RON POLLACK: I’m delighted to see so many good friends and colleagues. It’s wonderful to see you here for the 20th Annual Health Action Conference.

[applause]

RON POLLACK: You know, we meet at a very important time. There are so many things going on that present us with opportunities, as well as challenges. We’ve got three and a half more weeks until the close of the second open enrollment period. And hopefully, we’ll get many, many more people enrolled in health coverage who have not had it before.

Less than three weeks later, the Supreme Court is going to hear oral argument in King v. Burwell, which is the largest existential threat to the Affordable Care Act in approximately three dozen states. Congress, meanwhile, is going to continue its obsession about dealing with the Affordable Care Act in a way I don’t think any of us would describe as being constructive. And we have new ground to plow with respect to how we’re going to improve America’s healthcare system and to make sure that people have quality of care at an affordable price. And there is so much important work that we will be discussing about that here at the conference.

So my hope is that, as in the previous 19 conferences, that after you leave here, in addition to your being tired from staying up late at night, and talking with your colleagues, you feel energized, and you feel inspired for the important work that lies ahead in your communities across the country.

Now we have an excellent program. I think you will find it to be a terrific program. I just want to make one-- have you note one thing. In our program, we said that this morning Senator Sherrod Brown from Ohio would be speaking at this morning’s plenary. And we've had a change in plans because Senator Brown is on a committee and his
Republican colleagues called a hearing this morning that he is going to attend. So instead, he is going to join us tomorrow for lunch. So all of you good Buckeyes who were looking forward to seeing your Senator, he will be here, but he will not be here in the opening session.

So we’re going to get on with the program. And we’ve got three excellent speakers for you to hear this morning. The first person is a good friend and a wonderful person who I have treasured enormous contributions he has made to good thinking about healthcare. And I'm talking about Alan Weil. Alan Weil, over the course of the last year, was appointed Editor-In-Chief of Health Affairs. Now probably most of you know about Health Affairs. For those few of you who don’t, Health Affairs is the nation’s leading journal focusing on issues that intersect health, healthcare and policy.

Prior to serving as he is now at Health Affairs, Alan was the Executive Director of what we love to call NASHP, the National Association of State Health Policy, which is an independent, nonpartisan, nonprofit research and policy organization that analyzes different healthcare developments in the states.

And prior to that, Alan directed one of the largest privately funded social policy research projects ever undertaken in the United States when he directed the Urban Institute’s project on assessing the new federalism. Now Alan has not just studied healthcare, he’s been an active participant in it. Prior to these positions, Alan served as the Executive Director of the Colorado Department of Healthcare Policy. And he was Assistant General Counsel in the Massachusetts Department of Medical Security.

Now in addition to his responsibilities as Editor-In-Chief of Health Affairs, he moonlights on occasion. And he serves as a member of the Institute of Medicine’s Board on Healthcare Services. He’s a member of the Kaiser Commission on Medicaid and the Uninsured. He’s the Coeditor of two books. He publishes regularly in Peer Review
Journals and is called upon by major media outlets and by Congress to share his knowledge about developments in healthcare.

And above all of those things, Alan is really a nice guy. He’s one of the most thoughtful persons on healthcare. And so it’s a great pleasure, and please give a warm welcome to Alan Weil.

[applause]

ALAN WEIL: Thank you, Ron. Good morning to you all. It’s a great pleasure to participate in the 20th Conference of Families USA. And I just want to say, you picked the right title, “Building Real Progress.” I know as advocates, you always have your eye on the next battle, the next defensive maneuver you need to take to avoid retrenchment. But at least, for a moment, I’d ask you to take a look from the long view, and see what progress you have built over these 20 years.

Twenty years ago, one out of seven Americans was without health insurance. And according to the latest estimates, that rate is now one in nine, still too high. But there’s good reason to believe that number will continue to decline. That is real progress. Twenty years ago, children were uninsured at about the same rate as adults, and more than one in five poor children had no coverage at all. Children’s uninsurance rates are now in the low single digits. And the share of poor kids without coverage has been cut by two-thirds. That is real progress.

The age group most likely to lack coverage is young adults. We cut the uninsured rate for young adults from one in three to one in five. That is real progress. And this progress didn’t just happen. It’s occurred in an era when employer-sponsored insurance has drifted downward. Advocacy is what it took to extend coverage to working families who were
no longer able to obtain coverage through their jobs, or who had never been offered coverage in the first place.

Go back 20 years, only a handful of states provided Medicaid coverage to all kids and their parents living in poverty. Now, more than half cover everyone in poverty. That is real progress. Twenty years ago, we were in the midst of gradually expanding coverage to kids living in poverty. We completed that expansion long ago, and then we added on CHIP, the Children’s Health Insurance Program, which has brought coverage to kids in families earning up to twice, and in some states higher, than the poverty level. That is real progress.

Look at how different health insurance is today than it was 20 years ago, underwriting that excludes people from coverage based on health status. It’s gone. Annual and lifetime caps that kick in when you need insurance the most, it’s gone. Benefit packages that exclude necessary services, almost gone. Higher rates, higher premium rates for the sick, for women, they're gone. This is all real progress.

And 20 years ago, before the Supreme Court’s critical Olmstead decision, only one out of every five dollars in Medicaid was spent on what we then called-- Sorry, one out of every five dollars of what we called long-term care back then went to supports provided in home and in the community, with the balance of those funds, four-fifths, going to nursing home care.

