- where are the levers where the big differences could be made?

MS. SEBELIUS: Well, I think it really is all of the above. And, you know, back to our original conversation: every health provider group, health insurer, the pharma industry, the insurance industry and others all supported the passage of the Affordable Care Act. The American Medical Association, which has always opposed any health reform, including Medicare, was very much on board, stayed on board. Every single one of those groups opposes what the House and Senate are proposing to do because they see it as a move in the wrong direction.

But I think we're at a point in this country -- you know, the issue is not: Should everybody have health insurance? We're really talking about some way to pay for care. But it's I think: How do we get to be a healthier country? How do we keep people healthier in the first place? And that's got to be an all hands on deck approach. It takes providers, but it also -- I think employers can play a huge role with their employee populations. I think schools can play a very significant role in how our kids exercise, what they are eating on a daily basis. Housing, in terms of do neighborhoods have playgrounds? Are there safe places for kids to play?

So this has really got to be a sort of health in all sectors. It can't just be the Health Department. It can't be just doctors and nurses. It's really: How do you keep people healthier for longer periods of time? How do more elderly people age in place in a way that they are independent for a longer period of time? That really is the goal.

MS. WOODRUFF: How much do you -- I mean, for -- we don't know what's going to happen with the Senate version. Maybe they won't get anything passed. But it's possible they will continue to massage this and something will get through that will be different from Obamacare. Do you -- or how worried are you about that?

MS. SEBELIUS: Well, I'm worried for a lot of the -- I see people every day --

MS. WOODRUFF: Let me just interrupt. I'm

asking because, as you pointed out yourself a few minutes ago, it's only several million -- I mean, 9 million, 10 million, 20 million. It's not -- most people are covered by their insurer -- by their employer or covered by Medicare.

MS. SEBELIUS: But I think -- again, as part of this -- so the 9 million, 10 million, 11 million are individual marketplace customers potentially. The bigger group of Medicaid are the most vulnerable citizens that --

MS. WOODRUFF: Which is 60 --

MS. SEBELIUS: Almost 73 million people in that underlying program. So I'm very worried. I'm very worried what happens to the most vulnerable folks we have. I'm worried about people who again go back to bankruptcy if they can't pay their health bills or forego care and die earlier. And that happens -- I get stopped, Judy, every day by somebody who tells me a story and one of my recent ones is -- we live in Lawrence, Kansas, which is where the university is, and there's a great diner, the Ladybird Diner, with the best pie in the world. And the woman who runs the Ladybird Dinner, Meg, said to me the other day, "You know, Kathleen, this is your diner." I said, "Well that's cool, you know, I'll take it. Why is it my diner?"

She said, "I was a waitress for a long time. My husband is a carpenter. We've got three kids. I had to continue to be a waitress because I needed health insurance and the restaurant group provided my health insurance. My husband didn't have insurance because he is a self contractor. And I have a preexisting health condition." But she said when the Affordable Care Act was passed, I could get my own health insurance and now I have my own dinner.

And those are real people. And she's terrified. I mean, she's absolutely terrified about what the future looks like. Because it's not only just her health insurance, it may be her business. It may be, you know, the future. There are parents of kids with preexisting conditions who are terrified. There are older folks who

have retired who now can afford coverage who say, "What happens to me until I get to Medicare?" What will happen to my cancer treatment? What happens to my medication?"

So I'm fine, we will be fine, my family will be fine, but there are a whole lot of real people who are terrified about what this may mean.

MS. WOODRUFF: All right. Who has a question for the secretary? Right here, front row. Stand up and give us your name.

MS. NEWTON-SMALL: Thanks. Hi. My name is Jay Newton-Small. I'm co-founder of MemoryWell, which is a start-up in the ageing space. But I wanted to know about -- Alzheimer's and dementia is one of the largest drivers of expenses for Medicaid in particular since Medicare doesn't even really cover -- fit, you know -- cover care for.

