Peterson Fiscal Summit 2017:

Improving Healthcare to Deliver Better Quality Care at Lower Cost

May 23, 2017

Interviews With sylvia matthews burwell, jim capretta, AND Dr. atul Gawande

moderator: julie rovner

Improving our healthcare system to deliver higher quality care at lower cost is critically important to our nation’s long-term economic and fiscal well-being. The U.S. spends twice as much on healthcare as other advanced nations — often with outcomes that are no better. And healthcare represents 70 percent of the future growth in major entitlement spending, so there’s no viable solution to our debt problem that does not include healthcare reform. Healthcare is also a key economic issue that affects wages, growth, and opportunity. In this timely conversation, three renowned healthcare experts discussed the current prospects for healthcare reform in Congress, and also how innovations in delivery reform, payment reform, and data transparency can lead to better health outcomes at lower cost.

This interview with **Sylvia Mathews Burwell**, **James C. Capretta**, and **Atul Gawande** was conducted by **Julie Rovner**, Chief Washington Correspondent, Kaiser Health News, as part of the [**2017 Fiscal Summit**](http://www.pgpf.org/what-we-are-doing/fiscal-summit).

\* \* \*BEGIN NEW INTERVIEW\* \* \*

ANNOUNCER: Ladies and gentlemen, please welcome this afternoon's panel, the incoming president of American University, Sylvia Matthews Burwell, American Enterprise Institute's Jim Capretta, Dr. Atul Gawande of Ariadne Labs, and your moderator, Julie Rovner of Kaiser Health News. (APPLAUSE)

JULIE ROVNER: Thank you all very much. We have of course saved the best for last. I know (LAUGH) you've been talking about healthcare all day. But now we're gonna really talk about healthcare. I am so excited for this panel. I will start on the end. As you've heard, Sylvia Matthews Burwell is about to be the president of American University.

For the point of our discussion she was the Secretary of Health and Human Services under President Obama from 2014 until this past January. Prior to that she ran the Office of Management and Budget for President Obama. And prior to that she was the COO of the Bill and Melinda Gates Foundation.

To her right, my left, is James Capretta. He's the resident fellow, and Milton Friedman chair at the American Enterprise Institute in Washington DC. He was an associate director of OMB under President George W. Bush, and prior to that worked for the Senate Budget, and House Ways and Means Committees.

Finally to my immediate left you've already met Atul Gawande, who is a surgeon, a staff writer for *The New Yorker* magazine, and author of best-selling books, and executive director of Ariadne Labs, which studies innovative ways to improve healthcare, which you've always heard about-- already heard about. Anyway I wanna get right to it, 'cause there is so much to talk about.

I wanna start with the news of the day, which is the budget that President Trump appears to have kept his promise with not to cut Medicare, a little bit less so with social security, and definitely not-- kept his promise not to cut Medicaid. So I wanna start-- start at the end. What impact do each of you think that these cuts, if enacted, would have on the healthcare system?

SYLVIA MATTHEWS BURWELL: So I-- I think that-- the cuts that we're talking about are devastating would probably be-- the word that I would use. Because when one combines-- what was proposed in the House bill on the Affordable Care Act with these cuts they're even deeper.

And-- and we know those numbers are resulting in-- the last score that we had was 24 million people-- losing their healthcare. And I think when one thinks about Medicaid it's important, especially for this conversation, to reflect on the fact that-- I think people associate Medicaid simply with the poor.

But I don't think they also recognize that it's the elderly, and that it is the disabled. And when you combine that with the cuts that are the SSI, the social security cuts that you were referring to that are part of SSI disability, I haven't gotten to see the final numbers, but I think the overarching is indicative of these are some-- some very really damage.

And I think in-- as we're gonna have a healthcare discussion, that cuts to the NIH-- so when I left the Department of Health and Human Services, if we maintained the sequester levels of spending, our spending, when adjusted for inflation in terms of the largest research institution, one of the largest in the world, would have been at the same levels as when you were at OMB. And there's some years-- be-- (LAUGH) between that period of time.

