

NATIONAL PRESS CLUB LUNCHEON WITH THE HONORABLE KATHLEEN SEBELIUS

SUBJECT: HEALTHCARE REFORM AND YOU

MODERATOR: ALAN BJERGA, PRESIDENT, NATIONAL PRESS CLUB

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ALAN BJERGA: (Sounds gavel.) Good afternoon, and welcome to the National Press Club. My name is Alan Bjerga. I'm a reporter for Bloomberg News, and the President of the National Press Club. We're the world's leading professional organization for journalists and are committed to our profession's future through our programming and by fostering a free press worldwide. For more information about the National Press Club, please visit our website at www.press.org. And to donate to our programs, please visit www.press.org/library.

On behalf of our members worldwide, I'd like to welcome our speaker and our attendees at today's event, which includes guests of our speaker as well as working journalists. I'd also like to welcome our C-SPAN and Public Radio audiences. After the speech concludes, I will ask as many audience questions as time permits. I'd now like to introduce our head table guests.

From your right, Carlos Hamann, editor at Agence-France Presse Newswire in Washington; Marilou Donahue, producer and editor of Artistically Speaking; Peggy Eastman, president of Medical Publishing Enterprises; Jeanne Lambrew, Ph.D., Director of HHS Office of Health Reform, and a guest of the speaker; Susan Heavey, health reporter for Reuters; Jay Angoff, special advisor to the Secretary and a guest of the speaker's; Melissa Charbonneau, vice chair of our Speakers Committee and producer for Newshook Media.

Passing over our speaker for the moment, Doris Margolis, president of Editorial Associates, former Editor and Publisher of the Margolis Health Report, and the National

Press Club Speakers Committee member who arranged today's luncheon; Marilyn Tavenner, principal deputy administrator for the Centers for Medicare, and a guest of the speaker's; Martha Craver, associate editor for The Kiplinger Letter; Luke Russert, NBC news correspondent for Congress, and a new member of the National Press Club; and Jamie Friar, veteran Associated Press broadcast newsman, and a new member of the National Press Club. (Applause)

Kathleen Sebelius, Secretary of the Department of Health and Human Services, leads the principal agency charged with keeping Americans healthy, an 80,000 employee institution that's been the focus of some of the Obama Administration's top priorities. As the country's highest ranking health official, she has been a powerful voice for reforming our health insurance system, along with coordinating response to the 2009 H1N1 flu virus and providing a wide range of services from healthcare to child care to energy assistance during the economic downturn.

Sebelius, whose father was governor of Ohio and whose father-in-law was a Kansas Congressman, has decades of political experience in her own right. She served in the Kansas House of Representatives from 1987 until 1995, followed by eight years as the Kansas State Insurance Commissioner, where she was selected as public official for the year for 2000 by *Governing* magazine. In 2002, she was elected governor of Kansas, and in 2006 was reelected for another four year term. In 2005, *Time* magazine named her one of America's top five governors. She has two sons and her husband, Gary, is a federal magistrate and judge who claimed the title of "First Dude" years before Todd Palin attempted to take it as his own.

As Health and Human Services Secretary, Ms. Sebelius has played a prominent role in crafting the healthcare reform legislation and was with the President when he signed it into law two weeks ago. Today, she will succeed to expand our understanding of this very complex and controversial act, as she speaks on health reform and you. Ladies and gentlemen, welcome to the National Press Club the Honorable Kathleen Sebelius. (Applause)

MS. SEBELIUS: Well, thank you very much, Alan. It's my great pleasure to be here. I understand that this date had a bit of controversy. I promised to come as soon as the bill passed, and so it's been rescheduled just a few times. But glad to have the chance to visit with all of you. And I have to applaud you, too, for having a Kansan as your president. I like Kansans who run things. So it's good to see Alan again. (Applause) Yes. But pleased to have a chance to visit with all of you.

You know, when the conversation about reforming our health insurance system began nearly a year ago, there were some pundits who thought the days of America solving big problems were actually over. They wondered whether transformative legislation like Social Security or Medicare was part of a bygone era, like soda fountains and five cent matinees. But last month, I think those pundits got a definitive answer. After decades of asking "when are we going to fix our broken health insurance system," we finally have an answer, which is starting right now.

The law that President Obama has signed will give Americans more control of their healthcare. The mom who worries that she'll have to skip her next round of chemotherapy because her insurance policy puts a lifetime cap on her benefits, can stop worrying. This law makes those caps and other unfair insurance practices illegal. The factory worker who up until now puts off retirement because he knows his diabetes makes it impossible for him to get healthcare coverage as an individual on the open market can have some peace. This law will end insurance practices that allow insurance companies to discriminate based on preexisting conditions.

The entrepreneur who's been afraid that she wants to buy insurance but can't find an affordable policy finally gets some relief. This law will create a new consumer-friendly health marketplace where she can band together with other consumers to negotiate lower rates, just like Fortune 500 companies do. And the parents like me who believe that we need to reduce our long-term debt so our children will have the same opportunities we had to feel confident knowing this law just doesn't pay for itself, it actually reduces the deficit by more than \$100 billion over the first ten years, and over a trillion dollars over the next ten years.