MS. SEBELIUS: Long-term care, right.

MS. NEWTON-SMALL: Long-term care, exactly, for Alzheimer's and dementia. I was told by a provider in Virginia recently that Medicare -- that Alzheimer's and dementia are classified as psychiatric disorders under Medicaid and that when -- and you were talking about mental patients being released into the streets, you know, when they start to cut Medicaid and when they can't afford that anymore. And this provider told me that they thought that millions of people with Alzheimer's and dementia would be basically released into the streets when states start to cut Medicaid budgets. Is that true and is that in our future?

MS. SEBELIUS: Well, I don't think anybody knows what happens. But I can tell you as a governor who ran a Medicaid program, there isn't any flexibility to make big cuts and our state at least did not have money to make up 25 percent of the costs of that program. So when they talk about governor flexibility, what you really would have is state by state looking at who the populations are who are now covered by Medicaid, how much money is coming in from the federal government. And that's going to be

capped -- the most expensive populations in any state are not pregnant women, are not children -- are frail elderly in nursing homes or frail elderly in their homes who are kept in their homes because of home healthcare. And certainly Alzheimer's, dementia patients are in that.

So they are very vulnerable in terms of can we cut back on the services, how do we cut support to those folks. Because it's a question of how you balance money. And I don't know what's going to happen. But a governor would have to choose between: Do you cover, you know, poor kids or do you cover granny in the nursing home? Or maybe she gets Tuesdays and Thursdays and the kids get Monday and Friday.

But no state in the -- this is the largest amount of federal money that any state receives, let's just start there. Far more than education funds or highway funds or anything comes through the Medicaid program. If a state has an economic downturn and more people qualify, the federal money goes up. If there's a new outbreak, the federal government helps balance that cost. What the Congress -- the Republicans in Congress are talking about is flat caps from the federal government regardless of what happens in the state -- you're kind of on your own.

And we are in an era in 2017 -- we have 11,000 Americans a day turning 65, 11,000 a day, because the boomers are still coming into that area. We're going to have a lot more people in nursing homes, not fewer. We're going to have a lot more people hit dementia unfortunately, not fewer.

So as those costs go up, what -- again, both the House and the Senate are saying, "We will look back at what you spent in 2016 or 2017. We're going to cap that on a per capita basis and then we're going to lower overall what you're getting into the future." That's not a pretty picture, because those populations don't go away, they are still there.

MS. WOODRUFF: I see another question right here, this gentleman. Tell us your name?

MR. BROOKS: Hi. My name is Ross Brooks. I'm with Mountain Family Health Centers. We're the community health centers serving four counties here in Western Colorado. Thank you, Secretary --

MS. SEBELIUS: Good for you.

MR. BROOKS: -- Sebelius for your service. We are part -- and to contextualize the Colorado numbers in both the House and Senate versions, there's about 600,000 Medicaid patients in our state that are at risk of losing their health insurance.

MS. SEBELIUS: How much money would you lose in Colorado do you know for the expanded population?

MR. BROOKS: $4.5 billion dollars at least a year is about the cost for those 600,000 folks at our organization. There's 4,000 human beings that serve these communities that are at risk of losing their health insurance. So we obviously agree with your assessment of the nastiness of the bill.

My question is about value-based models. So you mention Medicare value-based models and some of the real improvements we're seeing there. We're part of a Medicaid value-based model called Payment Reform in Medicaid Expansion here in Western Colorado. It saved $80 per member per month while it's improving population health.

Why are the House and Senate not more interested in investing in those models that work that are saving taxpayer money and improving population health? Why are they not more interested in that than just gutting the programs?

MS. WOODRUFF: And remind everybody what value-based programs are?

