

TRANSCRIPT

**CONNECTING FINANCIAL MARKETS TO HEALTH POLICY
THE 21st ANNUAL WALL STREET COMES TO WASHINGTON”
ROUNDTABLE**

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CENTER FOR HEALTH POLICY AT THE BROOKINGS INSTITUTION

USC LEONARD D. SCHAEFFER CENTER FOR
HEALTH POLICY & ECONOMICS

Sponsored by the Jayne Koskinas Ted Giovanis Foundation for Health and Policy

Moderator:

PAUL GINSBURG, Leonard D. Schaeffer Chair in Health Policy Studies and Director of the Center for Health Policy, The Brookings Institution; Professor of Public Policy and Director of Public Policy, Schaeffer Center for Health Policy and Economics, University of Southern California

Panelists:

MATTHEW BORSCH, Healthcare Equity Research Analyst, Goldman Sachs

ANA GUPTE, Managing Director, Senior Analyst Healthcare Systems, Leerink Partners

SHERYL SKOLNICK, Director of Research, Mizuho Securities USA

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MR. GINSBURG: Good morning. I'd like to welcome you to the 21st Annual Wall Street Comes to Washington Conference. I'm Paul Ginsburg. I'm director of the Center for Health Policy at Brookings, and director of public policy at the USC Schaeffer Center for Health Policy & Economics. Many years ago, shortly after beginning the Center for Studying Health System Change site visit studies on changes in financing and delivery of care, I perceived how poorly informed policymakers were about what was happening on the ground in health care markets. I also perceived that Wall Street analysts were conducting their own research on these issues to inform their investor clients, and that policymakers also could benefit from the analysts' broader market perspective.

So after convening a meeting with analysts in New York to discuss market developments, I invited them the next year to come to Washington to have these discussions in front of a policy audience. Now this annual conference has exceeded the lifetime of the center and has moved with me to USC and now also to Brookings. So I'm delighted that Jayne Koskinas Ted Giovanis Foundation for Health and Policy recognizes the value of the conference by sponsoring the event for its fourth year. Through research and projects like this conference, the JKTG Foundation hopes to foster discussion about cost reduction, expanding access to care, and improving quality. The conference's main purpose is to give the Washington health policy community insights into market developments that are relevant to policy through a different source of information, equity analysts who advise investors about which publicly traded companies will do well and which ones will not.

Along with a thorough understanding of health care markets, and the companies they follow, all three of our analysts today closely follow public policy because the implications for publicly traded companies are so profound. They likely will have comments about the market responses to policies expected from the Trump administration and the Congress, comments which may be helpful to those crafting these policies. So the format of our meeting will be a roundtable discussion based on a series of questions that have been shared with the panelists in advance. We'll have two opportunities for questions from the audience, the first before we take a break at

10:30, and the second before we adjourn at noon. Note that the analysts are not permitted by their employers to answer questions about the outlook for specific companies. And a transcript and the Webcast of this conference will be available through the Brookings and the JKTG Foundation websites later this week.

And before you leave today, we'd appreciate it if you could take a moment to fill out the evaluation, the pink paper on your seats and leave it on the table outside the room. We have a terrific panel this morning. They're all veterans of this conference, have done very well in the past, and Matt Borsch of Goldman Sachs, Ana Gupte of Leerink Partners, and Sheryl Skolnick of Mizuho Securities. You have their bios in your materials that you picked up.

So I want to jump right into the discussion, asking a question of the analysts that's different from most of the questions I ask, which are about markets, but I thought it's a good way to get us into it. And it's really about investor reaction to the election. And I want to ask them to discuss how investors in health care have reacted to the election in terms of stock movements and different industry segments, and how things might look different in a few weeks or months, but if investors are right, what are the actions companies might actually take in terms of a different public policy environment? Who would like to begin?

MS. GUPTE: I'd like start. The first thing I think is the very obvious, the Medicaid managed care companies, Centene and Molina in particular., the Medicaid companies and the acute care hospitals all big selloff. Not surprising. I think most of us would interpret this big surprise, if you will, in the elections as a likely repeal of the Accountable Care Act (ACA). The replacement is quite unclear. Both those sectors saw enormous tailwinds from the Affordable Care Act, the hospitals with volume and with bad debt, and the Medicaid HMOs saw a lot of volume and topline tailwinds, though, as well. So they sold off.

The Medicare HMOs also started to see a lift, probably not as obvious initially, but then they rallied quite a bit. So Humana has seen quite a move since -- now it's reached almost \$200, you know, from 170 or something before the election, so a huge move, and expectation that the CMS from a Republican administration will be far more lenient, will deregulate, be less harsh on risk coding intensity, benchmark payments, all of that. So we saw a rally there. And most recently, I think the diversified HMOs have also now seen a move up. We've seen United have quite a big move, reached an intra-year high, and Aetna, and even Anthem, as well. And I think that's coming mostly from the expectation that there'll be a repeal of the health insurance fee, the tax, virtually all of the industry taxes, but benefiting the insurance industry quite a bit from tax reform, specifically related to the ACA, and then broader tax reform, which is likely to drive down their tax rate and bring some tailwinds, as well.

MS. SKOLNICK: So let me jump in here. So at about 10:30 when Hillary Clinton was struggling in Virginia, I started writing my note. And at 1:30 I sent it through when it was clear that Michigan was very pink. I like pink, but I don't like what happens to my hospital stocks, and I don't like what the outlook is for the health care sector, generally, when we have this kind of an unexpected outcome. And by 4:09 a.m. I downgraded the entire sector, both hospitals, managed care, and post-acute.

The problem that we face, and Ana has outlined a lot of what investors may believe or don't believe, but certainly in the first hours after the election results were blindingly obvious to

anyone with a television, it was very clear that what we -- the right answer to the question, "What will happen?" is, we don't have the foggiest clue. And to pretend otherwise, I think is not being fair to our investment community. We do not know. The administration hasn't been set yet. We don't even know who's running Health and Human Services. We don't know who the new administrator is for CMS. We don't know what implications new tax policy will have for health care. As Ana mentioned, some things may go away; some things may stay. Then we get, sort of, the backpedaling, "Well, gee, maybe we don't want to take 20 million people's insurance away, even though they, potentially, some of them voted for it. They told us they don't mind, so maybe we can take it away; maybe we can't take it away." This is the kind of dialogue that creates tremendous underlying uncertainty.

And what you're observing is the market convincing itself that everything will be fine for some sectors, or maybe not as bad. So the way I like to describe it is, normally, in a normal election cycle, you would have seen the Republican Party platform around health care coalesce around a plan. It could have been the better way. It could have been some other plan. But there would have been a platform, a group of concepts that were more than just ad hoc, well, we'll do this; maybe we'll do that, and throw things on a piece of paper. So we would have had a normal distribution of outcomes around that midpoint of the distribution. One standard deviation on either side would probably have had the right answer of what our health care system and policy will look like in the next four years.

But we don't have that. So in essence what you've done is you've introduced randomness, statistical chaos, as it were. And that chaotic state is kind of -- I describe it as, like, a colonization hex, because once you shoot that marble into the colony, it changes the color of all the other marbles around it, and that's exactly what you're seeing happening in the marketplace right now, is that once there is a notion of something that people can hang onto, it will change the perception of everything around it. But when you don't know what the shape of the distribution is, all you can do is identify what the endpoints are, because you don't know what the midpoint is, and you don't know any of the probabilities around the likely outcomes.

So what we do know is it is unlikely that anything will be better than what we have today from a provider perspective, from a hospital perspective, from a Medicaid managed care perspective. So if we preserve the level of Medicaid expansion as it is today, it's probably as good as it's going to get. All right? As an example.

So all we can do is measure the worst case and measure the best case and get comfortable around the worst case and the best case. And investors are starting to do that work. I had an hour-long conversation helping somebody this morning work through, what's the worst case? What's the best case for hospitals, for managed care, for others? But the problem that we face here is that the ACA, as those of you who understand it know, is much more than just the coverage expansion. So we have this whole value-based payment thrust that was born out of regulations contained in the ACA and built on since then. Has that train left the station? Have payers and providers, have primary care physicians, so integrated the premises of value-based care of patient-centered care, of all of the strides we've made in that direction, into their practices? If so, then companies like Optum, which is part of the United Health Group, which is fundamentally built on the promise of transforming and fixing health care, will they continue to have this acceleration and demand, or will the new administration, for example, back off the promise to move X percentage, whatever it is going to be, ultimately, of Medicare fee for service

to value-based care? Or will Medicare fee for service disappear in a forest of premium support? Now you see where I'm going here.

This is going to be much more than just simply block grants. Medicaid expansion, yes or no? Exchanges, yes or no? There is much more there. So what you're seeing right now is a desperate attempt to make certainty or surety out of uncertainty, when the right answer is it is tremendously -- in my view, tremendously uncertain right now. But we're investors. We can't not have an opinion. We can't not have a position, although portfolio managers can avoid the sector all together, and so we're rationalizing. And in that rationalization lies danger when we know nothing more today than we did a week ago.

MR. BORSCH: Yeah, maybe just a little brief add-on to both of those good summations. So I definitely agree with Sheryl that there is a high degree of uncertainty here. No one can dispute that. You know, our job, to a certain extent, as analysts is to try to predict the future. And I think, you know, looking at the current situation, investors are making directional bets here. They're making directional bets that we're going to see more commercial market deregulation, and that may, you know, go beyond the outlook for the individual market in the ACA exchanges and encompass areas like small group that have been pretty significantly impacted by the ACA regulations thus far. And over all, the market's saying, "That's a net positive."

Likewise, on an incremental shift toward Medicare privatization, I think it's a stretch to use the word privatization. It could just mean faster growth for Medicare Advantage. I think the markets reached that conclusion, as well, and directionally I would agree with that. And then, I think where the market has thrown up its hands is on Medicaid and the Medicaid expansion, and said, you know, "We just don't know, and we can't assume that that one's necessarily safe." And so that explains the depth of this selling that you've had in the Medicaid managed care names and also within some of the hospital companies.

Just finishing this off, also on antitrust policy, just incrementally that maybe antitrust policy will be a little bit more lenient under the next administration. So you saw the market shift in that direction, as well, bidding up the stocks of M&A target companies, Humana and Cigna.

MS. SKOLNICK: That's an interesting point, because I used to work in antitrust, and I worked there during the Reagan administration, and I can tell you, as a staff member, it was impossible to get anything through the administration. I mean, you could challenge it all you wanted until you were blue in the face, and it wouldn't go through.

But isn't it a little bit challenging for these companies that the trial date is so soon?

MR. BORSCH: No. I don't disagree. I think my point is incremental, not necessarily a conclusion that the landscape has changed with this election, because, in theory, at least, the process should be worked out or fully worked out by the time we get to the actual change of administration. You're right, Sheryl.

MS. GUPTE: I think one last one is the pharma stocks, which we didn't talk about, and none of us cover, but they have seen a massive rally that was a huge concern on drug pricing and it's very much market consensus at this point that this administration will, at the very least, back off on some of the drug pricing policy pressures, that the Clinton administration could have been putting on these companies. So it's pharma, and now the winners and the darlings, you know,

Medicaid, HMOs and hospitals in the doghouse. I think Medicare and the other HMOs are starting to show some nice movement up as well.

MR. GINSBURG: Okay, thank you. I have some questions about the scenarios for what the individual health insurance market would look like under just a plain repeal of the Affordable Care Act, or repeal and replace. So if budget reconciliation is used to repeal those parts of the ACA with significant spending or revenue implications, what impact would that have on the non-group market?

MR. BORSCH: If I could take a quick stab at this, Paul, I mean, if you think about an impact where what you primarily take away are the subsidies and the individual mandate, you take those two pieces away, you're going to have something that looks like the impact on, let's say, the New York State individual market. I say "we" because I'm a New Yorker, when we went to guaranteed issue with no mandate, so you spiral downwards from the 17 million covered lives today to some significantly smaller slice of coverage that is very expensive coverage, but it is available for people who need it in an emergency.

MS. GUPTE: I might disagree on that, though, a little, I think. Maybe I'm just overly optimistic about that. But, you know, I think my view is that the ACA tried to simplify two problems, or maybe three, all into one. One was about uninsurable people because of pre-existing conditions. The other was low-income folk who didn't have subsidies. And perhaps the young and healthy who thought they were so healthy they didn't need to get in. And this idealistic notion of a balanced risk pool that can be created with subsidies and a mandate, and then you can bring all of this adverse population all into one pool, I think is nirvana that no one would ever attain.

Now, I'm not saying that there weren't things that could have been done differently, but I don't think we would have ever gotten there. And the notion of bringing back state high risk pools, and I was going through the [Paul] Ryan white paper, I think It's a Better Way, I think that's what is' called, and they talk about the state high risk pools. I think they say it's at least \$25 billion in funding. I don't know that that will quite do it, but depending on how much they fund those up by, you're at least separating out this really adverse population, and from this notion that the young and healthy would then be able to balance this out. So you take care of one problem.

