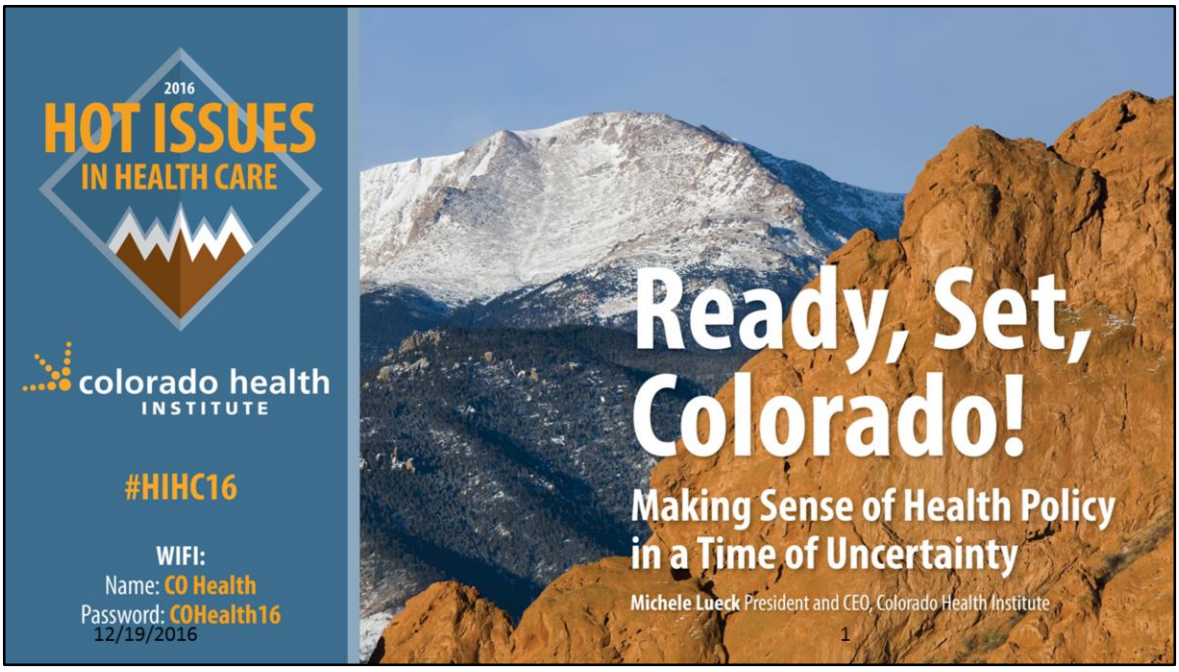


Good morning. Welcome to HIHC 2016.

This conference dates back to 2002. It was originally envisioned by Sheila Bugdanowitz and the team at the Rose Community Foundation. Today, we thank Sheila for the vision – and for supporting this event over the past 14 years.

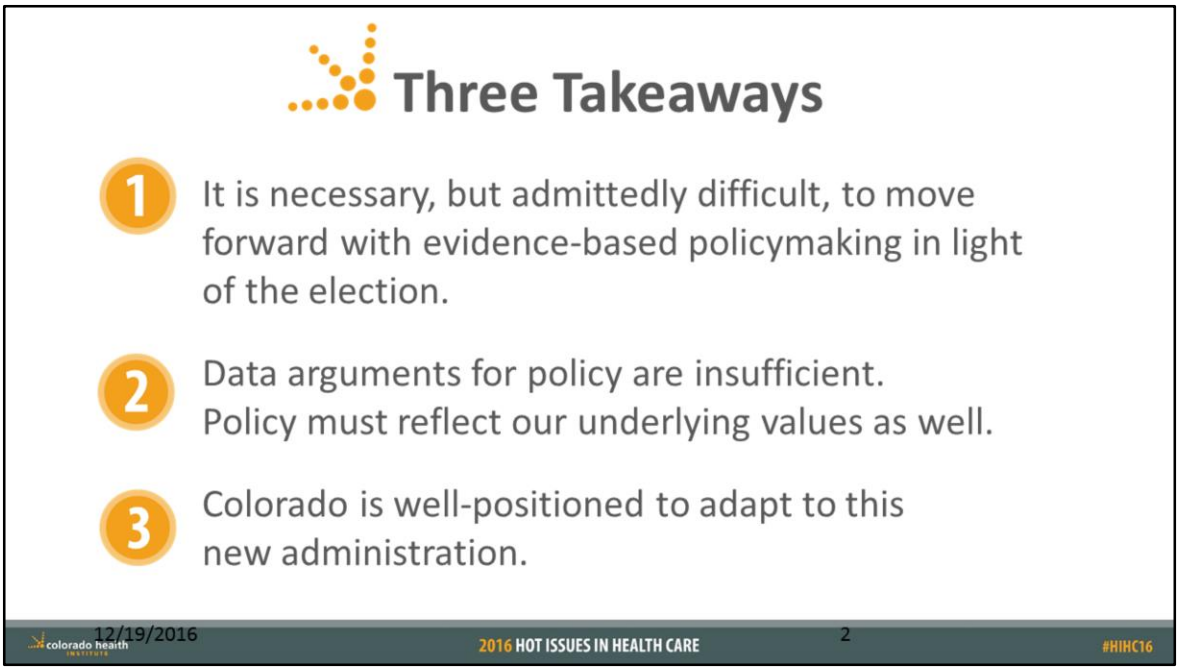
For those of you who are repeat customers, you know that Hot Issues was designed to tee up Colorado's upcoming legislative session. What are Colorado's hot issues? What does the research and evidence show? How might we as a community make the best health policy decisions to serve our great state?

These ideas very much continue to permeate the 2016 conference.

Our goal this year is to provide a sense of context here in Colorado. This requires us to move back and forth between the national stage, Colorado's own platform and local community work. As you will see, the agenda is designed to do just that. We

have a great line-up in store.

And as we dive into those relationships – national, state and local – I want to offer a few thoughts on not just how different our lives and work may be in over the next four years . . . But, how is some sense, they will be the same.