And when we think about the cuts to the Centers for Disease Control, you know, in terms of overall heath, having had to manage through Ebola-- as well as Zika, those cuts combined with the cuts that have com-- happened at the local level in terms of our ability to protect our own safety are all things that I find very concerning. (LAUGH)

JIM CAPRETTA: Well, from my perspective I-- I think, you know, maybe start from the perspective of what needs to be done fiscally. And then we'll talk about what's going on in the Medicaid program. So it's quite true that any fiscal plan that came forward that-- that was a good one would have addressed major entitlement reform from my perspective.

That the fiscal situation in the country is such that we're well into the retirement of the baby boom generation. And within five or ten years the fiscal situation's gonna get pretty bad. And so somethin's gonna have to give. And one of the big areas of course would be to reform the major entitlement programs of social security, and Medicare, and Medicaid.

All three of them are in need of some attention in that regard. They've chosen just to look at Medicaid. So I think that's probably was mistake number one. The second thing is to kind of come at this thing with-- a sense of realism. So as it was already stated that they assume in the budget that the-- and there's some kind of an enactment of repeal and replacement of the Affordable Care Act.

And they assigned $250 billion in savings to that. The House bill maybe is what they have in mind with that. But that already has $880 billion in Medicaid savings in it, which is used to finance some other things, especially the replacement tax credits. So they've spent some of that money in the $250 billion in net savings that they're cur-- they're counting.

And then they're saying they're gonna cut another $600 and some billion in addition to that. There's just-- very, very, very unlikely that could ever be achieved. And so at that point you're talking about something that looks more like a paper exercise than a real reform. And that's not how we're gonna get this done. And we do need major entitlement reform. Okay, so give 'em credit for maybe nodding in that direction. But the way they went about it I think is just not-- is ill advised.

DR. ATUL GAWANDE: The-- the only thing I would add to what both of you had to say is to step back a second, and say, "What is the goal from a healthcare point of view about what we're doing with healthcare?" In what way are we making people's lives better, or the healthcare system better, or a long run-- approach to-- healthcare better?

And the budget only takes a bill that already for every measure of performance of the health system, of-- and of the public's health already-- had no way in which it made it better. And every measure got worse. This would be devastating blows to our scientific infrastructure, to our public health infrastructure, and to-- health. And I'll just point out a couple of critical things that we've learned about the effects of just having had four years of implementation of the ACA.

We have seen that-- you take that away, and you will have more untreated sickness, and more death. And we have now increasingly abundant evidence of this. People who got coverage-- in the last four years have ended up with better primary care, more access to primary care, more access to emergency rooms-- more chronic illness treatment and care. You're also seeing better mental health management and care-- marked reductions in-- depression, in severe depression, as well as in-- being able to have treatment for addiction. So, you know, in terms of our experiences as patients-- this was to begin with-- a set of circumstances where we've moved the expectations towards how bad is this gonna get, and then just pushed it off the cliff.

ROVNER: So you've kind of alluded to my next question, which is, you know, we're in the midst of this healthcare debate. We're partway through it. And yet we don't seem to have any idea of what the goal should be of working on healthcare right now. So I-- I want you to each again, let's go way up to 30,000 feet, and I think I'll start with you, 'cause you were already talking about it.

What should be the goal that we are reaching for? As we know, as you-- as you so articulately suggested earlier, we spend way too much. There's no question that there isn't money to be saved. But what-- what should the federal government, with it's own tools, be aiming for in fixing healthcare?

GAWANDE: I think there are two really big goals-- that I think are crucial. Number one-- and-- and I'll say that in my conversations with both Republicans and Democrats there-- there's a wide constituency around the idea that we need to make sure that we do not make coverage worse, that we should try to make it better.

And so you see people like Susan Collins, and Cassidy who have been very explicit that the goal needs to be that we address the still gap for 20-- to 20 to 30 million people who lack coverage. The second, and I think this is underestimated as-- as an important set of goals, we need to be transitioning to a system where you have secure coverage not through your employer.

