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INDUSTRIES PERSPECTIVES ON HEALTHCARE: DELIVERY IN AN UNCERTAIN POLICY FUTURE

PANELISTS:

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MICHAEL REGIER, VANDERBILT UNIVERSITY MEDICAL CENTER

*Moderated by Professor Debbie Farringer, Belmont University
College of Law*

JANUARY 27, 2017

Professor Farringer: Thanks to everyone for coming. Thanks to Aubrey Beckham and Taylor Wilkins and Grace Ann for putting all of this together and for all their hard work. And for the whole team that came together pretty quickly. Actually, you know we just formed the journal and had all the student involvement at the very beginning of this first semester of the year. So to throw all this together and pull it all out has been amazing, so thanks so much to the students.

I am really excited to be able to introduce our panelists here for Industry Perspectives. And, its been really funny in trying to craft questions to think through what to ask these folks. It seems like it changes day to day with everything that is happening because it is such a moving target right now, in terms of where things are going and what we can expect. So a lot of what we are going to talk about today probably is just “what are some of the various things that have been thrown out there that might be changing the landscape of healthcare and what can practitioners think about?” “What do we need to consider?” And hopefully can just have some good conversation about various policy proposals and pieces and parts of health care reform.

So I am going to introduce our panelists. First, to my right here, is Michael Regier. He is general counsel and secretary for Vanderbilt University Medical Center in Nashville, Tennessee. He received his bachelor’s degree in business administration with highest distinction from the University of Kansas and his Juris Doctorate from the University of Virginia School of Law, where he

was a Dillard Fellow. He became General Counsel and Secretary of VMC on April 30th, 2016. He is responsible for all legal and regulatory matters as well as risk management and insurance, as well as the compliance program, which I am sure is a huge, huge job, so he has been busy. Before joining VUMC he had served since August 2012 as Vice President and Chief Legal Officer of Atlantic Health Systems in Morristown, New Jersey. Which I believe is a four-hospital – five hospital health system in New Jersey. And before there he served since June of 2007 as Senior Vice President of Legal Affairs and General Counsel and Secretary of VHA, now Visiant, in Irving, Texas. While at VHA he had responsibilities in legal, risk management, office services, public relations, and corporate communications teams, as well as the company's office of public policy in Washington, DC. Prior to VHA, Mr. Regier served since September 1995 as Senior Vice President, General Counsel, Secretary, and Corporate Responsibility Officer for the Seton Healthcare Network, now Seton Healthcare Family in Austin, Texas, where he was responsible for legal and corporate governance matters as well as the compliance program. He also has been in practice in Chicago, Illinois, prior to that since 1985.

To his right is Mr. Dick Cowart. Mr. Cowart is a recognized authority in advising senior management regarding policy, regulatory, and business issues relating to healthcare. He serves as strategic counsel to healthcare companies, both for-profit and non-profit, and counsels providers on business, policy, and governance issues, with an emphasis on business transactions. You might have seen him – he is nationally known speaker and writer on healthcare issues and is the national columnist for Medical News Inc. for 18 years and is our own local health business columnist for the Tennessean for more than 10 years. Mr. Cowart graduated Magna Cum Laude from the University of Southern Mississippi with his BSBA and with Honors from the University of Mississippi School of Law.

And our final panelist, to the far right, is Mr. Darin Gordon. He is the former Director of Tennessee's Medicaid program, TennCare, with 20 years of experience in public health finance, policy, and operations. He has served both Democratic and Republican governors and had been in healthcare policy and innovation nationally, through consultations with over 35 states. Mr. Gordon is a fellow of the Medical Leadership Institute, and a member of the Inaugural class of the Nashville Healthcare Council fellows program, and board member of Leadership Healthcare. Mr. Gordon is a member of the Cressey & Company Distinguished Executives Council and a Director of Addus Homecare, Unified

Care Group, and Siloam Health. He also serves as Chairman of 180 Health Partners and is an advisor for myNexus. He is President and CEO of Gordon and Associates, LLC.

So, thank you for coming.