The second thing I think they're suggestion is the community rating bans go back from 3:1 to 5:1, and in New York --

MR. GINSBURG: Let's hold off on that one until we --

MS. GUPTE: Okay.

MR. GINSBURG: -- finish the simple things.

MS. GUPTE: Sorry. Okay.

MS. SKOLNICK: Just repeal -- you can't do a replace.

MR. GINSBURG: Just repeal, because I think Matt brought up the point is that just a reconciliation repeal is probably -- not only will lead to the people in need of the subsidies not to

be an insured, not to be able to get insurance, but also many of the others who were already using the individual market, it's probably going to be a less useful market for them.

MS. SKOLNICK: So I'm more of the hospital analyst here, and my colleagues are more of the managed care analysts here. So let me maybe give it from the provider's side a little bit. We've had a lot of experimentation with individual insurance, and I think the New York market example that Matt gave is a very, very good one. You can try the high risk pools, and that certainly will try to carve out, you know, those who have had continuous coverage versus not continuous coverage. And a lot of this is going to be definitional. A lot of this is going to be -- I would say we're almost in uncharted policy territory when we talk about some of these things. There might be some experiments from some states that might provide some good insight and information. But the fundamental thing is, we had an individual market before. It didn't work. It was expensive. And there's fundamentally nothing's changed. If you repeal it in its entirety, what do you go back to? You've dismantled the individual market for all intents and purposes. You're going to have to now put it back, yeah, in some way, shape, or form.

The opportunity when I try to do something other than wearing black and be a little bit more, you know, optimistic about it is that maybe we can get some more things right this time if we try to structure the individual market. But the fundamental problem you have is, insurance is expensive because people who buy it are sick, and companies need to stay in business. So my comment is, you know, everything that we are talking about here, even if you're talking about unfettered competition, as soon as you talk about guaranteed issue and affordability in the same sentence, you have an impossibility theorem. It doesn't matter what they do. The market won't work.

MR. GINSBURG: Okay, okay. Well, why don't we move on to the next question which is, let's say now we're talking about repeal and replace. And, you know, what I've heard about replace is that there should be guaranteed issue with community rates. And so the question is, you know, what else would be needed to have a viable individual insurance market?

MS. GUPTE: So I think the high risk pools, I think are great. The community rating bands, widening the community rating bands to 5:1, I think makes a lot of sense. The New York market that, Matt, you alluded to, has I believe a 2:1 community rating band, which is very challenging. Age is correlated with disease, so it gives insurers at least some recourse to underwrite for illness, if you will. I don't think the mandate has worked, really. You know? I don't see any evidence from 2014 through 2016 we've had 28% of people between 18 to 34, which is the golden band. We haven't seen any improvement. There are hopes, I believe, that as the individuals start to see the 2.5% hit their tax returns you might see some improvement, but it's the carrot that works, it's not the stick. And so, yeah, the subsidies being taken away will shrink that market, but when I look back to what that market size was before the ACA, it was, like 15 to 17 million or something, in that range. Now we have almost 7 million in the off-exchange market, and less than 10 million in the on-exchange market, 8.5 million of which are subsidized. So the market shrunk, despite all these subsidies.

I don't know that we can kind of reverse the whole train completely, but I don't think that, you know, the proposal is out there that are being put out there are that unrealistic. The markets failed, and there's a reason it's failed. And something needs to be done.

MR. GINSBURG: Yeah, and I'm not sure the market has shrunk, because you're not counting all of the non-compliant plans that were grandfathered.

MS. GUPTE: That's in the off-exchange market, though --

MR. GINSBURG: No. Usually what's counted in the off-exchange market is the compliant plans. So you have this whole world of grandfathered and grandmothers plans --

MS. GUPTE: How many of those, do you remember?

MR. GINSBURG: I don't know.

MR. BORSCH: Well, if I could just jump in. Not that I'm the official arbiter of numbers, but I'll try.

MS. SKOLNICK: We rely on you. Go for it.

MR. BORSCH: So the latest figure out there is 10.4 million on exchange, and then 6.9 million -- off exchange. And of the 6.9 million, about 2 million are pre-ACA grandmothers or grandfathered policies. You put that together, that's an individual market of about 17 million. That's up from about 11 or 12 million individual market size in the pre-ACA.

MS. GUPTE: I don't think it was 11 to 12, but anyways (inaudible).

MS. SKOLNICK: And then how many of those slipped into -- how many of those might have qualified for Medicaid?

MS. GUPTE: How many of those (inaudible)?

MS. SKOLNICK: So, and in the prior market, yeah --

MR. GINSBURG: Oh, yeah.

MS. SKOLNICK: -- might have slipped onto -- there might be a few --

MR. GINSBURG: That's right.

MS. SKOLNICK: -- that you --

MS. GUPTE: That's true.

MS. SKOLNICK: -- you would have -- substituted for Medicaid.

MS. GUPTE: That's true.

MR. BORSCH: Can I take a stab, though at the --

MR. GINSBURG: Sure.

MR. BORSCH: -- replace? The interesting (inaudible), this is definitely seeing the glass half full and I definitely appreciate your perspective, Sheryl, that people are seeing what they want to see right now.

But let me continue and see what I want to see.

MS. SKOLNICK: Sure.

MR. BORSCH: If we see what we want to see here, what we could be on the cusp of is, you know, finally getting to a bipartisan -- in essence a bipartisan embrace of health care reform, because we had the partisan Affordable Care Act. And now the Republicans are inheriting that with a pledge to repeal and replace. But they will own it, and so they have to take it seriously. And, you know, what we could be looking at, and I say could, could be looking at, a restructuring where we have an individual market including the exchanges in whatever fashion they might be renamed where there is significantly more product flexibility so that products can be tailored to, let's say, younger and healthier populations. You retain the subsidies in some fashion, although perhaps they become tax credits. You widen the ratings bands so you take them from 3:1, maybe 5:1, maybe it's 6:1, and then you wrap around all of that risk pools. And you could. You just could end up with a solution there that actually enlarges the individual market from its current size of 17 million because you bring in the healthy segments of the population.

And let me throw in one other metric here would be some type of requirement for continuous coverage to replace the individual mandate along with a stricter policy for the special enrollment periods, if you were to put that all together. Now that's asking for a lot, I recognize. I'm definitely seeing the glass half full, but that would be the solution that maybe how it would look.

MS. SKOLNICK: You know, I'm reminded of something that I heard from a former Republicans staffer for Senator Frist who said -- reminds me every time that leadership changes, you know, it's a lot harder to be in leadership in Washington than it is to be out of favor. And so, you know, it is the Republicans. And that's actually the happiest I've been all day, that it's now the Republican's problem. You wanted it, you got it, okay. Now what are you going to do? So, you know, I appreciate the effort to see this as half full, but I think we need to be pretty realistic that the challenges here that face the ACA still exist, and the solutions that I've heard so far from everyone are just variations on a theme.

So it's a transfer of funds from one part of the federal Treasury from federal taxpayers in some way, shape, or form, that subsidizes the high cost of insurance for people, and forcing them in some way, shape, or form to buy insurance. And I'm wondering what's going to happen to the Republican constituency when they wake up one day, if repeal actually does get -- if it does actually get replaced in this way, and they realize it's exactly the same thing only a different name. So from where I sit, I'm not making any bets about what repeal is going to look like, to tell you the truth. I am just simply advising people that, you know, to look at the companies from the perspective of best case, worst case, and you know, here are the plans. Figure out which one you like the best, and that's what you're going to model. But there's real danger in this because there is no guarantee that the Republicans will get it right. There's no guarantee that anyone can get it right, because the fundamental problem is that the only ones who want to buy insurance are sick people. And what I worry about on the repeal side is, you still have a very sizable portion of the House that may not go along with the leadership on any kind of moderate repeal.

When you say bipartisan, I guess you can always hope, but you know, you all live around

here, you all work around here. You tell me. Is there any hope for bipartisanship in this new Congress that's coming up? I can't see it. But it also doesn't matter. If anything, I'm much more worried about what is one side of the GOP going to do to the other side of the GOP, whether or not they can even get to agreement, because from a company, a business and a human perspective, we need certainty on this. We don't have a lot of time.

And the one final point I'll make, and far be it from me to try to help anybody who might want to take benefits away, because I actually think it is a social problem that needs to be solved, but -- so that's sort of my policy stance. But I am reminded of when President Obama's administration came in in 2008 with, arguably, political capital and a mandate, and 60 votes in the Senate, which the GOP does not now have. And it took them two years, a loss of the 60th vote, and reconciliation to get the damn thing done. All right? Now, if I were in the Trump administration, and believe me, I'm not volunteering, I like my job, thank you very much. But if I were in the Trump administration, I wouldn't fritter away that time. I know they're all talking about it being complex. I know they're all talking about it being, you know, a difficult and sensitive issue. Whatever plan they're going to come up with, it's going to be as good or as bad as any other plan, because the problem is complex and difficult to solve. So pick one and get on with it.

HR1, first bill in the Senate, get it in there, get it acted on, and give the market certainty again. We can deal with it if it's bad news. We can deal with it if it's good news. We can't deal with it, and business, pro-business party, cannot deal with the uncertainty. It doesn't matter what replacement is. Just give it to us.

MR. GINSBURG: Yeah, well, let me move on to the final question of this series, which is, talk about transition. Let's say we are going to have a repeal and replace, or even, remember the president-elect using the word, you know, modifying. So whatever it is, given the uncertainty as to what's going to happen this year, I mean, in 2017/2018, are you concerned about holding the insurers who participate in the marketplaces in or could it be a real problem if they depart during this period of uncertainty and they're not there for the replacement?

MS. SKOLNICK: I think they've already departed. I think getting them back in is going to be next to impossible. I don't see anyone, sort of, raising their hand and volunteering to be shellacked a second time.

MR. BORSCH: I would disagree with that. I mean it remains to be seen, but, you know, the -- maybe you can put United in a separate category, but the plans that have left, or are leaving, Aetna and Human, in particular, have, you know, made deliberate efforts to keep placeholders on the table. You know, put -- Aetna, for example, is retaining plans in the off-exchange market. As few of them as possible, to be clear, but they're retaining plans in order to have a toehold presence so that they can re-expand once they look at the situation and decide that the market is re-stabilized and they can make a go at it again.

To be clear, unless there's some type of requirement, and I don't see this happening in the current political environment, the requirement that say, you have to be in the individual market if you're going to be in Medicare Advantage or something like that. And you have had some versions of that in certain states, but I think it takes a certain top-down regulatory environment for that to happen, and that doesn't look like the environment that we're going to be in. So you

have to go the carrot, not the stick, and you have to fix the individual market or have the prospect of fixing it in a way that makes participation enticing, which doesn't necessarily mean that you get United and Humana and Aetna back, you know, fully participating for 2018, but you've got a lot of plans out there. Most of the not-for-profit blues are participating, Anthem, the largest commercial public companies participating, of course, you know, Centene and Molina.

So there is potentially a lot to build on. If I could, not to -- just to make one other point, though, about the individual market and functioning, which is, it's not necessarily the case that only sick people want to buy coverage, and I think it is instructive to look at another market where you have selection dynamics that actually work. And that would be in Medicare Part B, because Medicare Part B is an optional program that requires a premium payment. And I think as most of the audience knows, when you turn 65, you're automatically enrolled in traditional Medicare. You're automatically enrolled in Part A, which is free. There's no real opt-out for Part A, but you don't pay for that. Part B requires a premium payment. You're automatically enrolled in that. If you do nothing, that premium payment which, for most Americans, is about \$105 a month or so, is automatically deducted from your Social Security check.

The reason that when people turn 65 they don't opt out of Medicare Part B and say, look, I'm a healthy 65 year old. I'll opt back into this when I turn 73 and I need healthcare is because every year Medicare Part B, if you do that, gets prohibitively more and more expensive. And so there's a requirement for continuous coverage.

So you could look at something like that working in the individual market. Now, the one caveat to that is Medicare Part B, of course, is 75 percent subsidized by the government, so that's a key asterisk.

MS. SKOLNICK: That's an interesting point that you raise because even when Part D was initially rolled out, if you look at the Part D roll out as a model for what could happen, as I recall, you had an open enrollment, and if you didn't show evidence of credible coverage then the next year when you tried to enroll it was really expensive.

So there wasn't a mandate, per say, but there sure were strict financial incentives that made it prohibitively expensive to opt out year one. Now, if you had a pension arrangement that gave you equivalent coverage or if you had an employer-based arrangement you had evidence of it and you were protected.

But that's an interesting mechanism that could certainly be considered that if you don't opt in that's fine. It's your choice, but it's going to become increasingly expensive provided that whatever subsidies you're eligible for don't cover you for that incremental premium. You could construct some things like that. That would be very interesting.

MR. GINSBURG: Thank you. Let me move on to the next section. It's a series of questions about the ACA marketplaces and, you know, these questions, except for the ones I have asked so far, were made up before the election, chaired with the analysts. When I went through them there was some obvious things, questions on public option that I'm not going to ask.

