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WHITHER HEALTH CARE REFORM?

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MR. CHERNOF: All right. Can you hear me now? There we go. Good evening everyone. It's a pleasure to be here. I'm Dr. Bruce Chernof, I'm the President and CEO of the SCAN Foundation. We're the sponsors of this evening's event. I'm really pleased to be here. I couldn't imagine a better panel for this evening's discussion than the folks we have here.

We're in a really challenging time. The SCAN Foundation believes that we need a transformed model of care for vulnerable older people. And frankly, we need a better model of care for all Americans and we're at the cusp of very important discussion of where we've been, where we're going and how we take the next steps. With that in mind, we have two incredible thought leaders and the world's best facilitator for this discussion. Lanhee Chen is a senior policy adviser at the Hoover Institute; Andy Slavitt, previous CMS director, now a senior advisor at the Bipartisan Policy Center; and Judy Woodruff from the PBS NewsHour is going to facilitate the discussion.

I think the thing I would challenge all of you, we could not ask for better speakers today and Judy will say more about each of them, but we need a substantive discussion at this point. We need thought leadership that brings folks together on solutions that are lasting and sustainable and I welcome today's discussion. Judy, it's all yours.

MS. WOODRUFF: Thank you very much, Bruce, thank you.

(Applause)

MS. WOODRUFF: And thank you to the SCAN Foundation for sponsoring this program this evening. I completely agree with Bruce, what we need right now, we're hearing a lot of -- or seeing a lot of heat around the question of healthcare. It would help, I think to try to shed some light on it and I can't think of two people who are better positioned, better positioned by virtue of
their background and knowledge and deep commitment to this subject; to talk about it.

I'm just going to say another brief word about the two of them. Lanhee Chen, on your far left, research fellow, as you heard, at the Hoover Institution, director of Domestic Policy Studies in the Public Policy Program at Stanford. He was a senior advisor to Senator Marco Rubio's 2016 Presidential campaign and in 2012 he was the policy director for Mitt Romney's presidential campaign. And during the George W. Bush administration, he was a senior official in the Department of Health and Human Services.

Our other panelist is Andy Slavitt. He is an entrepreneur who has worked both in the public and the private sectors under President Obama. He served for the last 2 years as the acting administrator for the Centers for Medicare and Medicaid Services; this followed his role leading the turnaround of Healthcare.gov. From the private sector, for 10 years before that he was an executive at United Health Group and earlier he was a founder and CEO of a tech-based consumer healthcare company. So they both bring, as we said, deep background, a lot of knowledge and a commitment to the reason we're here tonight.

The timing for this as you know couldn't be more perfect given what's going on in Washington with the unveiling in the Senate today by the majority Republicans of their proposal to overhaul Obamacare, the Affordable Care Act a couple of months after what we saw pass the House.

We are going to have a broader ranging conversation tonight. I want to leave the last 15 or 20 minutes or so for questions from all of you in the audience. We're going to get to the broader question, but I do want to start with a fundamental reaction to what we saw today from the Republicans, and I'm going to start with you, Andy Slavitt.

MR. SLAVITT: Thanks. And thank you, Judy it's great to be here at -- great to be here with you as well.
So, look I think what we saw today from the Senate was a bill that is best described as a slightly uglier stepsister of the House bill, very close to the House bill, I think, if in the main, many more similarities and differences. So I think the notion that the Senate was going to start over and rewrite something I think we now know that didn't happen. I think there are some fundamental differences. Medicaid, which has been cut by 25% under the House bill, is now being cut by an even greater amount. And in fact, the greatest cuts begin when the baby boomers turn 80. And as I think as we all know about Medicaid, in addition to taking care of kids and people living with disabilities, it's a half of the seniors in the country paid for their nursing homecare. So just as that kicks in that happens.

The MacArthur amendment, which came out of the House, which allowed for waivers of preexisting conditions and essential benefits, also got worse, at least worse from the perspective of giving people access to coverage that they need because they're now using a waiver process which has much broader authority, which allows many more things to be dropped, it even allows Medicaid to be substituted out for exchange services.

So from the standpoint of the American public, the American average -- average American family to whom the House bill was extremely unpopular, I think this bill will be more unpopular and I think more so for people who are older, more so for people who are sicker. I think if you were in your 20s and you make $70,000 a year I think it's a fine bill, if you're healthy. I think if that's not your circumstance, then there's some material elements of this bill that make things worse.

So essentially, if you read through the bill and you look at the math for most people they will have to pay more and they'll get less in terms of benefits and then and pay higher deductibles.

And then the final point I'd make, which is maybe the most important point to me, is the massive wealth transfer, the massive cut of services that go into the lower 40% of income earners. There's about $1
trillion of care cut for that group that's being
transferred to a tax cut and a tax cut for mostly wealthy
individuals and corporations. So a problematic bill, as
it's been said -- I -- as part of the Bipartisan Policy
Center, I'd love to see a bipartisan solution. I think a
bipartisan solution can't begin the way this bill began
rushed and in secret and doing real damage to lives of
many Americans.

MS. WOODRUFF: Lanhee Chen?

MR. CHEN: Well, I, you know, without surprise,
I fundamentally disagree with that assessment. First of
all it's great to be here with Andy and with Judy. And I
do think that what is most needed now is a fuller dialog
around these issues and I do agree the process was
unfortunate. The process through which a lot of this was
developed was not the ideal process anyone would have
picked to develop a law to revamp 20% of the U.S. economy.
That having been said, I think I depart probably from a
very different place than Andy does.

I think first of all there are some fundamental
reforms to our healthcare system, particularly around the
architecture of the cost of healthcare that are
desperately needed. And I don't think the Affordable Care
Act, even though it held that name, really addressed a lot
of those issues. In fact it exacerbated cost concerns for
many middle income Americans in states that are seeing
dramatically less competition in marketplaces and plans
with higher deductibles. It's a problem that we face
under current law.

So I tend to begin from the proposition that
something had to be done about costs, and I do think that
the Senate alternative is an improvement actually to the
House alternative in many ways. First of all, it gives
states actually much fuller flexibility to do a variety of
indeed very dramatic things. And I think that where
conservatives run afoul of each other sometimes is in the
notion of saying they want federalist solutions, saying
they want states to have freedom and flexibility to do
what they will, but then recoiling when states don't do
the things that they think are good ideas.
You see, I happen to think states should be allowed to do whatever states want to do. So if California wants to pursue single payer, as wrongheaded as I think that is, go knock yourself out, give it a shot, see how it goes.

So one of the things that the -- that the Senate reforms conceivably could do is to create a situation where California and Texas and Nebraska and Arizona could have very different health systems that actually relies on a provision within Obamacare, contained in something known as Section 1332, and really expands the ability of states to do things. And I -- so I just think that that's a great way to move the health system forward. I think to get more of that experimentation. Was it Justice Brandeis that said that, "The laboratories of democracy are what states are supposed to be." and indeed I think that's one of the things that the Senate bill does. So that sort of the first issue is around cost and around state flexibility.