As we get started, one of the things that I wanted to talk about first is, it seems relatively certain that at least some parts, or potentially all (it's not totally clear at this point), but some parts of the ACA¹ will be repealed. And there are various proposals for different replacement plans that have been discussed. And one of those proposals is the idea of changing Medicaid from its current structure into a "block grant" program. So can you describe—Mr. Gordon, I don't know if you are the best one to take this one given your history—but tell the audience a bit about what "block grant" programs are, what that would mean for the TennCare program and other Medicaid programs, and just some general information about "block grant" programs and how Tennessee would potentially prioritize needy populations under that.

Mr. Gordon: Sure. First, thanks for having me, I really appreciate it. Obviously, everywhere I go, the topic comes up pretty regularly. But, before I describe block grants, it might be helpful to orient people to kind of the current state of financing in Medicaid. Think about it in two parts: there are two investors in Medicaid—the state and the federal government. The primary investor is the federal government; they really put more into the equation. In essence, it is an open-entitlement program from the federal perspective. If a person is eligible for the program, or they need services that are covered under Medicaid, the federal government will put forth the funds needed to reimburse the state for their share of the cost of those services. However, on the state side, while they still have bought into this open entitlement concept, they are limited by the amount of state appropriation that they can contribute to this equation. So, it's not as if money can keep going to Medicaid no matter what as I think some of the articles out there imply today. It comes that way from the federal government, free flowing and no cap, but it still requires states to come up with their share of the funding. I remember talking to different finance commissioners over the years, and when they come in and try to figure out Medicaid and seeing that's the largest budget item, they would ask me "so how much total money can we get?" And I would respond, "as much state dollars as we can come up with to match it." But they would always respond, "there has got to be a limit," but there is no limit. And they

¹42. U.S.C. § 18001 *et seq.* (West 2017).

are baffled by this. I mean, literally, they would have to ask me this question over and over to get past it. But accepting federal dollars is always a challenge for states; and it creates a bit of friction because the states are constantly needing to make changes to these very large programs due to state dollar limitations, but the federal government limits states' flexibility to change these programs to live within the available state funds.

Okay, so, think about the block grant concept now. If there is a "one size fits all" on block grants is being contemplated, this will cause folks to be scared and worried—I tell people "I'm not scared of the concept of a block grant." I am, however, concerned over the details of a block grant. The idea being that, instead of the feds saying "regardless of how many people you have, or how many services are needed, I'm going to send you a set amount of money, the concept would be that "I'm going to send you some fixed amount of money from which to work with." Now, is that less than what you got the year before? Is it what you got the year before but trended at a slower trend rate? All those things matter. States can work within this, if designed well. I can tell you, I can design a block grant scenario that is something that I would be quite comfortable with. But, we don't know if that's ultimately going to be the case. Depending on how this comes through Congress, it could be more of a "function with 90% less money than you had the year before" approach. Then, that begs the question, "what types of changes am I allowed to make in order to live within that?" So, funding and flexibility are hand in hand in this equation. You can't answer only half of the equation. Like "we are going to give you this flexibility" – "Well that's great, so tell me what the financing is going to look like." And vice-versa. They are inextricably linked. The debate is on what it's going to look like. We will see. Is it a dramatic change? Yes. That is probably why you're hearing about this as regularly as you are. Because it's fundamental to the program and how it has been run for the last 50 years. It is worth pointing out that, block grants are not new. The concept of block grants in Medicaid actually was voted on in the Senate and the House under Clinton and ultimately passed in both houses under Clinton but ultimately was not signed into law by the President. So it is not a new concept. But, I think that people feel, more than any other time in our history, that we are likely to see some significant change in the financing of Medicaid. In order to, one, constrain the growth, and two, give more flexibility to the states to manage available funds.