But there were a lot of questions on the ACA insurance marketplaces. My initial instinct was, you know, maybe they're not relevant anymore. But then I started thinking, well look, this

structure is going to function for at least another two years, 2017 and '18. As we've gone into before, if there's a replacement the replacement might have some resemblances to what we have here.

So in a sense, the issues are the same. So I decided that many of the questions are really just as relevant, and might be extremely relevant for those newly coming into power to hear since as, I forget who said it, Mr. Trump and Republican Congress are going to own this. They're going to have to be very careful in how they build it.

So first question is with open enrollment now in full swing what seems different this year? What seems different this year are three developments: much larger premium increases, departures of a number of major insurers, and failures of many co-ops. This has led to discussions about market stability and affordability. So the large premium increases for 2017 appear to be strongly based on claims being larger than projected for 2016 than when those premiums were set.

When the 2016 premiums were set insurers had a full year of 2014 claims experience, and some 2015 experience, but 2016 premium experiences were modest. Now, of course, we have the end of the reinsurance. That's clearly a factor. I remember seeing lots of antidotes from insurance executives about something happens between when the 2016 rates were set and the 2017 rates were set a year later. What were the surprises to the carriers and the experience?

MS. SKOLNICK: I think they were two-fold. Maybe there's more, but at least two major factors. One was the three Rs. When they set the rates for 2016 they were expected the risk corridors to be reimbursed in full, and October was a huge surprise in 2015. I think that catalyzed the beginning of the end of the co-ops, if you will.

That then has carried over into also we've had claims issues that had not been observed in the 2015 plan year when they were pricing for 2016. I saw a distinct difference in the tone from all the players, including AETNA and Anthem, who's still on. But the second quarter of 2016 they were complaining heavily about an increased adverse selection that they hadn't observed before.

All of a sudden, the CEOs and the management teams got extremely bearish. One of the drivers cited was the gaming of the system with dialysis companies, for example. That was steering adverse members from Medicaid into the exchange population, and so that was creating a lot of pressure on the claims.

I also heard about prescription drug usage. That was inordinately high. They were not getting reimbursement from the second R, which was the risk adjuster, and so you've seen Mark Bertolini from AETNA on a soapbox on every TV show that lets him on about how the risk adjustment methodology needs to be changed as well.

Then finally, going into 2017 the reinsurance, which is the only R that ever really saved these companies from enormous losses that would have been even worse than what they're seeing is phasing out in '17. That's been quantified as something between 6 and 9 percent in a rate increase once you net it out against the fact that they don't pay into the reinsurance pool as far as the premiums go.

And so all of these things combined, I think, get you to that 25 percent, on average, rate

increase. You've now seen AETNA, Humana, United, and the Co-ops leaving. The risk adjusters are not collectable. The plans left behind like the Blues and Anthem and some of the regionals are very concerned about increased adverse selection. In fact, even the Medicaid HMOs which have been the one bright spot on the horizon are very concerned about risk adjustment payments not working out the way they'd like, and potentially they're hopeful, but they're also worried about adverse selection coming onto their books as well.

MR. BORSCH: Maybe if I could just jump in on the outlook for the exchange enrollment is we're now in the middle of the open enrollment period which started November 1st and ends January 31st. I think a lot of people are looking at the administration's, the current administration's projection that the number of sign-ups will increase to a material degree relative to a year ago. It's not very credible, unfortunately, given the current circumstances.

Because I think you've got to look at two sides and one side, in my view, significantly outweighs the other. I mean, on the one hand it's true that the individual mandate is now more fully phased in and you have greater awareness of that and greater awareness of the exchanges, generally, without all the outreach programs that have been conducted. Perhaps, with some greater level of restrictions on the special enrollment periods there's some awareness of that as well. That may, potentially, induce people to take up coverage at a greater rate.

But the flip side of it is, obviously, to point to what everybody knows here. The significantly higher level of premium increases. The significantly reduced level of product offerings. Even within those product offerings, the significantly more narrow provider offerings, provider networks that underlie those products.

I think that those sets of things will, at the end of the day, unfortunately, significantly offset the first set of things, and you're going to see signups materially lower than you would have in the last -- than we did in the last open enrollment period.

The one other thing that's an uncertainty impact is the election outcome. Will that impact the rate of signups at all? You could think about this one of two ways. You could say, well, maybe people are going to rush to sign up because they'd be worried that if they don't sign up that they'll lose the opportunity to do that, and that people who've signed up for coverage will be grandfathered in somehow.

Or will people say, oh, well, now that the Trump Administration is coming in with the Republicans all of this is going away anyway. I'm not going to bother. It's not clear what impact we're going to see there.

MR. GINSBURG: I think it's the departures of national insurers. I want to ask you about your interpretation of what's really behind them. In a sense, is it that the marketplaces are not an attractive business environment because of policies like special enrollments? That the marketplaces are a much smaller market than they had anticipated a few years ago or that these insurers are not well-suited for the very price conscious consumers in this market? Or a fourth one is the overall political uncertainty that has been experienced? You know, what's your sense of the key drivers of, you know, some of the national insurers to depart it?

MS. SKOLNICK: Can I take a first crack at this?

MR. GINSBURG: Sure.

MS. SKOLNICK: So, first of all, it is, you know, you take what they said. You know, let's assume that CEOs of major U.S. corporations don't routinely lie. Okay? Especially not in public which would be different, a change from what we've heard over the summer.

So the statements by these companies have been pretty straightforward. The risk pool is not big enough. It's not well-balanced enough. There is not enough premium that could be charged in the market to take account for that. The gaming of the system is severe. Sign up when you get sick, get treated, have, you know, big losses for the plans and then depart. That's not how insurance works, as those of us who, you know, understand insurance know.

So that, clearly, was the case. I think that's absolutely true. I think Ana gave you a really good example of this entire thing in her first comments about the fact that the risk pool is not well-balanced. It's not large enough. The risk cannot be diversified. It was pretty clear that that was the problem.

I would take a little issue at the notion of that these companies are not well-suited to compete in a price competitive environment. How do you compete in a price competitive environment when most of the people buying insurance on the exchange are subsidized and price insulated anyway? That's number one.

Number two, they're not allowed to actually determine what their level of benefits is and that's a very important tool not only to mitigate their risk, but also to be price competitive. So when you mandate the benefits and you mandate guaranteed issue, and you have narrow bands something's got to give and it's going to be price. If you can't raise the price by enough to offset the risk because the actuarial model breaks because the risk pool is ill defined then you have to exit the business.

I think that that's just the fundamental problem here is that the structure of this was unrealistic. You know, there was one other element here. So it's not just guaranteed issue. It's the limitation on lifetime caps and the limitation on maximum out of pocket. You're really, you know, we said this here once before that the ACA constructs an impossibility theorem for an actuarial model. You can't ask these guys to have unlimited risk and stay in business. You just can't. It doesn't work that way.

That's why I think the ones who have chosen to exit have had to do that. I mean, you know, there's billions of dollars of losses here that they're reported. Never mind what they've been protected by reinsurance and by other things. So I think it has nothing to do with being price competitive because we've certainly seen them irrationally price on multiple occasions often enough.

MS. GUPTE: Yes, and I think a couple examples of this was Anthem was probably the only large, public insurer that was very optimistic about the markets. All the way through maybe the end of 2015, and then I thought I heard kind of an 'oops' on the fourth quarter of '15. That they may have underestimated the claims and the adverse selection.

They've backed off considerably. They're still saying they're losing money in '16. They're hopeful that they get to breakeven in '17, and, you know, most of us who even give them a little

benefit of the doubt think wow, that's a buy. Then now, of course, you know, this is pre-Trump. Most of the investors are very skeptical that they get to breakeven in '17.

I think right now, as far as I know, Matt may have other ideas. On the Blue Cross/Blue Shield side we've seen a lot of exits. I think Blue Cross/Blue Shield of Florida, last I spoke to the president, he was still very bullish, but I don't know if he's changed his mind as well. Other than that, I don't think anyone is really --

MS. SKOLNICK: Yes, but we had a speaker yesterday at a conference that we sponsored, a Global Mizuho investor conference in New York yesterday from Blue Cross -- Horizon Blue Cross.

MS. GUPTE: Horizon.

MS. SKOLNICK: It was very interesting to hear what they had to say. So right now they're actually making money. I found that fascinating and I didn't really have an opportunity to follow up, but I suspect it's because the New Jersey insurance market was actually somewhat functional prior to --

MS. GUPTE: Maybe it was more --

MS. SKOLNICK: -- the reform.

MS. GUPTE: -- like New York, wasn't it?

MR. GINSBURG: I thought it was.

MS. GUPTE: Yes.

MS. SKOLNICK: Yes, yes.

MS. GUPTE: I think it was already terrible, so --

MS. SKOLNICK: It was already --

MS. GUPTE: -- this got the --

MS. SKOLNICK: -- dysfunctional.

MS. GUPTE: -- (inaudible) slightly better in place.

MS. SKOLNICK: Did I say functional? I meant to say dysfunctional.

MR. BORSCH: So it was less dysfunctional under the ACA than it was --

MS. GUPTE: Less, yes.

MR. BORSCH: -- before.

MS. GUPTE: Yes, relatively.

MS. SKOLNICK: Or equally dysfunctional and you learn how to behave in a dysfunctional

market. But there certainly were strategies and tactics that they have been able to pursue in the market, and pricing they've been able to get, and probably a high degree of subsidy.

Having said that, you know, when presented with this notion of the impossibility theorem of guaranteed issue unlimited risk and some of the things that have just been the broad strokes discussed in the very early stages, which clearly are not the final formative thinking of the administration to come. They would be very nervous and likely to not expose their other members and their mutual members to their losses. They are basically saying, we're out.

So there's a lot at risk here. Give credit to the Blues for staying in losing money and hoping for the best. But there has to be a limit. It's not, you know, they can't write a blank check of transferring income from insurance companies to the Federal Treasury.

MR. GINSBURG: Yes.

MS. SKOLNICK: It doesn't work that way.

MR. GINSBURG: I would agree with you, Sheryl, particularly on that last point. I mean, I think you are at a precipice here and it wouldn't take much to throw this into a tailspin.

MS. SKOLNICK: Right.

MR. BORSCH: Where, you know, a scenario that is not all that unlikely where enrollment is down, you know, pick a number, 20, 30 percent, maybe it's not that much but that could happen. Then we get into early next year and some of the public companies, probably before others, start to recognize that things aren't turning around and they're, in fact, getting worse.

Then you have a snowballing of exits. I say a snowballing because there is a fear of being the last plan standing in these markets. Look, I mean, in that scenario you'd be looking at a complete unwind that the only good news there is that because you'd be looking at a complete unwind it would demand a solution.

MS. SKOLNICK: It might be easier to replace in that sense. I mean, you know, just stepping back for a second. So I don't think any of us are arguing that the construct of the exchanges under the ACA was a healthy marketplace. So I don't want anybody to go away from -- you know, my comments, in particular, saying that I'm defending the ACA and it should stay the way it is. No.

What I am saying is, it sort of is what we have. It's not perfect. It's not great. There are people out there who needed this coverage, who want this coverage. We agreed to take care of them. So, you know, there is something of a social contract here, but there is no question the exchanges are deeply flawed. Deeply flawed for a lot of reasons. What surprises me more than anything else is that it took the companies as long as it did to figure that out.

MR. GINSBURG: Good points. Let me move on to a few questions about the insurance mergers. I'm talking about the large, national mergers. To what extent are these proposed mergers, you know, Anthem and CIGNA, AETNA/Humana, and the already approved Centene with Healthnet in response to companies specific issues or to broader changes in healthcare financing and deliver?

MS. GUPTE: I think it's a bit of both. You know, it's a bit of both. There's challenges with what we've seen under the Obama administration in the last eight years, and some clear shifts that were broader into your, you know, your moniker of broader changes that have sparked this. But there are also some very company specific factors.

As far as the broader changes, I think just the ACA, having medical loss ratio floors, incredible tax headwinds, I mean, when you look at the PNLs of these companies it's just astounding to see the tax breaks. And then you compare that with the rest of healthcare or otherwise, they're very unfairly being punished here. I think that put a lot of pressure on their earning streams. They've peddled hard. The public large companies have tried to make it but, you know, we get synergies, as you know, when you get to the opportunity side of that ledger.

You get synergies, fixed cost synergies. Clearly, they're guide to those. Medical cost synergies which they're far more cautious about saying anything about, but it is a huge impetus for merging with one another to get more negotiating leverage at the table with the providers. So I think that that's the other piece.

Specifically around AETNA and Humana, and AETNA must be really salivating and hoping this trial is successful at this point under this new administration and the GOP sweep because they did it heavily because they needed to diversify into Medicare Advantage. Humana is the prize there. So that was clearly the impetus on, you know, in addition to all the costs advantages.

As far as Anthem, it was about the employer market. They're in 14 states. They don't have a national footprint. Cigna brings them that, not perfect, but it at least gives them some independence from the Blue Cross/Blue Shield association and trying to cobble together a national network for the national accounts market.

Then in the select market between 50 and 250 employees Anthem was losing a lot of market share to Cigna and continues to. From the fully insured side to self-insured an stop loss. I think they're looking to have a full service solution for employers of all groups sizes with the, you know, with the merger with Cigna.