The second thing, I'll just say briefly is, I think there's been way too much demagoguing of Medicaid, way too much demagoguing of this by many of my friends on the left. This notion that Medicaid for those who need it most and for those who are poor and sick is going to be cut, is simply wrong. There is a core of the Medicaid program that is left untouched by the House bill and by the Senate bill for that matter. Now, there are financing changes that the Senate bill and the House bill envision, but what they don't envision is changing the eligibility fundamentally for people who really need coverage.

The question is how do you cover low income Americans that may currently be in Medicaid? Is there a better way? And I think this gets back to the state flexibility point I made, which is that I think there is a better way. The notion, for example, that people on Medicaid might be able to receive benefits through private plans on the exchange. This is an idea that the state of Arkansas has experimented with a little bit. I think it's a great idea.
So look, I think that it's not a perfect bill. I don’t want to sit here and say that it's absolutely the best thing that I've ever seen. I think there are many elements of it that could be improved, but I think it's a great step in the right direction and for that reason I am supportive.

MS. WOODRUFF: All right. Well, let me just pick up on the Medicaid because it is a big part of the discussion. We're not going to spend the whole hour on that. But Andy, what about this notion, Lanhee's point, that this doesn't go after all of Medicaid. Yes, there are -- there is a curve down in terms of the number of people who are covered, but I mean the argument out there is that Medicaid, as it's presently structured, is unsustainable.

MR. SLAVITT: Well, I guess it depends what your objective is. I mean you know who's not demagoguing Medicaid? Medicare beneficiaries, who are freaking petrified. The reality is we're going to have probably somewhere in mid-40 million-ish people who are -- who can coverage the Medicaid expansion, most of them will lose it. And it's very hard, I mean you can -- we can put, we can do a lot of gymnastics to try to describe how people aren't going to lose coverage, and I did heard some conservatives try that today. I think it's a challenge to say that. I mean this is not a bill that's going to add coverage to people, whether it's going to be the CBO's number or something different we would, I think all agree that no one really knows, but a lot of people are going to lose coverage.

And the Medicaid program costs less than commercial insurance, it costs less, far less than Medicare covers, 70% of the cost go to cover people living with disabilities, living in nursing homes, and half the people are kids. So when I look at that program, I say, can it be more efficient? Can the states have more flexibility? Absolutely. Is the way to do that to cut $800 billion from it? That's like saying I can make my eating more efficient by taking all the food out of my refrigerator.
So this innovation notion is a little bit academic to me because it's a means to an end. And if you're -- talk to most state governors, not just Democrats, but most Republican governors, they don't want to have their biggest budget item cut so dramatically. Yes, they would like more flexibility and I think -- I would agree with you that we can do plenty to do that. So if we were having a dialog about how to give states more flexibility, make sure we have the resources for people, not put a cap on the amount of resources going to people who need care. And if we were talking about how to fix exchanges and make them better, I think we would have a productive dialog. This bill takes us in the complete opposite direction.

MS. WOODRUFF: Lanhee?

MR. CHEN: Yeah, I mean on Medicaid I think there's a few things. First of all the notion that states are going to be forced to do anything in my mind is a little bit of a fiction because the states have very difficult decisions to make every year. Many states, in fact the majority of states have balanced budget amendments so they do have to figure out how to make X and Y match and so that's why this is going to be a challenge, I don't disagree with that. But a state like California, for example, could make the decision that it wants to plug whatever hole is left by raising taxes. It's perfectly able to make that decision. If the state wants to make that decision they can.

So the point I would make is that this ultimately will go to states to figure out how are they going to make all this work. And in the process I do think that there are some efficiencies and gains to be had. More broadly about the Medicaid program and the idea of it being an $800 billion cut, first of all the CMS actuary says that number is closer to about 350 billion and it just kind of depends on how you look at it because what's the appropriate baseline, right? We've been living in this world where we've made the decision that Medicaid apparently is the only way to cover a certain population. I just don't agree with that notion. I think there are many other ways to go at this.
And in fact, actually one of the things the Senate bill does that the House bill didn't do and Obamacare didn't do is to provide financial assistance to people making less than 100% of federal poverty to purchase private health insurance. So that is an innovation actually in the Senate bill that has not been contained in any of the version of Republican legislation before. So, I just think there's a lot that needs to be done with Medicaid and I think the financing of it is unsustainable to your original question.

MS. WOODRUFF: Andy, you want to come back one more time?

MR. SLAVITT: Yeah. I mean look states should have flexibility, but kids don't decide where they're going to live. So if you're living, if you're living in the state don't have --

MR. CHEN: But Andy kids --

MR. SLAVITT: Let me think of that state --

MR. CHEN: Kids aren't the ones who are affected by this.

MR. SLAVITT: Oh sure they are. Sure they are.

MR. CHEN: No, no, no, they're not.

MR. SLAVITT: They are --

MR. CHEN: Because the core -- listen, the core benefits of Medicaid would still go to kids. And many kids are in CHIP and CHIP -- we'll have a separate debate about CHIP by the way.

MR. SLAVITT: So what happens when you -- what happens when you cap the program and resources are constrained, you don't think services start to get cut? What about the real world, I mean I recognize on a chalkboard --
MR. CHEN: Uh-huh.

MR. SLAVITT: -- that it all looks like the math works, but the reality is that the lives people live every day, people -- kids with disabilities, they are going to have services cut. There's only -- there's no two ways about it, and it's not every state that is going to be able to raise revenues.

MR. CHEN: I don't --

MR. SLAVITT: So I get the theory that, yes sure the state could do that, but the reality is people living in these states counting on these services are going to lose them. And so this is not a program. Maybe there is other virtues here, maybe we'll get some phenomenal innovation -- and I liked Arkansas, I was a big promoter of Arkansas.

MR. CHEN: Yes.

MR. SLAVITT: I supported Indiana. I supported all kinds of ideas that states had to change their programs that were not things that necessarily were anybody's doctrine because I supported that right, but taking these resources away dramatically is going to impact people to such a significant way that I don't know how you can actually sit there and not acknowledge it.

MR. CHEN: The inequity -- one of the biggest inequities created by the Affordable Care Act is that it created massive economic subsidies to cover people outside of the core group of Medicaid beneficiaries, who were originally made eligible by the program. That is one of the massive inequities.

MR. SLAVITT: Is that fixed?

MR. CHEN: The Affordable Care Act.

MR. SLAVITT: Is that fixed?

MR. CHEN: Well, if you change the financing structure, one of the things you're going to do is, you're
going to begin to move in a direction where states have to prioritize.

MR. SLAVITT: Well, states are --

MR. CHEN: And the point is, the point is this, no one wants to see disabled kids and single moms not be able to access services, no one wants to see that. I hear some laughter in the room. Genuinely, no person, no political public figure I've met with has ever said, "Gosh I'd really love to figure out a way to kick those kids off -- "

MR. SLAVITT: (Inaudible) resources.