Mr. Cowart: If I might add just two quick points. First, the CMS administrator, Seema Verma, is not yet confirmed, and she is a good friend of Darin Gordon and Vice President Pence. In Indiana, they

had operated under a very broad waiver, so the idea that there would be a lot more flexibility is safe to say. Secondly, you may recall that the *Sebelius*² decision was really the first United States Supreme Court decision on the Affordable Care Act³. They stated that the federal government couldn't cram down the Medicaid expansion on the states. So I think that while there will be more flexibility, I think there will not be a cram down—I think the states will be given options. And depending on if your trend rate is up or your trend rate is down, and what your benefit package is, states will be able to design their flexibility.

Professor Farringer: That leads me to one question – or actually, go ahead.

Mr. Regier: Well, I was only going to say the only other caveat, is that's probably the first thing that the Republican majority will go after. And we can say to keep your eye on at a very high level, two things: the flexibility afforded to Executive Director and Chief Medical Officer of the State Medicaid plans; and then “where is the baseline set?” I think states, like Tennessee, that have been very, very efficient in managing their Medicaid plans (some might say stingy) and have had a 1.5% annual growth could be disadvantaged versus states like the state of New York, who have been experiencing 12 to 14% of year over year of growth, and also how that's will impact states with an 1115 waiver. That of course includes Tennessee, which was the first state in the nation to go to a fully managed care plan approach starting in 1994.

Professor Farringer: That leads nicely into my segue – do you think that states will be provided funding under block grants based on existing population or based on the amount of money they have been given in the past; so, are states that did not expand going to be negatively affected by the lack expansion?

Mr. Gordon: I would tell you, amongst the states, and some folks at the federal level, there are people who are trying to sort through this. The questions that they raise are “Are we at a disadvantage for not having expanded?” Similar to what was just said, the concept's specifics are not “out there.” It's not a concept that makes me run and hide. But all those details have to be thought through. And there seems to be a push to hurry up and get something out there. I would say, since everyone has agreed that there is going to be a replacement at the same time a repeal is imposed—we aren't going to have an immediate crisis here. I would just encourage everyone

² Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

³ See generally 42. U.S.C. § 18001 *et seq.*

working on this to be thoughtful, if there is ever a time to take something slow, 18% of GDP is something that we should REALLY take our time on to get it right. Make sure that you go through all these different levels of questions and make sure that you don't set up a system with perverse incentives.

Professor Farringer: Okay, so, that leads me to another question, sort of about the idea of repeal and replace. Most of what we talk about—most of what we hear about—is the pieces that need to be repealed. We don't hear a lot about the quality improvement and the quality-centered programs and a lot of the pilot programs that were enacted in connection with the ACA.⁴ So, what do you think is going to happen to some of those sorts of programs⁵ and pilot programs and reimbursement explorations that have been going on as part of the ACA, that really have nothing to do with insurance, nothing to do with the individual mandate, and not, I would say, the kind of hot-button issues that are causing the repeal discussion?

Mr. Regier: You are talking about, I think, the perfect storm scenario for hospitals. One thing that I would point out is the quality-based programs that are built into the ACA⁶ really didn't start—these didn't originate with President Obama. President Bush and former Health & Human Services Secretary Leavitt, had actually started the pay-for-performance quality-based system well before President Obama was elected into office. So these were Republican ideas that were wrapped into the ACA to appeal to those on the “R” side of the aisle, to try gain some political support for that statute. You know, as part of the “three-legged stool” of insurance reforms: increasing access to coverage, and improving quality while lowering costs—the three broad components of the ACA. I don't expect the quality initiatives to go away—they generally are saving money for the federal government. Which is—when the policy perspective is “we aren't getting what we are paying for in healthcare” —which IS the policy perspective on the federal level, I don't expect this will go away. A risk for providers, though, is that as pay-for-performance is forcing down Medicare reimbursement (which for a typical hospital provider is 40% to 45%, even so much as 50%), some institutions, at the same time, will lose the Medicaid expansion, which means we

⁴ 42 U.S.C. § 1395b-1 (West 2017); *see e.g.*, Ctrs. for Medicare & Medicaid Servs., *Linking Quality to Payment*, available at <https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html> (last visited Nov. 1, 2017).

⁵ *See e.g.*, Melinda K. Abrams et al., *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years*, THE COMMONWEALTH FUND (May 7, 2015) <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>.