MS. SEBELIUS: So again what the gentleman is talking about is having a proposition that says rather than just pay you by the number of tests you run or by, you know, the number of days you spend in a hospital or

whatever else, we will pay you a set amount of money and then give you incentives to actually keep your population healthier, and if there are savings, you get the savings. There is a financial incentive right now in a fee-for-service program that says the more you do, the more you get paid, right? If you switch to a value-based model, you could take that same amount of money and say, "If you keep people healthier, if you actually keep people out of the hospital, if you help them improve their health status, you actually save money across the board." So that's -- it's moving the financial incentives.

I have no idea why they are not paying more attention. Because actually it's what's happening right now in a pivot to a much more outcomes-based look at patients, keeping people healthier. And certainly it makes sense in the long run because not only does it save short-term money, but those folks are going to live long. They're going to be more productive workers that are going to take care of their kids. They are going to, you know, be in a situation where they are productive and producing on all levels for a much longer period of time.

So it -- this is a very blunt and frankly I think cruel way to look at saving Medicaid dollars, which is just slashing.

MS. WOODRUFF: Okay, there was a hand over here. Yes, sir, right there on the corner.

MR. PARNESS: Hi. Jeff Parness. I run New York Says Thank You Foundation, a disaster relief group. We had the privilege of meeting in Greensburg, Kansas after the tornado. Towns like Greensburg could exist because of the social contract. People know they are there for each other in difficult times. Do you ever fear that the social contract at the national level has been broken to the point where it politicizes all these very difficult decisions in healthcare where we might never be able to come together like folks in small towns like Greensburg can?

MS. SEBELIUS: I think it's a great question. There was certainly a lot of criticism and some of that I

think is absolutely right, that when the Affordable Care Act was passed it was all Democrats who did it.

MS. WOODRUFF: Yeah.

MS. SEBELIUS: I've shared this with Judy a bit before. Looking back on that 15 months of debate, five different committees in the House and Senate, thousands of hearings, lots of amendments, I wish we had had Republican votes. I'm not sure what we could have done to get Republican votes that we didn't do.

But I got to tell you, watching this process in secret, jamming it through -- I mean, nobody has even seen this bill yet. They are talking about voting on a bill next week, that still we have a discussion draft -- whatever the hell that means. And, you know, we don't even have the bill. We don't have a CBO score. We don't really know what the impact is going to be. And there's no question, they will not have any Democratic support.

So I find it terribly ironic that, you know, the criticism that these folks have had about the process that President Obama went through, they are repeating and taking in spades. And I do worry about the fact that at least again in a state like Kansas, which is notoriously not the most liberal state in the country, 80 percent of people think Medicaid is an important program. They want the health safety net to be in place. They're willing to pay their taxes to do that. They feel that's a social contract they are very willing to make.

So I think there is a disconnect between some of the -- and people voted -- I think a number of those individuals voted for Donald Trump and they heard Donald Trump say, "I am not going to touch Medicare, I think it's an important program. I'm not going to harm social security, I think it's important. I'm not going to take on Medicaid." Only to have him be elected and then now all of these are in the radar screen. And I think that does fray the trust of people. I think it does damage the social contract. And people really don't know who to believe or what to think about the future.

MS. WOODRUFF: Just quickly before we go to the next question out here, curious, did the new secretary of Health and Human Services, Tom Price, under President Trump reach out to either you or your successor at HHS to have any conversations about any of this?

MS. SEBELIUS: I don't know about Sylvia Burwell, my successor.

MS. WOODRUFF: Sylvia Burwell, who was your successor.

MS. SEBELIUS: I have not heard a word from not only Secretary Price or anyone who has come into that office.

MS. WOODRUFF: Yes, way back there. Hand up. Okay. Right here on that side. The back, yeah, waving.

SPEAKER: Hi. I'm Dough with the Aspen Institute. Thank you for being here. If this bill -- I think there's a lot of questions of whether or not this reform will be signed into law. But hypothetically if it is not, are we doomed to a future where Republican administrations do everything they can to destabilize the marketplace and Democratic administrations come back and have to just put everything back and it kind of flip flops back and forth for future? Or is there a way where we eventually get to stability?

