

## UVA LAW | UVA Alums on COVID Health Law Panel

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RISA GOLUBOFF: I'm Risa Goluboff. I'm Dean of the Law School at the University of Virginia. I am delighted to be here with you today and to welcome everyone. I want to first thank the *Virginia Journal of Law and Technology* and the Health Law Association for planning the event, conceiving, the event, and for inviting me to be a part of it. Especially want to thank Shweta Kumar, Kyle Connors, and Savanna Williams who have organized today's event.

Today's topic, "COVID-19 and the Future of Healthcare" could not be more timely. That is a huge understatement. The past year has brought sweeping changes to every aspect of our lives. And it has put healthcare and public health at the center of global and national conversations-- as well as, I know for me, the center of most daily conversations that I have with family and friends, and I'm sure that's true for many of you too. Conversations about who has access to healthcare, and how it's delivered, about the cost of healthcare, and who pays those costs, about the role of new technologies, and so much more.

The answers to these critical questions are frequently answered by lawyers, including the terrifically accomplished group of alumni that has assembled here today. At orientation, I told our incoming 1L students that change is all around us right now, and it is so often lawyers who lead our responses to change as a society. It's lawyers who unpack new challenges, who analyze them, who problem solve, and in so many corners of our society its lawyers at the forefront of change in the healthcare space playing a critical role in shaping what the health sector will look like in the future and what it looks like today.

And I am so privileged and honored to think about not just any lawyers who are playing these roles but UVA lawyers in particular. And I could not be more excited about the group of panelists who are here to talk to you about the future of healthcare, all UVA lawyers. Any one of them would bring incredible expertise and insight to our conversation. Taken together, they bring a breadth and depth of experience that covers almost all corners of the healthcare industry. So let me briefly introduce them to you.

Tom Moriarty is executive vice president, chief policy, and external affairs officer and general counsel of CVS Health. He leads the company's external affairs programs, including the policy, government, and public affairs, corporate communications, and legal and regulatory teams. As general counsel, Tom oversaw CVS Health's acquisition of Aetna, which has moved the company into the health

insurance space as well.

He joined CVS in 2012 after an accomplished career as a lawyer in the pharmaceutical industry, including stints at Merck and Merieux, as well as service as the general counsel and later president of Medco Health Solutions. Tom received his JD from the University of Virginia School of Law in 1989 and his bachelor's degree from Lafayette College.

Sandy van der Vaart is the Executive Vice President, Chief Legal Officer, and Chief Compliance Officer and Corporate Secretary of Labcorp, and she has led Labcorp's legal team since February of 2020. She first joined Labcorp's legal department in 2001, has served in a variety of leadership roles since then. Previously she was a member of the healthcare practice group at Smith Helms Mulliss and Moore, and a director of the North Carolina Medical Society's Managed Care Department.

She is a member of the Association of Corporate Counsel, and has previously served as President of the North Carolina Society of Healthcare Attorneys, and she has chaired the Health Law section of the North Carolina Bar Association. Sandy also received her JD from UVA Law in 1993, and she has a BS in nursing from the University of North Carolina at Chapel Hill.

Mike McAlevey is Vice President, General Counsel, and Business Development Leader of GE Healthcare. In this role Mike oversees GE Healthcare's global, legal, and compliance organizations and business development group. He joined GE in 2003 as Chief Corporate and Securities Counsel, and has held a number of leadership roles at the company since then.

Prior to that from 1998 to 2002 Mike served as the Deputy Director of the US Securities and Exchange Commission's division of Corporation Finance in Washington DC, and prior to that he was a partner with Alston Bird LLP in Atlanta. He received his law degree the same year as Tom Moriarty in 1989 from UVA, and he holds a bachelor's degree magna cum laude from Washington and Lee University, where he has also served as the rector of the board of trustees since May 2020.

Last but not least Michael Lampert is a partner in the healthcare practice at Ropes and Gray in Boston. He provides strategic, regulatory, and transactional advice to a wide range of institutional clients from healthcare systems, to pharmaceutical

companies, to physician practices. Recently Michael has provided critical guidance to clients in a variety of legal and regulatory issues associated with the COVID-19 pandemic.

He has been listed in Chambers USA, The Best Lawyers in America, The Legal 500, and Massachusetts Superlawyer Rising Stars. He received his JD in 2003 from UVA and is a member of the Order of the Coif, and editor of the *Virginia Law Review*. He received his in AB in government and Spanish summa cum laude and Phi Beta Kappa from Bowdoin College, and he clerked for the honorable Robert J. Cordy of the Supreme Judicial Court of Massachusetts.

I could not be more delighted and proud to have Tom, Sandy, Mike, and Michael share their insights with us today. So thank you all for taking the time to be here. The discussion will be moderated by 3L Kyle Connors. Kyle is a board member of our Health Law Association and managing editor of *The Virginia Journal of Law and Technology*. After graduation he will head to Boston to join the Life Sciences and Healthcare Group with Michael at Ropes and Gray. Kyle, I will turn things over to you now.