⁶ 42 U.S.C. § 1395b-1; 42 U.S.C. §§ 299b-31, 300kk, & 3299b.

will not have people getting Medicaid coverage; we will lose the mandate, and we are definitely going to lose the tax credits and tax subsidies provided under the ACA⁷, which will affect individuals' ability to buy insurance coverage. So I think there may be something to replace that, but it is likely that there will be fewer people with insurance—so more uncompensated care. And, we still have the reductions in disproportionate share funding because that was part of the bargain about expanding coverage. We will reduce the—there is a payment stream called the disproportionate share hospital funding which is made available by the federal government to those providers that provide a very high degree of care to the Medicaid population—which is, I think, admittedly outside the beltway to be reimbursed. That, I don't think, will come back, because the fiscal pressure is too great, and so you are going to have continued pressure on providers by way of lower reimbursement, higher quality expectations, fewer people with insurance, and fewer dollars coming from the federal government to help offset that cost. It's a dream world.

Mr. Cowart: First off, Repeal and Replace—I think we will talk about that separately. On quality, I think the two big pieces of bipartisan legislation were MACRA⁸ and Healthy Cures⁹, both of which passed the House and Senate with supermajorities. So, I think those are pretty solid. However, we have an HHS Secretary who is a general orthopedic surgeon.¹⁰ If you were to ask him if we should design quality regulations in Washington, he would tell you that's nice but physicians decide quality not Washington bureaucrats. Regarding competition, if we are ever going to have true price competition we've got to have common prices, and we've got to have some degree of transparency. What people are buying and what does it cost. The process works best when the government can set some parameters. Frame the marketplace, and then withdraw and allow the marketplace to do its thing. I think there is a lot of interest in creating a marketplace, creating transparency, getting pricing and quality data into the marketplace but not trying to regulate it from Washington. And I think you are going to see some interesting things that we have in Tennessee. Now, I think, one of the more interesting things is what the state put in its state employee health plan request for proposal. It included a section on bundled payments to cover all the state employee healthcare insurance. Whoever won

⁷42 U.S.C. § 18082. Ctrs. for Medicare and Medicaid Servs., *Premium Tax Credit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/premium-tax-credit/> (last visited Nov. 1, 2017).

⁸ Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114–10, 129 Stat. 87 (2015).

⁹ 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

¹⁰ Secretary of Health and Human Services at the time of publication was Tom Price.

that contract had to create pricing for 75 of these highest use procedures—essentially creating a pricing framework that could be used as marketplace price and transparency. The State was attempting to use its purchasing power to create a marketplace but not necessarily regulate that marketplace.

Mr. Gordon: Dr. Price, the future secretary of HHS, said a lot of things early on¹¹ that caused me to be concerned for the future of the Center of Medicare and Medicaid Innovation¹² but also about value based purchasing in general. Even before being considered for the Secretary of HHS, while he was with the Georgia Medical Association, he made comments regarding concerns over the move to value based purchasing.¹³ However, at his confirmation hearing a few days ago, he actually said he could see how the Center could be repurposed and used to promote innovations at the state level and how the move to value is the new direction things are moving towards. He said “I could see some value with continuing CMMI with a different focus” but he didn’t really go into a lot of detail. To some degree it made me feel “will the priorities be the same?” Probably not. May there be some different things they invest in? Probably. Dick is right, the degree of control of those programs might be lessened and allow things to flow more naturally from the states. But the idea of value first is one of the biggest components of all that. With Tennessee being a leader of the country on the move from volume to value, this is important. If you look at Arkansas or Ohio, you see other states stepping out as well and doing similar things to Tennessee and trying to move things forward. Medicare has been sampling a lot of value based models, but the states have been sampling a lot of value based models as well. So the move to value isn’t just being driven from within the beltway. So, even if they change some direction at the federal level on this topic, states will continue to push forward. In fact, I said whenever we applied for a grant to help implement value based purchasing that, I wish we hadn’t applied for the grant because we could have moved faster without it than with the grant. So the interest to move from volume has always been driven by the states because, like has been stated, it

¹¹ Linda Qiu, *Schumer: Trump and his HHS Pick Tom Price at Odds on Medicare*, POLITIFACT (Jan. 10, 2017, 1:58 PM) <http://www.politifact.com/truth-o-meter/statements/2017/jan/10/charles-schumer/schumer-trump-and-his-hhs-pick-tom-price-odds-medi/>.

