

THE ASPEN INSTITUTE

SPOTLIGHT HEALTH

THE CHOICE 2016: WHAT DOES IT MEAN FOR HEALTH AND HEALTH
CARE

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THE CHOICE 2016: WHAT DOES IT MEAN FOR
HEALTH AND HEALTH CARE

MS. JACOB: Hello everyone and welcome. My name is Jinnyn Jacob and I'm from Booz Allen Hamilton. We're thrilled to be a sponsor of *Spotlight Health* and of this panel, *The Choice 2016: What Does it Mean for Health and Health Care?*

As you can see, we have an amazing group of panelists behind us and we have an equally esteemed moderator. Joanne Kenen is a familiar face for those of us in Washington. She is the health editor of *Politico* and she has also been featured in magazines such as the *Washingtonian*, the *Washington Post*, *Slate* and the *Atlantic*. If you missed her there, she is also a regular commentator on television and on radio.

This is going to be an amazing event. Ladies and gentlemen, Joanne Kenen.

MS. KENEN: Hi.

(Applause)

MS. KENEN: Thank you. Is this on now? Can you hear me? Okay. Is this on? I can't see any of you. No? Okay. It's okay? All right, we got it. Let me introduce the panel. You know everybody up here, but we will go through them quickly. Former Senator majority leader, Tom Daschle, who has instructed me that here in Aspen his name is Tom. I'm used to shouting "Senator Daschle, Senator Daschle." I told him I've been practicing since last year.

Former Representative Mickey Edwards of Oklahoma, who is now affiliated with the Aspen Institute; Former Secretary of HSS, Kathleen Sebelius, who basically brought us the ACA; Former Secretary of HSS, Louis Sullivan; and Governor Steve Beshear, who was the only southern governor to implement the ACA and who covered about half million people in a state where they were really intense healthcare needs.

We don't want to spend the entire -- if you look to the title of this program, we're supposed to talk about a million things. So I told somebody it was like: everything you know about healthcare and you want me to ask. So we will talk about the Affordable Care Act because it's such a huge part of the landscape and 2016 will be a pivotal year of course. So we're going to talk about that for a while and then we're going to open it up and talk about a host of other issues, domestic and global on healthcare, and then we will have some time for the audience. But I'll tell you it's really hard for us up here to see the audience. But we will work on that.

Let's just start -- we could just go down the line, something -- you know, we all know that this election will -- as every; the last two elections -- also will determine whether the Affordable Care Act survives, more or less intact. Or whether -- you know, none of us know what Donald Trump would do, but he wouldn't leave it alone. And the Senate Republicans have a roadmap, maybe not for repealing, but for undoing a lot of it.

It's covering 20 million people. It has some problems that need to be fixed. Looking ahead what do we need to grapple with? You want to start, Senator Daschle -- I mean Tom?

(Laughter)

MR. DASCHLE: Well, Joanne, I think that, you know, we made a lot of progress in terms of new protections in the country over the last five years. Millions and millions of Americans have protections that they never had before, the confidence that we will never drop -- their insurance will never be dropped, that they have access regardless of preexisting condition, that there's parity between men and women, that young people can sign up.

And I think those are such powerful protections that I really can't imagine regardless of who gets elected president, regardless of who holds the majority that we're going to lose those protections. I also think with 20 million people now insured for the first time that it's

going to be awfully hard to roll it back. Others on the panel are experienced with regard to the implications of that. But it just seems to me that we've made progress that will be very, very difficult now to roll back.

There are huge differences philosophically about the marketplace, but the bottom-line is that I think this historic moment is one that we can build on and I think we will.

MS. KENEN: How do you have to build on it next year, one thing that you want to see happen?

MR. DASCHLE: Well, I think the most important thing as we look to the future is dealing with the other two aspects of the Affordable Care Act beyond coverage, and that is price and how we pay for healthcare and quality and how we improve it. I think those two things are going to be the focus of a lot of really bipartisan effort as we look to the future. There's a real opportunity there and I think we're off to a start. We've got a lot more work to do.

MS. KENEN: Mickey, you served in government for a long time at different era. You left in the mid-90s. Is that right?

MR. EDWARDS: Something like that, yeah.

MS. KENEN: Just around the time --

MR. EDWARDS: Abe Lincoln and I served together and we had a --

(Laughter)

MR. EDWARDS: -- hell of a good time together.

(Laughter)

MS. KENEN: You're a Republican. You've -- you're a Republican who is -- doesn't agree with everything that people currently running the House are doing. This is a big complicated law.

MR. EDWARDS: Yeah.

MS. KENEN: It's got some problems. What comes to mind for 2016?

MR. EDWARDS: Well, you know, basically, you know, I agree with what Tom said. First of all, there's a fairly good chance I think that the next president will be a Democrat. And while --

MS. KENEN: Anyone to look out for?

MR. EDWARDS: -- most of the power of the federal government actually is --

MR. DASCHLE: Here, here.

MR. EDWARDS: -- in Congress, not the executive branch, but the president has one really great power and this is veto power. So even if Republicans kept both Houses of Congress, if Hilary is president, there's not much change that's going to happen. In addition to which, the Republicans have a good chance to losing the Senate because they have so many more seats to defend this year than the Democrats do.

But, you know, Tom's right: there's not going to be a big roll back no matter what happens. For example -- and you're not going to get any help from the public. Because Gallup just did a poll: the majority of Americans want a single-payer plan and the majority of Americans just want ACA repealed, you know. So it depends on what argument, you know, they hear last.

But the fact is that in the plan that the Republicans just rolled out, they have already accepted a lot of the things that were in the ACA. They have accepted the idea: at least if you're continuing to have the continuous coverage with whoever you had it with before, you're going to be able to get covered without regard to preexisting condition. Young people are going to be able to keep, you know, on their parents' insurance.

So I think to some extent those who were really, really against more government in healthcare have already lost the battle and they are framing now their new reforms, their new approach, you know, built a lot on the ACA with tweaks here and there.