**KYLE  
CONNORS:**

All right. Thanks, Dean Goluboff. On behalf of the Health Law Association and *The Journal of Law and Technology*, I want to extend a warm welcome and our sincere thanks to our distinguished panelists for taking the time out of their busy schedules to participate in our discussion today. As general counsels for major corporations and partners in global law firms, you determine the direction of the legal profession. You all have been on the legal front lines of the pandemic and have shaped our response.

The panelists today each represent a different facet of the COVID-19 response. All panelists were asked to prepare a short introduction into how COVID-19 has affected their respective practices and industries and how their work has changed in the past year. In alphabetical order, our first panelist would be Mr. Lampert, but he's joining us a few minutes late due to a prior commitment. So then, up first we have Mr. McAlevey from GE Healthcare, which has been crucial in the medical device space in response to COVID-19. Mr. McAlevey?

**MIKE**

Thank you. Thank you very much, Kyle. Nice to see you all today. I thought that I'd

**MCALEVEY:**

talk about three ways in which the pandemic has affected our piece of the industry. When I say our piece of the industry, I'm talking about pharmaceutical diagnostics, and imaging, and some acute care products as well. I'll talk a little bit about our business in the context of these three points. Point number one is acute care, point number two is remote care, and point number three is digitization.

What COVID has done is basically drawn the future closer to the present. Another way, conversely thinking about it, accelerating change, because in each one of these areas this change was already afoot. In the acute care area, what we saw when COVID started was that everything stopped, and that the trend toward acute care began to accelerate. So what you saw in America and around the world was a shift of resources away from preventive care, a shift of resources away from chronic care, more toward acute care, and just dealing with the COVID patients first and then taking steps to protect the people who hadn't been infected yet.

In our business, it resulted in A Tale of Two Businesses. One side of our business, we deal with preventive and chronic care largely through elective procedures. You go in to get a scan of some sort, you make that decision, that decision can be postponed. That business slowed down. On the other side of our business, which is acute care, which is things like mobile X-ray, CT, ultrasound, ventilators-- which we'll talk about in a bit-- that part of the business really picked up. So Tale of Two Cities, but emphasis toward acute care. I don't think that's going to stop. I think that countries, given the trauma of this pandemic, will continue to invest in acute care capability in the future, making the system more resilient to these infectious disease shocks.

Second point-- remote care. Most people experience healthcare in the United States around the world in hospitals or in outpatient centers. What we're seeing more and more is people being able to access healthcare remotely from their homes, for example. Being able to use a tool like the one we're using right now. to talk with their physician about the challenges that they're having, and even having diagnostic tools with them at home-- a digital oximeter which can read the amount of oxygen in their blood, or heart rate monitors, blood pressure cuffs. All these kinds of things you can have at your home and then just receive that data and communicate it to your physician and choices can be made about the next step of care. So remote care will continue.

And digitization-- and I touched upon this because remote care and digitization touch each other. In the healthcare business, it is really a digital business. The amount of data that one gathers about patients, about procedures, about treatments, all of this kind of thing is brought together, and digitization allows more productivity in the system. Let me just give you a good example of an experience we had. We've got a tool called Command Center, which allows hospitals to be able to observe the critical parameters for each patient in the hospital.

And instead of having nurses or doctors walking around and visiting each one of those patients, they can just view them from a screen and a Control Center, and have all the information there, and artificial intelligence telling them when conditions are changing and when they may need to intervene. So it's actually a safety thing for healthcare providers. And it's also a productivity tool. So it's those three things: acute care, remote care, digitization are trends that I don't think are going to stop and were brought to us accelerated by COVID. Thank you.

**KYLE** Thank you, Mr. McAlevey. I see Mr. Lampert joined. Hi, Mr. Lampert.

**CONNORS:**

**MICHAEL** Hello. Forgive me, again, for having to have the 10 minute delay.

**LAMPERT:**

**KYLE** No problem. No problem. So thank you, Mr. McAlevey for launching us in so well.

**CONNORS:** Next we'll have a classmate of Mr. McAlevey, class of '89. Mr. Moriarty from CVS Health, which has been crucial in vaccine administration, COVID testing, and a huge player in health insurance markets, just to name a few. Mr. Moriarty?

**THOMAS**  
**MORIARTY:** Great. Well, thank you, Kyle, and I really appreciate the opportunity to speak with you all. If you go back really just about a year, today is when the pandemic was in full onset for this country-- obviously a lot of experience overseas brought here. And when I think about how we responded as a company, it really took on all aspects of what we do across our enterprise. So we have worked extremely closely with the administration-- the prior administration as well as the current administration-- working very directly with Operation Warp Speed, working with governors across the country as well, as they looked to tackle things like testing, COVID-19 testing, and now the incredibly important rollout of the vaccine.

So maybe I'll break it down into a few buckets like Mike did. But if I look at it first, the key issues we had to address really revolved around access to care. Physicians' offices shutting down, people were very afraid to go into hospitals. We saw an awful lot of what we call deferred care. People not doing the follow-up with their physicians, not going to the dentist, and doing other things. And that deferred care has really important impacts on the individual, but also on the longer term impact of healthcare in this country.

