

NATIONAL PRESS CLUB LUNCHEON WITH SYLVIA BURWELL
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBJECT: EXTOLLING THE AFFORDABLE CARE ACT (ACA) AND WARNING AGAINST
ITS REPEAL WITHOUT A COMPREHENSIVE, TIMELY REPLACEMENT

MODERATOR: THOMAS BURR OF THE NATIONAL PRESS CLUB

LOCATION: NATIONAL PRESS CLUB BALLROOM, WASHINGTON, D.C.

TIME: 1:00 P.M.

DATE: MONDAY, JANUARY 9, 2017

(C) COPYRIGHT 2008, NATIONAL PRESS CLUB, 529 14TH STREET, WASHINGTON, DC -
20045, USA. ALL RIGHTS RESERVED. ANY REPRODUCTION, REDISTRIBUTION OR
RETRANSMISSION IS EXPRESSLY PROHIBITED.

UNAUTHORIZED REPRODUCTION, REDISTRIBUTION OR RETRANSMISSION
CONSTITUTES A MISAPPROPRIATION UNDER APPLICABLE UNFAIR COMPETITION LAW, AND
THE NATIONAL PRESS CLUB RESERVES THE RIGHT TO PURSUE ALL REMEDIES AVAILABLE TO
IT IN RESPECT TO SUCH MISAPPROPRIATION.

FOR INFORMATION ON BECOMING A MEMBER OF THE NATIONAL PRESS CLUB,
PLEASE CALL 202-662-7505.

THOMAS BURR: [sounds gavel] Welcome to the National Press Club. My name is
Thomas Burr; I'm the Washington correspondent for the *Salt Lake Tribune* and the 109th
President of the National Press Club. Our guest today is the Secretary of the Department of
Health and Human Services, Sylvia Burwell. I would like to welcome our Public Radio and
C-SPAN audiences, and I want to remind you that you can follow the action on Twitter using
the hashtag #NPCLive. That's #NPCLive.

Now it's time to introduce our head table guests. I'd ask that each of you stand briefly
as your name is announced. Please hold your applause until I've finished introducing the
entire table. From your right, Dr. Charles Snyderman, Washington Bureau Chief and Health
and Science Correspondent for Audio Video News. Virgil Dixon, Washington Bureau Chief
and Modern Healthcare. Susan Heavey, Correspondent for Reuters News. Kelly Deal, a guest
of our speaker. Maureen Groppy, Washington Correspondent for the Indianapolis Star. Kiara
Diogostino, a guest of our speaker. Jeff Ballou, a News Editor, Al Jazeera English, and the
President-Elect of the National Press Club. [applause]

Skipping over our speaker for just a moment, Ferdos Al Farooq, a Senior Reporter at
MedTech Insight. Dina Fine Moran, Health and Medicine Editor at Scientific America. Tracy
Travado, a guest of our speaker. Marilyn Thompson, Senior Enterprise Editor at Kaiser
Health News. And Carl Livesdorph, Washington Columnist for the Dallas Morning News.
Thank you all.

[applause]

Ladies and gentlemen, happy new year and welcome to the National Press Club again. Today's luncheon speaker, Sylvia Matthews Burwell, was sworn in as the 22nd Secretary of Health and Human Services in June, 2014. She inherited the Affordable Care Act, known affectionately and not so affectionately as Obamacare, and was immediately charged with making it work after its rocky start.

As the Trump administration prepares to take office, and either repeal or at least significantly dismantle the Affordable Care Act, Secretary Burwell is here to provide her perspective on President Obama's signature domestic policy and legacy issue. As Secretary of HHS, Burwell has led more than 77,000 employees in work that strives for every American to lead healthy and productive lives.

She's also led the administration's efforts to deliver a smarter, more innovative, and more accountable government. As the HHS Secretary, she has overseen the development of the President's second term management agenda, including efforts to speed up high impact permitting projects and approve efficiencies and customer services. She has worked to ensure our regulatory system protects the health and safety of Americans and promote a healthier America through programs such as the President's Council on Sports, Fitness and Nutrition, which celebrated its 60th anniversary last year.

Now that we have enjoyed a healthy mill, as part of our new year's resolutions, to get fit and eat better, I ask you to give Secretary Burwell a warm National Press Club welcome.

[applause]

SYLVIA BURWELL: Thank you very much. And it's an honor to be here at the National Press Club. A little more than 100 years ago, a former President dropped by the Press Club. And of course, since it was Teddy Roosevelt, he regaled the audience with the story of surviving a lion's attack. He also hinted at an independent run for the Presidency. Just to be clear, I'm not going to do either of those. {laughter} Had you going for a second.

Roosevelt's party, the Bull Moose Party, would become the first in the United States to call for national health insurance reform. And so today, I am continuing a national conversation about our healthcare system that has lasted well over a century. We faced some very important choices with serious consequences. And I want to focus on how these choices will impact Americans' lives. I want to start by thanking the people sitting with me at lunch today, Kiara, Tracy, and Kelly, who are all here and telling their story about how the Affordable Care Act has made a difference in their lives.

Millions of people in communities around this country have stories just like theirs, lives made better, healthier, and more secure by the Affordable Care Act. Their willingness to share their experiences and speak out gives voices to so many others. And that voice, the voice of the American people who have benefited from this law, needs to be heard. Because through the noise of the rhetoric, they are actually the reality.

