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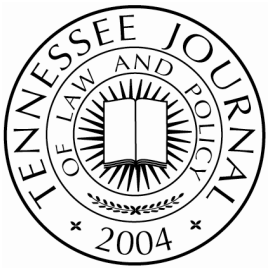

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A PRINCIPLED APPROACH TO HEALTHCARE

JAMES C. PYLES[1]

MR. ALEX LONG: Good morning, everyone. My name is Alex Long. I am the associate dean for academic affairs here at University of Tennessee College of Law ("UT") and on behalf of the College of Law, I would like to welcome you to Prognosis, Examining and Treating the Ailments of Healthcare Law and Policy, a symposium sponsored by U.T.'s Center for Advocacy and Dispute Resolution and the *Tennessee Journal of Law & Policy*. I know that our dean, Doug Blaze, would have liked to have been here this morning. He was called away on some business, so I am pinch-hitting for him. But in many ways, I think the timing of this symposium could not be any better, the icy roads and subarctic conditions notwithstanding. Less than forty-eight hours ago, as you all know, the Supreme Court of the United States heard oral arguments in *King v. Burwell*, a case in which the meaning and potentially the entire structure of the Affordable Care Act was called into question. Sadly, the Court did not provide us with audio, live audio of those oral arguments. But from what I understand, it was highly entertaining where Justice Scalia referred to the government's argument at one point as poppycock. And I don't know about you, but one of my rules of thumb is anytime Justice Scalia uses the phrase "poppycock," it is probably an interesting oral argument.

But the arguments in *King v. Burwell*, I think,

[1] Mr. Pyles is a Washington D.C. healthcare attorney, legislation author, and policy advocate. He was the principal author of the Independence at Home program, included as part of the Affordable Care Act. Mr. Pyles served six years in the Office of the General Counsel for the U.S. Department of Health, Education, and Welfare, and is a partner at the Washington D.C. firm of Powers, Pyles, Sutter, and Verville, PC.

remind everyone, once again, what a complex and divisive issue healthcare reform can be. Here in Tennessee, we have seen another example of that with Governor Haslam's attempt to expand healthcare coverage through the Insure Tennessee plan which, as everyone knows, I think, landed with a giant thud in the Tennessee legislature. But, once again, it reminded everyone how difficult it is to implement true healthcare reform.

And here at the University of Tennessee and at the College of Law, I think this symposium is particularly significant and timely for us because we have been trying to expand our healthcare offerings here at the law school. As some of you know, recently we have established a joint Juris Doctor and Masters in Public Health program with the Department of Public Health and our College of Education, Health and Human Services. So we have established, actually, a joint degree with the public health school there. And I am quoting from our literature here– it is designed to further the interrelationship between a legal system and the protection and promotion of the public's health, and emphasizes the role that policy, both public and private, plays in creating the conditions in which people can be healthy.

So I think today's symposium is timely and significant. I see some students. I see some recent alums. I see some folks around town that I know, so we are all happy to have you here. I think Professor Penny White and the editors of *Tennessee Journal of Law & Policy* have put together just an outstanding program here with a distinguished group of speakers. We are delighted to have you here. We hope you enjoy your time. During the breaks, feel free to go wander around the law school. If you have questions, by all means, find someone who looks like they know what they are doing and ask questions. But thank you so much for coming. Enjoy the program. I am going to turn it over to Michael.

MR. MICHAEL DAVIS: Thank you, Dean Long. And thank you especially to all of you for being here today, and braving the weather conditions. It is no longer a question of whether winter is coming, but when is it leaving. So we hope that is soon.

Since the beginning phases of this symposium, it has been the goal of the *Tennessee Journal of Law & Policy* to provide an exchange of ideas that could serve as a catalyst for our state to rethink healthcare and ideas that could serve to begin to treat the ailments that stand in the way of a healthier Tennessee. We have such a unique opportunity in front of us here today, not only because of the outstanding rank of speakers we have lined up joining us and the wealth of information that they will provide, but also because of the time at which we come together to share these ideas.

Whether we are legal professionals, healthcare professionals, educators, students or concerned community members, this is truly an exciting time for healthcare and what it means to our nation and the world. Today, we see advances in healthcare that bring tremendous promise and hope to people for a better, healthier tomorrow. Around the world we have seen tremendous advances in healthcare. We have seen viruses used to fight cancers with alarmingly positive results. We have seen incredible leaps in fighting debilitating, age-old diseases, such as hepatitis C and guinea worm. We have seen three-dimensional printing used for making prostheses and lab-grown organs, that were previously only the subject matter of science fiction, becoming science fact. Along with these scientific breakthroughs has come a growing recognition of the need to eliminate access to healthcare gaps, as well as reducing disparities in the kinds of treatment that are available for everyone. We have seen increasing efforts to establish improved systems of healthcare delivery and greater

discussion of people's rights to these services. In our nation, this is indeed a promising time, but it is also a crucial one.

Many may think the discussion over health, or the direction of healthcare in the U.S. ended with the passage of and the subsequent Supreme Court rulings about the Affordable Care Act. However, as we hear from our speakers today, and as indicated by the Supreme Court in the hearing of *King v. Burwell* just this week, our discussion may truly just be beginning. Today, we are considering three major topics relating to the United States and Tennessee's healthcare and health law policy of its future. We are hearing a review of the Affordable Care Act and analysis of how the U.S. will continue its approach to healthcare provision for its citizens through this legislation. We are hearing about innovations to healthcare services and how they can best be provided to our communities. These innovations address not just medical needs, but also the mental health sociological and environmental and legal needs. We are also hearing about how individuals who are helping and working in this healthcare landscape are adapting and improving it through cooperation across the healthcare and legal fields by integrating services to improve outcomes for all.

As you participate in today's symposium, I would encourage you to apply this information to your own role in the progress of healthcare. Whether you are a doctor, a judge, a social worker or a student, take time to take care, to be open, and to rethinking systems both large and small and realize that our healthcare laws, policies and provision of services do not happen without individuals like you. Your experience, ideas, and efforts, which are strengthened by discussions like today's, are the building blocks of that better, healthier tomorrow. Of course, any foundation for improving our healthcare system is built on principle, which leads me to introduce our first guest today.

It's my privilege to introduce James C. Pyles to deliver the keynote address, entitled, "A Principled Approach to Healthcare." Mr. Pyles has worked in healthcare law and policy for over forty years. Mr. Pyles is now one of the most respected voices in federal and state healthcare policy on patient privacy and is frequently sought out to author legislation and address current healthcare issues. Upon graduating from the University of Tennessee College of Law in 1972, Mr. Pyles worked for six years at the U.S. Department of Health, and was honored with a distinguished service award for handling complex Medicare legislation. Mr. Pyles went on to co-found the D.C. firm of Powers, Pyles, Sutter and Verville, and has been deeply involved in many health law issues ranging from health information technology ("IT") and home health, to chronic care coordination and ambulatory care services.

Mr. Pyles has participated intensely in healthcare reform at the state and the federal level and has authored legislation in many areas covered by the Medicare Act. He was the principal author of the Independence at Home program and was enacted as part of -- which was enacted as part of the Affordable Care Act. Mr. Pyles has built a reputation for expertise in nearly all areas of healthcare law, including reimbursement, fraud and abuse, provider and practitioner operations, home health and mental health, and serves as counsel to several national mental health and home care associations.

A prolific writer and speaker, Mr. Pyles has frequently been published on topics such as healthcare reform, veterans health privacy and the need for a health information privacy bill of rights. He has presented addresses before the 2011 Health Privacy Summit, the 2010 Health Reform Summit, and the American Health Lawyers Association. He has appeared on MSNBC, has been quoted in Business Week, Bloomberg News and numerous

other health and publications. Mr. Pyles is a bar member of Tennessee, Maryland, the District Columbia, and the U.S. District Court of the District of Columbia and the U.S. Supreme Court. He serves on the board of directors of the American Academy of Home Care Physicians and the Maryland National Capital of Home Care Association. He has been recognized as the 2002 Washington Psychiatric Society Advocate of the Year, and was also honored with the Richard Z. Steinmetz Award for outstanding contributions to home health and provider community in 1998. We too are honored to have Mr. Pyles with us here today at the University of Tennessee College of Law to begin our symposium with his address. Please join me in welcoming Jim Pyles.

MR. PYLES: Many thanks to Dean Blaze, Michael Davis, and all of you for allowing me to come and share some thoughts with you today. We really are at a unique time, I think, in the country's history. At least in my forty some years in this business, I don't think I have ever seen such change at least in the healthcare area. And I have never seen such a low level of trust by the public in elected officials or as dysfunctional a government as we seem to now have. It seems to some to be somewhat paralyzed. But those two situations, I think, can open up just endless opportunities for a school like the University of Tennessee. And I have to commend Dean Blaze because several years ago he came up and visited our law firm, and I chatted with him and he just inspired me with what we maybe could help the law school do. And so I have been working with him in the years since then.

It seems to me that, based on my experience, what is most needed in Washington today is an unbiased, impartial source of sound healthcare policy. And if there were an academic institution out there somewhere who could provide that back-up and serve as a resource for

members of Congress and their staffs, that would be a huge contribution. So in my forty years in this business I have, in health law and policy, I have never seen opportunities as great as they are today. Our firm has become, I think, because of the longevity of service by the members in it, we have become regarded as a policy resource for members of Congress and their staffs. I often get calls from fairly senior members of Congress and their staffs to ask us to review legislation, to ask us to tell them where are the pitfalls, does it have merit, is it something that will fall apart. We were heavily involved in a lot of the health law legislation that has been passed, although I cannot say they always listened to us. But the fact that Congress has to reach out to a firm like ours is just an indication of the help they need up there.

When I started in this business in 1972, when I graduated from U.T. College of Law, I wound up in the office of the general counsel for, what was then, HEW in Baltimore. I handled these odd cases that nobody wanted to have anything to do with. They were called Medicare cases. No one knew anything about Medicare. And when cases came up in the district courts or courts of appeals, the U.S attorneys there said, "Huh, I don't want to know anything about that, that's really complicated. So, new agency attorney, you just argue the case." So I wound up living on airplanes for about five or six years and litigating cases from one end of this country to the other on behalf of the federal government and on behalf of HEW. And what that did for me is it allowed me to litigate against some of the top law firms in the country. That is a hard way to learn, but it is a very fast way to learn. So I got my nose bent many times, but I learned from it and I tried not to make the same mistake twice. When I was handling those Medicare cases, I handled every single one in the country. I was the sole litigator for Medicare. There was not anything like an American Health Law Association. There

was no such thing as a specialty as health law. Today, our firm is largely dedicated to health law and policy. And there are many sections of large law firms that are dedicated to that. And I have to say, it is one of the most opportunity filled sections or sectors of the law today. So opportunities here for the school, and opportunities for the students graduating from the school are just unlimited in the health law area.

With the Affordable Care Act, which was the most sweeping piece of legislation, I think, in this country since the Constitution, it has affected every single person including many of you in multiple ways. If you are a provider, If you are also a purchaser of health insurance, then you are a practitioner, or you could be. It has taken all of the pieces of the healthcare delivery system and thrown them in the air and they were just beginning to come down, they are just beginning to come down in different places, but the Supreme Court, in *King v. Burwell*, could throw them all in the air again. But I can tell you, I may be one of the few people in the country who has actually read the Affordable Care Act and many of the regulations from start to finish. No one can read all of the regulations. I can tell you that we are going to be changing that law throughout, even during the youngest person's professional career in this room. Medicare was enacted in 1965 and has been amended almost every year since then. The Affordable Care Act is much more complex and applies to many more people. And if it sticks and hangs together, it will be amended every year. So we desperately need good policy in this area, and we desperately need a source for Congress to rely on to make good policy.

I did read the transcript from *King v. Burwell*, and the argument on Wednesday. And I am too old and too dumb to lie to you. So I will tell you, it is my prediction that the Supreme Court will uphold the subsidies by a six-three decision. And I know this is being recorded, so I

have every opportunity to be entirely embarrassed by this prediction. That is the sort of thing you can do when an old person.

I do need to exonerate my law firm for anything I say here. So I will just say that my views are not necessarily those of our firm. When I talked to Dean Blaze about this, I said, "Can I be honest in this talk?" He said, "Absolutely, just tell them what you think." So I am more honest than usual, and also, if I fail to insult either party, I want to apologize up front for the omission. So in our business, we really do have to be right down the middle of the road in, and I can tell you that I have been working lately with Senator Alexander's staff, and his staff, I do not know him, but his staff is top-notch. They are really good. I have been working with them on reforming the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and the privacy breach issue. They were very disturbed about that, and he is working with Senator Patty Murray of Washington State to come up with a bipartisan approach to addressing the health information privacy breach epidemic that is currently in our midst. He also released, along with Senator Hatch and Senator Barrasso of Wyoming, an op-ed or opinion piece two days ago outlining a back-up plan in case the Supreme Court does invalidate the subsidies in thirty-four states, including Tennessee, in the *King v. Burwell* decision.

By the way, think for a moment what is going to happen. Think of the timing of that decision. That decision will come out at the end of June, most likely. It will then go into effect somewhere between zero to twenty-five days later, unless the Supreme Court delays the mandate. That is right when the 2016 presidential elections will be heating up. If they knock out those subsidies, that will be the worst nightmare for the Republicans in Congress because then they are going to have to fix it and

you can just see the realization beginning to dawn on them. A much better deal for the Republicans, in my view, my personal opinion, is for the Supreme Court to uphold the subsidies and then allow the Republicans to go amend that bill over time, a piece at a time.

The great problem with the Affordable Care Act, in my opinion again, was when it was passed it was not bipartisan, and you cannot have legislation that sweeping, not be bipartisan. Otherwise, the party that was not involved in it is going to attack it every election. They have to attack it as a matter of pure political survival, and that is what we are seeing. So it is interesting to me to see that more than half of the public opposes Obamacare and more than half of the public supports the Affordable Care Act. They are the same thing, of course.

So anyway, here is a little bit of background for you. Not to put this up here to tell you that I know what I am talking about, but I have seen a lot. And I think I have seen everything in this business now at least twice. And I have not argued before the Supreme Court. One of my partners has argued three cases before the Supreme Court, two of which my partner won. But I can tell you just from arguing before three judge panels, that it is really exhilarating because one judge gets to shoot at you while the other two are reloading. And the same is true, of course, with the Supreme Court. By the way, I listened to the transcript of the *King v. Burwell* case. My heart went out to Mr. Carvin because he got one sentence out before Justice Ginsburg was all over him about standing. And that was the last time he was uninterrupted throughout his argument. And I know how exhausting that can be.

I have been forty-three years in this business. I am a slow learner. When I finally figured out where the law was coming from, it was a lot easier to change things at the source rather than do it a court at a time, so I devoted the last twenty-five years or so to really mostly help policy.

And what I have tried to do is I find issues that I really like, then I try to go out and find a client who will pay me to handle them. And it has worked really well so far, but it just means you cannot be too picky about how much you get paid. So here is a little bit of the background. And I just worked on most of the up and coming health laws.

Here is what I see. I see a dysfunctional Congress and dysfunctional laws. When Congress is dysfunctional, they do not talk to each other and make deals with each other, and the law they generate is generally worse. But the way you get good laws is by vetting them, by having input, by log rolling and taking into account lots of different considerations. Then again, that is why I say the Affordable Care Act, love it or hate it, was really imperfect because it was rammed through in a very hurried fashion. And that is why we are living with a lot of mistakes now, including what I think is probably a drafting error, and it is at the heart of *King v. Burwell*. And what I have seen when I started in this business is that the career staffers, on the Hill there was a cadre of congressional staff members who were there, they spanned administrations. And if their person got defeated, then they just went to work for somebody else. But they had an institutional memory. Those people are all gone now. I can only think of one senior staff member who is still on the Hill who works in the health area. Because they got burned out by just the constant vicious bickering, they could not even talk to the staffers for members of Congress for the other party. So they just said the hell with it and we are out of here. At least a lot of them did. And it was a great loss, it really was. And I hated to see that happen, but that has been one of the casualties of the lack of partisanship

How many of you all have seen this? Okay. How many in here see gold and white on the dress? And how many see black and blue? See, this is my point exactly. We all see the world differently. And we need a process by

which we can all come together and say, it is all right if you see gold and white and if you see black and blue. It is okay. It is okay. We can accommodate this in our laws. We are also losing some of the older members of Congress who are able to do this. I was never a great fan of Senator Kennedy, but he and Senator Hash could always sit down and come to some bipartisan common ground. They could find some common agreement somewhere. And some people today would call that unprincipled, but it is the only way Congress functions. That is exactly why it was designed the way it is.

I mean, one of the smartest people I have ever known was James Madison. And I say "known" because I have studied his writings extensively. And this is from Federalist number ten, which is generally viewed as one of the most influential Federalist papers. And if you look at this -- see if this works. If you look at the last phrase there, it talks about what faction does, it renders people much more disposed to vex and oppress each other than to cooperate for their common good. And his whole point in Federalist number ten is we need a union that is big enough, that has enough divergent views that it cannot be paralyzed by faction. But that is exactly what we have today. We now have a Congress and lobbyists who are trying to create a system that can be paralyzed by faction. And that is a shame. And I wish we had folks who had a better grounding in the structure and intended operation of our form of government.

And hopefully, you are getting that kind of education here at the University of Tennessee College of Law. So you understand that it is not such a bad thing if someone disagrees with you, you just have to figure out a way to get as much done as you can by talking to them. I loved that because I thought this was just perfect. This is exactly why I hate all the other ones, but I love my own. We hear that a lot. And I want a principled person, a

person who will fight for his, which is nice, but we also need to get something done. We need to run a country here. So now, I will say I have done enough reading throughout history to know it has been this bad previously. It has been, but it has not been this bad in my professional career.

So where are we? We get laws that we want, but we do not get laws that we need. We get laws enacted that are ineffective or flawed. And I would like to use just a couple of examples. One is the HIPAA privacy rule and the HIPAA law, which I have worked on since 1996 when it was first enacted. And it was then called the Kennedy-Kassebaum bill. And I have tried my hardest to see if we could make that law develop in a way that made some sense. And, boy, it has been a tough, tough job. It has been like pushing a chain uphill. But we now have one of the most complicated laws I have ever seen. Just yesterday, one of my clients was saying, "could you just give me a decision tree on how I can apply HIPAA to determine when I am in violation of it and what the patients' rights are, and what my rights are." And I thought, I could do that, but it would look like a redwood. It would look like a cedar tree. I mean, it has so many branches. We have a HIPAA privacy law right now that is so complicated that no member of the public can possibly understand it. And no practitioners, who are subject to it, can really understand it, and very few lawyers understand it. And that was the approach, in my view. This was, I think, the source of the naiveté of the people who were drafting it. We started with the assumption that because we now have the capability to transmit your health information electronically, we have a right to do it. And you do not, you just do not. There is nothing about electronic information systems that changed the public's expectations or needs. You, as an individual, like to think you might have some control. You do have control over your health information. It starts in your head

or your body. The question is, how do we get you to voluntarily disclose it to somebody else? And if you think if you disclose it and you think it is going to harm you, you would not do it. So your practitioners will be deprived of the information they need to treat you. So there again, this is Madison's thought. And this was not from Federalist number ten. Another thing Madison said is about how laws that are so voluminous that the public cannot understand them, are really worthless.

So in the five years since the enactment of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), it was supposed to go back and change Health Insurance Portability and Accountability Act ("HIPAA"), which was enacted in 1996. The HITECH Act was part of the American Recovery Reinvestment Act, which. was supposed to go back and make sense of HIPAA and straighten everything all out for folks and make electronic health information much easier to use. In the five years since it was enacted, over forty-one million Americans had their health privacy breached six times the population of the State of Tennessee and more than the population of any single state and more than the population of Canada. So we are now in the midst of an electronic health information privacy breach epidemic. I mean, there is no way these systems, these electronic systems can be made secure. Now the "techies" tell us that. And now we have, just in January, the Anthem breach. Eighty million people there. And now, I just saw yesterday, we are going to add another fifteen million to that, because they were also storing the identifying information on fifteen million people who were not beneficiaries of Anthem health plans.

And this was something that I really loved. A year or so ago, U.S. Department of Health and Human Services quietly published a notice in the Federal Register indicating how many hours it would take for the healthcare industry to implement the modified HIPAA rule as modified by

HITECH. Thirty-two million hours annually. Thirty-two million, and that doesn't deliver a single additional health service. That is just to comply with HIPAA. I was working with Joe Conn, who is a reporter at Modern Healthcare, on this. And we figured out that if you put all those hours together longitudinally, it takes you back to prior to the Hittites Civilization. It just shows you how the complexity of the HIPAA law will drive practitioners to their knees. And what this does is it drives up the costs.

So we have, under the American Recovery Reinvestment Act, authorized thirty billion dollars in incentives. Some people call those bribes, but incentives to practitioners to become meaningful users of health IT. It was not produced, and you can see, this is a recent study that came out and it showed physicians do not really like it very much. Patients do not feel like they are getting anything they can really use. I have a primary care physician, he as an older fellow and a great guy. He is one of the best. I have seen a lot of physicians, and this guy is really good. He plans to retire so he will not have to use the health information technology. He does not like it. He does not want to use it for his patients. One of the problems I see, which was not well thought out in advance, is that today when you go see your doctor, your doctor does not look at you, he looks at the computer screen. So my brother, I will confess, is a physician and is a psychoanalyst. And so what he has taught me is that the most important relationship in medicine is the relationship between you and your practitioner because it is all based on trust. And if you do not trust your practitioner, you are not going to confide in them, you are not going to cooperate with them, and we are not going to get good quality healthcare.

So we know that eighty percent of the public is now concerned about the privacy of their health information because they see articles about privacy breaches almost every day. People are withholding their information from

their practitioners now more than they did in the past. Health identity theft is the fastest growing type of identity theft. Ninety percent of providers have experienced at least one breach in 2013. And HHS found in 2003, buried in a Federal Register notice that they just cannot make these systems secure because a health record is now worth so much money, much more than a Social Security record, and that there is a huge incentive on the part of hackers, to figure out ways to get into these systems. The hackers are always ahead of the security systems.

The premise of the HITECH Act was that it would save seventy-seven billion dollars a year and a hundred thousand lives. And then the seventy-seven billion dollar funding was based on a study by Rand Corporation. And the fact that it would save a hundred thousand lives was supported by an Institute of Medicine study called To Err is Human.[2] Now, I must have been one of the few people in the country who read both of those studies, and neither one of them stood for the proposition for which they were being cited. So I remember I went to Senator Durbin's staff and said, "Hey, guys, these studies do not support the reason you are moving ahead with HITECH. And they said, "You know, you really should not talk like that, people will think you are crazy." So I said, "Well, all right, all right, let's do this then. Let's put a provision in the HITECH Act that requires the U.S. Government Accountability Office ("GAO") to create a report to Congress five years after the Act has passed, telling Congress whether in fact health IT has reduced costs seventy-seven billion and saved a hundred thousand lives a year." And they did, they stuck the provision in there. We found out later that the Rand study was funded by one of the biggest IT vendors in the country. And the New York Times found that out and published it on their front page.

And we found out also that the Institute of Medicine

study was written by IT and people who were trying to get health IT into the law. So we move now to the GAO study, which was going to then tell Congress whether what they were trying to do really achieved its professed purpose, but I found that the GAO study was written by the author of the Institute of Medicine study who had now left the Institute of Medicine and gone to work for the GAO. And the conclusion that this person reached in the GAO study, which came out in March of this year, was that we cannot tell if it is reducing costs or saving lives because HHS has not collected the data. Well, the statutory provision did not say, "tell us if it has been effective if HHS has the data," it said "tell us if it has been effective." And I am not anti-health IT, but there is enough studies out there now to show that the health IT system we have today is not saving lives and it is not reducing costs. It is driving up costs and we do not know if it is saving lives because it is adding errors to the system. This is just an illustration of how we can make bad law if it is not well grounded in good research.

Also, I just wanted to mention briefly that I remember when the Affordable Care Act was getting ready to be marked up and the Senate Finance Committee held a round table discussion. And in that round table discussion, the issue came up of what is the number one objective of health reform.

It was unanimous, bipartisan consent agreed that the number one purpose of that act was to reduce healthcare costs. And out of nine hundred and seventy-one provisions, there is only one provision that requires any reduction of healthcare costs, and that was the provision that I drafted, the Independence at Home program that says that if you participate in the Independence at Home program, you will treat the highest cost patients and it will reduce their costs by five percent a year and produce a good outcome. If you cannot do that, you are out. But that was the only provision out of nine hundred and seventy-one

provisions because the Affordable Care Act was really the product of lobbyists drafting who had their own clients' interest to further. And so it became a hodgepodge of interest groups.

So I thought I had to work on this health IT stuff for a number of years before I finally realized that it had been marketed as a game changer. And I finally realized, oh, my gosh, it really is a game changer, but not in the way people had thought, because we can now, for the first time in history of medicine, breach the health privacy of millions of Americans with the punch of a button. "Bang!" And it is gone. Imagine trying to steal eighty million paper files. You would not be hard to find. But Anthem lost at least eighty million. It is not clear if it is actually health information, but it is certainly health identity information that was stolen. And it is possible to steal it from anywhere in the world. You can be in Russia, China, Belarus, anywhere. With a paper record, you have got to go in a doctor's office and get the record, and you can probably only grab a few. And the breach in someone's privacy, when it is breached electronically is perpetuated. The information can exist in an infinite number of places for an infinite period of time. A paper record you can maybe get back. You cannot get an electronic impulse back. It is out there for good. And if you get your credit card stolen, you can replace it with a new one. But you cannot get a new health history. Once your health information is stolen and your medical record is corrupted by someone else filing a claim on your insurance, your health insurance and your health record is worthless. The doctors do not know what is you and what is not you. So as has been said, these are life-threatening situations. The last point here, from a legal standpoint, think of what a judge has to do today. It is my understanding that Anthem now has at least fifty-eight class action lawsuits pending against them.

So what does the judge do in a class action lawsuit

seeking to represent eighty million people? First, there has to be some showing of damage or a likelihood of damage. And if there is that, then how does the judge compute the damages? The damages could go throughout a person's life, maybe even to the next generation. So it is the Wild West out there in this area.

So you would think that the HIPAA law, since it has a provision that was supposed to protect privacy, would define privacy or list the right to privacy as one of citizens' rights. It does not. The provision, Section 264 of HIPAA, was stuck in at the last minute because there was a lengthy provision put in by a Senator from Utah that essentially wiped out privacy on the federal level. I, and several others, thought that was probably not very good public policy, so we got that provision knocked out. Nancy Kassebaum wanted to retire so Congress wanted to get this bill passed as a tribute to her before she retired. So they stuck in Section 264, which said that Congress would attempt to pass the privacy law later. And if they did not do it, then the secretary of HHS would issue regulations setting forth privacy provisions. But what we have got in the HIPAA rule does not include the right to privacy. It authorizes thousands of covered entities and business associates to use and disclose, identify information routinely without your consent. Up to 1996, your information could only be used or disclosed with your consent. Without your consent, and over your objections, for seventy-eight different purposes that were known that have been described or described in the regulations as treatment, payment and healthcare operations, but there's seventy-eight different purposes within those and plus a bunch of other purposes. The interesting thing is that the HIPAA rule does not apply to hackers. Really? I mean, is it not that who we should be applying it to? And, of course, it does not apply to the state and non state actors. It does not apply to North Korea. So, as you can see, I think that is

why they had me come in and give them about a two hour talk to the whole staff on where we came from with HIPAA, where we are now, and what needs to be done.

The thing I love about this, I just have to laugh because I actually wrote an article about this in 2001 when the *Bartnicki v. Vopper* case came out. Because the people who are the most vulnerable to damage from health IT breaches and the least able to protect themselves are members of Congress and the administration because the Supreme Court said in *Bartnicki v. Vopper*, that the media has a First Amendment right to publish information about a public figure, even if it is stolen. Now, they cannot participate in the theft, but if it was stolen by somebody else and given to the media, they have a First Amendment right to publish it. So that means that if North Korea wanted to influence a politicians vote, , they could say, "Hey, you know what, remember that time when you were feeling a little shaky after law school and considering suicide and you had to see that psychiatrist, I will publish that, we are going to let that come out unless you do what we want you to do." So it creates such an opportunity for blackmail. And members of Congress cannot do anything about it because there is a Constitutional right in the media to publish. So they cannot even pass a law to prevent it.

So I was reading An Unfinished Life, a book about former President John F. Kennedy. At the time this book came out, this decision came down. And I realized in reading the book that Kennedy had so many health issues that came out later after his death. He would never have reached the White House if that had been in an electronic record form and had been stolen and made public. And he had a lot of political enemies that would have made sure of that. Also, former President Ronald Reagan had a lot of issues as well that have come out since then.

So as I have said to people in Congress, the two most popular presidents in our lifetime would not have

reached the White House if their health records had been put in electronic form and subject to theft. And we will, as I say, you can hold me accountable for this as well. We will have an election that will be decided by a politician's health records because we are just getting to that point.

So, as I said, Section 264 of HIPAA was just a provision that was stuck in at the very last moment. It said that HHS would make recommendations to Congress with respect to the privacy rights that individuals should have and the procedures to exercise those rights. Congress was given thirty-six months to act. If they did not act, then HHS could issue rules within forty-two months. Well, because of the partisan gridlock, Congress could not come up with a bipartisan approach to health privacy. One reason was they did not understand and they got all "balled up" in the abortion issue. There are at least two branches to privacy law. One is decisional privacy. That is the abortion cases, which there are some. That is the third rail of D.C., and you cannot touch that. The other branch is informational privacy. And the courts and the Supreme Court are much more consistent on informational privacy. There is not an absolute right to informational privacy, but we all have a right to keep our information about ourselves private and we have had this right throughout the history of the country.