MR. CHEN: Let me let me just finish this one point. Let me just finish this one point. States are going to have to make decisions about the allocation of resources, no doubt about it. The question you ask yourself is this, are states going to make the decision to allocate those resources to poor kids who need help or are they going to allocate it somewhere else? It's the state's decision. I'm not saying that there won't be decisions states have to make, all I'm saying is this is part of that the challenge we're having around this debate on Medicaid is it's -- you want to hurt poor kids, you want to hurt poor kids, well that's not the purpose of this discussion.

MS. WOODRUFF: Let's come back to a fundamental question here, which I don't know that, I wouldn't say that it's gotten lost, but it seems to me that it underlies a lot of these questions about Medicaid, about the subsidies and that is, what is the role of the government in taking care of people who can't afford healthcare? To what extent should the American people be guaranteed some basic level of decent healthcare, Andy?

MR. SLAVITT: I think it's a great question Judy because if you -- I think it's because you start from two different premises on this, if you say look we're going to be constrained by our resources, do as much as we can, or if you say, you know what, we're going to essentially say that people shouldn't have to worry about paying for
healthcare, the Jimmy Kimmel test. They shouldn't have to worry about paying for healthcare when something happens. You'll land in two different places. I mean look, people don't want to cut pre-kindergarten programs. They don't want to cut a lot of things, but if you take away their money they don't have a choice. Pennsylvania has a $3 billion deficit. This bill will add another $3 billion to the deficit. I know that Governor Wolf doesn't want to take away services from people and he can tell kids that when he takes away their services, but he doesn't have a choice. Yes he can raise taxes, but the reality is that we are -- and I think to flip this to a little bit more of a positive direction as you have done.

MS. WOODRUFF: Right.

MR. SLAVITT: We are actually having that debate in a real way in this country. You don't always know it, but over the last few weeks and months -- and I've gone out and I've done 14 town halls across the country, meeting with ordinary Americans in districts, listening to people, Democrats and Republicans, and everybody in some way is honing in on their perspective to that question. And I think we will, over the next few years, this will one bite at the apple and I think we're going to have another election cycle and another one. We will, as a country, I think make a more of a determined decision on what we value. And I don't think it will mean that the states won't have the ability to innovate and so forth, but I will tell you this, when you didn't require essential benefits to be covered there were plenty of states, where expensive cancer drugs and HIV drugs just weren't covered.

So if you make a decision to say we're going to put some substance behind it and some consumer protections behind healthcare and give people what they need, then you've really got to do that.

MS. WOODRUFF: What about that fundamental?

MR. CHEN: Yeah, no I, look I think coverage is a very important metric and I think that it is something that conservatives and liberals should be able to agree
on, that coverage is an important thing and we ought to figure out how we move in that direction. I think there are questions about the allocation of coverage, in other words, where and what programs people fall into. I think sometimes in these debates we get a little too wedded to the notion that everyone, they've got to be in Medicaid, they've got to be in Medicaid versus. Look people have changes in life status, they have changes in jobs. They need greater portability of their health benefits. So if someone is in Medicaid one year and they make a little more money next year, they should be able to transition into a private plan that covers a lot of what they need.

So I do think that one of the things we've got to do is to create a more seamless structure particularly around lower income folks so that we can get them subsidized when they need to be subsidized. And if they need Medicaid when they need that that's fine but my point is, yes I do fundamentally think that coverage is an important thing and we ought to be aiming for it.

MR. CHEN: Look, but is that, how universally and is that -- how universal is the agreement among conservatives?

MR. CHEN: I don't think it's universal at all. I do think that there are some who think coverage is not a particularly meaningful metric because coverage can be inefficient.

MR. SLAVITT: I will say this so. I have been on right wing radio programs, where the hostess said to me, I am as conservative as they come and I think we need Medicaid for all because this is just a mess. I've talked to senators and Congress people, Republicans who have said that they're more open to thinking about that than ever. And 6 months ago I probably would have told you that the idea of something like Medicare for all will never happen. And I don't know that I would say that any more. I think I feel differently. I think the country's psyche is moving pretty strongly. I think this debate is educating a lot of people. I think there are a lot of things worthy of real challenging ourselves on because those -- it's not easy, it's not cheap to do those things, but something
that we just saw in Nevada, something we've -- some things we've seen in other states there's room for a lot of it, but fundamentally you can't take all this money out of the system and claim you're going to do anything that's going to help people more. They're just not that much efficiency.

MS. WOODRUFF: If the country's psyche is slowly changing though what about our political leaders? I mean is -- I mean how hard is it to get to something that both sides can live with comfortably?

MR. CHEN: I think it's hard because this is been such a polarizing political issue for so long. And the psyche certainly have leaders at the national level is definitely not at a place where they feel like they can sit down and have a conversation about areas of agreement.

I think in some states there very much is this notion and I think you're seeing some really great experimentation coming out of the states. But you know, to Andy's point I do think actually the debate is accelerating toward some kind of experimentation in the single payer vein. And we'll have to see where that ends up going. Nevada, the governor there just vetoed something, which you alluded to, this Medicaid for all bill. California, the Senate in California, they've passed a form of single payer that Governor Brown has said he's lukewarm on, but my guess is as this debate progresses he's going to get a little less lukewarm on it. So we'll see. I mean I think this debate has many more iterations to go, but the direction that Andy thinks is moving and I think is probably right.

MR. SLAVITT: And I would just say, I would say this, I'm sorry to -- about --

MS. WOODRUFF: Go ahead.

MR. SLAVITT: About people perspective on these issues. The one thing -- a couple things I hear universally, people should not have to have a political point of view about who they want for President to want the healthcare system to work for them, they shouldn't.
And people right now feel like they either have to declare that they're a Trump person or they believe in Obamacare and this is wrong. We have to find a way to get past that and I think the reality is bipartisanship will only happen when partisanship fails. Partisanship is easier. The majority party controls both houses and the Presidency. If they can get a bill passed they will, if it doesn't pass then I think there's a real reason for optimism because I know there are people of goodwill in both parties, yes I think you're exactly right there's some trust that will need to be built before anything happens. But I think there are people of both parties that if this fails will begin to build something that is more surgical and more constructive and I think it could happen, but it will not happen if they succeed. If they succeed we're going to have it happen is the back and forth of election cycles. We're going to have more polarization as the electorate --

MS. WOODRUFF: You mean if this bill passes?

MR. SLAVITT: If this bill passes yes, we're going to have a whole lot of people in a whole lot of pain waiting for the next election cycle to get redress and back and forth we will go and it will not be healthy for our system.

MS. WOODRUFF: What do each of you think is going to happen with the Senate?