Nearly 100 years after Roosevelt's speech, his call for healthcare reform was as urgent as ever. We had improved the healthcare system in bits and starts. But, by the time President Obama took office, the need for reform was overwhelming. More than 40 million Americans did not have health insurance. Millions were stuck with coverage that wouldn't actually protect them if they got sick. And costs were rising at an unsustainable rate, making coverage unaffordable for families, businesses, and the federal budget.

So we had to address three key issues at once. We had to expand access to coverage, improve its quality, and start making coverage more affordable. Access, quality, and affordability. We took on all three. And today, we can measure the nation's progress with the Affordable Care Act. On access, the uninsured rate has dropped below nine percent, the lowest rate ever in our nation. [applause] And that's partly due to the continued growth of the marketplaces. So far this year, 8.8 million people have gotten coverage through healthcare.gov, more than last year. And we've set a new record for the most sign-ups in a single day.

It's also due to the 31 states and D.C. that have expanded their Medicaid program. And that number may soon be 32, since North Carolina just announced its plans to expand. And more access is leading to better health. That's what Kiara showed me at a New Jersey diner last month. She signed up for Medicaid in 2014 when New Jersey expanded the program. Just a couple of months later, she was diagnosed with breast cancer. She says that without the Affordable Care Act, there's no way she could fight this cancer. But she's here today, and she's fighting it.

Kiara's story is just another example of how the Affordable Care Act has closed the gap between the healthcare that people desperately need and their ability to use it. Since the law passed, the share of Americans who can't afford needed care has fallen by one-third. Researchers have found that among Americans like Kiara, who have gotten covered under Medicaid expansion, more people are getting treatment for chronic conditions. More people are getting care from a doctor instead of an emergency room. And more say they are in excellent health, and fewer are racking up medical debt.

At the same time, we've raised the bar for quality. That's true if you're covered through Medicare, where you're paying less for prescription drugs because ACA closed the donut hole. It's true if you get covered in the individual market, where, before the law, most plans didn't cover maternity care. A third did not cover mental health. And almost one in ten did not cover prescription drugs. Today, every marketplace plan covers those services.

And it's true, if you get covered through your employer, which most of us do, where more than half of the people used to have plans with lifetime limits. But now, those limits on coverage aren't allowed. Tracy Travado knows how important these protections are. When her husband Carlo faced a leukemia diagnosis, she confronted a question that no one should have to consider. Would they be able to fight leukemia on a budget? That's because their insurance plan, which they had through Carlo's job, once had a lifetime limit. But when she called her insurance company, they told her, "President took care of that. We don't have those limits anymore." Those words, Tracy said, were among the sweetest she's ever heard.

And while we've made all this progress on access and quality, we've also been holding down healthcare cost growth. Our national economy is now projected to spend \$2.6 trillion dollars less on healthcare over the course of a decade than it was projected to spend before the Healthcare Act—the Affordable Care Act passed. And that's even as 20 million more people are actually covered.

When policymakers look at any replacement for the Affordable Care Act, they should ask themselves three questions. First, does it cover as many people? Second, does it maintain the quality of coverage, the benefits we just talked about? And finally, does it keep bending that healthcare cost curve in the right direction? If it fails on any of these, it is then a step backwards. In access, quality, and affordability, the Affordable Care Act has helped make real progress for American families across the country.

But there is much more to do. In July, President Obama laid out ways we can improve the Affordable Care Act and further strengthen our healthcare system. He proposed tackling some of our most intransigent healthcare challenges, like addressing marketplace competition in parts of the country where there's too little competition right now. Helping families who still can't afford their coverage. And finally, lowering the cost of prescription drugs.

But we haven't just proposed ideas, we've actually tried to put our words into action. The President and our whole team at HHS had been putting the tools of the ACA to work, bending the healthcare cost curve, and improving the quality of healthcare. We've been doing this by changing the way we pay for care, so that we reward the quality of care, not the quantity of services delivered. We've been improving the way care is delivered, by promoting coordination and actually prioritizing and paying for wellness and prevention. And we've been working to unlock healthcare data and information so that doctors can make the most informed decisions, and patients can be active participants in their care.

We started to see some promising results. Accountable care organizations, for example, saved \$466 million dollars in 2015. And today, millions of Americans are getting higher quality and less expensive care. This is key to our vision for the future. You bring down costs across the entire system when you invest in getting people covered, and coverage, and care that help them stay healthy. This type of change isn't easy. And it's hard to capture in simple slogans. As for silver bullets, they don't exist. Instead, one of the most important things that I've learned from implementing the Affordable Care Act is that if something sounds too good to be true, it usually is.

And as we enter an important moment in the debate about the future of healthcare in America, I want to speak to three ideas that we've heard, that fit that description. The first of these is the notion that you can repeal the bulk of the Affordable Care Act but still guarantee that people with preexisting conditions can buy affordable coverage.

Last week our department released an analysis confirming that millions of Americans with preexisting conditions got coverage under the law. One of those Americans was Kelly Deal, lead guitarist of the rock band The Breeders. Like so many others, the law let her

pursue her passion and stay covered despite a preexisting condition. That's great. And it's great there's widespread agreement that people like Kelly should be able to get health insurance when they need it.

But we didn't make that goal a reality just by saying it's illegal for insurers to deny coverage because of a preexisting condition. In fact, some states actually tried that before the Affordable Care Act. Insurance commissioners from Washington and Rhode Island have described what happened next. Premiums rose sharply, making coverage unaffordable for sick and healthy residents alike.