Now, I want to be clear. The affordable healthcare act is not a magic formula that will cure all the problems in the health system. It takes time for all the benefits to kick in. And if you look at history of major social legislation like Medicare, you'll see that there are always revisions and adjustments along the way. But this law, in and of itself, is the biggest expansion in healthcare coverage since Medicare, the biggest middle class tax cut for healthcare in American history, the most aggressive cost cutting law in healthcare that we've ever had. And the most ambitious healthcare innovation legislation that we've ever seen passed, all rolled into one.

I'm convinced that the more Americans learn about this legislation, the more they'll like it. But our work didn't end when President Obama put down his pen. In some ways, it has just begun. We have a great framework. Now, we have to carry it out effectively. And to do that, we need to do several things at the same time. We need to communicate clearly with the American people. Many of our friends and neighbors still have questions about what's in the law. And it's understandable. Given the complexity of the healthcare system, which makes up over a sixth of our economy, it would be surprising if people didn't have some questions about what happened.

And it didn't really help that they were bombarded by nearly \$200 million of ads over the last year, many of which were intentionally misleading. So for these Americans, our department needs to serve as a nationwide health insurance reform help desk. If they have questions, we'll have to have the answers. If people aren't sure what to believe, we'll have to have the facts. And we now the only way the law will reach its full potential is if Americans understand and take advantage of the new benefits and choices that are actually going to be available to them. So here are some of the facts. If you like your doctor, you keep your doctor. If you like your health plan, you keep your health plan. The law builds on the health system that we have.

And it makes three key changes. First, it makes sure that every American who has an insurance policy gets some real security by creating a series of common sense rules that require insurance companies to treat you fairly. Second, it makes insurance more affordable for millions of Americans by creating a new insurance marketplace called exchanges. And by providing tax credits for those who need additional financial help. And third, it starts to bring down costs for families, businesses and governments with the broadest healthcare cost cutting package ever, one that includes every serious idea for health savings that was proposed over the last year of debate. And that's the basic outline.

Now, one way to carry out the law would be to make all the changes immediately. But that is likely to totally overwhelm our healthcare system, and it wouldn't give us enough time, for example, to work with states to design a new functional health marketplace. And since the President's goal from the outset was to strengthen the current health and insurance system for all Americans without disrupting it, we took a different approach. The law implements reforms quickly, but not all at once. Instead, they'll fit together like puzzle pieces, one neatly fitting into the next.

We know we had to give some immediate relief to millions of Americans struggling with the current healthcare system. So for many of them, there really is help right away. For example, starting on June 15th of this year, seniors who have hit the donut hole, the prescription drug gap, will get a \$250 rebate check some time between now and the end of the year to help them afford their medicines this year.

There's a new tax credit available in 2010 to help small business owners, like the man who wrote me and said, "As a small business owner, I'm near the breaking point. With guaranteed annual increases 10 to 15 times inflation, eventually I'll go out of business or be forced to cancel insurance all together." At the same time, we're adding new protections that make insurance stronger for Americans who already have it. The new rule ends lifetime caps on benefits and that takes effect this year.

So does a rule preventing insurance companies from canceling your coverage when you get sick, which happens to people each and every day. The new health reform law also makes it easier for Americans to get insurance. Right now, it's totally legal for insurance companies to refuse to cover children who have a preexisting condition. In other words, we have an insurance system right now that often excludes young people, sick kids, who need it the most. Starting this fall, that practice is outlawed. Their benefits will have to be covered and the children themselves will have to be covered in policies.

We also are creating a high risk temporary pool program that's available to adults who are currently shut out of insurance because of their preexisting conditions. And young adults who need coverage will be able to stay on their parents insurance until the age of 26. All of that happens this year.

During the early years of implementation, we'll be working with providers across the country to turn Medicare into a quality driven, high value healthcare purchaser. When

seniors walk into the hospital or the doctor's office, they should get the best care possible each and every time. And we run the world's largest health insurance program, so Medicare has a lot of clout when it leads by example.

History has shown that if Medicare can find smarter ways to pay for care, other insurers will copy them and we'll all get better results. Under the new law, Americans will start getting more control over their healthcare this year. By this fall, it'll be easier for seniors to get medicines, easier for families and young adults to get coverage, easier for small businesses to cover their workers. And every American who has health insurance will have more security.

Now, if you have questions about what happens this year, or want to see the whole list of first year benefits, I encourage you to visit our website early and often, healthreform.gov. What's going to make these 2010 reforms even more effective is that it really builds on some significant improvements that were made to the healthcare system in 2009. It's part of this story that a lot of people have already overlooked. For example, one of the first bills that President Obama signed into law was the CHIP Reauthorization Act. And by the end of last year, we had already enrolled 2 ½ million previously uninsured children in the CHIP program and in Medicaid. We have five million more we think are eligible, and not yet enrolled so that's a major effort under way.