So in December of 2000, the Clinton administration issued the final HIPAA privacy rule and it applied to cover entities. It did not apply, oddly enough, to the health information and privacy practice travel with that. Instead it applied only to three types of covered entities: the health plans, health clearing houses, and healthcare providers. And it did not provide a right to privacy. As a matter of fact, after the rule came out, the Clinton Administration held its first briefing. I was at the first briefing and I asked the first question. And I said, question, "I see here that you have this privacy rule and it lists the rights that individuals

have, I do not see the right to privacy listed among their rights." The person who was giving the briefing was standing before double doors that led out into a hallway. He turned on his heel, ripped open the door and looked into the hall. And I said, "I do not think the answer is out there." He was so uncomfortable with the fact that they had not bothered to address the issue that we all have. I continued, "do I have a right to privacy if my information is held electronically? That is the question any consumer wants to know. You do not want to know if a covered entity or business associate or God knows what else. You want to know, do I have a right to privacy? What are my rights?" And they did not bother to address that issue. So no right to privacy was in there.

They did recognize a right of consent for routine use and disclosures by providers, one of the three types of covered entities. And they did that based on findings that this is what we have done throughout the history of the country; the Hippocratic oath, the American Medical Association standards of ethics, common law, everything. The Clinton administration did a pretty good job of researching the background to privacy in the country before issuing their HIPAA privacy rule. So in April 12, 2001, some of you may remember, George W. Bush came into office and he put a moratorium on every regulation that had not already gone into effect because his administration was going to go back and review them. Well, I knew that the HIPAA rule was going to be at the top of their. And I knew that the vendor and the insurance community was trying very hard to knock out the right of consent, because they do not want you to have any right to privacy.

They want to access all your information. So I thought, "well, I could sue them . because they were way past the statutory deadline anyway." I probably could have walked into court and forced them to put the rule into effect. But I thought, "you know what, I think I will try

something different." I called up one of the top reporters at the New York Times, and I said, "it would be interesting if you ran an article that said the first official action of the Bush administration is to eliminate the privacy rights of all citizens of the United States? Would that not be an interesting story?" Two days later, I unfold the New York Times, and Robert Pare, the lead health reporter for the New York Times, runs that story on the front page. And so, we will skip along here. Then a week later, HHS issues a rule, puts into effect and says, "the President considers this a tremendous victory for American consumers." And I thought, "how about that? I did not even have to go to court." But then in 2002, HHS reversed their position and they eliminated the right of consent for patients and instead substituted what is in the preamble that the federal regulatory gives permission to disclose your information. So now when you get that HIPAA form when you go to your doctor, it does not give you any rights. The form just tells you what HIPAA says. And the federal government now has given regulatory permission to every covered entity and now business associates to use and disclose your health information without your consent and over your objection. This is interesting. And there are a lot of case law and a lot of writing that shows that the right to privacy is one of the core concepts in our form of government. I actually believe that.

So what was the rationale for eliminating our right of consent? Well, the Bush administration in the final rule said, that the right to consent had unintended consequences because providers would not be able to immediately deliver healthcare. Well, they skipped over the fact that throughout the history of the country, since the founding of the country, everybody had a right of consent. That was the standard practice, and the tradition in this country. And the prior administration had actually made that finding in the preamble. And I rated the issue. I said, "well, wait,

wait, wait. I mean, what about practitioners whose standards of ethics say they cannot disclose information without patient consent?" They said, "oh, not a problem. We will just make the HIPAA rule a floor of federal protection. So if you want to comply with your standards of ethics, then you can still do that." Well, of course, everything has now sort of drifted down to the law's common denominator. And if you go into most practitioners' offices these days, you will get just the HIPAA rule and that is the new practice of your provider. But they did say that HIPAA was not even best practices and that standards of ethics retained their vitality, whatever that means. I am not sure what that means.

So then we have the HITECH Act that came along in 2009, which contained subtitle D, large provision in that Act entitled, privacy. And it was designed to address all the concerns that people had about HIPAA not really adequately protecting people's privacy. And it contains a whole long list of detailed definitions of every single key term in that Act. It does not define privacy. And I was in a meeting with the Ways and Means committee staff and I pointed that out to them, I said, "Hey, you did not define privacy," and one very smart health staffer, who also had a very coarse mouth said, "well, we would probably screw it up if we tried to define it anyway." So they just did not put in the definition.

Still no right to privacy mentioned in the HITECH Act. And the American Recovery and Reinvestment Act established this process for developing privacy policy as we go forward. And it was to be done by two committees, the Health Information Technology Policy Committee and the Health Information Technology Standards Committee. Look at the rights of the consumers on these committees. Consumers are a tiny minority on these committees. And guess who the consumers appointed to these committees would be? They are people who are in favor of the wider

use of health IT with no privacy rights. So these committees are, in my view, do not represent the views of the public. And there is only one group we cannot do without in the healthcare delivery system, there is only one component in there, and that is the public, that is the patient. We can do without insurance companies. We can do without a lot of the practitioners, but we cannot do without the patient. So the patient, the consumer, is the most important person in the healthcare delivery system, yet they are powerless in developing the rules that apply to their most sensitive information. Information about your mental health, your psychiatric care, your drug treatment is the most sensitive information.

So what would a principled approach have taken if we had done this a different way? If we had an institution such as the University of Tennessee being able to pull in the business interest, perhaps with a heavy dose of law. One of the things you might do is what the Clinton administration did at the very beginning, look back at what has the public's expectation of privacy been throughout the history of the country? Does the public really care about it? And are their expectations and needs really reflected in any body of law that we have had or standards that we have had in effect? If you look in the U.S. Health and Human Services finding in the 2000 HIPAA rule, they conclude, that privacy is a fundamental right in this country. That is their conclusion, although some people would fight about that. But that was their conclusion after a lengthy rule making process. The Congressional finding in the 1974 Privacy Act, Congress finds that the right to privacy is a personal fundamental right protected by the Constitution of the United States. Well, we know the Constitution protects us against the government, it does not really protect us against each other unless you are speaking of the Thirteenth Amendment which repealed or eliminated slavery. But the Supreme Court, at least under the Fourth Amendment, has

found that there is a right to privacy. And in *Whalen v. Roe* said that they did not disagree that there was a right to privacy recognized under the Fifth Amendment right to liberty. So you see, the right to privacy has a pretty rich history, and on up through the present.

President Obama said, in 2012, that one thing should be clear, even though we live in a world which we share personal information more freely than in the past, we must reject the conclusion that privacy is an outmoded value. It has been at the heart of our democracy from its inception and we need it now more than ever. Why did he issue that statement? Well, because the European Union adopted a set of privacy rules that said if any other country wants to deal with the European Union, they have to have privacy rules as strict as ours. So that came out, which was based on a publication of consumer privacy rights that came out of the Commerce Department, not out of HHS. So, and just recently, I did not have time to put this even in the White House legislation into effect. This was to rights proposed by the White House, that we would have more privacy rights with respect to a sweater that we purchase online than we would for our mental health information, because health information is exempt from the Consumer Privacy Bill of Rights.

Let's look at professional ethics that most medical professionals are bound by. If you look at the Hippocratic Oath, which is recognized as our right to not have our information disclosed without our consent. If you look at the American Medical Association standards of professional ethics today, it says that doctors must protect your information within the fullest constraints of the law, whatever that means. But it at least means, one would think, that as much as the law would permit. The Center for Medicare & Medicaid Services ("CMS") found, or HHS found that all fifty states recognize the common law or statutory right to privacy. Here is the Restatement of Torts

that recognizes a right to privacy. That is, so what we see, a principled approach would have recognized and defined a patient's right to privacy of health information based on Constitutional law, common law and standards of professional ethics. It would have been based on an established practice and patient expectations, if we all agree that the patient is the most important part of this healthcare delivery system, which I think most people would agree to. And we would have developed a health IT system that is shared and shaped by patients' rights and expectations, rather than trying to alter patients' rights and expectations to fit the current capability of IT systems. I made this point to the director of the Office of the National Coordinator, and he looked like he had been struck by lightning. He said, "oh, gee, we really should have done that, should we not do it?"

So right now, as I say, I am now working with Senator Alexander's office to maybe go back and start a principled approach to help information privacy. But in the meantime, we spent thirty billion dollars and we have breached the privacy of a hundred and twenty million people getting to this point. HHS, in probably one of the most insightful statements I have ever seen out of a federal agency, had this statement in the original HIPAA Rules. "In short, the entire healthcare delivery system is built upon the willingness of individuals to share the most intimate details of their lives with the healthcare providers." Well, how about that? That is, if that is true, if the entire healthcare delivery system depends upon that voluntary exchange of information, then we better, by gosh, assure you that your health information is going to remain private and that you do have privacy rights.

If we had that approach, we would have taken principled privacy protections and apply to whoever handles it, whether it is North Korea, China or the latest mafia, or local mafia boss. There is no reason why health

privacy protections should not run with the information. You do not care when your privacy is breached, who did it, you just care that it happened and you want to make sure that you have some recourse with that. So, also, the thing I kind of like about this, and it occurred to me after I worked on this for a while, it is also politically defensible.

Senator Hatch had his chief of staff give a talk in a session I was attending two or three weeks ago. He was talking about what they planned to do with the new Republican led Congress and Senate and I asked, "what do you think about health information privacy, is that something you are going to move on and try to protect?" His staff person said, "I have visited every single county in the State of Utah, and I can tell you this is the number one issue for the citizens of Utah." I was, whether it is true or not, pretty impressed that they get it if you ask any politician, do you think your constituents have a right of privacy, you will get, "oh, absolutely, are you kidding? Who would not believe in that?" So a principled approach to health information and privacy is good health policy, good business and good politics. That is the sort of thing, the sort of analysis I would hope you would get with a policy shop like the one at the University of Tennessee.

So what makes good law? I have thought about this over the years a lot. The Bill of Rights, the first ten Amendments adopted in 1791, has not been amended or repealed since. The Eighteenth Amendment, prohibition, was adopted in 1919 and repealed by the Twenty-first Amendment in 1933. Now, I suggest to you that the Bill of Rights and the Twenty-first Amendment are more consistent with human nature and what people want. It is a good thing. It is good for your health to not drink, but people want the right to make that decision for themselves. Just as with the Affordable Care Act, health insurance is a good thing for you, but people want the right in this country to make that decision for themselves. That mandate in

there is the most unpopular part of it. Now, I understand why it is in there. You have got to avoid the insurance death spiral and all that sort of thing. But we, in the United States, founded this country on the desire of the people who founded it to have some autonomy. So it is just the way we are wired. And, you know, I come from Scottish extractions, so I can tell you, all Scots want to be really independent, except when you are separated from England, I guess. So the Bill of Rights and the Twenty-first Amendment are much more consistent with the freedoms that Americans want and expect, and the Eighteenth Amendment is not. And I have often wondered, what has allowed the Constitution to last as long as it has? And why with relatively little changes. And I listened to a Constitutional law professor who gave lecture on this some years ago that I attended. And she came up with just a great point. She said the one thing that the Constitution gives us all is hope. If you do not like the government the way it is today, every two, four, six years, you can change it. And that keeps people off the barricades. And if you do not have that hope, then you tend to take things into your own hands.

So in crafting any law, I would just suggest to you that at least a starting point should be to at least look and consider, what has gone before. This stakeholder approach that now is popular in D.C. is the craziest thing I've ever heard of. It's like having surgery and having all of the folks who could possibly be involved in that surgery come and decide how it should be done. We have vendors there, we have the bill collector there, we have the janitorial service there, you know, we have the people holding the bonds on the hospital, we have the doctors and we have consumers who maybe are a tiny fraction of the people at that meeting, all deciding how your surgery should be done. It's ridiculous. We should be starting with a principled approach, which is, let's see, do we have certain principles

that we adhere to? And if we do, then let's lay those out. And then let's -- the question is, not how we craft this policy out of whole cloth, but how do we craft a policy that supports the principles that reflect human experience and expectation. That is good law, it gets you good law, in my humble opinion. So any -- any nonpartisan academic source of policy research, it seems to me, should be grounded in Constitutional law, common law and canons of professional ethics. And I can tell you, staff members on the Hill today, they're brilliant people who come out of some of the finest graduate schools in the country, but they just don't know much. They don't have enough experience because all of the senior people are gone, and they don't have time to think and research these issues. That's why I say to you, you really -- a school like this or some institution, some source of research is desperately needed.

And I thought it was interesting how I know when I came out of here and I took the oath, every now and then I pull it up and look at it again. And I thought, hmm, that's interesting. And I think I had, while I was here, I think I had one Constitutional law course. So one of the bits of advice I would have for any of the students who are here, is take every Constitutional law course you can.

I was arguing a case in Northern Virginia before a federal district court judge many, many years ago and he said, Counsel, where did all these laws come from? I said, uh, Congress? Wrong. They come from the Constitution. I was like, wow, that's really -- that's right. It really is. So I think as we approach anything, whether it's the Affordable Care Act or health reform or whatever, if you can start broadly, if you can start with the principles that we all agree on, narrow down, that process may then lead you to an area where the -- areas of disagreement, a conclusion, where the areas of disagreement are not as broad. And because I think we all agree on the broad principles that -- on which the country is founded, it is just when you get

into the details that becomes a problem.

So to paraphrase what I said at the beginning, what I would love for this institution to be able to do is to go to Washington. I'm from Tennessee Law and I'm here to help. Believe me, they need your help in D.C.

MR. MICHAEL DAVIS: Sure.

MR. PYLES: -- A couple of questions? Any questions out there? Anybody? Have I worn you out?

UNIDENTIFIED SPEAKER: In the early part of your remarks, you said that Congress would probably have to amend this law bits and pieces every year for years to come beyond our lifetime. Do you see that really happening in any substantive way? I mean, will they be able to agree on the little things that need to be fixed? And is that going on behind the scenes? Because when we watch the television or read the newspapers, the impression is they're not agreeing on anything.

MR. PYLES: Yeah. Actually, I'll restate that. Why do I think -- just for the people who are listening online. Do I think there's any likelihood that Congress would make the changes to this law over time that need to be made? The answer is yes, yes, I think they would. We -- this law must be bipartisan. It has to be bipartisan if it's going to be this sweeping and it's going to be put into effect. It cannot -- whether you love it or hate it, if you're Republican or Democrat, it's just got to have the input of both parties in it. And so now -- we didn't do it up front, which we should have done, in my view. So now we're going to have to do it the hard way. We're going to have to do bipartisan health reform the hard way. The Republicans are going to have enough amendments in that law so that they can say -- they can say this is my law too. And I think they will. There are lots -- there's actually bipartisan agreement that lots of

provisions in the law should stay. I mean, nobody -- you don't hear anybody saying, we should do away with the right to get health insurance if you have a pre-existing condition. Everybody agrees with that. Universal access to health insurance, everybody agrees with that.

Things like the mandate and how the mandate is accomplished, there are various ways to do that. And so I think you get bipartisan or enough bipartisan agreement to pass amendments to it because Congress will continue to change, but the law is very flawed. I mean, it was rammed through. It didn't go through a conference committee like most laws do to improve -- improve it at the last minute. So just as with Medicare being amended every year, I think you'll see this law amended every year. And most of those amendments will occur early on in the infancy of the implementation.

Yeah, I absolutely do, and I think Senator Alexander feels that way as well and as do many Republicans. And there are some really bright conscientious people there on both sides. And, you know, on the Republican side, certainly Alexander, McConnell's a very smart guy. They know that their best -- the best chance -- the best route for Republicans is to leave that law in place and change it gradually over time. If the Supreme Court should uproot the core concept of that law, we could have major insurance companies -- will likely have major insurance companies pulling out of many of the states that don't have state run subsidies. And that could just cause the whole health insurance system to collapse. Yes?

UNIDENTIFIED SPEAKER: Do you really think they have -- they couldn't get the HIPAA law right (inaudible) bipartisan (inaudible).

What makes you think they're going to do anything on this?

MR. PYLES: Yeah. The question is if they didn't get HIPAA right, why should I think they'll get the Affordable Care Act right? Well, for one thing, I think if the law stands and the Supreme Court upholds the subsidies, then they've got a lifetime to do it. They can do it gradually over time. And I think time and talk often produce better results. And once you take the pressure off, or the Democrats felt like they had to get that law pushed through Congress in order for national health insurance to have any chance, and the Republicans didn't participate in it. So I think if you have an infinite period of time to make the law better, you will. And there are all sorts of unintended consequences we're seeing with this law.

Now, for one thing, like back in the health IT period, for a moment, no one understood that you could use health IT to go back over all the health claims in the country that have been submitted in the last year and up-code them. Because up until now we haven't really been doing a very accurate job, physicians and practitioners haven't been doing a very accurate job of coding health insurance. So you're going to see the cost of healthcare in this country increase simply because now we have computer programs that can go back over all the claims, identify the ones that possibly could have been under-coded and we can resubmit them and up-code them. And now the insurance companies have a huge incentive to do that, because under the Affordable Care Act, if an insurance company insures people who are sicker than average, they get an additional bonus payment out of a pool. Insurance companies now are flooding the market with letters to practitioners saying, you know we think a few of your claims here may not have been accurately coded, could we maybe recode them? Which allows the insurance companies to show that the people they're insuring were sicker, that gets them then additional payments from the pool. So we have a race, a race to the top. All insurance

companies now are trying to show that they insure the sickest people.

And I do believe they will. And I do believe that we will eventually get to a time or a place where we have more collaboration from members of Congress. But, as I say, whether it's Democrat or Republican, what the staffs all will tell you today that they need somebody to look, or somebody when they need an answer, they don't have time to research it. They would love to be able to reach out to some institution like this and just get down the middle of the road research on where have we been as a country and what's the law currently, so that they could then have an evolutionary rather than a revolutionary approach to drafting laws. Any -- yes, sir?

UNIDENTIFIED SPEAKER: Back to the right of privacy, do you think that it's been devalued recently? We parents have beat up on our children with their exposure to social media where they've gotten numb to it. They don't mind to share their whole life with the world. And it's just not as big as it used to be. 9/11, we opened the door and let more privacy disappear. You know, Snowden, nobody really cares about him. It just seems like people don't care about that anymore. Do you think that's true?

MR. PYLES: The question was, do I think privacy has been devalued in the informational age and do I think that's true. I think to some extent it has, but I do think every survey I've seen indicates that people still really care. And I'll tell you where they really care the most is, if you ask a father, what would you think of your fourteen year old daughter's mental health record being disclosed among a bunch of records that are hacked? And they're out there, and that information is out there for the rest of her life to perhaps limit her opportunities, your job opportunities. Because it will. I mean, as Dave Camp, who is a Republican from Michigan, said when I was briefing the Ways and Means

Committee was, he snorted and he said, if anybody in this town knows you've even seen a psychiatrist, your career is over.

So, yeah, I think the interest in privacy has been somewhat devalued with the informational age because we have so much information now floating around. But people still, most people still don't care about most things being exposed, but every, almost everybody, cares about something. And at the very least beyond that, we're going to get you to voluntarily disclose the most intimate details of your health to your practitioner, we have to, I think we should assure you that that information is not going to be used to harm you or your family. And you can't say that once that information goes into an HIT system today, you cannot, no one, can say that. It can well harm you, you and your family. So I do think we'll see. I do think people still value that, but that's just an example of, as I say, what I think is needed today, which is a principled approach. With that, I see my time is up. Thank you very much. It's been a pleasure.

MR. MICHAEL DAVIS: Thank you so much, Mr. Pyles, for that address. And we're looking forward to your commentary on our first panel, which will be happening today at 10:00. We're still running pretty much on schedule. We'll start our next session at 10:05. And we, again, welcome you here to the symposium today. Thank you for coming. And we'll reconvene at 10:05.

CHECK-UP: CURRENT AND FUTURE CHALLENGES UNDER THE AFFORDABLE CARE ACT

JAMES C. PYLES[3]
DR. PAUL CAMPBELL ERWIN[4]
GORDON BONNYMAN,[5]

MR. MICHAEL DAVIS: We will go ahead and get started again. Thank you again for joining us. I forgot to introduce myself earlier today. My name is Michael Davis. I am the symposium editor with *The Tennessee Journal of Law & Policy*, the main sponsor of today's symposium. Again, we would like to thank everyone for coming out today, braving the weather. Our first discussion panel is titled, Check-up, the current and future challenges under the Affordable Care Act.

The patient protection in Affordable Care Act, also known as Obamacare, has been one of the largest changes in history, and not just U.S. healthcare, but the U.S. government. Since its passage, it has provided healthcare insurance to nearly twenty million more Americans and has done away with practices like refusal of coverage for pre-existing conditions. It was passed as a law in 2010 following two years of intense debate. This was debated and this debate continued however with legal challenges rising all the way to the U.S. Supreme Court. Though the Act survived these challenges, it is still at the center of

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[5] Co-Founder, Tennessee Justice Center, a non-profit law firm in Nashville, TN that focuses on access to healthcare and the impact of healthcare reform on Tennessee.

much debate and even a new Supreme Court case of *King v. Burwell*, as we have previously mentioned, that was just heard this week.

This panel will examine the implementation of the ACA thus far, the changes that it has brought to the U.S., Tennessee healthcare, and the legal issues that have arisen because of it, as well as the policy choices that it presents for state governments. This session will allow each of the panelists time to address a particular area of the Affordable Care Act, discuss the issues raised during these presentations together, and then allow for a a period of time for questions from the audience.

Our panelists for this discussion are Jim Pyles, who we introduced as our keynote speaker earlier this morning. Mr. Pyles, if you enjoyed your earlier introduction, I'll be happy to go back over that again, but if you'll waive that. In addition to all the professional compliments and accomplishments that we mentioned before, I discovered the other day that Mr. Pyles was an avid rugby player in college, and actually founded the U.T. rugby club. And as we drove past the old rugby field the other day, I noticed more than just a twinge of sadness to note that it had been turned into a Wal-Mart. I also discovered that he plays a mean guitar, which both of these things should serve as evidence that Washington D.C. lawyers are actually human beings too. Thank you once again.

Next we have Gordon Bonnyman, who was a co-founder of the Tennessee Justice Center, a non-profit law firm in Nashville, Tennessee that focuses on access to healthcare and impacts of the healthcare reform on Tennessee. He served as its executive director from its creation in 1994 until just recently, when he handed off the reins to co-founder Michelle Johnson in 2014. Mr. Bonnyman has written and lectured extensively on matters of health law and policy. He has litigated countless cases in defense of the uninsured and disadvantaged, has appeared

before the U.S. Supreme Court and has served as counsel in several landmark Tennessee cases for children's, disabled and inmates' rights. Mr. Bonnyman has received awards for public service and advocacy from numerous organizations, including the American Bar Association, the ACLU of Tennessee, the American Bar Association, the Tennessee Primary Care Association and the National Legal Aid and Defender Association, and was even named Tennessean of the Year by Nashville's The Tennessean newspaper in 2003. In addition to all this, I personally know that Mr. Bonnyman also possesses a rare and rarely seen talent of playing a mean kazoo.

Next, we have Dr. Paul Erwin. He is the department head at the University of Tennessee, Department of Public Health. Dr. Erwin joined the faculty in U.T. in 2007 to establish the Center for Public Health, which served as a springboard for establishing the Department of Public Health in 2010. Dr. Erwin worked with the Tennessee Department of Health for sixteen years, with the last twelve years spent as the director of East Tennessee Regional Health Office. He has focused extensively on community based health assessment and planning, engaging local community health councils, faculty and students at the University of Tennessee. We thank you especially as a medical doctor for subjecting yourself this morning to what all doctors love the most, a room full of lawyers.

You may note that we also had Susan Cooper, former commissioner of the Tennessee Department of Health and current senior vice president of Regional One Health scheduled for this panel, but who, due to the weather today, very much regrets that she is unable to make it from Memphis. And we thank her as well.

We'll start our this panel off today with our first question to you, Dr. Erwin. Many of the goals of the ACA were to improve healthcare access and coverage to fight preventable health problems. What methods has the ACA

used to achieve these goals and how well has it been doing?

DR. ERWIN: Indeed, it's not just because of stumbling into a room full of lawyers that I think I might be in the wrong place, but certainly sitting up front with Mr. Pyles and Mr. Bonnyman, knowing all of their accomplishments, I do wonder that I stumbled into the wrong place. But be that as it may, I appreciate the opportunity to share a few perspectives with you this morning. I appreciate also the associate dean mentioning the new joint JD/MPH degree that we have now here at the University of Tennessee in public health law. And we actually have one of the students who is in her second year of law. And most of that second year she spends in the public health department or in the department of public health across the campus with us. And so we're excited about the opportunity to connect law and health in that way.

So what I'm going to talk with you in the time that I have here is to touch on several elements that have had relatively little public discourse regarding the Affordable Care Act. I'm going to provide something about a thirty thousand foot view, maybe not quite that high, with a few examples down to the local level. But what I'm going to talk about this morning are both challenges, as well as opportunities, under the Affordable Care Act, with a primary focus on the public health related elements of the ACA.

And so the perspectives that I'm going to bring are not the perspectives of Mr. Pyles, who has been in the thick of the action in D.C., nor the perspectives of Mr. Bonnyman, who has litigated many cases that eventually pertain to the Affordable Care Act, but the perspectives of my own roots in public health practice. And so these are indeed the elements that I'm going to touch on. We all know the triple aims of healthcare reform of better care, better health outcomes and lower costs. But achieving the

goals of healthcare reform, achieving the goals of the triple aim will require strong partnerships between the healthcare delivery system and the public health community. So what I'll do is highlight several of the key ACA provisions that are particularly relevant to public health by covering the following, the National Prevention Council and Strategy, Prevention and Public Health Fund, the community, both clinical and community prevention under the ACA, and then I'll touch on delivery system reform.

So I'll start with the National Prevention Council and Strategy. Of the many mandates within the ACA, one of the things that the ACA mandated was the creation of the National Prevention, Health Promotion and Public Health Council, or simply known as the National Prevention Council. This is a group that's chaired by the U.S. Surgeon General and includes the heads of over twenty federal agencies or departments, including the secretaries of the departments of education, agriculture, transportation, and labor. And then many of the more commonly health focused departments and agencies, such as Health and Human Services, the CDC, the FDA, EPA and others. The formation of this council and the mandate to form this council is really the recognition that, as then surgeon general, Regina Benjamin said that, quote, many of the strongest predictors of health and well-being fall outside of the healthcare setting. So these are what we in public health, in fact, refer to as the social determinants of health; education, employment opportunities, transportation, the environment. Things that eventually necessitate what we also now refer to as health in all policies approach. Again, the recognition that transportation policy is health policy, the tax policy is health policy and then environmental policy is health policy.

The National Prevention Council was charged with issuing a national prevention strategy. And it has produced

that and now has regular meetings to oversee the implementation of the national prevention strategy. So this is a pictorial of the national prevention strategy, which includes at the center here, the overarching goal to increase the number of Americans who are healthy at every stage of life. The four strategic directions are in the first circle, or in the first circle around the center there; clinical and community preventive services, the elimination of health disparities, empowered people, healthy and safe community environments. And then surrounded by seven priority areas on the outside; tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, mental and emotional well-being, reproductive and sexual health, and injury and violence free living. The national prevention strategy thus makes clear that achieving health and well-being, indeed achieving the triple aim, will require much more than simply increasing insurance coverage, which has been sort of the primary public focus on the Affordable Care Act.

Closely connected to the Prevention Council and, in fact, why it creates the opportunities for implementation of the national prevention strategy is the prevention in public health fund. The purpose of the prevention in public health fund is to provide for expanded and sustained national investment and prevention in public health programs to improve health and help restrain the rate of growth in private and public health sector, healthcare costs. It was initially scheduled to start at around five hundred million in fiscal year 2012, and then increase up to a level of two billion in the current fiscal year. But a funny thing happened on the way to the forum. Indeed those nasty physicians, those pesky physicians got in the way of some of the earlier funding for this when we realized that some of the initial allocation was used as an offset for a short-term fix for physician payments under Medicare. In reality then, what the public health and prevention fund has done

is to raise to one billion in the current fiscal year, and then scheduled to rise two billion dollars by fiscal year 2022, and remaining at that level thereafter. So the funds are available automatically at the beginning of each fiscal year. But, as we know, the allocation and then the subsequent use are not necessarily the same thing.

The next two slides don't appear in the slide sets that you're looking at if you downloaded those slides. I wanted to add in a couple of examples of the use of the prevention in public health funds. In that first line, the ACL, it's not that ligament in your knee, it's the Administration for Community Living, which is a relatively new federal agency that houses as an umbrella the agencies on aging and disabilities. But you can see there, some of the examples of the activities, the allocation and the planned use of funds. I make note of several of those CDC funded programs, including breast and cervical cancer screening. Breast and cervical cancer screening had been funded under CDC for many, many years. Indeed, when I was regional health officer for the Tennessee Department of Health, we had a very active breast and cervical cancer screening program down at the local health department level. This was funded primarily by CDC.

Many of the programs and activities that you're going to see on this list are unfortunately CDC funded programs that the funding for which, in the usual allocation of funds for the CDC, have seen significant budget cuts in the last several years. And the prevention of public health fund has been, in fact, one mechanism to restore some of that funding. But many of these programs, indeed if not most, particularly the CDC programs, touch Tennesseans. I mentioned the breast and cervical cancer one, certainly the tobacco prevention ones, the preventive health and health services grants, all of these activities touch Tennesseans on a daily basis. Immunization grants are an important mechanism for allowing regional and local health

departments, as well as private providers, to provide immunizations particularly to children. But you can see there that the total, although I've cut out several of the programs, for the current fiscal year for these is close to one billion dollars.

The next two topics, clinical prevention and community prevention under the Affordable Care Act, include most of both the challenges and the opportunities, vis-a-vis the ACA and public health, that will be most apparent down to the local level. Clinical prevention plays a major role in the ACA implementation. Just to sort of back up and count for a minute, I think I'm correct, and please correct me if I'm wrong, as of January of 2015, twenty-nine states and D.C. had expanded Medicaid. Is that –

MR. PYLES: Correct.

DR. ERWIN: – the right number that you're aware of? Twenty-nine states. And a gain of insurance coverage then for ten million people under this expanded Medicaid, approximately 11.4 who have enrolled in the exchanges, and three million who have stayed on because of their parents having insurance and their being under the age of twenty-six. So that's a total of 24.4 million people who have insurance who previously didn't have insurance. A sizeable chunk of the original uninsured population prior to ACA. So clinical prevention then plays a role because of the large number that it eventually touches. So one of the things the ACA does is to authorize the preventive services task force. Now, this task force has already been in existence for a couple of decades under the umbrella of the Agency for Healthcare Research and Quality, or AHRQ. But ACA codifies the U.S. preventive services task force just as it does the community preventive services task force, that I'll touch on next.