MS. KENEN: How do you get past, though, this? I mean there are things that have to be addressed. And you have a Republican Congress that has voted depending on who you ask, you know, 54, 58, 62, tie, whatever, to repeal it or take part of it away or defund it. We always say that, you know, there have been more repeal votes than are flavors of Baskin-Robbins.

How do you get to a point where this is completely dug in, can't talk about -- in any law you have to make tweaks and fixes. The most noncontroversial law in the world if it's complicated, you have to come back. We fix Medicare every single year for 55 years. What does it take to get unstuck and say, "Okay, it is here, it is surviving and we're not just going to have a repeal vote every week. We're going to try to address affordability or address the underserved or address whatever we need to address." How do you -- what is it going to take? If you're right and if it is President Hilary Clinton, what is she going to have to tell Mitch McConnell or whoever it is how to move on?

MR. EDWARDS: Well, she can't make the mistake that Barack Obama made, which is going in and telling Congress what to do. It doesn't work that way. So what has to happen is that you have to have a lot of reliance on the Congress itself. And one of the things that's different is that John Boehner is gone, Paul Ryan is there.

I've got to say something nice about Paul because I just blasted him, you know, for supporting Trump. But Paul Ryan believes: "You know, okay, we've listened to the Tea Party. You're 40 out of our 240 or whatever it is members. We heard you. You know, we're going to move forward. We're going to bring things up. We're going to deal with him. He's already started moving in that direction."

So I think there's going to be a mood in Congress, especially in the House -- I don't know about in the Senate. You know, I don't know anything about Harry Reid. I can't understand him at all. But in term -- sorry.

MS. KENEN: But he won't be there.

MR. EDWARDS: Yeah, he won't be there anyway. But in terms of the House, I think you're going to see a Congress House that is much more willing to find accommodation and find common ground.

MS. KENEN: Well, that's a very optimistic approach. Kathleen, you have grappled with Congress. You're free of that now. What -- if you were back in, which I know you don't want to be, and you had to set the agenda for ACA 2.0, where do you start, assuming that Congress wasn't letting you do something?

MS. SEBELIUS: Well, I wish Mickey were right. I don't have quite that optimistic view. And it's not just the Affordable Care -- I mean Congress is stuck.

MS. KENEN: We could -- they can't fix Zika.

MS. SEBELIUS: They can't build a road.

MS. KENEN: Right.

MS. SEBELIUS: They can't pass a highway bill. They can't, yeah, do Zika funding. They can't -- so this is not unique in terms of the Affordable Care Act. But, you know, Tom and Mickey have both said the framework about the number of uninsured Americans who now have coverage is historic, lowest uninsured rate ever in this country. I don't think we will back away from that.

I think there is huge bipartisan agreement on moving Medicare from fee-for-service to a value-based purchaser, from a passive payer to an active purchaser and really driving the way healthcare is delivered in a very different way, looking at outcomes, keeping people healthy

in the first place, paying providers differently. I think that's all very good and I don't hear anybody saying let's roll that back and let's get rid of that. That's a big piece of the Affordable Care Act.

There are also pieces like huge new antifraud protections for Medicare. I mean when all this nonsense about repeal -- there are so many pieces of this puzzle that have been put together in the last 6 years. I don't know how you repeal it.

But I think the House proposal gives you an idea -- I mean the Republicans once again put on the table a drastically cut Medicaid program, the federal and state program for lower income folks, slashing a huge amount out of the budget and really jeopardizing a lot of the care and coverage for poor women, poor children, frail and elderly, nursing home coverage. But they also put again the proposal that you would change Medicare from a guaranteed benefit plan to a guaranteed contribution plan and let people shop with their own vouchers.

Those are very different ideas. They have nothing to do with the marketplace. They have nothing to do with the preexisting condition. I think that's where a lot of the debate may be going forward, because those are Paul Ryan's favorite proposals. He made them as budget chair. He made them again the last couple of years. He put them back on the table as part of the House plan. And I think that maybe where a lot of the discussion is for the next administration.

MS. KENEN: Next. You served in a different administration in a different era and a more -- again, a more bipartisan era. When you look at the amount of bitterness about this and has, you know, a certain Republican administration, what occurs to you as -- and how do you want to see it move ahead?

MR. SULLIVAN: Well, I think one of the optimistic things that I see is the fact that Paul Ryan has stated often that he wants the Republicans to be for something rather than being against something. And I think I agree with my colleagues here that the Affordable

Care Act is here to stay. I'm sure there will be tinkering and there are certainly some things that should be improved with it. But I think that one of the areas that hopefully we could find bipartisan support is really improving health promotion, prevention activities.

Here you have tremendous evidence now that didn't exist 20 years ago that lifestyle does influence health. If you take personal responsibility for things such as exercise, vaccinations, diet, et cetera, this has real benefits. I think everyone can agree with that. This is one way to not only improve health, but also to reduce costs.

So I think this is one of the things that hopefully Ryan and his Republican colleagues can join with the next administration in pushing this forward, because I don't see any upside for the continued efforts to try and repeal this. I think it has been going so many times it's really a broken record. So I would anticipate that the Congress wants to move forward and not continue to go over battles that really haven't changed anything.

The other thing I would say is we need to move forward to say "now that we have the expanded insurance, there are a number of other things that we need to do." Manpower is an issue that I'm very much concerned about. You talk with any professional association: we need more doctors, we need more nurses, we need more pharmacists, public health workers. We need to have people who will deliver what the Affordable Care Act is to provide.

And this is another way to really address cost, because the system is not used rationally. We need to really educate our citizens to really use clinics, doctors' offices rather than emergency rooms, where the care is very episodic, it's not as good, much more expensive.

So I see an effort to not only push health promotion, disease prevention activities, improving health literacy, but also an educated effort -- an effort to educate the public about how to use a system of ways that they will be better off as well as unnecessary costs will

be avoided. So hopefully we will see something like that happen.