MS. SEBELIUS: Well, it -- again, it's a great question. I think that -- and this isn't my viewpoint. This is based on economists and a lot of conversation with insurers. What folks would say was that 2017 was looking as a stable year. The first couple of years were a lot of sorting out, companies moving in and out, folks testing things. They had a trend line of rates. People knew where they were going and that people were very optimistic before the change in administration that this plan was really starting to gel and people knew where they were.

I frankly don't know -- and let's -- you know, whether the House and Senate bill become law or not. I have no idea what's going to happen with 2018. Because

here's the problem: insurance companies right now are filing rates and they don't know what the rules are. They don't know if there will be payment for subsidies for the lower income. And the way the law works, insurance companies front the subsidies and they get paid back. $7 billion is on the line. So insurance companies don't know if that's going to happen. They have an administration who says we're not going to enforce the individual mandate, which is at least an encouragement for younger and healthier people to come in so they don't pay a tax penalty. They won't say whether or not they are actually going to run the infrastructure used by 37 states to offer the plans on the website and provide the opportunity for people for the first time ever to actually go on a website and purchase insurance and qualify for a tax credit.

So it's very unclear what happens in six months. How do people -- open enrollment for 2018 is supposed to start in November. And so any bill -- let's assume that there's a debate over the summer and that some bill gets passed in the fall, that's not what's going to be in place in 2018. So I don't have any idea for the 12 million folks who signed up for marketplace coverage what they are looking at in six months, much less down the road.

So I think step one is: the administration has to very quickly stabilize something, say what the rules are, what they are going to do. And so far they've been unwilling to do that. And then hopefully we can get to a point where maybe there is some agreement on how to move forward, some of what the Republicans want, some of what the Democrats want. But we got a short-term crisis because nobody knows what is going to happen immediately and no new law will be in place and be able to be up and running by this fall.

MS. WOODRUFF: Any question? Right here, the woman right there, the fourth row or so.

MS. CLAYTON. Hi. Denise Clayton. I'm a health economists at RTI International. We do a lot of thinking about value-based payments. And new leaks indicate that the Trump administration is thinking about value-based payments for pharmaceuticals. And I was wondering if

you've heard anything about that executive order, what you think about it?

MS. SEBELIUS: I have heard a little bit about it and you might be the better -- I mean, again, what I know, people at least say that they care about it a lot -- they care about costs. And they are not necessarily only talking about premiums. They are talking about out-of-pocket costs. So they care about what they're paying for health insurance. They care about: do they have coverage for things that they think they need in medicine that they need to buy. And most Americans are really unhappy with drug pricing and they want government to do something about that.

I will tell you that that was one of our failures. We tried to put some drug pricing framework and Medicare negotiation into the bill in 2010 and there were enough Democrats who said we won't go forward if you go after the price of drugs. That has changed. If you brought that same bill to the floor today and asked Democrats would you vote for it, they'd be thrilled to vote for it. But in 2010 they would not.

There is nothing so far that has been proposed to deal with the cost of drugs and overall costs. Someone was suggesting that one of the things the executive order would suggest is that prices for drugs need to go up in Europe.

(Laughter)

MS. SEBELIUS: Because one of the things always talked about is that Europeans pay a lot less for drugs than we do. So rather than lower them for America, let's raise them in Europe. And if that's accurate, that's the craziest thing I've ever heard of in my life.

So I do think we've got -- I'm a fan of what pharmaceuticals have been able to do for the health and wellbeing and lives of Americans, no question about it. Huge breakthroughs, huge measures of diseases that were killers that now are no longer killers, cures that are on the horizon. But the fact that we don't have any

framework around what a drug company's CEO can charge to anybody at any time is frankly outrageous and I think we've got to grapple with that. But nothing I see in this plan -- so the American public has said these are what we care about and nothing in either the House or the Senate plan deals with those real issues, costs, coverage, drugs.