There are several key elements of clinical

prevention under the ACA, particularly in section 2713. First of all, any recommendation carrying an A or B level grade in the guide to clinical preventive services is provided without any out-of-pocket expenses to individuals. So, for example, an A recommendation, which means that there's a high certainty that there's good benefit from this clinical preventive screening, such as screening for high blood pressure or screening for colon cancer; a B recommendation, which says there's a moderate certainty that there is good benefit and the benefits outweigh the harms, such as for breast and cervical cancer screening. So anything that the U.S. preventive services task force says has an A or B grade recommendation are automatically provided -- supposed to be provided to individuals without added costs.

Immunizations that are recommended by the advisory committee on immunization practices, which is under the auspices of the CDC, are also included in section 2713, including Evidence-informed preventive care and screening guidelines for infants, children and adolescents. This includes screening that are usually referred to as EPSDT, early periodic screening, diagnosis and treatment, which covers an array of screenings for young children, including oral health and blood lead. Preventive care and screening services for women, including comprehensive sexually transmitted disease and family planning services. Again, all of these are covered under 2713. They are covered with no cost sharing with most employer-based plans and individual plans and the Medicaid expanded population.

Now, there are several implications for public health practice down at the local level for these changes under the Affordable Care Act. The upside is that many people who previously wouldn't have taken advantage of prevention, primary prevention and secondary prevention that's now funded under the Affordable Care Act, will have

access to those preventive services. But it could have an interesting, and already is in some states, an interesting and sometimes challenging impact to the public health practice environment. Many clinical services that are offered by local health departments, such as testing and treating for sexually transmitted infections, are now included in section 2713, will and are impacting the local health department delivery of these services. The Knox County Health Department, for example, has begun billing for these services where in previous years they were not billing. It changes the dynamics of how they function. In addition, we know that some states, Massachusetts being a good example, cut its state funding for sexually transmitted diseases because these services are being provided under the auspices of health reform. The unfortunate aspect of that is many pieces of public health practice, including surveillance and reporting for sexually transmitted disease and infection, were supported by the funds that also supported those clinical services. I don't think that we've yet seen the impact of the Affordable Care Act on the provision of childhood immunizations, but it's something that we need to keep track of.

Let me mention a few of the community prevention services under the Affordable Care Act. Just as with the clinical preventive services task force, the ACA authorizes the community preventive services task force, which is under the auspices of the CDC and provides recommendations about evidence-based community practices. For example, tobacco prevention or cardiovascular disease prevention at the community level. What does the evidence show what works? The largest investment under the community prevention, under the Affordable Care Act, is through the communities putting prevention to practice or putting prevention to work, addressing obesity and tobacco use at the local level. Other elements within the community prevention aspects of the

ACA included community transformation grants. These were focused on chronic disease prevention. They ended in 2014, but that was a good example of the use of the prevention in public health funds, partnerships to improve community health, with a focus on policy and systems change, again, community-oriented change. Federal nutrition labeling requirements for chain restaurants included in this aspect of the Affordable Care Act. Another activity under this domain includes the establishment of a national diabetes prevention program. And then we have the IRS requirements for nonprofit hospitals to conduct community health needs assessment as an indication or showing their community benefit aspects. This has a significant impact on public health and public health practice down to the local level, because the law explicitly requires inclusion of public health officials in the development of those community health needs assessments.

I was talking with Dr. Martha Buchanan, the director of the Knox County Health Department, earlier this week and getting an update from her on what's going on with community health needs assessments here locally. And she said that the Knox County Health Department had signed MOUs with Covenant, with U.T. and Tennova to support community health needs assessments and community health improvement plans. And that actually Covenant and U.T. had each provided ten thousand dollars to the Knox County Health Department to support their work in providing the community health needs assessment that will be required by the IRS. I would add to what's listed here, there's also broader provider eligibility for preventive services. So for example, allowing community health workers or other non-licensed providers to be able to provide clinical preventive services. This overall focus on community preventive services reinforces two key points. That some of the most important determinants of health are structural or upstream, and that addressing these factors

requires a health in all policies approach.

Finally, the delivery system reform aspects of the Affordable Care Act, and I think Mr. Bonnyman will probably touch on more of these in more detail than I will, but I'll list just a few of these. The Medicaid Health Homes. So a number of the ACA provisions and programs are focused on realizing that the healthcare system works in ways that can emphasize community based prevention and population health outcomes. Medicaid Health Homes are meant to be patient centered, comprehensive, team based, coordinated, accessible and focused on quality and safety. They have been around for many years. Actually, at least a couple of decades, but under sort of different labels in different ways. But it's meant to provide an opportunity for patients at the level of the provider to get coordinated care across the entire spectrum of primary, secondary and tertiary prevention.

The accountable care organizations, which I know other speakers today will spend much more time on than I will here. Networks of providers and hospitals that agree to be held accountable for improving health and spending and -- that is to improve health and decrease spending. There's a provision for being able to share in the financial savings when those savings accrued, but also there's a significant financial risk that the accountable care organizations can also carry as well. Center for Medicare and Medicaid innovation and state innovation models began funding a number of -- of model or demonstration sites at the state level across the country with a goal of decreasing spending and increasing the quality of care. Community and population health models are a group that make up a third of the areas under the state innovation models. And there are a number of really good examples of, again, state level activities that try and bridge primary care and public health.

There's really not much more I need to say about health information technology than what Mr. Pyles has

already said, except that under the Affordable Care Act, there is the requirement that providers health information systems be capable of transmitting immunization information and syndromic surveillance data to public health departments. So these are -- these are not the only public health related elements in the Affordable Care Act. There are several others, including the support for the public health workforce. But the ones I've covered have the greatest challenges, I think, and the greatest opportunities to integrate the healthcare delivery system and public health. And thus, those elements of the Affordable Care Act which, I believe, have the greatest potential to impact and ultimately improve the health of the public. I will stop there and hand it over to the next speaker.

MR. MICHAEL DAVIS: Thank you. Our next question will be for Mr. Bonnyman.

Mr. Bonnyman, I hope you can cover in your presentation, what have been some of the most significant results, or lack thereof, of the Affordable Care Act here in Tennessee?

MR. BONNYMAN: Okay. Thank you. Thanks, Michael. Well, it's a pleasure to be here and I'm honored to be here in the company of the fellow presenters who, in the case of Jim, is a fellow college of law classmate. And it's great to see him after all these years. I notice that his slide said, "How Did We Get Here." I wrote mine without plagiarizing this slide. I'm talking here about the ACA, and I think it's important to talk about how we got to the ACA because it is difficult but important to remember that there once was a large bipartisan consensus around the absolutely imperative nature of health reform, and as that great Eastern philosopher, Yogi Berra, says, "if you don't know where you're going, you're liable to end up some place

else," and it's important to remember where we thought we were going when we got into the development and implementation of the ACA, which was to address a problem that everybody acknowledged had to be addressed.

I think, particularly this week, as we reflect on the possibility that the Supreme Court might fatally undermine the law and as we see, as we have in Tennessee, within the past month, our inability to come to even a minimal level of collaboration about implementation going forward, I think the larger question for the ACA is what does it say about our ability as a nation in 2015 to come together and address an enormous social economic political problem that has vexed us for decades, that there has been a general consensus, that was beyond the capacity of either individuals, the private sector business interest in the country or state governments to address.

And so that's why we ended up with a federal approach in the ACA. It is a deeply flawed piece of legislation. But I think if we don't stick with it and if we don't make it work, or if the Supreme Court invalidates it in an era where anybody who is paying attention knows there's no prospect of Congress coming back and making another substantial try at it, it would -- it would really cause me to have some doubts about whether we're capable of doing the sort of heavy lifting that our country has done for two hundred years. Of when we come together, we see a major problem and we address it collectively. Always in a flawed way, but generally in a way that, as Jim was saying, lends itself to reiterative improvements over the years to come. If we walk away from the ACA, I think that will raise some broader questions that transcend health reform. And it should be very disturbing to all of us as citizens, and certainly those of us whose profession is in the law which is, after all, ultimately the business of resolving conflict peacefully and orderly in the ways in which we all live together. I heard a conservative Republican senator at a

conference six years ago give a talk about controlling the federal deficit. And his point was that if you want to control the federal deficit, you have to get the Medicare and Medicaid programs under control. Those are the enormous healthcare entitlement programs. And you cannot control the cost in those programs, which are such an enormous part of the federal deficit issue unless you address underlying medical inflation. Those programs are no more inflationary than healthcare generally. And, in fact, they are less inflationary and so you can't fix them in isolation. That was a talk that you would hear today from President Obama justifying the ACA or other proponents of the ACA. The fact that it was given by a Republican six years ago, I think speaks to the distance we've come since then in terms of losing sight of why it was that we embarked on health reform to begin with. Medical inflation has been eating everybody's lunch for fifty years.

Healthcare costs have inflated over the rate of growth, consumer price index, individual household income, overall rate of growth of domestic products since the 1960's. So we all learned a lesson in the great recession and the mortgage crisis that precipitated that, that if you are a homeowner with a variable rate mortgage and your income either stagnates or goes up at a lower rate than your interest rate on your mortgage, you will ultimately lose your home and become homeless. And that's what's been going on with healthcare for fifty years. The rate of growth of the cost of healthcare has outstripped the rate of purchasing power from the people who, whether it's industry, government or families, and that's made it unsustainable. And so that's why we've seen through good times as well as bad, increases in the rate of insurance.

This slide, which is probably difficult to see the details of, but just take my word for it, the little bitty bar on the left is 1960 and the one on the right is 2010. And I used 2010 because that was the year, of course, that the ACA

was enacted. So if we again, to try to set the stage for why did we do this, what's the backdrop for the ACA. We had healthcare expenditures, both in terms of absolute terms and as a percentage of gross domestic product rising at a rate that was unsustainable. And that, of course, had tremendous impact on families, on businesses. We financed healthcare to a great extent in this country, through employer sponsored insurance. And that is a burden that when we go to competing internationally, our businesses, that's a burden that they are -- they bear that their overseas competitors in other advanced industrialized nations don't have to carry. So it certainly affects our competitiveness. And it particularly affects government as the largest purchaser of health services, largest single purchaser. And the federal government, as I was just saying, is a major contributor to federal deficit problems. State governments are all bound by their Constitutions to have balanced budgets. And so Medicaid is the largest areas of expense in their budgets after education. And with that inflating more rapidly than revenues, we've seen for thirty years recurrent crises in budgets at the state level as they try to keep pace with the cost.

This is, I think, the most subversive bar graph I've ever seen in my life. It comes from the Common Wealth Fund and it is, you don't usually think of bar graphs as being subversive, but this is. Trust me. This is healthcare spending per capita by source of funding. There's more recent data, but, again, I used 2009 because that's before the ACA. You don't see dramatically different patterns since the ACA. And what this graph does is it breaks out spending. And, as you probably already know, hopefully know, we have by far the most costly healthcare on the planet and, as far as we know, in the cosmos here in the United States. It far exceeds the cost in other countries. What I think is subversive about this graph is that it shows that the -- the -- let me just explain, by the way, the gray

down at the bottom is public spending, the white is private spending and the blue on top is out-of-pocket spending. And what you'll notice about this is that our public spending exceeds all these other industrialized nations, with the exception of Norway. That's our public spending.

Now, what's really dramatic here is that the other distinguishing feature is that everybody else, that's what they spend. They spend, you know, except for Norway, less than we do, through their taxes to buy healthcare. But then after we've paid the IRS and paid our local taxes, we have the privilege of spending all this additional money that they generally do not spend for private spending. And that's a lot of that is businesses buying coverage for their employees. And then on top of that, there's more. We get to spend a good chunk of change on out-of-pocket spending. The reason why I think this is so subversive is that it really kind of, I think, blows up the whole debate about socialized medicine.

Again, look at these public-spending figures. The OECD, that's the Orientation for Economic Cooperation Development. It's a club of the twenty-nine most affluent industrialized countries in the world. They share data. And what it shows is that the median public spending for healthcare in those twenty-nine countries is twenty-four hundred dollars. In the United Kingdom, famously the home of socialized medicine, national health service, their public spending is twenty-nine hundred and thirty-five dollars. In the United States, our public spending for healthcare is thirty-seven ninety-five. So we spend over half again as much as the OECD median on public spending. Which is why, I say, that the debate about socialized medicine, we don't need to have that. That ship sailed about fifty years ago when we adopted Medicare and Medicaid. When we did that, government assumed a dominant role in financing healthcare in this country and delivery of a dominant role in shaping the

healthcare. Public spending accounts for nearly healthcare expenditures, as you saw half of all on that subversive graph I showed you. And government rules and policies, as Jim would tell you, influence a lot of the private spending as well. So when Medicare sets the rules, private commercial payers typically follow those rules as well. And government regulation and financial incentives therefore powerfully shape healthcare delivery. What you pay for is what you get. Or at least, create the incentives that you create drive the actual delivery of services. It may not be what you thought you were buying, but we know that the healthcare system is very much shaped by the incentives embedded in payment mechanisms.

And so what we have here now, in 2015, and what we had importantly in 2010 on the eve of the passage of the ACA was, I think, by most fair understandings of the term, a government driven healthcare system for better and for (inaudible). And what do we get for all that money? Not much. We're thirty-first in life expectancy, first in healthcare costs. So when you hear people saying, we're number one in healthcare in the world, that's true if you're talking about cost, not so much if you're talking about outcomes and quality. Dr. Erwin referred to the triple aims of health reform to control the costs, expand coverage and improve quality and efficiency. And these are all interrelated. As he noted, the heat and the controversy around the ACA is focused on the coverage provisions; the individual mandate, the Medicaid expansion and now, as of this week, the legality of the premium subsidies in a majority of the states, all relate to coverage. But those are connected to the other things. You cannot control the efficiency of the system. You can't demand that a system be accountable for its quality if substantial numbers of people who consume services from that system are not part of it except on an episodic basis, which is the status of people who don't have coverage and therefore only show up in

times of crisis. You can't manage their care. And if you can't manage their care, then you cannot hold the providers accountable and the system accountable the purpose intransient with us for incapable of solving and that the private sector has been incapable of solving. And I would suggest, although I've never heard anybody acknowledge it that supports the ACA, it was to take an already government driven system and try to make it work better than it's been working. I say that just again because we hear so much about, oh, it's a government takeover. Sorry, the government took over fifty years ago. This is trying to take a system that doesn't work well by any objective international comparison, and make it work better.

What was Tennessee's response? Well, let's look at the insurance exchange. A critical provision of the ACA in terms of expanding coverage was to mandate insurance reforms that would all be mediated through online insurance for the outcomes. So that's the backdrop. And again, of the ACA was to deal with a very and damaging problem that had been decades, and that states have been exchanges or marketplaces. The law provided that these would be established by the states, but if the states declined or failed to operate the exchanges themselves it would default to the federal government to operate the exchanges. And that, of course, is the backdrop for *King v. Burwell* because thirty-four of the states did not, either for ideological or practical reasons, elect to operate exchanges. Therefore, the federal government is operating the exchanges in those states. And the statutory argument made by the plaintiffs in *King v. Burwell* is, the statute does not authorize the provision of premium subsidies or cost sharing reductions, except in states which operate their own exchanges.

We accepted in Tennessee a lot of federal money available under the ACA to create a state based exchange.

And then there were demonstrations at the State Capitol by the Tea Party. And in December 2012, Governor Haslam announced that we were not going to operate a state exchange after all, and it defaulted to the Federally Facilitated Marketplace, known as the FFM, or more popularly known by its online address, www.healthcare.gov. When we made that decision, because of the language of the ACA, we ceased to qualify and receive tens of millions of dollars in funding to do outreach and enrollment support to help Tennesseans navigate the new system. But that wasn't all that Tennessee did in this area. Because on the eve of opening of the marketplace in October of 2013, when everything was to go live in September, the State Department of Commerce and Insurance issued a bunch of emergency rules which effectively barred any private parties other than insurance agents, licensed insurance agents, from helping anyone navigate the new marketplace. And if there's anything on which there was agreement regarding the controversial ACA, it was that it's very complex, that purchasing insurance is inherently difficult for many people and that you need a lot of help. So by deciding not to operate the exchange, we forfeited the federal money that would have been available to help with those activities, and then in September, we piled on with regulations, which basically made it impossible for a vast cadre of volunteers that had been training to do this as well.

In October, the U.S. District Court in Nashville restrained the state rules on First Amendment grounds, and they were substantially revised to basically do away with the limitations that had so hamstrung enrollment. But that was only as a result application eligibility Health Insurance Program, known as CHIP. In Tennessee it's known as Cover Kids. It revised the enrollment and eligibility process for Medicaid, known in Tennessee as TennCare. It created a no wrong door policy, which was that instead of going

one place for CHIP, another for Medicaid, another for private insurance, you could go to the online marketplace and you would be screened for all available sources of subsidized coverage. You could go to your state and apply in person, online or by phone, same deal, you would be screened for everything. You would still have to go to the marketplace for commercial coverage, but if you came to the state, you could be considered for Medicaid or CHIP regardless of what state office you came to. What was Tennessee's response to the reforms in the ACA? The ACA revised enrollment process for the Children's Tennessee, in response in January 2014, when the new coverages were to take effect, responded by closing the offices of the Department of Human Services, which for forty years had been the place where you applied for Medicaid or TennCare, closing those to enrollment. We are the only state that closed the state door. Instead of no wrong door, we have no door. You cannot apply through the state for TennCare now with the exception of programs for people over sixty-five seeking nursing home services or Medicare subsidies program services. Ordinary, TennCare applicants have to go through the marketplace.

What was ironic about this requirement was that the state did that at a time when state politicians were trash talking the marketplace and all of the well-known difficulties people had when they went to the marketplace. State officials were saying, we are so proud of the fact that we don't have those problems. Well, we didn't have those problems because we weren't operating an exchange, and moreover, we were requiring everybody to go to the marketplace to apply for TennCare. And as the United States District Court for the Middle District of Tennessee, it's little surprise that Tennesseans who were applying for benefits found that they were unavailable to get decisions. Because, in effect, the state was dumping on the marketplace a responsibility that was the state's, and for

which the marketplace was not designed, and so, in September of last year, the state was preliminarily enjoined in the *Wilson* case to provide administrative appeals that tens of thousands of people stuck in limbo as a result of the state's decision, combined with the difficulties that the marketplace was having.

All of this was justified by the state on the grounds that they were going to have a new IT system in place, known as TEDS, TennCare Eligibility Determination System. And in January, state officials acknowledged that TEDS, which was to have been operational by October of 2013, was never going to work. They walked away from their contract. They will rebuild it. We don't know when we will have a working IT system.

What about Medicaid expansion? The provisions I was just talking about had to do with how we enroll people and what the eligibility process would look like. The most\important Medicaid feature of the ACA was to fill the coverage gap between the people who would be getting subsidies on the exchange. Those are the people whose coverage is at risk now under the *King v. Burwell* challenge. Fill the gap between those folks and the people who qualified already for Medicaid. It's not well understood, I think, by many people that Medicaid, which is the health program for the poor, excludes huge numbers of poor people. Because in addition to being poor, you have to meet categorical requirements. That is, you have to fall into a favored category. You have to be a child, over sixty-five, have disabilities, or be blind. If you are an ordinary able-bodied person who's an adult without children, you can have zero income, you can be working minimum wage with no insurance, and you cannot qualify for Medicaid in most states. Not in Tennessee.

And so the ACA did away with those requirements and said that anybody with less than a hundred and thirty-eight percent of poverty, which is basically around

minimum wage full-time work for an individual or minimum wage full-time work for a couple, both of whom are employed at minimum wage jobs and have two kids. It's around fifteen thousand, thirty-two thousand. Below that, Medicaid was to expand to make those people eligible. The reason for that was that when the deal making went on that produced the ACA, the commercial insurers said, we would like to have a lot more business. If you're going to make us do away with medical underwriting and excluding pre-existing conditions and all that, then we can accept that if you will broaden our market in subsidized coverage for the middle class. We don't want poor people. Let them go under Medicaid. We don't went them because we've well established that they tend to be less healthy, more costly, more difficult to manage, so let Medicaid deal with them. So those subsidies, that are at issue in *King v. Burwell*, are not available to the poor. So we have this anomalous situation right now where if the state did not elect to expand Medicaid, which was in effect an option that was extended to them as a result of the *NFIB v. Sebelius* decision by the Supreme Court, which said the ACA could not coerce states into expanding Medicaid as the law was designed to do, then it became a state option. And in twenty something states, including ours, the state responded by saying, we're not going to expand Medicaid, you can't make us. So we have this anomalous situation now where people with incomes up to as much as ninety-six thousand dollars for a family of four, receive subsidies on the exchange. And if they're below two hundred and fifty percent of poverty, cost sharing reductions. But people below poverty, who are not eligible for TennCare, get nothing and remain uninsured – the so-called coverage gaps.

So, in March 25th, 2013, Governor Haslam announced he was not going to expand Medicaid, but that he would seek a conservative alternative to Medicaid expansion. Because Medicaid or TennCare is perceived,

particularly among the most conservative parts of the Republican party in Tennessee, which did have a super majority in the legislature, it now has, technically speaking, a super-duper majority in the state legislature. The conservative factions were hostile to a Medicaid expansion, and so Governor Haslam announced that he would come up with a conservative alternative. He came back, as probably all of you know, in February, called a special session for the General Assembly to address a program that he calls Insure Tennessee. Three days into the session, it was blocked in a Senate committee and not considered by the entire body.

That has pretty interesting consequences for the state. It leaves an estimated two hundred and eighty thousand Tennesseans, most of whom are working low wage jobs, again, basically minimum wage range folks without health coverage. Twenty-eight thousand of those are military vets. It costs us over 2.7 million dollars a day, one billion dollars annually in lost federal funds that were earmarked for the expansion -- expanded coverage. That has adverse effects on local economies and state revenues because the economic activity that would have been generated that -- by that would have been a significant source of additional tax revenues at both levels. Very importantly, it has an enormous impact on healthcare infrastructure.

The ACA was funded on a pay-go basis, which means it had to be designed so that over a ten year period, it would pay for itself. And the way that worked was to take back significant amounts of money from Medicare and Medicaid, not in absolute terms, but against the -- as projected against what would have been the rate of growth. If you're going to take back a lot of money from Medicare or Medicaid, a lot of that's going to come out of hospitals. Because the Willie Sutton principle, you rob banks because that's where they keep the money. A lot of those

entitlement monies go into hospitals. The hospital industry made a bargain in all of this, said we will support the ACA and we will allow some of those give-backs in terms of our rates, many of which significantly are tied to outcome imprudence. The importance of the ACA is not just what it does to the rates, but that it links the rates to outcomes, which is very important. Back to the triple aim. You can't control costs if you do so in a way that is indifferent to quality. You can't improve quality if you don't align the incentives right.

So they, starting in October of 2013, hospitals started seeing their payments affected by things such as their readmission rates within thirty days. The idea being if Medicare patients are coming back within thirty days of discharge, either inappropriate discharge planning was done or they were discharged too soon, or you didn't do what you were supposed to do to get them well enough to leave when you discharged them. And we're going to incentivize you to prevent that sort of fault, faulty care in the future by adjusting your Medicare rates. Those things are beginning to bite and they will bite even more in the years going forward.

When we decided not to do a Medicaid expansion, and then more recently when we decided not to adopt Insure Tennessee, hospitals became the victims of an enormous bait and switch scam, in which the bait was you will get this expanded coverage and the revenues from serving patients who formerly would have been bad debt, and in return you're going to see these changes in your rates that adversely affect your revenues. And all of a sudden that changes into which, well, not so much. You're going to still experience the cuts, but you won't see the off-setting increases in revenues. And working from audited reports that are compiled by the health department, we did a calculation looking at losses, hospitals that had losses in two out of three years or would have had losses in two out

of three years, if you just took out one piece of the Medicaid reimbursement. And we found that fifty-four out of a hundred and twenty hospitals are at risk.

So what's the state's response to *King v. Burwell*? There's pending legislation that would bar Tennessee from establishing an insurance exchange, which means that if the Supreme Court decides *King v. Burwell* in favor of the plaintiffs and says that the states that don't operate a state exchange, their residents cannot qualify for premium tax credits; this pending legislation would preclude us from then establishing a state exchange so Tennesseans could continue to qualify for those subsidies. The Urban Institute estimates without the ACA subsidies, two hundred and thirty thousand Tennesseans, who now get coverage with subsidies, will lose coverage. I should say that actually the Urban Institute analysis is more sophisticated than that. It's not just the people who get subsidies who will lose coverage, it also includes some people who are buying without subsidies. In fact, they're buying in the commercial market that exists outside of the exchange. They too will be affected because the loss of subsidies means that eighty percent of Tennesseans, who get coverage through the federal marketplace right now, receive subsidies. Most of those will find it unaffordable and will lose their coverage. The people, who will remain covered in spite of the loss of the subsidies, will be the people who are most desperate to have coverage. And you'll buy it whether it's affordable or not. Who are those people? They are older, sicker patients. Technically, that's referred to as adverse selection in the insurance industry. And when you set up adverse selection, you then feed into what you famously heard, if you listened to the recording of the oral argument the other day, as the death spiral. You get what we've seen for years with high risk insurance pools, where if only the sickest people get in and their rates then drive the premiums up, then more people find it unaffordable and you get a sicker and sicker

concentration of people. Or only the people who are most desperately ill can afford to or will make the sacrifices to stay in an increasingly unstable insurance pool. And so, some of the two hundred thirty thousand people that will lose their coverage will be people who are buying it out in a larger individual market, and the individual consequences of these state responses are pretty significant.

The Institute of Medicine has documented that the uninsured lives sicker and dies sooner. They've done the math on that. The U.T. Center for Health Services Research, using the IOM data, projected that there are a hundred and thirty-eight preventable deaths for every hundred thousand people that move in the ranks of TennCare to the ranks of the uninsured, that would be the same if you looked at it in terms of people who are moving from the marketplace to the ranks of the uninsured. So that's pretty significant. It works out to, if we pass the stated legislation that would bar us from operating a state marketplace and if *King v. Burwell* is resolved in favor of the plaintiff, we will end up with two hundred and eighty thousand people that we have out there now that were deprived of coverage as a result of the rejection of Insure Tennessee, another two hundred and thirty thousand who would lose it as a result of *King v. Burwell*, and the state's refusal to operate a state exchange. That's a half of a million people. You can do the math, we're talking about an extra couple preventable deaths each day as a result of public policy decisions. And if you're not moved by the epidemiological research about mortality, then I think we all know at least that even if you get the care, even if you survive, the medical debt is financially ruinous. Back to the point, why did we get into this business, because healthcare is unaffordable? And if you don't have coverage, you're bankrupted. So policy has very real consequences, which is why I hope that we, as a society, will figure out that we need to stick with this and see it through to real reform.

Thank you.

MR. MICHAEL DAVIS: Thank you so much, Mr. Bonnyman. The next question, though, Mr. Pyles, we would love to hear any thoughts that you have on the ACA that you haven't already expressed or that haven't been touched on at this point. But also, particularly interested in your opinion, what can benefit the political climate in states like Tennessee to allow lawmakers to reach more consensus on effective action in healthcare?

MR. PYLES: Oh, gosh. Well, I have to think that many of your state legislators have not heard Gordon Bonnyman speak. And what he just said was -- I absolutely agree with him on all of it. Except one other thing I would add to it is the prediction of the analyst is that the insurance companies, rather than going into the death spiral, will just pull out of the state. I mean, they have to do that to survive. And so, I think a number of the justices of the Supreme Court, including Kennedy, were right that the consequences of eliminating the subsidies would be just catastrophic for most of the states that don't have state run exchanges right now. So I do think over time, I think the public will get educated, I think and then the legislatures will get educated. Somebody asked me during the break, you know, what makes me think members of Congress would do the right thing or get something done. It's because they want to get elected. And when many of their constituents come to some conclusion, or the majority of their constituents come to some conclusion, they will come to that conclusion too or they will be gone. They will be out. They'll find they will get to spend more time with their family.

But on the Affordable Care Act, just a couple of other observations about it. I think, well, I'll just say this. If I were your investment counselor, I would not buy stock in hospitals or the insurers of the Affordable Care states as it is. Because I don't know how the insurance industry

survives the Affordable Care Act. I mean, just -- not for it or against it or anything. I just don't understand how it works. Because up until the Affordable Care Act, insurers did not spread risk, they avoided risk. They didn't insure really sick people. The bottom line of the Affordable Care Act, as Gordon said, much more eloquently than I can, is in requiring insurance companies to really insure sick people. And up until then, if you had a pre-existing condition, they would try to not get you insurance at all. Or if you somehow snuck through, then they would just try to price you out of the market by increasing the premiums. And then as a third fallback measure, they would cap their liability by capping the amount they would pay out for you annually or over a lifetime. They can't do any of that now under the Affordable Care Act. Plus, the premium, their ability to raise premiums has been limited. And any increase above ten percent has to be approved by the federal and state governments.

So if you look at that from forty thousand feet, what we've done, we have opened up the cash flow out of insurance companies and while choking off their income, their ability to increase income. I just don't see how that works. I don't see how they survive that long-term. Now, their early or initial reaction was, oh, we'll just enroll all the young invincibles who don't need healthcare and are paying insurance rates. But the premiums for those people are much lower because you can get a rate based on age. So I just don't know -- that's one problem. Another problem I see is with all insurance, as Gordon said, under the Affordable Care Act and was said previously, it covers preventive care with no co-pay. While it's certainly the humane thing to do, but what do you think happens when you go out and you authorize a practitioner to go out and look at a population of twenty-four to thirty million people who previously got their insurance from the ER, from the emergency room. What happens when you go out and look

for chronic disease in that population? What do you think you're going to find? You're going to find a whole lot of chronic disease that previously was going untreated. And then what are you going to have to do? You're going to have to treat it. So my prediction to you is that if the Affordable Care Act sticks, you're going to see a spike in chronic disease in this country over the next five or ten years like we've never seen before. Not because we have more of it, but because we looked for it. That, in turn, then drives up healthcare costs. Because if you really want to reduce healthcare costs, just increase the speed limit to eighty miles an hour. Because when people live longer, they get more healthcare. And when you treat their chronic diseases, that drives up cost. And, you know, if they don't live longer, then it's a big savings.