So most of the new jobs being added, like, well over three quarters, are in spaces where they're temporary workers, independent contractors, and other forms that do not come with benefits. And for-- and that's more and more the future of the economy is that we're needing to move a place-- to a place where we recognize that most of the new jobs are in capacities where you're not gonna get coverage through your employer.

And so securing that when you get coverage on your own you have-- a secure way of doing that with affordable-- approaches are crucial for the middleclass to be able to prosper going forward. And our only choices are to expand Medicaid to become a middleclass entitlement to enable people to-- opt into Medicare advantage plans, or those kinds of options, or we have the exchanges, and we make them work.

CAPRETTA: Well, from my perspective the-- the goals should be sort of three I would say. One would be kind of at a high level political level, which is greater social consensus and stability around the-- sort of an approach of distributing financial responsibility, and personal responsibility, and societal responsibility, and dividing up who's paying for what.

I think a lot of health reform is really a question of trying to do that, and finding a consensus where everybody says, "Okay. We've reached honorable resolution of that question." That would be one goal I think, and an important one. The second one would be to do it in a way that achieves some level of near 100% enrollment in health insurance.

I'm not a big believer in the notion that health insurance is the be all, and end all. 'Cause I think a lot of the data indicates it's not, that just having in-- insurance of course is-- a way of financing very expensive care that people need in that kind of situation. But a lot of the hel-- health outcomes data doesn't show huge improvement having health insurance versus not. So I think--

GAWANDE: I'll disagree with that. But you can go on.

CAPRETTA: Yeah. (LAUGH)

BURWELL: I'm glad you did. 'Cause I was going to.

CAPRETTA: Yeah. (LAUGHTER) So I-- I think the-- but it-- that doesn't mean people shouldn't have health insurance. I do think they should have health insurance. I do think it's a way of making sure that there's a ready access point for care when something big happens in most-- you know, that's it's most valuable use.

So everybody should have health insurance. So that ought to be a goal. And then the third goal I would say is to bring discipline to the system, so that there's lots more actors involved who are looking for figuring out, and then picking low cost, high value options for getting their services, as opposed to high cost, wasteful options, which is typical in many circumstances. So those are the three things I would do. And-- and-- I think that would be worthy exercise.

BURWELL: In terms of goals I think-- the goals are similar to the goals of the Affordable Care Act, which are access, affordability, and quality, and I would add in a fiscally responsible way. And-- to get to the earlier point about making sure that we-- we think about those things.

But I think if one focuses on those three goals as one has the conversation about healthcare, and I think it's also important to recognize that it's a conversation for healthcare for the nation. You know, there are obviously, you know, about-- in terms of 150 million people, you know, employer based care, versus Medicare, versus Medicaid, we'll just use-- and the marketplace.

The marketplace is obviously the smallest. Individual insurance is the smallest of those. But when we think about healthcare in our country I think we have to think about all of those. And while the entitlement issue is a driver both in state budgets-- in terms of the Medicaid issue, as well as the federal budget and the Medicare issue, I think looking at the overarching picture, which I think is something we'll talk a little bit about today, and reforming our entire system-- on that front is a very important thing.

Because when we look at cost efficiency on a per capita basis, and the cost efficiency, Medicaid is the most efficient with Medicare next. And then the private system is the-- the-- the most expensive. And we have made some progress. That's the other thing, and I think it's lost in this conversation, is with regard to let's do affordability for the taxpayer, that fiscal element.

If one looks at what CBO projected-- the healthcare cost, Medicare cost to be during the period from 2009 up through about 2014-2015, when we look at what actually happened from those projections over $400 billion was saved in terms of they projected this, we were lower.

And so some progress has been made in the quality space, readmissions. In the period from 2010 to 2015 readmissions, which we'll use that as-- one proxy for quality, has been reduced by over 500,000. And that translates to quality of care, but also money in terms of savings.

ROVNER: Did you wanna take on the-- the question about the value of insurance?