MS. WOODRUFF: Okay, less than two minutes. Who has a great final question out there? I'm looking, I'm looking. Back there. Yeah, a lot of pressure on you, in the back there.

SPEAKER: Thank you. I'm Kerry Mantha (phonetic). I run a Scandinavian health care investment fund. And I wondered, you know, a little bit. You mentioned early on that -- earlier that no one would build this framework of insurance and one of the big benefits of ACA has been the ability for individuals to buy in the market. I think we're just starting to see some of the unique benefits of that in terms of alignment of long-term health goals and health behaviors.

And so in light of all that and particularly it seems that the economy may be moving toward sort of more self-employment or new frameworks that now -- since -- I'm surprised we haven't heard more discussion about moving away from the employer sponsored health care models. So kind of zooming on that, is that something that you think there is the potential to the common ground between Democrats and Republicans and will we ever see more discussion on that?

MS. SEBELIUS: You know, it's a great question and I think there has been discussion put forward in the past just nibbling around the edges. So one of the ways to disassociate health insurance with work is get rid of the tax credit given to employers for providing health coverage. You just flatten it out and you say, "You want to give this as a benefit, that's fine. But you're really not going to get a tax break from the federal government to do that because it keeps that very strong hold."

There is enormous pushback, so the law took away the tax break for the most expensive plans and said, you

know, it's a cost driver, as well as it begins to disassociate a bit from employer coverage. A huge pushback on that.

So I don't know if you can get over -- I mean, again, philosophically does it make sense? Probably, you know, to have people in a marketplace. I think the goal of the -- one of the things that employers are able to do, which is a huge benefit to people, is negotiate price reductions. "I'll give you my 5,000 Ford employees in this plant, Mr. Hospital, and you give me a 20 percent reduction in your per bed costs." "I will give you my 5,000 employees to this network of pharmacies and you give me a drug discount." An individual working for Ford Motor Company can't do that on his or her own, they don't have the leverage. But an employer negotiating on behalf of a big group can do that.

So there are -- it isn't as simple as just saying, you know, people shouldn't have employer-based coverage anymore. It also deals with pricing and coverage. It's one of the reasons again the Affordable Care Act moved to try and put people in the individual market in a big virtual pool and say, okay, there is some leverage in those pooling arrangements that could help lower costs.

But you're absolutely right: as we move into an economic stream where more and more people are working on their own, more people are shifting jobs more often so, you know, nobody goes to work any longer for a company and then 50 years later finishes with that company and they are relying on them for their checks and their benefits, their retirement plan and their health coverage, I think we are going to see more individualized markets of how people move around. And that's probably a good thing. It gives people -- but again, the plan that says, "You don't lose your coverage if you lose your job. You have the same rules as if you were in a big plan about preexisting coverage. So if you have a preexisting condition" -- "if you're a heart attack survivor and you're out on your own, you want to retire early, you can buy health coverage."

I mean, all of those pieces were protections

that are in employer plans that just didn't exist for people in the market and that's one of the reasons that that's so important to keep those consumer protections in place. Or people are just -- if you're young and healthy, you're fine. If you're older or sick or lower income, you're screwed in the old marketplace. And insurers can pick and -- it's a lot cheaper to insure people who promise you they won't get sick. Not rocket science. So picking apart a market, making sure you eliminate people who get sick or have difficult conditions or are expensive patients is a smarter strategy if you want to make money.

MS. WOODRUFF: A lot of really, really good questions and they are all hard. How terrific to have --

MS. SEBELIUS: It's complicated. Who knew?

(Laughter)

MS. WOODRUFF: Who knew? How terrific to have Secretary Sebelius.

MS. SEBELIUS: Thank you.

(Applause)

MS. WOODRUFF: Yeah, who knew it was --

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