And so we started a very aggressive calling program out to our members, because we can see in the data, where follow-up visits were not being done, where maintenance medications for diabetes, cardiovascular disease, et cetera were not being reordered and refilled. And as a result of that, we were able to address a lot of these gaps in care. We greatly accelerated virtual care.

So people were afraid to go into physicians' offices, so we brought the physician office to the patient using devices such as this, whether it's Zoom or other virtual capabilities. And we saw an almost 900% increase in telehealth and virtual care over the last year, and that has made a very significant difference and impact for people.

Another area where we saw a lot of deferred care was in oncology and cancer related care. People either not going to follow-ups or not going for screenings. And obviously you know each day that is missed in cancer is this truly-- has a big, big impact. And again, we developed a very sophisticated targeted program around oncology specifically to make sure people were getting the follow-up care that they needed.

Another big bucket that we addressed was the need for COVID-19 testing. I had the honor of representing CVS in the Rose Garden where the big announcement was made about the role that pharmacy--

[PHONE RINGS]

--would play overall in testing. And what we have done over the last year or so-- excuse me. And what we have done in the last year or so is basically done almost 10% of all COVID-19 testing in the country. And how did we do that? We started a

brand new business almost overnight-- leveraging our drive-through pharmacies across the country-- some 5,000 locations-- where you could go to get your COVID-19 testing. You could schedule it, simply stay in your car, and have the testing done there.

We then also brought to the market, thanks to Sandy's team and others at Labcorp and Quest, the ability to do that PCR testing, but then also the ability to do what's called rapid scan testing, where you get the results in 15 minutes or so. And we purchased about 1,200-- what can only be referred to as kiosks-- almost literally like the moving pods that you see, and we converted those into testing centers and placed in the communities across the country, particularly in lower income and areas that had disproportionate impact from COVID. And that's made a huge difference.

The other area we've worked obviously is in vaccinations. We along with Walgreens were selected through a federal program to do all the vaccinations for long term care in assisted living facilities. So over the last, say, two months or so, two and a half months, we have done over 40,000 clinics across the country. We have vaccinated some four and a half million Americans who live in long term care and assisted living.

And the impact has been significant. You've seen a 94% decrease in COVID infections in long term care and nursing homes, and you've seen an 89% drop in deaths as a result of that. The next wave of this, you're starting to see it obviously almost daily in the press, is the rollout of the national vaccination program outside of long term care. We have the capacity to do up to 25 million doses a month, and that can make a big impact for people as we go forward.

And then the last area I'll highlight is the need for public private partnerships. So throughout this past year, working with the White House, working with Operation Warp Speed, working with governors across the country as they develop their own local needed solutions, and frankly working very closely with Quest, Labcorp, and other industries has made a huge impact at how we have rolled this out. So those are just some thoughts, and I look forward to the discussion.

**KYLE**

Thanks Mr. Moriarty. In preparing for this panel I did see that Rose Garden video that

**CONNORS:** you mentioned. It's almost surreal that it's been about a year since that happened. I think now we're going to move on to Miss van der Vaart, whose company Labcorp has done a monumental job in the diagnostics and testing around COVID-19. I did some research this morning, and according to the COVID Tracking Project, Labcorp has done over 10% of all the tests run in the US for COVID-19 thus far. So, Miss van der Vaart, can you take it from there?

**SANDY VAN DER VAART:** Thank you, Kyle, it's a pleasure to be here with this panel and with all of you from UVA Law. So last year really was an unprecedented year for all of us. For our industry, it really shown a very bright spotlight on what we do. That can be positive and it can be negative. But Labcorp actually has two businesses. So we have our diagnostic testing business, which performs the PCR testing. And then we also have a drug development contract research organization business which supports pharmaceutical companies in developing various treatments including COVID vaccines and treatments.

These businesses have largely been more business to business. So we have had direct consumer interaction in the past, but it was certainly much, much more in 2020 which created a lot of opportunities as well as challenges. The other interesting part of this experience for us is, we had a new CEO and a relatively newly formed executive team. So Adam Schechter, who is our CEO, became CEO on November 1, 2019. We had great strategy discussions in early 2020, and then about this time last year we were in the midst of a pandemic.

But Adam came from Merck-- 30 years at Merck-- he actually led their vaccines business. He had been on the Labcorp board for six years. So we had a lot of experience with the company. And while many members of our executive team, like myself, had been with the company-- our CFO had been with the company-- we also had some new folks. And I would say that the pandemic and the experience brought us together very quickly as an executive team, and it actually, I think, accelerated things for us as, Mike mentioned.

But one of the things that was really important for our company, and our industry is that science and innovation led the way. So we were the first lab about a year ago to get an EUA for our COVID PCR test. We had tremendous experience and had been a pioneer in PCR testing. And early on, Adam and our leadership team developed

what we called our guiding principles, which really we adhered to throughout.