So I think if the Affordable Care Act sticks, and, plus, as Gordon just said, if you want to, we have a healthcare delivery system we cannot afford because the rate of growth in healthcare expenditures is higher in GDP, and it has been for twenty years. And we're number eleven among industrialized countries in quality and outcome. So we've got to do something. But I think we are headed to phasing insurance companies out of the indemnity business so that their risk of healthcare coverage will be borne like it is under Medicare, by the population generally. And the insurance companies will be left with the business that they like pretty much, which is just claims processing and administration, which has a pretty predictable profit margin. But I don't know today how a health insurance company predicts whether they can survive. Plus, between now and June, when the *King v. Burwell* case comes down, the insurance companies really don't know what their future is. I mean, holy smoke. If they strike down the subsidies, the health insurance business in this country will be in total chaos.

So I think where we're headed is eventually with the

Affordable Care Act -- and it's probably not a bad thing, is the sort of thing that you see Norway did, where the risk is borne by the public generally, and the insurance companies just kind of process claims. And it's national health insurance, is essentially what it is, or Medicare for everybody. So I think that's probably where it's headed. And if states like Tennessee won't go along with it, then -- I think eventually they will because I think the public will demand it. So that I think is what I think is the long-term effect of the Affordable Care -- now, one thing -- all you need to know, I'll just give you -- throw this out for you. All you need to know about healthcare reform in this country is what the Congressional Budget Office found in 2005, and that is five percent of Medicare beneficiaries account for fifty percent of the cost or more than fifty percent of the cost. The same statistics generally -- it'll vary a little bit -- but the same statistics generally apply to Medicaid and private insurance. Well, if that's true, then wouldn't it be in our interest to see who the five percent are? We know who they are. They are people with multiple chronic diseases and disabilities. These are the people who account for the vast majority of the cost in any healthcare system, in Medicare, Medicaid, private insurance.

So if you look at how we treat these people, and these are people with multiple chronic conditions, as I say. But the really good news for the country is our healthcare delivery system does a terrible job of taking care of these people. We don't pay for chronic care coordination in this country. The insurance companies typically haven't. It's wonderful news because if we have an unaffordable system that was the worst among eleven countries and we were doing all the right things, there would be nothing to do. But we're number one, and we can celebrate that, in cost, and we're the eleventh worst healthcare in outcomes because we're not doing as well as we could with that five percent. We can do a really good job with that. And if we want to

move those people out of the way, the easiest way to save money on those people is move their healthcare out of the hospital, if they have to go into the hospital. Those forty percent of healthcare costs are driven by hospitalizations. So those are the statistics that drove me to design the Independence at Home program, which provides home based primary care to the five percent of people who drive fifty percent of the cost. And the savings are achieved by keeping them out of the hospital, out of the ER and out of the nursing home. And just as sort of a by-product of that, they prefer that care and their families prefer that care.

So that was what drove me to sort of get involved in that, but there are ways to -- the good news is there are ways to reduce the cost of the healthcare system we have. And it is by doing a better job of taking care of the most costly patients. As I say, the system we have right now is doing a really horrible job of that. You know, the system is set up for the convenience of hospitals and doctors. It's set up so that a doctor can see a patient every fifteen minutes in his office, in his or her office. That's great for the doctor, it maximizes income. But it isn't very good for a patient who can't get there or a patient that takes more than fifteen minutes. So we can do a whole lot better. Anyway, I hope I answered your question.

MR. MICHAEL DAVIS: Yes, definitely. Thank you. At this point, we would like to have Dr. Erwin and Mr. Bonnyman rejoin us here. And in light of one of the true purposes of a symposium is to have interactive discussion among experts. One of my favorite things is to listen to experts in a particular field discuss amongst themselves their reactions to each other's thoughts and the issues that are going on today. So we would like to give them the next ten or so minutes, I know Dr. Erwin has an engagement he has to get to right at 11:45, so we're going to stay on track. We would like to open up the floor to you panelists to

discuss your remarks to each other's presentations.

DR. ERWIN: Well, I've got a couple. Jim, I really appreciated your using the example that I use when I teach epidemiology to undergraduates and graduate students, that when people have health insurance, my goodness, we start finding all of these diseases. And the prevalence and the incidence of disease goes up, and it looks like healthcare reform has failed. Because all of a sudden, all of these indicators that you thought you were addressing are actually trending up. I have not heard people outside of health directly be able to make this example. Do other people in your circles get that?

MR. PYLES: I've never heard anybody make that point except me. But I'm sure there must be people out there who have the same thoughts. It's the humane thing to do, it's the right thing to do. But we need to understand, as you said, what the results are, what the expectations are. We can't go into this thinking that preventive care produces near-term savings, it doesn't. It may produce long-term savings. And it is, as I say, it's the humane thing to do. I mean, now they're conducting a screening test for diabetes in fifth graders in West Virginia and they're finding a lot of diabetes. I mean, that's huge, because intervention at that early stage can really make a difference in someone's life. So we do need to decide as a country what we are going to do. If our only goal is to reduce healthcare costs, then that drives you into one direction. But if it is to provide a bit more humane healthcare delivery system and improve the quality of lives of people, as some of Gordon's comments touched on, that leads you to believe that we may have to, at least for a period of time, I mean, put up with a more expensive or at least a healthcare system that has higher overall costs, maybe a lower capita cost.

DR. ERWIN: Thanks, Jim. Gordon, I've had the good

fortune of hearing you talk in a number of different settings, and probably for the last year and a half, or if not more, you've been making this point about the potential for so many hospitals to shut their doors. Going on the notion that all politics is local and many of our politicians in the State of Tennessee do listen to what's important in their small communities, I'm not hearing any of this, that there's anyone up in arms about this potential, and when you close Fort Sanders Sevier County Hospital in Sevier County, that will have a major impact. Or a Harriman hospital --

MR. BONNYMAN: Yeah.

DR. ERWIN: -- would be even a better example.

MR. BONNYMAN: I mean, hospitals are typically either the largest or among the largest employers in their communities. And they are great employers because they have entry level, minimum wage, all the way up to the surgeons. Vanderbilt, a big academic medical center in Nashville, where I live, has laid off thousands of people that they've attributed directly to the failure to do the Medicaid expansion or/and Insure Tennessee. But they're going to still be there. And if they aren't there, there are plenty of hospital beds in Nashville. It's a bigger issue in the rural areas because if you lose your only hospital, you don't only lose one of your largest employers, you lose your doctors. You can't recruit doctors to a community if they don't have a hospital to place them in. And if you don't have a doctor and you don't have hospitals, then how are you going to recruit industry? I mean, we've seen this across the country and we've seen it in a few communities in Tennessee that have lost their hospitals. If you lose a hospital, it's not just about healthcare. You transform that community irrevocably to the point where in a few years, your best and your brightest kids walk across the stage, collect their diploma and keep walking straight out the

door, and you don't see them again except for weddings and funerals. And that is not the community that most people want to live in. And you know, we hear so much about the partisanship and the need for bipartisanship in Washington, the days of bipartisanship are long gone in Tennessee. It's a moot point. We only have one party in Tennessee, it's the Republican party. And so I think what we need in Tennessee and what was not on display during the special session was evidence based pragmatic politics, regardless who the party is. That was the outcome, the defeat of Insure Tennessee in the special session was about ideology. And specifically, you had Americans for Prosperity who came in and spent a lot of money, terrorized a lot of Republicans into believing that they would be defeated in the next primary by opponents from the right. And the question of what would happen to local hospitals, what would happen to those communities, what would happen to twenty-eight thousand vets that don't have coverage, those just were not the basis on which it was decided. It was not based on facts. It was not based on pragmatism. I mean, Governor Haslam is conservative. He brought forward a conservative alternative to Medicaid expansion. It was not a Democratic proposal. This was not between Republicans and Democrats. This was between political leaders who were trying to govern and deal with very practical problems about the state budget, about hospital survival, about community economic viability, and folks who believe that they should make decisions based entirely on ideological principles and that's the real divider that we have in Tennessee right now.

MR. MICHAEL DAVIS: Thank you very much, gentlemen. Right now we would like to open up the floor to you, our audience members. If you have any questions for our panelists, we'll take the next few minutes to hear from you.

UNIDENTIFIED SPEAKER: Is there any move to standardize the charges for healthcare? Last year I had the joy of being in a hospital in the surgical suite for a while. The charges that were itemized on my bills that came were more than a quarter of a million dollars. What my insurer actually paid --

MR. BONNYMAN: You were only there for a couple of days, I gather? And you got off light.

UNIDENTIFIED SPEAKER: What my insurer actually paid, under their contract with these providers, was about thirty-five thousand dollars. Stunning. A quarter of a million for thirty-five thousand. I'm sure the hospital was profitable at the thirty-five thousand. What's the insanity of suing people and forcing them into bankruptcy with a quarter of a million? Is there any way we can --

MR. BONNYMAN: While those charges are -- don't get me started. I mean, I literally litigated class actions over charges. And the irony is those charges are like the sticker price at a car lot, they mean nothing except to the naive. Or in the case of hospital bills, to the uninsured. The only people who actually are required to pay the charges are the people who have no coverage. And they get sued for the full sticker price, even though it bears no relationship to the cost. The hospitals themselves can't tell you what the cost of things are. I mean, they have been, as an example, I overheard a conversation between a hospital administrator and a neonatologist a few years ago at a hospital, that will remain nameless, but whose initials are Vanderbilt University Medical Center. And the neonatologist was indignant. He said, you know, you keep piling all the cost over onto my NICU, neonatal intensive care unit, and you make us look like we're so inefficient. And the reason for that is everybody wants to pay for sick babies and they don't want to pay for a whole bunch of other stuff. They

don't want to pay for the executive suite; they don't want to pay for the parking lot; So you allocate all that cost to us and you're totally distorting what our actual costs and productivity is. And the administrator at that point, you know, said, I'm sorry, I have to be some place. It goes back to a critical point about the ACA, which at its base, is trying to align incentives in a way that will drive good care as opposed to the kind of wretched care that we have now. When I say wretched care, it's not a reflection on clinicians. It is a system problem. You've got the best trained, you know, most qualified clinicians literally in the world and they work in a system that is dysfunctional because the parts don't work together because the incentives are aligned improperly.

So long-winded answer to your question about hospital charges, charges are an artifact of a system that is full of bad incentives and bears no relationship to actual costs, much less a value. You've got cost, and then you've got value. It's even further divorced from value. I mean, take central line infections, as an example. If you've got a central line infection at a hospital, which you shouldn't do if there's appropriate infection control, what happens traditionally in the United States, the hospital gets paid more because you have to stay longer. And they get paid more for each bed pan, every Band-Aid, so forth and so on. One of the first changes in the ACA was to start penalizing for central line infections. So hopefully, your hospital bill will be an -- you know, an artifact of a whacked out system ten or fifteen years from now. But it's very much exhibit A for what a goofy deal we've got going before the ACA and right now until the ACA begins to change things.

MR. PYLES: One idea in the Affordable Care Act was to make prices more transparent so the public could see what they are. I don't really quite see how that works. If my daughter has a mass in her abdomen, I'm not going to go

see who the lowest bidder is to have her operated on. I want the best damn healthcare money can buy. And all of it covered by insurance these days. And the idea, right now, that's prevailing in D.C. is if we can just, as payers, somehow get a handle on costs, we could then reward lower costs or better outcomes and we get a better lower per capita cost, and penalize high cost. That's the idea. So you see the ACOs and a whole lot of the other ACOs. You get all of the participants in the healthcare delivery system that is part of one integrated unit, the federal government adopts quality measures, quality measures which are designed to reduce costs, and you impose those on a CEO of the ACO, who imposes those on a medical director, who imposes those on all the group practice plans if they're a part of the system. The idea being then that you're going to get better quality at lower cost. The problem with that is, the patient gets nothing new. There's no new service there. So the patient gets nothing out 135 of that. Maybe if they're paying out-of-pocket, they would get a lower cost, maybe not.

The worst problem with that is the gatekeepers, or the primary care practitioners, these are the people who determine whether someone gets care and where they go. So the idea behind the ACOs is if we have this process, we get everybody in that is part of it, and they're all subject to the same quality measures and pressure to keep prices down, and we then let them share in the savings at the end that the whole system achieves. Then the primary care doctor will do an analysis where he'll say, well, if I reduce my cost twenty percent and reduce my volume twenty percent, then I will get rewarded if the whole system achieves savings and if my piece of the savings at least matches the twenty percent that I lost out of my income. In the words of Scalia, poppycock. That's just not going to work. The thing about fee for service that is bad is that it increases the incentive for more volume. The bad thing

about going away from it is people just don't work that way. It's just not consistent with human nature. I mean, imagine paying a lawyer -- telling a lawyer you're not going to pay a fee for service, you're going to pay them, you know, some percentage of the money they save. The legal profession would come to a grinding halt. I do think what you could do, and this is what we've done in our Independence at Home program we were talking about, is practitioners under that program who treat the highest cost people, get paid fee for service during the year, but they get eighty percent of the savings beyond the first five percent. They have to achieve a minimum savings of five percent. The first five percent goes to Medicare. And then they get eighty percent of any savings beyond that and they have to achieve good outcomes according to certain quality measures. So what that does is it takes the incentive away that the fee for service has and allows physicians to start thinking of more effective ways to treat people. And the thing I love about it the most is it makes the sickest people the most desirable to treat because they're the easiest ones to achieve savings on. That is cool, I think. I mean, that's really kind of fun to do that. And so I think the bottom line is where we are with the ACA sort of starts a framework and establishes a framework where a lot of these new systems can be tested and see if they work.

My own personal view is I frankly don't see how ACOs can be a success because, for one thing, under ACOs, no system, no ACO can determine what its risks are. Because CMS reserves the right to change the quality measures at the end of every year, and you have a three-year contract. So you want to enter a three-year contract where you're accountable for results, and you don't know what results you're going to be accountable for. I mean, no businessperson is going to enter into that deal, I don't think. I actually said that. ACOs are not a health reform law, they are a management tool. Because if you have a midlevel

person come to you and suggest that ACOs are a good idea, you should fire that person right there because they're going to cost you money one day. So it's really a screening tool. I'm just sort of facetious about that. But it's patients that are in a medical home; they send them to the doctor's office. And really it was designed to provide reimbursement, upfront reimbursement for physicians to do chronic care management, which is a good thing. But it's like Steve Martin used to say, how do you make a million dollars? Well, first you get a million dollars. And so if the money is going in the wrong direction, and you're paying the doctor more for doing what we would hope they were doing all along.

So I don't think there is eighty percent of medical homes that are going to quit doing it either. But these are the kinds of models that are going to have to be tested. And one thing for certain is, we will not pay more for quality healthcare. I asked that question once. So the CMS said, you know, we're going to have quality measure, we'll improve quality. I asked the question, well, what if we found that quality required a twenty-five percent increase in cost, would that be an acceptable answer? Their answer was not just no, it was hell, no.

So unfortunately, in this environment, you can have better quality but it's got to reduce cost. It's going nowhere. If the ACO don't produce savings, you can take it to the bank, they are not going to last. If the patients in medical homes don't achieve savings, they won't last. But I do think what we are going to see is, physicians are not stupid, they'll see that they really need to exercise some discretion in trying to reduce healthcare costs. And we do see the cost curve already bending somewhat, but it has to bend a whole lot more and a lot faster.

MR. MICHAEL DAVIS: Thank you, gentlemen.

MR. BONNYMAN: If I can just add one thing on that. I

mean, it's the discussion about accountable care organizations you just heard. Part of the rap on the ACA is it doesn't have definite cost controls. Well, sometimes that rap is coming from people who if had the government imposed price controls, they would be the first to be objecting to that on ideological as well as practical reasons. There's a recognition that government mandated price controls don't work. There are a whole bunch of things like ACOs that have been tried on a small scale and now we're trying to take them to a larger scale. We don't know if that's going to work. So the short version of the way cost controls and quality improvement are pursued in the ACA is to throw a big bowl of spaghetti at the wall and over the years we'll find out what sticks and what doesn't. We know the government can't just mandate something Soviet style and expect it to work. So there's going to be a whole bunch of failures out there as well until we sort this out. Which goes back to Jim's initial point, which is if we don't do this in a political environment in which politicians, whether they're in Washington and they're in different parties or they're in Tennessee and they're all of the same party but different mindsets, can't say, look, we can't just throw rocks at this, we've got to see it through, then we're in real deep yogurt. On the other hand, if they will do what, over time, the republic has shown it's capable of doing, then the ACA we have now, one thing you can say for sure, the ACA we have now will not be the ACA we'll have in five years. It is just going to have to be reformed in reiterative process that will go on for many years.

MR. MICHAEL DAVIS: Thank you, gentlemen. Thank you for your questions. Please join me in giving them a big round of applause. Dr. Erwin had to take off earlier. He had a previous engagement, but we would like to take a moment to commemorate this symposium to show our gratitude to you today, Mr. Pyles and Mr. Bonnyman. We would like for you to have these gifts on behalf of the

Tennessee Journal of Law & Policy and the Advocacy Center and the College of Law. And for those of you that can't see because we've got them wrapped up and they're small, we have these commemorative stamps that we had made up just for this occasion to give to our speakers today. We hope that you all will have these. Thank you so much.

MR. PYLES: You're welcome.

MR. BONNYMAN: Thank you, Michael. I appreciate it.

MR. MICHAEL DAVIS: And it's good that you have those now because I hear that the price is going up next month about ten cents, so.

MR. PYLES: That's all right. It's covered by insurance.

MR. MICHAEL DAVIS: Please join me once more in congratulating our speakers. This brings us to our lunch break.

MOVING FORWARD IN TENNESSEE HEALTHCARE

DWIGHT TARWATER[6]

MR. MICHAEL DAVIS: Thank you again for joining us. Our next speaker is Dwight Tarwater. Mr. Tarwater, began as the general counsel to Governor Haslam on December 8th of this year. Mr. Tarwater practiced law in Knoxville since his licensure in 1980, most of those years in the law firm he helped begin in 1987, Paine, Tarwater, and Bickers, LLP. He has vast courtroom experience, having tried cases locally, across the State of Tennessee, and in several other states. On appeal, he has represented clients before the Tennessee Court of Appeals, The Tennessee Supreme Court and in the U.S. Courts of Appeals for the 4th, 6th, 10th, and 11th Circuits. A Knoxville native, Tarwater is listed in four separate categories in this year's edition of Best Lawyers in America, and has been named Lawyer of the Year for the Knoxville area five times. He received his undergraduate degree from the University of Tennessee, where he was elected a Torchbearer, the University's highest honor. He received his law degree from the University of Tennessee College of Law.

Mr. Tarwater has been a member of the Knoxville, Tennessee and American Bar Associations since 1980. He served as president of the Knoxville Barristers, and served for nine years on the Board of Governors of the Knoxville Bar Association, as the bar's secretary, president-elect and as president. He served as East Tennessee Governor of the Tennessee Bar Association through 1991 and '92. Mr.

[6] General Counsel to Governor Bill Haslam and former partner at Paine, Tarwater, and Bickers, LLP, Knoxville, Tennessee.

Tarwater's involvement in leadership in the legal field is extensive. He is a member of the Tennessee Association for Justice, the Defense Research Institute, the International Association of Defense Counsel, Litigation Counsel of America, and the Trial Attorneys of America. In 2006, he became a fellow in the American College of Trial Lawyers. At his firm, he has made pro bono representation a priority. He has served on the Board of Directors of the Knoxville Legal Aid Society, Volunteer Legal Assistance Program, and Pro Bono Project. His firm has been honored with the Pro Bono Law Firm of the Year Award presented by Legal Aid of East Tennessee in 2010, 2012 and 2013. Knoxville has been very fortunate to have him for so many years, and though the Knoxville legal landscape is very different without him, we are happy to share his efforts and abilities with the rest of the state as Counsel to the Governor. We are just as fortunate to have him back here back with us in Knoxville today to discuss Tennessee's way forward in healthcare. Please join me in welcoming Dwight Tarwater.

MR. TARWATER: Thank you, Michael, and thanks to all of you for allowing me to speak to you today. It's an honor to come back to Knoxville. I still have a home here, so I have a place to stay when I come, and I get to spend a long weekend and see my kids and my friends. And so I was all too happy to accept this speaking engagement when I accepted it. I thought that I would be explaining to you the new healthcare reform movement in Tennessee called Insure Tennessee. But there's a lot that can be learned from the Insure Tennessee experience, and so maybe I'll give you a little bit of an inside peek at the program and what happened and a little bit about the aftermath and what's going on.

I asked Michael if it had been mentioned today, and he said Gordon Bonnyman had mentioned Insure Tennessee. And I see him, my friend, Gordon, here sitting

on the front row who is going to probably ask me a bunch of questions. So don't ask me anything about coverages, and don't ask me anything about what we're going to do, because I don't know. But I'll be glad to answer questions. And I'll answer questions about pretty much anything. My life is kind of an open book. I had to go through a background check to get this job, and so I don't have any secrets anymore. I had to disclose what Gary Housepian and I did, you know, when we were in law school together. No, I'm kidding, I'm kidding, I'm kidding. But I'll be glad to answer any of your questions about my journey, how I got to Nashville, about relationships that were formed here at this law school that actually led me to Nashville. And so I'll save some time for some questions at the end.

I've lectured here before, twice. My former law partner, Don Paine, was a pretty storied evidence professor here, and he asked me to speak on two occasions to his evidence class. And so the very first day that I went in, he introduced me and he said, and I was only probably thirty or thirty-one years old, and he said, listen, this is my young partner, and he's been trying some cases, and he knows a lot about evidence and I asked him to come and share some personal insights. So my opening line was this: I told the students and the faculty that I promised myself that if I could ever get out of here, I would never ever come back. And they all laughed and thought that was funny. And, of course, here I am and very loyal to the College Law. But the second question that was asked, they gave hypothetical on a hearsay objection. And they said now Don said, now, tell the students how you make a hearsay objection. So I thought to myself and I had this wave of legal intellectualism come over me, and I rose to my feet and I said, "Objection. Hearsay." And Don said, "Hey that was really good. That was really good. I like the way you of me a -- do that." And Don then said, "Now, your opposing counsel says, 'No, Your Honor, it's not hearsay because it's

a statement or an admission against the financial interests of the declarant.'" And Don said, "Now, when you hear that, Dwight, tell them what you say when they say it's not hearsay." And in another burst of legal acumen, I said, "What you say then is, it is too hearsay." And Don said, "I'm never asking you to come back. I'm never asking you to come back here again and talk to my students." But he did, because I got to talk twice.

So I'm pretty challenged technologically, but I'm going to start talking to you a little bit about Insure Tennessee, talk to you a little bit about the aftermath, I want to speak to you a little bit about the *King v. Burwell* case that was argued before the United States Supreme Court on Wednesday, which is a pretty major case, and we'll see what happens. And then I'll allow plenty of time for questions. Now, as we approach what happened with Insure Tennessee, and let me back up and tell you a little bit of a story about Insure Tennessee. You may have heard Michael say I started with the Governor on December the 8th. That first week, I landed right in the middle of Insure Tennessee. And I can tell you that healthcare law is not something that I've really ever done. So I had to learn it, and I had to learn it pretty fast. My litigation experience was very, very broad, but it had very little to do with healthcare. I represented product manufacturers, I represented commercial interests, I represented pharmaceutical companies, but I didn't deal much with healthcare law and policy. And when it was presented to me, I made my first great pronouncement to Governor Haslam, my first week of work, and I said, "Governor, the Department is never going to agree to that. They will never agree to that. If they do that in Tennessee, the Department will have to do that in every single state. The deal is too good for Tennessee. The deal is too good for Tennesseans. It has too much in there that this administration has pushed back on." Well, that first great pronouncement was

obviously wrong, because the secretary did agree, and there was an agreement, regardless of what you hear. There was an agreement. And I'll talk to you a little bit about how that came down.

So let's talk about Insure Tennessee, and see if I can get these slides right. Okay. So you can quibble with my percentages, okay, but let's start with how Tennesseans are covered with healthcare coverage. Forty-seven percent are covered through their employers. Five percent purchase their coverage individually. Eighteen percent, twenty percent, something in that range, are covered under our State's version of Medicaid which is also known as TennCare. Fourteen percent are under Federal Medicare. You got me on those two percent, I don't know about them. And then approximately fourteen, fifteen percent of Tennesseans are uninsured. So let's start with that background and let's talk about Tennessee's Medicaid program, known as TennCare.

It's a fully integrated managed care program, as I said, serves about twenty percent of the population. Generally speaking, and I'm going to apply it at a very high level here, but generally speaking, it will cover low income individuals, pregnant women, children, the elderly and the disabled. Probably the most vulnerable set of folks that need healthcare TennCare covers. There are annual income limits. So it's for low income, generally low income folks. Just to give you an idea about the role of TennCare in the government process, the TennCare budget is just shy of 10.3 billion. The entire state budget is 33.3 billion. So providing healthcare and education are two of the primary focuses of state government and this administration. The state pays about 3.3 billion of the 10.3. The remaining funds obviously come from the Federal Government.

So with that backdrop, let's talk about something that I know you guys have been talking about already, which is the Affordable Care Act, and I see Mr. Pyles

smiling in the background. And I'm not here to advocate for the Affordable Care Act, nor am I here to criticize the Affordable Care Act. That's one of the benefits of being the Governor's lawyer, it's the law, so it's up to me to deal with the law, and that's a great spot to be in. Others can deal with the policies, the politics, what's right, what's wrong, what's good and what's bad. But one thing is for sure, it's the law, it passed. President Obama won the election in 2008, in 2010 the Affordable Care Act was passed, and it was a major reform in healthcare. It was designed to expand coverage, which undoubtedly it did. It was also designed to reduce individual healthcare costs. There may be a question about that part of it. But it did a number of things; ended preexisting condition exclusions, extended coverage for young adults, set minimum standards, there was an individual mandate which required individuals to purchase coverage and provided these tax breaks through Federal subsidies. We're going to talk about that in a minute in connection with the *King v. Burwell* case.

There was an employer mandate, a health insurance market place where exchanges were created. There's a federal exchange, and then the states were free to create their own exchange so that individuals who needed coverage and were required to comply with the requirements of the Affordable Care Act could purchase coverage. And then there was a Medicaid eligibility expansion which was generally in the Act required. So what happens is, is then immediately - you know, near and dear to my heart - folks lawyered up and went to court and started fighting about the Affordable Care Act. And the primary case today is *NFIB v. Sebelius* generally upholding the challenges to the Affordable Care Act but holding that Medicaid expansion, expanding the population became optional, could not be forced on the states. Each state would have the option of expanding Medicaid, so they could do it or not, as the case may be. And so that case was

decided in 2012. And our Governor at that time felt like that the Affordable Care Act was not consistent with the policies that he believed in and that he wanted as part of his administration for Tennessee, so he went to work shortly after that to figure out a Tennessee specific solution to Medicaid expansion. He announced that he would not expand Medicaid in the traditional sense of the word and went to work to figure out a way forward.

Now, because the states were not required to expand, it created this thing, which I don't know whether you talked about it today yet, but a coverage gap, okay. There were certain individuals, uninsured individuals, in Tennessee who did not have coverage and did not have available coverage because they couldn't afford it or because of for whatever reason. But this coverage gap would have included persons who don't generally meet the income limits for Medicaid or TennCare, and they don't make enough to qualify for the tax credits that would be available if they would go out on the exchange and purchase coverage. And then there are some who maybe could qualify for the credit who just can't afford it, who just can't get it done. So that's kind of bureaucratic definitionalism, so let me be more specific about that. There were approximately two hundred and eighty thousand low income Tennesseans who do not have coverage who would have coverage under Insure Tennessee. So about a quarter of a million of your friends and neighbors, who according to our data, fifty-four percent of that population are working people. The working folks, they just don't make enough money. So it's the person that works at McDonald's, it's the person who cleans our houses or who sweeps up at the law school. Generally speaking, working poor, two hundred and eighty thousand. So in March 2013, Governor Haslam began negotiations with Sylvia Burwell at the Department of Health and Human Services, and those negotiations continued for twenty

months until that day in December that I told you about when he came back in and said we have a deal with the Department on Insure Tennessee.

So let's talk briefly about what Insure Tennessee was, what it would have done and what happened. So here is the coverage gap illustrated again. So Insure Tennessee would provide health insurance coverage to uninsured Tennesseans, generally ages nineteen to sixty-four. These are people who would earn less than a hundred and thirty-eight percent of the federal poverty level, and it would create no new taxes for Tennesseans, no new taxes. So generally speaking, for an individual, that's someone who makes about sixteen thousand dollars a year. And as I had said previously, fifty-four percent are working in food service, construction, cleaning, sales, transportation, that's the population. Think about that for a second. Fifty-four percent of this population is working. A healthy workforce is a virtue, is a virtue. It can only have a positive impact. And what Governor Haslam and his staff designed were these two plans. There was the volunteer plan, and those who enrolled in the volunteer plan would receive a voucher, a fixed contribution voucher to buy employer sponsored insurance in the market place. So if the person's employer would provide a vehicle for coverage, these vouchers would assist those volunteers to be able to get healthcare at their work.

And then the healthy incentives plan would establish a series of accounts where the insured would get credit for healthy lifestyle, for a healthy lifestyle, for healthy activities. So this was some ownership that the patients would actually have, and they would be rewarded for utilizing the healthcare process responsibility and also making healthy choices. And there were many, many other details to the plan, and I'm really not the person to ask about what the coverages were going to be and what the co-pays were going to be and what the pharmacy benefit was

going to be and how it would work and all that kind of stuff. But generally speaking, for the purposes of our discussion today. I think it's important to understand that there were incentives built into this program that would require some effort on the part of the insured to take some ownership and some responsibility over their own healthcare. It also provided for some payment reforms, so on the providers' side, there were some incentives to do that a little better. It was a very market based approach which is consistent with what this administration and this Governor believes is the Tennessee way, which is you make good choices, you do good things, you engage in healthy behaviors, you work hard, you produce and you get rewarded for that. And so it was a broad coalition on the payment side, the provider's side, the patient's side, the hospital's side. We'll talk about it a little more as we go forward.