MR. BORSCH: If I could just throw in one note on that. I mean, I would look at it maybe a little bit more simply in terms of why they merged. I'm not disagreeing with all of the, you know, individual reasons that may have influenced the particular mergers that happened. But in general, these are for profit companies and in any industry with for profit companies that tendency is they're going to -- what do they want at the end of the day?

The best environment for a for profit company to be operating under in one in which it's a monopoly and it has very high barriers to entry. That's a perfect business environment. So companies left to their own devices are going to merge into that configuration until they're stopped from doing so. That's just to simplify it --

MS. SKOLNICK: That's correct.

MR. BORSCH: -- to its essence.

MS. SKOLNICK: I would agree with that. You know, I'm also reminded of a couple of things that were said along the way. So I remember when the deals were announced, and not

covering any of those four, I won't comment on the prospects for those companies, but I'll just make an observation.

There was a notion that the Obama administration and the ACA somehow was predicated on further consolidation of the managed care sector. That it was supportive of it and that it wanted it. So you can imagine the rude awakening when the DOJ actually started to talk in terms of challenging these things.

But I'll just sort of move the discussion along a little bit. These companies have made some pretty cogent arguments for why they need to merge. The other thing that you do, what's hidden here is, you know, you want to build scale because scale's more efficient in this business. It is a scale business, so you can also add that to the litany of reasons.

But they've been explaining to their investors why these are mission critical things that they need to do, and even take to court to prevent the DOJ challenge. That's, obviously, something that's pretty unusual to do. If they don't get to do these deals now they have to go back and recreate themselves, and they have to deal with, you know, an investor base that says, okay, you just told us how mission critical it was that you all merge. Now you're going to come back and tell us how mission critical it is for you all to be independent and how great a job you're going to do.

So I think this is make or break for these companies in that sense, in terms of what their thesis is. What they're going to need to have in order to succeed going forward. You know, probably the best thing they could do is ask the judge for a continuance until the end of January because I suspect a new DOJ will be a whole lot more interested in hearing what they have to say.

MS. GUPTE: At the scheduling hearing they fought for it to happen at the end --

MS. SKOLNICK: Early.

MS. GUPTE: -- of '16.

MS. SKOLNICK: Yes, to happen early. So that may be a decision that they regret, but who knew?

MR. GINSBURG: Well, I'm sure we talked about these mergers a year ago. You know, as a result of a year and a half of consideration of these mergers is there anything that's clear to you about the impacts on, you know, healthcare purchasers and providers of these mergers?

MS. GUPTE: Well, I think providers, I said, I do believe it's going to give [plans] more negotiating leverage. I think that's a very taboo thing to say and, obviously, all of the provider lobbies and associations that send millions of letters to every state attorney general and the DOJ didn't do it, you know, just because they were trying to help the Department of Justice. So that's where I think this goes on the provider side.

On the other hand, I guess, you know, you've got to look at it in context of also the value-based care trends which we've all talked about and not sure whether and to what extent this new administration and Congress will foster that. But a larger company and maybe a cross-Medicare and commercial, particularly with Aetna and Humana, I think you could bring some of these

principles through CMS into the commercial arena.

You know, conversely, as well, from commercial back to Medicare. So I think there's some value add there potentially for the providers partnering with companies that have a more diversified and a larger book of business at scale.

As far as the purchasers, I think they will be under pressure to put, you know, some of those savings back through to employers and to consumers. You still have medical loss ratio floors, so they are capped in terms of their medical underwriting margins. As far as I can see, the Bill HR-3762 does not repeal the medical loss ratio floor, so most likely it looks like they're here to stay, so, you know, I would think that there's some value for the customers in the deals as well.

But, you know, they're going to let a lot of it fall to the bottom line. Obviously, we as analysts, have baked that into our estimates if those deals close.

MR. GINSBURG: Good. Next question. This is about leverage between health plans, providers, pharmaceutical companies. Is there a trend in whether plans or providers are gaining or losing leverage?

MS. SKOLNICK: So there's an interesting development with Tenet and Humana, for example, being at odds. Tenet is out of network with Humana right now in Florida. Actually, I think nationally, but certainly Florida. You know, it's going to hit their volume and they've got a pretty smart managed care negotiator who was raised and trained at United Health Group so he's certainly learned the tough and rough way to handle these negotiations because United tends to be tough and rough with the hospitals.

You know, we'll have to see how that works. So if that's a sign of the times, you know, it's one data point. I would say that these are never easy negotiations with the hospitals. I think there are issues around the hospitals acquired a lot of physician practices, for a variety of reasons. They have been trying to get, you know, their hospital managed care pricing for their hospitalists and hospital employed physicians for these new groups, and the health plans have been trying -- you know, it's just a step up. It's just an increase in margin for the hospital, and the health plans have been trying to push hard and back against that. So the hospitals haven't always succeeded.

I would say, you know, there hasn't been any real evidence of a change in tone, but the tone hasn't been conciliatory for a long time on the hospital side. What I think is going to be really interesting and where there's going to be more of a battleground because there's already been a lot of finger pointing, has been on the issue of pharma pricing for, like, the Epipen is sort of the classic case of this.

Where there's a lot of finger pointing back between the, not so much the health plan per say, but the PBM. That dynamic of, you know, the lack of transparency of how PBMs make their money versus the very great transparency of how big pharmaceutical company margins are is going to be a bit of a battleground, I think, going forward.

As the PBM contracts begin to shift from we're making money off of rebates and we're making money off of spreads to, perhaps, some other value added services that they can define, and, you know, it's not all about price. Then, perhaps, that conversation can change a little bit.

But that's an area that I think we need to watch.

I would suggest that pharmaceutical companies understand that the pricing issue that went away was the headline and Twitter issue. The fundamental pricing issue that when you and I go to the pharmacy, because formularies have changed, because our out of pocket costs have risen under these new formularies as the health plans are trying, on behalf of employers who are their customers, as the PBMs are trying to control the total spend for their customer, the employer.

We are paying more of our drug cost and we're seeing more of this very high cost and increases. Because that's a consumer driven item that's probably not going to go away as a topic. It's probably not going to go away as a pressure for the pharma companies.

On the flip side, though, there is some talk about increased support of research and development, so the biotech companies are happy. The spec pharma companies are confused, but they are still feeling the pricing pressure, and the PBMs are probably going to have to look at being a little bit more transparent. Do they have to give up margin or not? We'll have to see.

But I think because this has nothing to do with which administration is running things. This is a constituent services hand in the pocket, pull out the wallet, pay the money issue. I think it's going to continue to be an issue for everyone in the system from the health plan, to the PBM, to the pharm manufacturer, the distributor, all the way down to the consumer.

MR. GINSBURG: I want to follow up on the PBM. It's always struck me that the fact that some major insurers have their own PBM, you know, and they aren't going to make, (inaudible), and buy those services implies some really serious problems in the whole nature of contracting between plans and PBMs. Does anyone have any more thoughts about, you know, how this PBM relationship, you know, as intermediaries between the plans and manufacturers might evolve?

MS. GUPTE: So is the question about captive versus standalone PBMs or whether an insurer should have a captive PBM and --

MR. GINSBURG: Well, not so much on the --

MS. GUPTE: -- the drivers?

MR. GINSBURG: Yes, in a sense it's, you know, why do they have captive PBMs?

MS. GUPTE: Yes.

MR. GINSBURG: I've always thought that was, you know, not a sense making. It was cheaper than buying it, but because it was so difficult to have a contract with PBMs that they had confidence and, you know, if you look at the Anthem suing --

MS. GUPTE: Express Scripts.

MR. GINSBURG: -- Express Scripts on that.

MS. GUPTE: Yes. Well, let me take a crack at that. I think just back to a very fundamental, high-level principle. Why does managed care exist? They exist and it's been reinforced by this

administration to moderate healthcare costs, and they've been doing that for hospitals, at least in the last several years it's been going quite well on the, you know, on the outpatient/inpatient side.

I think in the ideal state they would like to be that intermediary entirely for the pharmaceutical side as well and try to do that. You know, in 2006 - '07 when Ron Williams was CEO of AETNA he had a very strong vision of having a vertically integrated PBM within the company. I think the whole notion of outsourcing would have been (inaudible) at the time.

What happened though, unfortunately for the insurance companies, is they lag considerable in scale on the number of adjusted scripts compare to CVS or an express group. So the kind of discounts that they get with the pharma manufacturers is severely disadvantaged, and they could never quite succeed, you know, with that kind of a scale disadvantage.

They had issues with their script filling. Their mail order facilities. To the point that even their employer medical benefits contracts were getting threatened because there was quality issues in terms of how the script filling and so on, and how that went. So Anthem was the first, and it was just a complete reversal of the kind of, you know, the vision of having a captive PBM in 2009. They, I think also, had sanctions, if I remember right, in Medicare on the Part D, and they outsourced the whole thing in a very big way to Express.

It took some time for Cigna and AETNA to come to the same conclusion. They're definitely more along the lines of, you know what I would call, retain the brain and outsource the brawn. So they have the formularies largely in house, the customer servicing is in house, but they're outsourcing the discounts because they're trying to play catch up and they cannot live at that kind of a disadvantage.

They're outsourcing, in some cases, AETNA is on the mail order side and Cigna still hasn't done that. The world has changed since then. You know, and I think now we have -- the plans have had more script fills, particularly United and Humana who have an organic source of script growth with Medicare Part D and United showed this. They finally got to a point where they had adequate scale to get decent discounts. Then did the Catamaran acquisition and successfully brought a full service PBM, not just a service, their own book of business, but third-party.

That's created, I think, PBM envy, captive PBM envy in, you know, the rest of the book. I think AETNA and Anthem would clearly like to do something different. Hoping the deals close so that their script fills and their volume gets substantially expanded, particularly AETNA where Human has the Part D. I mean, 450 million scripts or something, which just enormously gives them, you know, scale advantage.

The other thing that happened, I think, is that the specialty drug trend overtook on the small molecule side, on the branded side. Finally, the plans now, I think, feel that with physician networks they have specialist networks where they have an advantage and they can do something different. They're beginning to deliver that and Optum is showing that and Anthem is showing that despite the fact that they outsource their PBM, at least as far as the more commoditized functions to Express.

MS. SKOLNICK: Can I just? A couple of things. First of all, Ana, you are lucky that you're not as old as I am, so you won't remember this.

MS. GUPTE: You may be surprised.

MS. SKOLNICK: I'm old. In the late 1990s, I believe it was 1998, United Healthcare, as it was known at the time, sold Diversified Pharmacy Services, its PBM and exited the business. So they actually had it and got rid of it.

Not quite sure why. And when they did the Pacific Care acquisition they had a small company prescription solution that was doing the Medicare Advantage, which actually one of their leaders, a female executive, fought tooth and nail to convince them to need.

And why is it so important. I'm going to take a little bit of a different tack on this. If you want to look at the healthcare system you have to be patient centered. And if you're going to be patient centered you cannot leave off the single most frequent interaction with the healthcare system a patient has, which is at the pharmacist desk, from your consideration of the total 360 degree look at the patient. By integrating the pharmacy and the pharmacy data real time, synchronized -- and I hate the way that words get used -- but completely integrated. They have this massive data lake where everything they know, everything, and it's all buried down there. But pulled it all together so that when you have a patient who all of the sudden pops up as being wait a minute this patient actually could be really sick, or this patient actually -- why is this patient on that drug. It's not just drug interactions but more than that. Then you can intervene to make sure that that patient is getting the healthcare they really need. And that's where the real cost savings comes from.

So if you're thinking about this far into the future, assuming that not just value based care but transforming the healthcare system so that you're focused on doing the right thing at the right time in the right setting, for the right reason, at the right cost. You can't just have a piece of pharmacy there and a piece of primary care there and a piece of acute care there and expect the managed care company to be able to manage all of those pieces simultaneously. If they're really going to manage care it has to all be integrated. And I think that's the vision that United has that the others may or may not have, but if you don't have all the pieces and they're not already integrated and sitting on top of the same data and the same technology and the same analytics and the same ability to predict that someone who is on this drug is going to have that disease, you're not going to be as far a long, you're going to be playing catch up.

And I think that's the actual risk of the distraction of these mergers, is that these companies are going to end up playing catch up to where, other things equal, assuming that the election results don't change anything, where United is trying to drag the market kicking and screaming.

MR. GINSBURG: Yes. You're saying that's without external PBM you just cannot have that level of integration.

MS. SKOLNICK: You can't be as tight. It's not just the formulary it's the active care management that matters.