The first of those was to build as much capacity as we could as quickly as we could. And science, again, was critical to doing that. So we got our first EUA and launched our testing about a year ago. And we continued to add as many instruments and platforms as we could to get the capacity increased as fast as we could.

At the end of last year, we could do-- and still-- we can do 275,000 PCR tests a day across 16 laboratories, including some of our drug development laboratories. So these are laboratories that don't typically do diagnostic testing. But when we saw that the demand was surging last summer so greatly, we brought up testing in our clinical trials lab in Indianapolis.

We had a request from the UK government to bring up testing there. So we brought up testing at one of our clinical trials labs in the UK. So just tremendous focus on building that capacity. And frankly, when we started buying equipment and increasing that capacity in March, our base business had dropped by 50%. So both Mike and Tom talked about physician offices shuttering and people not getting care. So our regular lab testing business greatly dropped which had a revenue impact, but we made the decision that our country needed the testing. So we were going to buy everything we could get our hands on frankly, to expand capacity.

And science also led the way there. So you can have the instruments, but if you don't have the supplies to collect the specimens then you can't do the testing. And there was one point where the nasopharyngeal swabs that you use to collect the specimen were in really short supply. There was a-- the main manufacturer was out Italy. They weren't able to produce.

So our science team was the first lab to validate using just a regular nasal swab. It looks kind of like a Q-tip, frankly, to collect the specimen, which was a great innovation in terms of addressing a supply shortage-- also a whole lot better for patients-- because if you had the experience of having a nasopharyngeal swab collection, it's not particularly pleasant. That also enabled the at home tests that we were the first lab to get an EUA for our Pixel at home tests, which is a kit that we send to individuals, and they can collect the specimens themselves in their home. Very convenient-- also avoids people having to go into a healthcare facility so helps

to stop the spread.

So there was just a lot of innovation, and science was very much at the forefront of the pandemic for us. And that continues, and it will continue. It's really accelerated for us demonstrating our scientific capability. So we now are doing sequencing a variance for the CDC. We were the first lab to identify a number of the variants. That's very important to our pharmaceutical vaccine-- the companies that are developing vaccines-- because they're very interested in the variants and how their vaccines are going to perform against that. So that science and innovation continues.

The other part of building capacity was really collaboration, and Tom mentioned the collaboration with federal and state agencies. We had that as well. We collaborated with our industries and the American Clinical Lab Association. We came together to support all the drive up testing, or collection sites, the CVS and some other pharmacies, we were supporting them in having the specimens collected and then using our logistics to get the specimens to our labs. So we have a very large logistics system, couriers, planes, we can get the specimens to our labs very efficiently.

We were also helping various federal and state agencies to manage through the pandemic through data. So we report and have always reported to the CDC various infectious disease results. The demand for information was almost as great as the demand for tests. So we have been-- since a year ago-- every day reporting the number of tests we ran the previous day, the number of positive, the number of negatives, the number of indeterminants, and I heard this morning from the person who coordinates that, [? Theresa ?] [? Lay, ?] that a year ago as a group we had performed 7,200 test the previous day.

At this point, collectively, we've performed 110 million tests. But that data was provided, and is being provided, every morning to HHS by our laboratories. And we also report to all the states, some of them multiple times a day, because they wanted to know-- have very real time information about what was happening.

The other guiding principles for us really had to do with access-- equal access to testing, regardless of ability to pay or whether you were an important customer. So we made a decision early on that we were going to accept the Medicare price from

everybody, whatever it was. And we also made the decision that no one would be advantaged or disadvantaged by the ability to pay.

So we didn't charge up front anybody, and for the most part you were not allowed to for PCR testing. But there were some companies that were doing the at home consumer testing, that the whole business model is, you collect upfront with a credit card. And we actually for our Pixel test had to change our processes to not collect, because we made the decision you should be able to get that test regardless.

And we also didn't prioritize except where HHS asked us to prioritize. So they asked us to prioritize hospital inpatients and healthcare workers. It was very important to get them tested and get the results back. And so those were the only tests that we prioritized. And we got a lot of requests from important customers and important people to prioritize testing. The sports teams were willing to pay a lot more, frankly, to do their testing. They wanted it done the day before a game or whatever, but we just decided that wasn't the right thing to do.

And so, I would echo some of the other comments, that I would say coming out of this-- and I believe we are going to come out of it-- what it has really done for us is to accelerate the science, and innovation, and the unique capabilities that we have through both our diagnostics and our drug development businesses, because the data that we get from all the testing that we do is helpful in recruiting patients for clinical trials, it's helpful for informing decisions about treatments and vaccines, and so we're continuing really to accelerate all that combined expertise.

The other thing I think will continue is the spotlight will be on us. So really to be able to get information out there-- accurate information out there-- our CEO got a lot of requests, as well as did our chief scientist, to be on television-- to do interviews. That's not something our company had done before. As a lawyer, you know that's not necessarily always a good thing. But that continues, and I think we'll also continue to really try to get information out to the public more directly.