MS. KENEN: You implemented the Affordable Care Act. You had an exchange that worked. You had outreach. You were smart enough to call it Connect, not Obamacare in a southern state that really didn't like Obamacare but it fell in love with Connect. You covered a half million people mostly through Medicaid. It is seen as a tremendous success story by people who wanted to have it be a success story.

You were term limited and you were succeeded by a Republican who ran on a repeal message: "I'm going to undo the Affordable Care Act in the state of Kentucky." As the campaign developed, the message changed a little bit. He went from "I'm going to get rid of Medicaid" to "I'm going to change it." But it doesn't -- what -- his vision and he is in charge now. He has gotten rid of the state exchange. He's going to use the federal exchange. He's trying to get waivers that would change Medicaid quite a lot for people, make it hard, more skin in the game. They would have to pay more. I think he wants work requirements.

What does that tell you about -- you know, people up here are saying, "No, it's here to stay. It can't be taken away." In your state there's an effort to roll back. So what, you know -- and you're fighting it. I mean it's sort of your full-time job now. You're, you know, "I want you" -- you set up a group to fight that.

But what do we need to pay attention to about the potential for repealing, undermining, making it look very different?

MR. BESHEAR: Well, first of all, I agree with my federal colleagues up here that it's here to stay. But what I'm telling you and they know it and this whole audience knows it is that that place up there is broken. It is broken. Nobody sits down and talks to each other. All they do is yell at each other all day long, then go out and raise money so that they can come back the next day and yell at each other some more.

MS. KENEN: Yell at someone else.

MR. BESHEAR: And it's crazy. The only reason that Donald Trump has any traction at all is because people are frustrated. People look at Washington, D.C. and say, "My god, that's the last place" -- it's the last place I wanted to go. I had people asking me to run for the Senate. I said you got to be crazy. You know, I was governor. I was able to get something done. Why do you want to go up there?

You know, Kentucky needed the Affordable Care Act more than any other state in the country in my mind. We had some of the worst health statistics. We were at the bottom of every list that you looked at. And when I became governor in 2007, the recession hit, I had no idea. If you had told me I'd be known as the healthcare governor in Kentucky, I would have laughed you out of the room.

I mean I didn't have any money. We weren't going to do anything of any significance and then along came the Affordable Care Act. And in spite of the fact that Obamacare is a curse word in Kentucky -- you're right, we changed the name -- I decided this is our one chance. We got to grab this.

We did and the numbers speak for themselves. You know, we took our uninsured rate from over 20 percent to 7.5 percent a year-and-a-half. I mean our uncompensated care rate which providers were having to deal with went from 25 percent to less than 5 percent a year-and-a-half.

I mean it works; it works. Now we got a guy, a Tea Party Republican, who ideologically wants to change it. Now, we got every study in the world that says it works, it pays for itself, it's sustainable, it's affordable and he says, "I don't believe them. They are all liars." Now, this Deloitte; this is PricewaterhouseCoopers. You know, all of these international firms.

So we're fighting a fight right now. And he's

filed for a waiver that has so many things in it that will never be accepted. And we're going to see where we go. But, you know, the action right now is not really at the federal level. It's at the state level. Shame on the Supreme Court for saying that expanded Medicaid wasn't mandatory. But we've got these fights going on out in the states right now.

And I'll tell you one thing, though: people like this. Now, in my state President Obama has a 30 percent approval rating, but they like this healthcare. When we threw the switch on this and Kathleen Sebelius helped us do it, we threw the switch on this and hundreds of thousands of people came out of the woodwork wanting to find out about this.

And my message to them was very simple. I said, "Look, you don't have to like President Obama, you don't have to like me, because it's not about him or me. It's about you. It's about your family. It's about your kids. So just look at this. Just take a look at it. I think you are going to like what you see." And god they love it.

And so I think overall in the long-term -- and I think it's the same thing in every other state -- people are going to make sure that this stays around. But if you want to know how to change this mess up there, you all have to change it. You got to start throwing these bums out and getting people up there who will work with each other.

(Applause)

MS. KENEN: Kathleen, when the Supreme Court in 2012 made Medicaid optional for states and you were HSS secretary, were you like thinking, "Okay, all these red states are going to walk away," or did the administration or you think "it's free money, we're paying for it all, they are going to stick with us"? I mean the federal government paid 100 percent of Medicaid expansion.

And a few Republican governors made that case. I mean in Arizona Brewer said, "Why should I send my tax

dollars to another state? Let's cover my poor people here." She made a fiscally conservative argument as well as a moral argument.

What did you think initially, because we're still -- some 18, 19 states still haven't expanded?

MS. SEBELIUS: Well, the day that President Obama signed the law March of 2010, 27 state attorney generals sued us saying the law was unconstitutional. So we knew that there was a battle underway. It started the day the law went into effect. The Supreme Court decision, I have to tell you out of all the speculation about what they might have done, you know, striking down the mandate, denying the taxes, no one ever saw this coming, no one.

MS. KENEN: Yeah, we had like 43 different stories prepared, not a sentence about that -- yeah.

MS. SEBELIUS: And I spent a lot of time up until the day I left working with governors saying, "You know, we want to be as flexible as possible. Call it anything you want. If you would like me to go out and denounce you on the front steps of the lawn, if that would help, happy to do it. You know, we will work around you have a lot of flexibility around premium levels, around other issues. But, you know, we really think this is a very" -- "it is the single most generous federal/state cost sharing every passed."

MS. KENEN: A hundred percent is --

MS. SEBELIUS: A hundred percent for the first three years and then gradually --

MS. KENEN: Right, down to 90.

MS. SEBELIUS: -- down to 90 percent.

MS. KENEN: Right.

MS. SEBELIUS: And I think that, as Steve says and knows very well, you know, the uncompensated care for hospitals, the -- so what you still have going on unfortunately in spite of the financial issues is still politics playing out. And we have a lot of governors -- I would say there are probably 10 governors, 10 Republican governors who would love to put this into effect. They cannot now get their state legislators to pass the bills and they are trying.