Then with the passage of the Recovery Act, again early in 2009, which was primarily a job creation bill, but also one of the best health innovation bills in American history. Under the Recovery Act, we funded proven local health and wellness strategies to help give families more health choices in their neighborhood. Expanded almost double community health centers, which currently provide high quality primary care to 19 million Americans a year; invested in the National Health Service Corps to strengthen the primary care workforce, especially in underserved areas; and made an historic event in health information technology which helped patients fill out fewer forms and helps providers deliver better care.

I saw an example of the kind of improved care in 21st century health delivery yesterday when I was in Cincinnati and visited Children's Hospital. They have a very innovative technology system throughout the hospital dealing with some of the sickest kids, not only in the Ohio region, but they gather children who come there from across the country and from international sources because they are renowned for doing some very complicated surgeries. I visited the neonatal intensive care unit, and part of why they're having such success is their use of electronic health records. They have had a thousand days in this hospital without any safety incident, which is a record that a lot of hospitals would love to replicate. And they do it with an automated checklist that appears at every incubator, at every crib, reminding providers of the various steps that have to be taken to keep the hospital setting as safe and secure as possible.

So our goal is to spread these outcomes across the entire country. Today, I'm happy to announce the last round of our health information technology grants which helped create 60 help IT extension centers around the country. Think of these centers like

Apple geniuses for help IT. So if a small provider group or a doctor's office wants to switch to electronic records, they'll have a health extension center close at hand, boots on the ground to help them implement these new strategies, getting the expert advice and technical assistance they need to get that system up and running.

So those building blocks of 2009 are now the template that the new reform has added to in 2010. And we end up beginning to see the healthcare system where it's easier to get coverage, easier to afford care, easier to find a doctor, to make healthy choices, to access your own health information. A healthcare system where Americans are going to get a lot more health for the investment we're currently spending.

The changes also create the foundation for 2014 when some of the major features of the new law kick in. That's when the health insurance exchanges become operational and tax credits become available for individuals and families to help buy insurance coverage. This is a huge breakthrough for healthcare consumers, some of whom don't have coverage at all, some of whom are desperately under insured. For the first time, the question so many people write to me, "Where can I find affordable insurance?" we'll have an easier answer for every person in America. Instead of having to visit dozens of different websites and try to shop at a market on your own, there'll be a one stop shop where the benefits for different plans will be clearly listed and costs will be able to be compared. That's part of the new law. And as America's help desk, we want to make sure that every American knows about the benefits and choices that come out of it.

So over the next several months, we'll be reaching out directly to Americans across the country to make sure they know how to take advantage of the benefits in the new law. We've already begun to educate seniors about prescription drug assistance. We've put out a series of fact sheets that explain step by step to small business owners how they can collect their healthcare tax credits this year.

And soon, we'll have similar fact sheets for employers who want to take advantage of a new reinsurance program that also hits this year. That will help them provide coverage for early retirees. Again, bookmarking the website, healthreform.gov will give regular updates on these reforms as they're implemented and put in place. You can go there to read the fact sheets, to get questions answered and watch weekly web chats. And we'll take questions live from around the country.

We're also working with a lot of the stakeholder groups to broadcast the information about the bill more widely. And we realize that a number of the populations we need to reach may not be so tech savvy, so we're going to be reaching out through partnerships and collaboration. For years, Americans have struggled with a health insurance system that was opaque, unnecessarily confusing and often overwhelming to navigate. Our goal, as we implement this law, is to be the opposite of that; to be as clear and transparent as possible. As soon as we know something, we're going to tell you. But ultimately we recognize that actions do speak louder than words. And no matter how good a job we do educating Americans about the benefits for them in the bill, it won't be much use unless we also implement those policies responsibly and effectively.

And the President has already said to me many times, “we need to get this right.” The letters I get every day make it clear, we have no time to waste. So in the weeks since the President signed this historic legislation into law, we've already started acting. We're restructuring the Centers for Medicare and Medicaid services, so it's better prepared to take on the new responsibilities under health insurance reform.

Last Friday, we began working with states, some of my former colleagues as governor, to create high risk pools that will help uninsured Americans with preexisting conditions that they need to get coverage. Now, today, we're sending new guidance to Medicare advantage plans which include stronger cost sharing protections for all seniors. And later this week, we'll open new Medicaid options to cover low income adults.

Unfortunately, some of the scam artists are moving just as quickly. We've already heard reports from at least a couple of states to report crooks trying already to capitalize on the new law and setting up 1-800 numbers, going door to door in senior centers trying to sell fraudulent insurance, the kind of criminal activity which preys on Americans who are the most vulnerable in our healthcare system, and it's totally outrageous. It's why I sent a letter today to my former colleagues, state insurance commissioners, and to our country's attorneys general, asking them to investigate and prosecute these kinds of scams. And also to put seniors, particularly, on notice that Medicare sales aren't conducted door to door on a usual basis.