¹² 42 U.S.C. § 1315a.

¹³ See Bruce Japsen, *As Trump’s HHS Secretary, Tom Price Could Slow Shift to Value-Based Care*, FORBES (Nov. 29, 2016, 7:02 AM) <https://www.forbes.com/sites/brucejapsen/2016/11/29/as-trumps-hhs-secretary-tom-price-could-slow-shift-to-value-based-care/#5f8ec250636f>; see also Shannon Muchmore, *As HHS Secretary, Price Would Likely Focus on State Healthcare Reform*, MODERN HEALTHCARE (Nov. 22, 2016), <http://www.modernhealthcare.com/article/20161122/NEWS/161129971>.

is a building block to a more functioning market. In and of itself, it isn't going to make a functioning market, although it is a critical tool. Once you get to a point of understanding what all is encompassed in a particular procedure—from start to finish—then you are better able to help people understand what all they would be purchasing and how to compare, apples to apples, both quality and cost. So, I don't see that movement stopping. Dr. Price's more recent comments are encouraging to a lot of folks. It gives comfort that, in some form or fashion, there will continue to be a focus and funding to support greater innovation.

To your point, I think we do see a lot of uncertainty, not just with providers but also the investment community. There are a lot of folks holding back to wait and see where things are headed. If anyone is out there right now trying to get providers to sign a new agreement with them related to some grant they received, I would probably think they are going to have a hard time convincing the provider to change processes and change their systems to accommodate that right now. So I think the broader system is pausing, or at least has slowed down, for the moment until we see more details on what is likely to come. And when those details are available, things will gear back up and we will begin to see changes accelerate once again.

Professor Farringer: Do you think that is true for accountable care organizations (ACOs)?

Mr. Gordon: I do think that is true for some ACOs. It depends on where or how they originated. Some ACOs came directly out of grant funding from Medicare. Others originated more organically—driven by local market dynamics. Some ACOs were born out of a change in the healthcare world more generally. But if, let's say, Medicare suddenly does back out, of participating in ACOs, then the ACOs are going to be hard-pressed to make it work. Could they continue? Yes. The big question would be what would be everyone's purchasing situation? If I as a payer go to Vanderbilt and I say I am going to do an ACO arrangement this way and another person says they will do it a different way, and another says they will do it yet another way, you are setting Vanderbilt, and the model, up for failure. So, if any one of those large payers back out, then an ACO is going to struggle to be a viable option. And I don't think we know enough at this point.

Mr. Cowart: I think it is important to understand that in the 50+ years we have had Medicare, it was principally a fee for service programs; Part A for hospitals and Part B for doctors and

outpatients. In the early 90s, Part C, Medicare Advantage is created, and then Medicare Part D under President Bush for pharmacy benefits. You had essentially two models at both ends of the spectrum - fee for service and capitation. What is in the middle is a shared savings program. Medicare's version of that is called an Accountable Care Organization. And there is a lot in the private sector also private payers. So, I think there is going to be a lot of activity in the shared savings space—that is not limited only to Medicare ACOs.

Professor Farringer: It will just be how we all coalesce.

Mr. Regier: Well, I mean the clear impetus is to say to the provider community, (from the payer's side), "we expect you to be prepared to accept financial and operating risks for a population of our enrollees for a period of time, and for all the services they need from the beginning of life to the end of life." So, there is flexibility in how you do that. Like, how you structure that kind of a model. We have taken the approach today to try to assemble an affiliated network, on the theory that you cannot afford to own everything. An affiliated network, to one day be in the position to be able to accept that degree of risk for a population, is difficult. So that is one way that you can try to position yourself to be like an ACO at that level.