But I think it took seven years for all the states to finally join the Children's Health Insurance program. This is only year three for enrollment in Medicare -- I mean Medicaid and you already have two-thirds of the states there. So I really do think it's a matter of time.

And, you know, when you ask people what is it that you don't like about Obamacare, in most Republican states it's the Obama part of Obamacare. And I'm somewhat optimistic that maybe when this president leaves office and it can be a little less personalized that it will become more attractive.

MS. KENEN: And through that one, right?

MS. SEBELIUS: No, it won't ever be her care.

MR. SULLIVAN: And to add to what Kathleen has said: my state of Georgia would have had a half million more citizens covered had they expanded Medicaid, would have brought \$2 billion more into the state's budget. I'm serving on the board of Grady Hospital, our safety net hospital. Grady runs an annual deficit; though, it's managed very well among public hospitals. But our estimate was that our negative budget of losing \$10 million a year would have changed to having a positive balance of \$75 million.

Now, ACA, the effort for private hospital change, they are doing very well by this. It's bringing money into the health system and into the economy. So I

agree. I think we're going to see a number of governors who have really been resisting this in a number of states who are going to see -- no, I feel the same way.

I pay my tax dollars. I'm in Georgia. I want to see those dollars taking care of people in my state. And it is illogical for me to stand by and feel that this doesn't affect me when I have citizens without health insurance, they are not working. That really hurts our economy. So I agree. I think we're going to see a lot of dominos fall as this progresses.

MR. BESHEAR: Joanne, just one point because Louis is from Georgia. Georgia is losing a lot of the rural hospitals right now.

MR. SULLIVAN: Oh, yes.

MR. BEHSEAR: They are closing because they are going bankrupt. Mine are all in the black.

MS. SEBELIUS: Kansas.

MS. KENEN: Kansas, right.

MS. SEBELIUS: Many hospitals have closed --

MS. KENEN: Yeah.

MS. SEBELIUS: -- in Kansas.

MR. BEHSEAR: Yeah. Mine are all in the black because that uncompensated care has gone down so much.

MS. KENEN: Yeah, I mean that's -- do you want -

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MR. DASCHLE: And I would just say, I think Kathleen deserves enormous credit for another thing that we haven't mentioned yet and that is the flexibility that the secretaries need to show to accommodate the unique needs and concerns and even ideas that governors have.

You know, I think one of the most successful aspects of this is that the Medicaid program of Kentucky is vastly different than the Medicaid program in Maryland or in Oregon and I think the reason why is because the Affordable Care Act saw the need to give the secretary enormous flexibility and authority really to adapt to those circumstances.

So what you see is just an array of different options and workshops really that are going to be tested and tried and in some cases will not work, other cases will. But we're learning a lot in this process as we go forward thanks in part to that flexibility.

MR. EDWARDS: One of the things that's most surprising to me as a Republican is that -- first, the argument that was used in Arizona by Jan Brewer, you know, that, "It's our money. Let's keep it here. Keep it for our people." The flexibility Tom just talked about. I mean those are Republican positions. Those are Republican conservative issues.

And so the fact that they did not embrace it. I happen to know some Republican governors who are hoping they get a chance, but, you know, they can't be too open about it. They get a lot of push back from people maybe because it's the name or whatever. I mean this was not a leftwing proposal.

MS. KENEN: On the phone all of you said -- when we talked before all you said you didn't want to spend the whole panel on the Affordable Care Act. Actually, if I let you, you would. But let's --

MS. SEBELIUS: I wouldn't.

(Laughter)

MS. KENEN: Let's talk about -- I mean not only do we have longstanding problems in this country: you referred to disparities, lack of prevention, just bad health, the issues you've had there, then we have a whole

-- every turn down we have a new one. Last year we were talking about Ebola. I mean how many people in the room knew how to pronounce Zika six weeks ago? There's the opioids, there's mental health. These things came up on -- in our preliminary call. There's a list here that could keep us for a month.

Why don't you -- why don't we just -- let's just sort of touch on some of them. Talk about what's at stake in 2016 to talk about what has to happen next year? And you did mention on the call beforehand your state is hard -- every state is hard hit by opioids. There's no state that is not hit. It is changing the culture of how we think about some of these problems. But talk about -- and Congress has passed -- the Senate and the House have both passed some legislation. They haven't finalized and they haven't agreed on the money. It's not -- that one probably will move at some point because it looks like it can. What keeps you up at night?

MR. BESHEAR: Well, that issue --

MS. KENEN: What have you seen in your state?

MR. BESHEAR: -- kept me up at night and still keeps me up at night because it's an old issue that is just getting worse. And I will say that the opioid issue is the first issue -- you know, in Kentucky, I was a Democratic governor. I had a Democratic House and a Republican Senate. But I always like to say that we were probably the last place in the country where democracy still worked because we could get together and do some things.

And that was one of the first issues that I was able to get Republicans and Democrats together and agree that we had a horrendous problem. We had pill mills all over the state. We had the pill pipeline to Florida and other places. I mean it was just a total mess.

And so we passed some really tough legislation, but it was a holistic approach that included treatment.

It included more beds. But we ran the pill mills out of the state. We made all the providers use the monitoring - the electronic monitoring prescription system so that you stop --

MS. KENEN: It's a database that you can look for the -- you can stop --

MR. BESHEAR: Right, you can stop the doctor shopping. Somebody around the -- they bought yesterday around the corner, you could catch him. And so, you know, we did that. And, boy, it really started having a great effect. And it's -- but it's like the whac-a-mole game. You know, we knocked that down and here came heroin and here came cocaine and all the other stuff, the illegal drugs.

MS. KENEN: And the HIV resurge in some of the states.

MR. BESHEAR: Yeah. And so we passed comprehensive legislation there that, you know, broadened the use of Naloxone for first responders so we could save lives. Of all things in Kentucky, we allowed needle exchanges. Wow! I mean, you know, we've really got progressive.