In true CHI fashion, I offer these three takeaways from my initial reflections on health policy at the end of 2016:

First, it is necessary, but admittedly difficult, to move forward with evidence-based policymaking in light of the election.

Second, data arguments for policy are insufficient. Policy must reflect and articulate our underlying values as well.

And finally, Colorado is well-positioned to adapt to this new administration

Let me explain.

Now when I mentioned that we have a great line-up for you this year, it is not the line-up that we thought we'd have on November 7 of this year. But we have worked, diligently and creatively to bring you a relevant, timely and valuable session.

Today we know that in 37 short days President-Elect Trump will become President Trump. And while this may have come as a surprise to many on both the right and the left, the reality of this electoral outcome is settling in.

Pick up any newspaper, blog or Twitter feed, and you can see that uncertainty rules the day. The cabinet is being filled in and we see hints at policy objectives. But it's safe to say that today we cannot know for certain what many programs and policies influencing Medicaid, Medicare of the Affordable Care Act will look like in 12 months or 24 months or even 48 months.

When I woke up on November 9, my opening remarks for this Hot Issues in Health Care conference came to mind as I was thinking about what to say.

Now, after a few weeks, it has become clear what I can't say:

1. There is no certainty about the course of this administration. Trump not a "typical" Republican and his early cabinet picks, addresses and Tweets confuse the message even more

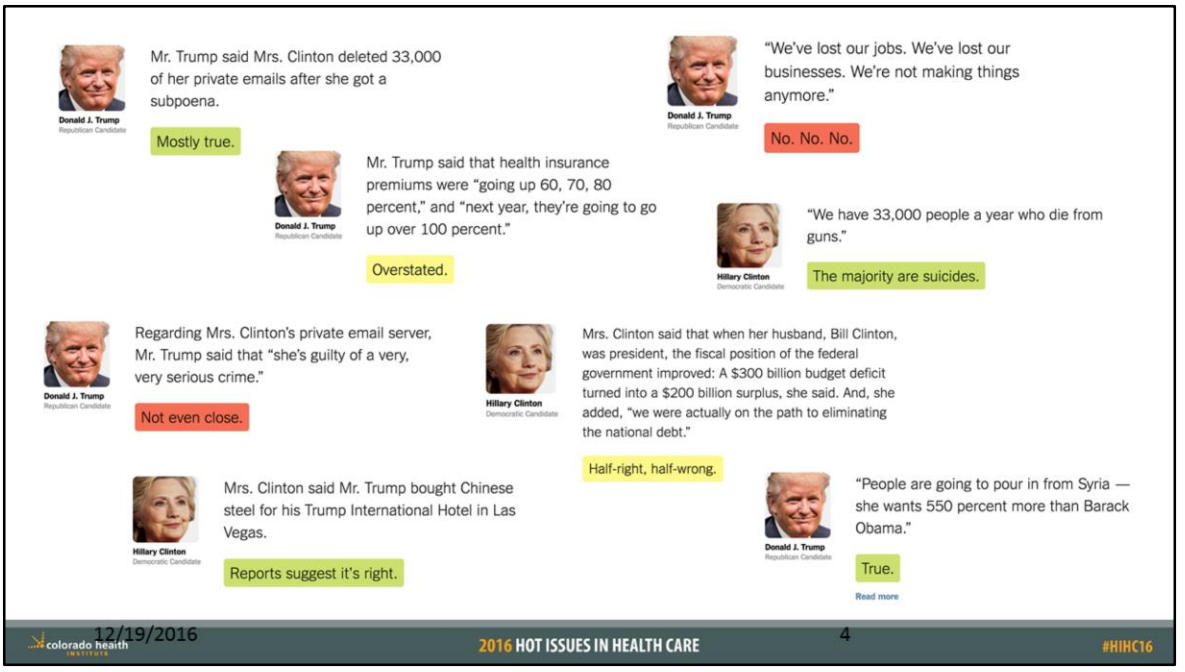
2. What just happened. How did the polls get it wrong? How did Trump triumph in different states – such as the Rust Belt states? Others are more equipped to answer this question – like Sarah Kliff, who you will hear from after me - to share their real-

time D.C.-based insights.

3. Timing of repeal, replace, reform, redo, recommit. As far as I am concerned, the tea leaves are not readable. The selections of Tom Price to head the U.S. Department of Health & Human Services and Seema Verma to head the Centers for Medicare & Medicaid Services certainly set a tone, a posture, about an eagerness to repeal the ACA. But timing and replacement policies are elusive. Change could happen as quickly as the reconciliation process this winter or elements of the ACA, such as the State Innovation Model and the Center for Medicare & Medicaid Innovation, could hold until the money is exhausted in 2019. We simply do not know. Yet.

So instead, I am going to reflect on purpose – the purpose of the Colorado Health Institute and of all policymakers in the room – and the values over which we fight – in politics, on Twitter and places in between. For these values are at the core of our policy debates and decisions. And while the outcomes we expect to see in a Trump administration will most likely be very different than the last eight years, at its core policy addresses deeply-held and essential values.

We need to understand these values as we head into the upcoming, and inevitable, policy battles.



The Colorado Health Institute is predicated on a fundamental proposition: Better data, sound analysis and disciplined research lead to better policymaking and better health outcomes.