Mr. Gordon: One last point on that...any of those payment or quality initiatives that we have talked about in this conversation, require some degree of alignment. States are out there and they are trying out new things and so are the private payers, they are out front. And everyone is concerned what Medicare is going to do. All the efforts over the last 5 years since the states were investing in this could all be for nothing if Medicare goes in a completely different direction. If they go in another direction it can shift the entire system. So that is something that everyone is going to want to watch. Not so much "will an ACO develop?" I think the elements and the principles behind those are fine. I think that the principles will still be there. I think the question will be "will Medicare come out with a direction or will they let it be something that everyone else drives?"

Professor Farringer: Okay! So, one other thing that has been talked about, I think it was talked about in the debates leading up to the Presidential election and significantly since the election, is the idea that we would include in any replacement plan the ability of people to purchase insurance across state lines. So, maybe talk about that a little bit to the audience and tell us some of the pros and cons of the approach and why its proponents say it would ultimately reduce

healthcare spending. And then any legal concerns that might come up with that – especially I think on the insurance side from the state’s perspective. States all have their own insurance laws that are driven towards protecting their residents, related to making sure that their residents and insurers of the state are not doing things that are hurtful to their own residents. So, what are some of the legal implications for states as we think through this?

Mr. Cowart: Sure. We might need a primer on Repeal and Replace before we do a primer on insurance. Repeal and Replace is a campaign term. We are not going to replace the Affordable Care Act without 60 Republican senators. And you may recall six years ago when Scott Brown won the election in Massachusetts, there were only 59 Democrat Senators. Because they attempted to cram through the Affordable Care Act, there are many technical errors. And they ultimately had to pass it through using budget reconciliation. For those law students who are here, the House represents the passion of the People. They pass things pretty much on party lines. The Senate is supposed to be the waiting pot for deliberation, so it takes 60 votes to suspend debate, or cloture. It is not 60 votes to pass. So that’s why that magic number is 60; otherwise you have filibusters. Now one of the things that is exempt from cloture is the federal budget. The nation needs to have an annual budget. So it only requires a majority. And by the way, since we are watching it on TV every morning, the Democrats decided that every confirmation, except the United States Supreme Court, is exempt from cloture. The nominees are all going to be confirmed unless there is some crime in their background. On Repeal and Replace, it is largely going to be budget-driven because of reconciliation—it’s got to be. It’s going to take away the individual mandate,¹⁴ take away the employer mandates,¹⁵ and the Cadillac tax,¹⁶ and take away the medical device tax,¹⁷ all of which produces the money to fund everything. Without new taxes you can’t do much because you don’t have any money. So the reformers have got to say “what can we do that doesn’t require new taxes?” Because also we want to pass tax reform. All that is kind of a stage. You have to understand that you have to fill the vacuum

¹⁴ 26 U.S.C. § 5000A (West 2017); *see also* 78 FED. REG. 78256-01 (Dec. 26, 2013) (to be codified at 26 C.F.R. at pts. 1 and 602); *See e.g.*, Ctrs. for Medicare and Medicare Servs., *The Fee for Not Having Health Insurance*, HEALTHCARE.GOV, <https://www.healthcare.gov/fees/fee-for-not-being-covered/> (last visited Nov. 1, 2017).

¹⁵ 26 U.S.C. § 4980H; *see also* Internal Rev. Serv., *Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, U.S. Dep’t of Treasury, <https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act> (last visited Nov. 1, 2017).

¹⁶ 26 U.S.C. § 4980I.

¹⁷ Internal Rev. Serv., *Medical Device Excise Tax*, U.S. Dep’t of Treasury, <https://www.irs.gov/newsroom/medical-device-excise-tax-frequently-asked-questions> (last visited Nov. 1, 2017).