With the Affordable Care Act, we took a different approach. The law prohibited insurers from discriminating against people based on their medical history, full stop. But it also recognized that health insurance operates on a simple rule. Sick and healthy people both have to be in the system. So the law created tax credits to make coverage more affordable and it also created the individual responsibility provision, which requires everyone who can afford it to get coverage or pay a penalty. That requirement is less popular. But it's the only evidence-based way to ensure a balanced risk pool. Without it, the Congressional Budget Office estimates that premiums would be a whole lot higher. And it's good for healthy people too. After all, you never know when an illness or injury is going to strike you. And just ask anyone with Tony Romo in their fantasy football lineup this year. You never know what will happen.

A second idea you may hear is that we can make coverage cheaper for everyone by lowering standards. Opponents of the law say that you should be able to buy a plan that covers only what you need. At first, it sounds kind of good. I think we can all agree that health coverage should be tailored to your needs. But when you go down this path of coverage a la carte, you face some tough questions. First, which benefits should we allow insurance plans to drop? Mental health? Maternity coverage? Prescription Drugs? The limits on out of pocket costs? All of these benefits were missing from a large share of plans before the Affordable Care Act. Plans without them were certainly cheaper. But, as the Congressional Budget Office recently pointed out, it's not clear that that counted as coverage.

Equally important in a world of a la carte health insurance, how are people who need certain services supposed to get them at an affordable price? Let me give an example. Suppose we let plans carve out outpatient—inpatient mental health coverage. It's a service that's both expensive and relatively uncommon. So plans sold without it will be cheaper. And most people will buy the cheaper plans, except people who need inpatient mental health treatment. In fact, they'll rise—their costs will rise high enough to cover the full cost of these services. What that means is that people aren't insuring against the health risk of needing treatment, they're actually buying the treatment on their own out of pocket.

All of a sudden, the insurance market in mental health has unraveled. And if a person finds out his depression needs the intensive treatment of an inpatient mental health program, you'll be on your own. Making coverage lighter by cutting back standards creates more

standards than it solves. It might work for the healthy and the wealthy, but it will put needed care out of the reach of millions of Americans.

The third issue I want to touch on is the idea of a Medicaid block grant or per capita cap. Medicaid is a vital health insurance program that covers more than 70 million children, people with disabilities, seniors, and low income adults. It's also the most efficient insurance program that we have. Covering people at a lower cost than commercial coverage, or even Medicare, with satisfaction rates that meet or exceed employer coverage.

But even with low per person costs, Medicaid is a major line item in state budgets, and a significant investment for the federal government. It's tempting to think that there could be a simple silver bullet that could cut costs without cutting coverage. That's what block grants and per capita caps claim to offer.

In the past, congressional proposals have cut federal funding for Medicaid by a third to a half, after ten years, while claiming that increased flexibility for states will make up the difference. But in healthcare, there's no free lunch. Outside experts concluded that these types of proposals would end coverage for at least 14 to 20 million people. That's because block grants and per capita caps don't give states new tools to control costs. They just shift the costs to states, giving them the so-called flexibility to decide whose coverage to cut.

Medicaid already gives states real flexibilities today. For example, waivers give states the options to innovate and improve their Medicaid programs, on a case-by-case basis, and in close partnership with the federal government. Arkansas used a waiver to integrate Medicaid expansion with its health insurance marketplace. And just today will be approving a Washington State waiver that will improve health and bring down costs by improving coordination of behavioral and physical health services.

Ironically, block grants and per capita cap proposals could actually set back the efforts that are already occurring through these waivers, which often rely on upfront federal investments. Block grants and per capita caps also leave states on their own to deal with unexpected challenges like natural disasters, spikes in drug overdoses, or public health emergencies like Zika.

Finally, I want to address an idea that sidesteps most of the tough challenges. Last week Congress took a first step toward repealing the Affordable Care Act without any replacement at all. Not only does this approach fail to tackle the many tough tradeoffs that come with real healthcare reform, it doesn't even succeed in delaying them.

Here are three things that would happen. First, as I've said before, the Affordable Care Act, if it's repealed without a replacement, the damage to the country's individual insurance market will begin this spring. If health insurance companies don't know what the market will look like going forward, many will either raise prices or drop out. That means more Americans won't be able to afford coverage, and others won't be able to find it at all.

Second, states and hospitals will be in budget limbo. Governors of both parties have said that repeal and delay would create unacceptable uncertainty for their state budgets and their states' economies. Meanwhile, some rural or community hospitals will have to shrink or even shut down if they can't count on funding through Medicaid.

And third, if Congress never enacts a comprehensive replacement, the consequences for American healthcare are quite stark. We would not just go backwards, we would fall behind where we actually started. With no replacement, experts have estimated that 30 million Americans would lose their health insurance, ten million more than the number who have gained coverage through the Affordable Care Act. And that's because the congressional repeal plan could lead to the unraveling of the individual market.

And our only chance of not going over that cliff depends on opponents of the law doing, in the next two years, what they haven't done in the past six, develop a comprehensive replacement plan. We face serious consequences. But delaying tough choices isn't what Americans get to do in their daily lives. And it's not what they deserve from Washington, D.C. There are millions of Americans who live with the reality of the choices that will be made in the weeks and months ahead, people like Tracy and Kelly and Kiara.

President Lyndon Johnson knew the true importance of this reality when he signed the law that would create Medicare. And he told that audience when he did the signing ceremony that day, "In this town, and in 1,000 towns like it, there are men and women in pain who will now find some ease." Our laws and our policies ultimately are defined by the impact on our bosses, the American people. We're judged by how well the men and women in towns across this country do. Because in the final analysis, those men and women are us. When you're facing illness, when your child is facing an illness, there is nothing more important in your life.