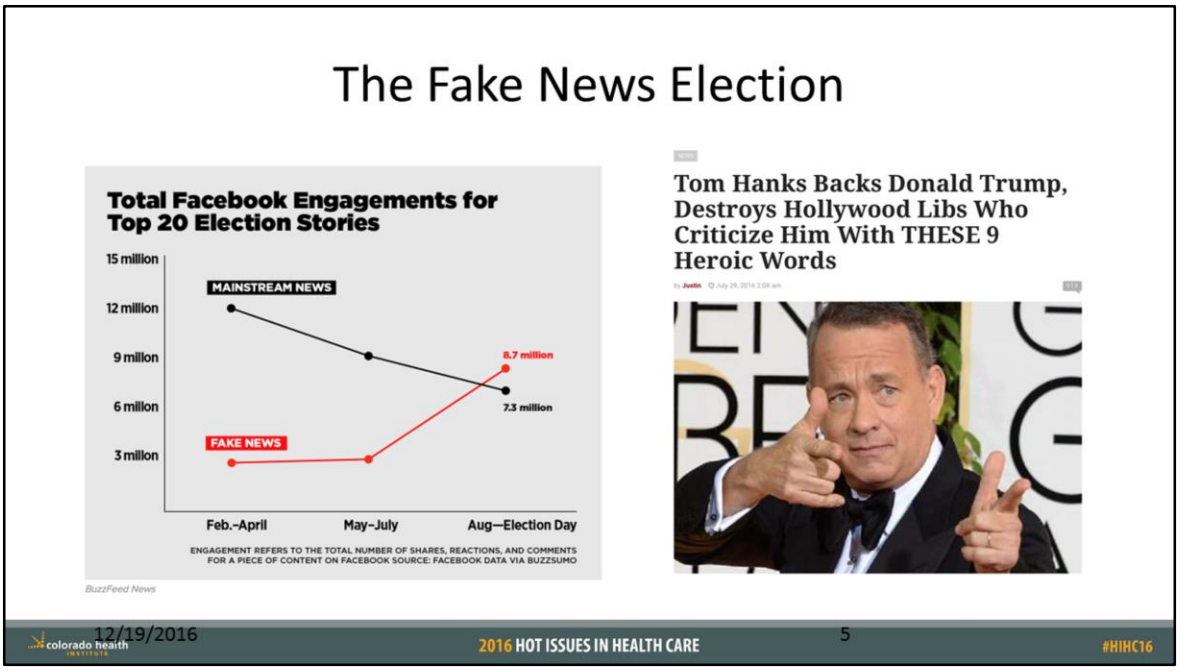
By extension, the values of your respective organizations and your participation here today – YOU are also in the fact business. You also believe that better data, sound analysis and disciplined research lead to better policymaking and ultimately better health – or education or transportation or you name it – for all of us.

That's why you are at this conference.

So if we believe in evidence and the soundness of fact, how do we make sense what just happened in the presidential election?

Presidential candidates – on the trail and in debates - had a loose association with the "facts."

It was an election where for the first time, we heard about "phony numbers," improbable inner city crime rates and "rigged elections."



And it wasn't just the candidates.

But to the team at CHI, what's troubling about this election is not, particularly, the results.
This was an election where you could make up facts as you went along.
We see this in the debate over what to do about "fake news."
Just months ago, it was pretty easy to spot fake news. Sites like The Onion wrote outlandish things in a journalistic style for comedy.
CLICK: But this year, we saw a proliferation of websites spreading inaccuracies and even outright lies. This one claimed Tom Hanks endorsed Donald Trump. Actually, Tom Hanks supported Hillary Clinton and raised money for her.
CLICK: BuzzFeed analyzed all the Facebook reactions to the Top 20 election stories and found that, by the end of the election, people were sharing fake news more than real news on Facebook.

This is troubling for an organization like the Colorado Health Institute. And, I know, for all of us here today.

Source: https://www.buzzfeed.com/craigsilverman/viral-fake-election-news-outperformed-real-news-on-facebook?utm_term=.cw7WJL6pw#.geKDKqap5

Campaign Rhetoric is As Old As Campaigns

A commentator noted recently that we are in an era where public discourse is taking place in a "fact free zone." But before we get too alarmed . . .

We have a long history of broken political promises and exaggerations in campaign speeches.

Still, we do seem to be at an apex of fact distortion.

President Obama pledged to close the prison camp at Guantanamo Bay. President George H.W. Bush famously said, "read my lips: no new taxes," and we all know where these two pledges ended up.

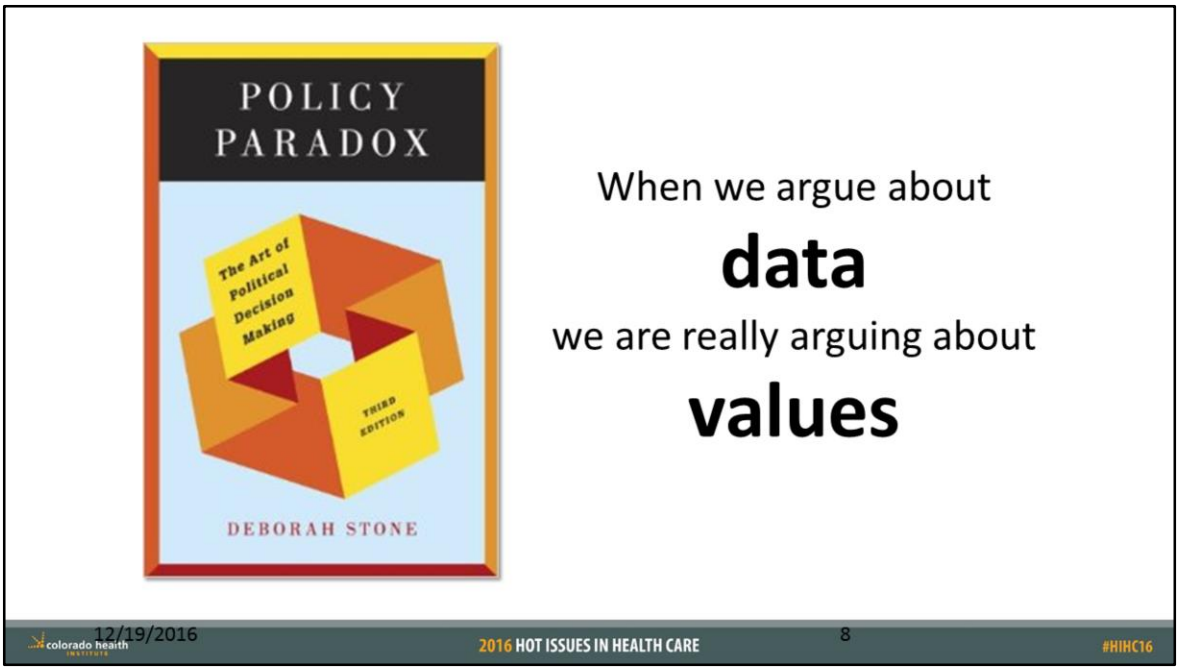
It's also noteworthy - and amusing - to note that Donald Trump has been making headlines for a long, long time. Look at the bottom left of the New York Post in 1990 and you will see his face – and a story about a real estate deal.