MR. BORSCH: If I could just jump in for a second though, I think the question that you're posing here is, you know, is there a role for smaller plans, you know, can smaller plans be viable in the current environment. And I think, you know, we don't know. The answer is probably they can in particularly integrated plans. We're talking about integration but plans that are integrated on smaller, more local scale, will they continue to have a role. You know, the Geisingers -- I

was going to say Group Health of Puget Sound, but they were bought by Kaiser. You know, they don't have the scale to run their own PBMs. Now they can run some of those functions. So they have to rely on virtual integration. So I wouldn't disagree with your point about integration, but they need to rely on virtual integration and they need an intermediary to contract with. And they may want and demand that that intermediary not be an Optum, that it be an entity that's independent of being a plan that's competing against them. We'll see. The lines are being --

MS. SKOLNICK: That's been the argument about Optum for a while, that they wouldn't be able to succeed because they were owned by United, but meanwhile it's an 80 some odd billion dollar company. A significant portion of that is outside and the outside business is growing, but there will always be people who will never trust someone who is owned by the competitor.

MR. BORSCH: Right. I will say PBM is potentially -- you know, we'll see. This is being tested right now and I'm not going to try to rush the conclusion, but PBM is a different category from some other services, that it may be that health plans are less willing to buy that from a competitor than they are when it comes to other services that are maybe more distant from the core function.

So I guess what I'm suggesting is what we're seeing is a bifurcation here where the largest managed care companies are inevitably going to running the PBMs in house, but that there's a whole other segment of the industry which unless it washes away is going to be relying on virtual integration. And the good news for virtual integration is that every day as technology gets stronger and stronger you can do more and more of that virtually without necessarily having everything in house.

MR. GINSBURG: Good, let me move on to one more topic before we go for questions and break, and it's about spending trends. You know, we've had years of relatively low spending trends, particularly in Medicare. It has triggered debate about the importance of the recession and the slow recovery. For instance, other factors that may prove more durable. So from your perspective what are the key factors behind the last few years of relatively low spending trends?

MS. GUPTE: I think the biggest one in 2008 after the recession is -- and now it all seems so obvious and we hardly talk about it -- is the adoption of high deductible plans. There was not a big trend at that time and there has been a huge increase in penetration and that's driven down utilization. It continues to -- I think there's more opportunity to increase penetration even though maybe the size of the deductible may not increase that much now that potentially the Cadillac Tax has been at least delayed and very likely will get repealed even before the whole Trump thing happened.

I think on the other side -- and this year has been a big kind of a aha it seems like, and maybe Sheryl and Matt have a different perspective, but my sense when I talked to the hospital companies in the last few months is that they're all of the sudden waking up to this notion of lower cost sites of service. And it's beginning to hit their volumes. They think it was masked by the Affordable Care Act. They had a lot of volume from Medicaid expansion and exchanges and it was hard to tell, is the ACA or this something else.

And after the ACA tapered off now they're talking about make shifting not just from hospital inpatient to hospital outpatient, but heavily to freestanding ambulatory surgery centers. And, you

know, Optum is building out these regional kind of compacts around a primary care delivery system with urgent care and with freestanding ASC and owning hospice, anything that's not hospital related. And so that make shifting is leading to a lower effective unit price equation and it's moderating the spending trends as well.

And then the third one I think is the whole notion of value based care, which I think is probably more in the nascent stages, in the early stages, but you are seeing a move from fee for service to fee for value. And that's also driving different behavior on the provider side and remains to be seen if CMMI survives in its current incarnation and what the new regime is likely to do. But it feels like on that the train has left the station. And with the more fiscally conservative policies that we'll see, you know, I don't think that we're going to see much of a pullback on that as well.

So, you know, all of those things together make me optimistic that spending trends will remain moderated, that it is structural, that it is not purely a cyclical phenomenon. We are seeing a bit of a rebound from just pent up demand, particularly in the orthopedic side, hips and knees. But a lot of those procedures are taking place in an ambulatory setting, which is like 25 percent of the cost of an inpatient, 50 percent or so of an outpatient setting. When I look at the Tenet P & L, which has an inpatient arm and the outpatient on the hospital side and an ambulatory arm with the recent JV they did with United Surgical Partners, it's so clear that even though they do well and the strategy makes sense it's going to take a while before the cannibalization of the higher priced business will work itself through that P & L and they'll actually see some growth in EBITDA.

MS. SKOLNICK: So there's a couple of interesting things, and I don't really disagree with anything that Ana said, but let me just give you a couple of things. So, first of all, it's called OptumCare and it's built around primary care practices predominantly and it is all about patient centered care, it's all about right care, right time, right place, right reason, right cost -- at the right price rather. And it is expected to be one of the single biggest contributors to United Health Group's Optum business over time. And the doctors are all in. And not everybody who applies to become an OptumCare physician actually gets in, which I think is kind of interesting because you have to be willing to change the way you practice medicine, which, you know, if you want to talk about bending that cost curve, that's how you do it. So that's part one.

Part two is I'd like you all to pay attention, for those of you who are kind of metrics drive. Look at what's happening to ER visits and the rate of growth for the publicly traded companies and for hospitals. The emergency room is known as the front door of the hospital. Between 60 and 70 percent of admissions actually start in the emergency room. You roll in and you end up in a bed; 60-70 percent of the beds are filled with those ER patients. So obviously when those ER patients are no pay patients, when they're uninsured, it hurts your P & L. When they're insured it helps your P & L. Just back to that original conversation we were having. So just keep that in mind.

What we're actually seeing and what we saw in the fourth quarter of 2013 was really interesting. Remember the fourth quarter of 2013, the last quarter before ACA enrollment started, was that the growth rate for several of the public companies and their ER visits same story year over year was negative. So it dropped. And then you did, you had this ACA spike. And it's absolutely blindingly obvious, if you plot it out it just goes straight up and comes

straight down and it's very narrow over a period of roughly eight quarters, maybe nine. And then second quarter of this year, third quarter of this year already reported you started to see a very precipitous slowdown in the rate of growth of ER visits. And the companies are attributing this to freestanding emergency rooms. But if you look at who's doing freestanding emergency rooms, there's a public company called Adpetus who has had to change those strategies because our good friends at managed care realized they were being price gouged and they're not going to pay for these things unless they're attached to an emergency room, unless they're attached to a hospital. And they're certainly not going to pay those prices.

So I find it a little bit hard to believe this rate of growth is because of competition. I think this is the canary in the coal mine. And the one reason that I'm optimistic for our society from a healthcare perspective is that if we are really moving to this model of right care and avoiding the emergency room because we don't need to be in the emergency room unless it's an emergency, that the hospital model is changing very dramatically.

So since 2006 I've had this theory I've called starvation in the land of plenty, which is lots of old people, no money to pay for it. We are there. And in addition now what we're seeing is the structural change of where we are being treated as technology, as philosophy, as policy, coalesce around less inpatient, where you get sick, where you're exposed to infection, where the care is challenged often times -- these are not necessarily efficiently run operations -- versus outpatient go home.

So it's very clear that we need to watch. This could be the start of some very significant declines in utilization and one of the highest cost settings. That's point number one.

Point number two, post acute. So Kindred recently reported their earnings. They operate facilities in post acute setting, plus they bought a major home health company a couple of years ago to try to offer an integrated post acute continuum to deal with bundling from CJR [Comprehensive Care for Joint Replacement Model]. And they're exiting the nursing home industry provided their landlord, Ventas, will let them, and they're letting them, but they have to sell some facilities to get there. And that might not be so easy. So what we're already seeing is the utilization of high cost settings in decline. And that's very, very important, and I think that's a sea change. So I'm optimistic from it from that perspective. And the final thing I'll say is this is actually a bipartisan issue. And while that might be a little surprising, just think about the budget equation. Per capita spending times the number of capitas. You can't make per capita spending zero. You might try, but you can't make it zero.

So even though it's coming down because we're being smarter about where we're spending our dollars, and also don't forget sequestration and a lot of other things that caused it to come down, but fundamentally the number of capitas is going to rise so quickly into that part of the population, this is the same story you've all heard, baby boomers like me we're going to take all the rest of you for a ride and we're going to spend your money, okay, because we're all going to be sick. And I'm doing my best to get there. Okay. (Laughter) I've got to get some benefit. So the only way we're going to be able to handle this is the per capita spending. And you can't price zero so it means you must attack utilization. It's got to be smart, it's got to be precise, where we get our treatment has got to be effective. So watch all this business about doing these joints outpatients because if you look at the readmission rates from the outpatient joints you're total cost of care may actually be a lot higher. So we need to move from per event, fee for service, to

episode of care. And that's what we're doing and where we're doing it we're successfully seeing the compression of spending per capita.

MR. GINSBURG: All right. Matt?

MR. BORSCH: Yeah. No, let me just chime in a little bit. First of all, Sheryl, I agree with what both of you said directionally. I think you're a little bit overly "Optum-mistic". (Laughter)

MS. SKOLNICK: You had to be there. (Laughter)

MR. BORSCH: So let me just speak up for the cyclical side of this, which -- and I definitely agree that all of these secular themes are at work here, but the cyclical side of it is important too. And I think it's important to look at some of the broad trends and the model that we followed, which originally I think was developed by Milliman, is one in which we find healthcare spending slowing for a period of three to five years in the wake of each recession. If you look back 30 years, 40 years even, you can see actually a remarkably strong statistically significant relationship along those lines with the regression model. And so exemplified by trend bottoming in 1986 after the 1982 recession, bottoming in 1996 after the '91 recession, and less dramatically but I think still the case, bottoming in 2006-2007 -- 2006 I suppose, after the 2001-2002 slowdown, and then finally -- and the large companies agree with this view that trend on a per capital basis, leaving aside the ACA, bottomed in 2013 following the 2008 recession.

Now why is this? Is this just some wild coincidence? I mean you think about the delayed and lagged responses by employer purchasers. As you go into a recession, first of all employers often aren't aware that they are in a recession until it's over or nearly over. And in the context of that they're feeling significant bottom line pressure. They look to cut costs across every category. Employee benefits is something that they attack using whatever happens to be the cost containment mechanisms du jour. So 20-25 years ago that would have been managed care. Today it still is, but cost sharing has taken its place maybe as the key mechanism. And all of that when employers step on the accelerator to put these cost containing mechanisms in place, it has a multiyear lag and a multiyear flow through, and that combines with the cycle of the weakened and then recovering consumer and helps explain why you have these multiyear lags. And we think we're seeing that play through again today, though not necessarily with a big resurgence on the other end of it.

MR. GINSBURG: Thank you. We've got a few minutes if there are questions before our break. Please wait until the microphone comes to you and -- yes, sir.

SPEAKER: Sergei Castille, Financial News to Moscow, Russia. I have two very short questions. In your state exchanges which are doing well, for instance, California maybe, and if could those states enact their own exchanges if Obamacare gets repealed?

Thanks.

MS. GUPTE: Yeah, California is doing better than the other exchanges no doubt. I think Peter Lee has, as you all know, done a very good job and is the poster child for how you can get an exchange like this up and running. They've done a good job of bringing in the sick and healthy. I believe they did not allow the grandmothering of the non compliant plans, which helped them with a more balanced risk pull. So they are an example of an exchange that maybe

then the Republicans need to consider is that the model for what the others could be.

You all are the D.C. folk and obviously we've been trying to get intelligence from what might happen, and one of the things I've heard is that Republican governors who apply for 1332 waivers may get more, may be given the flexibility to try things on their own. Now, however, if you repeal all of the funding sources and just defund the ACA, which it appears the dry run reconciliation bill did across all the consumer and the industry fees and taxes and the DSH cuts to the hospitals and how do you fund it. You know, that I think becomes the question.

But is it possible that they could work? Maybe.

MR. GINSBURG: Next question. Yes, Mike?

MR. MILLER: Thanks, Paul. Mike Miller, I'm a health policy physician and actually lived here and then in Massachusetts during Romney Care -- went in effect, then moved back here and actually pre ACA had trouble getting insurance back here because the market had changed.

So I want to follow up on his question and say was it possible if everything rolls back from the ACA to our prior world, pre ACA, that other states may look around and say we don't like the new world and want to try and replicate what Massachusetts had done and Romney Care beyond just the exchanges, which in theory they didn't need the more money that the ACA put into it.

MS. SKOLNICK: They just needed the stable funding that they had.

MR. MILLER: Yeah. Obviously it would be blue states that are more wealthy, but creating more divisions.

MS. SKOLNICK: So this is an interesting thought. So just how hands off will the federal government be under GOP control of both houses and the White House. And it's a really interesting question. I mean the whole theory about Medicaid block grants, for example, is hey, it's a state, all health care is local, give all the power to the states, let them decide, they know their people, they understand their markets better than we do, the federal government shouldn't be mandating. So I mean that's why I think Matt and I kind of looked at each other. And Ana was the only one of us brave enough to answer that last question by the way you'll notice is because I think the right answer is we don't know. It is possible, but we don't know. And it depends how much internal consistency -- the sort of states can do everything on their own if we just sort of give them something to work with -- how much internal consistency there is in that policy, in the administration and there is no way of knowing that now.

MR. GINSBURG: Yeah. Time for one more question. Yes, Alice. Could someone bring the microphone to her?

MS. RIVLIN: Thank you. Alice Rivlin, Brookings. There has been very little discussion of Medicare, except for Part D. But it's obviously a much bigger deal. In my opinion Mr. Trump stayed away from it very wisely. Medicare can only give you trouble if you're saying you're going to reform it in a campaign, and he didn't, but Paul Ryan has. And even after the election he says we're coming back to Medicare reform, by which he means premium support. How much is that a wild card if we actually get into a political fight about Medicare? What does that

do to the things you've been talking about?