We all, at one point or another, will need to lean on this healthcare system of ours for support. When that occurs, no matter where you are, you want the system to work. And that's what I've learned in my life and from the many Americans that I've been privileged to meet as I've traveled across the country. So today, it's incumbent on all of us to ask the tough questions, to bring the conversation back to the reality and the substance, to elevate the facts and dispense with the fiction, to make sure that this conversation reflects the gravity of its impact on millions of Americans.

Thank you. And with that, I'm happy to take your questions.

[applause]

THOMAS BURR: Thank you Madam Secretary. Just a quick reminder for the C-Span and Public Radio audiences, that our luncheons are open to the public, so the applause you may hear is not necessarily from the reporters who are covering the luncheon. I wanted to start off with—and we're going to dig a little deeper, I think, at some of the points you raised. But of the proposals out there to replace the Affordable Care Act, have you seen one that you like or at least one that you think will do the least harm?

SYLVIA BURWELL: You know, I think we haven't seen a real proposal for a replacement. We have not seen—That's, I think, what this conversation is about. We have not seen a plan that can be measured or scored, to answer the three fundamental questions that I articulated. We need to know what does it do to access the number of insured? What does it do to affordability in terms of premiums and costs to the federal government? And what does it do in terms of quality? What benefits are preserved? And that's a place where we look forward to seeing.

I think the administration has been clear, we believe that improvements need to be made in the Affordable Care Act. We've articulated what we think those are and why we think we need those. But we have not seen a plan that is out there, that is actually a real plan, with the details that can answer the most fundamental questions that the American people actually deserve to know what the answers are before you take something like this away.

THOMAS BURR: So we have seen a few ideas from Republicans, not in full, I guess, scorable form. But let me ask you about a few of these if I can. The idea of selling coverage across state lines, that's a Republican thing. Do you think that would help?

SYLVIA BURWELL: The concept of selling, right now many of you probably know that insurance companies sell policies across state lines, large national companies sell the policies across state lines. So the state line idea is generally one that we've seen, I think, 400,000 is the estimate of how many people would be covered. I'm not sure what you do with the other 19 million in terms of the insurance. And then the other question is, generally speaking, selling across state lines becomes a race to the bottom with regard to those quality issues. In other words, do you let one state have a very low—they don't cover maternity leave, they don't cover mental health, they don't cover—And then you have a race to the bottom.

So I think this is why the conversation needs to focus on the substance. What are you trying to do? How are you trying to impact access, affordability, quality? What is your proposal to impact those? We believe we need additional improvements in affordability. We want to see more competition that will have that downward pressure. But connecting ideas to the substance of what they do is what we think is important at this point in time.

THOMAS BURR: I've also heard a lot of Republicans talk about the boosting in some form health savings accounts. Is that something that would help if there is a replacement for ACA?

SYLVIA BURWELL: The question of HSAs or health savings accounts, it's generally a tax break. It's a form of tax assistance. So you can put money away that isn't taxed. And so the question is, what are you trying to achieve? And for whom are you trying to achieve it? And what does it cost to do that? So the question of how one benefits whom at what cost. So that's the analysis that I think needs to be done. And, as I said, putting together a comprehensive plan that one can look at and understand. I have often said that the Affordable Care Act and our healthcare system is a little like a game of Jenga. And you

might think that looks like the good piece to pull out or keep in. But the tower will fall, because it's related as I described when I described how preexisting conditions interact in the system.

THOMAS BURR: Without the individual mandate, can any system work? For example, is the individual mandate the bottom piece in Jenga?

SYLVIA BURWELL: You know, the individual mandate is a fundamental part of the concept of insurance. Insurance is about spreading risk. And so you want everyone in the pool. And that's why those are important parts of it. When one does not do that, the costs become exorbitant. And so that's why, and as I articulated, in the Affordable Care Act it was a combination of the two things. The individual—requiring individuals to be in the system, those who can afford it, and so that they don't come into the system, do uncompensated care, increase prices for everything else, and the tax credits are subsidies. Those two things together created the ability for the preexisting conditions in others to come in.

THOMAS BURR: Thank you. Looking ahead, what do you say technically, not politically, but technically will be the Republicans' biggest obstacle in unwinding Obamacare?

SYLVIA BURWELL: At the table today, that's the biggest obstacle. It's the fact that this is real. And it affects everybody's lives. Most people, it affects obviously 20 million folks who now have insurance. But it affects everybody in this room, even if you have employer—but I'm assuming most folks in this room have employer-based care. Or maybe some folks are on their parents' plan until 26. But it affects everyone. And so that's what's different.

When the conversation shifts from the rhetoric to the reality of, do you want to pay that additional copay for those preventative services that are going to bring the long-term costs in healthcare down? Whether it's your mammogram or your colonoscopy or your preventative care in contraception, do you want those changes? Do you want the annual limits? Do you want to be in a place—I met the woman who, before the Affordable Care Act, she delayed her chemotherapy because she'd hit her annual limit. I met the child who had a very serious cancer. And by 15, had hit his lifetime limit, was not insurable.

And that's the reason, and that's what I think is the most important thing. It's not Washington, it's the nation. And that's why the conversation and the voice of the American people right now is so important. It's why we started hashtag-#coveragematters, so that people can tell their stories, because that's, to me, that is the most important thing.