The kind of communication and collaboration will be a key to making the law work for every American. Over the next few years, we'll be working with providers, employers, consumers and seniors to get the law right. Many of the reforms are really carried out at the state level. I did serve for eight years as an insurance commissioner and I know how tough and effective state regulators can be. And it's why the states are presumed to have the responsibility to oversee the development of the insurance exchanges, to provide the regulatory oversight and the consumer protection. The law provides resources and assistance to states.

But when it comes to the specifics, we assume that the people on the ground actually know best and can do the job best. I've also served as a governor, and I understand the kinds of budget challenges that states across the country are facing. And what I've said over and over again is that this bill is actually an incredibly state-friendly bill. There's no question that as the market begins to expand in 2014, a part of the law makes that healthcare coverage a partnership between the states and federal government.

But for the three years following 2014, the federal government picks up 100 percent of the bill. And after that, states start paying a share, which rises to the top total of 10 percent by 2020. So there are some new costs in insurance expansion borne by the states. But I would argue that those costs are far balanced by new benefits to states, including less spending on uncompensated care, which states spend on each and every day, saving from reduced insurance paperwork, more resources from the federal government to cover children in every state, more money back from the drug claw back,

more money to crack down on fraud and abuse. And that doesn't even count the people who get better care, live healthier lives and end up as more productive workers. So as a former governor, I can say unequivocally if my state had been offered this deal during my seven years as governor, I would have taken it in a heartbeat.

At HHS, we intend to work closely with the states as the lead federal department for implementing the bill. So in closing today, I want to share just a couple of the operating principles for making sure the full benefits of this law reach all the American people.

First, we will be transparent and that just doesn't mean sharing what we know. It also means making it as convenient as possible for American people to access that information. Today, just for example, we're announcing the first time ever release of Medicare data, something we're calling our Medicare dashboard. This is an online tool that will make it much easier for Americans to search and sort aggregate Medicare data with full protections of patient privacy. We're launching today Medicare's inpatient hospital data where you'll be able to sort by state, by condition and by hospital, making price comparisons for the first time ever. But it's just the first step of many we'll be giving consumers and purchasers and providers the health information they need to make smarter choices.

Secondly, we believe we have to make every dollar count. Eliminating waste and fraud in our healthcare system is a key part of the law. It's also a principle we're going to apply to every step of implementation. And one of the ways we intend to save money is depending heavily on people and systems that are already in place, not starting with the assumption that we have to build a new bureaucracy. Our department has incredible talent, great resources and expertise in the healthcare system. So as we move forward, we rely on our existing resources as much as possible to fulfill our new responsibilities under the law.

Third and most important, we don't ever want to lose sight of why we pursued this legislation in the first place, fought so hard for it, and are celebrating it as an historic accomplishment. Over the last year, I've read letter after letter from families and small business owners who feel totally powerless in the existing health insurance system we have. Their premiums continue to go up, sometimes by 30, 40 or 50 percent a year and they don't understand why.

They'd argue with their insurance company, but they're afraid their coverage will get canceled or they'll be penalized. They switch to another plan, but they don't have any choices or options. And sometimes with preexisting conditions, they absolutely know they can't get another policy. Even Americans who have good insurance through their jobs worry about next month or next year, worry about their kids, worry about their families. They see more and more of their paychecks being eaten up by rising premiums every year. And they know how quickly the partial security they have could disappear if they lost their job or switched jobs or retired.

So our goal is to put these Americans back in charge of their own healthcare, providing information and education if it's needed, setting basic guidelines that will help foster a competitive insurance market, serving as an umpire to make sure insurance companies treat all Americans fairly. And providing targeted resources to help empower consumers. But ultimately, this isn't about us. It's about the American people. It's about giving Americans more choices, more security, more control. And there will be bumps along the way. There are going to be some twists and turns, it won't be easy. But after decades of standing still, we are finally moving forward. So again, I'm pleased to be with you and would be happy to take your questions if you have some questions. Thank you. (Applause)

MR. BJERGA: And thank you for your address, Secretary. First of all, I want to apologize in advance if I refer to ever as Governor, as I asked you, Governor, questions so many times during my years at the *Wichita Eagle*. And understanding the Kansas identification, we're all proud of the great state of Kansas, which should have been playing for the national championship last night, just for the record. And I'm sure your family in Ohio and my family in Minnesota were also following the state of Kansas very closely as well.

So, leading into this, your experience as a governor of the state of Kansas, and your statement that you would have jumped at this opportunity had you been governor when this plan came through. Several governors in several states have been jumping at this opportunity. In fact, they are suing the government trying to stop this plan. Kansas is not one of them, but several states are. And with them gearing up for a big legal battle, why do you think this happened, and do you fear that these lawsuits could slow the progress of health reform?