Now we have an almost even split between institutional care and home and community-based services. That is real progress. So, while you focus on the issues of today and next year, while you consider the concerns that are in front of you today, please don’t lose sight of how far we've come. You have, we have over 20 years built real progress.
Now, as I noted at the outset, progress is always under attack. These gains are hard to hold. And Ron, in his introduction, mentioned some of the challenges today. I'm going to expand just a little bit on each of them. You're almost undoubtedly familiar with all. But I think it is important to start out this morning with an understanding of what the risks are associated with the progress that we’ve made.

Ron mentioned King v. Burwell, a Supreme Court case hearing that will occur in a little more than a month, with a decision to follow. Challenging the availability of premium subsidies, which are a critical element of the Affordable Care Act, they're what made coverage affordable to moderate income Americans. They are challenged-- The lawsuit challenges the availability of those subsidies in states that have deferred to the federal government to run their health insurance exchange or marketplace.

Now people like Ron, who are much closer to the drafting of the ACA than I was, Ken, I'm sure regale you with stories that the construction of the law wasn’t exactly done artfully with a lot of time for back-and-forth and double and triple checking. The process by which the Act was enacted was quite challenging. And in that, there are some inconsistencies or aspects of the law that are a little hard to figure out.

So the Supreme Court is going to make this decision. And it seems, to those of us who look at the overall structure of the law and what it’s trying to accomplish, that there was no sense that Congress only intended these subsidies to be available in state-based exchanges. But the Supreme Court is the final arbiter. And, if they support the law as it is, it will clear the path to additional implementation. If they don’t, action will be required in part by states who may change their decision about whether or not to run an exchange, so that they can bring that in-house, and therefore not be subject to the limitations that the Court might find. And we may need changes at the federal level in the statutory structure to recognize Congress’s original intent that these subsidies be available.
It’s hard to know what the path will need to be until we read the opinion. Remember, the last big challenge to the Affordable Care Act yielded results that no one quite anticipated. So we probably shouldn’t get ahead of ourselves, but we should be aware of the likelihood of a response when that case is decided.

The second major attack on the law is the ongoing drumbeat to simply repeal. Repeal, repeal-replace, repeal-don’t replace, repeal-and talk about, at that point, what we might want to do. That story has not change. There is a large segment of Congress, and they speak for a large segment of the American people, who have not come to embrace what the law represents. And they will continue to advocate for repeal.

With the President we have today, I think it’s fairly safe to say that those efforts are hard to imagine turning into anything that would fundamentally threaten the law. But, we have elections in this country. And our legislative and our Presidential leadership change. And we should be aware and understand that those forces for repeal remain strong, that the view that the law should go away remains strong, and never step away from the job of assuring that people understand what the law has done, good and bad. But, from the numbers I just gave you, I would say mostly good. And keep the energy about what this law has been doing, so that that threat is at least held at bay.

But a somewhat more immediate set of challenges is related to the programs of Medicaid and CHIP, which really need to be seen together. I have worked a lot on Medicaid, but I'm reminded that the Children’s Health Insurance Program authorization ends September 30th of this year. And if the Congress fails to reauthorize the funding, a lot of things happen, including many children who probably won't lose coverage entirely, although some might, but they would move into other programs that either impose higher costs on families, or don’t have as good coverage. So the reauthorization of CHIP is critical.
The ongoing effort to restructure the Medicaid program, convert it into a block grant, or what are called per capita caps, the idea saying that the federal government is going to cap how much it will put into the program, states run the program, let the states make the hard decisions. Have them scale back on coverage while the federal government essentially washes its hands of that commitment. The desire on the part of many in Congress to fundamentally alter the design of the program is still there. And those efforts will, I believe, continue and may gain force, given the political changes we’ve seen.

And then, within Medicaid and CHIP, there is the opportunity of the Secretary to grant waivers. Now as someone who’s run a state agency that runs Medicaid, many years ago in Colorado, as someone who’s worked for many years with states on implementing health programs, I'm a supporter of state flexibility and the opportunity it creates. I do believe that there are states that will only adopt a Medicaid expansion if they are able to cut some sort of a deal with the federal government, so that they feel like they’ve had a bigger hand in shaping the program than they would otherwise have.

So I'm not against that sort of flexibility, but the waivers sit on top of a statute that defines fundamental protections for enrollees in the Medicaid and CHIP programs. And as states push harder and harder, and as Congress pushes harder on the Medicaid program, there will be political pressure for the scope of those waivers to expand. And it will be very important for advocates to keep an eye on those discussions and assure that the administrative processes, as well as the legislative processes, at the state and the federal levels, are-- that you're holding those elected officials and appointed officials accountable for their decisions, so that those basic protections are not eroded.

And, of course, we've seen so many states adopt the Medicaid expansion, and as you work to increase that number, you also obviously have to watch as, in some states, the interest in the expansion that they already adopted is beginning to wane, and as states have to kick in some of the funding, the politics of that will change as well.
I'm reminded, if I may, of a paper I wrote, published in *Health Affairs* more than a decade ago, called “There's Something About Medicaid.” And this is what is said at the time, and I think it’s still true. I said, Medicaid is a program loved by few, denigrated by many, and misunderstood by most. I said, if money is at the heart of debates over Medicaid, the millions of indigent people whose varied and complex medical needs are met by the program are its soul. The amount of human suffering the program alleviates is immense. In the absence of a comprehensive healthcare system that meets the acute and chronic care needs of the nation, Medicaid perfectly fits the metaphor of the safety net.