So how do we **reconcile** this deeply held belief – in facts, research and evidence -- with what we just experienced – fake news, denial of facts, creation of new facts, creative interpretations?

I'd offer three potential ideas:

1. First, we may see this as our particular challenge. We need to "create the demand" among policymakers and others to scrutinize news . . . and value what we provide.
2. Fake news will be mitigated. Mark Zuckerberg of Facebook and now Hillary Clinton are weighing in the importance of cleaning this up.
3. We will find technological solutions. We have learned how to push out fake news. We will find a way to send out corrections or clarifications.

Still, even as I thought about offering these ideas and solutions, they they left me a little flat. They seem rather inadequate.



Like many of us, I turned to experts. How can we make sense of all of this? I found this very interesting political scientist, Deborah Stone, through John McDonough's recent blog in *Health Affairs.* It's titled *"The 2016 Election Reveals The Differences On Health Care are Deeper Than Ever."*

John McDonough is a Harvard professor, former member of the Massachusetts House of Representatives and was a senior advisor on the ACA.

Stone and McDonough both believe this: That when we argue about data, what we are really arguing about are values.

What I learned – am still am learning – is that data and values are inseparable.

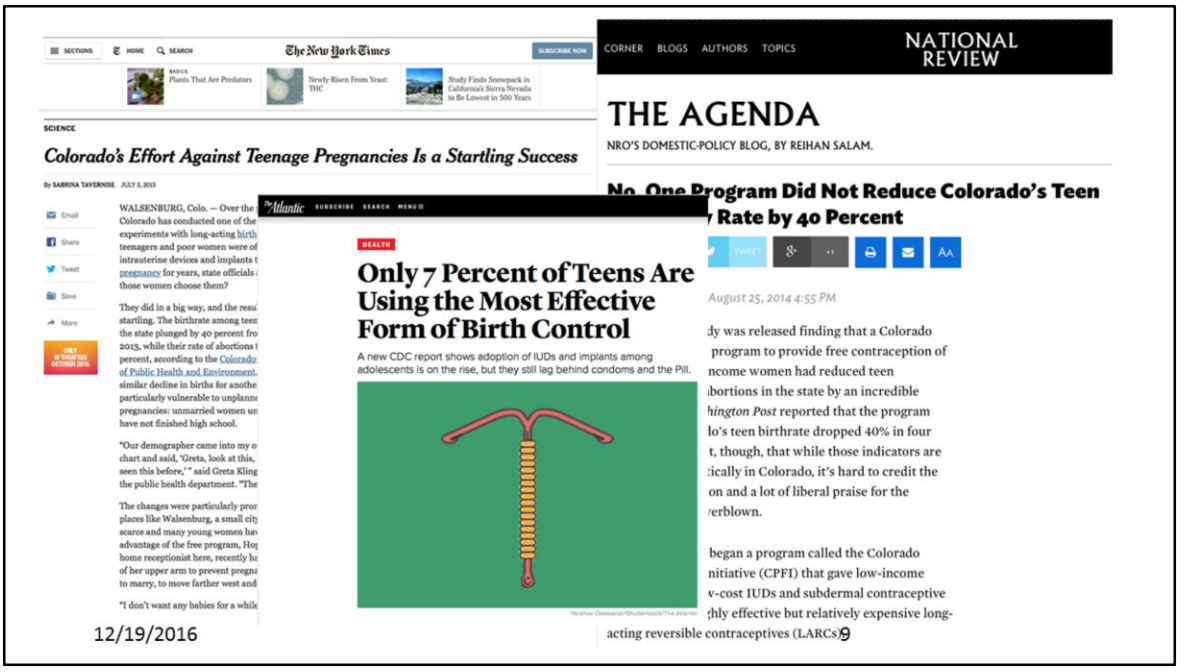
Then I started thinking about how to apply this interesting concept here.

First a couple of definitions. Data equal the things I have referenced here – sound analysis, disciplined research and the counting up of things.

Values are big lofty societal goals, equality, liberty.

Our departments today – education, public health, human services, health care - are designed to realize those values based on this concept. Think of our SNAP program for food and nutrition, TANF for families in need, Medicaid for medical services for our most vulnerable. These are institutional, programmatic attempts to accommodate these values.

So I wanted to test the idea. When we argue over data are we really arguing about these values? And when I applied this to my own work, I think, in large part, this holds true Let me explain . . .



The Colorado Long Acting Reversible Contraceptives (LARC) story.

This is story familiar to many of us here in the room. It's a Colorado success story in which we have seen a dramatic decrease in teen pregnancies.

A national organization, the Milbank Foundation, asked the Colorado Health Institute to investigate the keys to this success. In particular, they were interested in knowing how a $20 million anonymous donation to the state to support providing LARC – long acting reversible contraception – to low-income women was significant in the results we saw.

We conducted this research and recently presented our findings to 40 state health cabinets throughout the country. In short, what we found was a significant correlation between the large investment and the reduction in teen births. It was NOT causation, mind you. Just correlation.

What was most fascinating in hindsight were the discussions and arguments that we facilitated between progressive health cabinets and conservative ones. Sparks flew.

What we found was that state delegations argued over our analysis – over the DATA. Some argued that other dynamics were happening to influence birth rates, economic recession and recovery, job availability, changes to systems of care, improved access, could have all played a role. It wasn't the availability of LARCs. Progressives argued that the story was so passe because the data are so convincing. Doesn't everyone do this?