GAWANDE: Well, I-- I-- I mentioned some of it briefly. But I th-- we have-- strong data now coming in, both from the Massachusetts experiment, which is now almost a decade old, and-- data from-- people who've gained coverage under the ACA-- that you have improved care sp-- of various kinds.

So there are the insurance benefits, which you were talking about. It is a protection against catastrophic health expenditures, and people are not-- facing bankruptcies at-- at nearly the race otherwise. But the big gains are-- that come from improved access to primary care, emergency care-- and so on, has been improved health indicators. So marked improvements for people's-- levels of chronic melt-- mental illness, and-- physical function.

And that's also translating into-- growing levels of improvement in survival. So the estimates for the Medicaid expansions, it depends on which state it is, but it-- for every 250 to 800 people, so Massachusetts-- we're-- we're a healthier state, every-- for every 800 people added on we saved one life every year. In-- in other states where you have poorer health, or poorer populations it's been-- about 250 people who gained coverage. And one person will have their life saved that year-- and for the next years to come.

So-- I don't wanna underestimate the health gains. But I think there is more to it than the story, which is also the larger picture you were talking about, both of you were talking about, which is the-- the coherence of the entire health system from a quality, and affordability point of view as well.

ROVNER: And I will point out that there's been a robust debate over the last at least 15 years about the-- the value of health insurance on health, and whether that is-- how much of an indicator that is. We seem to be living in-- in a Washington full of alternative facts these days. So I thought I would give eas-- each of you the opportunity to-- to come up with what is the-- the single most misunderstood thing about the 2017 healthcare debate, the thing that you keep seeing that makes you completely crazy? (LAUGH) I'll let you start. (LAUGHTER)

CAPRETTA: Wow. That'd be a long list I suppose. But-- I guess the-- the-- the thing that kinda bothers me the most is that the-- well, I think there's a misplaced emphasis amongst the Republicans frankly on trying to-- address what they think is lower premiums by changing, you know, the insurance regulatory structure, which, you know, is really-- a marginal fight on-- on a side issue from my perspective, that it's not highly consequential in the overall scheme of things.

We're just basically divvying up a little bit differently, depending on how you regulated, who's paying for the cost of care, and maybe allowing slightly lower premiums for healthy people, and slightly higher premiums for unhealthy people. So is that really worth all of the back and forth I think that they're going through over it? I really don't think so.

I think that's sort of ending up bringing a lot of attention on something that's really a side marginal issue. So I think there's a misunderstanding that the kind of competition that they want, which I agree with, has to be only on the level of insurance premiums.

To be honest with ya the-- the kinda competition that is most beneficial is when you have different suppliers of medical services (LAUGH) actually having to compete, and figure out how to do their businesses a little bit better to bring their costs down. And so that's the-- the real kinda competition that they should be focused on, not so much, you know, how to get a slightly lower premium, because I'm, you know, not gonna be counted in the same pool as somebody else. So I think that's a misunderstanding.

BURWELL: You know, I probably-- agree with that in terms of the what dri-- the importance of that competition, and driving that competition. I would just add in terms of frustration around the facts is just actually at the-- just at the largest level, that people don't actually engage with the facts, or the substance, or want the analysis-- to make the decision.

And I think that's been an important part of the evolution of the conversation since November really in terms of people coming to grips with the facts are. And whether those are the facts that more people do have access to health insurance, and have health insurance, that-- there had been changes, and that many people now just accept that preexisting conditions should not keep you out of health insurance, and the facts of where we actually are as a nation including in the-- the cost, and price element.

Because one of the things in the premiums space-- a fact that I think is little known is that in five of the last six years in the employer based market, and I would assume that most people in this room actually are in the employer based market is my guess, and for those people you've had five of the last six years of slowest growth we've seen in premiums.

Now in the marketplace I'm-- (MIC NOISE) my last year, an unfortunate year to have-- premium increases (LAUGH) that were strong in a number of places. But again that fact, yes, Arizona had incredibly unreasonable premium increases. But in states like Ohio it as 2%, which is actually very, very low for health inflation. And for the vast majority of people what-- were they impacted or not? No, because of the way the subsidies.