It is the quintessential safety net. The Affordable Care Act has expanded coverage. But there are still many gaps. And my views of the future debates about Medicaid are unchanged, that the debates often take place having to do with a focus on money, but really are about people, people’s lives, people’s dignity. And that’s what should animate our discussions about the future of Medicaid.

Now I would never tell you, as advocates, that you should back away from your focus on insurance coverage. Those gains, as I described, have been hard fought. And they are hard to hold. But I do think something else has changed in the last 20 years that opens up a whole other path for advocacy. And I would be remiss, standing before you, if I didn’t spend a few minutes talking about what I think is the future or part of the future and encourage you to embrace that future, because I believe the opportunities are tremendous, and the importance is tremendous.

I was thinking back to 20 years ago, and I realized that almost 20 years ago is when Ron and I met. We sat on a Commission together, appointed by President Clinton. There were a few other obscure people on that Commission, Risa Lavizzo-Mourey, now the President of Robert Wood Johnson Foundation, Don Berwick, formerly the head of the Centers for
Medicare and Medicaid Services, Mary Wakefield, the head of HRSA, Kathleen Sebelius, former Secretary, it was a bunch of slackers on that Commission. [laughter]

And we, you know, as all commissions do, we issued a report. And I brought it so I could show Ron and remind him. You know, it’s typeset. We didn’t have word processors so well back then. The title of the Commission was the President’s Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. And I am here to say that the understanding and focus on quality and the system of delivery for healthcare has elevated to such a high point, that I believe advocates really need to focus in this area as well as you focus on coverage. Because in those 20 years, not only did we issue this report, but the Institute of Medicine issued its seminal report “To Err is Human.” Beth McGlynn at Rand showed how rare it is for people to receive care that meets basic quality standards.

Our ability to measure and report on quality has matured. There is now a movement afoot, very strong in some places, taking off in others, to pay in healthcare for value as opposed to just volume. It sounds good. But it’s an idea that cries out for consumer and patient advocacy.

And I want to give you five quick reasons why advocates need to pay close attention to delivery system reform and payment reform, just as you have led the way in your work on coverage.

So the first reason is that the whole concept of value is actually a little squishy. And often, people would say, “Well, value is sort of quality divided by cost. How much do you get for how much you pay.” Well we know that the healthcare system is notoriously opaque when it comes to cost. But at least that’s a number. Quality is much more complex and much more amorphous.
Where is the leadership in the value movement coming from? A lot of it is embedded in the Affordable Care Act, and it’s coming out of Medicaid and Medicare in a way that that program has never played before. But the private health insurance market, and private payers have picked up this mantle as well, and they are also driving towards accountable care organizations with a private-- through a private lens as well as the public ones. They're driving to pay for performance and pay for value.

I think these are good and valuable moves. But if quality is defined by Medicare and commercial health insurance, it’s going to focus on the conditions that are prevalent and of greatest concern to middle class and aging Americans, which is great to pay attention to them. But it’s easy to leave behind the needs of those at greatest risk, those with disabilities, those with great social barriers to receiving appropriate care, those-- the conditions of youth, because they're not well represented in Medicare, and the most expensive of them are not in commercial insurance.

So the first reason advocates have to pay close attention to this reform discussion is that the definition of value depends, in part, on the definition of quality. And our understanding of quality needs to be animated by the concerns about quality for the entire population, not just those who have good health insurance coverage.

Second reason you need to pay attention is that some analysis has been done by authors including those who’ve published in Health Affairs, analyzing how these pay-for-performance programs work. The idea is you want to give an incentive to institutions to provide better quality care. Well, not surprisingly, safety net institutions, those that serve the most vulnerable, stand to lose in these pay-for-performance schemes because they have, in many instances, a more challenging population. Their ability to invest in the systems to improve care may be lower because the funding, the tax base in a rural community is eroding. Or they're an inner city institution that doesn’t have the suburban tax base financing them as well.
We need to watch, not just that we reward those and define the rewards for quality well, but we need to be careful that the institutions that meet the needs of who are most vulnerable are not harmed by programs that are designed to give extra resources to those institutions that are providing high quality and high value. We need to move the whole system, not just the top of the system, forward, in terms of quality. And that requires advocacy on behalf of those institutions and the people served by those institutions, so that the formulas that are used to allocate resources do not disadvantage them.

The third reason advocates need to pay attention is the risk of averages harming those who are most vulnerable. So, when you come up with a pay-for-performance scheme, you think, what is the performance? And you're looking at, often, overall performance. But you need to disaggregate that performance. You need to look at racial and ethnic disparities. You need to look at income disparities. You need to look at the experience of care of those who are most vulnerable for health reasons, as well as social reasons.

You can do a great job screening people. You can do a great job keeping people’s blood pressure under control. But, for the person with a traumatic brain injury, or with HIV and AIDS, their needs for care are very different. And we need to be careful, as we define value and quality, that we’re not rewarding good performance for those who are average but leading hospitals or insurance companies to steer clear of those whose needs are greatest when, after all, they're the ones who are most dependent on the healthcare system.