MR. CHEN: I think the votes will be there next week notwithstanding the opposition that a few senators have voiced. I mean it's always you know, I can't vote for it now, but here's all the things I want and here's my list of demands. My sense is that Senator McConnell is a very savvy leader of his conference and he understands his conference quite well. Yes, so I mean I think they will get there. I think the challenge will then be, is it going to be acceptable to the House? What the Senate has put out there is it going to be acceptable to the guys in the House? And by and large if it gets to the Senate I think there's going to be incredible political pressure on them to vote for it.
MR. SLAVITT: So first of all, I think you should take that as someone who has very knowledgeable about this. So there's a lot of credibility to what Lanhee says. Look, I would say on the one hand there should be a zero percent chance it would pass. And the reason I say that is because if we were a year ago, go through this summer and some would say, "Hey, we've got something to pass it's going to take some 20 million people they're going to lose insurance, their costs are going to go up and there are many are going to lose preexisting conditions and we say all that will ever pass and that's exactly the opposite of what Trump is saying.

On the other hand that's not the world we live in. We live in a world where the political leaders in Washington are basically the people who are most effective in helping people raise funds and it's expensive to run races in this country and it becomes a very, very difficult to buck leadership, more difficult to buck leadership today than ever before. So for a variety of reasons and that's not the only one, but for a variety of reasons it's hard for these guys to buck the trend. I always give the benefit to the home team, which is the majority, and I think it is an uphill battle for people who do not want this to pass, despite the fact that I think there is no reason it should pass. I think there is a uphill battle to prevent this from passing.

MS. WOODRUFF: How much is cost of healthcare services an impediment to getting this figured out, or is that even any more -- or is it now just so written into the system, Lanhee that --

MR. CHEN: Yeah.

MS. WOODRUFF: -- that people just assume it's going to be there, it's going to keep climbing.

MR. CHEN: Yeah. It's a big issue and we see cost in so many different ways in our healthcare system. So for many Americans it's premiums and particularly for Americans that have been in some of these state exchanges they've had some challenges around premium increases. If you're an employer sponsored plan, which is 160 million
Americans, you know, most Americans get their insurance through an employer, your health premiums are probably going up year-over-year -- by a decelerating percentage, over the last couple years, but they're still going up.

And by and large that's the prism through which people see it, but health insurance is very complicated in the sense that it's a combination of many different factors that determines cost. And so even though people think their costs are going up I think really it is more of a -- there are clearly hard measures to measure that it's going up, but there's also just an impression people have that sort of built into themselves about the healthcare system. They feel health care is just getting more and more expensive and I'm getting less and less for what I'm paying. And I think it's -- that is a very, very big part of what's animating the Republican effort on this bill right now.

MS. WOODRUFF: How do you see the cost?

MR. SLAVITT: So first of all, I would agree that the Democrats don't talk enough about cost and sustainability. And those are very important items. Here's the reality though. If you -- all you have to do is go to the pharmacy and look at what your drug actually costs or look at the bill when your kid spent four hours in the emergency room, or you spent two days and it is tens of thousands of dollars to realize that you had enormous cost problem. And it's a unit cost problem it's actually not a utilization problem. We have a problem, unit costs.

But here's the ugly underbelly of this, we are addicted to the jobs in healthcare. And if you really want to take out costs in healthcare, number one that means addressing pharma, which is a big difficult thing to do in D.C., we can talk about why that is, but it's much more difficult than it should be, but a lot of the costs come inside our hospital system or inpatient system and that's the employed so many Americans these days. And I think it's a very, very difficult challenge. So I think very difficult to get serious about it, my view on the answer to that is we've got to start focusing on all of
the things that cause people to use the healthcare system.

Our problem in our healthcare system is not the 67-year old jogger with two fit bits, not our problem. Our problem is the woman who lives two bus stops away from the dialysis center and probably two bus stops away from the nearest grocery store and if she misses her bus she's got a -- she's in renal failure and she's -- she may spend weeks and months in the hospital. We've got to reinvest in those areas. We've got to focus on those areas. And we've got to focus on cost in a serious way. But that's not a fig leaf. We should not use that as a fig leaf for not giving people the coverage they need.

MS. WOODRUFF: Lanhee do you want on comment on what Andy's said?

MR. CHEN: Yeah, no. Look I think that's all right. I think that we don't do nearly enough to keep people healthy and that's part of the challenge that we face is that we are a healthcare economy oriented around sick care and it's been that way for a long time. We also have very little transparency around cost and quality. This has been a problem that's relatively intractable, it's getting better there's more innovation and technology and disruption that's helping us to look at these things in a serious way, but if you ask the average American how much their healthcare actually costs they really can't tell you how much it actually costs. I mean they may get a bill from the hospital, but they don't necessarily believe that what they see in the hospital bill is how much their care actually costs nor should they frankly in many situations.

So we have a transparency problem, we have an information asymmetry still, massive out information asymmetries between consumers and providers of healthcare and those are things we're going to have to address if we are ever going to solve this problem.

MS. WOODRUFF: I told the two of you that I wanted to ask you to each ask the other a question. So I'm going to do that now.
MR. CHEN: Not it.

(Laughter)

MS. WOODRUFF: Andy, you go first.

MR. SLAVITT: Yes. Well look I think my fundamental question would be what would you have -- what would your team in the Senate have to see to vote no on principle? What would they have to see in this bill that say, this is destructive enough that I'm just not going to support it?

MR. CHEN: I think that the big question mark is what -- and there still hasn't been a lot of modeling, good modeling on this, which is what is going to be the long-term impact on cost, right because the big argument around why to vote for this thing is because you're addressing costs, but if you don't have really good solid evidence. And one of the issues we were talking about earlier is the Senate bill does not currently include any kind of a penalty for one who might decide to game the system and that in my mind is a big problem.

And that is something that is going to drive up costs if unless they get some way in there of protecting against this problem of people gaming the system and only buying health insurance when they need it. That's one of the reasons why the ACA has struggled is because there hasn't been adequate enforcement of the individual mandate and the economists would argue the individual mandate hasn't been strong enough. So unless they get that right that's going to a problem for costs, I think if there continues to be a drumbeat of, hey this may not actually lower costs that much, this may still be a concern in the long run I think some Republicans are going to start to get cold feet on it because that would be their sort of biggest rationale for supporting the bill.

So my question would be, where do you see areas where Democrats are willing to cross over and work with Republicans within -- I mean let's just assume we're out two weeks this bill fails, the President decides to move on to tweeting about something else, and we're really left
with what we're left with, which is a system -- the ACA, I think, even its staunchest supporters will acknowledge, is broken in a lot of ways. So where are areas of agreement? Where can we fix it together?

MR. SLAVITT: So I'm not going to go with the ACA is broken, so I'm not going to lead there. I'm going to go with, it has been through a combination of purposeful neglect and even stronger action damage done to it, and I would also say that my expectation would be five years out of any new bill that we'll see about 70% working and 30% not. So when it's neglected, purposely pushed back, so I'm just not going to accept your premise.

Having said that plenty of challenges and plenty of things we would have loved to do and should still do working together and I think you can get Democrats on the table around it. I mean look if you take away the wealth transfer element in this for Democrats, if you take away -- I know you don't like that term --

MS. WOODRUFF: You're talking about the tax cut?

MR. CHEN: Well, it's not like I don't like that term. The ACA is a wealth transfer, too.

MR. SLAVITT: Fine, fine.