THOMAS BURR: Thank you. So Republicans, however, we listen to them often, they keep saying the system is collapsing. There are some dire straits out there, and it needs a complete overhaul. Do you believe that's true?

SYLVIA BURWELL: You know, I would just pose the question, I think most people like children on their policy to 26, making sure preexisting conditions are covered. As

a matter of fact, I think we've heard a lot of people, including those same Republicans, say, "That's working. That's good." In terms of the question of collapse, maybe they're referring to the marketplace. But, as I mentioned in my remarks, 8.8 million folks, even in the headwinds we are facing, which so we know the headwinds, at our call centers we've received 35,000 phone calls from individuals in this country saying, "Is it okay for me to sign up for coverage in 2017?" Even in those headwinds, 8.8 million Americans have signed up. That's just in the federal marketplace. We'll have the total numbers out in the day or so that include the state-based marketplace. And we had a day that broke all records in terms of sign-ups. Most of those individuals, when surveyed not by us but by external consumer groups, say their coverage is satisfactory.

Are there things that need to be improved? Are there places where more competition will help and more affordability? Yes. But the idea of disaster and collapse I think those comments need to be examined.

THOMAS BURR: You talked about this in your speech, but maybe you could elaborate a little more. There is an idea out there right now that the Republicans will repeal Obamacare and delay it a couple years, with some kind of replacement to come down the road. You talked about the impacts that would have on the healthcare system. But also the impacts you mentioned a minute ago, American people worried about what they're going to do. Can you elaborate on that a little more?

SYLVIA BURWELL: You know, we continue to get the questions. And the fear, as a matter of fact, some of you may have seen the President did an interview with Fox, an interview. And there was a woman from Kentucky who actually had signed many people up for the Affordable Care Act, voted for the President-elect. And I discussed with her afterwards, she's a person who is there in Kentucky. And she said it's hard. She keeps getting asked, "Is it going to be okay? Is it going to be okay? Should I sign up?" And so that is very difficult.

I think the other thing that folks want to focus on is, in that design that was just described, where you vote for repeal, and you delay the replacement, and you don't know where it is, insurance companies make their decisions on going into the marketplace for 2018 in the first six months of the year. So by June, insurance companies will have to have decided, am I going to be in? Am I going to provide coverage? And for those, and at what price?

And with this delay knowing what you're doing—And the question is, is why? Why? Why do you want to repeal it without telling what we're going to do? I know it's hard. I've been working on it. I know it's hard. But that's not what we owe the American people. It's not what we owe the 20 million. It's not what we owe the 150 million who have coverage that is better. And so I think that's the question that we need to talk about over the next weeks.

THOMAS BURR: On the opposite side, are Democrats, do you believe, willing to compromise some provisions of the ACA to get others? Or is it an all-or-nothing situation?

SYLVIA BURWELL: Yeah, President has expressed it. Democrats have expressed it. Chuck Schumer has said it. The conversation about improvements or changes and what words you use to describe those, different sides may use different words, but let's have a conversation. Let's see a plan. Let's see a plan to have a conversation, a plan that has details that can tell you. I don't think most women think that it's a nitty-gritty detail whether or not their contraception is covered at no additional cost. I don't think it's a nitty-gritty detail whether or not your preexisting condition is really protected.

And that's the level that the conversation needs to get to. And that's because this isn't about Washington, D.C. This is about one of the most important things in every person's life, the basics of your health, how you're going to keep it, and how you're going to do something when it's not there.

THOMAS BURR: As Indiana's Governor, Vice President-elect Mike Pence fought the administration's review of Indiana's alternative Medicaid program, can you comment on how well Healthy Indiana has worked, and if it's a good model for other states?

SYLVIA BURWELL: You know, obviously I spent a lot of time with the Vice President-elect negotiating that waiver. And the Vice President-elect and then-Governor and I spent time on this waiver. And while I think he would tell you it didn't have everything he wanted, and I would tell you it didn't have everything I wanted, we were able to come to a place where we both believed that this was what was best for the folks of Indiana and for the taxpayers' money, which I also need to make sure I'm watching when we do the Medicaid negotiations.

We're in the middle of measuring what that is happening in Indiana. We do know that it has expanded coverage. We need to measure what happened in that waiver. But I think it's a reflection of the flexibility that exists in the system today, an important flexibility that was reflected in the work that we did with the Governor of Indiana, in the work that we did with Alaska, in the work that we have just done with the Governor of Arkansas, a Republican Governor that followed a Democrat, and wanted changes to the way the expansion occurred in Arkansas. And that was approved in December. And, as I mentioned, we're going forward with another waiver today in Washington State.

So I think what we need to do is work and have the conversations. These are very real conversations, as I mentioned. The Governor, new Governor of North Carolina has now said, and has put in that he would like to try and expand Medicaid for them. And that's hundreds of thousands of people.

So I think, again, it's moving these conversations to substance, measurement, reality. Glad that—I'm glad that we did the Medicaid expansion in Indiana. I want to make sure we measure. And I think we see more and more people getting covered. Look at when Governor Edwards down in Louisiana covered—expanded coverage, we saw the numbers and the sign-ups increase very, very rapidly.

THOMAS BURR: We'll run North Carolina for a second. Can you comment about your path forward there? The Governor wants an expansion, the legislature may not want said expansion. How do you proceed?

SYLVIA BURWELL: You know, with regard to the interpretation of state law, we leave that to the Governor and his team in the state. With regard to our role, we will process the Governor's proposal as expeditiously as possible when we get it.