The fourth reason advocates need to pay attention to these reforms is that I view the reforms as a tremendous opportunity to reallocate resources to the social sector, where we could actually reduce the need for healthcare services by improving people’s income and employment and education. After all, we all know that a large share of the disease burden
in this country is tied to poor social conditions of people living in poverty, having jobs that don’t pay enough, or that put stresses on families, living in unsafe neighborhoods.

There is no doubt in my mind that fundamentally, if we want to improve health in this country, we need to take money out of the healthcare system, where strong analysts have found that anywhere between 20 and 30 percent, and some would estimate higher of the money we spend, provides no value in terms of health outcomes. We need to pull that money out of healthcare and put it into education, put it into communities, put it into housing, put it into other sectors, so that we’re not battling health versus other needs, but we’re seeing holistically what it takes for people to be healthy.

That kind of moving large numbers, we’re talking millions and billions of dollars out of a sector that is very happy to keep the money, that is an advocacy job. That’s a job that requires your push around things like the provision in the Affordable Care Act requiring nonprofit hospitals to do a community assessment and allocate, figure out those resources and allocate them appropriately. But it takes much more than that.

So fundamentally, I believe that, if we’re going to move resources where they're going to have the greatest effect on health, we need advocates to push for reallocating resources to the social sector.

And the final reason is, unfortunately, the simple math of it, which is, if we don’t constrain cost growth in the healthcare system, not only will we not be able to pay for these other priorities, but we will not be able to hold the ground on the coverage expansions that I described at the outset.

In the 20 years that you all have been meeting, health as a share of GDP has risen from about 13 percent to about 17 percent. Medicare and Medicaid as a share of GDP risen from four and a half percent to six and a half percent. That may sound small. But in an
economy as large as ours, that is phenomenal growth. In 1990, those two programs were 11 percent of the federal budget. In 2010, 20 years later, they were twice that, 22 percent of the federal budget.

Now we did publish, not long ago, the latest data from the federal government, showing the lowest rate of spending growth ever in the United States. You may recall, in the State of the Union Address, President Clinton said one year doesn’t make a trend. He was talking about climate change. But he did cite the fact that we had a year-- that we had the lowest rate of spending growth. The problem is, unlike in climate change, where we’ve had year after year after year of confirming data, in healthcare, we’ve had year after year of excess growth. One good year is promising. But it doesn’t tell us that we’ve succeeded.

Fundamentally, if we can't make this healthcare system more affordable, we’re not going to be able to hold the gains that we have already made. And that, in and of itself, should motivate you to engage with that topic.

So I just want to close with one last way that I think things have really changed over the past 20 years. As you convene and talk about building real progress, I think one of the amazing sources of progress is that there is now a fundamental expectation that patient voices and consumer voices will be part of the discussion. We have, out of our report, the creation of the National Quality Forum, which includes consumer representation.

We have a decade of the move towards the patient centered medical home, changing the practice of primary care. We have the CAPS Survey, the Consumer Assessment of their Experience built into quality measures. A growing movement for shared decision-making, patients engaged in their care, nascent discussions around end of life care that we know does not well represent patient needs.
The triple aim, which animates discussions around the country, one of the three parts of that aim is the patient experience of care. People are talking about it everywhere. And I have to take some pleasure in the fact that there was that time that there was the creation of what were called “consumer-directed health plans.” That was a marketing trick. Those are high deductible plans. There was no consumer direction in them. Now we’re clamoring for data. And we understand that high deductible plans have to be-- have a lot of risks, and that people need a lot better information if they're going to be able to function within them.

From my own perspective, every month we run an article called “Narrative Matters.” It’s a personal story about someone’s experience with the healthcare system. In 2014, three of our ten most read articles in the entire journal over the year came out of “Narrative Matters.” There is a focus on the patient and consumer experience that simply didn’t exist 20 years ago. What has changed? We’re focusing, but there's also, in my view, a maturity in the advocacy community.

More than 20 years ago, when I moved to Colorado, I worked for a small nonprofit advocacy organization called The Colorado Children’s Campaign. I went on the website this morning. Their staff don’t even fit on one page anymore. We were in a basement. Now they're Suite 420. I don’t know where it is, but it’s not a basement.

Now I didn’t work at the Children’s Campaign for all that long. So I'm not going to take the credit. But you have built real progress. There is lots more building to do, on coverage and on improving the healthcare system. So my message to you is to encourage you, keep on building, and together, we will keep on making progress. Thank you very much.

[applause]
RON POLLACK: Thank you so much, Alan. All of you get your subscriptions for *Health Affairs*, and you can get more of that wisdom in between conferences. We’re delighted that Alan was willing to join us. I'm very pleased to introduce our next speaker, Congressman G.K. Butterfield. Congressman Butterfield was first elected to serve the First District of North Carolina in a special election in July of 2004. And he has rapidly ascended in terms of his responsibilities and leadership in the Congress. He serves in the Democratic Leadership as the Chief Deputy Whip. He is currently the Chair of the Congressional Black Caucus. That obviously is very important, in terms of making sure that communities of color are included in a helpful way in policymaking. He sits on the Health Subcommittee of the Committee on Energy and Commerce in the House, which, among other responsibilities, has oversight of the Medicaid program.