MR. CHEN: Let's just let's just call it what it is.

MR. SLAVITT: Well you asked me the question.

MR. CHEN: I do.

MR. SLAVITT: I'm a Democrat.

MR. CHEN: I did.

MR. SLAVITT: So I'm telling you how Democrats think. Democrats think about it. This is from their perspective cutting $1 trillion of health care services
for poor people and putting in a tax cut, even if it's reversing an old tax cut doesn't matter, that's not something they're ever going to get onboard. They may be able to sneak one person on, but I doubt it. But if you took that off the table and said we're not talking about the wealth transfer. We're talking about how to make the system work better, we're talking about ways to make the exchanges work better, to getting the exchanges more stable, leave Medicaid alone and focus on what actually people thought they were hearing when people said repeal and replace. They thought they were hearing make my deductibles lower. They're getting make my deductibles higher. They thought they're hearing make my premiums lower. In the main, at least right now, for people, particularly older people, they're getting make by premiums higher. They're getting lower benefits.

MR. CHEN: I am sure it's not true.

MR. SLAVITT: Of course it's true. Of course, it's true.

MR. CHEN: That's not true.

MR. SLAVITT: Of course, it's true.

MR. CHEN: That's not what the -- well anyway, go on --

MR. SLAVITT: But in any case --

MR. CHEN: You're answering the question, sorry.

MR. SLAVITT: In any case, you can get plenty of constructive energy around a whole mess of things that would improve even state flexibility, even I think health savings accounts, even things that are kind of more traditional Republican ideas. If they're focused on things that are truly addressing the needs of the American people as they see them, which is middle-class affordability. Remember this bill reduces subsidies to the middle class. We should be taking it up. We should
be covering more of the middle class with subsidies, not less, and I think that everyone else in America, if you're an employee, if you're Medicaid, you're on Medicare, you're in the VA, you get some form of government help for your health insurance. If you make over 400% of poverty, you don't. And now that's being reduced to 350%. So I don't think this is what voters bargained for. I think if we got back to something that was solution oriented, more surgical, I think you could see Democratic support.

MS. WOODRUFF: So are we coming to some common ground here or not?

MR. SLAVITT: Look, I think what you're witnessing here is, I hope, we find two people with very goodwill who listen to each other, respect each other's ideas, but probably couldn't agree on the basics because we probably start from two different places. Nonetheless, if that were the attitude in Washington, I think they could get something done. I think Washington -- you know, there aren't people like Lanhee and I that can actually set policy and move things forward with reasoned discussion like this yet, and I think we're a distance from it. And again I think it's going to take good going on the other side of this rainbow for it to happen, and if so, I think they'll probably start small. There's a couple of bills coming up later in the year that are mandatory bills that can be used by both sides to do some things, right. That's possible.

MS. WOODRUFF: Well, let me just pick up on that and I want to turn to the audience in a few minutes, but what do you see out there that gives you hope that some of these tough problems can be resolved? What do you see going on in the states? What do you know about that you think needs more attention --

MR. CHEN: Yeah.

MS. WOODRUFF: -- that can be translated into something bigger, can be scaled up?
MR. CHEN: Yeah. I think there's a couple things. I see many states right now who are choosing to make more of an investment in social determinants of health. I see states that are making more of an investment in a value-based model in the delivery of care in their public programs, which I think is crucially important. I do see states thinking about how do you help people who are working multiple jobs to make ends meet, who are cycling in and out of different coverage every year because that doesn't serve anybody well, right.

We don't want people cycling in and out of government programs because it's expensive administratively for the government to have to do that, and then it's expensive and timely and costly for the individual who has to get different coverage every year. I see states trying to make more of an effort to bridge that gap at the low end. And then I do see some states making a real effort around trying to lower premiums to the extent that they can because Washington has failed in a lot of ways to come to consensus on how to do this.

Some states are trying to figure out, "Hey, how can we do better?" Alaska is a great example I think of a state that's tried to do a little bit around figuring out how to allocate risk to lower costs. So I think there is a lot of great stuff happening at the state level.

And even the stuff I don't agree with, I want to see that stuff played out at the state level because I want to see what works and doesn't. And if I'm proven wrong, great; if I'm proven right, even better. But you know, it's one of those things where I think there's a lot of stuff happening that we need to let play out.

MS. WOODRUFF: Andy?

MR. SLAVITT: Yeah. I mean look at the end of the day, all this stuff is a means to an end, and the end is we can describe in a variety of ways, but it's having more healthy babies born, having fewer unwanted pregnancies, having people who have issues get them
detected early rather than have them detected later. And the beautiful thing about take what Louisiana's done with Medicaid expansion. They have a public website, and I'm not sure if you've seen in it, but it's great, and it's updated every day with outcomes. And they track very specific, clear goals.

I would agree that some of the states that are focused on social determinants of health like Oregon and some really exciting things going on. And in the private sector, I think Medicare Advantage has unleashed things in the private sector that are great innovations that hopefully will be transferred over. But again I'll come back to this, if we're not focused on the people, the oldest and poorest and sickest, if we're not focused there, our eyes are off the ball. Our eyes are off the ball. That's where the greatest challenges to cost come in this country; that's where innovation needs to be. We don't need another gizmo. We don't need more innovations where we're finding new ways to do cool things. We need to figure out how to care for people who have the most challenging circumstances.

MS. WOODRUFF: And where is that being done well?

MR. SLAVITT: I think Oregon is doing it quite well. Right now, I think there are states even in a state like Texas, which is taking its social services budget and its health care budget and it's trying to put them together to say, "Hey, maybe if we spend a little more on housing and social services, then we'll spend less on health care." I mean one of the reasons why we spend so much more than the rest of the world on health care is because we spend so much less on social service needs than the rest of the world does. So if we started to flip that around, I think we would spend less on health care.

Now it's a bit generational. We have to have the patience to make those investments and do that, but we're not going to take a bite out of costs unless we do it in some highly draconian ways that free market people
would never support, unless we actually do some of these — make these fundamental investments.

MS. WOODRUFF: Okay. I'm ready to turn it over to questions in the audience. I have more questions myself, and I can't see you because of lights. So I just kind of see a hand back there. Go ahead. I think we're bringing you a microphone. If you could stand up and give us your name.

SPEAKER: What percentage of the problem in dollars is Big Pharma and how do you deal with that? That seems to me to be the cleanest, the piece with the least number of tails around, and if we could get our hands around that, how much would we save?

MR. CHEN: Yeah. I mean I think Andy and I probably have a slight difference of opinion on this, too. I mean I don't disagree that we have a problem around pricing. I think we would disagree on what the sources and ways of addressing those problems all are.

MR. SLAVITT: How do you know?

MR. CHEN: Because I know. I mean I know that we have a drug approval process that doesn't work for the cures of the 21st century. I know that we don't have nearly enough competition amongst generic providers. I know that we don't have nearly enough activity from a regulatory perspective to bring the FDA into what it needs to be, which is a 21st century agency. It's an agency designed in the 1960s, it's still largely operating in the 1960s. So I think those are all problems.