So it's a whole litany of just can we get to what is actually substantively true? Because I think that gets us to your other question, which is what are our goals? Enhancing competition, so we can force downward pressure. What are our goals? Making sure we have access, affordability, and quality. And so getting the conversation centered on the substance of what we're trying to achieve, and then the facts around where we are, and the approaches to get there, which I think is one of the things you were getting to, Jim.

CAPRETTA: Right. (LAUGH)

GAWANDE: Like-- like you there's so many-- so many facts that-- that can-- can drive you crazy. And I'm tempted to go in after the-- the-- the-- the-- the exchanges are collapsing. Right? So they're-- they are having serious problems pricing in an environment where you have no certainly about whether there's gonna be a mandate, no certainty about whether there's gonna be changes in minimum benefit ec-- in the-- in the benefit expectation, no-- no certainly about whether they're gonna market your plan or not as you go out into the-- into the world, and whether there's gonna be subsidies for people around cost sharing.

And so, you know, my discussions with people who have to be in the business of creating a price-- (SIREN) by mid June, that's the drop dead deadline when they have to offer a price to go out in-- into the world, and they're being told that they-- that-- they won't have any guidance on this information. (SIREN)

And the only way they cope is either to pull out, leaving many states with one or no insurers in that market, or they will-- have to be able to-- set a price that is so high that it buffers them against any conditions that might be out there. And that is this self-fulfilling prophecy of-- you know, lighting the match that-- causes the fire, and then asking, "How did this happen?" (LAUGH)

We're in a place where I think it's inevitable now. I think that the-- that there are gonna be areas where it will not be possible to-- have real competition in the marketplaces. And so the-- just because-- you know, not very many insurers are gonna wanna jump into these circumstances. My concern is that that leaves us in a bad place almost no matter what happens out of the debate, which is that the-- the marketplaces lose credibility from both wings.

You know, we've had learned how to structure. You know, interestingly Medicare runs a marketplace. They run a marketplace for Medicare advantage plans. And it's gone very smoothly. And it orchestrates a competition against prices every year.

BURWELL: And for Part D.

GAWANDE: What's that?

BURWELL: And for Part D.

GAWANDE: And for Part D. You know, it took-- takes learning how to do that. And there were stumbling blocks along the way when Part D started out in-- in running a marketplace. But I think that this process will lead us to lose confidence in the idea that when you're buying insurance on your own that-- that we can structure fair marketplaces where this happens. And then the only place that leaves us is-- is to-- either leave people's-- suffering in the middle, or-- or have to move in the direction of expanding Medicaid-- to put up more and more of that population.

ROVNER: I think one of the things that's gotten us into this entire situation, and I sort of blame myself, is a lack of understanding of how the healthcare system works. Nobody has-- everybody touches their piece of the elephant, and nobody has any idea sort of, you know, what the bigger picture is.

I-- I brought a tweet that I copied down. Let's see if I can find it. It's-- from this afternoon. This was Jen Bendery from Buzzfeed who said, "Bob Corker," senator from Tennessee, "Says senate Republicans' process for writing a health bill is quote, 'Very awkward at best,' quote, 'Because there are no experts or actuaries in the room.'" (LAUGH) So my question is who's the most important to educate, the public, the policymakers, people in the health system themselves? And how do we do this (LAUGH), I mean, as it gets more complicated?

GAWANDE: This is actually really simple. The answer is, yes (LAUGH), and you have hearings. (LAUGH) I don't know what it-- (LAUGH) that's it. That's what it boil-- (LAUGHTER) boils down to. (LAUGHTER) You-- you educate everybody. And-- you have hearings where the actuaries, and the-- and-- and the public gets to hear the discussion about it.

CAPRETTA: Yeah. I-- (LAUGH) I think our system is so complex that-- that the-- what the policymakers need to focus on isn't so much the-- the really micro details, but getting the architecture basically right, and setting it in motion, so that it can self-correct over time.