And one of the things that we’re so thrilled about, as to why he is here today, he’s Co-Chair of the State Medicaid Expansion Caucus in the Congress, where he’s trying to make sure that the other 23 states that have not yet expanded coverage actually do so. Prior to serving in the Congress, Representative Butterfield founded a law practice. And he’s best known for the litigation on voting rights cases that resulted in a significant number of African Americans being elected to public office.

In 1988, he was elected as resident Superior Court judge, presiding over civil and criminal cases in 46 counties in North Carolina. And for two years, he served on the North Carolina Supreme Court. So we are thrilled to bring to you and have speak to us today, Congressman Butterfield, who I am sure is going to talk to us about the importance of actually moving forward on Medicaid expansions in his home state of North Carolina and in other states across the country. Please welcome Congressman Butterfield.

[applause]
G.K. BUTTERFIELD: Thank you and good morning, one and all. You know, I tried to discourage long introductions. But the more he said it, the better it sounded. And so thank you very much for those very kind and generous words of introduction. As was mentioned, I am a ten-year Congressman from the State of North Carolina. I sit on the Energy and Commerce Committee and on the Subcommittee on Health. I worked very hard to get in this position, and I will not disappoint you. I want to make that pledge to you today.

But thank all of you for coming to Washington. I understand most of you came in yesterday and will be here through the weekend. And just welcome. Welcome all of you to the Nation’s Capital. This is a wonderful city to be in and to be a part of. And I just want you to enjoy your stay here in Washington.

As all of you know, we have a new political landscape in Washington, unlike it was over the last many years. Over the years, we have had a divided Congress. The Democrats would control one chamber, and the Republicans controlled the other. And one of the two would occupy the White House. But the landscape is now a little different. As of the November election, the entire Congress is now in the hands of the Republicans. And the White House continues to be a Democratic White House. And so, the whole paradigm has now changed in Washington. And we are trying to recalibrate. And I hope you will try to recalibrate with us. But it’s a real challenge. We are going to work very hard to try to build bipartisan coalitions and reach across the aisle when and where we can to try to make a difference for the American people.

But I’m delighted to be here with you today. And I don’t know many of you. I suppose some of you may be from the Southern part of our country, from North Carolina and other places. And so thank you for all that you do. Thank you to Families USA and to the Executive Director for inviting me. Also would like to recognize a good friend. I did not know Sylvia Burwell before I came to Washington, but she has distinguished herself. She
started off over at OPM, Office of Personnel Management, and now she’s at HHS. And just want to thank her for all that she is doing for all of us.

Let me just talk about Medicaid and Medicare. This is the 50th anniversary. You certainly know that. I am 67 years old. And so I was a teenager when LBJ formulated the idea of Medicaid and Medicare. And I cannot imagine what this country would be like today if we did not have the advantage of those two wonderful, wonderful programs. Poor people, when I was growing up in the South, had no access to healthcare, no access to healthcare, even in times of emergency. Whenever families, low income families would have an emergency, they would self-medicate and end up usually passing away. If they were critically ill, then usually the community doctor would get his bag-- no hers back then-- would get his little medical bag, and go around to the house, and give them an aspirin and some encouragement, and move on to the next patient.

But times have changed. We now have these two wonderful programs. And now they are 50 years old. There is no achievement that even comes close to those two programs, no medical achievements. The Affordable Care Act is a very close competitor. And I'm very proud of that legislation.

When we first wrote-- and I'm on the committee that wrote the Affordable Care Act-- When we first started, the Republicans would always use the word “Obamacare.” If you would yield five minutes to a Republican member to speak on the Affordable Care Act, he or she would use the word “Obamacare” 15 or 16 times within a five-minute frame period. One of my colleagues and I just sat there one day and checked off the number of times they called it “Obamacare.”

But then, when I heard President Obama start referring to it as “Obamacare,” then I took less offense to it. And so now, I use that phrase with affection, with affection, because that Act has done so much for so many, and it’s continuing to do so.
In addition to providing affordable health insurance to some for the first time, ACA also provides for significant expansion of states’ Medicaid programs, you know that, so that individuals with incomes that are less than 138 percent of poverty can finally have basic access to care. Now the bill was 2700 pages. And I cannot take credit for most of those pages. But I can take a small part of the credit for the Medicaid expansion piece, because that’s the piece that I dwelled on for so long, because I know, and I knew then, what it would mean for my district.

My district is the fourth poorest district in the United States of America. And so you could imagine the number of low income families that benefit from Medicaid. And we recognize that, in most states, Medicaid only applied to families, not to healthy, childless adults. And so we wrote the thing so that we could include the new population of single, childless adults. And I was very proud of that, but very disappointed when the Supreme Court gave us that Monday morning surprise when they said that it was optional to the states and not mandatory.

For far too long, access to quality healthcare has been seen as a privilege and not a right. It is a right that should be enjoyed by each and every American, regardless of their circumstance. And that’s why the President and congressional Democrats fought so hard for mandatory Medicaid expansion as part of the Act. Millions of Americans with incomes less than the federal poverty level who would not qualify for insurance through the exchange would finally be able to get a basic level of health insurance through the expanded program.