THOMAS BURR: Thank you. President Obama promised the Affordable Care Act would create a vibrant, highly competitive market that would lower the cost of insurance. That hasn't necessarily happened. Why did that fail to come to pass?

SYLVIA BURWELL: You know, I think the question is, where it has happened, how much it has happened. Because for all of us, as I said, I think mostly in this room, the 150 million folks who have insurance through your employer, in five of the last six years, your premium growth has been the lowest that has been recorded. And so in terms of helping with the costs, we know that Medicare spending has been much lower than was predicted. Over \$300 billion dollars lower than was predicted before the Affordable Care Act. And we know for many Americans who are in the marketplace, that coverage is affordable right now. And it is open enrollment. And I encourage anyone who has not signed up to go shop, check for yourself, and see if you can find a plan. Because over 70 percent of folks in the marketplace find a plan for \$75 dollars or less a month in premiums.

And so, is it complete? Do we need to do more on affordability? Absolutely. That's why we'd like to suggest a public option that would create competition and downward pressure on price. It's why we also think it would be great if the Secretary of Health and Human Services had the ability to negotiate on high cost drugs. And so those are the kinds of things.

But in terms of, has progress been made? Yes. We've saved billions, from reducing the number of readmissions. Often I think we don't also include in the conversation, one of the things the Affordable Care Act did, was it gave us tools to try and experience for cost savings for the whole system. And so we've reduced the number of readmissions, when people have to go back into the hospital, that's bad for individuals, it's costly for the system. Reduce those dramatically. In addition, have been able to do things like create models.

HHS, CMS, the Center for Medicare and Medicaid Services, worked with the YMCAs across the country and did a program to lower those number of people who are prediabetic that become diabetic. The average savings over 15 months for the individuals was over \$2,600 dollars, and they lost five percent of their body fat. Those are the kinds of things that are the long-term changes we need on affordability.

THOMAS BURR: You've brought up several topics that we're going to get to. But we've talked a lot about the accomplishments of the ACA.

SYLVIA BURWELL: Just in case.

THOMAS BURR: Good. What was the greatest failure of the ACA?

SYLVIA BURWELL: You know, not—You'd want to go further faster. You would want to make more progress. You'd want to see, but you know, those are all things that I think that question has to be viewed in the context of what has been accomplished. And that's where the conversation has not often gone. And I think when one gets to the substance of the conversation, and what you're seeing in the last weeks, when people get to that substance, you see a different one. But I think further faster is always an answer and a place about that.

I think it is important to reflect what the ACA is in its entirety, because people use a shorthand. And one of the things that I think led a little bit to that, you know, is the marketplace and what happened around the first opening of the marketplace. But people define it that way, instead of broadly. And that's something we need to continue to work on, work on making sure people define success by number of insured, not just the marketplace. Number two, making sure people understand the broad benefits. And number three, these are all places where I believe we can work and do better and are focused on doing better, is making sure the American people's voice is heard.

THOMAS BURR: We have a lot of questions about this, so let's just get to the point. The United States is one of the few developed countries that does not offer our citizens the same universal healthcare. Why is that?

SYLVIA BURWELL: You know, the system—One of the things about the whole conversation about the Affordable Care Act is that, you know, there wasn't a compromise. And I know in the votes—you know, I wasn't here for that part, I was not back in Washington, I came after. But during that period of time, you know, compromises were made. This is a market-based system. That was part of the compromise. There were ideas. We saw what had happened in Massachusetts, led by a strong Republican Governor. And this is a system. It is our system.

We have a market-based system. That is the system we have. That is where we can work and make improvements. I think you're right to reflect that, when you actually go through the statistics on people that want change to the Affordable Care Act, a large portion of those actually want single payer as the alternative, versus the other. But we have a system. This system can work. We can have a competitive marketplace. We can work to get universal coverage. And I think the way we do that is by having the real conversation about, what is it we're trying to do? If we want more affordability, and we want more competition, then what's the path to get there? That's the conversation. That's where we need to push.

THOMAS BURR: Since you just talked about that, do you think it's going to be more challenging for Republicans to actually repeal the Affordable Care Act, given that parts of it were born with the Heritage Foundation, and Governor Romney, as you mentioned, passed Romneycare?

SYLVIA BURWELL: You know, I think in one sense, it's not even where it comes from. What I think is the most important point is what it does. And I don't think it's about whose idea or whose side, in terms of I think you're appropriately reflecting. There were important things that came from conservative approaches that are part of the system and are part of what is working now.

And so it's not so much about which side, it's about what is working and what needs to work better. And it's about how this relates to the American people. Again, I just keep coming back, that is what's most important here. That's the reality of the issue. And that's how we should all be the lens through which we view this issue.

THOMAS BURR: Personal question for you. Do you believe healthcare is a right or a commodity?

SYLVIA BURWELL: I believe that healthcare is a right. And I believe that because I believe it is fundamental in our nation, in terms of all the other things with a nation as wealthy as ours, that making sure that people have access to affordable coverage is something that we, as a nation, believe and should stand for.

THOMAS BURR: You succeeded Kathleen Sebelius. Was there anything she told you that has helped you in your job?

SYLVIA BURWELL: Kathleen was a friend and partner before I came to this role when I was at OMB. We were partners in the work that we did together. And Kathleen has been great. You know, it's funny. The most important thing that Kathleen told me is more than about the Affordable Care Act. It was about the people. Kathleen said, "You're not going to find a group of more dedicated, hardworking, creative, helpful, just people who are there for all the right reasons." And that's across the department, from the commission core officers, when no one would go in to fight Ebola.