MR. BORSCH: Let me try, let me just give a try to that. You know, my first reaction is I think that's going to end up that the Medicare privatization is going to take back burner because we already have the Medicare Advantage program in place. And so to the extent policy makers on the Republican side can do things to accelerate the growth of Medicare advantage -- and some of that may just mean how a Trump administration sits on top of rate regulations for Medicare Advantage over the next four years, but it might also include things like, for example, suggestion that the policy be changed that when you turn 65 instead of automatically going into traditional Medicare you're auto assigned into a Medicare Advantage plan. That might sound controversial, but of course that would be something that anyone could simply opt out of if they didn't like that. But that presumably would have a pretty significant impact.

I think though the reason that maybe it won't be front burner is because Medicare as a fiscal problem, while certainly it faces a fiscal crisis, the sense of crisis has abated to some degree over the last, you know, call it six years because of the unexpected slowdown in Medicare spending trend. And so I think that's a reason why you're probably not going to see Medicare be the focus of healthcare policy changes. Now, you know, could easily be proven wrong.

MS. SKOLNICK: So I'll take it so -- that may very well be true and I'm not arguing or disputing, but if it is a focus, so let's take the if it's a focus since we're all speculating here because we don't know. So I see a couple of really significant issues here. First of all, one thing that was mentioned earlier on in the year and that I think is really problematic is this whole structure of the call notice and the benchmarking and the complicated way in which Medicare Advantage rates are set. And I would love to see simplification of that process just because I don't understand a word of that letter and I have to spend a lot of time trying to understand a word of that letter. And complicated things tend to not work especially efficiently. So decoupling Medicare Advantage from fee for service rates might actually liberate and make it an alternative payment mechanism, might liberate it from both a policy and a functional perspective in a good way.

And, second, I would say so I actually believe that if it is the third rail and if you don't need to touch it you shouldn't. But there is a significant risk for hospitals and potentially for managed care plans that not only do you see the drive to push more people into Medicare Advantage plans, but also then realizing very shortly that you've now created a monster and you're spending on MA is high, you now need to contract that spending. And the more you decouple it from the benchmarking the easier it is to do that, the simpler you make it to slash. So I would actually be in favor of it to a limited extent, but seeing that as a possibility.

Now, from a provider perspective, just give you some numbers. So for a couple of the publicly traded companies they're kind enough to give us a revenue per inpatient admission by payer type. And managed care, commercial managed care of course -- and this is not acuity adjusted, this is raw, so it's maybe not fair -- but with that proviso, you know, commercial managed care is your best payer, they're going to pay you on average for the public companies between \$13-18,000 a case. Let's just call it \$15,000 or \$16,000 a case on average. And then fee for service is going to pay you \$13,000, and then Medicare Advantage is going to pay you \$11,000. So if you take about a \$2,000 different -- and it's a sliding scale wherever you start, you know, Medicare Advantage will be on average about \$2,000 less. That's a combination of

acuity and pricing. And as a result of that, you know, if you just switch those people over they'll come to your hospital less frequently because they're going to be kept out of the emergency room, they're going to be redirected, they might have better primary care or they might now, but they might, and so they may be lower acuity when they see you and more of what they do may be outpatient because you've got an intervention as to a managed care plan. The bottom line is for every number of those capitas that shifts from fee for service for MA you lose \$2,000. It's all margin.

So it's a very challenging outlook to continue this shift to MA for the provider side alone. Never mind the managed care side, but providers all the way down the line. It's very challenging.

MS. GUPTE: It's actually positive I think for managed care if you have a lot of Medicare. And the volume swell will just dwarf any, you know, rate pressures that you might have. And the fixed cost leverage that you get will at least keep your margins stable if not expanding. It's just like the most humungous best case for Humana. None of us would believe it's happening. I think we're all kind of bidding the stock up on the expectation that we'll have a more kinder and gentler CMS, but I think it's just a huge best case.

And I guess, to Sheryl's concern though about spending then getting unbridled for Medicare Advantage, I mean isn't the point of premium support to move from kind of a defined benefit to a defined contribution hybrid option, right?

MS. GUPTE: And that's really scary because then you're going to have uninsured 85 year olds. (Laughter) Oh boy, I can't wait to see what hospitals do with that.

MR. GINSBURG: Okay. I think it's time for us to go into our break. Let's reconvene at 10:50 a.m.

(Recess)

MR. GINSBURG: It's time to reconvene. We've got some questions on value-based care, and a number of other things that were starting to come up this morning. So, I'd like to begin with two questions about Medicaid. One is about, you know, what's your sense of how Medicaid managed care is evolving? You know, what are some of the changes in the way it's being done, if at all? Or is it very stable, and it's just expanding as more states convert to it?

MR. BORSCH: Well, I mean, we are in an interesting time for Medicaid Managed Care obviously right now, the market is freaking out about whether we are going to lose the entire ACA Medicaid expansion. Leaving that aside for the moment Medicaid managed care generally is now penetrating the high-spending, more vulnerable populations, and that's a controversial move, it's not yet fully proven that the Medicaid managed care organization can do a good with those populations, balancing cost containment against the need to protect the care relationships and patters that those members are seeking.

So, this is where we are, and whereas today more than two-thirds, maybe three-quarters of the total Medicaid population is already in managed care, it's also true that only about 40 percent or so of the total Medicaid spending, federal and state dollars combined, is actually managed care. So you have this -- you know, that mismatch is basically because of the high-spending

populations, dual eligible, LTSS that are not yet in managed care.

MR. GINSBURG: Thanks. And I take it the -- You know, we've had a few years experience now of hospitals with the Medicaid expansions, and is the bottom line a big positive for hospitals?

MS. SKOLNICK: So, clearly the one source of identifiable benefit in exchange for \$155 billion in cuts over 10 years to pay for, it has been Medicaid expansion that packed up in hospitals. You can actually see, in looking back at hospital by hospital data which I've done..., and the compression of results through 2013, cost report year, and this very rapid expansion of EBITDAR and EBITDA, and for those hospitals. In not so much the '14 year, but in the June '15 year data; you can see it in '14, so you can go from '13 to '14, and all of a sudden you see a little uptick, and from '14 to '15 you see a strong move towards profitability in Medicaid expansion states.

And it's especially true in the rural hospitals, because I cover a company called Quorum which is 38 rural hospitals and community health systems which has 150 hospitals at the moment, and a very strong proportion of those are rural and in small cities. And you can actually see in the data for them as well as for Tenet, and other companies with a bigger relative exposure to Medicaid expansion states that there is a very significant uptick in profitability, more so, and what's interesting is you see it in Pennsylvania; you begin to see it in '15 numbers that you didn't see in '14 numbers, so you know it's related to a Medicaid expansion, because they were late to expand. You know, if the Medicaid expansion were somehow, for example, in some of my fondest imaginations about what could happen positively here, one might argue that Medicaid block grants might give some of the states the optionality to say, well, wait a minute, if we are going to sustain the level of current spending per capita, and the number of capita is higher in the states that are Medicaid expansion states, and states that didn't expand will get less than states that did expand.

So, maybe if I'm running one of those states, I say, wait a minute, before all this get started, I want to make sure I get as much as I can from the federal government, therefore maybe now it's Republican-controlled maybe it's -- excuse the expression -- kosher, for us to go ahead and expand Medicaid, because now it's a Republican idea, it's going to be endorsed and we are going to have control over how we do it, there is no strings attached, et cetera, et cetera.

So, you could actually see that benefiting the hospitals, that would be one ray of hope and light that I would sort of hand out there for the hospitals. But they very definitely have benefited from that piece in particular. The exchange is obviously, the hospitals have benefited where the health plans have not, because they've been the beneficiary of where much of this excess cost of the adversely-selected risk pool has been showing up.

Certainly, initially showing in the emergency room and then, you know, to the extent that they had poor health status coming in, in follow-on care, but you know, what's really interesting from a stock market perspective is, before the election, reform was good for hospital, but reforms impact was dying out. And so there was already a bare case out there for owning the hospital, and the hospitals had already come down strongly off their highs, when it became very much apparent that volume comparisons were tougher, and that they weren't seeing volume growth and that, you know, we attributed much of this to the falloff effect of not having new people

enrolling in the ACA sponsored plans. Be it Medicaid expansion plans, or Medicaid expansion or exchange plans.

And so there was already a bare case coming into this, that reform wasn't good enough for hospitals. And so you just compound it in what they had before which had been 5 or 6 percent of their EBITDA, depending on who you were talking about, maybe a little bit more for some of the companies, will now go away as your worst-case scenario. It can put the hospitals in some dire straits. Like the point that Ana made, that the managed care company have had very significant negative impact, cuts in advance of coverage, tax in advance of coverage, so have the hospitals.

I mean these groups -- all the groups who saw Medicare reimbursement cut, which are not just the hospital, they are the post-acute companies, they are included in the ACA for example, is also home health rebasing, and things like that, all of them have paid for, but the ones that have benefited most from it have been the hospitals.

MS. GUPTE: Can I ask question of Sheryl? What about the DSH cuts, the DSH cuts are supposed to be -- are on the docket I should say, to be repealed, as well, so what would be the net impact, do you think, going back to the original DSH payments, relative to not having Medicaid expansion.

MS. SKOLNICK: Do you know what was interesting was that most of the publicly-traded companies did not have that much of a negative impact of dish cuts, as we looked around at what they were, and in fact some of them, and the way in which the formula for dish payments, depended upon how many uninsured there were in the state prior, versus how many uninsured, what the reduction has been, and it was tied to that.

And so as a result, you know, most of -- not all -- but most of the companies actually were expected to get an increase in dish payments in the early part of the ACA, not a decrease, modest, but an increase, which was a counterintuitive outcome but you know it was formulaic, and that's what happened.

MR. GINSBURG: Yeah. I would like to go into the question about alternative payment models, value payment, what we are calling it, first I want to ask about provider perspectives, on ACOs and bundled payments. You know, how eager are they to engage in these contracts, what role do they see this place is going to play in the future?

MS. SKOLNICK: So, I'll take a crack at that one, since it's really actually quite interesting, so the premise of an ACO, fundamentally, if you are a hospital, is to empty out your hospital beds, because hospital care is expensive and it's not always appropriate. And so the trek was that you would see increased market share, but you would see fewer hospital days per patient of your current population but, you'd have a bigger population, and I love the argument, well, we'll make up on volume what we lose on price. Hmm, it doesn't often work that way.

So, you know, it's been, generally speaking, the Medicare ACOs and we know have not been successful for the hospital participants, but for a handful. However, what we are seeing is hospital expressing and provider groups physicians as well, expressing significant interests in joining population health-based plans, everybody was preparing for these sorts of things that was all paid for, you know, instead of fee-for-service, it's going to be fee-for-value, it's going to be oriented, it's going to be tied to quality, and some of that's already happening. But what we are

not seeing, and what we haven't seen are these broad-based move towards population health at risk plans being offered or negotiated by the health plans in the hospitals.

That has not happened, and if you talk to some of the bigger providers out there, like HCA, they'll say to you, we would be happy to explore that if somebody would offer it to us but, you know, no one has really offered, and we are not going to give a discount that we haven't been asked to give. So, you know, it is a bit of a challenge to see how that -- you know, how the hospital-driven ACOs would ever be, you know, fully accepted by hospital management teams because it's just an anathema. It means you have to empty your beds and that's their model.

On the other hand, where we have seen a lot of ACOs being formed is between the physicians and the health plans, and other provider groups in the health plans. And, you know, there are well over 750 of them, around, you know, just in -- well call them well-defined actually ACOs, but there are many other kinds of variations on this that have been tried. It's not clear what they are having on utilization, it's not clear what impact they are having on changing complete behavior, but where there is some evidence of at-risk schemes and arrangements, they do seem to have the effect of changing provider behavior, which changes specifically physician behavior, since they, you know, are the start, and they are the source of all of this, it's also changing consumer behavior. but not nearly the kind of impact that you would have expected.

MS. GUPTE: I think bundling this seems to be appetite. I wouldn't say that they are wildly enthusiastic on the public side but, you know, Tenet and HCA seemed relatively positive. And I've talked to -- through the not-for-profits they are quite positive, and then, you know, they are saying --

MS. SKOLNICK: Yeah. Bundling is the difference, bundling is a different story.

MS. GUPTE: Bundling is different, yeah.

MS. SKOLNICK: It's not an --

MS. GUPTE: It's not an ACO, but bundling, I think they like, so it's price just gone off the DRG, but they think the offsets from the post-acute squeeze, and then increase a little bit of an increase and length of stay, they still end up expanding their margins and some of them are touting that they'll be more profitable and growing faster, so we'll see.

MR. GINSBURG: Yeah. So, perhaps the rule is that what's interesting to you as the provider is an arrangement where there are other provider services that you can succeed by cutting, but if it's your own services like the hospital, the ACO, you won't do that.