But, in 2012, as you know and I know, the Supreme Court ruled that the state Medicaid expansion should be voluntary. They said that it was an overreach on our part in order to make it mandatory to the states, and that it should be voluntary. I guess the only good
news that came out of that decision was that the remainder of the Act was declared a proper exercise of authority by the Congress. And so it is now the law of the land.

Now, nearly half a century after Medicaid was created to help the least among us, 23 states still believe it best not to expand their programs, thereby further disadvantaging millions of their residents by denying them access to the federal dollars that they rightfully deserve. And, as you know, we were willing to pay for it, up until the year 2016. And, after that, we would pay 90 cents on every dollar for the states to take care of their indigent population. States have refused to expand their Medicaid program regardless of the consequences.

The federal government has committed to pay 100 percent of the cost of the expansion. And, as I said, 90 percent beyond that. Nationally, the states would see only a 1.6 percent increase in their share of Medicaid spending, a 1.6 increase to provide healthcare, healthcare for millions of Americans. As Chairman, the new Chairman of the Congressional Black Caucus, and my staff told me to stop saying new, but I'm new. And so, I'm going to call it what it is.

Two weeks into the job as Chairman of the Congressional Black Caucus, I am particularly sensitive to the fact that some 20 percent of all uninsured adults are African American. More than half of uninsured African Americans have family incomes below 100 percent of the poverty level. And sadly, it comes as no surprise, that nearly two-thirds of all of the uninsured live in states that are not expanding their Medicaid programs. As a Representative from North Carolina, I am acutely aware that expanding Medicaid will save my little state, my little State of North Carolina more than $65 million dollars over the next eight years and would benefit our economy by adding nearly $1.5 billion dollars to our revenue. It makes no sense not to expand the program.
Expansion would not only save jobs, but help create jobs as well. And that’s just in my state. The benefits of Medicaid expansion far outweigh the cost, because the cost of inaction is simply too great.

Pungo Hospital, most of you have never heard of Pungo Hospital. I hadn’t either, until a year and a half ago. But Pungo Hospital, located just outside of my district in a tiny town called Belhaven, has closed its doors, literally closed its doors, because of the refusal to expand Medicaid. They were counting-- That was part of their business plan. They had counted on the expansion of Medicaid in order to pay the bills.

The decision by the governor and our Republican-led legislature has cost a young lady in that community her life. Her name was Porsche Gibbs. Porsche was 48 years old. She had a heart attack, very true story. You may have seen it on the national news. She had a heart attack, died on her way to the nearest open hospital, which was an hour away. How do we explain to her family-- and I've met her son-- and the other families who will no doubt experience the unavoidable death of a loved one? Why ensuring her access to emergency care didn’t fall within the state’s budget? How do we explain to her family that she died because our governor and our state legislature are playing politics with our state’s hospitals?

It was stories like Ms. Gibbs’, and countless others across the country, that motivated Congressman Hank Johnson of Georgia and myself to form the State Medicaid Expansion Caucus. We are joined by 33 members who understand the urgent and pressing need for low income people to have access to healthcare that they deserve. And we invite any member, Republican or Democrat or otherwise, to join us in our work.

You all cut on the time, so I don’t know how long I've been talking. I was told 10 minutes. And I hope Secretary Burwell is not out there waiting. I'm almost finished.
But friends, our mission is to demonstrate to governors and state legislatures the overwhelming support of the public to provide the most basic access to healthcare for low income people. The majority of Caucus members are from states that have made the short-sighted and politically motivated decision to exclude the very people the Medicaid program was established to help.

It’s a shame that Congressman Johnson and I had to start this Caucus. Twenty-three states’ decisions not to accept hundreds of millions of dollars in federal support absolutely defies logic. It will prove catastrophic for the very people the Medicaid program is intended to help. Until all states, your states, my state, until all states expand their program and grow their program, we are going to continue to have uncompensated care.

Like the majority of the public, members of the State Medicaid Expansion Caucus are tired of inaction. And we are demanding-- Yes, we are demanding change. People who may not be as fortunate as you or me are dying. That’s a fact, dying as a result of political gainsmanship. And, frankly, they deserve better than to be abused for political gain. Let’s play politics on something else and not this.

But those opposing the ACA and Medicaid expansion clearly have a different view. During the 113th Congress, the House took more than 50 votes that would delay, dismantle or repeal the Act. Thankfully, Senate Democrats pushed back very hard. But unfortunately, the political landscape has now changed. Just two days after the new Congress was sworn in, the House passed the misleadingly titled “Save American Workers Act” that would have practical impact on all but gutting the ACA’s employer mandate provision. Currently, in order to qualify for employer-sponsored insurance, an individual must work a minimum of 30 hours per week. If the bill becomes law, employees must work a minimum of 40 hours per week to qualify for that same health coverage. That sounds like a very benign change. But it would have gutted the law.
So, for large employers hoping to avoid having to provide employer-sponsored insurance, they need only reduce the weekly hours of their employees to 39 hours per week. If enacted, the nonpartisan CBO warns that raising the threshold could affect many more workers than are affected under current laws, leave more workers uninsured, and raise the deficit by as much as $74 billion dollars over a 10-year period. This is the first of what we expect to be dozens and dozens of attempts by the Republicans to dismantle the Act.

And so I want to thank you very much for your interest in Medicaid expansion. Thank you for all that you do for low income families and middle class families all across America. And I want you to know that, in the Congress, you have a friend. You have an ally. And we will work together with you and with your leadership to make America more healthy and stronger and economically viable.