Let me just get a little water and take a breath. So as I said, there would be no additional state taxes involved. I'll talk to you about the funding model here in just a second. It would also align incentives on the provider's side. So it was balanced and a really good idea the way that it was designed.

So here's the funding model. According to the Affordable Care Act, any newly eligible population like this would be covered by federal dollars, a hundred percent by federal dollars through December 31st, 2016. On January 1, 2017, the match becomes ninety-five percent instead of a hundred percent, which would leave five percent for the state to pick up. And on January 1, 2020, the federal match would adjust to ninety percent. So the question then became how to cover that reduced percentage, because the five percent, I can assure you, is a lot of money, and the ten percent is obviously twice as much money. And so the Governor went to the hospitals, and the hospitals agreed to cover the five percent shortage

in 2017 and the ten percent shortage beginning January 1, 2020. As a matter of fact, when the program was announced, several members of the Tennessee Hospital Association stood side-by-side by this Governor in support of this program.

Now, the question becomes, how would they do that? And this is how it works. There is this statute, 715.804 which is the annual hospital assessment. It is renewed annually. It's renewed annually, reviewed annually by the legislature. And currently the hospital assessment is 4.52 percent of the base, okay. The base mostly being revenue, and so the base can change depending on the hospital. And the legislature can change that base, that percentage, on an annual basis, and so they will renew this or not renew it, as the case may be, during this legislative session, so 715.804. So the hospitals simply say figure out what the cost is going to be to cover that five percent shortage or the ten percent shortage, up our base and it's paid for. And that was the plan. And so thinking that this was not going to be a slam dunk but it was going to be something that virtually all stake holders seemed to support on both side of the aisle, the Governor said, let's call a special session, we can focus strictly on Insure Tennessee, and let's get it voted up and down in a week or two, and then we'll get on to business of the regular session. And so on January 8, he issued a proclamation calling this special session. And a special session was called to consider and to authorize the implementation of Insure Tennessee. We haven't had a lot of special sessions in Tennessee, maybe twenty in the whole history of the state. I think the last one was in the mid 2000's maybe. There was, I know, one in the '90's. So it's a little bit of a unique vehicle, but it was designed so that with a laser focus the House and the Senate and the committees can focus on this program which ordinarily would be a function of the executive branch. But could focus and authorize and give their

blessing to Insure Tennessee, give the legislative blessing to Insure Tennessee.

Now, ordinarily if it's an executive function, why would he call the special session? Well, there were two reasons that he did. First, when he announced that he would not expand traditional Medicaid under the Affordable Care Act, he said if I can find a way, I will come back to you. I will come back to you General Assembly, and we'll all be in this together. So let me have some time and, of course, it took twenty months of negotiation to get where he got with the department. And he gave them his word, he said, I'll come back to you and you can join in. That's the main reason. There was another reason, after the *Sebelius* case when expansion became optional, not mandatory, there's a statute passed by the General Assembly sponsored in the senate by Senator Kelsey, Brian Kelsey of Memphis. And, oh, by the way, let me just -- here is the statute that was passed in March of 2014. It says, "The Governor shall not make any decision or obligate the state in any way with regard to the expansion of optional enrollment in the Medicaid Program pursuant to the Affordable Care Act unless authorized by joint resolution of the General Assembly." One can take the position that this statute does not apply to Insure Tennessee. One can also take the position that the statute does apply to Insure Tennessee, and Senator Kelsey, who is a very bright young senator with a law degree from Georgetown from Memphis, is pretty much ideologically -- I won't speak for him, but he seems to be ideologically opposed to any kind of expansion or any kind of use of Affordable Care Act dollars. Those are beliefs that he has that are in good faith, but he got this idea that maybe I can get this bill through which will make the Governor come to us in case he wants to expand optional enrollment in the Medicaid Program. And so this statute is on the books.

Now, I can tell you, the reason the Governor went

to the General Assembly is not necessarily because of this statute, it's more because that's what he told them he would do. But he did, and he went with a coalition that would blow your mind, that would blow your mind. Organization after organization after organization supported this bill. Some opposed it, obviously. But look -- well, if you just look at the top right corner, how many times do you think the Tennessee Catholic Public Policy Commission and Planned Parenthood have been on the same side of a bill? All of the Chambers of Commerce and the AFL-CIO supported this program. Virtually all the hospitals, the health insurance companies, the Tennessee Medical Association, just a very, very broad, broad coalition. And if one thinks about it, you have an opportunity to cover two hundred and eighty thousand Tennesseans with no increase in state taxes. A healthier workforce, a positive economic impact, a very big boom, a very big benefit to rural hospitals, many of whom are struggling under the current healthcare delivery system.

And so what happened? Well, he called the session, committees were set up to look at the bill. Health and Welfare Committee in the Senate being one of them. And that's really the only one I'm going to talk about because it's the only one that matters. But it was to go through Commerce and Insurance, it was to go through a group of committees. So on Wednesday, the third day of the special session, the Health and Welfare Committee voted on whether to send the bill out of committee. And I'm assuming the Health and Welfare Committee is set up to make decisions regarding what's good for health and welfare, and this was the vote. By seven to four, it never made it out of committee. Seven noes. You can see, Senator Bell, Senator Bowling, Senator Crowe, Senator Gardenshire, Senator Kelsey, Senator Niceley from up in Strawberry Plains and Senator Roberts. The yesses on the committee were Rick Briggs, a freshman senator from

Knox County, Senator Jackson, Senator Massey from Knoxville, and Senator Yarbro, a freshman senator from Nashville. And that ended. That stopped Insure Tennessee in its tracks. So shortly after the committee voted, the special session was adjourned and we went back to our offices to work on the legislative package for the regular session and the other things that we do on the Governor's staff.

Now, I want to talk to you about some of the things that we heard, okay. And I'm not saying -- all of those committee members, I know many of them. These are good people. They are good public servants, they tried to decide based on everything they had, and the decisions that they make are the decisions that they make. I don't exactly know why each one voted no. Sometimes it's hard to understand why there was such stringent opposition to the bill. Many of you may know, I don't know, did anybody get a call, did anybody get a robo call? I see some heads shaking in the back. Yes, there was a lot of money from out of state interests that flowed into Tennessee to advertise, to run commercials, to make calls opposing Insure Tennessee.

In fact, it was interesting there were actually legislators or senators targeted in certain districts and ads would be run, tell your senator to vote no on Insure Tennessee or tell your representative to vote no on Insure Tennessee. It was a fascinating process. There was a group called Americans for Prosperity and they had on these red shirts and they were all over the capitol during these committee hearings and pretty much in opposition to Insure Tennessee. So I don't know why each senator voted the way they did, but I know some of the things that we heard, not from them, but just heard around as some of maybe the criticisms or, you know, the negatives, I suppose, if there can be any of this proposed legislation. So one of them was that this is Obamcare. Insure Tennessee is really Obamacare. And it's not Obamacare. It couldn't be further

from Obamacare, although the funds that would have been accessed would have been appropriated through the Affordable Care Act. But we detailed -- and this is a slide that came right out of one of the presentations in committee. But some of the differences are highlighted there, the participation was voluntary versus the individual mandate, taxes, no taxes, personal responsibility versus solely on coverage, payment reform versus increased healthcare costs. So that was one of the arguments. The second argument was, well, we don't know enough. We don't know enough about this program, so we're uncertain what that means, and we don't know whether the federal government would actually approve this. And that's a question that is a little bit more complicated. So let me talk about that.

Here's how it works. We have an agreement with the federal government to operate the state version of Medicaid. From time to time that agreement is amended. So the Insure Tennessee was TennCare Demonstration Amendment Number 25. It's been amended twenty-five times. So what happens is, is that a detailed document called a Waiver Request is prepared. In this instance, there was an oral agreement with the department, the Waiver Request was then submitted. There's a waiting period, and then the government gets back and either accepts the waiver or doesn't accept the waiver. The waiver obviously was conditioned on legislative approval. So it was about twenty pages long, it was in great detail, much more detailed than I'm speaking to you today. There was a summary. There were informational sessions. The Governor flew all over the state meeting with people. We met with legislators and we met with the General Assembly. So there was a detailed written document, which explained the waiver.

Number three, it's going to raise our taxes. Well, it's not going to raise our taxes because it would use the federal

funding. And if you think about it for a minute, we're all paying income tax; right? Everybody is filing their income tax returns and paying income tax to the federal government. Well, some of your tax dollars are going to the state version of Medicare or Medicaid in California and New Jersey for this optional population that is being covered in other states, so we're actually paying federal income taxes that are going elsewhere to cover populations in other states. Well, it's going to bankrupt the state, and we know that's not going to happen because first, it's going to be covered by the federal funding and the hospital assessment. And secondly, the program itself would terminate if those two sources of funding went away. So if it's not going to be funded by the federal government and if it's not going to be funded by the hospital assessment, then the program ends, it ends, and that's in the waiver. Plus, our data, and of course, you can make the data say pretty much what you want it to say, but the economic impact our studies show that it would result in a positive one billion dollars of positive economic impact. And this is due to new jobs, a healthier workforce, a more robust hospital industry. So not only was it not going to bankrupt the state, it was actually going to have a positive effect.

And myth number five is you can't get out. So Senator Kelsey said, you know, this is going to be like "Hotel California," you can check in but you can't check out. Senator Kelsey is a young man. Those of us who grew up with the Eagles know that he probably didn't get that quite right. You can check out, but you can never leave is really what "Hotel California" says.

But anyway, there are at least four good reasons why we know this program could terminate and the state could get out of this. First of all, the United States Supreme Court says it can in *Sebelius*. Secondly, the Attorney General said this, "The state may unilaterally decide to discontinue coverage for the Insure Tennessee population

as long as the implementation of that decision satisfies the procedures." So the Supreme Court, the Attorney General, the waiver itself said Insure Tennessee will end if this occurs, the federal match rate is reduced or the revenues from the hospital funds don't continue to pay for it. But if you don't believe the Supreme Court and the Attorney General and the language of the contract, surely we can believe the Secretary of Health and Human Services who said on January 23, 2015, consistent with that guidance, Tennessee may take up Medicaid coverage expansion and later drop it at state option. There's no requirement for the state to remain the coverage, and there would be no financial penalty and no reduction to federal matching dollars.

So that's what happened with Insure Tennessee. In your packet, I put a set of bills in there that had been introduced since Insure Tennessee went down. They're detailed in there along with the names of their sponsors. You might get a kick out of looking at some of them, and we'll look at a few nuggets here in a second. Let me talk about *King v. Burwell.* I see that I'm running a little bit short of time. *King v. Burwell* was argued Wednesday, was a great case. Hold on, it's going to be an interesting one to see how the court rules. But it has to do with these -- do you remember early on I talked to you about the individual mandate and the tax credits, the subsidies that are available for those who purchase insurance on the federal market place. Well, the Affordable Care Act says the tax credit subsidies are available through an exchange established by the state. Thirty-four states have declined to establish their own exchanges. So this insured population is going to the federal exchange. So what could happen if *King* wins and those tax credit subsidies are not available to, or are only available to the exchanges established by the state, then it could create a huge amount of chaos in the market. And it's going to result in premiums going up. This so-called death

spiral that I'm about to talk to you about where if the tax credit subsidies are only available on exchanges established by the federal government and they're not available to those on the state government that means the state exchanges, and the premiums for those who purchase on state exchanges are going to go up. And as that goes up, then it becomes less affordable and the Affordable Care Act then doesn't become so affordable.

I got a couple of nuggets from the oral argument that I thought you might be interested in. So the Solicitor General arguing on behalf of the government is arguing, well, the exchange established by the state really means state and federal exchanges. Even though it just says state, it really means both. The statute wouldn't make any sense if it was read any other way and cannot be the statute that Congress intended, it simply cannot be the statute that Congress intended. Maybe it was a drafting error. Who knows? I don't think he argued that, but it's what it says. And he had this exchange, the Solicitor General says, "This cannot be the statute that Congress intended." Justice Scalia, "It may not be the statute they intended. The question is whether it's the statute they wrote." So you get kind of an idea, you know, that there could be a group of three on one side and a group of four on the other side which would leave swing votes being Justice Kennedy and Justice Roberts. Justice Roberts was very quiet during the argument. Justice Kennedy said this, "Let me say that from the standpoint of the dynamics of federalism, there's something very powerful to the point that if your argument is accepted, the states are being told either create your own exchange or we'll send your insurance market into a death spiral. We'll have people pay mandated taxes which won't get any credit on the subsidies. The cost of insurance will then be sky high. But this is not coercion? It seems to me that under your argument, perhaps you will prevail in the plain words of the statute, but there's a serious

constitutional problem if we adopt your argument." When Justice Kennedy said that, the hospital stocks rose. So you can't ever predict what they're going to do. But keep your eye on that one. If anybody wants to write for the Law Review, this one is rich when it comes out. So what are we doing in the legislature? Well, here's our friend, Senator Kelsey again, and he understands that *King v. Burwell* could invalidate these tax subsidies and make them only available on state run exchanges. Tennessee does not have a state run exchange. The Tennesseans who receive this insurance are buying the money -- are buying the insurance, buying the coverage, I'm sorry, buying the coverage on the federal exchanges. So Senator Kelsey introduces a bill that says it would prohibit Tennessee from operating a health insurance exchange contingent on *King v. Burwell*. So what Senator Kelsey is saying is, if King wins, this legislation would prohibit Tennessee from establishing its own exchange.

UNIDENTIFIED SPEAKER: That's really sad.

MR. TARWATER: Yes.

UNIDENTIFIED SPEAKER: But think about it, contingent on *King* in what way?

MR. TARWATER: Well, on King winning.

UNIDENTIFIED SPEAKER: Okay. Hopefully it says that though.

MR. TARWATER: Well, I've got another problem with it. There's this Article II, Section 12 of the State Constitution says, "Each House may determine the rules of its proceedings." Sounds kind of innocuous, doesn't it? Except it has been interpreted to mean that one General Assembly can't bind a future General Assembly. So what Senator

Kelsey's bill is trying to do is say if this occurs sometime out in the future, we're going to bind the future General Assembly. So I think that probably there's a valid and a very effective constitutional argument that you can't bind a future General Assembly. So here's a few nuggets of current legislation that has been filed.

I see that I've got five minutes, pretty close. That means I don't have too much time for questions, but I'll do the best I can. So here's a bill that's just the opposite of Senator Kelsey's bill. Senator Kelsey's bill says you can't establish a state exchange if King wins. This bill says, if King wins you're required to establish a state exchange. So the mirror image of the Kelsey bill.

The statute that I talked with you about previously in my presentation about requiring the Governor to go to the General Assembly, there's a bill now that's been introduced that would repeal that requirement. There's a few things going on with extending TennCare to veterans, creating a voucher program. There's this wishful thinking that we, in Tennessee, we would like to have a block grant from the federal government and that way, we can run our own Medicare Program -- Medicaid Program. I'm sorry. And here's a good one, this bill just would end it all, just say, you know, let's just throw them all out. So that would terminate the Medicaid Program in Tennessee. And here's one of our own personal favorites, authorizes the Governor to go back and do Insure Tennessee again.

So on that happy note, I'm done. I'll be glad to take any questions. Keep in mind, I fly on a very high level, and so if there are questions about coverages or things like that, I'm probably not the guy. But, yes, ma'am.

UNIDENTIFIED SPEAKER: I have sort of a more big picture question.

MR. TARWATER: Good.

UNIDENTIFIED SPEAKER: Yeah. I'm not an attorney, but I come from a public health policy standpoint. So I guess just in your experiences or based on your knowledge of the origin of this legislation, how did they decide that incentives would increase positive health behavior? I guess I'm just like -- do you think that 30 incentives would increase positive health behaviors, and how would those be eating? example, okay, -- (inaudible). like -- like, how would you define healthy?

MR. TARWATER: There are lots of -- I know in my new health insurance program, I agree to do certain things. I fill out a questionnaire and I say, this is what I eat, this is what I smoke, and this is what I don't smoke, and this is how much I drink, and this is how many fruits and vegetables I eat, and this is how much exercise I get, and this is how much stress I've got in my life. So there are ways that they can assess those things that speaking over a population would be beneficial. Now, frankly, I have no idea in the healthy incentives plan the specifics of what was proposed, but I'm guessing it would be something like that.

UNIDENTIFIED SPEAKER: I guess I'm just wondering how many people they thought would like sign up for that in this income population?

MR. TARWATER: Well, you know what, they've got a chance to get covered. Interesting.

UNIDENTIFIED SPEAKER: Yeah. It would be.

MR. TARWATER: Yes, sir.

UNIDENTIFIED SPEAKER: What are the chances for the Governor to go back to the federal government and re-introduce this bill, they'll still keep that (Inaudible).

MR. TARWATER: That's a good question, and I don't think anybody really knows the answer to that. Right now, we're in the regular session. We're very busy with a thousand bills. You know, we got the message, and it may be that things will change. The Governor said he's not giving up, he's not giving up on those two hundred and eighty thousand Tennesseans, and he's not giving up on Tennessee and the positive impact that this would have. How -- what that's going to look like in the future, I don't think any of us know right now.

Gail, Your Honor.

UNIDENTIFIED SPEAKER: What about the idea of the legislature having gone in and kind of grabbed the executive hand and taken from them (Inaudible).

MR. TARWATER: Separation of powers?

UNIDENTIFIED SPEAKER: Do you see any balance here that could be tested in other ways?

MR. TARWATER: Yes, I do. I do, and I think there could very well have been a separation of powers problem with the original Kelsey legislation which required government -- but the Governor signed it. Plus, he said, you know, I'll do it, I'll bring it back to you. We'll be in this together. I don't think he quite figured that it would get the reception it got, but it did. Yes, sir.

UNIDENTIFIED SPEAKER: How can you possibly trust anything the Obama regimen or anybody that is inhis administrative people say?

MR. TARWATER: That is an argument that we've heard. And that's not a question for me to answer. But I do understand the argument, and we've heard that.

UNIDENTIFIED SPEAKER: I just wanted to comment (Inaudible). I was wondering, there is a study here about insurance premiums, if you had taken that fact into account and whether also you have talked to the insurance companies about whether it's likely they will pull out?

MR. TARWATER: I'm not sure, Jim, if I understood the question. Is this a *King v. Burwell question* or is this --

UNIDENTIFIED SPEAKER: This is a *King v. Burwell* question. If they knock down the subsidies according to the study, healthcare insurance premiums in the State of Tennessee would go up a hundred and ninety-two percent for about two hundred thousand people, and they're also projecting some insurers will pull out at this point.

MR. TARWATER: I have not seen that particular number. I know the Nashville Tennessean had an article on *King v. Burwell* and the potential impact that it would have on the state. I just can't remember what the numbers were.

MICHAEL DAVIS: I think we'll have to move on at this point, but, Mr. Tarwater, thank you so much for your presentation today. As Tennesseans, this is information that is vital to us, it's very important for us to know about and understand and I can think of very few people who we would rather have that information you. So, thank you very much for being here.

Mr. Tarwater will also be joining the last panel today, so please stick around to hear comments on the role of the legal and healthcare from than us for our his professionals in the future of healthcare in Tennessee and the nation.

BEST PRACTICES AND COST CONTROLS: IMPROVING HEALTHCARE ACCESS THROUGH INNOVATION AND COMMUNICATION

DENNIS FREEMAN[7]
LISA RENEE HOLDERBY-FOX[8]
GARY HOUSEPIAN[9]

MR. MICHAEL DAVIS: Our second panel is titled Best Practices and Cost Controls: Improving Healthcare Access Through Innovation and Communication. This panel will discuss emerging ideas and existing policy innovations and access to healthcare through increased cooperation between the medical and legal fields. We live in a seeming healthcare paradox in the United States. We have some of the most incredible advances in medical science happening within our borders, yet still we see citizens suffering, even dying, from preventable diseases. We have some of the most advanced care facilities in the world, yet many cannot access this care due to high costs that we continue to see climb. Furthermore, we spend more on healthcare than any other country in the world, yet have large segments of our population that are obese, malnourished, or live with basic health needs unmet. It is clear that more money alone does not fix these problems, and that service integration must

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[9] Executive Director of Legal Aid Society of Middle Tennessee and the Cumberlands.

play a role in truly improving America's healthcare.

To address this, we have with us today Gary Housepian, Executive Director of the Legal Aid Society of Middle Tennessee and the Cumberlands. Mr. Housepian was formerly Managing Attorney of the Disability Law and Advocacy Center of Tennessee, General Counsel to the Tennessee Department of Mental Health and General Counsel to the Tennessee Department of Human Services. He has worked as a staff attorney at the Legal Aid Society of Knoxville and as a VISTA with the Legal Aid Services to migrant farm workers in El Mirage, Arizona. He has served as a hearing committee member for the Board of Professional Responsibility and as Chair of the Board of the Tennessee Alliance for Legal Services. He has received many awards and recognitions, including the Arc of Tennessee Outstanding Community Leadership Award in 2005. He is a Fellow of the Nashville Bar Association and a member of the Tennessee Supreme Court's Access to Justice Commissions Resource Development Committee. He is among sixteen civil/legal aid leaders who were recently selected for the Second Annual 2015, "Where Health Meets Justice Fellowship." I also understand that he is a fan of Detroit sports teams, particularly the Red Wings, the Lions and the Tigers. I understand that the Pistons are conspicuously missing from that list, probably for good reason. Thank you for joining us today, Dr. Housepian.

Lisa Renee Holderby-Fox is Director of Workforce Innovations in the Central Massachusetts Area Health Education Center. Ms. Holderby-Fox is a community health worker with almost twenty years' experience working to improve health in Massachusetts, and since 2010 has served two terms on the National Healthcare Workforce Commission. I've also learned that Ms. Holderby-Fox worked as a paralegal for several years. And that, when coupled with her extensive social work career, uniquely qualifies her to be able to translate into plain

English just about anything in the world that all these doctors and lawyers are saying today. So please welcome her and direct any questions that you may have to her.

Dennis Freeman is Chief Executive Officer of Cherokee Health Systems, Incorporated. Cherokee Health Systems is a community-based provider of integrated primary care and behavioral health services in East Tennessee. Cherokee now has more than five hundred employees and an annual budget of thirty-seven million, and two dozen service locations. Dr. Freeman is a licensed psychologist in the State of Tennessee, has been credentialed by the National Register of Health Services Providers in Psychology since 1975. His professional interests include health services development and management, preservation of the safety net, managed care, and the blending of behavioral health and primary care services.

You will also notice that Ellen Lawton, Law Professor at Georgetown and Lead Research Scientist at the National Center for Medical-Legal Partnership, was scheduled to be here with us here today as well, but she also sends her regrets that she could not make it because of the weather.

To start our panel, we'll direct our first question to Mr. Housepian. In what ways have increasingly integrated services been beneficial to your practice and in the outcomes of your clients and to the communities in which you work?

MR. HOUSEPIAN: Thank you, Michael. Michael introduced me as Dr. Housepian, but I did sleep at the Four Points Hotel last night, but that doesn't qualify me to be a doctor. But I do hope that I'll be able to kind of share with you some of my experiences working with the medical field with this.

I first started here in Legal Aid in 1978, so it's good

to be back here in Knoxville and this legal community. I think one of the first things that I wanted to address too is answering the question why. Why should healthcare address civil/legal needs? As part of this response, the patient and population health. It's first asking why. Why should the health industry and the legal industry work together in this? Because we typically have seen them really working against each other, and who would have thunk it that perhaps they would be working together.

One of the reasons why is that every low income individual that will be seen will have two to three civil/legal needs that will create barriers to healthy eating, healthy housing, employment, and safety. So by addressing those needs to improve a person's health, will help the medical treatment be more successful and effective. We'll talk about this later, this thing called SDOH, social determinants of health. But it puts us in a unique opportunity to provide this integrated relationship between the legal industry and the healthcare. So why is this even particularly important? Well, because the population we're talking about is the vulnerable population. The healthcare industry that we're talking about here is dealing with people who are vulnerable. Vulnerable means because of culture and economics, barriers, I mean language barriers, or even the type of disease or illness they might have tends to isolate them and put them at risk. And as we'll talk later, those are individuals that become very costly and have very poor health. Legal services also deals with those very same vulnerable populations. And at the core of those vulnerable populations is that indispensable thing of good health and how does good health impact upon those vulnerable populations, to improve them so that they can have a better health and improved health.

So let's talk a little bit about this. First of all, the legal system itself. And I have to kind of talk about that because I'm a lawyer. We at the Legal Aid Society of

Middle Tennessee have thirty-two lawyers, we cover forty-eight counties, we have over four hundred and thirty-five thousand people eligible for our services. So there are lots of opportunities to try to help people. But the fact of the matter is in Tennessee, according to a civil justice index, we rank forty-sixth in the country in the acceptability of civil/legal services, services to people who are poor. So it's more. Thankfully, there's two or three other states besides Mississippi, and you say thank God for Mississippi, there are two or three other states that are even below us. So for about every one lawyer, there's fifteen thousand people that might need help. In saying that, I'm not going to sit here and lament about, woe is us, too many people to help, so much to do. Instead, I want to turn that to there is so much to do, and that means we have to be more targeted, more deliberate in how we deliver services to individuals so that we can have the greatest impact. And that's where there's this wonderful relationship that we share with the medical field. They want to have quality and have the best impact for the people they serve.

And so how can we do that in an integrated fashion that's truly holistic. Because typically what we've dealt with is doctors and medical providers look at a situation and they're looking at the biological issues that are facing them. And those things that are not biological that they can't fix, well, you know, they can't do anything about it. But part of what we're talking about is that those issues, those what we call health harming legal needs can be addressed.

Now that doesn't say that legal services is the answer, but we are part of the answer. If we want to move our healthcare for our Tennesseans to improve, it's going to require this collaboration and cooperation to look at what's really going on here. Because when you look at it and we talk about all those legal problems, what we do in Legal Aid, it really is related to their health. I mean seventy-two percent of the issues we work on, if you're helping someone

with domestic violence, that's impacting upon the safety of that individual and their health. If you're helping someone on keeping them in safe and affordable housing, that impacts upon their health because they're living in healthy housing as opposed to being in substandard housing. If you're getting people income benefits, be it under Society Security or supplemental security income or food stamp benefits, those things are going to enable them to have income that's going to allow them to have healthy eating and healthy lifestyles. If we work on just basic health access and eligibility, those things again impact upon that. Working on a person's employment issues, those things are going to impact upon the healthiness of that individual and their family. So although we talk about working on health cases might be a small percentage, the fact of the matter is, the bulk of our work in Legal Aid is about people's health, impacting upon their health. So it's really legal care that we're providing for them. I mean we talk a lot about the concept of and our pledge of liberty and justice for all, you know, that that's part of our pledge. I wonder if we ought to re-frame that, because that doesn't seem to have really connected in the form of justice for all. I wonder if maybe it should be well being for all because that's what we're really talking about here. When we're working on cases at Legal Aid, we're working on trying to improve the well being of that individual and the impact upon them.

So what's happened has developed over the years -- and this started in Boston over twenty years ago when they started seeing individuals in their emergency rooms of the hospital with asthma problems. And they kept on seeing these individuals coming in and out of the hospital and treating them on an emergency basis because of asthma. Well, what happened, what was going on is that they were living in substandard housing, and part of the problem was the kids. In order for the individuals to deal with the asthma problems, they were told to run the air conditioning units to

try to help. But the landlord said, you can't run those air conditioning, so the people were faced with not running the air conditioning and also not being able to have these kids in safe environments. So they collaborated with the Greater Boston Legal Services Program, and they addressed those social determinants of health that was going on after those patients left the hospital. And that's what we're talking about, is what happens after someone leaves that clinic or leaves that hospital, what things are going on out there that are adversely impacting upon that person's health that's adversely impacting upon their treatment so that they don't come back again or so that they don't come back in worse condition.

So that's what became formed at that time, was this integrated relationship between the medical providers and the legal aid services workers there. So in order to do that, that required helpful information from the medical team to talk about what was going on there, that there was a relationship with the living conditions to justify the advocacy because more is needed than just simply a referral, there needed to be advocacy being done. So that formed this partnership early on twenty years ago. And now it has really kind of blossomed. There are over two hundred and sixty-two of these partnerships in thirty-six states and half of them are in a hospital setting and another half are also in the community health centers. Your federally qualified health centers are a prevalent place where these are being done, where you are meeting with individuals or where they are at and forming this relationship with it.

So what's the key component of these partnerships and how does that help? How does that help us in addressing is my first question. That's practices. What you're working on is you work with the medical provider under this model. And first of all, you try to get a feel for what is the need of that population, that is, who are you

seeing there, what are the problems that they're having. Almost like a hot spotters type thing. And then once you're looking at those issues that they're facing, then be able to train those individuals in the medical setting to identify those health-harming legal needs and how can we address them in the legal services community. So that means if so-and-so was being treated for diabetes but at the end of the month they don't have enough money for their prescriptions or they're not taking their prescriptions at the end of the month, well, maybe we can help with some type of income supports. Maybe they're eligible for SNAP benefits or something to be able to turn around that adverse impact that's going on after they leave that healthcare professional. It's identifying those legal needs that we could address in there. So that requires training, and it requires the three-sixty approach of not only training the professionals there, but getting back to them and saying, this is what we're able to do so that they can see the value of us working as a team, because that's what we are talking about. When they were looking at this for the first time, what was missing with the healthcare industry? Who was missing in the form of that team? You can have all the specialists you want there, who was missing from the team was the lawyer, a lawyer inside the doctor's office. And that has been the central premise with this in forming these medical/legal partnerships.

Now, again, what has to be done, first of all, in this partnership is identifying what that need might be in that community. I mean what you're looking at, you're trying to look at not just the patient, but you're looking at populations. What are the things that are -- what are the structural barriers that are out there that might be adversely impacting a certain population. It might be an immigrant population, it might be individuals that are homeless, it might be people with certain diseases that are impacting on them. When you look at those -- the needs of those populations and defining them and then coming up with a

strategy to address them. Ultimately, the best thing if you're able to identify some issues that could have systemic impact, be able to advocate to policy measures that this system or these changes, perhaps even in health eligibility, are adversely impacting upon a population so that it's more costly.