MS. KENEN: Fell unto your administration doctrine.

MR. BESHEAR: Yeah. Oh, yeah. And we got needle exchanges, Naloxone legislation. We got tougher penalties on traffickers. But, you know, again it was a holistic approach that really paid a lot of attention to treatment, because if we don't start investing there -- I mean you can't -- you cannot convict your way out of a drug problem. You got to treat people and get them to be productive citizens again and that's not an easy task to do.

(Applause)

MS. KENEN: What are you seeing in the communities you're working with in Georgia? How are attitudes changing? What resources are there? What resources are just hopelessly not there?

MR. SULLIVAN: Well, I think the problem that we have with opioids is really changing our culture. One of the main things is the stigma that has been associated with drug use, I think that's disappearing because everyone knows someone, if they don't have someone in their family, who is affected by this.

And we've had enough from our medical colleagues showing that addiction is a disease. It's not lifestyle. That there are changes in the brain when one becomes addicted that really are real. So that we have to find ways to treat our citizens, to find -- to have them come out of the closet so that they will offer themselves for treatment. This along with expanded mental health services are needed as well.

So I think that this is a crisis that we're going through now. It's remarkable just how bad it is. But I think one of the optimistic things about it is I think people's attitudes are changing and we will be able to get more funding and more therapeutic approaches and centers for it. So that's the upside. But it will take some time to get through this.

MS. KENEN: But how much -- going back to the Medicaid expansion -- I mean you have recognition, you have a change in how people speak about and think about and want to deal with opioids and heroin and it's a pretty dramatic change that's happened pretty quickly. I agree with you. Do you have the capacity? I mean again Medicaid didn't expand in Georgia. There would have been more mental health services. There are still waiting lists and problems in the states that did. But how much of a difference -- how much would the mental health piece be better off?

MR. SULLIVAN: No, no, we need to enhance our infrastructure and the most important part of infrastructure are our personnel. We need to have not only physicians, but nurses, physicians' assistants, others, counselors, et cetera. So we need to have these individuals available when they are needed. Because if we don't have access to these individuals for treatment and counseling, then the problem is going to linger and fester and continue and get worse.

So that's why I say it's important that we have the insurance. There's still more work to be done to expand it. But we also have to work to see that we have the personnel and the right kinds of personnel.

We are going through a change in our manpower. Years ago we talked about doctors, nurses, dentists, et cetera. But now we're talking about patient navigators, community health workers, pharmacists providing health education for many of our citizens, which is a new role.

So we need to see that we have the right kinds of personnel -- not then that only will provide care, but in the long run will reduce costs so that people will receive care when they need it rather than having a problem linger and they come in later with much more severe condition. So we need to address manpower as a part of this problem.

MS. SEBELIUS: Well, I'm going to shift a little. Joanne challenged us a bit to think about other challenges and I'm going to shift to global issues a bit. You know, in 2009 when I came to the department, we were just in the midst of the outbreak of H1N1, which turned out to be luckily less dramatic than it could have been. But it was the first pandemic in 70 years. We didn't have a vaccine. We didn't have the infrastructure. We didn't know how to deliver the vaccine. They hadn't gone through these steps.

Here we are in 2016 and since then we've had H1N1, we've had Ebola and now Zika. And I think that it

has provoked some really important conversations where Americans hopefully now realize that the only way to deal with diseases over there is deal with them right here -- is to help build an infrastructure of identification and tracking and treatment in various parts of the world. But also that diseases don't stop at the borders. You can't build a wall that makes sure that the mosquitoes don't come.

MS. KENEN: A really big net.

MS. SEBELIUS: A really big wall or a really big net.

(Laughter)

MS. SEBELIUS: I'm sure it would be a great wall.

MS. KENEN: And make the mosquitoes pay for it.

MS. SEBELIUS: And charge the mosquitoes -- charge the mosquitoes, yes.

(Laughter)

MS. SEBELIUS: But I think there has been a reluctance to see --

MS. KENEN: But not the Canadian mosquitoes.

MS. KENEN: They can come in.

MS. SEBELIUS: Yeah -- that global health was about somebody else. I think finally folks are saying "really this is about us." The only way to keep Americans safe and secure is really deal with all of these issues.

And we don't have any longer after 9/11 -- and I know Tom was -- I don't know, Mickey, if you were still in the House. I know Tom was in the Senate -- where, you know, there was an enormous amount of revenue put forward

on a multiyear basis to start dealing with bioterrorism threats and be prepared for antiretrovirals and look at areas that may threaten the health and security of Americans. That money is all gone and there has been an absolute unwillingness of Congress to refund that pipeline, to relook at this issue.

So one at a time -- I mean you just saw -- the House just passed a bill on Zika virus. Most of the money that they passed, they took out of Ebola funding and they took out of the department's infrastructure and they are just kicking the can back and forth. It's half of the money that CDC said they needed in the first place. But none of it is new money. None of it will actually help put together this infrastructure.

And it's pretty terrifying, because these are diseases that could have lifetime impact on lots of our citizens going forward and they certainly will have a devastating impact across the globe. And we have to really start stepping up on global health issues.

MS. KENEN: In 2011 -- in 2001 rather after 9/11 and the anthrax was in your office, there was actually a very sort of strategically smart thing that Senator Kennedy did with Senator Frist, in which they did the bio-terror bill. It actually -- Senator Frist understood a lot of things about -- I guess here he has to be Bill, but he's not here. It doesn't matter.

He understood public health and he understood the depletion of public health resources in the United States and he called it a bio-terror bill and Kennedy worked with him and you worked with him.

MS. SEBELIUS: \$80 billion.

MS. KENEN: And you were able to do by calling it bio-terror. You were also able to get some counting (phonetic) in Montana. You know, in those days it was a fax machine that they needed that they didn't have so that

they could actually communicate with the CDC, communicate with each other.