Thank you very much for having me today.

[applause]

**RON POLLACK:** Thank you so much, Congressman Butterfield. We have a wonderful treat in store for us. For many of us, it is an opportunity to welcome a relatively new friend. And that is the Secretary of Health and Human Services, Sylvia Matthews Burwell. Now Secretary Burwell has now served for a little over seven months. I'm presuming, with all the things on her plate, it probably feels like a little more like seven years. Sevens run wild in the Department of Health and Human Services. She has oversight of 77,000 employees who affect us in every walk of life.

Secretary Burwell has a much deserved professional and personal reputation as being an extraordinary leader in the public and private sectors. In the private sector, she served as President of the Wal-Mart Foundation, leading efforts to end hunger and empower
women around the world. At the Bill and Melinda Gates Foundation, she was President of Global Development Program that helped get needed vaccinations to low income people and to promote children’s health.

In the public sector, in the Clinton Administration, she had numerous very important jobs, Deputy Director of OMB, Deputy Chief of Staff to the President, Chief of Staff to the Secretary of the Treasury, and Staff Director of the National Economic Council. And in the Obama Administration, before serving as Secretary of Health and Human Services, she served as a Director of the Office of Management Budget.

Now Secretary Burwell has done an extraordinarily effective job in making sure that enrollment through the Affordable Care Act would be done effectively. She and her colleagues made the website and the technology a whole lot better. And she has worked tirelessly to promote enrollment in communities across the country.

But I would say, if I could pick out one thing that endears us to the good Secretary, is her tireless efforts to try to expand coverage for the poor. She is working with governors to try to encourage them to expand coverage for the poor, and she’s doing it with an excellent sense of balance, balance meaning encouraging the states to come in and expand coverage, but understanding full well that those proposals that expand coverage, not through the traditional expansion of Medicaid, but through programs that require waivers, that we continue the very important protections that have traditionally been the hallmark of the Medicaid program, who is eligible, what benefits they get, what are the out-of-pocket costs.

So it is with great pleasure and an honor to introduce-- and please give a warm welcome to the Secretary of Health and Human Services, Sylvia Matthews Burwell.

[applause]
SYLVIA MATTHEWS BURWELL: Thank you. Thank you, and good morning. And I will agree, some days it does feel like a dog year, in terms of the sevens, seven months, seven years. I want to thank you, Ron. It’s an honor to be here. And it’s an honor just to share this stage with Ron Pollack in the middle of open enrollment. A very important time for us at HHS, and an important leader who helped get us to the point where we are excited and pressing on in open enrollment, and where we are. So it’s an important time and an honor to be with you and this entire room during this time.

And two nights away, when we heard the President, we heard him say that we here in America are freer to write our own future than any other nation on earth. And, as I begin, I actually want to thank you all in this room for doing what you're doing to write the story of a healthier America. For your hard work, your commitment, and for being the voice of healthcare consumers.

For your work on health reform 2.0, and the initiatives and the priorities that we share, from expanding Medicaid, which has been talked about by the Congressman touched on just now, and what I was working on with the team right before I came, to making coverage more affordable, to improving the quality of care that is delivered.

For all the differences of opinion in our country, when it comes to healthcare policy, and how we move forward, there is one area for which we have unanimous agreement. The system that’s been in place for the last 50 years has under-delivered on affordability, quality and access. Today, thanks to the Affordable Care Act and the work of so many folks in this room, we are making progress in all of these areas.

The evidence shows that the Affordable Care Act is working, and families, businesses and taxpayers, are better off as a result. We have achieved a historic reduction in the number of the uninsured. Middle class families have more security. And many of those
who already had insurance have better coverage. At the same time, we’re spending our healthcare dollars more wisely. And we’re starting to receive higher quality.

This is what I want to talk to you about today. I know that I don’t have to remind anyone in this room that we have been wrestling with this question of how to decrease the number of uninsured for over a century. And you’ve lived this cause, and you have the worn shoe leather to prove it. By the time President Obama took the oath of office, our system had broken down to such a degree that we were spending far more as an economy on healthcare, in both gross and per capita terms, than all the other developed countries around the world. The prices we paid far outweighed the progress that we’d made.

As we heard the President say on Tuesday, in the past year alone, about 10 million uninsured Americans have finally gained coverage. [applause] What’s more, since October, 2013, more than 9.7 million Americans were enrolled in Medicaid and CHIP. To date, governors from 27 states, plus D.C., as was just mentioned, including those who disagree on elements of the Affordable Care Act, have reached the same conclusion. Expansion is good for the people, and it’s good for the state economy. In addition, some who have not yet expanded Medicaid have expressed interest, whether that’s Wyoming, Indiana, Alaska. And I want to see all 50 states expand in ways that work for their states, to that point of flexibility. And I know you do too.

We also are making progress when it comes to affordability. You might have seen the recent Commonwealth Fund Study, which found that fewer Americans are having to forego medical care because of affordability. For the first time since this question was introduced in 2005, the percentage of adults who had problems paying medical bills or were paying off medical debt declined from 41 percent in 2012 down to 35 percent in 2014.
One area of affordability where we are achieving some especially significant results is marketplace insurance coverage. As I mentioned up front, we are currently in the midst of open enrollment. I'm sure I do not need to remind anyone in this room that that deadline is February 15th, something I say early and often, including this morning at 7:55 on satellites to Indiana and Ohio. As consumers shop for coverage on the marketplace this open enrollment, they are benefiting from choice and competition, with more health insurance issuers competing for their business this year.