I think that the bigger question also is, how can we start to get a little bit more understanding around what we're actually paying for. And so I actually think that we need to be doing more around evidence-based pricing, looking at the efficiency of drugs as opposed to just kind of what people see on TV. I do think that's a problem. But maybe I don't disagree with you as much, I don't like this notion of, "Well, the easiest way to do
this is to stick it to pharmaceutical innovators." I just don't agree with that.

MR. SLAVITT: We agree with on all of that, and look, if someone developed a cure for Alzheimer's tomorrow, it's our country's job to figure out how to pay for it.

MR. CHEN: Yeah.

MR. SLAVITT: We're the wealthiest country in the world. That would be -- or should be a high priority. But I don't think we have a stark tradeoff between innovation and managing costs, and here's why. The reason is because we see, at least in Medicare, the 50 drugs with the highest cost increases, increase every year over the last 10 years by 20% to 30% or more, and these are not drugs that are innovating any longer. These are just branded drugs that are doing nothing different. So there is built-in inflation and I've had plenty of pharmaceutical company CEOs telling me, "Look, when we don't make our volume numbers, we raise the price." And there's no check on that, none.

So we can do all those things that Lanhee said and we should because they're fundamental, and I don't disagree with any one of them. But if we pretend that we don't have a problem with the way drug pricing works, the unit cost works -- I'll just tell you, I talked to a woman who has had mental health problem. She says that the ACA goes away, she'll no longer be able to afford the drug that allows her to go to work and function. People are so fundamentally scared of losing access to the things they've come to depend on, people with chronic illnesses that it's really personal, really frightening.

And if we don't address it, then over the course of the next few years, it's going to take up -- right now it's about 17% to 18% of health care costs, it's going to take up close to 25% over the next few years. We can't afford to do that unless we're taking everything else down
by a greater amount and there is absolutely no evidence yet that we're doing that.

MS. WOODRUFF: So how do you address it?

MR. SLAVITT: I think it's a series of things. I think you probably have to take the true innovative drugs, the biologics, and you've got to put them in a separate track, and I think you've got to focus on value and say, look, if we've got a rheumatoid arthritic drug that cures people, but it only cures one in three people it takes, if it cures Lanhee, we'll pay for the drug. If we take it and it doesn't, we shouldn't pay for it. That's not how it works today. We should use some sort of value-based pricing.

When it comes to drugs that are no longer being innovated but are on the market, we should make sure that patent protection is real but limited, and then we should use some benchmarks. And if one drug works better and the VA pays $38 for it, why should Medicaid pay $138 for it. So we should do some sensible things there. And then I agree with Lanhee, if we can't get the generic pipeline better -- and I don't think it's an FDA problem right now. It's mislabeled an FDA problem -- we ought to do something, and I think there's plenty of ways that we can do that, but we can't let these drugs that are just sitting out there inflate, inflate, inflate in an unlimited way.

MR. CHEN: No. Yeah, I mean I --

MS. WOODRUFF: Okay. I have to cover up. Okay, right here, yeah.

MR. ANDERSON: J. Scott Anderson, Miami. When you're addressing drug pricing, part of the problem is the rebates that get paid to the PBMs who had absolutely no value, yet extract billions of dollars from the system, which is really extortion to get people on a tier. And if the companies didn't need to pay that, the price that the
consumer paid would be much less. Why don't we abolish PBMs as part of the solution?

MS. WOODRUFF: Tell everybody what PBMs are.

MR. SLAVITT: So Pharmacy Benefit Manager basically negotiates to buy the drug more cheaply so that you can get it for less in your pharmacy and they work for employers and health plans to do it. Look, I talked to a major pharmaceutical company, who is thinking about essentially doing just what you're talking about, taking the step of saying, you know what, we're going to find another way of doing this. When it's true enough, when we have opaque processes and people taking money out of the system, and we have I think seven different actors taking money out of the drug cost, it is a problem.

I will say I don't think that's an excuse for pharma companies. I think pharma companies would like to say it's entirely PBMs. I think PBMs would like to say it's entirely pharma companies. The one thing everybody in healthcare is great at is we are all really good at describing why it's somebody else's fault.

MR. CHEN: Right.

MR. SLAVITT: It's all of our fault. Let's just say that. It's all of our fault and we all need to work on it and make progress.

MS. WOODRUFF: You want to add something?

MR. CHEN: Yeah. No, no, I think I think that's right. I do think that we have this sort of, in some cases policy over the years has created whole industries, and certainly one of the side effects of Part D, the creation of the prescription drug benefit was the acceleration of these middlemen, these Pharmacy Benefit Managers. But I do think that it's the case that we have to figure out a way to get more transparency, to Andy's point, about the opacity of our healthcare system. It's just opaque everywhere and that creates opportunities,
frankly, for people to probably be making money in a way that they ought not to be.

MS. WOODRUFF: A lot of people agree with that. Yes? Okay, I'm sorry, I just cannot see anything. Yes.

SPEAKER: Just a question about facts, which seem to be no longer reality based. Can you talk about the problem that you have in health care getting people to agree to just baseline numbers and facts?

MR. SLAVITT: Yeah. So maybe I'll take the first stab at this. I mean I'll talk about -- actually the way I'll answer this is talk about Congressional Budget Office. You love the Congressional Budget Office when they give you numbers you like and you hate it when they give you numbers you don't. That is a reality. But we believe in it. It's an institution and they're never exactly right, and we always have to go back and look at what they can do better.

But fundamentally people shouldn't have to take my word or Lanhee's word because they know we've got a dog in this fight. They shouldn't have to take a member of -- someone that is -- an analyst's perspective on this who is obviously biased. So you need to have a CBO that when it comes out with a number, we say maybe we can challenge it, we can question it a little bit, but to a certain extent if we can't say we've got facts coming out of there, then we've got a problem. And when the director of the Office of Management and Budget, Mulvaney, says that the CBO has outlived its day because he didn't like the answer he got, it was one of the most significant, and I think offensive attacks on not just honest discourse but facts, and on the institutions that we need to rely on facts.

So we need those institutions. That doesn't have to be the only one of them, but we need trusted institutions that we can go to. That's one. It's got a Republican leader. There's no reason to think anybody in there is biased one way or the other, and we ought to just say at very least it's going to be very close to the right
answer, even though we're not going to love it all the time.

MR. CHEN: Yeah. I mean I think that there's no question in my mind that there are very important institutions like the Congressional Budget Office, there's another one the Joint Committee on Taxation, the Actuary within CMS, I mean all these are credible institutions. The best you can do is to say, here's their estimate and here's what we know to be reality, the fact of what's happening now, and let's see if they're right or wrong.