But the essential premise in all this between the legal and the medical professions is quality. And that requires time, it requires investment and belief, that overall we're going to be able to reverse those trends, and be consistent with the Affordable Care Act reforms. We really need to look at some reforms here. How do we do things in the form of prevention to keep things from getting to those situations that Jim was talking about earlier where individuals have these chronic, high-cost needs that make these individuals super utilizers, what is it that we can do early on. It may not typically be something that you might think would happen. You may be seeing a family and you just simply ask the question, "How is everything going at home with your child?" And come to find out, that child is having all kinds of issues at school, and understanding that perhaps the child has not been identified as needing special education or the child is facing suspension or expulsion. All those things can adversely impact upon that family and be able to comply not only with the medical treatment, but increase stress to that family and also for that child.

We know that education is the primary characteristic that's going to be able to keep a child out of poverty as they become an adult. So perhaps through that holistic approach of just simply having a conversation with that patient, that we are going to be able to perhaps not only address the parent's needs but also that child's needs so that child is going to be able to grow up healthy and thriving through accessing education. Because we know as practitioners that kids, there are kids that we know, statistically kids of color and kids of disability, are

disproportionately expelled and suspended from school. So what better place to identify that and see if we can do something about it than right there in the healthcare office. And again, it's meeting the patients where they're at, sitting down with them. But those things take time, and in order for this to really occur and first have meaningful change, there has to be an investment, that we can't keep doing what we've been doing. We've got to try something different, we've got to try something innovative. I tell people all the time.

Another thing we share with the medical field is this concept of critical thinking. There ought to be critical thinking being done by practitioners in the medical field and it ought to be done by lawyers too. Because you don't just simply listen to what a client says is going on, you have to probe deeper. Because what they think is going on with their health or even their life and legal problems might not be really the driving force that's going on. They might be not able to pay the utility bill, and you say, well, geez, maybe we can find some place for you to get some money. And come to find out, the reason they can't pay the utility bill is because they get all the payday loans or they've got some other consumer transactions weighing heavily on their disposal income. So it requires a specialist, and that specialist happens to be a lawyer, to do that.

But I do think, to speak frankly with you, I think we, with even our scarce resources, have to start thinking about how we do things differently as a legal aid provider, that is, how do we look at and seek out partnerships such as in the medical field to really strategically deliver our services, to really go to the clients where we're at. Because we have fallen into the trap that a lot of times the medical industry might be in, and that is what I call the whack-a-mole mentality. That is, as they call in, we react, we respond, and we've got enough that are calling in to say grace over, so why go out and try to see if there are some

other people that we ought to help. But the fact of the matter is, we can't just simply do that. We're charged with a greater responsibility as Legal Aid workers to go out and find out those strategetic partnerships, whether it be in the medical field or in the education field or any other professional field and say, what do you see in there? What's happening? Who do you lose sleep over that you need some help with?

And then we ought to figure out some way to get some services to them. And it might mean that there's some other people we're not going to be able to help, but we've got to be looking at who can we make the biggest impact on to improve their life and well-being. And the same thing with the medical industry. What this is trying to do is, we're going to do this, how about you doing this. Let's really look at your patient holistically. Let's really look and see what's really going on there. They're coming in and complaining about this, but let's talk about what else is going on, if we're really looking, because they're all interrelated. They are not segregated. They are all going to impact upon that person's ability to comply, be able to be engaged with their medical treatment and all those things. One thing I can tell you, stress is huge for the poverty population, and it's going to have all kinds of impact upon them, on their ability to comply with things and also to be able to make good decisions. When you're poor, you can't afford to make too many bad decisions. They have harsh consequences.

So that is sort of the national landscape of sort of this national medical/legal partnership movement. Again, it's an exciting opportunity. It requires engagement, it requires people willing to say, we've got to do something more innovative, we've got to try something different. Do you know what, it means we've got to shift away from, and maybe there might not be any incentives financially for it, but we've got to say quality care wise, well-being wise, we need to spend time to make this happen. And again, that

speaks to not only the health community but to the legal community. We've got to sit there and say, this deserves the quality, this deserves the time to do that. Now, on our front, just to kind of shift my hat from speaking from Ellen's standpoint, a national standpoint let me tell you what we do in the Legal Aid Society. We have multiple medical/legal partnerships that we have. We have a medical/legal partnership with a group called Shade Tree Clinic operated by Vanderbilt University Hospital. This is a student run clinic in which we work with medical students there as part of teaching curriculum where they do work in serving individuals there. And at that location, we're working with the doctors, but also the students, in looking at those social determinants of health and how those issues do have an answer and that we could be part of that answer. And so they will identify those things and get with us and then they'll make a referral to us to work with them. That requires training with them, it requires questionnaires, and we just make that a part of it so that they look at their practice as new professionals to include that component in serving their patients.

We also have a clinic with United Neighbor Health Services in Nashville where we just recently are trying to look at a new location. But it serves low-income poverty individuals. And I'll give you an example of the challenges sometimes with that. I was meeting with them this past Tuesday at this new location and doing a training with our medical/legal partnership lawyer who was saying, here is what we're doing, here is how we can help you. And you could tell, they're just sort of, we don't have time for this. We don't have time to ask these three or four questions. It's just, we've only got so much time, so many minutes and there's only so much we can do. And so as I was feeling that in the room as we were trying to get a new partner with us and see whether or not this could work, I just simply asked the nurse practitioner there, okay, why don't you tell

me your most difficult patient. Tell me the patient or patients that make you lose sleep at night. She says, well, I've got this guy who has cancer of the kidneys but he doesn't have any health insurance. He's one of those individuals under the Medicaid expansion, would be covered, but he can't work anymore and he's got no health insurance.

She said, all I'm doing is keeping him through medications. I mean here's someone -- you talk about impact, here's someone who's going to die under this person's watch, and all they're able to give him is medications because he doesn't have health insurance, he can't get to a specialist. I mean that's right here in Tennessee. So I said, if we can get him SSI, he can get Medicaid. Oh. So Tuesday we talked to them, and now we're trying to look and see, can we accelerate an application to this guy to get Supplemental Security Income Disability Benefits which automatically gets someone Medicaid, which might get him the treatment he needs that will prolong his life or make his life healthier and happier. But it's not even on our radar screen. It's something again that they can't fix because it's a biological problem. Biological problems are the only things they can take care of, and so that's all they do. And the rest of them is, oh, well, it's kind of random. But if we have a concentrated team effort approach and say, hey, legal is part of our legal team, let's see what they can do about this. Then you're trying to really address something that they never thought before could be addressed through legal intervention.

So the third medical/legal partnership we have is right here in the East Tennessee area, and that's with Dayspring Health Clinics in which we have a partnership in Campbell County and Claiborne County at their rural health clinics. In that, we've been able to train the professionals there and try to identify those legal problems and again, provide access to a vulnerable population that

typically would not have access to legal services and be able to get assistance. So through the training with those individuals, we have a portal there, at least, with those medical care providers so they can identify those health-harming legal needs and see if we can help them with it.

So there's this whole idea of medical/legal partnerships provide a wide range. We're going to explore medical/legal partnerships and mental health providers like Centerstone, the Mental Health Co-op in Nashville that does a lot of crisis stabilization, in looking at what is it we can do to help those populations. What is it we can do with the issues that you're seeing there so that you're not dealing with them on the whack-a-mole mentality and approach with it, but how can we develop better systems of care for these individuals through an integrated approach. Thank you.

MR. MICHAEL DAVIS: The next question is for Mr. Freeman. Regarding cost control in healthcare, we usually consider the monetary costs, but what are some of the non-monetary costs that result from not using best practices and healthcare policy?

MR. DENNIS FREEMAN: So you see my title of how our mental health system in this country is failing. That's really not a very hard case to make. I mean you look on our streets, you see the homeless population, most of them having psychiatric disorders, substance abuse problems. You look in our schools, you see the behavior problems, you see expulsions. You look in our courts, you look in our jails, it's not a hard case to make, there's plenty of evidence. You know, it's not that the treatment doesn't work, the treatment really works, it's just pretty hard for folks to find it. This slide kind of tells the story, you know, in a year's time about eighteen percent of the U.S. population have a diagnosable psychiatric or substance abuse issue. Fifty-seven percent of that population don't access care in a

year's time. And of those that do, only about ten percent of the population that need help end up faceto-face with a mental health professional. Three times as many, about thirty-three percent, show up in primary care looking for some help with a behavioral issue. So access is pretty challenging to find. Now, most people show up in primary care looking for behavioral health help, but most behavioral health professionals practice someplace else. I think it would be neat if we had the patients and the behaviors at the same location where it would be more likely to get something done. So access is a huge problem for the behavioral health system. About ten percent of the folks who really need help find it. Even if people call in in crisis to a behavioral health professional, often there's a couple of months' wait before they end up being seen. Maybe we should be grateful for stigma, at least that keeps the demand down. So access is a huge problem.

If we look at quality, outcomes, you know, the behavioral health field is really far behind. General medical care in terms of looking for specific outcomes and reporting certain outcomes. I was going to say it was a liability that most behavioral health providers don't have electronic health records, but after hearing Mr. Pyles today, maybe that is a blessing. But I've come through a challenge, they're not very clear cut for behavioral health issues. And costs, we now know that behavioral health issues drive a whole lot of healthcare costs. It's not that the behavioral health treatment itself is very expensive, it's not. You know, if you look at payouts from insurance companies, maybe five percent of the premium dollar really goes to behavioral health. But if we look at the co-morbidities of folks with chronic medical conditions who also have a psychiatric diagnosis, actuaries tell us the cost of treating those medical conditions has doubled, if 54 not tripled. So behavioral health really derives a whole lot of the cost that really figures into the cost issue in this

country.

Now, incarceration is in no way evidence-based treatment. Expulsion from school is not evidence-based treatment. Being in a juvenile detention center is not evidence-based treatment. But a whole lot of folks with behavioral health disorders end up in jail, end up expelled from school. And policy, it's hard to define what our U.S. mental healthcare policy is. If policy is defined by dollars, which I think probably is the best definition, if you're looking where the dollars go in the behavioral health system, they almost all go to rehabilitation. You know, the dollars mostly go to the systems that are treating folks who have long-standing psychiatric problems. There's not a lot of emphasis on early detection, early intervention. If you'll look at what's happened over the past economic downturn, about four billion dollars has disappeared from state funding for behavioral health kinds of services. Now, as the economy gets better, my hope is those dollars will be restored. But around the country, that's really not the case.

So federal policy I guess comes out of SAMSHA. A long time ago the direct federal to state to 55 community funding went away, so there's some block grant money that comes to the states, and that doesn't necessarily get down at the community level like many of us community providers wish that it would. I recently saw a reference to federal government employees and federal agencies ranking their job satisfaction. I think there were over a hundred and seventy federal agencies; SAMSHA employees ranked their job satisfaction in the lowest five of any of the federal agencies. I think that says something about our U.S. policy. So really when we're looking where the funding goes for behavioral health, too much goes too late to too few. You know, we really see that a lot of the dollars are really being spent on folks with serious illnesses.

We look at what's really happened in terms of the thinking about behavioral health over time, it's become

more and more medicalized. There's a heavy emphasis now on the biological model. We hear that folks with substance disorders have a disease. We hear that depression is really a chemical imbalance. It seems to have forgotten the bio/psycho social model that many of us were trained in. You walk into a doctor's office these days and you utter an "I feel" statement, and the prescription pad is likely to come out and you're going to get a prescription. Sixty percent of the world's psychotropic medications are swallowed by Americans. We've got five percent of the population, sixty percent of the psychotropic medications. In fact, you can pull salmon out of the Atlantic Ocean and find traces of Prozac. There's Prozac, and probably other anti-depressants, psychotic meds or anti-anxiety medsin the water supply. You know, everybody is depressed, everybody is anxious at some time. You don't really necessarily need a pill.

Gary did a great job talking about social determinants of health. If you think about the impact on psychiatric disorders, it's at least as great as it is on social disorders, all those social determinants. If you walked into a public housing complex or a homeless shelter and you gave a depression screening, almost everybody would score in the depressed range. So is that evidence of a chemical imbalance? Our director of psychiatry says we don't have any pills for a bad life, but yet many people in the behavioral health profession continue to medicate folks without attending to the social determinants Gary spoke to. Silos are great for the storage of grain, but probably not so good for keeping behavioral healthcare from the rest of general medical care. Psychiatric problems rarely occur in a vacuum. If we look at the adult population in the United States, of those folks with a serious psychiatric problem, sixty-eight percent also have a co-occurring medical problem. Folks with medical problems, chronic medical problems, about twenty-nine percent also have a psychiatric

problem. So really in this siloed system of care where behavioral health has always been so separate from general medical care, it is very hard to reach the kind of collaboration that really addresses all of the problems that come with people when they cross the treatment threshold.

So the whole system, I think, has to change, and there are some promising directions now. The patient centered medical home model. It's not a new model, it's been around for two or three decades, but it has new currencies spurred on by the Affordable Care Act. The thinking is really putting the patient at the center of treatment, having patients embrace their responsibility for their health, and putting around that patient, who is the captain of the team, a team of professionals, not only the medical provider, but outreach specialists, community based people. And now I think we know that primary care is also the best platform for the provision of behavioral health services.

So this is kind of the way we do it at Cherokee Health Systems. You know, we have imbedded behaviorists, who are full-time members of that primary care team. They are available at the point of care when a patient walks in. The primary care provider detects some behavioral issue and can hand that person off right on the spot to a specially skilled behaviorist who can do intervention there. There is also psychiatric consultation available real-time to that primary care provider. The goal is really to deliver behavioral health services in that primary care context, right there in the primary care area. So there's a very broad scope of practice for these behaviors. They're dealing not only with psychiatric issues but they're all dealing with those social determinants of health. Healthy patients accept responsibility for their care, helping patients form better health habits. So this, I think, is the future of behavioral healthcare. So the cartoon says, will I still be able to not exercise? Isn't this really the crux

of our healthcare issues, health costs? I mean as individuals, we all really have to accept responsibility for our own health. So what these behaviors in primary care do, they really help that patient embrace those responsibilities helping foster an informed and activated patient.

Cherokee is a federally qualified health center. There are twelve hundred of these organizations around the country that are created really to serve the needs of under served populations. Gary mentioned a couple of our colleague organizations. Around the country these organizations now see twenty-three million patients so that's seven percent of the U.S. population gets primary care from a federally qualified health center. But we target under-served populations, so one in seven uninsured Americans get primary care through a health center. One in seven Medicaid recipients in the country and one in seven rural Americans get their care from a qualified health center. There's been significant growth. The Affordable Care Act really spurred the health centers along with some new funds. But you see where the growth has really occurred in health centers, sixty-nine percent in medical care. Dental care has about doubled, but behavioral healthcare in the health centers has tripled.

I've learned a lot just preparing to come and meet with you. I had no idea that Legal Aid attorneys were working in federally qualified health centers until I started reading up on that. There are sixty now, I think, around the country I read of these medical/legal partnerships. Over the years when I've done clinical work, I've often reached out to Legal Aid attorneys, you know, I've probably worked with some of you in this area. They have been enormously helpful to patients within the areas that Gary talked about. But I hadn't really thought about collaborating this service internally, working side-by-side with our medical providers. So I expect to get out of here pretty soon and

become the sixty-first.

MR. MICHAEL DAVIS: Thank you very much, Dr. Freeman. Ms. Holderby-Fox will be our next presenter. She comes to us from Massachusetts today.

We do thank you very much for being here, and I would start you off with this question. Even if everyone in America were to suddenly have adequate access to medical, dental, and mental health treatment, chronic illness and mental health problems would doubtlessly not completely disappear. What, in your experience, can be done to address the community in environmental issues that contribute to these problems?

MS. HOLDERBY-FOX: Thank you. And so I'm going to do that through a small presentation. But, actually, before I do say anything else, I just want to say that increasing access does not necessarily mean improved health outcomes. I mean we've seen in my home state, almost everybody has health insurance, but we're not necessarily yet a healthier state than we were a couple of years ago. So that's the first part of my answer to that question. And, actually, I'm going to go back. I just wanted to start by sharing a quick story with you. I have been in the field for over twenty years as a community health worker. My very first gig as a CHW was for a maternal child health program. We had the goal of getting high-risk pregnant women in to see their OBs for at least thirteen prenatal visits. Sounds easy. I thought it was easy when I accepted the job. We started doing the work and we realized a couple of things. One is, it's going to take a lot more than me going out doing a home visit and connecting people with traditional resources to get them into prenatal care. I think we heard that earlier, that it takes more than just getting somebody in for a visit. But as we're doing this work, we're reaching out to women, we're reaching out to young families, we're

connecting them with resources. And over and over and over again, we were hitting things that we couldn't address by connecting somebody to a healthcare provider, that we couldn't address by connecting somebody to a local community action center. Who we really needed to connect with to address some of these issues were folks in the legal field. And that was literally about the same time the medical and legal partnerships were happening in Boston. But I say that to say that it's going to take all of us in the room doing our piece of what we can do to really and truly improve access and to improve health outcomes.

So I wanted to talk a little bit about CHWs because I think that we are a piece of that puzzle. So what you see in front of you is the Department of Labor Classification Requests Definition that the APHA CHW Section of American Public Health Association, Community Health Workers Section submitted in 2010. What I would like to point out here is that they're not saying, you know, CHWs are CHWs because we have all of these wonderful degrees. They're not saying that CHWs are CHWs because we can do this one thing that nobody else can do. But what we're saying are CHWs are CHWs because we know our communities inside and out. Nine times out of ten we are part of that community. Nine times out of ten we have the same struggles as those other folks in those communities. So when we talk about vulnerable populations, we talk about the under-served, we talk about folks who really and truly might need that extra nudge, we're from those communities. And so we know those people, we think the best. But we really work to build a capacity to increase their health knowledge and build self-sufficiency. And again, we can't do that by ourselves. We need all of you all in the room to help us.

This is the second piece of this definition talking about conducting outreach, utilizing programs in the community that promote, maintain and improve individual

and community health. So we're looking at the big picture as well. What I think is really interesting about this 63 definition, is first I want to start off by making sure we're all on the same page when I say CHW because I'll say that a lot in the next ten or fifteen minutes. But I also wanted to share with you that the Department of Labor Request was a policy effort that CHWs took on, not just in Massachusetts but it was something that we did nationally. So I really kind of want you all thinking as you're thinking about what do we do next, how do we really impact health policy, but to think about bringing on some nontraditional partners to do that. Nobody thought we were going to be successful in requesting a new labor category at the Department of Labor. We were. It was a lot of work, but we did that. And again, I just want to make sure we're on the same page, when you hear me say community health worker, the previous speaker mentioned outreach workers, the same folks. It depends on where you work, what your activities may be. The bottom line is, we think of health holistically. In my home state, they had over forty different job titles for community health worker. So for many years we have been using this umbrella visual because it allows folks to get a good sense of who we're talking about community health workers. Just to give you an example, so although I can't about when we're talking a quick snapshot, we may say to you today, call so-and-so as the community health worker in Tennessee, I can tell you you have lots of community health workers in Tennessee. This is a graphic from the Department of Labor in their May 2013 report really taking a look at the number of CHWs that are employed in the country. I also want to say you'll see there's a blank spot there. That is South Dakota. That does not mean that they don't have CHWs in South Dakota, it simply means they did not have the data when they released this report. We're everywhere, there's about a hundred and twenty thousand of us across the country.

Okay, so here's the nitty-gritty. So when I talk about populations served by community health workers, people with disabilities, disorders, substance abuse, homeless folks, immigrants, refugees, older adults, persons living at risk with or have contracted HIV and AIDS, pregnant women, migrant workers. This is not an inclusive list of everybody that we work with, but it gives you a good sense. We're working with folks that quite honestly need something more than an insurance card to get to the doctors.

Common Activities: client advocacy, health education, outreach, health system navigation. What I would like to say is these stats came from a Massachusetts report. Our Department of Public Health did a survey under our state to see how many CHWs are here, what are they doing, who are they working with, and that's where this information came from. What I would like to say to you though is, client advocacy is the thing that we do the most. So doesn't it make sense that we really partner with all of you all and partner with others in the legal field to really insure that our communities are healthy. We talk about insurance enrollment, another area that I just heard that you really partner and work with legal partners and community health centers to make sure that people are enrolling. CHWs also do that, so we can assist in that effort. And then chronic disease self-management. The thing that I would like to say is that the last couple of these are really medically focused, but I want you to know that CHWs work everywhere. We work in health centers, we work for community-based organizations, we work for faith based organizations. Myself, I have never worked in a healthcare delivery system as a community health worker. I think right now we have lots of opportunities in healthcare. But I say that to you because I want you to think far and wide when you think about CHWs in the communities where you live, work and practice.

So what we do best, I think, is promote health equity and social justice. Everything that we do as a workforce really centers around that. So again, I think that makes us very natural partners in some of this. I think that what we can do is let the community, no, I'm sorry, there's a word missing there, know that we serve the correct way they should be treated, the rights that they have and what they qualify for. If they understand that, then they know what to expect and they know what they can ask for. I can't go to the doctor's office and see if the doctor is treating client A and client B in the same way, but I can teach clients A and B exactly the way they should be treated. I think this is the way to eliminate health disparities. This quote came from a CHW on Cape Cod, and I really wanted to share that with you because again, I think the opportunities are in healthcare right now, but our field is much broader. And when we think about eliminating health disparities and promoting health access, we're thinking about social justice and promoting health equity.

Containing Costs. We've talked a lot about the ACA today. I'm just going to skip that. But Chapter 224, I'll come back to. Patient centered medical homes, we've heard about. Accountable health organizations, we've heard about. State innovation models, really how to do things differently. A lot of grants went out around the country. What I want to say here is that all of these are pieces of health policy, and all of these had input from CHWs. In fact, in some cases, CHWs wrote portions of the legislation. When we talk about the ACA, I wish I could say I was in the room with everybody, pen to paper writing.

That's not the case, but we did get calls from around the country from many of the legislators that were working on the ACA, knowing that they wanted to include CHWs. They're doing this big overall of health delivery and health payment, they wanted to include it. Excuse me. I'm sorry. They wanted to include CHWs in that effort. So many of us

gave input into that as they were developing the policy.

I'll come back to 224. Patient centered medical homes. That's nothing new, we just heard about that. But I will say that CHWs are working to change some of the policy around what those patient centered medical homes look like, so that we are included and so that we've got some legal partners there as well. And I'm going to leave it. I'm going to come back to 224, that's why I'm kind of bouncing around that a little bit. I want to spend some time on that. But I think if we're talking about prevention, maximizing our healthcare dollars, we've got to get creative around policy to do that.

So I talked a little bit about the ACA and how CHWs were engaged. The Standard Occupational Classification Code, that was a very long process for us. That was a five-year process, but we felt it was important to change policy to make sure that we were included as a workforce. Across the country folks are talking about certification education and workforce regulations for CHWs.

Again, I see that as a natural kind of intersect. What we're asking in all of those cases is that CHWs are engaged, involved in part of the leadership. I can tell you that in states that have certification for CHWs, that have statewide certification, there are three. Only one of those were CHWs fully engaged, but not one CHW has actually drafted the bill. Now, we had to go around to get some of our legal partners and help us with the legalese and where does this fit in the statute. But the bottom line is, we want to be more engaged in policy development. We want to do this. We see this as the best practices to really make sure that the people that we work with are represented, quite honestly, and receive what they need.

Chapter 58. I just am going to touch on that for a second because I don't want anybody to throw anything. But you know that we in Massachusetts started our

healthcare reform work by passing a law in 2006. What I think I want you all to take away from that is that a group of CHWs, along with a few lawyers that had a very serious interest in making sure that CHWs were on everybody's radar and wanted to assist us in developing policies, actually helped us to write what we thought at the time would be a piece of stand-alone legislation. Just so that we wanted to put ourselves on the radar, we wanted the legislature to know we were here, and we thought that would be a great way, just this little piece of legislation won't cost anything. Lo and behold, it was included in Chapter 58. So that was an unexpected bonus. But again, as we're talking about how do we really improve health, we understood that we've got to get engaged in policy development, otherwise, we're really missing the boat. And I will say in Chapter 58 CHWs have a whole section that literally they lifted the language that we crafted and just dumped it into our health reform law. So we're really excited about that.

You all have copies, or at least on the jump drive of a couple of policies that the American Public Health Association has passed, both around CHWs and really improving health, eliminating health disparities. The other piece, again, we want to be engaged in policy development. We know that we've got to do this if we're going to help our populations. So we sat down and wrote that, again, with the help of folks from the Health Law Forum at APHA. So you see lots of kind of intersections between the two fields.

Cost savings in the making. We talked about the states that employ CHWs. What I want to say is that it was about forty-three thousand, if I remember off the top of my head, CHWs employed in the country, but we also have a very large volunteer workforce. And when I gave you the number of a hundred and twenty thousand, that included paid CHWs, volunteer CHWs, that's why that number was much larger. I would like you to know that there is over

forty CHW and CHR community health representatives from organizations across the country. Unfortunately, when we did the last count a few months ago, there was not one yet in Tennessee, but I'm hoping to see one in Tennessee soon. And we talked about the medical/legal partnerships. And so I say this and show you this to ask you all when you leave today to really begin thinking about how you can engage CHWs, and not necessarily through the health centers, because we're not always employed there. But you can utilize reaching out through the CHW organizations across the country to do that.

I have said CHW a lot of times, but I also want you to know that community health representatives, or CHRs, are our counterparts in the Native American communities. Promotores(as) de salud are our counterparts, particularly in Spanish speaking communities and along the U.S. border.

So Chapter 224 was really designed and we passed this healthcare reform law in 2006, we've got most of the folks in Massachusetts signed up for healthcare. Nobody thought about the costs. We didn't even begin to tackle costs. We talked a lot today about healthcare costs. So Chapter 224 really looked at containing healthcare costs. The piece that I want to focus on is the wellness and prevention, because I think that we all know, we've heard it over and over today, that we've really got to invest sometimes on the front end to improve outcomes, to improve health outcomes from the back end. So I'm going to talk about the Prevention and Wellness Trust Fund that Massachusetts has developed. And again, I'm not sharing that to say, hey, you know what, every state needs to do this, but I'm sharing it so that you all can take little bits and nuggets and think about different ways of doing things.

And the other thing I want to call out as an expansion of the primary care workforce, oftentimes we think about doctors, nurses, medical assistants, the folks

that are physically in the office, but I will say that they have also considered how do they maximize CHW potential and how do we really invest in the CHW workforce.

Prevention and Wellness Trust Fund, this is the thing that everybody asks me about everywhere. It was created in 2012. That's a very formal long name for improving the quality of healthcare and reducing costs, to increase transparency, efficiency and innovation. What does that mean? It's our Prevention and Wellness Trust Fund. What that fund did, we have sixty million dollars that the legislature approved over three years, and we're charged with "proving" that prevention works. That if you invest on the front end, you're going to save healthcare dollars on the back end. They funded nine communities in our state to do this. Those communities, they needed to be clinical community partnerships. They also needed to include state or local health departments and CHWs were mentioned in the workforce. They really wanted folks to include CHWs. We're included as team members for several of these interventions, so again, we're hoping that we can prove that prevention works and we'll get more money. But then it also really speaks to how teams of people work to improve health. And I say that because I'm part of the Lister Community Prevention and Wellness Trust Fund Grant. And we are one of very few of the nine that have said, you know what, we can't do this alone. We've got the health department here, we've got the CHWs here, we've got the hospitals, you've got the health centers there. The piece that was missing were legal partners. We didn't realize that right away, but as we were thinking about, okay, what is this project going to look like. We're saying, wait a minute, we know that the people that we're going to be reaching out to and that we're going to be engaging are going to have issues that the health center can't solve. They're going to have issues that community health workers may not be able

to solve. But you know what, if they've got some legal issues, i.e., housing as we heard in the asthma example earlier, we need legal partners to do this. And so early on in our process we pulled in Community Legal Aid so that we've got them at the table. So it's not a traditional medical/legal partnership. But when I think about medical/legal partnerships and think a little more broadly, this is a way that it could look. So as I've said, CHWs are a piece of the puzzle. We're not the answer, but again, I'm going to ask you all, as you have and continue to work on policy, healthcare policy, just remember that there's a workforce that is very interested in working on the health policy, we want to assist you in this effort, because the bottom line is, we want our communities to be healthy. Thank you.

MR. MICHAEL DAVIS: At this time, we'll now hear from our panelists' responses to the presentations thus far. If you would like to join us back up front again. I'll put this mic back in front of you. And to start you all off with a question, and again, you can feel free to guide this part of the discussion in any way that you would like, what would be your vision of integrated healthcare and legal support to the underprivileged in (a) a perfect system, or (b) a system that works as well as it practically can?

MR. HOUSEPIAN: Well, I guess the vision for it would be that in every opportunity, every time that we're serving a low income individual in a healthcare setting, the vision is that there's going to be engagement, awareness, assessment of those social determinants that might be a legal need that is harming their health. The vision is, is we need to not only identify that but to meet that need, which is pretty ambitious, but I think that ought to be our aspiration or vision for a better community, a better society. I mean health is a core value that we all should be promoting, and to have that recognition or identification that we're going to

try to do the best we can on those issues that have the biggest impact on that individual's health to make us really move up those rankings as far as -- because you're really talking about the quality here. So I think what that does too is, in order to kind of make that vision a reality, it requires the constant assessment of what are we doing, why are we doing it, what is the impact this is going to be, and each of us in our own disciplines and challenge ourselves to that and say, okay, how can we work together. But, we shouldn't compromise beyond that vision. We ought to think about how can we do that with respect to individuals with regard to health. I mean, that's the lynchpin for strong families, strong community.