What's more, in the first month of open enrollment, 87 percent of the people who selected 2015 plans through healthcare.gov got financial assistance to help lower the cost of their premiums. There also is good news in terms of access. Since open enrollment began on November 15th, yesterday we announced that over 7.1 million consumers have selected a plan or been automatically enrolled through healthcare.gov.

To continue to make progress, we need your help encouraging friends and families and neighbors to visit healthcare.gov, to call 1-800-318-2596, or go to localhealth.healthcare.gov to find out where they can find that in-person assistance. We’ve worked to make the shopping experience and enrolling easier for the consumer. And we’ve done that by working on the website as was mentioned, but also in terms of things like, for 70 percent of the new applicants, that application went from 76 screens down to 16 screens. For those that are coming in to re-enroll, what we did was we moved to pre-populated information. So 90 percent of your information is already in. So you don’t have to retype that information. You can just read your name and address again. So again, that deadline is February 15th. It’s my job. I'm contractually obligated to mention it at least three times in any remarks. [laughter]

And before I close, I also just want to say a brief word on quality, a topic I know you all are interested in as well. It’s within our common interests to build a healthcare delivery system that is better, smarter and healthier, a system where medical information and
medical bills are easy to read and understand, a system that puts information in the hands of patients and their doctors and empowers them to make better choices.

Our vision centers around finding ways to deliver care, pay providers, and distribute information. And, as you may know, Medicare and Medicaid together cover one in three Americans. So one of the things we’re doing is leveraging our grant and rule-making opportunities to improve the quality of care that beneficiaries receive while spending dollars more wisely.

We understand that it’s our role, and our responsibility, to lead in this space, and we will. What we won't do and can't do is go it alone. Patients, physicians, government, business, we all have a stake in this. And I believe that this shared purpose calls for deeper partnerships in this space.

For example, taxpayers have saved $116 billion dollars to compare to where we would have been with current Medicare trends since 2010. And according to our preliminary data, between 2010 and 2013, our nation reduced hospital acquired conditions by 1.3 million events, or things that happen, things like falls or infections. And much of this progress has come in the last year. This represents a 17 percent reduction, which is significant. Fifty thousand fewer people lost their lives, and we generated $12 billion dollars in savings.

I want to leave you today with a story. I recently met a woman in Arizona named Donna Greathouse. And for seven years, Donna couldn’t get insurance because she has a preexisting condition. She looked into signing up through a state high risk pool but couldn’t afford the $1,100 dollar monthly premium. But, when the marketplace opened last year, she found coverage for $155 dollars a month after her tax credits.
After reviewing her options this year, she chose to stay in the same plan. And I want to share with you Donna’s own words. “Literally, I’d be walking outside and think, if I fell and tripped on a curb, I’d be in big trouble financially. I have the peace of mind, now, knowing that if I fall down and break my leg, I’ll be taken care of and won’t go bankrupt. That was a constant fear that I had before.”

Let me close by once again thanking you for all your work. It’s because of you and your colleagues that this law is working and millions of Americans have financial security, like Donna talked about, and health security. Health coverage that’s affordable. Health coverage that’s there when they need it.

I look forward to continuing this work with all of you as we get more and more folks covered. Remember that date-- Everybody remember that date, February-- Good, good, good, everybody got the date-- to improve the quality of care that’s delivered and to spend our dollars, health dollars more wisely. So the most important person we get covered is the next person we get covered. Thank you all for having me today. And I look forward to getting more of those folks covered. Thank you.

[applause]

RON POLLACK: Thank you, Secretary Burwell, for taking the time to join us in your very busy schedule. We really appreciate it. So this is the close of this morning’s plenary. I want to have Patrick Willard, the Field Director of Families USA, who he’s organized a team for this conference, I have to say yesterday, I was watching Patrick, and he looked like an expectant dad, waiting for the conference to begin. But I think the baby has been delivered. [laughter]

PATRICK WILLARD: Thank you. So now we’re going to be getting ready for the workshop sessions. And the workshop sessions will begin at 11 o’clock. So you're going
to have a break here between now and 11 o’clock. But you probably need that time to make sure you get to these workshop sessions. Some of them are going to be up on the lobby level in the congressional side. Others will be here in the Columbia Rooms that we have set aside for us.

When you go to the workshops, and you have the workshop sign-up sheets, if you could take a look at your name tag, you will see that there is a small number there on the bottom right hand of your name tag. If you could take that number, and when you sign in, make sure you put that number down as well. That will help us to be able to get back in touch with you and make sure you get resources from these workshops and all that, that we need to make sure these are successful workshops.

So the workshops, again, will begin at 11 o’clock. They will run until 12 o’clock. We want you back in the room here, because the program is going to start at 12:15, when we will have Senator Warren speak to us at the beginning of the lunch. So make sure that you’re back here before 12:15, because we want to start promptly at 12:15. So take a break. Get to the workshops that you need to. You can find them here in the program and the different sites that’ll be set aside. Again, we have Columbia and Congressional workshops upstairs. Thanks so much.

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