**KYLE  
CONNORS:**

Thanks Miss van der Vaart. I did some research, and Labcorp came out with one of the first commercial tests five days after the FDA issued that non-binding guidance saying that they would not object. And that was on March 5th. So that's a year and 11 days ago.

**SANDY VAN  
DER VAART:** Yes.

**KYLE  
CONNORS:** So I thought that was interesting. So next we have Mr. Lampert. He's worked extensively with institutional providers such as academic medical centers and hospitals, health systems, and universities in responding to COVID-19. Mr. Lampert?

**MICHAEL  
LAMPERT:** Sure, absolutely. Well, glad to go. Thanks a ton for having me. And Sandy, thanks to the scientists-- so this morning-- I feel totally fine, but I did have to get a COVID test. And it was one of the little Q-tip ones. It was fabulous. It was absolutely the best. It was a test of my nose, not my brain. It was ideal. So thanks to the scientists. I'll kind of run through maybe a couple of ways of how the effect has gone for different sectors that I work with.

One sector-- I do a lot of work with academic medical centers on the university side, school of medicine, with their health systems, their faculty practice plans. And there it's been a really diverse and totally fascinating experience. One, they're healthcare providers. And so from a-- and some are university-based-- so from a financial perspective, they've had quite a ride-- and not the good kind of ride-- that the hospitals tend to make their money on procedures that are elective procedures.

I mean, they have a huge fixed cost base. And if they can't have a procedure level that is going to be consistent, they're going to be, candidly, in a financial world of hurt. And that's exactly what happened. When you shut down, and you say, all we're doing is taking COVID cases now and highly urgent stuff, and we are going to put off-- I needed to have oral surgery, I still haven't had that oral surgery. Mass General Hospital is a lovely Institution, and they don't really want me to have the surgery, just because they want the money, but they wouldn't mind the revenue that they'd get from that. And I haven't had that.

And so, there's been a lot of financial advising. A lot of advising of institutions around their financial situation, what it means for their bond debt, what it means for their debt covenants that they might be tripping, because those types of institutions-- and I should have guessed it, but I candidly didn't. Coming in I thought, look, it's going to be a pandemic. Pandemics are great for healthcare. Well, they're great for part of healthcare, but they're really bad for other parts of healthcare

from a business perspective. So that was one area.

Then another set of just fascinating questions. Universities have brilliant human beings there who invent all sorts of stuff. Sandy was talking about the shortage of swabs. And I remember getting forwarded from a university-- from the general council-- this long email chain that the general counsel had finally gotten, and she was glad she got it. It was between these faculty members who realized that there weren't enough swabs, that they needed swabs, and they figured out that they're all human beings, so they could just print a bunch, do 3D printing of a bunch of swabs.

And then there was this chain that someone where they found a place to get some polymer, and they were going to run it. And they were thrilled they were going to be able to print 5,000 of these swabs a day and they were going to bring them over to the hospital. Well, there's no FDA approval whatsoever for these swabs that they were going to create. These are phenomenal human beings, hearts of gold, brilliant scientists, and we need to figure out what to do. And there was a real question what to do, because there was a real shortage.

This was almost-- I remember that happened, it was probably about 11 and half months ago. And it was on the East Coast, so just as we were really beginning to figure out what to do. And so there were these questions that had just never come up. Related ones, again, universities-- so universities, many of the ones for which I do work, have faculty practice plans, where doctors who are the professors at the medical school also see patients. And some of the patients they see are students. And some of those doctors are mental health providers. And they have relationships with-- care relationships with students. These students were all told not to come home from spring break.

So university on the East Coast, doctor on the East Coast, licensed on the East Coast, patient stranded on the West Coast, has had a care relationship for mental health counseling, and it would be a really bad patient care thing to happen for that physician no longer to be able to maintain that care relationship that had been developed over the course of the year. That physician under the laws of the state of California had no business talking to that patient.

And so, figuring out what to do for licensure on a really quick basis, I think, it is just

fascinating and it involved a lot of work for state legislatures or the National Conference of Governors. It involved, candidly, a lot of risk assessments by institutions to say, we are in a somewhat different area right now, and where are we going to be comfortable making a judgment that x is appropriate to do? We're not going to put a COVID flag over everything, but we are in some cases. And doing those risk assessments, I think, was just fascinating.

Test approvals-- figuring out tests. I've been lucky to work with a bunch of institutions that had invented a lot of their tests, that developed their own pool testing. So development of those tests, commercialization, getting EUA-- that's the FDA authorization-- to then get immunity for that. And then think, OK, we're bringing students back, how are we going to require testing? I imagine folks at UVA who are on campus who have participated in a program. But what could be required? What do we do when we find out that someone is positive?