It sounds like we made some gains. And that we've actually as we've become more globalized and, you know, sort of being hit in the face with how fast diseases can travel and new scary ones -- are we worst off than we were 15 year ago?

MR. DASCHLE: We are worst off. And, you know, I think, Joanne, what triggered all of that of course was the real feeling that we were threatened. And because we felt we were threatened, we found enormous bipartisanship. I mean there were two things that we did in that period that I think were striking. One was we came with the money, and two, we created the infrastructure to be able to think about how to best spend that money. As we prepared for our defenses, we went forward.

But now, as Kathleen said, the money has dissipated and really the infrastructure that we had created is virtually gone as well. There is little doubt that at some point in the future -- we don't know when -- we're going to have another attack. Whether it's natural or manmade, we are going to see the same kinds of threats we faced already and we're not prepared today.

We need to stockpile some of these measures. We need to have the resources necessary. But even more importantly, we need the organizational effort within the government itself to be able to work with the state and to work at the federal level to ensure that we are protected. We don't have that today. I think it's just a crime that the Congress left town without dealing with Zika and finding the funding necessary to address it because it's a problem that's only going to get worse.

MS. KENEN: Yeah, the earliest they can fix this now will be mid-July and that's well, well, well into mosquito season in a big chunk of America. I think some of them were surprised -- I think some of the Senate maybe surprised that it didn't get a little further than it got

in the House last night, 3:00 o'clock in the morning, whenever it was.

One or two things before we turn to audience questions. I know there was another issue. Mickey, you want to --

MR. EDWARDS: Oh, there's a couple. You know, one of the things in terms of what Kathleen was saying. One of the ways that people in other countries were able to deal with some of these crisis is through help we gave through our foreign assistance programs and there is a big push to cutback even more on foreign assistance, which is not -- hasn't been adequate in a long time. That's part of the problem.

And let me just mention two other things -- one has been mentioned -- but at different ends of the age spectrum. One is on mental health. This is a particularly large problem for young people access to mental health, not only insurance coverage, but facilities near enough, you know, to be able to do this.

The other end of the spectrum is dealing with cancer, you know, because the incidence of cancer is increasing. We can take care of it more. There is more survival. But as people get older -- you know, the ageing population has more cancer. And that's another area where we need to put more funding.

So all of the efforts, you know, in Congress about how do you cut spending, cut spending -- there are some areas where we need to be spending a lot more than we are and that's a couple of them.

MS. KENEN: That's one of the areas where there has been some bipartisanship both last year and this year there has been a big increase in the funding for NIH. I think it's \$2 billion they are talking about.

MS. SEBELIUS: But it's never new money.

MS. KENEN: No.

MS. SEBELIUS: It's taking money from someplace else. So that drops dramatically. I mean it's the worst time in the world to cut back on funding and research because the science --

MS. KENEN: It's really exciting.

MS. SEBELIUS: -- is so dazzling --

MS. KENEN: Right.

MS. SEBELIUS: -- and the breakthroughs have been so enormous and the --

MS. KENEN: And they are real, right.

MS. SEBELIUS: -- human genome can map precision medical responses. But we are slashing budgets, which makes no sense.

MS. KENEN: We should probably turn to the audience. Who has the mics? I can't see very well from up here. And please make sure you are giving a question, not a speech because I'm tougher than I look. I raise teenagers. I will cut you off.

(Laughter)

SPEAKER: I have a mic.

SPEAKER: You have a mic back?

MS. KENEN: Okay. Who?

SPEAKER: In the second row.

SPEAKER: Oh, I'm sorry.

MS. KENEN: Stand up; maybe I will be able to see you.

SPEAKER: Right here in the --

MS. KENEN: Okay. Could you identify yourself and the question?

SPEAKER: Yes. My name is Larry Yum (phonetic) and I live in Tucson, Arizona and my question is related to the election. And I watch a lot of news and I'm hearing things for the first time tonight, things that I haven't heard before. And I'm wondering what your opinion is of the news media's job and the way they cover the election.

Is it going to be possible for any of these real issues to get any kind of traction when it seems as though the media is so fixated on giving surrogates for Trump and Clinton equal time and allowing them to say whatever they want? It seems like we never get down to the real issues. And I was just wondering if anyone had some thoughts about whether that's going to get any better or if it's going to stay the way it is.

MR. EDWARDS: Well, I think we're required to start by saying *POLITICO* is really good.

MS. KENEN: I've got nine --

(Laughter)

MS. KENEN: I have nine healthcare reporters, three additional ones who are on digital health and we cover all of this and we have a free daily newsletter that you can sign up for. We also have a paid one you can sign up for, but there's a free one.

MR. EDWARDS: But I do say that's a relevant question. And if Donald Trump becomes president, which is a scary as hell thought -- if he becomes president, the news media is complicit in this. Their ability to ignore this, you know. And was it Les Moonves, the head of CBS: "You know, we don't know if Trump is good for America, but

he is good for CBS." You know, the pursuit of short-term ratings and money by the media has really been disgraceful this year.

MS. KENEN: Right. A question?

SPEAKER: Yeah.

SPEAKER: (Off mic). It's on now.

SPEAKER: It's on now? Okay. This question is addressed to anyone on the panel. We have all read in the last few weeks about a number of insurance companies who matter and opting out or basing rates 25-30 percent because they underestimated what the cost structure was going to be. It was all -- you know, everybody was out there saying we are going to get all these new people, all these young people. But guess what? We are going to get people who are not so healthy. How can you -- you know, what's going to happen?

MS. KENEN: They --

MR. DASCHLE: Well, I think Kathleen can answer this better than --

MS. KENEN: I mean the insurers have lost \$2.7 billion.

MR. DASCHLE: -- any of the rest can.

MS. KENEN: It's real.

MR. DASCHLE: I think one of the most important things that got very little attention is how critical the risk corridor mechanisms we've built into the law were. I mean that was our deal with the insurance companies because this was a new model and we really didn't know how to predict just how this was all going to play out. So what we said is we're going to share some of the risk with you. But the Congress has refused to provide the funding

that would allow for the kind of risk amelioration that is so critical here. I mean that's a really big part of it.