with something. If you want to know the founding of Repeal and Replace principles, there was a Blair House summit¹⁸ with five leading Democrats and five leading Republicans, go to the CSPAN in the archives, find the Republican plan of the summit, and those are the building blocks.¹⁹ One of those building blocks is insurance across state lines. Insurance across state lines is really likely. When we look at auto insurance, costs are down. It is a lot less expensive than it used to be because it is a highly competitive model. For auto insurance, there are all kinds of coverage packages. The Affordable Care Act²⁰ has a standard national benefit package. We mustn't change that. We must also end up with more catastrophic coverage. The process thus far is whoever can provide the cheapest price gets the business. People buy on price, not on benefits. Unless they are really sick, and then, if you are an insurer, you don't want them to buy anything. The other thing is, we never federalized any insurance regulation. Property, casualty, and life insurance, since the early 1900s, has been regulated by the states. The whole concern of the state insurance commissioners has been to try and regulate this in some way. It has them scared—I mean really scared. And particularly in states like Tennessee where the insurance commissioner doesn't have a lot of statutory authority.

Professor Farringer: Read between the lines! I was going to ask you about that. Do you think it is too difficult?

Mr. Gordon: I think it is going to happen. I think it will pass. I think you will see that. I think where it will fall is less clear. I think all our crystal balls are out of order. I think it will pass, the question will be, is it realistic? And also, how will it play out? Each state's commissioner of insurance has developed a set of regulatory guidelines and regulatory frameworks. For them to say that their own standards are not good standards would be unusual. To have someone come into your state and not abide by those standards, is probably going to be problematic. An Insurance commissioner would likely be a little concerned about that. But I also think about it from a market perspective because in some cases it is not because of the regulatory framework that a plan isn't going into a market. Even if you change the regulatory criteria, they will still have to

¹⁸ *White House Health Care Summit, Part 1*, C-SPAN (Feb. 25, 2010) <https://www.c-span.org/video/?292260-1/white-house-health-care-summit-part-1>; see also Kristi Keck, John Helton and David DeSola, *Highlights from Obama's Health Care Summit*, CNN POLITICS (Feb. 25, 2010 9:12 PM)

<http://www.cnn.com/2010/POLITICS/02/25/health.care.summit.updates/index.html>.

¹⁹ Noam N. Levey and Kyle Kim, *A Side-by-Side Comparison of Obamacare and the GOP's replacement plans*, L. A. TIMES (July 13, 2017).

²⁰ 42 U.S.C. § 18022.

make a business decision on how likely they could be successful in penetrating that market. If it is just not something that they think they can do successfully, regardless of the regulatory environment, then they just won't do it. If you think about what is involved when you take my insurance product and move from Tennessee to Alabama, then that insurance company has to maintain a presence there and establish provider networks there to support me. We will just have to see how that plays out. There will be a long run-away before we see it play out and get a better sense of the practical implications of that.

Mr. Gordon: I like the theory of it, I am just stumbling over the details of how you are actually going to make this work. Are you going to have a federally mandated set of minimum benefits that must be offered as a condition of federal law? And then, how transparent is that going to be to a consumer? If the approach is that there would be some set of standard disclosure requirements, and consumers could at least look at some standard format to say “this is clearly what is covered, this is what I’m getting,” that kind of conversation might be helpful to a consumer trying to compare their options. How you have that for 50 states, which already have an established framework, is going to require a long time to create and implement. It will take a long, long time. And I suspect that there will be many theories on how that will and ought to be done. There are some folks that are very aggressive and there are other states that are not as aggressive from a regulatory perspective, and so how does that all play out?

Professor Farringer: Okay, let’s jump a little bit into... Dick, you alluded to one of the biggest things that has been mentioned—the removal of the individual mandate, which is the removal of the requirement that all purchase insurance, either under an exchange or through their employer. So, there has not been a lot of talk of the other two pegs of that equation, which are subsidies and credits provided to individuals that cannot afford insurance, and then also the fact that right now insurers cannot deny insurance to those individuals with preexisting conditions. So, talk to me about the individual mandate. And if the administration says that we are not going to enforce it or if that is the only piece that changes, what is the implication? What do insurers think about that? What do providers think about that? What are the implications?