And now the next phase, what about vaccine? Can we require a vaccine for somebody to be on campus? I personally think the answer is yes. The Chronicle of Higher Education, which is this-- people think it's the Bible in higher ed-- it tends to think no. And so, we're going to have to figure out what the right answer is there. But can a school say, look you're not vaccinated, you can't be on campus. So our questions coming up now around tests, other things, how are we going to-- we've invented a test, we think it is a phenomenal test-- it is a phenomenal test-- and we're testing our university. But look, there's a school down the road. We'd like to provide that testing there. There is a manufacturing plant down the road, we'd like to provide that employer based testing there.

The question, what are we going to charge for that? And if we start charging for that less than what Medicare pays us for that, are we now setting what's called the usual and customary price that's below the Medicare price, that is going to erode our ability to bill Medicare for the Medicare price or other payers for that price. So just fascinating questions-- grim questions-- around resource allocation. By resources I mean ventilators. Who gets to have a ventilator. How are we going to set up a protocol if we don't have enough, which had frankly a lot of enforcement lawyers on it.

And then there's been-- a lot of that was a reorientation, I think, to the core too. I do

a lot of transactions where a university academic medical center is part of it. And those certainly dried up-- immediately stopped-- because there was a reorientation saying, what's the core, what do we have to do? That's certainly changed over time from a transactional perspective. In each domain, I think people have figured out how to have a Zoom like this, and how to operate, how to meet the moment, and then how to continue to grow businesses. So that's picked up again.

That's the provider AMC side. Labs, I do work with labs with some manufacturers, some vaccine manufacturers. Now I have no idea how to advise on a clinical trial personally. So, but I really enjoy being on calls with colleagues who do, because I think it's just fascinating in designing clinical trials for vaccines. I do know how to do things around compliance requirements, compliance standards, for operations by vaccine manufacturers that are now walking into areas where they haven't been before.

Investors, that's a totally different area, But just to say it, we haven't talked about it yet. So the world-- there was a what-- it was 20, 30% market drop almost exactly a year ago. The world sort of stopped. We thought we were going to go into a deep economic freeze on private equity firms. Those deals stopped. The ones I was working on in their footprints, and it took a couple of months for them to pick up, but then found that starting in about June the private equity market, and the market of lifesciences transactions, and some of the AMC transactions-- although candidly fewer of them-- it really became quite active. And so there was a question of we're sort of doing deals by Zoom rather than in rooms.

And an area that I think has been fascinating is looking-- which kind of bisects a lot of what I've been talking about-- is enhanced vertical integration in the healthcare industry. To say, not just a deal between an academic medical center, an academic medical center, but a deal between a lab and health system, or between a health system and a payor, or between a health system in the payor and a retail health provider. Payors have done really well and are in really good financial position.

Let's go back to my example of my tooth-- the oral surgery I have to have. Cigna has not paid for me to have that oral surgery now. Cigna hasn't paid for really anything for me right now. They've paid for a couple of COVID tests and that's-- and a couple of telehealth visits with my PCP, and that's it. I have continued to pay Cigna

my premium on a monthly basis. Payors are doing well. And so, and providers-- going back to what I said about AMC, in a way not so much, some of them.

And so I think, that there has been a-- and it was happening anyway for other reasons-- but a lot of what I think was the back half of last year, beginning now, is focus on vertical integration. How do we essentially pull financial risk down in a way that is consistent with-- and I do think promoted by-- two things. One, where money sits now, which is at the payor's level at the top. Two, the experience of integration, and the experience of telehealth connectivity, the experience of consumer-based care that we've all had. I've seen the doctor four times, but I've never gone to the hospital since COVID. And so there are a lot of different ways we've gotten care.

Quickly a couple other thoughts which are very different. Some of what I do involves government investigations, and those have been very, very different now. And it's not what we've talked about. But if you take FBI agents and you say that they can't go meet with people, because they can't leave, your government investigations don't go very quickly. What we haven't seen a lot of, except in the most egregious cases, is active enforcement around things like the CARES Act, around the huge amounts of money that report to the healthcare system.

I vividly recall one day talking to a client that they had received-- not expecting it-- something like \$40 million in their bank account the day before from HHS, because it was the first wave of CARES Act money that got to them. They didn't ask for it. They didn't want it. They didn't know how to pay it. The rules have changed dramatically since then. That enforcement hasn't picked up yet, but I think that there will be a lot of opportunities for it, because that's what the False Claims Act is all about.

And very last, the business of the law firm. It has now been a year since I've been in my office. It will be 18 months by Labor Day, which is our expected first day back, Gray had said, we won't be back before Labor Day-- won't have required to be back before Labor Day. And I remember the first meeting we had the first day thereafter getting the email that said something like, 3,000 people logged in remotely, and miraculously the system didn't crash.

My secretary, she got a laptop sent to her, and an internet phone sent to her, so

that staff could continue to work remotely. So it has been fascinating to see the increase in some levels of connectivity, the humanisation-- the number of people who now know my four-year-old and my one-year-old, and the fact that I keep crayons in my desk right here. So when they walk in, I can give them the crayons and they can go there. There's a level of connectivity that hasn't happened before. And there's a level of spontaneity that is utterly, I think, necessary.