We were calling countries around the world to try and get their doctors to go into West Africa, and no one would, until our commission core officers go to the hospital that the Department of Defense built, and are there to take care of those doctors. To the people who helped on my first July 4th, there were four and five and six year olds who were in holding pens on the border. And the people that worked 24/7 to get those small children placed in safe places. So the big thing that Kathleen shared, which was true, important, and a joy, is the quality of people.

THOMAS BURR: So following on that, what advice do you have for President-elect Trump's nominee, Tom Price, that you would give him coming in? And any anecdotes from your time that you would share with him?

SYLVIA BURWELL: I would say the most important thing is put the customer at the center of all the work that you do at HHS. And whether that's the kid who you're trying—and the parent for Head Start, or the research, the endpoint of that research, the person who has cancer that we're doing the research on, view things through the consumer at the center.

And I see many of those who follow healthcare closely in the room, and that I've been with since the beginning of this time. And they would tell you—and then I repeated from every open enrollment and everything, the theme that goes through is we put the consumer at the center. And that's the thing that I would just emphasize to my successor. Start with that. Because if you start with that and build out, you're generally going to get to a good place.

THOMAS BURR: Changing subjects for a second, what is HHS doing to stem the opioid epidemic across rural America?

SYLVIA BURWELL: So HHS has a number of pieces and parts they're a part of. And we have put together a three-part strategy to focus on stemming the tide and reducing the number of opioid overdose deaths and those that become addicted. And so it has three parts to it. The first part is prescribing and working on the prescriptions. And in the United States in 2013, there were 250 million prescriptions for opioids. And so you can think about that math. That doesn't feel right.

And so one of the most important things we did was put out new prescribing guidelines from the Center for Disease Control and Prevention to help physicians, to help those that are trying to deal with legitimate pain, that comes into their office. And prescribing guidelines. And the Surgeon General has been a very important part of getting those to be adopted.

Second is make Naloxone available. And Naloxone, or Narcan, which some people call it, is what you give people so, when they are having an overdose, they don't die. And it's sad, but it is a very important part of reducing the overdose deaths, is having access to that. So FDA has approved nasal Naloxone, which I'm sure you can imagine is easier than injectable Naloxone. We have worked to create greater access to Naloxone. And that's both using grants from SAMHSA, our Substance Abuse and Mental Health Administration at HHS, as well as working with states on the regulations that they use to guide how it's used.

The third element, and this one we've made important progress in the last—actually here in December, here in Washington, D.C. And that's providing access to medication-assisted treatment. For those who suffer from substance misuse disorder, or addiction many people sometimes call it, that—getting them the treatment they need to help them, because they are already on that path.

THOMAS BURR: Thank you. The Obama administration has made some major pushes in medical research, such as the Precision Medicine Initiative and the Cancer Moon Shot. Are you at all concerned those kind of projects are at risk under the new administration?

SYLVIA BURWELL: I think that both of those—I would put both of those in a category. My first January, so I was confirmed in June and then did a speech, I think in January. But one of the first major speeches that I gave publicly was something I referred to as the “common ground agenda.” Because I believed, even with the deep partisanship that

existed around the Affordable Care Act, that there were places of common ground. And I gave a speech and talked about it.

And in that speech, opioids—we just got that money through the bill—was one of the issues. Global health security. While it took a while to get the Zika sup—the Ebola sup came in funding and support for our Ebola efforts came more quickly. The third area was in this space. And in this space of research and precision medicine and making progress like that and cancer. So I believe those are both spaces, precision medicine and cancer and NIH research, where there is strong bipartisan support, there has been. And there will continue to be.

The last thing on the list, in that list—and usually I do threes, but an exception for this was delivery system reform. Reforming the fundamentals of our healthcare system, in terms of moving to a place where we pay differently what I mentioned in the speech. Don't pay for quantity of services, pay for quality. Number two, making sure that we integrate and coordinate care and do more prevention. And number three, data.

And we see progress in that. That's another place where there's been bipartisan legislation, MACRA. I won't go into it. That would be nerding out, even for this group. {laughter} But another place where we have seen progress.

THOMAS BURR: I think several of us reporters love the term nerd, so it works out just fine. NIH Director Francis Collins has raised concerns about the United States falling behind on basic medical research due to a lack of funding. Do you feel the same? And how do you think we should address that?

SYLVIA BURWELL: You know, I'll revert to my other hat, when I was at the Office of Management and Budget. And so when I came up to be the Director of the Office of Management and Budget, when I came in, sequester was in place. I arrived, and I arrived at OMB. And one of my first days at OMB was the alternative furlough day. At OMB we had more furloughs than any other agency in government, because we're all people, so there's nothing to cut, except have people stay home.

And so the reason I raise that is, the question of what our discretionary spending should be as a nation, as a percentage of GDP, is one of the ways that I think we should think about this, in terms of how do we think about that spending? And what are our priorities as a nation? And I think we have expressed—and in the budgets I worked on, and in the budgets I've contributed to, and my current seat, you know, funding for the National Institutes of Health and the research has been something that we've prioritized year after year.

And I think it's part of a broader question of how we think about what we spend our resources on, and what we dedicate, and whether that's to infrastructure and roads, or to research, or to making sure we have a public health system that can stand up when cases of Ebola come to our shores.

THOMAS BURR: Potential candidates for President-elect's Trump's pick for FDA Commissioner have said they would like the agency to approve products strictly based on safety and not efficacy. Could you speak to us about whether change in that regulatory standard is a good or bad idea?