And there I think, you know-- the-- question that really is I think at the center of a lot of our debate is how much decision making should be handled through a federal regulatory process, and how much decision making should be left to other parties, employers, consumers, individuals, states, and so on? And this kinda goes back to-- your question of what's one of the goals. I think we need to-- to sorta grapple with our-- country, our-- our political process needs to grapple with coming to some consensus about divvying up who's responsible for making those decisions.

And so if they can get the basic architecture right, get some buy-in from both parties about who's deciding what when, then the decision making will flow, you know, in the following years. And I think, you know, one of the big complaints about the Affordable Care Act, I mean, there's-- it's-- been stated, and I agree with, it's done many things to bring people into coverage.

It's subsidized a lot of people through the Medicaid program into coverage, and through the marketplaces. A lot of people have health insurance that didn't have it before. But a complaint that p-- would be made is that a lot of the decision making (UNINTEL) have been pretty heavily centralized with the federal government. Is that a good or a bad thing? That's a political science question really that you have to answer over ten or 15 years.

It's not somethin' you can answer in one year what happens to the system over time when you run decision making all through that kind of a process. So those are the kinds of things I would think we need to focus on, not so much makin' sure every member of Congress knows every detail. (LAUGH)

BURWELL: I think the all of the above to answer the initial question in terms of who needs to be educated. Because I think in a democracy on an issue that is as important as healthcare is for every individual, and their families, as well as the economic implications of healthcare in our country for businesses, for the federal government, for individuals, I say all of the-- above in terms of who needs to be educated.

I think that that is-- a complex process. And, you know, to use-- a tools example, you know, there were over 100 hearings on the ACA. And whether that is the forum that people get educated in or not in terms of the public or not, it is an important part of the process. I would also argue that actually committees need to have expertise.

Chairman Brady, who was just here before us, is truly an expert in text policy. That's-- he is the chairman of the Ways and Means Committee. He is an expert. He is who-- how as a system-- the democracy, and the way we have it work. We elect officials. There are committees that can have that kind of expertise.

I actually think it is important. And I do think that there are some questions that some might consider details, like our certain types of women health (SLUR) coverage covered or not that actually are important to-- to know, and understand in terms of what you're doing. I mean, we had a member-- we had members say, "Well, I don't know if this is going to fix the problem I'm trying to fix." And then they vote.

And so (LAUGH) how do we-- I actually think there is a certain level of detail, and a certain expectation we should have. And I agree-- the question of-- what role does the executive branch have, and what role do others have with regard to the questions of regulation I think is also an important one, and-- and a fair one to do.

And I think the way you get that f-- more freedom is you do-- just a certain level of consumer protections. When you think about essential health benefits there aren't that many. They were designed, and based on science. And you may disagree, and may wanna pull one or two out. But once you have that in place, the certain types of protections, so for instance do we think that policies that are in the individual markets should cover maternity?

Should they cover hospitalization? (CAR HORN) Should they cover drugs? I mean, the-- the list-- if I read-- if we went through the whole list, I think most of you are sitting here nodding when I'm saying this. You know, to think that if you bought a policy in the individual market before the Affordable Care Act, the likelihood-- I mean, there was probably about a 50% chance you could've-- I could've purchased a policy that would not have covered when I got pregnant, and had a child.

And would you think to check that? Wouldn't ya think that would be-- and so this question, I agree with you. I think what you try and do is it's kinda like a really big ranch, which is you have places to roam, which I think is what you're suggesting, for insurers, for health systems, and that sort of thing. But there is a fence.

And the fence has been something that's been divined by science, and a basic agreement. We believe preexisting conditions are something that should be covered. We believe maternity. We believe mental health should be covered. And then have some freedom, you know, and some of the flexibility you're talking about.

ROVNER: Good. Well, I have many more questions. But we are out of time. So I wanna thank my panel. And I'm sure we will do this again soon. Thank you.

GAWANDE: Thank you, Julie. (APPLAUSE)

BURWELL: Thank you. (APPLAUSE)

\* \* \*END OF INTERVIEW\* \* \*