Now in some cases CBO's been more right than in other cases, and so that's just what we have to accept. I think the challenge is this. There are so many different more sources of so-called facts now that it's very difficult sometimes to separate the wheat from the chaff, and particularly in an era, where we just follow the media or follow the views that we agree with. It's so easy to get random numbers that have no basis in reality into the debate, and that's one of the challenges, from both the left and the right. So it would be great if we could just accept, and there probably was a time when we did more of that, where we simply said, look, this was CBO's estimate. We're going to have to live with it. It's not a great estimate for Republicans on this particular bill. We're going to have to live with it and let's figure out how we make it better.

MR. SLAVITT: And I'm finding the actuary's estimate is more favorable in some respects and it's actually less favorable in many other respects if you read through it. But it's another data point and I think if we're all willing to call things out and say, you know what, that's a trusted source. I don't love this particular answer, but it's a trusted source and we say that to the American public, we'd be doing a great service.

MS. WOODRUFF: All right. Over here. Go ahead. If you could stand up and just give us your name. Thank you.
SPEAKER: (Inaudible) being heard. There we go, okay. (inaudible) yeah, I'll shout, if I have to. Anyway I've heard many Republicans, not just you, say people don't necessarily have to be in the Medicaid system to be able to get health care, but the Senate Bill, as it's written now, appears not to have any alternative to that. And all I hear is things like, wow, let's have the states be this incubator of democracy or whatever new ideas, et cetera. But we're saying to the states apparently, we're going to cut the kind of Medicaid funding that you can get by 25% and give you the freedom to have at it.

And it doesn't seem to me as though the numbers are really adding up and the opportunity for people to get health care, we haven't really talked about. We kind of talked about whether health care is a right or not, but is health care a right. And if it is, then how do we just cut 25% out of Medicaid payments, and how does that actually in reality get taken care of?

MR. CHEN: I'll try first. I think that there is an effort in the Senate bill to try and create more targeted assistance. So to Andy's point about it compressing the amount of assistance available for people on what was the higher end of the income scale, in terms of the subsidization under the ACA, there's an effort to compress that a little bit. You know, in my view it'd be great if we could see if we could figure out even more, how to put even more money into subsidizing or how to help people purchase private health insurance at the low end of the income scale because I agree with you, they get displaced from Medicaid the answer in my mind is not that they should not have coverage.

We ought to figure out some way to get that subsidization right, even if it means compressing the top end down a little bit more because I think that there is that population that we should really be targeting assistance at. So that's my view. So I don't necessarily disagree with the fact that the level of subsidization, particularly at the low end certainly was not enough in
the House bill, certainly was not enough. I think the Senate bill does a little better job of that. I think that they could probably even do a little better job still on top of that.

In terms of state innovation, let me just say this. One of the great things actually about this section of the Affordable Care Act, I referenced earlier, which in many ways I think the Senate bill actually supercharges, is it says a state can get all of the federal money coming into its state; from Medicaid, from the tax credits that are owed citizens in its state, even funds from Medicare and other public programs, and put together with all of that money, try to figure out. If we were going to reimagine the health care system in a state, not just about Medicaid and separate programs, what would it look like.

And I think that's really the exciting thing in this provision that I think states have really just begun to touch the tip of the iceberg on. Oklahoma is a great example of a state that put together a really interesting vision of how it might integrate different parts of its health care system to help people both at the low end but also people who are middle income and people who are working jobs and doing well.

So to your point, I think the answer is not just let's think about things in the siloed programs anymore. It's really about how do we really open up this architecture to create interesting ideas.

MR. SLAVITT: So what Lanhee just said frightens me and here's why it frightens me because the innovation provision that he's talking about, it's called 1332 waiver. Essentially it says if a state has another way of getting people covered with high-quality coverage that they can do that. They could submit a waiver and they can do that. And that's exactly when he referred to Alaska, that's what we did when I was in the Obama administration with Alaska. In a different way we did it, it was great.
What they're now proposing, to be very clear, is to say what you can now do is you can take people out of Medicaid and put them in a private market plan, you could actually pull all the tax credits that come to the state out, and take it to the federal budget. You can spend it on other things. There's really no limit, and I would say this. In Medicaid people who are making $15,000, $20,000 a year have most of their care covered. When you're in the exchange, the new standard that they're putting forward is that 58% of the care is going to be covered.

I will tell you if you put people who make $20,000 a year into an exchange product that has such a small part of their care covered, which they will be allowed to do, the state will say, (inaudible) and that may be great for them, but it will be horrible.

So that is far different than what this provision is intended to do. And I think it will cause great concern for lots and lots of people, and it will make coverage unaffordable for people. I think there's almost no question about it.

MR. CHEN: Well, I mean the purpose of the changes to 1332 is to make coverage precisely more affordable. One of the challenges with the original provision, as written in the ACA, is that it basically said to states, look, you can have all this flexibility to do all these things, and by the way you can't really have the flexibility because we're going to tell you exactly what you have to do. And so one of the things I think Republicans are trying to do, and again one of the changes they might consider is putting some guardrails around these 1332 changes.

MR. SLAVITT: I think a middle zone --

MR. CHEN: Perfectly agree with you completely that we could use some guardrails so that they're not pilfering money designed for lower income people and spending it on cotton subsidies.
MR. SLAVITT: Other needs.

MR. CHEN: Whatever.

MR. SLAVITT: Other needs.

MR. CHEN: Yeah. No, I'm perfectly fine with the guardrails, but my point is that I think the original provision was so narrow that I think a lot of states felt very constrained. They wanted to come up with interesting ideas, but they couldn't.

MR. SLAVITT: I agree with you.

MR. CHEN: So we've got to find a middle ground here and I think the Senate bill actually I'm really encouraged that it begins -- it takes us down the road of having that conversation.

MR. SLAVITT: I agree with you. I think the Obama administration was too conservative. I was actually rallying to make it a little bit more liberal. I would have moved it about five degrees; this moved it about 100 degrees. So the guardrails would have to be dramatically brought back because as of now there are no guardrails. This is just basically less coverage and quite harmful, and I don't think that's where we want to be. I do think this is a kind of place where Democrats and Republicans could agree on really solid guardrails. Hope they would make --

MR. CHEN: That could be a productive discussion, absolutely.

MS. WOODRUFF: The gentleman also pushed a question on whether there's a right to health care. Is there more to be said about that?

MR. CHEN: No, I mean you know I don't conceive of it as a right in the same way that we conceive of other fundamental rights, but I think that we need to do everything we can to make sure people have access to
affordable health care, but I don't -- I'm uncomfortable putting it in the same category --

MS. WOODRUFF: What's the difference? If you don't think it's a right but you do think we should do.

MR. CHEN: Because I do not believe it is government's sole responsibility to guarantee that right, whereas I do believe it's government's sole responsibility to guarantee other fundamental rights.

MR. SLAVITT: So I think your right to health care should be just as much as your right to basic education and to use the highways. Doesn't mean --

MR. CHEN: I don't think those are rights in the same way, either --

MR. SLAVITT: Doesn't mean you get to go to Stanford. It doesn't mean you get everything you need. So there are boundaries to this. We don't guarantee everybody access to private schools, but we guarantee people certain fundamental things. And if we in our country don't believe that we can take people who have sick family members and have them not go bankrupt as a result of this. And remember in 2010 and in the decade before, the leading cause of personal bankruptcy was a medical bill. That's been cut in half since the ACA. So with all due respect, the ACA ain't broken. The ACA ain't broken. Cutting bankruptcies in half is not broken. That's good. If there's things we can do to fix it, we should fix it, but that's the right direction to be. We should not be having families go bankrupt because of a medical bill, period.