You know, I think the other thing: when you hear about these rate increases, keep in mind that the average premium is around \$104. I mean that's not too bad when you consider what you're getting in value for coverage. So it may be percentage wise a lot, but anywhere from \$75 to \$104 a month is much of a tolerable premium level than I think a lot of people realize.

SPEAKER: The headline is 25 or 30.

MR. DASCHLE: It is.

MS. SEBELIUS: Right.

MR. DASCHLE: Yeah.

SPEAKER: And so nobody is looking at the real numbers.

MR. DASCHLE: Exactly.

MS. SEBELIUS: And the real numbers vary from state to state. I mean there's no question that competition helps driven down rates. And one of the goals of the marketplaces was to get new companies to write individual coverage. Twenty-five percent of the people who wrote in marketplaces across the country, 25% of the insurers year one were brand new. Another 25% percent came in year two.

United, which frankly has done the most bizarre thing I've seen, where they issue a press release a day based on a state a day. United wasn't in at all in 2014. They came into three or four states in 2015. They played bigger in 2016 and now they are pulling out. But that has not really changed the overall composition in most states and there are other insurers who are expanding.

But Tom is right, the framework -- and this is not new to the Affordable Care Act. It's about market risk. For five years it was supposed to be risk adjusted, so everybody was sort of bidding blind. And we said if you had far more older and sick people in your plan than you got in your plan, we would shift that balance a little bit. And when Congress didn't fund that, you're suddenly on the hook for a brand new vulnerable plan.

So they are still fragile. And in some states there isn't enough competition and that has allowed rates to go up. But by and large there are lots of new insurers playing and the rates are still I think very acceptable for most of the people who are buying coverage.

SPEAKER: Competition with whom?

MS. SEBELIUS: Competition is where it's at, yeah.

MR. BESHEAR: We ended up -- in Kentucky for years before the Affordable Care Act we had two companies. That's it. And they kind of had their way because there wasn't enough competition. This last year we had seven companies providing these plans all over the state. It's amazing that, you know, we turned around in Kentucky and went from two to seven. And like they said, that competition is what -- in the long run is going to get these rates where they ought to be.

MS. SEBELIUS: And you will see -- just one more anecdote -- because you are going to see a lot more about this, the proposals of the big insurance companies to go from five big companies to three. The mergers that are pending are now being looked at by the Justice Department, looked at by the FDC, looked at by state regulators, where part of the issue that is -- the federal regulatory lens is: will this make health insurance less competition; will this be good for the consumer; if you shrink the market by that much, what happens to people at the end of the day.

MS. KENEN: There.

SPEAKER: You've explained the difficulties with medical care in the country and I understand it. By the same token, the three largest items in our federal budget, is social security, Medicare, Medicaid and interest on the debt. I'm curious as to how we start to deal with what appears to be continuing increasing costs as our population gets older to pay for medical care for all of us?

MR. SULLIVAN: Well, I would start we need to do a number of things to redesign the system because the system is not used rationally by a number of our citizens. In my state, in Atlanta, we have too many of our citizens who call for the ambulance to go to the emergency room where there's a \$1,500 bill generated when indeed they have some ache that would have been taken care of for \$100 at a local clinic. So -- and there are many examples of that.

So I agree. I think we all agree that we are spending too much, but we are not spending it in the most rational way. That's why we need to redesign system.

I was talking earlier about manpower issues. We load our health profession students up with debt to get an education and then when they graduate we say we want them to go into rural areas and practice primary care when they are looking at a debt of \$150,000 or \$200,000. That is something that did not exist 30 years ago. There was scholarships, many ways that students could provide their education. But what we are now doing is generating health professionals who are going out and trying to find ways to reduce that debt. So we have a dysfunctional system.

So there are a number of things that we must do if the system is going to be viable. Another is emphasizing health promotion, disease prevention to prevent illness from occurring in the first place. So there are a number of things that have to be done to address that, but we have to have the will to do it.

MR. KENEN: Tom, do you want to talk about some of the areas of bipartisanship that has been delivered -- like we have to explain what delivery system reform is, otherwise they will think they are not getting their mail. But, you know, some of the -- there has been a bipartisan progress and understanding about -- that addresses his question.

MR. DASCHLE: No, I think there is. Once we get beyond the Affordable Care Act there's a lot of support, as Kathleen I think mentioned earlier, about the need to move away from the volume driven system we have today. One of the reasons we spend more than anybody else in the world is we have a volume driven fee-for-service mechanism that rewards more volume and really doesn't bring into the equation the quality that is so critical.

We don't have the transparency. I always like to say -- I don't like to say it, but we have to admit healthcare is the only sector of the economy where at the time of purchase we don't know what it's going to cost or who is going to pay. There is a lot more transparency around sports in America than there is around health and we've got to change that.

You know, we -- and on those kinds of things -- you know, there's a bipartisan effort underway now to bring telemedicine into healthcare a lot more effectively. You know, there's some wonderful things we can do with telehealth in home health settings and in all kinds of new settings that just didn't exist before. All of those things I think are areas where there is meaningful bipartisan support. The effort towards population health and wellness, something Louis has mentioned a couple of times now, that bipartisan support for. We just have to come up with mechanisms to ensure that we take this sense of commitment and consensus and turn it into good public policy.

MS. SEBELIUS: Well, there was a lot in the framework of the law that gave for the first time some new tools. And I know that -- I mean these are not my

numbers. These are the Congressional Budget Office and bipartisan economists. Health inflation over the last five, six, seven years has risen at the slowest rate ever recorded in the history of the United States in public plans and in private plans.

Now, it's everybody feels they are paying too much and it still is too much. And as Tom said, we still spend almost twice per capita what any country on earth spends on healthcare and our health results are pretty mediocre. To me that's one of the real issues. We are not getting a very good bang for our buck. Our citizens live sicker and die younger than most of our global competitors.