MS. GUPTE: Yeah. It's a zero sum game, and my guess, someone is going to get squeeze.

MS. SKOLNICK: Actually it's going to be a negative sum game, so at some point the hospitals are going to realize that their lengths of stay are going to be compromised. It's not really a fair test yet, because CJR doesn't put the hospitals at risk yet, they don't go with financial risk until next year, so this is all experimentation, and they are learning, and it's nice to have many years where it's phased in where you get to learn.

But, you know, it's still fee-for-service reimbursement for each of the slivers and then they'll

figure out, you know, this amount later on, how much of a benefit or cut you are going to get. So, it's going to be an interesting -- it's going to be very interesting. I will say though that the data that's come out from BPCI [Bundled Payment for Care Improvement] in Health Affairs, was fascinating because you didn't get the increase in home health to the extent that you saw some increase in home health, you saw a very steep decrease in subacute nursing home care, but not in home health.

And so the question is, where are these patients going? Are they going home with no follow-up care, or are they going home with outpatient? Can they actually drive, and they are not homebound? It's really fascinating to see how this is really changing the practice of medicine, while using financial incentives, and that's what it's all about.

MR. GINSBURG: Okay. What about -- let me think -- To what extent are hospitals or physician organizations working closely with selected post-acute providers, and either ACOs or bundled payment. Just, I want you to look at the partnerships, the relationships?

MS. SKOLNICK: So, you've seen Community Health Systems which has a bit of a leverage problem, they are trying to significantly deliver, just for the record, I have an underperformed rating in the \$3 price target on the stock, in case you are wondering about my position on that. But to be clear, they have certain assets that they can sell, and perhaps use for strategic leverage, and one of the smarter things they did was take their home health agency, across their hospitals, and sell 80 percent of it to one of the home health care companies. And they'll retain a 20 percent interest, and presumably create networks. And I've pointed much of the same thing.

You are seeing Health Care Encompass, which is a very fine home health agency company, and they have said that they've been very successful in negotiating sort of one-on-one partnerships as being part of post-acute network for acute care. So you are beginning to see these kinds of virtual alignments.

But, you know, at the end of the day the star scores are going to matter. The quality is going to matter, and the readmission rates are really what are going to dictate this.

MR. GINSBURG: You know, is there sufficient expertise in the post-acute sector to really do this transformation?

MS. SKOLNICK: I think there are some really interesting things being done in the post-acute from -- There are a couple of private companies that are doing interesting things with a sort of an awful patient looking at the total episode of care, and intervening at the front end, so that you save money at the backend. Are they really post-acute? I don't know, I call them a disruptor, because they are disrupting behavior. But within the post-acute network, or the post-acute companies, I think there are some -- some business leaders get the joke. I mean, they know where this is going. They understand that you need to be able to have a much more holistic view of the patient across an entire episode of care.

And they have to -- if they are going to play a role, they have to make sure that whatever status the patient comes in at, they at least get no worse, they do get better, and the bleeding in terms of the cost of their care stops for that condition. So, there are some who are willing to enter into some innovative kinds of arrangements, but I don't see much in terms of what those innovative arrangements are, yet. It's still very early.

MR. BORSCH: I guess I would just add to that. I think what we are still experimenting with and probably will continue to for quite a while is, you know, what is the best model? What are the best models? If you look at a market like Southern California, a lot of this is driven by primary care physician groups.

MS. SKOLNICK: That's correct, who are generally at risk, yeah.

MR. BORSCH: (Crosstalk). They are generally, oh, yes, absolutely, and generally they are the integrators of care. But outside of markets where that has evolved over a long period of time, it tends to be more companies and facilities that have emerged to fill the gap, if they are the ones with organizational scale, and risk tolerance to pursue these types of arrangements.

MS. SKOLNICK: And that's a great observation because, you know, you see Northwell Health, that's pursued an awful lot of these kinds of innovations who was in front of the curb on DPCI. Sort of the interesting factoid there, is that when they had two of their hospitals were in DPCI, they are old North Shore OIJ. And so they've now become Northwell Health with aspirations from Massachusetts to Pennsylvania to D.C., so they are coming.

And what they found was that the cost savings to the system of avoiding a nursing home stay after a joint replacement was so significant with actual improvement in quality in their model, not just neutral, but improvement. That they just sacrificed their bottom line by changing their practice protocols, and unless there's extraordinary circumstances, none of their joint patients will end up in subacute.

MR. GINSBURG: It sounds like some of the early efforts particularly under bundled payment to integrate post-acute care, has been not depending on the capability of post-acute care, but the patients just aren't going into the facilities.

MS. SKOLNICK: Yeah. They are emptying out pretty quickly.

MR. GINSBURG: Good. One question about delivery systems that are either developing their own limited network, insurance products, either their own, or in partnership with an insurer for the Medicare Advantage market, or for the ACA marketplaces; what's your sense of whether we are going to see a lot of success in that area, or is it really going to be quite marginal?

MS. GUPTE: My view would be marginal. I think that tends to be the experience that we've seen for the few systems that try to do that hasn't been resounding positive. They haven't been walking away from it, like they have from exchanges, but it's a little experiment without much success. If you talked to Kaiser, you know, and they are integrated providers, so it's a more balanced perspective I'd say, for all of it.

You know, the health plans think that the health systems closely underestimate the challenges that the challenges plan side of it have to undergo to gain membership, it's the distribution advantage, and all of those things that they don't have any capabilities around population health management, building out the networks with, you know, primary care docs that are successful. All of that which, I think, a lot goes into this that is not, I think, appreciated as easily by the health systems when they walk into this.

MS. SKOLNICK: So, our former colleague, Carl McDonald, whom we all remember, I'm

sure fondly, used to say, you know, the managed care companies, if you will, have been managing this risk for what, 30 years now, and from time to time, even they spectacularly don't get it right. You can't expect hospitals to be able to manage this risk at all. That's not what they do.

MR. GINSBURG: Yeah. A consultant once told me a very concrete reason why joint ventures with insurers work better because the insurers can get a low-price network to supplement the delivery systems network. But I guess it's -- I want to shift to the private health plan perspectives on ACO's bundled payments. How eager are the plans to pursue these types of reforms?

MS. GUPTE: I think they are excited about the risk-sharing arrangements. They've been looking for this for a long time, they talked about it for years before they had got some cover, if you will, from D.C., and now the train has left the station, every day I look, you know, at Aetna or Cigna, or one of them is talking about the next ACO arrangement that they are building out from a private plan perspective. And whatever I've heard so far on the bundling side as well, it sounds like they are very much jumping at the bid to move in that direction as well, and just piggyback off of all the reform that CMS has already pushed forward.

MR. BORSCH: And I would mostly agree with you, but I think that, you know, the jury is still out on how supportive the managed care companies are really and truly being for these types of arrangements. I mean they are entering into them, there's no question some of them, or they are aggressively pushing forward but there's always going to be attention when it comes to the question of delegation and giving up roles and responsibilities.

Because if you look at, you know, a deleted model like what prevails in the Southern California market, that isn't necessarily where they pairs ideally want to get to if they think it through, and they may end up there. But that's a tough transition, because you talk about in a market like that, and a model like that, delegating and in a sense, you know, offloading a lot of functions that you've been doing successfully, internally for a long time.

MS. GUPTE: I think Optum is doing some interesting things, with OptumInsight. You know, they talk about it as strategic relationships that they are building. They look at the readiness to take on risk quotient, if you will, among health systems, and then make a strategic choice around where they may partner with this health system on OptumInsight, which is health IT platform.

They may actually donate, you know, some capital as well, and then build that strategic relationship. I believe right now with North Shore, LIJ, and then they have the Dignity, but they haven't been picking -- And they've been very selective but, you know, it's a broad arrangement and how they are doing it. I kind of agree with Matt, I wonder about Aetna, and Cigna, and if this is just PR, or is there any substance behind it. And maybe it comes more to -- not that the plans don't want it -- but the incentive alignment is quite minimal, but you know, with hospital, they want to fill bides, so unless you can find equation where the contract is the win-win, it's challenging to do that.

On the other hand, a primary care medical home type model that Medicare Advantage has, it's just an obvious win-win on both sides with the primary care doc.

MS. SKOLNICK: We are definitely seeing -- I'm definitely seeing a lot more innovation on

the Medicare Advantage with these sorts of arrangements, or at risk, or changes and behavior, all the things we've just talking about, because the nature of that market. First of all there's plenty of opportunity to extract cost savings, at a constant level of outcome, but also, and because the structure of how they are paid, rewards them for improving patient experience, improving patient outcome, improving patient care.

Whereas, in the private sector depending on the contract you have with the employer, they may not actually reward you for that. So there's a very clear, as you go around and you talk to some of the primary care groups with Optum Care, who are sort of leading in the patient-centered home, kind of arrangement. Or any of these changes and practice banners. I'm not even going to say it's changes in behavior; it's just changed in practice banner. So instead of putting an end-of-life patient in the hospital, you encourage them to accept hospice, and save a lot of money.

But whatever it is, you are definitely seeing that more in the Medicare Advantage side, just because they savings are there, and the quality metrics will reflect that fact that you get better satisfaction and outcome, which gets you better reimbursement, and so it's a financial incentive for both parties.

MS. GUPTE: I agree.

MR. GINSBURG: What about -- you know, some areas, you know, there's a very dominant private insurance plan, and it's usually Blue Cross, Blue Shield plan, which is going to get -- has an advantage in commercial rates, over the other competitors? And are these people dragging their feet, or are they actually, ironically and probably in the best position to pursue this, if they want to?

MS. SKOLNICK: What's Blue Cross, Blue Shield of Alabama doing?

MR. BORSCH: I don't know, but I mean should be --

MS. SKOLNICK: I mean, that would be the question, because they are pretty dominant.

MR. BORSCH: This would be a classical example of where I suspect, you know, there's a lot of internal angst that these plans are about, you know, how much of what they've done for the last 20 years, are they really, you know, willing to give up. And in many cases they may have good reason to be reticent, to give up those functions, because they are not necessarily things that are going to be done well when they delegated them down to the provider level. I think in more cases than not, there is a real reluctance, and so the question of how long is it going to take, and what changes, you know, competitive patterns or maybe can enforce that?

MS. GUPTE: Yeah. The Blues I think, you know, to your question I think, they have the advantage of actually moving such partnership forward perhaps, the competitive advantage, in that regard. However, they are resting on their laurels to some degree, because they just enjoy straight discounts that are carrying them through better than the others. Also to Sheryl's point I think the savings are largely in Medicare, and those are much immediate, and Blues tend to be more commercially driven.

And so that reduces the incentive for them to see an improvement. I'm hopeful that Anthem will -- will do more of what I've seen a little bit of. You know, they've had a ton of leadership

transition in the last 1 year, and completely distracted with all the issues with the individual market and all that. But they have started up, some interesting things as far as provider partnerships, on the oncology side, with their physician networks, to manage treatment paradigms.

They have this partnership called Vivity, in Southern California with multiple providers, so very innovative things, where because of their scale, their desire to move out of being just purely local Blues and just working with their discounts, and make-shifting into Medicare, and they have Medicaid, but they'll do more here.

MR. GINSBURG: What about the fact that half of, say, commercially insured people, are in self-insured plans? And so to what extent has been, you know, working with the employer to get their buy-in to this, it's been something that has really been a restraint on private insurers and pursuing this?

MS. SKOLNICK: I think it's a real factor. You can't move faster than the market or your customer is willing to move and, you know, some of these things that the health plans, it's hard to get your first large-scale customer to bite on some of these more innovative ideas, or I will say even disruptive ideas, because you really are going to make some parts of the continuum here uncomfortable, and you'll have some complaints.

But generally speaking, there are some employers out there, you might think about perhaps CalPERS that used to be GE, some of them have always been very innovative and very forward thinking, and willing to take that step of being the first to leap into a new benefit structure, or a patient management paradigm. But I think that's absolutely correct, you are definitely limited by the willingness of your customer to be innovative. I think that as we get into -- And by the way, I think your point on cyclicalness is absolutely correct. We cannot forget that this is a cyclical business, and I don't forget it. I just think that the level of the cycle may be affected by the decisions we make to use or not use health care at the time, but that's okay. Do you start here, do you start from there.

But in any event, one of the things that I think we do to take into account here is just how much these employers are screaming in pain from the cost of their health insurance bill. And the more that they find themselves unable to pull on the same levers that they did before, the more willing they are to find new levers to pull.

MR. BORSCH: I mean, there are -- You know, the trend amongst employers is still towards more self-insuring, you see that happening in the middle market, and even in the small group market in response to the community risk pooling rules. But at the same time there are some signs that some of the large employers are maybe pushing a little bit in the other direction, starting to do some of what we would have called sliced contracting back in the '90s. So that could perhaps start to enable some of the integration of providers.