MS. SEBELIUS: Well, I think the vast majority of lawsuits have been filed by attorneys general in states where they have also some interest in higher office. And in consultation with our legal team and their consultation with the Justice Department, first of all, we are confident that the law is on solid constitutional ground, on firm grounds. I'm going to let the lawyers go debate the situation. I think our job, really, is to focus on talking to the American people about what really is in the bill, how the law will work to their benefit, what's available for them. And that's really where we're going to spend our time and energy. But we're confident that the legal standing of the law is solid and that this has more to do with politics than with policy.

MR. BJERGA: And at the same time there were challenges often coming from the conservative side of the spectrum. You also have people often on the more left hand of the spectrum saying, "Well, this plan is a start, but it could go further directions." And I'm wondering to what extent you would characterize this healthcare reform plan as a start, and if there may be additional steps in healthcare reform that should be taken once becomes implemented?

MS. SEBELIUS: Well, I think there's no question there was a wide spectrum at the beginning of the debate. Certainly, people who felt what would be advisable in the

United States was scrap the current sort of third party insurance system and start again. Have a single payer system mirroring what a lot of other developed countries have. Others who said, "What we really need to do is have a total market-based strategy. Take the rules off insurers, get rid of the barriers that currently prevent them from operating in a creative way. And the market strategies will really solve the situation we're in." I think the President and Congress chose what is a middle ground approach, a kind of common sense approach, not dismantling the market for the 180 million Americans who currently have employer-based health insurance. It works pretty well, and they like it. Not dismantling the insurance rules, but figuring a strategy that builds on the current system; made it stronger and also opened up the private market, creating new marketplaces for the 30 million Americans who don't have coverage currently.

I am sure over time this law will be revisited. You know, my dad was in Congress in 1965 when Medicare was passed. He served on the Energy and Commerce Committee. Medicare has changed a number of times in the 45 years that it has been in place. I would suggest we wouldn't recognize what the law looked like. But the template of saying once you reach 65 or once you are severely disabled in this country, you should have guaranteed healthcare, is a principle that has been under constant improvement. I think the principle of saying all Americans should have affordable, available healthcare is one that we will continue to work on, but is a significant step from any place we've ever been before in the United States.

MR. BJERGA: What concerns do you have that the insurance industry will evade, rather than comply, with the law looking for loopholes? And what steps will HHS take if this happens?

MS. SEBELIUS: Well, I think that there is a principle that has been in place in health insurance for a number of years which isn't terribly complicated. It is a whole lot cheaper to insure people who promise not to get sick than people who do get sick. It's the same principle used in property casualty coverage where you don't want to come and insure homes in tornado alley, like Kansas. You'd rather find a place where storms don't hit.

I think that working with the insurers to actually look for ways that develop a new business model is going to be very important and is going to require oversight and vigilance. It means changing the rules. It also means that insurance companies will be competing on the basis of price for new customers. And have to be, I would say, not basing their customer selection on cherry picking the market, on eliminating certain groups and individuals. Insurance commissioners at the ground level will have the initial responsibility for oversight consumer protection. We have urged them already. In some states, there isn't a full benefit of the legal authority to have rigorous rate review, to have actuarial studies done before rates are increased. You can see around the country, some states have been very aggressive in limiting the kinds of rate increases that have been allowed. Other states have not at all.

So I think it's going to require states stepping up becoming more vigilant on rate review, more vigilant on consumer protection. And we're certainly going to be working as a backstop to that. But the tradeoff of having additional customers for the private market means, I think, that the new rules will be followed and will be vigorously enforced.

MR. BJERGA: One member of the audience asks, "How did the student loan direct pay program get into the healthcare bill?"

MS. SEBELIUS: Well, it turns out that the history of reconciliation bills often have included in the past education and health measures together. They both have significant budget impacts. That's really kind of the measure of reconciliation, if there is a significant impact on the budget. The student loan and community college reinvestment bill had been passed by the House of Representatives, was being considered in the Senate and I think that members of the House and Senate thought it was an opportunity, really, to accelerate passage of what in and of itself is an historic piece of legislation; about \$58 billion over the first ten years will be saved from eliminating the third party loans that currently are going to benefit students who want to attend college and reinvesting those funds, in doubling the Pell grants, in raising the threshold of the Pell grants for the first time in about 15 years, in limiting the payment of loans.

One of the most inspirational piece of the puzzle is that a student will never have to-- or a graduate will never have to pay more than 10 percent of his or her income in order to fully pay back the loan. Encouraging people to take on jobs that may not pay as much in terms of salary, social workers and teachers will not be eliminated from taking on those jobs.

If you, after ten years, have paid to the full amount, you're considered finished, completed. They don't want graduates to continue to pay after a decade. If you provide some public service or military service, you're considered to have your debt paid in five years; again, encouraging public service. So this is a major investment that I would highly recommend to the Press Club, if you haven't had Secretary Duncan here, to talk about this piece of legislation it is one worth-- a conversation worth having.

MR. BJERGA: Can you help us get Secretary Duncan here?