SYLVIA BURWELL: When one thinks about it, again, I think just bringing the conversation to what are you trying to do. I think what we want in our country is innovation in drugs, and we want safety, and we want the drugs to be effective, and people to have an ability to judge and do that. And so simply doing a safety trial, that it doesn't cause harm to you when you take it, you know, there have been trials. And, you know, having spent lots of time when I was at the Gates Foundation and other places on trials, where something that met the basic safety test, later on you learn actually causes more of the disease. You know, it creates things that make you more susceptible to HIV.

And so the question is, again, what are we trying to do? Do you want more speed? Is that what people want? Or do you want people who have extreme circumstances to be able to try things? But get to the question of, what is it you're trying to achieve? And then, let's work together to find a place. What's the change that is being sought?

THOMAS BURR: Thank you. What do you think the outlook is for Medicare to be able to negotiate drug prices in the coming years, to drive down costs?

SYLVIA BURWELL: You know, this is another one where everyone—we need to move from the slogans, get on those high cost drugs to, okay, so how are you going to do it? And there are only so many tools. And, you know, I come from—You heard, I came from Wal-Mart. And, you know, everyday low price happens because of negotiations. I mean that's the way that, you know, a player does that.

And so the question of one's ability to do that, I think, would make a difference. In what we see as a growing percentage of overall healthcare costs. When we look at healthcare costs, whether it's Medicaid, whether it's the employer-based system, whether it's Medicaid, those drug costs are continuing to grow as a percentage of total cost. So even if we're doing a good job of controlling the other costs, this one continues to grow. So we believe it is a tool. The question of, can it happen, I think the question needs to be, what's the alternative? What do you want to choose? Do you want to choose not slowing drug costs? Or do you want to choose a different approach to do it?

THOMAS BURR: One of the bigger concerns in healthcare beyond cost and coverage has been cyber attacks, against hospital systems and potential vulnerabilities and connected medical devices. Based on your experience, what advice do you have for the next administration and the medical industry on how to challenge this?

SYLVIA BURWELL: Prioritize it. When I—The day that I was actually confirmed, that June 9th, there was a meeting of AHIP, which is the health insurance association. And so the CEOs were in town. And I went, you know, directly from the vote. The vote had occurred. I, you know, was at—And I think I even went from OMB at that point. But I went,

and it was interesting, because I'm sure you can imagine, those CEOs thought one of the first things out of my mouth was going to be about the marketplace, and we did talk about that, because that was the season where we were going to go into the second open enrollment. And they had some important questions about technology and other issues. And we did discuss that.

But one of the most important things I said to them was, cyber security. And it was before these incidents and events. And they were kind of—This is important. This is very important. And I would tell my successor, it has to be prioritized. People don't want to spend money on it. They don't want to spend time on it. It is extremely important that you put in place the protections, as much as you can. And even companies that had done protections, there are very advanced players. But the important thing is to do as much as we can to protect on that front.

THOMAS BURR: A question from the audience, one of the key accomplishments, the questioner says, of the Affordable Care Act, was the reauthorization of the Indian Healthcare Improvement Act, which passed as part of the ACA.

SYLVIA BURWELL: Yes.

THOMAS BURR: And authorized an Office of Indian Women's Health, an Office of Indian Men's Health. Neither has been set up so far. Will you be able to set those up before you leave office?

SYLVIA BURWELL: No, we'll not get those set up before. But I think what's important is the advancements that have been made in Indian health, and how one goes about doing that. And there have been, obviously, the provisions of the Affordable Care Act. Native Americans can sign up during any period, in terms of it. They have special enrollment times that they can do it. The coverage is leading to clinics that I have visited on reservations having funding flows, just like rural hospitals that will allow the folks who live, and parts of the tribes to be better served during this time.

My predecessor set up something called the Secretary's Tribal Advisory Council, which is a group of Native American leaders from across the country, that come together throughout the year with the senior leadership of HHS, to make the important progress on those issues. It is still incredibly difficult in the tribes and in reservations, on reservations across our country. It is one of the most acute health problems our nation faces. And whether it's the very high rate of suicide, including teen suicide—So these things are very important, in terms of the need that needs to be met, and the progress that needs to be made. That provision, if the Affordable Care Act would be repealed, would be repealed as well, which is an important thing to note as well.

THOMAS BURR: Thank you Madam Secretary. Before I ask the last question, a quick reminder, the National Press Club is the world's leading professional organization for journalists. And we fight for a free press, worldwide. For more information about the Club, please visit our website at www.press.org, that's press.org. Also, a quick reminder of our

upcoming events. On Wednesday we'll host Energy Secretary Ernest Muniz to speak about the Obama administration's accomplishments, and the Trump administration's potential changes to said accomplishments. On Saturday we'll inaugurate my successor, Al Jazeera's Jeff Ballou, as the Club's 110th President.

Now I would like to present our guest with the traditional National Press Club mug.
[applause]

SYLVIA BURWELL: Thank you. That's great. Thank you all for having me.

[applause]

THOMAS BURR: Thank you. One last question if I could. I'm wondering, after January 20, what your plans are. Specifically, what beach are you headed to? {laughter}

SYLVIA BURWELL: So my plans after January 20th are to walk our nine and our seven year old to school, and then that Monday that follows, to actually pick them up. To both walk them to school, and pick them up. So that is the main plan that I have when we leave.

THOMAS BURR: Thank you Madam Secretary, and we are adjourned.

[applause]

[Gavel]

END