Mr. Cowart: At least politically, Congress has to keep the no preexisting condition provision²¹ and they have to keep the children,

²¹ 45 C.F.R. § 147.108 (2017)

up to age 26,²² on the parent's policy provision—those are key. But again, what Congress does next is dependent on how much money is available and whether they reconcile tax cuts while removing (the “repeal” part is removing that tax part) the tax credits. At the end of the day you have “x” amount of dollars. It is not nearly the same amount of money that Congress had under the Affordable Care Act. I think that these will be tax credits. There is some discussion about making it catastrophic coverage credit, so making it kind of a chronic disease super fund that is administrated at the state levels. To say that these are available in a catastrophe, the government's role in funding this and the citizen's role in funding primary care. So I believe that there will not be an individual mandate. There is probably going to be an employer mandate. That is just an anathema to this administration.

Mr. Regier: I am going to say this, part of the deal from the hospital industry's perspective, part of the deal was “we are going to get an coverage expansion and so we hospitals are going to suck it up and take reductions in Medicare payments and in disproportionate share funding.” So that deal, now appears to be going away. I am very concerned just as a public health matter at the number of people who will no longer have insurance. I have heard too many people still saying “repeal and restore.” A number of folks are saying “we are getting rid of this horrible bill and we are going to restore choice”—well, choice was no insurance for 47 million people in this country. That was not a choice and that is not acceptable. So that, I think, is going to be a very big priority for the provider side. And I am encouraged because the President has said that it is going to be huge, it is going to be great, and it is going to be wonderful. And, at Vanderbilt, I would say that we are ready to sit down and talk with anybody at any time and at any place to collaborate on a plan to increase access to coverage for people in Tennessee and the surrounding states.

Professor Farringer: What about insurers?

Mr. Gordon: Providers and insurers actually are in agreement on the idea of broadly based coverage, for a variety of reasons. Really, on the insurance side, the whole idea behind the mandate was to balance out the risk pools. States that have expanded to 138% of the poverty level, took on some of the risk for those that were 100-138% of poverty that would have otherwise been incurred in the individual market in those states and that may have moderated the risk in those

²² 29 C.F.R. § 2590.715-2714 (2017); Ctrs. for Medicare and Medicaid Servs., *Premium Tax Credit*, HEALTHCARE.GOV, <https://www.healthcare.gov/young-adults/children-under-26> (last visited Nov. 1, 2017).

markets, but even so, there were still problems. Risk adjustments, risk corridors and reinsurance would have helped stabilize the market as well but these common actuarial tools ended up getting caught in the political world and were not fully leveraged. If you use these actuarial levers that are common to stabilize a volatile market, you help to balance out some of the issues. We would not have seen the degree of issues that seem to have played out across the country if those tools could have been more fully used. I say all that but the individual mandate was also supposed to be a way to try to balance out all that, but it didn't work. There is a lot of interconnectedness. Does that mean you cannot do things? No. It just means you have to understand how all these things fit together. I, personally, was not convinced that the way that the individual mandate was structured, that it, had enough of an effect that people were looking for and hoped for. So, that one component, and I haven't seen information out there that says "those that got insured, that the mandate was the biggest driver or if it was the subsidies?" So the question is what works most effectively? A lot would argue, it goes back to Dick's point, people are very price sensitive. When you look at the penalties, I mean, I had people reach out to me saying "I did the math, I want a non-ACA plan, it is significantly less costly than an ACA compliant plan."²³ But I would say, in looking at the entire system, you have to recognize that price matters.

Mr. Cowart: Michael mentioned one phrase I want to—one of the big wild cards—"Repeal and Restore." The "Restore" piece depends on provider unity. If you are in the South, you needed to expand Medicaid to get whole. There are many moving parts. If we are going to end up with an auto insurance model, providers may close ranks and say "Restore my Medicare cuts." Restore my Medicare payments and I'll deal with that. And it would not be a bad judgment call for a provider. If you restore these healthcare cuts and you eliminate the taxes, there is no money to fund anything. That is why you end up with these local options—because there is no money except for a few tax credits.

²³ *What Does ACA-Compliant Mean?*, HEALTHCHOICEONE, <https://healthchoiceone.com/what-does-aca-compliant-mean/> (last visited Nov. 1, 2017).