When we parsed those comments, it was clear that one side was neither right nor

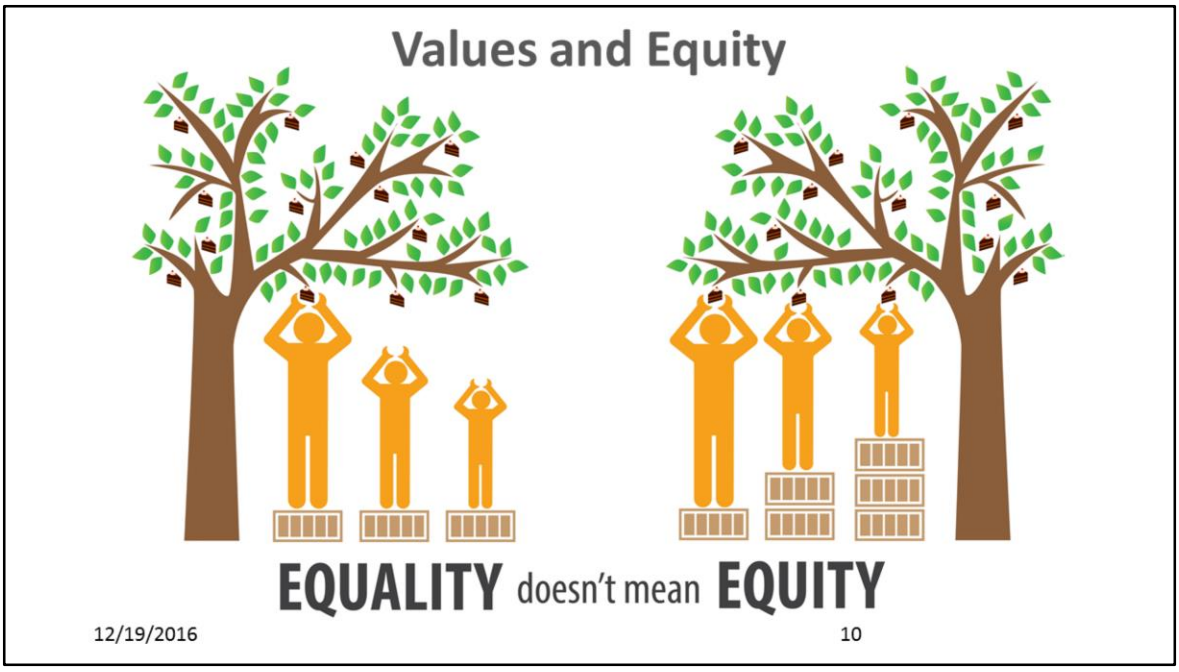
wrong. And the data that we presented wasn't really at issue. It really was the underlying values that this story embodied.

The values:
Abstinence should be the policy.
Families should make their own personal choices.
Medicaid should or shouldn't be in the family planning business.

At one point a legislator said, "This is not right. We should not be talking about teenage girls like this."

So they argued about the data. But that masked the real argument, which was about values.

I challenge you to think about your work and the times where data discussions were actually values discussions.



So one of my takeaways from Stone and McDonough is that we must keep advancing the evidence and the data. But we must acknowledge and articulate the underlying values. Only then will we reconcile our 2016 election experience with our own deeply held idea that better health is achieved through policy decisions grounded in evidence, data and research.

I want to explore two examples of values. The first is a highly conceptual one that is on our minds frequently – equity. he other is more practical but looming – the role of government.

We have all seen some variation of this delineation of equality where everyone gets the same, uniform measure of something. Versus the depiction of equity – where everyone gets what they need to accomplish something – picking an apple or becoming educated or having the opportunity to be healthy.

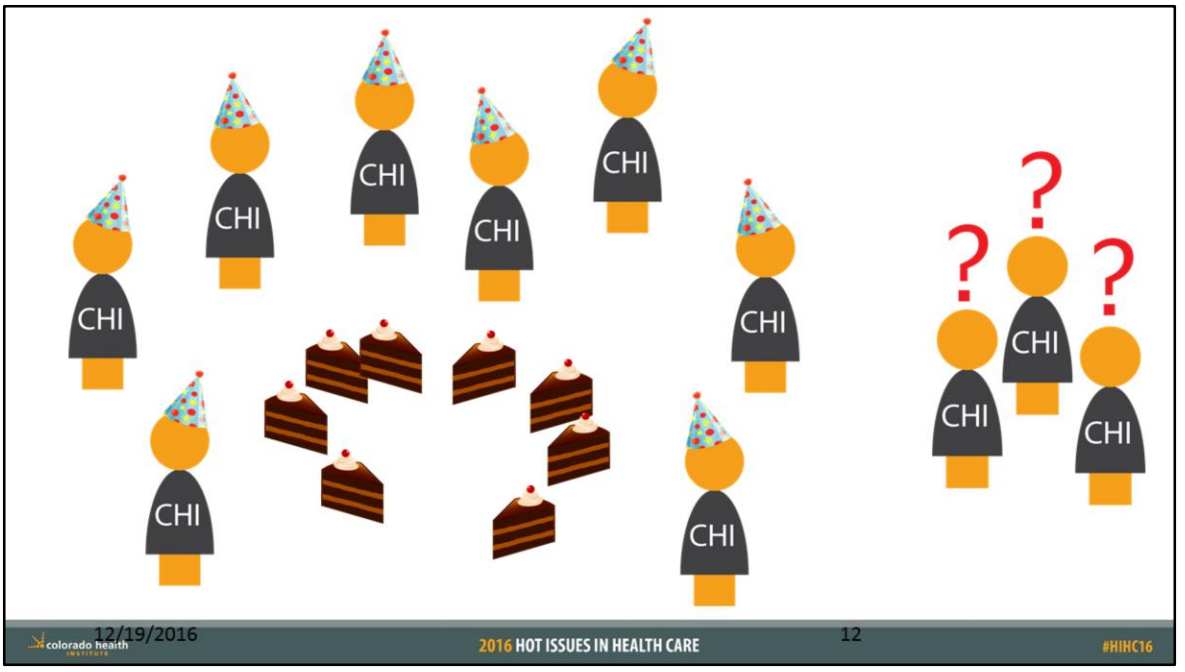
We have a firmly-rooted notion in both of these principles – equal rights and opportunities. But how we make choices based on equality and equity, well that's where policy gets interesting.