**KYLE** Thanks, Michael. Thank you.

**CONNORS:**

**MICHAEL** Yeah, go ahead.

**LAMPERT:**

**KYLE** No, thank you. I know that Miss van der Vaart is leaving in about 10 minutes. I was wondering if we could do a quick rapid fire question to each panelist. Maybe your answer in one to two minutes. So the first question is to Miss van der Vaart. Thank you for bringing up the FDA, Michael-- it seems like-- or Mr. Lampert. It seems like the FDA is coming up a lot in the answers today. So I was just wondering, Miss van der Vaart, the difficulties you guys had, or non-difficulties in getting out the COVID tests based on the regulatory challenges in last March and February.

**SANDY VAN DER VAART:** Yeah. The FDA was really supportive as was the CDC and HHS. So we've had a longstanding very good relationship with the FDA. And I think we have a lot of credibility in terms of our science and our scientific teams. And we made the decision. We got an FDA EUA for everything that we rolled out, even when it wasn't required, because we thought that the scientific discipline around that was important. And our credibility with them is important.

So I think that's an important message for us as lawyers, just to keep in mind, that you build these relationships over years, and you can lose them in a heartbeat if you don't work well with the agencies. But I would say, they were very helpful to us, including to launch-- to get the EUA for our first tests, we had to get positive sample, because we didn't have any, because we hadn't been running the tests. And they actually worked with us on a weekend to get a sample within a matter of hours. So they really helped us accelerate. Thank you.

**KYLE** Thanks Miss van der Vaart. And Mr. Lampert brought up ventilators. And who better

**CONNORS:** to talk about ventilators with than-- he already unmuted himself-- Mr. McAlevey. My question is, so GE Healthcare is a global medical technology lifescience company. And at the beginning of a pandemic, many critical medical devices, such as ventilators, largely produced by GE Healthcare were believed to be in short supply. The result was that \$336 billion deal from the federal government with a partnership under Ford under the Defense Production Act. What was it like negotiating such a large contract with the federal government under this rarely used law?

**MIKE**  
**MCALEVEY:** Yeah. Well, I'm suffering from post-traumatic stress, I think. Yeah. It wasn't as bad as you would seem. The initial view, I think, of the administration and private industry was not to invoke the Defense Production Act. There was a libertarian streak in that administration, and a lot in private industry were quite fearful of what it may mean if it was implemented, and the government requiring businesses to make certain things, or commandeering their means of production.

It didn't turn out like that at all. I think that the Defense Production Act is a very broad statute. It's got a lot of authorities in it, one of which is something called a rated order. And a rated order is something that where the government says, thou shalt prioritize my order in front of all other orders that you may have now or in the future. And that's where we came into contact with it.

We made one line of very high end ventilators that the government was very interested in. We had a very full order book already for that. We were fearful that the government would have us revoke all those orders-- many of which were outside the country-- and we negotiated very successfully with Mike Pence and with Peter Navarro at the time to allow us to create capacity in our own way without them having to intervene.

One of the ways we were able to do that was the Ford partnership. We realized that the country needed help. The government needed help. We went and found a small company in Florida that had a 510(k) cleared product but did not have the means of production to be able to make it rapidly. We have enormous regulatory and technical capability. Ford had more unused manufacturing capacity.

So we went to Ford, and we partnered with them and said, look we will do the

regulatory technical piece of it, the marketing piece of it, you all make it. And we will make 50,000 ventilators for emergency use for government. And that's what we did. And it was a 50,000 ventilator order. We fulfilled it. They're now sitting in warehouses all over the United States. I'm not sure that any of them have been used. But we did meet the demand. And the Defense Production Act is not something to be feared. The government was actually quite constructive in the negotiation. Thanks.

**KYLE  
CONNORS:**

Thanks, Mr. McAlevey. Mr. Moriarty, one aspect of the CVS business is a neighborhood healthcare provider. These locations have taken on the additional monumental task of acting as these vaccination hubs. What type of challenges has CVS encountered on this aspect of the rollout?

**THOMAS  
MORIARTY:**

Many, I think, is the answer. But just to break it down a little bit. I mean, the way CVS has come together, we're essentially three Fortune 50 businesses under one roof. And then as we look enterprise-wide, how do those business intersect, and where do we bring more value to the consumers we serve. So we meet the healthcare needs of one in three Americans every year. We service over 100 million folks each and every year.

And I think where this really became complicated was in the breadth of our businesses. All of the issues around the CARES Act implementation-- emergency orders, both at the federal and state level-- we had to essentially accelerate what we call the Office of Legal Mandates, because we had to ensure compliance across the board in doing this. And how does that take life? So for example, we have pharmacy technicians who are trained healthcare professionals helping pharmacists meet the needs of patients at the pharmacy counter, dispensing medications, and the like. In some states they're allowed to do vaccinations, in a lot of states they're not.

So one of the key initiatives we had was working with HHS, and CMS, and the White House to have a national standard issued, that as vaccines rolled out, as testing continues to be needed, that pharmacy technicians can do that. And the impact of that, not just for us, but across the board, is it basically almost quadruples your workforce that could administer vaccinations and the like. And where are folks? They're in the communities.