MS. SEBELIUS: Sure.

MR. BJERGA: We appreciate it. Could you tell us a little bit more about the low income Medicaid possibility that you spoke of in your remarks?

MS. SEBELIUS: Well, starting this year, there are opportunities for states to immediately begin to cover the so-called childless adult population where a lot of uninsured Americans fit into that category. There are states who have moved ahead already and are covering that population, but getting no federal assistance or help for doing that. So the first step is likely to be that states who are currently providing state

only funds for that population will be able to pull down some federal assistance and hopefully expand the population.

Others may well since it's a Medicaid match of 60 percent federal dollars to 40 cents of state dollars, may well look at earlier expansion prior to the 2014 deadline. So the opportunity to draw down some federal funds for this population begins right away.

MR. BJERGA: Also mentioned in your remarks, the National High Risk Pool Program. The healthcare law calls for this program to be in place within about three months. And many questions need to be answered about how it's going to work in the context of existing state high risk pools, states that lack pools that want to develop them, and states that have no plans to develop pools. For those Americans interested in the more reasonably priced coverage the new federal high risk pool promises to provide, how soon do you realistically think they will be able to secure coverage?

MS. SEBELIUS: I think we will have pools up and running this year in 2010. And about 34 states right now run high risk pools that often are quite expensive. Even though they're pegged to some sort of market rate, they still are often too expensive for many individuals. I think there are only about 200,000 people around the country total who are involved in the high risk pool. So what we anticipate is that a lot of states will set up a parallel pool for this new population. The price will be pegged at 100 percent of market rate, so still not terribly inexpensive, but much better than often someone with a preexisting condition could get a quote on the marketplace if they could get insured at all.

And if a state chooses not to run their own program, we will have a federal fallback, either several at the regional level, one national. We haven't decided until we hear from states. But I've already written to governors and insurance commissioners giving them an outline of the program, asking who intends to participate. We intend, then, to quickly work one-on-one with each of the state groups to figure out how exactly they want to set it up, how quickly they can get them up and running and then we will actually be the backstop for Americans who don't have a pool in their own state but want that kind of coverage available.

MR. BJERGA: Next week at the Press Club, we're not going to have Arnie Duncan quite yet, but we are going to have Dennis Quaid, who is going to be talking about the prevention of potentially deadly medical errors because of some of the personal tragedies he has experienced. This questioner asks, is there anything in the new law that addresses the problem of medical errors in hospitals, prescription drug mistakes such as bad coding for medicine?

MS. SEBELIUS: Well, I think there are lots of quality improvement measures in the new law. But two particular investments that I think can have a huge amount of impact on hospital errors, one is the transfer from paper records, paper coding, to electronic records. There's no question that having the ability to pull up a record and have a provider have to enter a prescription order into an electronic record that absolutely blocks a contraindicated drug or puts a red flag up so that you really cannot have the

wrong medicine ordered for that patient population. In a hospital like, again, Cincinnati Children's where I visited yesterday, they also have a bar coded dispensing system where you cannot release the drug from a prepackaged system unless it's bar coded. The baby I was visiting, along with his mom, is four weeks old. He has a wrist band that is bar coded so the nurse indicated to me she has to bar code his wrist and bar code the dispenser or the drug is not released to make sure it's the right patient, the right dose at the right time. So that in and of itself I think is a huge step forward. About 20 percent of hospitals have some kind of electronic record, but not nearly enough and it's part of what the investment is about.

There's also a lot of information and research going on about how to work on hospital associated infections, which is another huge issue. A hundred thousand people a year die in American hospitals, not because of what brought them to the hospital, but what happens to them while they're in the hospital. Hundreds of thousands more have very costly, very consuming injuries because of that same situation. It's a challenge we have taken on with the American Hospital Association. There are some pretty simple checklists that have been shown to dramatically reduce hospital associated infections, cut them two-thirds, don't require new equipment, don't require any fancy training. They're just not implemented in hospital after hospital, they're not in place in way too many of our medical care. We currently pay the same amount for incidents whether or not something happened related to hospital safety or not. We still were paying, up until last year, for so-called never incidents where the wrong limb is amputated, the wrong drug is given, a patient is dropped on the floor. You would get the same payment out of the public insurance system as the best possible result.

So we can use, I think, the payment system to begin to drive and put in place incentives, initially incentives, to promote better care. But eventually, disincentives for bad care, and I think we've got to start doing that very quickly.

MR. BJERGA: There's a serious shortage of gerontologists, which is a concern as the population ages. How can this problem be solved, and what role do you see HHS playing?

MS. SEBELIUS: I'd say there's a shortage of certainly doctors with a specialty on the aging population. There also is a shortage of primary care and family care docs who often have that same skill. We have already begun to change the payment formula in the Medicare system to more appropriately compensate medical providers who choose a range of family primary care services. We will continue to accelerate that. We are also part of the investment act in 2009, part of the Recovery Act in terms of workforce initiatives, and part of this bill helps us build a more ample primary care workforce. And for the future, which again I think is critically important, and paying more scholarships to providers who work in areas where we see a growing need, and certainly gerontology is one of them.