Equity tackles the question of distribution, particularly of finite resources. ***Who gets what and when.*** And if you think about Medicaid, or Education or Human Services, the departments that I just mentioned, they are all in this equity business.

Let's think a minute about chocolate cake. And imagine for a moment that chocolate cake grew on trees.

Why should we think of chocolate cake and not equity? For one, it's just more fun. Second, it's more tactile. We can image a chocolate cake in a way that it's hard to imagine equity. And third, if you hang in there with me, I can promise you a chocolate cupcake at the end of this session.

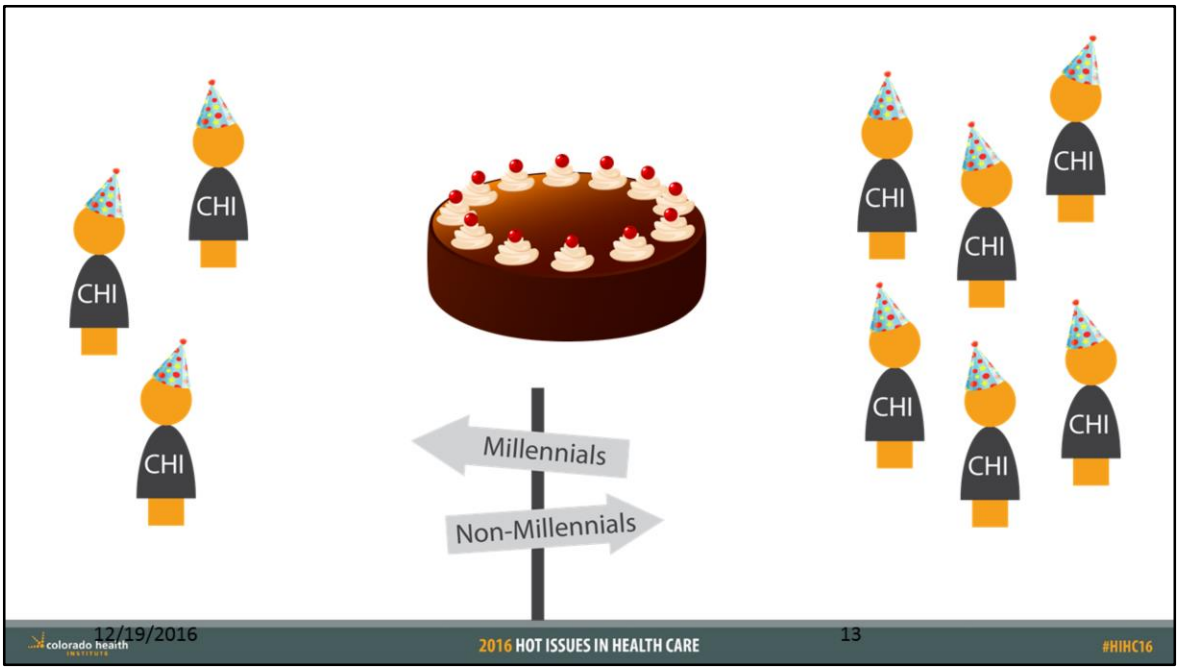
My birthday was last month, and it was a big important one. CHIers got me a chocolate cake. Now remember, equity is about how we divide up a finite resource. And for those of you who have visited our offices, chocolate cake is definitely a finite resource.



I thanked everyone for my cake and then we cut even slices and handed them out to everyone.

Was this an equitable allocation of a shared resource?

What about the people late to the meeting or who were not even invited? Equal slices, unequal invitations.



Then, another voice arose. It came from the Millennials on my team. Millennials are deprived in many ways, or so they told me.

While older people (that's me) had access to cooking lessons, home economics or expectations to learn to cook, Millennials just didn't They don't have the tools, knowledge and ability to make their own chocolate cakes. So, they argued that they are disadvantaged when it comes to chocolate cake. And society should make up for that disadvantage somehow. One way? They would take half the cake even though they represent only a third of CHIers.

That was, they thought, equitable..

But then more questions arose. What about people allergic to chocolate? Even if they could get a piece of cake, they couldn't derive value from it. What about vegans? Should they even get a slice? Do you have an alternative?

Deborah Stone, in a similar exercise, offers eight different ways to create equitable solutions to dividing up a chocolate cake.

We argue about the same things in health care.

Health care or health insurance or health outcomes. They are our chocolate cake.

We believe that all of us should have some chocolate cake and some opportunity for health. How do we divvy that up? That's the heart of policy discussions and conflict.

Do we all have a right to primary care, regardless of location, income or insurance status? Do we have access to a clinician or one of our choosing? In person or virtually? When we make decisions about how care is allocated – the rules around care – we are in a sense dividing up the chocolate cake.

The ACA articulated a pretty specific way that the cake would be distributed. If the cake is health insurance, well, everyone was going to have some. Right? We did that through enhanced public insurance (Medicaid expansion) and through private markets (the federal exchanges).

We have to look no further than our recent debates/discussions about ColoradoCare or Amendment 69.

Proponents of ColoradoCare often led with a statement about values, that health care is a universal and human right.

So, given its definitive defeat at the polls, let's back up and ask what our shared values are.

The idea that health care is a human right is not shared by all across the political spectrum. So the question becomes: If it's not a fundamental human right, how is health a shared value?

And we might want to think about this in terms of the following:

1. Recipients: Everyone? All Coloradans? Residency requirements? With our without documentation?
2. Services: Access to a clinician or a clinician of your choice? Mental health or physical health? What about oral health? Long term services and supports?
3. Process: Who decides? How is care received?

I suggest we think long and hard – and with an open mind - about this issue as we look to 2017 and beyond.