So one of the trends we've seen that's been accelerated is what I call the deinstitutionalization of healthcare. It's moving from large academic centers. It's moving from large institutional settings and moving much more into community-based settings. And that's clearly a part of our strategy if you look at health hubs and other things. So I think the pandemic has accelerated things. It hasn't changed our strategy, it's accelerated it. And you're going to see more and more of these community based offerings.

**KYLE  
CONNORS:**

Thanks. Thanks so much. If you guys wouldn't mind, if we could move to a couple UVA Law specific questions. This is an incredible group assembled, all UVA Law alumni. So we are wondering if you could answer maybe one to two minutes, because we're running a little bit short on time towards here at the end. And I'll ask Miss van der Vaart first, because I know she has to head out soon. What led you to UVA Law, and in what ways did UVA prepare you for-- I know you took a very interesting path coming in with the BS in nursing. So I'd be curious and interested to hear.

**SANDY VAN  
DER VAART:**

Yeah. Well, when I made the decision to go back to law school, I had two children. So I was geographically pretty limited. I was living in North Carolina at the time. But I had been interested in health law actually through a course I took in nursing school on law and ethics. So when I was looking at law schools, I wanted to go to a top tier law school, but I wanted to stay in the area.

And I was just so fortunate to get into UVA. I have family in Charlottesville, which I couldn't have gotten through law school with two young children without the support of all my family. It also had a burgeoning-- and not typical-- very strong health law practice. So I was sad to read that Professor Watlington passed away about two years ago. But he was a wonderful mentor for me. And I knew I wanted to do health law when I went to law school.

Honestly, I didn't know exactly what health law was, and there were not a lot of courses at the time. But I had a great education at UVA Law, and it really launched my career, which has been much more in regulatory, commercial, and not in litigation, which is where I thought it would be when I went to law school. So I appreciate it. I am going to drop off now, because I have another commitment. But

it was great to be with you all. Thank you.

**KYLE**  
**CONNORS:** Thank you so much for joining. I think your assistant, Mr. Moriarty, mentioned you had to drop off at one as well. So if you have an answer to this question? Any professors that influenced you as well?

**THOMAS**  
**MORIARTY:** Yes, it's probably similar to Sandy's answer. So in college, I was lucky enough to have two internships in Washington DC on the Hill. And always had an interest in law, politics, and regulation, and frankly policy more broadly. And UVA just has an incredible tradition of law and politics, and really teaching folks to understand the intersection of law, policy, regulation, and how that really impacts not just the shaping of laws, but how businesses have to mold their businesses to meet that standard.

So again, I was lucky enough to get in, and I never looked back. Because the ability to go back and forth to DC was really important. But then also the reputation of the school and the opportunities that it provided me. So I think there were a number of professors, some that you will never have heard of probably. But the faculty was always accessible and really offered, I think, real life practical advice as we worked our way through the three years.

**KYLE**  
**CONNORS:** Thanks. Mr. Lambert, to you?

**MICHAEL**  
**LAMPERT:** Sure. Well, I think I found my way there for a couple of reasons. First, I mean, to be candid, great school that I got into, so I was lucky that they made that decision. And I decided to run before they took it back. Second, I liked the cultural view of the school, which is to say, the collegiality that was the reputation of the school, and that I certainly found. I mean, being able to share outlines with colleagues, having this forced curve, that essentially made-- people weren't afraid that they needed to push off the kid-- the student behind them-- to get up.

And instead, we could just have a class of colleagues that were enjoying the intellectual exercise was fabulous. I didn't take any health law classes. I took no health law classes at law school. And I look back at the courses that I loved, the ones I remember are the ones that fundamentally showed that there are frameworks that make sense, and that you kind of figure it out. Like torts was a fun

class, because it just taught me I could figure it out. Contracts, I could figure it out. Corporations, super useful for the structure. That's what, as I look back, what I remember most.

**KYLE** Thanks. Mr. McAlevey?

**CONNORS:**

**MIKE** Yeah. I'll finish this up. I think, as a jet is getting ready to come by. So I'm going to pick up the pace here. UVA culturally, I agree with Michael, it seemed like a good fit. I visited it, and it seemed like a diverse place that had a civil culture and it seemed like a good place for that. And second, I was really-- at the time I was coming through law school-- Tom and I were coming through-- there were basically two predominant schools of thought effecting legal scholarship-- one was law and economics and the other was critical legal studies.

And UVA was very strong on law and economics. And that's something that made sense to me, notwithstanding having been a liberal arts major in college, I tend to look at the world in economic terms. And I thought it would be a great way to understand the law in its practical application, and I wasn't disappointed. Thanks.

**KYLE** Well, I think we're at our time limit, or about 30 seconds away, and I want to just express our sincere appreciation to the panelists participating today. I hope that the conversation was interesting and informative, and thank you for participating and tuning in.

**CONNORS:**