MR. BJERGA: What is your own view of using acupuncture, meditation and other alternative healing methods in healthcare coverage?

MS. SEBELIUS: There clearly are plans in place, and I anticipate there will be plans offered in the new exchanges, which will give patients a wide variety of choices. And I think that while there's likely to be a definition of what is a preventive care plan, insurers are likely to compete based on having a more wide range of choices for consumers. And you know, there's some pretty interesting data about cost effectiveness that we will continue to monitor. I think our comparative effectiveness research will continue to look at variety of alternatives for expensive care, whether or not earlier interventions are more homeopathic therapies, or a variety of choices, are ones that really do lead to better health outcomes at a lower cost. And I think those are often consumer choices, and also wise healthcare choices.

MR. BJERGA: This audience member asks for your thoughts on raising the Medicare and other healthcare plan eligibility age gradually to 70 to help keep costs down?

MS. SEBELIUS: Well, one of the groups that the President has now put in place by executive order and is likely to be convened in the not too distant future is an entitlement commission looking at Social Security, looking at Medicare, I assume Medicaid will be part of that. And so the rules of those various long-term government programs, the eligibility ages, the kind of benefits provided versus the costs of the program I think will be a topic that will be robustly debated and discussed by the entitlement commission. And I think it's very appropriate.

Much of our long-term deficit in this country is directly related to various entitlement programs that we have. So it's likely to be appropriate to look at everything from age of entry to what the benefit package looks like, how long people qualify, whether or not there's any contribution based on income. And I think all of those issues will be part of the conversation of the entitlement commission.

MR. BJERGA: Part of the healthcare reform package is an emphasis on preventing disease and disability. Such an emphasis would result not only in significant monetary savings, but also in greatly reduced suffering. Fattening foods and sodas are known to increase healthcare costs. Yet, regulating them or taxing them is highly difficult politically. Does HHS and the government need to rethink its approach toward food regulation and taxation in light of healthcare reform?

MS. SEBELIUS: Well, there's no question there's a major emphasis in health reform, and I would say that also started as part of the Recovery Act in prevention and wellness. In spite of the persistent reluctance of the Congressional Budget Office to score anything related to prevention and wellness, I am a believer that it doesn't take much of a rocket scientist to understand if we're spending 75 cents of every health dollar on chronic disease treatment and 8 cents of every health dollar on prevention, rebalancing those numbers a little bit and trying to get at some of the underlying causes for chronic disease would actually save money in the long run.

One of the reasons that Congress put a major first time prevention and wellness investment out the door in the Recovery Act was just to get at long-term healthcare costs and healthier Americans. And it's focused on two areas; obesity and tobacco cessation. We did pretty well on tobacco until the last five or six years where at about 20 percent young smokers, old smokers, it hasn't gone down at all. Tobacco is by far the number one leading cause of preventable disease and death in this country. So going after that, again. There is a whole range of issues dealing with obesity and certainly at the state and local level, the consideration of taxes on soft drinks, on fatty foods, on snack foods, is one of the policy choices that people are beginning to look at.

We have put 36 grants out the door just in the last two weeks that are going to communities across the country to look at prevention and wellness strategies and what works on the ground. We really don't know a lot, particularly-- we know about tobacco. We don't know a lot about obesity-related strategies that have really been effective over time. There haven't been a lot of tests, there hasn't been a lot of research. So we're really hoping to learn a lot more about what policies really work, what works at the local level. There also is a huge effort under way as part of the First Lady's Let's Move campaign, which has the goal of eliminating childhood obesity in a generation, a very important goal of looking at all of the kinds of food choices.

And one of them is the choices available to kids in cafeterias and in vending machines in schools. The Secretary of Education, the Secretary of Agriculture, are very much at work to redo school nutrition standards. We're working with the Food and Drug Administration to look at food labeling standards. Part of the bill requires now posting of calories on fast food menus that will be available and easy to read for consumers. So there's going to be a lot more information, a lot more policy effort coming from lots of different directions on trying to get to some of the underlying causes of chronic disease.

MR. BJERGA: Given your years as a state insurance commissioner and your interaction with the industry as Secretary of HHS, do CEOs of health insurance companies make too much money?

MS. SEBELIUS: Well, they make a lot more money than I do. You know, that's a shareholder decision. I think what is troubling is the disconnect between, on one hand, arguing for enormous rate increases and what appears to be excessive salaries, overhead costs going forward. Well Point became kind of the prime example of this where their fourth quarter 2009 profit statement showed a \$2.7 billion profit and within ten days, they had filed up to 40 percent rate increases for the California market, and announced that the CEO got a 51 percent salary increase.