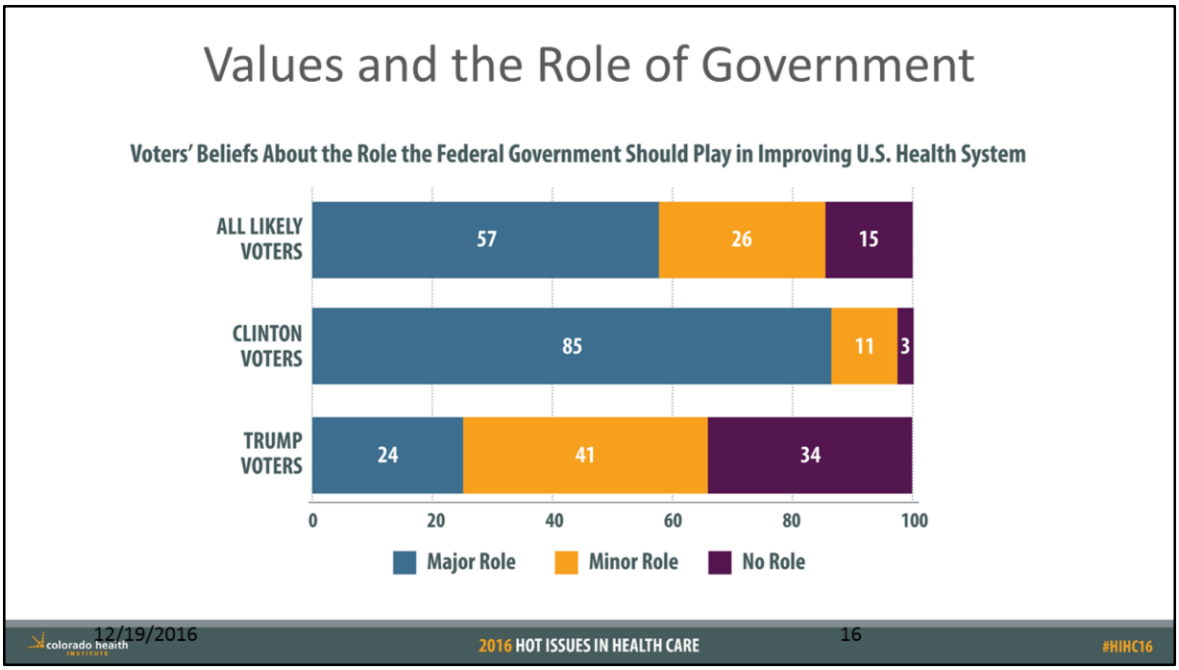
If we are stymied or asked to change course, let's return to our VALUES. We want an equitable distribution. Is there another way to get there?

I would like to refer to this letter recently written by John Douglas, executive director of the Tri-County Health Department: “I think it’s useful to remind ourselves of our core values - Respect, Integrity, Courage, Excellence, Leadership, and Collaboration. Respect for all members of our communities and those who seek our services—regardless of nationality, race, ethnicity, sexual orientation, age, social background, insurance status, income, religion, or any other factor-- is of particular importance in addressing community concerns, and I am confident that we will continue to demonstrate this core value in all of our interactions.”

Another key aspect of this idea of equitable distribution is the idea of the decision maker. This brings me to the second value that I want to explore with you today.

Tim Dunbar was the decision-maker for my birthday cake. He is trusted to be fair and equitable in our organization.
For the ACA, the decision-maker is – in large part – the government.

And we as a country don’t agree that the government should act in this role.



We need to look no further than recent polls to see that unlike equity – at least at its highest, most generalizable level – we as a country do not hold shared values on the role of government in health.

This slide depicts answers to a simple question, "What is the role the federal government should play in improving the US Health System?"

The results are startling:

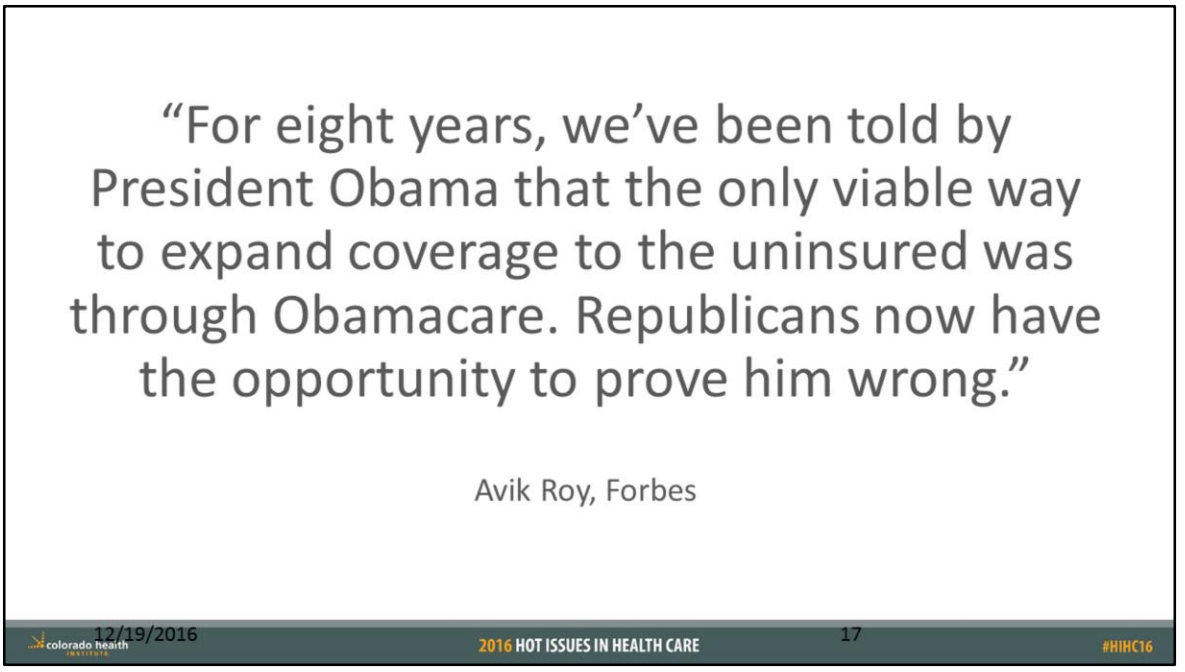
Of likely Clinton voters, 85 percent think that the government should play a major role in improving the U.S. health system.