MS. HOLDERBY-FOX: If I could just add to that. Can you folks hear me? Part of it, I think, is redesigning what our healthcare teams look like, and it would be great, in my opinion, to always have somebody with a legal background as part of that healthcare team. CHWs, part of that healthcare team. So you've got not only a mental health person directly a part of that healthcare team. As we're talking about looking at folks holistically and we're making sure they have what they need, we need the expertise that everybody brings, and we need it kind of in a central place. So that not necessarily every time I'm going to say, oh, wait a minute and let me see if I can get Gary on the phone. Gary is part of our team right from the get-go.

MR. DENNIS FREEMAN: I think from my perspective, you know, today we cancelled a meeting. We have thirty-eight outreach workers in our organization, and they had been kind of traditional community mental health case managers, and we changed the job title to community health worker.

So today, we cancelled it, but we're going to bring them all in, and I'm going to use some of your material for sure. That sounds great. We have a weekly treatment team

meeting, and we do bring everybody together, and we do have these outreach workers but we don't have legal. So it would be really cool to have an attorney as part of these treatment team meetings where the staff get together and they talk about folks that are troubling to them. Difficult folks that are not moving well in terms of their care, and many of the issues are, of course, social determinants and those sorts of things.

MR. HOUSEPIAN: I'm not going to be Pollyanna about this, okay, the fact is, it does require a shift in a culture. I mean it requires the buy-in of people. Like most things, it almost has to get personal before people really believe in something to see that it's going to work. Because all the other incentives are, although there are changes a coming, and there are going to be significant changes in the healthcare delivery system, there's still a lot of incentives that just are not there for this. And I speak not to just the healthcare industry but I think the legal services network has to think about doing things more radically innovative to do that. But it's going to take steps, incremental steps, not only within our own systems, but as we merge together, to think about how better we can make someone whole.

MS. HOLDERBY-FOX: And I think the other piece is that we're having this conversation. Because the way we were doing things was not working, otherwise we wouldn't need the ACA, we wouldn't need our cost containment, it wasn't working. So I think that the fact that we're even having these conversations, and who would have thought that you would have invited a community health worker to come to your symposium. In fact, when I got the invitation, I thought, this doesn't seem to make any sense to me, and then the more I thought about it, of course it makes sense. And you all were already thinking outside the box.

MR. MICHAEL DAVIS: At this point, we would like to

open our floor up to our audience to ask any questions.

UNIDENTIFIED SPEAKER: I gather today a lot we've talked about is providing ways to treat the poor and the chronically ill, although I'm sure not all of the categories are by individual choice, I suspect that individual choice has a lot to do with both those categories. Mr. Freeman, I believe, was the one that showed the cartoon of the individual that said, "Can I continue to not exercise?" You know, I think this nation was built on individual responsibility, and I suspect that probably had a lot to do with why the Governor's new insurance package didn't pass, because it's not socializing medicine. As one speaker said, we've had socialized medicine for a long time, it's free medicine. So there is a difference, I think. And so my question is this: Where is individual responsibility, not just to pay for this, but also to maintain better health? I mean isn't that in here somewhere? Don't we have to make people accountable? Don't we have to let them suffer to some extent? I hate to make that point, but you know, if everybody is on the wagon, who is going to pull it? I think Fred Thompson used to use that a lot. And I think that's the push back. Thank you.

MS. HOLDERBY-FOX: So one of the things that I didn't say earlier is that part of the philosophy that community health workers have is around self-determination. We hope to give folks the tools so that we put ourselves out of work. And you're right, folks have to make some decisions, but you need to have the information to make appropriate decisions, and you may need a little extra support to follow through with that correct decision that you would like to make to improve health. So I think a lot of times it's giving folks an extra nudge or letting them know they're not alone. But I can tell you from personal experience that folks don't want handouts. They don't want it. And so I think to think about this as what we're doing for those folks may not

necessarily be the correct way to think about it, but think about what do those folks need to be successful. Now, whether that's in health or getting them help to go back to school or folks coming back into the community after being incarcerated. I think that sometimes just a nudge, or to let them know that they're not doing it alone. Am I saying that we should do everything for folks? No. But I think that the playing field is not level for lots of reasons when we talk about social determinants of health. And I think that some of the strategies that we're talking about, we hope anyhow, will help to begin to level that playing field.

MR. DENNIS FREEMAN: Yes, I agree personal responsibility is key. I mean our tag line is together in managing health, and we really think that the patient has to be at the core of that, they have to accept responsibility. You know, everybody should pay something for their care, and we think these are all principles that govern the way that we operate. But we don't all start from the same place, and we really have to reach down and help some people initially until they can accept the responsibility. So you can't treat everybody the same.

MR. HOUSEPIAN: Yes, I can't agree more with both Dennis and Renee. I think too often there have been poor programs in the past with maybe not such good outcomes. But as my mom says, "What are you going to do about it?" Ninety-two years old and she's still telling me, "What are you going to do about it?" And what you do about it is to try something different, you try something new, you don't exclude people because of some people didn't do so well on the program designed before or people didn't do a very good job of giving the opportunities. I personally have found that some of the most courageous, strongest people that I have met in my life are my clients that have come battling some adversities, the tough hand they've been dealt, things just turned on them very quickly and it ended

up becoming a snowballing impact. I've met families trying to take care of individuals with intellectual disabilities that haven't asked for anything at all throughout their lives, but as behaviors increase, they need more help and more support so they can stay together as family. I think we need to continue to not give up with the idea that at certain times in certain people in their lives, and they've come back to me later and said, you really helped me during a tough time, that we don't exclude them because other people messed up. But we need to keep moving forward trying to find something that is a shared responsibility but also recognizes that sometimes we need to try to do something different and help people out with programs or supports to get through it.

MS. HOLDERBY-FOX: And I just want to add that, I mean, you never know what the seed that you planted today is going to grow tomorrow. I'm a by-product of a split family. I was a single parent raising two kids on welfare. You know, folks would say to me, this is all you're going to do, This is all you're going to do. So you just never know, and I just kind of say that to say don't write anybody off completely. And, yes, people need to take some ownership to be healthy, questions from and some self-responsibility, but people want people want to be good parents.

MR. MICHAEL DAVIS: Do we have any other questions from our audience?

UNIDENTIFIED SPEAKER: I have one. Listening to the three of you talk about more multi-disciplinary treatment, holistic, each of you represent a separate discipline that want to work more together. I was trying to picture in my mind, were you talking about the three disciplines you represent, the three of you together in a big hospital or in a small community clinic or public health department? Mr. Housepian, are you going to be relocating Legal Aid to the

public health department? I guess I'm trying to picture what it is you're saying. Are you going to have a little bus that goes around, or how are you going to do that?

MR. HOUSEPIAN: If I could go ahead and respond first. Again, it's recognizing and looking at resources. We cover twenty thousand square miles and eight offices and thirty-two lawyers. We can't be everywhere all the time. But what we can do is have ways, even through technology, but also through training and relationships to make sure that we have close nexus in connection with each other so that we know what they're seeing and they're clear about how we can help them with it. And it can be in any setting they could be at. We've had them in hospitals, we've had them in health centers. I would like to see that we be able to develop those partnerships with the mental health providers also. So the sky is the limit on how you do it. You have to recognize the efficiency. I can't have a lawyer sit at a clinic five days a week. They might be able to come over there a half a day a week for some trainings, and maybe de-briefing on eight or nine cases and have that face-to-face so you're really kind of looking at what's going on with people here. Because there's no substitute for physically being there, but we do have a limitation of resources and supports to do that. And it's beyond just the medical field too. There are other networks, non-profits and whatever, that we should be networking with to make sure that we're meeting the needs of our community. But being responsive to your question, I think it could be anywhere, but you also have to recognize the limitation of resources, because I've got lawyers that need to be in court and everything else. But I think there are ways to do it; phone calls, video conferencing, different things. There's telemedicine that's going on, we can do it with tele-lawyering. So the sky is the limit with it.

MS. HOLDERBY-FOX: And I would just add to that, I

think part of the challenge for all of us, and I think we're all up to the challenge, is thinking outside of the box. We know that we want to shift the way teams look. And how can we do that in an effective way that's effective for the Legal Aid organization that you're working with, that's effective for the health center, that's effective for the CHWs? On the other hand, I would love to see in a perfect world that literally in the health center, for example. There's a team that has a doc, a nurse, PAs, CHW, a lawyer. You know, you're not going to make the money that you might make somewhere else other than a health center maybe. But just that idea is just very exciting to me. But I think we've got to be creative and work with what we have and do things that are efficient.

MR. DENNIS FREEMAN: We're a community-based provider in primary care and behavioral health. We saw sixty-four thousand two hundred and eighty-nine different patients last year. It's a pretty large operation. Seventy primary care providers. We have already thirty-eight outreach workers. For an operation our size, I could see employing a lawyer part-time, contracting some way. We use a lot of tele-health already. So it would be very easy to teleconference a lawyer into our treatment team meetings. So I think most of the pieces are already there.

MR. HOUSEPIAN: Another example is, some of these things -- there's different models. I mean I don't want to -- there are some really fully integrated medical/legal partnerships, other ones that are referral networks. An example of a very informal but effective one is our Oak Ridge office. Theresa-Vay Smith is here. She works with the Emory Valley and works with a provider regarding individuals' intellectual disabilities. When their services are being reduced or they need more services, they know to call and have a family connect with Theresa-Vay that she's going to be able to help them to be able to detail what the

needs are of that individual so that their care plan does meet their needs and that individual is going to be able to stay in that home, and that family is going to be able to care for them and provide the supports that they can along with it. But all that is a phone call away, but that's based upon years of experience with Theresa-Vay and our organization of being responsive and saying this is what we can help you with. We don't want things referred to us that might be a dead end, that is, we can't help you with those other miscellaneous things, but clearly defining what is that need that we can meet that's going to improve bad health.

MR. MICHAEL DAVIS: Thank you very much to our panelists today. We really appreciate your taking time out of your busy schedules to be here with us and the wealth of information that you presented. We would like for you also to have these gifts in appreciation of your time today. Mr. Freeman, Mr. Housepian, and Ms. Holderby-Fox. Please join me one more time in thanking them.

This brings us to our afternoon break. We have one more exciting panel scheduled this afternoon. Mr. Tarwater is going to be with us again. LifePoint Hospital's Vice President and Associate General Counsel, Scott Richardson, and General Counsel of the Tennessee Department of Health, Jane Young, which we hope to be teleconferencing in from Middle Tennessee today.

NEW HEALTHCARE LANDSCAPE

SCOTT RICHARDSON[10]
DWIGHT TARWATER[11]
JANE YOUNG[12]

MR. MICHAEL DAVIS: New Healthcare Landscape. We will focus on how current medical and legal professionals can work together to prepare themselves for a more integrated, collaborative healthcare industry. Today it's no small task to put oneself through the education required to be in positions that help people in the service professions. That task that awaits those people upon entering their field is no small one either. Difficult structures, regulations, political climates, public perceptions and entrenched social structures and rigidity and distance between otherwise related service fields all require careful navigation for today and tomorrow's healthcare providers, legal counsels, advocates and healthcare leaders.

With this in mind, it is evident that we all have a part to play in cooperating and collaborating to overcome these challenges. To address this further, we welcome the following panels: Scott Richardson, who is the Vice President and Associate General Counsel at LifePoint Hospital in Nashville, Tennessee. He oversees legal services for the company's central group hospitals. Scott has previously worked in the medical field at a nonprofit hospital in Kentucky, Highlands Regional, and also he works with LifePoint Hospital to support the company's

10 Vice-President and Associate General Counsel at LifePoint Hospitals, Nashville, Tennessee.
11 General Counsel to Governor Bill Haslam, former partner at Paine, Tarwater, and Bickers, LLP, Knoxville, Tennessee.
12 General Counsel, Tennessee Department of Health.

quality and medical staff covenants and initiatives, and prior to his current position, Scott was a partner with the Nashville firm of Bradley, Arant, Boult & Cummings.

Jane Young, who is held up in Nashville because of the weather, but with us today through the miracles of modern technology, is General Counsel for the Tennessee Department of Health. As General Counsel, she is responsible for oversight of all legal matters for the Department. This includes supervision of the staff of 38 employees and legal work for more than 30 boards and numerous state and public health programs. Her duties also involve serving as the Ethics and Compliance Officer for TDOH. Ms. Young has previously served as staff attorney for the Supreme Court and as Senior Counsel with the Tennessee Attorney General's office where she represented the State of Tennessee in state and federal courts, in criminal appeals, employment, prison civil rights and education. She has served as staff attorney with the United States Department of Health and Human Services and has also worked as an Administrative Law Judge with the Tennessee Board of Equalization. Ms. Young's community involvement has included work with the Volunteer Legal Aid of East Tennessee's pro bono program and as a volunteer member of the Foster Care Review Board, from which she received the Outstanding Service Award in 2010. She also has served as a member of the Ethics Review Committee of Life Care Center of Red Bank and is an elder in the Second Presbyterian Church in Chattanooga. Ms. Young received her Bachelor of Arts degree from Samford University, her law degree from the University of Tennessee.

Also joining us again is Dwight Tarwater, who for some of you may have missed his introduction earlier. He is currently serving as General Counsel to Governor Haslam in Nashville, because he had simply done everything there possibly was to do in Knoxville. We

again thank him for taking his time from his busy schedule to be with us today.

We will begin this panel discussion with a question to Ms. Young. Ms. Young, what are some of the ways that healthcare and health law professionals are currently cooperating or interacting to improve their respective fields and case outcomes and what could most improve this system?

MS. YOUNG: Thank you very much, Michael. I'm grateful to be here through the miracle of technology, and sorry that I wasn't willing to brave the weather, unlike my fellow panelists. The question was posed to us, which I think, as I thought about it, I think that it merges very nicely with a healthcare crisis that occurred that the Department of Health was at the epicenter of in 2012. At the Department of Health, our mission is to protect, promote and improve the health and prosperity of people in Tennessee, and we take that very seriously, of course, and we are less involved with healthcare as our commissioner, Dr. John Dreiser, likes to refer to it and more involved with health. One of the primary functions of the Department is the regulation of healthcare professionals and entities which Michael alluded to earlier, but a major function of the Department is the study and prevention of disease outbreak, whether it's a vector-borne disease, such as something that one might get through a mosquito bite or outbreaks that are related to food safety, such as salmonella or E. coli, or healthcare associated infections, such as those that patients in a hospital might develop. As you can imagine, there's a great deal of overlap between the legal functions, when we are doing these studies and performing these functions and the legal functions, and we sort of work hand in hand, and I thought that what might be interesting for everyone today was to sort of demonstrate this through something that occurred in 2012, and that's the Tennessee 2012 fungal meningitis outbreak that was discovered here

in Tennessee. I think those who were around the nation during that time should be aware of that. So I am going to first give a brief overview of that and then talk about a couple issues that involve and still involve collaboration and cooperation among healthcare and legal professionals such as those in my office here at the Tennessee Department of Health, Office of General Counsel. This is somewhat of a mystery story that I love, and so what I thought we would do is begin at the beginning, and I have placed on the screen the original e-mail that was sent on September 18, 2012.

A doctor, Dr. April Petit from Vanderbilt, sent an e-mail in the afternoon to Tim Jones, who is the state's epidemiologist, concerning a patient that she was treating who was diagnosed with a case of a rare form of meningitis, a form of fungal meningitis, which we later learned is the rarest form. The patient had been receiving lumbar epidural steroid injections for pain relief and she was concerned that the shots that the patient had received might be the cause of the infection. Dr. Jones thanked her, as you can see in the e-mail, for the note and shared it with Dr. Marion Kainer, who is the program director for Healthcare Associated Infections here at the Department. Within days, Dr. Kainer had discovered that there were more cases similar to the original case or the seminal case that was referred to her by Dr. Petit. Dr. Kainer worked feverishly, became the stuff of legends later on, and she slept in a cot in her office for days, but she learned of four cases in Tennessee. Soon she and colleagues had linked the Tennessee cases to steroid injections supplied by a Massachusetts compounding pharmacy. The pharmacy was the New England Compounding Center, which I'm sure you all have heard of, in Framingham, Massachusetts. When we first found out the name of the pharmacy, I was out of town at a parents' weekend at my daughter's college in North Carolina, and I learned from my colleague that it

was NECC in Framingham, and I thought, wow that's a pharmacy in Massachusetts and at least it's not a pharmacy in Tennessee. Quickly I learned, however, that this particular pharmacy was licensed in pretty much every state in the union, including Tennessee, and they were shipping products to Tennessee and into other states. Within eight days, Dr. Kainer and the CDC and others, FDA, had convinced NECC officials to recall the three lots that were associated with the infections. The particular steroid is methylprednisolone acetate or MPA. So that's pretty amazing; I understand from our epidemiologist, pretty quick work here. Subsequently, the investigation continued. As epidemiologists do, they had to determine who was exposed to these tainted medications. They determined that there were over a thousand patients exposed. They contacted these people. There was outreach to the patients by the Tennessee Department of Health, public health workers. More than 180 staff assisted in this outreach, consisting of more than 7,000 hours. I know that they tracked down one person who was on vacation and maybe was canoeing or something in another state. A hundred percent of these people were contacted and warned to seek care if symptoms appeared. There was laboratory testing, there was public messaging, and the investigation continued and the warning continued.

Essentially what this was was an unprecedented healthcare disaster with multiple states affected. And here is a map and you can see the light -- I hope you can make it out -- the light color is one to 11 cases, 12 to 40 cases in the medium color, and then the dark blue is equal to or over 41 cases. The hardest hit states were Tennessee with 153 cases of fungal meningitis, and Michigan had the most with 264, and I think the Michigan situation was the subject of a 60 Minutes investigation and show. This slide was done by the epidemiologist. What we have is a situation where the red line indicates -- the line on the left, I think that's the Y

axis, indicates the number of cases, and the X axis shows as this played out. And what we have is, as the cases go up, there's a dramatic downturn in late September to early October in the number of fatalities, which indicates determining the source of the infection quickly, and then doing warnings was just of utmost importance so that people could know that they were at risk and seek medical care, because as is true in most healthcare situations or most illnesses, early diagnosis is very important. And we see that in Tennessee. We had 153 cases. As they went up, the deaths went down, and unfortunately, we had 16 people who died in Tennessee as a result of receiving these injections that were tainted with MPA.

So this brings us to what went well and what did not, always something important from the Department of Health's standpoint. We have a room, the State Operations, State Health Operations Center, we call it the SHOC, where anytime there is a need to bring forces together for any purpose, and SHOC was activated, and multiple people were working in the SHOC trying to go through the medical records determining what caused this. There was a need for medical information from various clinics, various hospitals, patient records, and we needed them quickly so that the work could be done, and we needed to do it in the most efficient way possible. Certainly there was no problem really getting the records from the standpoint of HIPAA, because as you all well know, there is an exception for public health surveillance, and there is no need for patient consent for these records to be sent. Certainly we have a state statute that deals with our receiving those records as well. But the question becomes how quickly can we get them? Fortunately, in this case most of the hospitals that were involved, well, all of them were willing to allow our doctors to have electronic access to the medical records. However, when we looked at the state statute, the statute that allows us to have access is 68-1-104, it does not

talk about electronic access, and so as we looked on it, the doctors with whom we work, our state chief medical officer, Dr. Jones, and the state epidemiologist, Dr, Kainer, and others, determined that this needs to be qualified so that there would be no question in the future that that access be received by us having access to the servers. So stakeholders were talked with, legislation was drafted, which would amend a couple of statutes, and is currently in consultation with the governor's team, and Dwight has I'm sure mentioned how it goes forward from the Department without the governor's approval and indeed support.

And in this case, a bill has been drafted, bill 0098, which has been filed and is being worked through the legislature and hopefully will pass that will provide that the Commissioner of Health or his or her designee can obtain healthcare records by remote electronic access during a public health threat such as the fungal meningitis outbreak or perhaps such as something like Ebola or anything, so when time is of the essence, we can do it in the most efficient manner and our doctors can have access to it with where they are working and not have to physically go out and look at those records. The drafting of the legislation is done by our office, the understanding of the applicable federal law and regulations under HIPAA, the understanding of the state law, and yet we have to work with the medical professionals and scientists to understand what is to be done. The second issue that I wanted to talk about is the issue of compounding pharmacies. Prior to this outbreak, I had never heard of a compounding pharmacy. I later learned that compounding of medications has been done since the beginning of time. There's references to it in the Bible. But I was not familiar with it. Compounding pharmacies are those that specially make medications typically for special patients or for patients who need a special formulation that is not available on the market. And for years now the issue of who regulates to ensure the

safety of compounding medications has been unclear, to hear some tell it, and the question is, does the FDA, the Food and Drug Administration, regulate the safety of medications as they do clearly with respect to manufactured medications, or do State Boards of Pharmacy, which exist in every state, to regulate the practice of pharmacy, do they regulate the compounding of medications? It's a regulatory gray area.

Pharmacies, unfortunately, some bad actors, quite honestly, such as NECC, who we believe have tried to drive through that gray area and claim that they are exempt from FDA regulations because they are a pharmacy and so they should be licensed as the drugstore down the street, even though, as we found out in the NECC situation, they were essentially manufacturing medications that were used by hospitals and clinics, and they were buying these medications in a bulk fashion and then using them to treat their patients by injecting them. So there was a human cry about this. Ultimately there were hearings held before Congress, for example. Senator Lamar Alexander, who at that time was the senior minority member on the Senate Health, Education, Labor and Pensions Committee, conducted hearings. We had many people who came to testify, along with the FDA Commissioner Margaret Hamburg and others, our own Dr. Kainer, and you see her pictured there, testified before Congress, and Senator Alexander, I recalled him saying that someone needed to be held responsible, and we do have this area where it's kind of more than one person responsible, nobody is really responsible. Dr. Kainer was very familiar, even prior to this outbreak, with the danger posed by certain compounding medications, people with sterile medications, which is what we had in this case. Sterile is very dangerous, because it has potential to be very dangerous because obviously you're injecting it into a person's body, such as in this case, the epidural space of the spine.

There was action by Congress, and ultimately the Congress in November of 2013 passed, and the president signed, the Drug Quality and Security Act. A portion of that deals with the compounding of medications, attempts to remove the loophole and make It clear or clearer when the FDA will regulate compounding medications. Additionally, at the same time in Tennessee, the Board of Pharmacy was very concerned about the outbreak, obviously, and the issue of sterile compounding. There were rules for sterile compounding; however, stakeholders got together, went through those rules, and attorneys were involved in every step of the way in drafting the rules. New rules were adopted by the Board of Pharmacy, promulgated, which set forth -- for example, they adopted the United States Pharmacopeial Standards with regard to sterile compounding, and at the same time the Board of Pharmacy did an audit and review of all compounding pharmacies in the state and there was an uptick in inspections as well. This presentation is going more toward what we are doing in the future in terms of promoting and improving and protecting the health.

We also took some punitive action. Obviously NECC's license was surrendered. Barry Cadden, the pharmacist in charge, his license was revoked as well. And Tennessee, I'm proud to say, was the only state that assessed a civil penalty, which became quite complicated due to the bankruptcy proceedings and so forth, but ultimately the Board of Pharmacy assessed a five million dollar penalty against Cadden and NECC. What the results of all this are, at least now we have -- the guidance is still being developed even as we speak, but we have a continuum where we can see who is in charge of regulating these entities. On the left-hand side, obviously, traditional manufactured drugs will be regulated by the FDA. Drugs compounded in what is called an outsourcing facility would be regulated by the FDA. High-risk drugs that are not

compounded pursuant to a patient's specific prescription or somewhere in the middle, but they are done in massive amount, FDA will take jurisdiction. Drugs compounded, which are copies of commercially-available products, are also a little bit in the middle. And then drugs compounded for individuals in small quantities pursuant to a prescription, for example, a child, those will continue to be regulated by State Boards of Pharmacy. So what we have is lawyers and doctors and scientists and pharmacists working together to protect health. Thank you.

MR. DAVIS: Thank you very much, Ms. Young. Next we go to Mr. Scott Richardson. He's also joining us today from Middle Tennessee, and we thank him for making the trek through the ice and snow. To start off, we would like to ask, what have traditionally been the barriers to the legal and healthcare fields collaboration?

MR. RICHARDSON: Well, of course, this is my opinion, probably an oversimplification, but I see it as the legal professionals being a little more conservative. It's easy for us to say, as practitioners, no. We have a hundred reasons not to do something. We are very analytical, and we find the faults and we expose those to our clients, and I used to do that in private practice. I find myself, after going in-house being on the other side of that and being pulled more into saying yes, that we can do something and here's maybe how we can do it. I think the healthcare profession has to move forward. They are used to making decisions. They are used to making mistakes and dealing with those. So that slight difference in perspective, coming from more conservative than more moving forward, I think is where the two professionals sometimes differ. What I have chosen to talk about today, this collaboration for quality, I think highlights that. I hope it does.

I am in-house with LifePoint Hospitals. I am assigned to our Quality Department. That is new for me. I

came out of a hospital business development side of hospitals back before I went to law school. So I was used to how they were structured and how they moved, but I did find myself on those conversations saying no, we shouldn't report the individual, it's too risky, we don't have an obligation to do it, let's stick to what we are obligated to do. Now I find myself on the other side saying I know it's risky, but we want to do it, we think it's the right thing. So how can we do that in the safest way possible?

Patients' safety is an area that I have seen most changed since I have been in healthcare. It progresses normally as things do, but in the last four or five years, I've seen sort of a very ramped-up focus on patient safety, and it comes from a lot of different perspectives. First is the obvious. We are all concerned about patient safety. We are all going to be patients possibly or our loved ones or our familys are going to be patients.

There is also the sanction side of it. Medicare has the never events, those things that happen in a hospital or a nursing home that are never supposed to happen and will never be paid by Medicare. There are also reimbursement effects from readmissions. Currently, I think you can have a three-percent decrease in Medicare reimbursement for an excessively high readmission rate this year. Other economics, I mean, it hits the news when there's a bad patient care event. Their score card, government score cards, that are out there for everyone to see, so there is a lot of areas why and reasons why patient safety is important.

I am going to talk about three things today. I am going to talk about what we call the culture of safety, which is I think sort of a primitive way of looking at patient safety in the hospital setting and how attorneys interact in that. I also want to talk about two programs that build off of that.

One is the Hospital Engagement Networks, which is a CMS program, but is actually just a collaboration of hospitals that come together to look at certain aspects of

patient safety. There are a couple in Tennessee we will talk about. Also, there are the Patient Safety Organizations, which were created back in 2005. Those have been around since 2005, but are really just poised to take off, and we will talk a little more about that.

For the foundation of culture of safety, I would go back to a publication from the Institute of Medicine in 2001. It was called, "The Err is Human," and it has been extremely important in the patient safety area. This was the publication that thought that maybe 98,000 deaths per year were caused by inadvertent medical errors. It is not really a bad apple model. It is not you find the bad doctors, you get rid of the bad doctors, and you are going to fix this problem. This is a structural problem. They looked at it as being harms caused by the way that our hospitals and our healthcare system was put together. So we have to look at that, sort of building off of that was some work done by David Marx.

He is an attorney, but not acting as an attorney. He was acting more as a consultant and a commentator. His focus was on a just culture, justice as injustice, and also played off of the culture of safety. He talked about shared accountability of hospitals and individuals, accountable for the systems they have designed and supporting safe choices of patients, visitors and staff. He is still working in the field. I think he has expanded a bit into aeronautics as well, but really his emphasis is on engineering safe outcomes.

Now, what patient safety and the announcements of patient safety used to look like in hospitals was primarily a root cause analysis. This was a Joint Commission requirement from several years ago. It is an excellent tool and is still used. I was looking at some root cause analysis data last week.

If there is a problem, an adverse event, let's say someone dies of an overdose in a hospital, you would bring everyone together that had any stake in that to look at what

went wrong, figure it out and change the system. Well, the culture of safety and what we're seeing now in hospitals are taking that and really expanding it. It is very much a contact sport. You are going to see things in hospitals now, such as learning boards. These are boards that may be behind a nurse's station where the nurses will write down patient safety concerns they have, maybe a near miss, things they want to look at. There are briefings, debriefings, and huddles. There are numerous meetings that go on. Face-to-face interactions when there is a shift change and nurses talk about what went wrong, what is going on, and what to watch with the patients.

Before surgery, there is also a huddle. Everyone on the surgical team gets together and they talk to each other. Now, remember, this is what we are doing, this is who this patient is, and this is how it's going to go, so everyone is on the same page, and also bring in executive teams, patient safety rounds. Every morning they are out walking the floors, talking to staff and talking about safety issues. So how does that bring in the legal side of it?

Personnel policies in the new culture of safety era are a little bit in turmoil in that a lot of the ways that we handled personnel problems before really did not apply to how we want culture of safety to work out in our hospital. We do not look as much at there is a bad outcome. Therefore, you do not progressively go from your first warning, your written warning, and then you're terminated. Instead we look at what the cause of the accident might have been or the adverse event. We look at it in terms of, was it human error, was it just a mistake, a mishap, or something that was completely unintentional? If that is the case, then we will actually console the practitioner or the person that had the accident and we will look at the structure that allowed that accident to happen.

At risk behavior, on the other hand, is where someone may not fully comprehend the risk of the behavior

that they're doing or they disregard that risk, thinking that there's a better outcome for that. That is a coaching moment now. We will talk to the employee. They will look at what the incentives and disincentives are, positive and negative, that could be changed to prevent that behavior in the future and try to move forward. Certainl,y the old model fits with reckless behavior, which is a complete disregard of the risks or taking an unjustifiable risk, and that is usually punished the way we have traditionally punished.

What is important to note is, you have to develop a system and apply a system to your personnel policies that take into account the same error can be treated in three completely different ways. Medical staff policies have changed. When I first started working in hospitals and working with medical staffs, we had disruptive physicians. Those are physicians that threw things, that screamed at the nursing staff or screamed at other doctors, maybe brought a gun to work and put it in their locker every now. Those were the disruptive physicians. We had disruptive physician policy as part of our medical staff bylaws, but we do not have that anymore.

What we have is behavior that undermines a culture of safety, and that is a term that came from Joint Commission a few years ago, which we have adopted into our policies, and it was very difficult to make that switch for me. After awhile, however, I think it became apparent to why we are doing it. We are not talking about physicians as a whole bad physician, a disruptive physician labeled that way. Instead, we are talking about behavior that we hope to change. It is also very key in the culture of safety that the physician behavior be aligned with the hospital behavior. If we teach our employees that if someone is not washing their hands, you tell them to wash their hands. Well, if they tell Doctor Smith to wash his hands and he blows up on them in front of the patient or he

dresses them down at the nurse's station and humiliates them, the next time Doctor Smith does not wash his hands, that nurse is not going to say anything to him, and you start to erode that culture.