MR. CHEN: Look, I think that it is broken because 116% year-over-year increases in premiums suggests it's broken. The fact that you've got, in many situations, coverage becoming more unaffordable for middle-class families, I do think that that means it's broken. Again, I agree fundamentally that we should look for ways to fix it. This is a difference in nomenclature.
MR. SLAVITT: If we cared about it, we wouldn't have brought the Rate Stabilization Fund like the Senate did. If we really cared about that instead of making it look bad, if we really believed in that, we wouldn't have --

MR. CHEN: Those are not the reasons why the costs are going up.

MR. SLAVITT: No, but they're a huge part of the reason.

MR. CHEN: Well, no, I'll tell you the reason why costs are going up. One of the reason why costs are going up are because of all of the mandates created around the coverage of the difference.

MR. SLAVITT: How expensive is a maternity benefit? How much does that add to premiums?

MR. CHEN: When you add up all of that --

MR. SLAVITT: Go ahead and add up for us.

MR. CHEN: When you add up all of that --

MR. SLAVITT: Add it all up for us.

MR. CHEN: -- it could be 26% of the cost of the plan.

MR. SLAVITT: What are you going to pay? So go through and tell us what you're going to cut for premiums, let's say.

MR. CHEN: I've had this discussion actually with someone else before. It's not productive for me to sit here and tell you which benefits I'll cutting --

MR. SLAVITT: You just said it.
MR. CHEN: I think you ought to be able to
decide, Andy, what benefits you want in your plan. That's
my only point.

MR. SLAVITT: Guess what happens.

MR. CHEN: Andy, I think you should be able to
make a decision.

MR. SLAVITT: I run an insurance company.

MR. CHEN: Okay, well, it's your decision to
make.

MR. SLAVITT: That's not how it works. That's
not how it works.

MR. CHEN: Not you as an insurance provider, but
you as a consumer should be able to buy a plan with the
benefits that you want.

MR. SLAVITT: You can't be the only plan to
offer an AIDS drug.

MR. CHEN: That's my point.

MS. WOODRUFF: We are not --

MR. SLAVITT: You don't know how the market
works for a free market guy. You can't do that. You got
to have rules.

MS. WOODRUFF: We're not going to resolve it.
We're not going to resolve it.

MR. CHEN: And there are rules. States have
rules, states have rules, Andy. States have plenty of
rules.

MS. WOODRUFF: I was going to call --
MR. SLAVITT: There's no insurance coverage in Colorado. In this state --

MR. CHEN: States have plenty of rules.

MR. SLAVITT: In this state, before the ACA you could not buy maternity coverage, period. You couldn't buy it.

MS. WOODRUFF: All right. I was going to call for another question. But is there one more question? Okay, here. This is our final question.

MS. SABIN: Hi. Ellen Sabin. I have two questions, but the second one is to end on a positive note. So the first question is going back to Ron, I think question about transparency and facts. No matter what your politics are, we haven't really spoken about the process of how secret and how sequestered the conversation was, which really concerned me. And I would love for you guys to speak to that just for a moment because whether you agree with the politics, whichever side you agree with, we're all suspicious of secrecy. But my second question just --

MS. WOODRUFF: I want you to hold off on the second question. I want them to briefly address the first one. A lot of what has been said --

MR. CHEN: Yeah. I mean so I wish it were a much more open process as well. So I don't disagree with that. I think the argument you would get -- I'm just going to give you the argument because that's what I'm partially here to do. The argument that they would say to you is we've been telling you for seven years all the things we were going to do, and so that's why this should not come as a surprise. There have been hearings on all of these different provisions. We've talked about all of these different things at various points in the past. I recognize that's not the same as having that discussion right now, but these ideas and the things that we're
talking about are not new, and that would be the argument. But I don't disagree with you at all about this process.

MR. SLAVITT: Yeah. I mean, look, there's two reasons you keep things secret, either they're bad or they're not important. So what are we saying? Are we saying that this isn't important enough? Are we saying that this is so bad that we don't want to have a discourse on it? Why are we rushing to a vote before the 4th of July? Obviously because people are petrified of having Senators go home and actually talk to, guess what, their constituents. This bill has so -- depending on how you poll it, somewhere between 18% to 25% popularity, and if you compare it to the ACA, which was a punching bag for all those years, now that the ACA has something to compare it against, the ACA is 55% popularity.

So why are we having it in secret? Because McConnell is smart. He's no dummy. He's just doing the smart thing to get this passed and this is how this government is operating, and I think trust is eroding and I think it's unfortunate.

MS. WOODRUFF: Final question.

MS. SABIN: Yeah. And my second may be positive. We're all used to listening to very smart, studied policy wonks who can highly argue and convince us of their sides. I guess it would hearten me to hear both of you say something about each other's side that you agree with as a way to end, whatever it is because I think we're missing that in the discourse today.

MS. WOODRUFF: I think we've actually heard each of them say I think a couple things. So what would you emphasize?

MR. CHEN: Well, I'll just say this. I have a lot of friends and colleagues who feel differently than I do who I work with on health care, and to a tee all with them I have a great passion for trying to improve health in this country, and I appreciate that. I think we
disagree about how to get there, but I really appreciate that passion that they bring and I think it's sincere and I think it's real and I think it's needed.

MR. SLAVITT: Yeah. No, no, indeed I'm not going to say something funny. Look, I think there are obviously serious minded people like yourself, who I think, are in a position where I truly believe you've tried to add good things into this bill because I do believe you're focused on trying to get us in the right direction, even with the differences that we know about and we've discussed. And I think there's others like that. I think you know Bill Cassidy has his moments as someone who I think seriously cares. I think sadly many of them used to be in the Congress like Bill Frist that aren't any longer who are serious about it. Mike Leavitt I think is tremendously serious about this.

But here's a reality that I think many of us don't appreciate. If you look at the Congress, there's a large portion of people in the Congress who don't know even the difference between Medicare and Medicaid. I mean there's a lot of people in the Congress who in the 2010 wave that in 2009 were selling cars, and I don't mean that in a demeaning way. I mean that was the wave, the political wave that was started. And so they too -- you think you fall prey to misleading facts and sound bites and stuff, they do as well. And I think where sometimes our side tries to inflict -- say that there's a lot of malice on your side, I don't think that's always the case. I think sometimes we've not educated each other and people aren't listening, and they're people aren't as much of ill-will as people might say.

MS. WOODRUFF: I think that's a very good note to end on. Thank you for that. Thank you Andy Slavitt and Lanhee Chen. Thank you.

(Applause)

MR. SLAVITT: Thank you.
MS. WOODRUFF: Thank you.

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