So there does seem to be a disconnect, which is why I asked the top five health insurers to give us the data. Let us put it up on a website. If their rate increases are actuarially justified by healthcare costs, which is what was the verbal exchange, then give us the information, let us make it transparent, and begin to educate the American public what's really going on. So far, we haven't gotten that information, but I look forward to taking a look at it.

MR. BJERGA: When will the Centers for Medicare and Medicaid Services have a new commissioner in place to spearhead the implementation of the healthcare reform bill?

MS. SEBELIUS: Well, the President will make a decision about naming a new administrator. What we are doing, though, currently is building a team with the anticipation of a more robust role for Medicare and Medicaid. A key member of that team is here, Marilyn Tavenner, who you heard introduced earlier who we stole from the State of Virginia and we're thrilled to have her. She is the principal deputy at CMS. We have added Tony Rogers, who came to us from the State of Arizona running their Medicaid system and health strategy system. He will become head of the new Center for Medicare. We've added Peter Budetti, who will be focused on fraud and abuse. And those are all brand new positions, administrative positions, and really will help us have a much more robust innovation and quality strategy, a very enhanced effort on cracking down on fraud and abuse, and an ability to really deal with a lot of the Medicare challenges that the bill has presented, moving Medicare to a much more value purchasing operation. With the \$400-plus billion that we spend every year, we have an opportunity to really help change the delivery system, I think, in a pretty significant way to the benefit of beneficiaries and consumers across the country.

MR. BJERGA: Many of the questions addressed today are about the future of healthcare reform. People are always looking ahead. But, of course, this has been a very bruising political battle that's just been taking place over the past several months. There was Obama Care and death panels and misinformation and bricks and late night votes and procedural controversies. This person writes, "I'm concerned about the widening gap between Democrats and Republicans made worse by the controversy surrounding the healthcare legislation. What is HHS planning to do to try to bring everyone together again?"

MS. SEBELIUS: Well, I'm concerned about it, too. I don't think it bodes well for our future when we can't have a robust debate, but also a resolution of major challenges in some sort of a bipartisan fashion. I am disappointed that from the outset of this debate. A year ago before I was ever even appointed Secretary, there were already sort of political battle lines being drawn and people saying, "We will never participate in this conversation," which I don't think is healthy going forward.

I am also convinced that once we have an opportunity not just the Department of Health and Human Services, but working with stakeholder groups, working with consumer advocates, getting information out, when people understand what exactly is in the law, what isn't in the law, what it does, what kind of time table the implementation strategy is taking, that there will be a lot of engagement and enthusiasm about it. Will that help our next round of debates? I don't know, I hope so. I am a believer that finding some common ground is important going forward. I was a Democrat elected in an overwhelmingly Republican state, and found building coalitions to be something that is critically important. We'll go right back to work and try do that.

But one of the things that I think got lost in the shuffle along the way, which is somewhat remarkable, is that there are groups and organizations among them the American Medical Association representing the healthcare providers in this country who have historically opposed any kind of health reform legislation, including Medicare, vigorously opposed it. And yet, they were at the table with this puzzle. There were lots of business groups, some definitely opposed, but some who came to the table, I think a recognition that we really had a broken system and that we had an opportunity to make some significant changes and people didn't want to lose that opportunity. So I think at the end of the day, that will be the common ground, that we have not lost that opportunity and now we need to bring people back together about how we work together in implementation.

MR. BJERGA: We are almost out of time, but before asking the last question, we have a couple of important matters to take care of. First, to remind our members and guests of future speakers. On Monday, April 12th, as mentioned earlier, Dennis Quaid will be discussing the prevention of potentially deadly medical errors. On April 15th, Secretary Napolitano of Homeland Security will be here discussing the state of the nations and the world's aviation security system. And on April 19th, Congressman Sandra Levin, the new Chairman of the House Ways and Means Committee will be speaking on financial reform and other topics.

Also would like to present today's speaker, thanks very much for your time here today, here is the legendary National Press Club mug. (Applause)

MS. SEBELIUS: Lovely, thank you.

MR. BJERGA: And now for the last question. Given the debate and your position, what was your biggest challenge to staying healthy during the months of stressful healthcare bill deliberations?

MS. SEBELIUS: Well, I'm a runner so I-- and I figure as long as no one's chasing me, I will continue to run. That helps sort out my days to go down on the Mall, hum a little "God Bless America," and believe that the sun will come up. And sure enough, it has, so I'm pleased again to be with you today, and thank you for inviting me. Hopefully, you all will visit our website, healthreform.gov. We'd love to have your input about what's working and what's not working in terms of information that you're finding it hard to find or digest. We want to make sure this is a work of continuous improvement. Under the great leadership of Dr. Jeanne Lambrew, our work will go on. And we have a lot to communicate with to the American people and would love your help and support as that goes forward. Thank you very much. (Applause)

MR. BJERGA: And thank you, Governor-- I mean, Secretary. And thank you very much to the National Press Club staff for putting together today's event, as well as the attendees who came today. Thank you, this meeting's adjourned. (Sounds gavel.)

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