We started requiring more from our employees to speak up when they saw a problem. In order to try to solve the problem, the more we saw them sort of frustrated by the fact that we did not have policies in place and medical staff policies that would support that.

Retaliation is also an important part in our new behavior policies for our medical staff, making sure that they understand retaliating against someone that may have mentioned that they had misbehaved is unacceptable. As a result, every point of counsel, we make sure that it's mentioned, every written document that may go on during a disciplinary phase with the physician. It is also a very subtle policy. Therefore, throwing something is pretty overtly disruptive, but not answering calls, not participating in meetings, even rolling your eyes. Bad attitude actually is also something now we have to try to get our hands around, because it can be just as disruptive to this culture of safety as anything else.

Event management is sort of a shorthand way of talking about communicating errors to patients. A lot of hospitals have a policy to be up front with their patients when there is an error that happens. Sometimes those are very difficult discussions. Sometimes it is as easy as we ran the wrong lab, we need to take another blood sample. Our policy is that we will tell you that that is what happened. When you have physicians involved who are independent and may disagree on what the error was or how it happened, those can be very difficult questions. These situations usually involve the attorneys to work with them. I know one large system where the attorney actually goes with the doctor or the CEO into the patient room and breaks the news that there's been an error.

There is also Tennessee Evidence Rule 409.1 that is Expressions of Sympathy or Benevolence, and I cited here, you can look at it, I do not want to read it to you word for word, but essentially you are permitted to console or act of benevolence to someone that has been in an accident and it will be inadmissible as proof of liability in a civil action. An admission of fault in that period, however, will not be ruled to be inadmissible. That is still something that we struggle with.

When you take the step of saying yes, we made a mistake, there is a lot behind that. The first example of sort of taking this culture of safety and putting it to practice on a very large scale I think is Hospital Engagement Networks. This is something that CMS had been doing before. I am familiar with the program from fiscal year 2012. LifePoint was a part of that.

LifePoint had a Hospital Engagement Network. The Tennessee Hospital Association also had one of the twenty-six (26) Hospital Engagement Networks that were selected. These are multiple hospitals in our situation and fifty-eight (58) hospitals at the time were involved. The goals of the Hospital Engagement Network were to look at some very basic patient harms that have been around forever. These were almost to the point that people just expect that you are going to have things like adverse drug events, injuries from falls, pressure ulcers, and surgical site infections. It is almost as if, well, there's a certain acceptable rate of these.

The Hospital Engagement Networks looked at it from how can we bring these to zero or how can we start getting close to zero? They were actually very successful in that. We do not get to zero, but I jotted down some of the results.

The Tennessee Hospital Association's Hospital Engagement Network had a sixty-two percent (62%) decrease in their adverse drug events or the hospitals that

participated in their Hospital Engagement Network. The New Jersey Hospital Association had a sixty-five percent (65%) reduction. Premier, which is a very large hospital chain, has decreased falls resulting from fractures or dislocations by twenty-five percent (25%) over four hundred (400) hospitals. That is a lot of people that were positively affected by this program. I believe that I just heard that there is going to be another round of continuing research on these programs.

In working with the Hospital Engagement Networks, I was fortunate enough to work with ours almost from the start when we were selected. We had the problems that I mentioned before, such as personnel policies, medical staff bylaws. We looked at all of those issues, but when we started collaborating across hospitals, new problems emerged. There are a lot of HIPAA concerns. The constant interaction I was talking about at the hospital level with meetings and meetings, the same thing is happening among hospitals, so there are a lot of discussions. There is also a lot of forthright. This is a problem we are having and this is a very specific program sometimes. Therefore, we would often have to sort of scrub what we were talking about, and you can tell other hospitals were doing that as well. This was due to attorney-client privilege.

There was one of the Hospital Engagement Networks, not our Hospital Engagement Network, who wanted to do, either through telemedicine or some sort of teleconference like we are doing today, grand rounds and morbidity and mortality conferences for their doctors. A doctor would get up and say we had an unexpected death and this is everything that happened. Well, that is very scary for attorneys, and I am not sure that they ever got comfortable enough with it. It is that eagerness to share and to talk that came out of these collaborations, however, that I think we are going to continue to see and we will see in the

next point. That is the second example of collaboration I wanted to mention, which is the Patient Safety Organization.

Patient Safety Organizations are different from Hospital Engagement Networks. , Hospital Engagement Networks is a lot of people interacting at sort of where the care is provided, looking at where the problems are, how can we fix them and making sure that there's a lot of communication. Patient Safety Organizations are a good complement to that, however, because there is a lot of patient data that members of this Patient Safety Organizations on patient safety will pull together and dump into this central organization. That is Patient Safety Organization.

The Patient Safety Organization then takes that, analyzes it, so they can look across hospitals, they can look over time, and locate areas where improved care and safer patient care may be approachable. It is a federal act, signed by George W. Bush in 2005, but there were not regulations until 2009. Therefore, we are fairly young as far as these programs go.

There is also even a nudge in the Affordable Care Act. There is a requirement that hospitals with over fifty (50) hospital beds must have a patient safety evaluation system in place. Now the requirement is by January 2017. It had been January 2015. That got changed early last year. They just were not going to make the deadline. Further, the PSES is a function that feeds in a Patient Safety Organization. Therefore, essentially we are going to be mandating Patient Safety Organizations by 2017. Now, a little more on what they do.

They are an entity and sometimes they are sort of embedded within its own organization. Sometimes it is a separate entity. I will give you some examples of the best way to do it. A lot of hospital associations have their own Patient Safety Organizations, and they may focus on two or

three different types of information. All the hospitals that are a member of that Patient Safety Organization will then monthly upload a lot of data into that organization. There are also health systems that have PSOs.

If you have locations in a variety of states, it is particularly difficult to meet all the quality requirements for multiple states. Therefore, a federal-mandated Patient Safety Organization is often the easiest way to go. In Tennessee, TeamHealth locally has its own Patient Safety Organization, looking at physician data. HCA, Community Health, also has a Patient Safety Organization in Tennessee.

There is also something called PsychSave, which is a subsidiary or component of UHS out of Pennsylvania. Then, the Tennessee Hospital Association also has a PSO called Tennessee Center for Patient Safety. All the data that gets uploaded into this Patient Safety Organization is called Patient Safety Work Product. As you can see, it is extremely broad. Anytime a data reports information that has to do with patient safety, healthcare quality or healthcare outcome, those examples cover a broad range, anytime an investigation, behavior evaluations, patient safety audits, investigation. So there is a lot of different types of data.

Now, some Patient Safety Organizations are more specific about a certain type of event. Therefore, not everyone will take these. You will see this broad use probably more in your hospital systems. What is not PSWP, medical and billing records, of course, information collected for national practitioner data bank reports. That is where you report physicians that have been sanctioned. To the Risk Management Department you report your potential claims and any evidence of a crime.

Now, what is the strongest, I think the strongest nudge for hospitals and other entities to belong to a Patient Safety Organization, is this broad federal privilege. The

acronym is Privilege and Confidentiality Protection, information that's been disclosed to the PSO cannot be used in civil, criminal, or administrative proceedings even if that's a proceeding against a specific provider. It is not subject to the Freedom of Information Act and can't be used for an adverse employment action. So it's fairly broad protection.

There is also a confidentiality component. What you send into a PSO is considered confidential, and for someone that would leak that information, there are civil money penalties. That is actually implemented I think by OCR. Tennessee has its own Patient Safety and Quality Improvement Act from 2011. You can spend an entire hour on that alone. I will point out that it has a lot of the protections privilege wise for the information that's covered under the federal act, but it has something a little different. There is an immunity given to persons that provide, in good faith, information to that quality source, the GYC under the Act, and there is a presumption of good faith. That is a bonus that you don't get directly from a PSO. So Tennessee has been very forward in that.

What do they do for patient safety? If you go to PSO website, you will see information about best practices, so they have analyzed the data. They have seen what works where and they will disseminate that back to its member organizations. You will see quality alerts. When they're seeing a sudden spike in the type of activity, they can catch that on a weekly or monthly basis certainly. They'll recommend protocols and policies, look at who has got policies that are effective, and may have lower harm rates and try to disseminate that among the members. So there's a lot of benefits to being a part of that system.

Again, getting back to how do the healthcare professionals and attorneys interact at this point. PSOs are very much a legal structure. They are difficult to get in place. They're something that you have to be certified by

AHRQ. To get one up and going certainly requires some legal advice. I think it also requires some legal care and feeding.

What that means is, that the attorneys have an opportunity in the legal profession to work with hospitals to work with physicians who also can dump data into this PSO, to find out where they're looking for improvements and what is going to be important. I think it informs the legal professionals in general about what is going on.

Another reason why our court cases, and I won't go through these, and they are very small, but they are in your handouts. These are some court cases where the broad privilege of PSOs have been challenged. For the most part, there have been favorable results from there. They have upheld the privilege. There's one that I'll note to our north here. Kentucky had a case where its Court of Appeals had sort of broadly defined one of the exceptions to the privilege, which is when you're making a report to the state, and they held that if there was a state statute that said you had to collect information, that that was also excluded. They just denied rehearing on that in December.

I included in your materials just a quick bibliography. There's a lot of things here that may be new. I'll point out just a couple. Ridley Barron, if you have never heard of him or heard of his story, I heard him speak a few years ago. He had an extremely compelling and moving experience around the Admission of Error and how that's handled in the health system.

He had a terrible accident and his son was in the hospital and actually died from a drug overdose of something that didn't get prepared properly. He turned that into a positive experience within the clinical side of it, but he had a distinct problem with the attorneys and the administration for the hospital, which they eventually worked through, but I think it's a very important thing to look at, if you are interested in that area at all. I would also

point out here, hospital and health networks' websites in that first site. If you want to know more about this culture of safety, they actually have some videos on that site where they talk about culture of safety. They also talk about some of the work they're doing in specific areas. That's all I have.

MR. DAVIS: Thank you very much, Mr. Richardson. We will turn back to Mr. Tarwater. I would like to ask you, ask someone who is new to healthcare law, as you told us you were before, what are some of the things that you have seen that those in the healthcare field can do to help and educate those in the medical field and vice versa?

MR. TARWATER: I'm going to give you a short answer and then I'm going to circle back. The answer is, have an idea, have a plan.

So let me circle back to your keynote speaker, Mr. Pyles, and I understand that he made three major points. There should a principled approach to healthcare, principled approach. Of course, I'm sure that defining the principles is a question, but that's what we do as a citizenry and an electorate. Focus on patient needs. Seems so easy to say. I would simply ask why is it so hard to do?

He called for greater cooperation between medical and legal and governmental communities. So when I think about those three things, a principled approach to healthcare, patient needs, collaborative effort, it seems that Insure Tennessee was a perfect laboratory for that experiment. It was certainly a principled plan. It was a Tennessee specific alternative approach based on business principles, conservative principles, market-based promoted personal responsibility, addressed cost and payment reform. New principles, different principles offered to Tennesseans, offered to address patient needs, 280,000 patient needs, and it was a collaborative effort. If you remember from my slide, there were dozens and dozens of business groups,

professional groups, drug companies, hospital associations, medical associations, labor unions, and religious groups, all combined in this collaborative effort towards this principled plan to address patient needs.

TennCare, the Bureau of TennCare met with 350 stakeholders between March of 2013 and December of 2014 to discuss this plan and to gain support. Obviously, it was a collaborative effort between state and federal government. So then what happened? What happened in this principled approach to healthcare which addressed patient needs and was an amazing collaborative effort among so many? I think that's a question that we all should ask ourselves as it relates not to Insure Tennessee, but to healthcare generally as we go forward. Where do we go and how do we get there?

I would suggest, back to my short answer, have an idea, have a plan. It's okay to disagree and it's okay to agree, principally, collegially, respectfully, but then for those that disagree, what is your plan? What is your plan to address healthcare for the 280,000 uninsured in Tennessee? What's your 22 plan? So I would suggest that this is a great dialogue to have and great communication to have and that there may be someone in this room that will go forth and have a plan and have an idea. I sure hope so, because I do think that the three cornerstones of this conference, principle plans for healthcare, patient needs and collaborative efforts, are certainly the way to go.

MR. DAVIS: So at this time we would like to just open the panel back up to our panelists to discuss anything about the issues that you have heard throughout the day or within this panel, to have that conversation of experts in keeping with a true symposium.

Feel free to pose any questions amongst yourselves and discuss anything that you think would be best for Tennessee or the nation in moving forward with healthcare

in that collaborative and cooperative spirit between the healthcare fields and the legal field.

MR. RICHARDSON: I have something. I was just interested in how our experience with NECC, how has that informed or maybe changed how we approach things like Ebola as far as preparedness? Are there any similarities or distinctions there?

MS. YOUNG: I think that the thing that I learned, there is an amazing group of professionals who are prepared to activate at anytime. We have the infrastructure in place to deal with this, but we are learning.

The thing that's important is, for example, in the planning for Ebola, lots of planning went into effect that didn't have to be, fortunately, implemented, and it involved things like THA hospitals and so forth. So NECC is a little different in the sense that it's a healthcare-acquired infection or it was caused by a product, if you will, as opposed to something that occurs, such as a disease, contagious disease. So we do have the infrastructure in place. It can be implemented at anytime, and the speed with which this can be done, it's just amazing really.

UNIDENTIFIED SPEAKER: I was wondering how much physician input you got, or do you know? I think you got there later on in the process, but was there much physician input?

MR. TARWATER: Into Insure Tennessee?

UNIDENTIFIED SPEAKER: Yes.

MR. TARWATER: A tremendous amount. Certainly not universal agreement, but the TMA was signed on and all of the major hospitals were signed on. Some powerful testimony, including unsolicited testimony from an

emergency room physician in Jackson, Tennessee. So lots of physician input, and, of course, certainly not universal agreement, but mostly favorable, mostly positive, yes. Good question, though. Thank you.

UNIDENTIFIED SPEAKER: Did the people who shot it down, did they actually have a plan in the works, or did they just say we're not doing that?

MR. TARWATER: I wouldn't purport to speak for them. There have been some bills introduced. I'm not sure any of them would adequately cover. Well, you saw one bill to end Medicaid. So that was probably not focused on patient needs. No, I haven't seen much.

UNIDENTIFIED SPEAKER: If we had a producer from Fox News in here today and also one from MSNBC, the Fox person would go away hearing that all the insurance companies are going to go out of business, right, and they'd scare everyone to death that likes insurance companies. The MSNBC person would report that we're all going to die if we don't support every aspect of the current plan. Then we come along, we have a system promoted by Governor of Tennessee who is anything but a liberal, right? He's a very conservator governor. But it was killed in committee. So it makes you wonder, how do we move this thing forward, right, if we can't, if someone like Bill Haslam can't get something to pass committee, what are we going to do nationally? I know I'm probably not asking a question you can answer. It just strikes me that we have got a hard path forward here.

MR. TARWATER: Maybe Jim should take that one. He's in the back of the room smiling.

MR. PYLES: I appreciate your comments. I was just thinking about if you were going to make another run at it,

what you might think about doing. Timing is everything, so I would think that when the Supreme Court comes down with their decision, whatever it is, it's going to present an opportunity for you to spring again, but you're going to really need to get -- you're going to need to have all your ducks in a row to do it, because if they strike down the subsidies, Tennessee is in chaos, so many of the hospitals here won't survive, because you're cutting Medicare by 270 billion over ten years, with the thinking that the hospitals would have many more insured people, they won't have many more insured people. So they're going to still have the cuts and nothing to replace it with. So that will knock out a lot of the hospitals in Tennessee.

You're going to have 192 percent increase in premiums here, which will probably be a death spiral to the insurance companies, probably cause many of the insurers to pull out. The chaos in Washington is going to be nothing compared to what it is here. If they uphold it, if they say that the subsidies are authorized, then you also have an opportunity, because then you can say Tennessee residents have an opportunity to those subsidies, but I was thinking as far as the principled approach we talked about.

One of the things I typically do is, when I'm against someone who's not agreeing with me, is, I try to make sure I take a more principled approach than they are taking. What most people really are fired up by is autonomy, individual autonomy. They don't want to be told what to do. So I think you can make a pretty good argument that health insurance is a liberating benefit, because it allows you to do lots of things you couldn't otherwise do, you and your family. It creates opportunity, which I think might be a good argument against those who say, well, you are giving up some autonomy by having to purchase healthcare and -- I don't know what TennCare -- your plan actually did, but I would suggest if you do it again, the timing to do it would be after the Supreme Court decision comes down

and sort of have a plan that -- you could go either way. Either way the Supreme Court goes, you could take another run at it.

Tennessee is a wonderful state in that you have everything the country is considering all coming to a head here. You have got the same sex marriage case pending in the Supreme Court and you have Tennessee plaintiffs in that. So Tennessee is a real --it's a microcosm, the whole country, and I'm sure sometimes you would like to -- you would prefer maybe a little less excitement, but you have an opportunity here to do some really good things here too. So I think you're going to have another shot at it, and I do think your three principles you identified there are a good way to go at it, and you have got some powerful allies. You could script them with some of these ideals. You might get it done.

MR. TARWATER: Sounds like I have some job security.

MS. YOUNG: You talked about a culture of safety in the hospital environment. With respect to healthcare health, we talk about a culture of health, and Dr. Dreiser talks about the big three plus one that drive our health outcome. If you keep Tennessee in the bottom ranking in terms of overall health -- that's our obesity, lack of exercise, lack of movement, smoking, and then the plus one is drug abuse, prescription drug abuse, particularly opioids, and we get questioned often, when we're making budget presentations, about how can we change the culture to one where that is the choice that people make. I think we have the Governor's Health Foundation of Mr. Johnson and Healthier Tennessee Initiative, and do we see those same sorts of initiatives in industry and in hospitals? I guess this goes to both of you.

MR. RICHARDSON: I don't know if I'm answering exactly the question, but in talking about developing that culture at the hospital, you know, certain hospitals may

have that great person that drives their safety, and that may work here and there, but when that person goes, you lose it. I think the experience that we have seen is that it is sort of an all-hands-on-deck focus from the absolute top down, and the Hospital Engagement Network was that focus. There were incentives in the right place. There was support from the top management down. But it is a daily grind, and I think as people got used to doing root cause analysis. So now it's sort of second nature when something happens, people seem to spontaneously get in a group and start analyzing it. I think the just culture or culture of safety initiatives just have to be repeated for maybe several years before it becomes just ingrained that this is how healthcare is done. This is the only way to do it and this is how we're going to do it.

MR. TARWATER: Jane, I think a lot of the larger employers do have healthy incentive programs. Perhaps the smaller ones not so much. And those of us in government, that is something that we believe in, a healthier worker. But when you were asking your question, it brought something to mind that came up during our discussions about the pharmacy benefit. Jane, isn't it true that -- and maybe you have more of a feel for this -- but Tennesseans are pretty high on the list for prescription medicines. Am I right about that?

MS. YOUNG: Absolutely. If not, we may be the number one state. I don't have the numbers at my fingertips, but, yes, we are –

UNIDENTIFIED SPEAKER: I think at one point it was like 13 prescriptions per person.

MS. YOUNG: It depends on what type of prescription medicine are we talking about, but particularly what we focus on a lot, obviously, the plus one is the opioid abuse,

which is multifaceted. I mean, we have issues, I mean, culture issues, law enforcement issues, regulatory issues. It's just all over the place. So yes.

MR. TARWATER: But I would think that more prescription drugs per capita per person doesn't necessarily mean better health. Is there a correlation on that, does anybody know?

UNIDENTIFIED SPEAKER: I think it's the opposite. If you are in good health, you won't be on drugs.

MS. YOUNG: I think that it does. I mean, I think the fact is that we are high in prescription use per capita and we are one of the least healthy nations by the various national health standards and the national health rankings and so forth. So clearly there is no correlation between that.

If anything, it's a negative correlation, I suppose, and I'm speculating now, but I suppose with respect to things like prescription medications and lower cholesterol and things like that, I mean, that perhaps is indicative of obviously a poor diet and other things, not always.

Then with respect to opioid abuse, it's indicative of an addiction and a dependency issue that is present. For example, we are the first state we know in the U.S. to track neonatal abstinence syndrome at birth as a matter of public health. Neonatal abstinence syndrome is the birth of a child who is born from a mother who has used opioid medications and the baby is dependent upon those medications. We are the first state to make that a reportable disease, and we have people that are working on that. So that's an indicator of where we are with regard to prescription drug abuse an use or opioid use and abuse. I mean, the primary prevention, as Dr. Dreiser likes to call it, beestings are the things that promote health and they are what drive our rankings more. So I think then he would even say than access to care. It is extremely important.

UNIDENTIFIED SPEAKER: We set priorities in our state and in our country right now and it's laudable and I support it, but we are trying to get more computers in our school system. That's wonderful, but we have removed some of the basic things that will promote health, which is PE classes that were mandatory when I was growing up, and it's nice to have children who know how to work with a computer, but if that is all they do, they are going to be obese. So there's just little bitty things that we can do like that to get our heads thinking in a different way than we thought of the last ten years or so.

I don't hear anybody talking about physical education other than just as a word that they toss off. We have got great team sports in all of our schools, but that is just the elite. That's not the mass of the bodies. How much is that going to cost? I don't know, but I think those sorts of things need to be talked about, not just -- we know that we have got prescriptions.

Writing prescriptions is all we have done that I can think of that has -- we are spending our money doing that, and it's just not healing anything. I have been kind on the sideline of a task force in Knoxville talking about the incidents of children born drug dependent. A whole spectrum of the health system and legal system has been looking at this for, I don't know, about a year or so now. Putting together a program so that when these mothers hit the system, that rather than the state going, okay, it's time to take that baby born drug dependent, and that's what we have been doing for years and years now. The state has not been raising good kids, we know that.

So there's the thought that, well, is there something we can do to keep some of these children, at least even one out of a hundred at this point, because we don't have the ability to keep absorbing drug-addicted babies into our system. It's breaking our system. I say this by saying that

that's a very important process that this county is going through right now, and those sorts of thoughts, those sorts of collaborations we're talking about today, that's being done I think on the local level in some position. I don't know what's being done about getting our children out in front of the television and out in front of computers and getting them back outside again so that they can be physically healthy. I don't know that that's being done. Can you speak about that?

MR. DAVIS: That can of course be directed at nearly any Tennessean I think in this room, but if any of our panelists can comment to that, we would love to hear that, and we have got a little bit of time for some comment and maybe one more question after that.

UNIDENTIFIED SPEAKER: There is a lot of local initiatives trying to get kids more active, so I know that people are trying to do things, like the Knoxville Area Coalition on Childhood Obesity is doing a lot in this area. Quite a few things in the Knox County Health Department and also the Rural Regional Health Department. But I just wanted to make a comment because the question keeps coming up, well, what do we do? I think it's important to remember, well, two things.

One, we need to go back to what the evidence says, because when we are pushing policies through -- and I'm sure everyone in this room knows this -- that we have to make sure, like with ACA and the menu labeling. There's no evidence that menu labeling makes people make healthier decisions, at least not the people who need to make healthier decisions, but just keeping that in mind.

I think that the second thing, which is in my opinion far more important, is, ask the people who we are trying to help what do they want, because maybe they don't want access to care and maybe that's why they have told the senators we actually just want a park or a safe place for our

kids to play. I think it's important as Tennesseans just to remember to go back to Tennesseans as the most important stakeholder, not an afterthought and not someone that we just bring into the discussion, but we don't have that trusting relationship for them to really feel like they can tell us things like that.

So as practitioners, I think it's important to remember we need to create those relationships within the community to where they feel like they can trust us and tell us what they really want, because if we don't give them what they really want, then there's not going to be trust there. Maybe if you do put a water fountain in the park, then in the future you can maybe talk more about some other things that might increase their overall health and well-being, like prescription drugs, like we need to talk to the drug-addicted mothers what would make you – what do you want, how can we help you, because we know the incentives we're giving are not working.

So I think it's an interesting time in health policy where we have an opportunity where things that we're doing we know are not working and the evidence shows that, so what can we do to make changes and how can we start to think outside the box and think differently? You know, our employees aren't using the incentive programs. Why not? What are we going to do about that? That type of thing. So the incentives are there, but they're not working. Then I have one question about the disease control database, how the state can act in a public health crisis, for Jane. Would that apply to chronic diseases in the statute?

MS. YOUNG: What is the question again?

UNIDENTIFIED SPEAKER: Would the potential statute, could that apply to chronic diseases since it says the state of public health crisis?

MS. YOUNG: No. We are talking about access to records in a public health emergency situation, an outbreak of disease, trying to get to the source of it, which we already have the ability to review those records. We are just trying to get them electronically the same way. So in terms of reporting other type of diseases, there are other statutes that are involved with the reporting of diseases, but the electronic is not geared toward that, the potential statute.

MR. DAVIS: Thanks for your question. Do we have any other brief comments or questions from the audience? We would definitely like to thank our panelists here today, Dwight Tarwater, Scott Richardson, and Jane Young. Please join me in giving them a round of applause.

For those of you all that may have missed that earlier, we have these lovely commemorative stamps that we had made for this occasion that we're giving to all our speakers today, and we would like to give these to you all here. Jane, we have one of these for you as well, which presents us with the hilarious situation of having to mail you a postage stamp.

Right now I would like to take a few minutes to thank a lot of people that have helped put this entire symposium together. Thank you so much, of course, to our panelists. We really appreciate all the effort that you have put into coming out today and imparting your knowledge with us. That is going to make such an impact on our region and our state.

Also I like to take this time to recognize some people here at U.T. who were integral in putting this symposium together, which has been months in the making, and because of their efforts, it has been a great success. Please stand and be recognized if you are here.

We would like to sincerely thank our student volunteers who have helped throughout the day, especially the symposium committee, Cassie Kamp, Laura Vaught, Steffen Pelletier, Will Lay, and Karen Anderson. We

would also like to thank all the *Tennessee Journal of Law and Policy* Members and Board, the TJLP Editor in Chief, Jason Collver, Micki Fox with the *Tennessee Law Review*, and Dean Carol Parker, Dean Doug Blaze, and especially Jenny Lackey in the Center for Advocacy for all of her help with arranging all of our materials and being in contact with so many of our panelists so well. Also most especially, Penny White, who was not here today, but without her encouragement and efforts, all this would not have been possible. A sincere thank you to everyone who helped with this and a job very well done. Jason, I believe you have some comments.

MR. COLLVER: My name is Jason Collver. I'm the Editor in Chief of the Tennessee Journal of Law and Policy. Thank you everyone for coming today. Thanks for coming to speak. This was a great symposium on a very important subject for our community and for our state. Now, Michael listed off a plethora of people who have been a great help to this symposium, but one person that has not been thanked is Michael himself. This symposium would not have happened if it was not for Michael. He has been working on this for over nine months at this point, and he has done a lot of work. There is no way that we could have pulled this off without him. He has extensive knowledge in this area, and we just want to say thank you, and as a little token of our gratitude. Thank you.

MR. DAVIS: Thank you, Jason. This really has been something that's of great interest to me. I worked for nearly ten years in the mental health case management area and in social work, so having everyone come together today and talk about these sorts of things that are important to the state that I grew up in and the region that I grew up in is really not like work to me. This has been really more of, to use a cliché, a labor of love. I really have loved putting this together.

I would like to just close with some very brief remarks. I would like to thank, of course, our panelists that have been here today. Just to thank everyone, all of our panelists, we had Lisa Renee Holderby-Fox, Dennis Freeman, Gary Housepian, Gordon Bonnyman and our keynote speaker, Jim Pyles. Let's give them a round of applause. We hope this has been a rewarding and thought-provoking day for you.

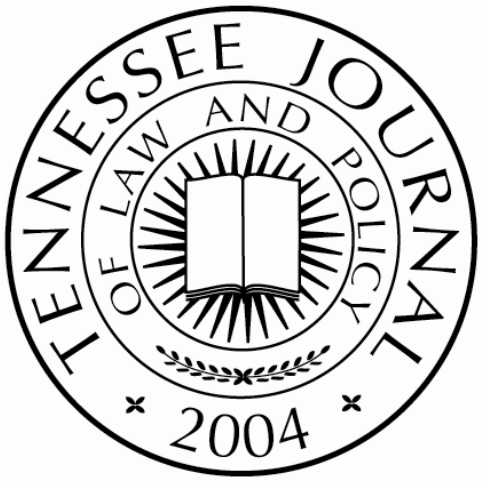
If we have recognized anything today, it's that we have true challenges ahead of us in how we continue to design our healthcare system. Success is vital not because of our careers, our political parties or our ideologies benefit from it, but because in the end we are all recipients of healthcare.

As we heard earlier today, we have tremendous division on how best to reform our healthcare system. We have groups that seem diametrically opposed to one another in answering the questions of who will pay the costs if we provide more healthcare? What will we do to meet those demands? Perhaps most importantly, who will pay the costs if we do not?

What is also incredibly important is to realize that these groups are all made up of individuals, and we are those individuals. With so many theoretical and practical challenges that await us, it is little wonder that healthcare and its law and policy will require some of the best efforts from our brightest individuals. So if we want effective change, we must be open as individuals to new ideas and facts so that we learn what really can be effective. This will require not only the collaborative efforts and attitudes that we have discussed today, but also the courage to break from old thinking that has proven not to work. Even discovering this proof, the evidence on which we will base our next healthcare decisions will take a lot of courage.

Due to the enormous challenges we face in keeping an efficient and affordable healthcare system that keeps the

patient and their right at its center. It will take courage to form the new teams and the collaborations that will maintain and improve public health and respond to emerging issues and health crises. Most of all, to bring us full circle to where we started out today. It will require core principles that will keep us focused on why we are doing this so that we and future generations of this country can enjoy our liberties on equal footing of good health. We hope you have enjoyed the symposium and that you can put what you have learned here to good use in your work. This concludes our symposium. Thank you for being here and safe travels.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