Of likely Trump voters, that number drops to 24 percent.

That's a 61 percentage point swing! That's room for tremendously different views – and values – about how government should act in one of our largest economic sectors.

Government's role in health? Again, what's at issue are fundamental values.

Source: http://www.politico.com/f/?id=00000158-039b-d881-adda-77db04b70000



This idea of less government is taking hold in post-Obama policy discussions. Analysts such as Avik Roy are interested in proving that there are other ways forward. These ideas are making their way through policy circles and the popular press.

I think it's safe to say that we will see ideas in the next administration that:

Rely less on government and more on the private sector,
Rely less on entitlement and more on self-resilience or responsibility.
Shift risk from the feds to the states (block grants and waivers).
Shift from government involvement to self-determination.
Rise of social conservatism (ie: retraction of family planning investments).

These pillars will be the hallmarks of new policies in health care.

http://www.forbes.com/sites/theapothecary/2016/11/30/the-price-is-right-tom-price-is-trumps-strong-pick-for-hhs-secretary/#1fb159d03881

I encourage all of us to have an open mind about the opportunities a new administration can afford us.

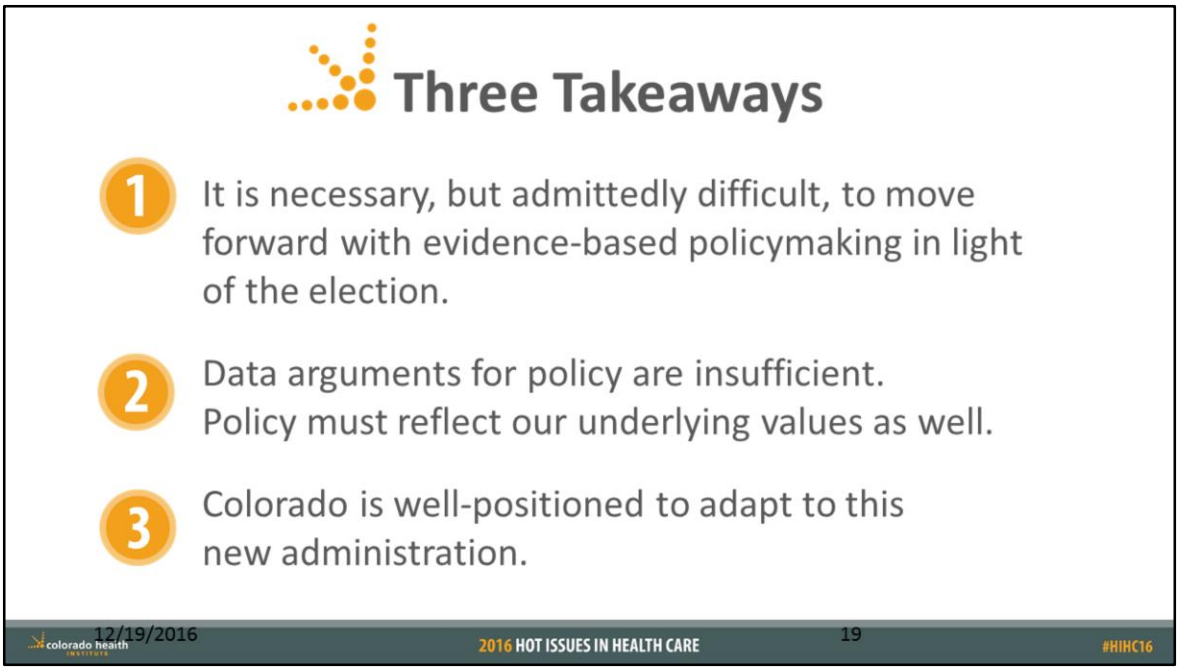
I was struck by this idea from Zeke Emanuel on the ACA or a replacement. You will remember Zeke as one of the chief architects of the Affordable Care Act.

“I'm not wedded to any particular thing. I'm wedded to getting the United States the best health care system it can have. It has to have a universal health care coverage system. It has to guarantee people who have illnesses that they can get affordable insurance.

It has to innovate in the delivery of care so we have higher quality care at consistently lower costs. That's the goal. There are many ways to that goal, but we've got to agree on those four elements as the goal.”

As a state and policy community, we must ask what are our shared goals?

Source: NPR http://www.npr.org/2016/11/21/502841490/trumps-pick-for-hhs-chief-could-foreshadow-plans-for-obamacare



So where does this leave us when we think about our lives, our work and our great state of Colorado?

Well, here's what I think:

1. It is necessary, but admittedly difficult, to move forward with evidence-based policymaking in light of the election. We as a community of policy makers and legislators must insist on surfacing the evidence and be disciplined in our approach.

2. We must also remember that Data arguments for policy are alone insufficient. Policy must reflect our underlying values and articulate those values as well. This is something that we will be thinking long and hard about at CHI this coming year… and

3. Colorado is well-positioned to pivot to this new administration. Now is the time for us to move beyond consensus to real partnership. To creating a vision that drives us forward.

You will hear ideas and thoughts throughout this conference on ways we can use evidence, scale sound ideas and advance our entire state. You will hear about our upcoming legislative sessions and the bills that will be run and how health centers can or should be our epicenters of health. You will hear from distinguished community partners who live on the front line of our policy ideas.

And you will hear about the challenges – and opportunities – that a Trump Administration will hold. I am not suggesting that the next four years will necessarily be easy ones. The values that we have adopted under the ACA – whether you embrace them or not – are sure to be uprooted and challenged. But I am bullish on Colorado.

As you move through these days and coming months, think through this

What's the data and what are the values we seek to achieve?
What are other ways of achieving our goals?
Where do Colorado values align with the new administration and where do thy not?

How can we sharpen our gaze, find a way forward, and wisely choose our battles -- for the things that matter most?

Thank you.