And that's part of the shift, is how you make Medicare -- Medicare spends \$1 trillion a year on health services. How you take that trillion dollars and make that a lever to a value based proposal. And that's really underway.

So whether it's cost coming down on Medicare overall -- I mean the per capita of Medicaid -- there are 11,000 people in this country who turn 65 every week, 11,000 people. So we are going to have cost go up in Medicare just based on numbers of people who are eligible for the program. But per capita costs are as low as they have been in years and that's really I think turning a corner that we just haven't seen.

MS. KENEN: Do you want to talk a little bit about what governors are doing about Medicaid because there's the old -- you know, you have the cut benefits: you can cut providers or you can come up with a new way of paying. And that --

MR. BESHEAR: Well, I will tell you what we had to do in Kentucky and nobody thought we could do it. During the recession I mean we were looking at going under, you know. I mean there wasn't any money. There wasn't any tax money coming in, but the expenses kept going. And unlike the federal government, we've got to

balance our budget. I know that's a novel idea, but we have to balance our budget every year.

And so the Medicaid program I was faced with cutting benefits, which I was just determined not to do, or doing something. And what we did is we took our fee-for-service thing and just wiped it out. I mean we went to managed care. And by that what I mean is that we brought private companies in and they answered RFPs and we basically approved them. People signed up and the Medicaid program went to them.

And instead of paying \$50 every time a doctor did a -- took your temperature. And so they would take your temperature eight times, you know, so eight times 50. That's fee-for-service. That's what we are talking about, is that every time somebody does something they get paid for it and all you are doing is writing them a check.

What we did is say, "Company, you got a hundred thousand of our people. We are going to pay you X dollars this year for that person. You got to manage their case. You got to make sure that they do get good healthcare. You are not getting any more money. So you get with that hospital. And, you know, when somebody goes there for a headache to the emergency room, you are only going to get 15 bucks for giving them some aspirin and telling them to go home and they have to go to a doctor down the road tomorrow and figure out what's wrong."

You know, you've got to get to a point to where somebody is managing that person and making sure that they get what they need -- but it's not always what you want; it's what you need. And that's tough. I mean that's not an easy thing to do. And there's a game. You know, companies will sometimes -- because they got to make money. So some of that \$100 that I just gave him for a year for that person, they got to make money off of that. So they got to manage that person, but, you know, don't cut too many corners. You can see where you can get into real issues with that.

But when we are talking about going to a value based system, that's kind of -- that's what we are saying, is that we want a person to get the healthcare they need, but you don't pay for every sponge that goes out like we do today.

MS. KENEN: We have time probably for just one or two more. Right here.

SPEAKER: Yeah. Dan Ovadi (phonetic). I'm an orthopedic surgeon and master's in public health. Let me first address your bit about the risk corridors that Tom talked about. That was exactly the approach that was used when Medicare Part D went through during the Bush administration. There wasn't any complaints from anyone about, you know, paying insurance companies, whatever. If they lost money, they would get reimbursed. And if they made extra money, the government would get money from them. Very much like what we did in the auto bailout.

With respect to some of the optimism up here, first of all, I think the fundamental problem if you drill down on this is Republicans. And I don't mean to attack you, Mickey, and you may not be like the typical Republican. They fundamental --

MR. EDWARDS: I wrote a book in 2008 (inaudible).

SPEAKER: They fundamentally don't believe that everyone should have healthcare. That is their fundamental philosophical viewpoint. And they don't believe that everyone is deserving. The deserving should have; the others should not. So unless you change that mindset, all this stuff about you asking for more funding in Georgia for all these people, public health -- that ain't going to happen.

Kathleen is telling us all they are doing is shifting money around for Zika. They don't want to raise taxes. That's the fundamental problem that we're not

paying taxes in this country. And I could go on this stuff for hours and hours. But --

(Applause)

SPEAKER: And I won't bother you with it. But I just don't see this stuff happening. We did a research project last year and I talked to Bill Haslam in Tennessee. Great guy; loved to have it. Worked with all the -- you know, the 1115 --

SPEAKER: Waivers.

SPEAKER: -- waivers.

MS. KENEN: Trying to do Medicaid. His legislature won't let him, yeah.

SPEAKER: Yeah, yeah. And he was all for it and it was going to help Tennessee tremendously. And all the rural hospitals were closing down. He couldn't get anything through. And, you know, the country is so goddamn polarized now with Democrats and Republicans hating each other more than ever. There's absolutely no way that we are going to get a compromise on this stuff I don't think.

MS. KENEN: Okay, thank you. Right. One more question and please make it a question. We've got one more.

SPEAKER: It is just a simple question.

MS. KENEN: A real question.

SPEAKER: Yes.

SPEAKER: Bill Williams -- oh, I'm sorry. Somebody else -- I just want to say the Colorado ballot has single payer initiative for this year. What does the panel think about states doing single payer? I mean I know they tried it in Vermont and it didn't work. Is that

a viable option or does it have to be kind of a national program or nothing?

MS. KENEN: A quick answer so we can then wrap it up.

MS. SEBELIUS: You know, I don't know enough about the Colorado initiative. I do think when the bill was first put together, the hope was to have a public option, which would have basically been a single payer option as one of the choices. I'm a believer that if you can make that a viable plan, that's a good choice for people to have, because we still -- you know, while competition works, we are again one of the only countries in the world that takes a 12 to 30 percent layer on the top for administrative costs and paperwork and executive salaries and agents and brokers and whatever else.

So -- but I just don't know enough about -- if you are asking can the Colorado plan work, I don't know how it's structured. But the public option certainly could have worked I think.

MS. KENEN: All right. Anyone else wants to say about Colorado? From that we're going to wrap up. Vermont did not manage to do it and they had a governor who was trying and Colorado has a governor who is not for it, so --

All right. Thank you all for being here tonight. We did cover a lot of ground. Thank the panel. Right.

(Applause)

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