MR. GINSBURG: When I asked the question about self-insured employers, I wasn't concerned so much at the really big ones because those are the people that have the staff, have the benefit consultants, who can perceive the potential. But I was thinking more about just the process of going from one 500-person employer to another one. People who don't really have sophisticated benefit staffs that, you know, what it takes to convince them to go along. And I do

know that when the Blue Cross Blue Shield of Massachusetts, you know, went forward with their alternative quality contracts, one of the reasons they did it only for their HMO enrollees was just because of the enormity of the task, particularly in the Blue Cross Blue Shield worlds of getting the self-insured employers in because they're talking about, you know, employers all over the country who might have employees in Massachusetts.

What's your sense about which approaches to alternative payment are -- the private payers see as the, you know, their biggest areas of opportunity? In a sense, are they focusing on the population based or on the episodes? Or on the primary care?

MR. BORSCH: I think there's a recognition from lessons learned from the late '90s when there was a lot of premature global capitation happening in markets with provider organizations that were ill-suited to take on that risk. So I think payers are being pretty smart with it by and large and they're approaching, you know, they're approaching the task in a very step-wise and graduated fashion. So more emphasis on episodes and a slow approach to moving towards real, you know, population-based reimbursement and only doing that with organizations that have really proven that they're willing to, or that they're able to take on that responsibility.

MS. GUPTA: I think it's more primary care at this point in time. I think they're cautiously optimistic about the other alternative payment models, but there is a big focus from OptumCare to do that. Humana, I think, has pulled back a bit from buying practices, but they continue to focus with Medicare Advantage on the primary care model. So any of these changes around macro or, you know, all of the other things proposed by CMS have an impact, you know, possibly even to the positive for someone like OptumCare. If physicians feel like they are just too overwhelmed with the complexity, instead of selling themselves to hospitals, there may be more opportunity to go to a plan.

MS. SKOLNICK: The one thing that I would just say that some of the smarter health plans have learned is they try to transform a model or intervene in a way, you know, the markets are structured, is that there is no such thing as "one size fits all" in healthcare; that all healthcare, like all politics, is local. And so what will work in Southern California and Las Vegas, and maybe a couple of other sort of risk-capable provider markets, will never work in New York where you have very strongly independent practitioners and a lot of regulation around the behavior of for-profit entities and others. You know, so there is a real difference, not to mention difference in population densities, and sometimes urban healthcare can be as challenging as rural healthcare can be in the sense of, you know, you've got smaller size markets but you have same sort of population demographics. So there's an awful lot going on that we have to be careful not to generalize too much.

I think, as usual, where you see the real leadership of these alternative payment models are in not just Medicare Advantage but in the western states predominantly. And also, you've got some in Texas, because some of the development of Texas -- the Medicare and Medicaid markets in Texas actually, you know, fostered this under PacifiCare. But there is a very healthy respect among all of the providers who are trying to look at taking risk, as well as the health plans for the nature of their local market and the task ahead of changing that behavior from a fee-for-service to a risk-based model. And there will be, you know, they're all trying to avoid the blowups of the past where, you know, the provider groups failed and PacifiCare had to pay claims twice. So there's a real life example and real life incentive here to be very focused on

how fast your local market really can change and whether the population demographics are such that, including the growth rates, are such that it can support the investment that you're going to need to make in order to get these changes.

MR. GINSBURG: Good. One last question about narrow network plans, and we've seen them being extremely important in the marketplaces. I presume that there's significant and private exchanges, but what's your sense about, you know, thinking of the totality of private health insurance? Do you expect narrow networks or just more limited network than we have today to become very important in the future?

MR. BORSCH: Well, it makes sense that you're seeing it in the individual market, and you see it to a certain extent in Medicare Advantage. I mean, maybe it's pretty clear that when you have an individual buying or selecting a health plan, it's much easier for an individual to say, well, you know, I can choose from amongst 20 narrow network plans and pick the one that is going to work for 99 percent of my possible care needs, as opposed to an employer who is contracting on behalf of a geographic and otherwise diverse workforce and is going to really only look at the capability of contracting therefore with a limited number of plans that have pretty broad networks.

The problem here though is when you think about, okay, the idea behind private exchanges is breaking that open and taking the employer lives and enabling those lives to more readily select narrow network integrated plans, you've got a little bit of a chicken and an egg or maybe a big chicken and an egg dilemma here where the formation of lower cost narrow network integrated plans or integrated provider organizations is dependent on the critical mass of lives in things like private exchanges selecting and buying those types of products.

The flip side of it is that you're not going to get to the critical mass of those lives in private exchange-like vehicles until you already have the lower price narrow network plan options available. I mean, that's a dilemma that might seem unsolvable but you get there bit by bit over time. But I think that's a little bit of why we are where we are now and partly why the private exchange adoption has stalled to the degree that it has, at least relative to where expectations were at their hippest maybe three years ago.

MR. GINSBURG: Actually, that's a good topic to get into if any others have more to say about private exchanges. I was going to ask you about whether they've stalled, and I guess they have. And you think that's the key reason?

MR. BORSCH: I mean, I think when you look at the rationale to move to private exchanges, there are a few different reasons given. I've gone to one of them, which is not necessarily the first on the list of purchasers. Purchasers might say, well, I just want to move to defined contribution and offload this responsibility for purchasing to the employee level and get it out of the role of being the paternalistic employer purchaser. That is clearly one of the roles, being able to, you know, then budget that expense on some predictable basis tied to maybe some type of escalator is another rationale. And then the last one is, you know, getting to the ability to leverage narrow network integrated plans, which I think is the most powerful of them but, you know, all of those are really tough transitions to make which is why I think it's been a slower process than some people had hoped a few years ago.

MS. GUPTE: And the Cadillac tax is now put on the back burner until 2020, will most likely get repealed. High deductible health plans have proved to be quite effective in keeping medical cost trends down. So the need to do something as disruptive as a private exchange for a large employer, I think and the burning platform is no longer there. So here we are with seven million actives. I think on the retiree side you may see -- continue to see more of it.

And then on the small group side, I mean, there was, you know, there was a kind of construct around, it would help them potentially pool risk, and that might be one more impetus to build out private exchanges. I believe maybe Mercer is the one that does the more fully insured kind. Towers, I think, is more of the self-insured above 1,000 employees jumbo. But now, you know, as we look at what might happen with the election, coming back to that, the association health plans is one more option that's being tabled for small group employers to pool risk. And then facilitate and ease their ability to move to self-insured and stop loss you again might see, you know, less of an incentive to go to private exchanges.

MR. GINSBURG: Yeah. Is there, you know, given the sharp movement as far as higher deductibles as part of the benefit tie downs, do any employers talk about running out of room to do this? You know, will there come a point to say, you know, if the deductible gets even bigger it really, you know, it's questioned, you know, why did we get into health insurance in the first place if we're really not providing access to care? Any evidence we might be near a point where some employers just don't see this as an option anymore?

MR. BORSCH: Sheryl, I see you shaking your head.

MS. SKOLNICK: I'm not aware of anyone who is saying that. That's what I'm saying, you know --

MR. BORSCH: Well, we're hearing a little bit of that from some of the health benefit consultants who work with middle-sized employers. We're hearing of some buy-down fatigue going on and it's somewhat correlated perhaps with a tighter labor market. And so a little bit of backing off there. I'm not going to say that we have a characterization that that's necessarily widespread but there is some of that going on.

MS. SKOLNICK: So buy down fatigue as opposed to concern that the deductibles are too high?

MR. BORSCH: I'm piling the two together.

MS. SKOLNICK: Okay. Because I would say --

MR. BORSCH: We can't go higher on -- the deductible is already \$3,000. We can't take it up to \$4,000 or \$5,000.

MS. SKOLNICK: Really? You think --

MR. BORSCH: I think there's some of that going on. I'm not --

MS. SKOLNICK: That would be good news. I haven't actually heard that, so I'm learning from you, which is great. Thank you. But I actually hadn't heard that but I know that, you know, there are -- there are certainly beginning to be -- what I have been hearing though is

beginning to be from the employee side a fair amount of pushback. It's like, whoa, wait a minute. You know, I don't really have health insurance. I'm self-insured for the first three or four or five or six thousand dollars of my family's healthcare cost and, you know, it just doesn't kick in. There's beginning to be a realization, I think, on that side. So that was why I was sort of shaking my head. I'm not hearing it from employers but maybe just because of where I sit I tend to get that feedback more from the consumer side.

MS. GUPTE: I have heard though that, again, with the Cadillac tax, and I think I mentioned this at the beginning of this panel, that their impetus to raise the size of the deductible has now become much less. There still is headroom to penetrated high-deductible health plans more within their employee base. And, of course, at some point, you know, that reaches a ceiling as well. But I've heard this from some of the third party, not the benefit consultants but like the players like Fidelity and so on, you know, who manage benefits in kind of an infrastructure way.

MR. GINSBURG: Yeah. And that, as someone mentioned, we could be moving into a tighter labor market which is something we remember from a long time ago. And we also knew what the tight labor market did in the -- I guess this was the late '80s.

MS. SKOLNICK: Late '90s.

MR. GINSBURG: Late '90s. That's right. Late '90s.

MS. SKOLNICK: We were at full employment, Internet-driven, go-go, gaga economy. The good old days of when we were all rock star analysts.

MR. BORSCH: Speak for yourself.

MS. SKOLNICK: Yeah, I was, actually.

MR. GINSBURG: So that could be another cyclical term that could change a lot of these things.

Hospital employment of physicians. How much further will this trend go?

MS. SKOLNICK: Oh, god, I hope not much more. Hospitals are really, really not good at managing doctors. This is, you know, we've seen this story before. It didn't end well before, and honestly, the feedback, just the -- I'll just say, the observation one makes that LifePoint, Community both expressing some difficulty in, you know, achieving profitability on the acquired physician practices for different reasons perhaps but, you know, doctors in hospitals are fundamentally -- should be well suited to each other but they're really not.

So you know, there's another issue though, and it's a financial issue. So part of the reason why the hospitals were really interested in acquiring the doctor practices was they could take them from the outpatient reimbursement schedule and make them a hospital-based unit and get immediate bump-up in the reimbursement from Medicare. And again, they tried to do that also with the managed care companies to greater or lesser success, depending upon the market power of the players. So if the health plan had more market power, it was a no; if the hospital was a must-have hospital in the network, it was a yes. And so, you know, now with them basically

saying, well, wait a minute. There's sort of this site-neutral thing at the outpatient rate, and that has been finalized, I think we'll see the drive to -- for the financial arbitrage as an incentive essentially stops, and now there's got to be a real notion of integration and coordination of care, and some other clinical quality reason why perhaps you should be integrated other than just the financial engineering reason. So I suspect it's going to pretty much stop because it's nothing but losses for the hospitals. The only reason why you wouldn't want to do it is you don't want to let the health plans buy them because that's even worse.

MR. GINSBURG: I always thought the health plans were buying them strictly to keep them away from hospitals.

MS. SKOLNICK: And then make a business out of it. I mean, yeah. That's creativity at its finest.

MR. GINSBURG: Good. If there aren't any more comments on that, we'll move on to the next topic, which is on physician consolidation.

We had a conference a few weeks ago here on surprise medical billing, and one of the speakers noted how some of the hospital-based physician specialties, such as emergency physicians, have become highly consolidated into a small number of national firms. And I've seen Matt's coverage of some of them, perhaps the others of you cover them, too. And I just want to comment how extensive has consolidation become in this area and what's been happening?

MS. SKOLNICK: So the chief financial officer of LifePoint left his job to go be the CEO of Team Health and three weeks later got acquired. I hope he got a lot of stock and I hope he vests. You know, it's covered for us by Anne Heins. You know, it's pretty significant and I'm not sure if it says that, you know, the economics of that business are beginning to become pressured, so again, you need to build scale and you need to be able to offer benefits to these employed physicians that a bigger company can perhaps do. There probably are some arguments around that and national contracting, again, may, especially if you're dealing with consolidating chains on both sides, both managed care, bilateral consolidation, above and below, you manage care and other providers around you. But yeah, we certainly have seen that, and it remains to be seen how successful that will be.

MR. BORSCH: Excuse me. Sorry.

MS. SKOLNICK: Yeah, go ahead.

MR. BORSCH: I was just going to say, I mean, one of the interesting experiments, which hasn't worked out all that well thus far, but certainly a company to watch is DaVita and DaVita Medical Group. And yeah, it's been -- it's not been a good acquisition for them at all.

MS. SKOLNICK: No, not at all.

MR. BORSCH: Heretofore, but I think this is a company that was looking at the eventual, if not, you know, near-term stagnation of the dialysis business and saying, you know, what is going to be a growth engine in the future? And so they acquired Health Care Partners, and Health Care Partners was, and is a -- now renamed David Medical Group -- an organization of

primary care-led physician groups in Southern California, and a handful of other markets operating under a very advanced, delegated, integrated care model. And they were looking for a partner or an acquirer that was: (a) not a payer; (b) not a hospital company; (c) was large and well capitalized; and (d) a healthcare company. So their list got very small, and the marriage with DaVita ended up making a lot of sense.

But it's been a really tough road for them to take that model and advance it into new markets. And frequently, where DaVita Medical Group has been looking at acquisitions, they find themselves outbid by the local hospital or by the payer, or by both. And meanwhile, the results that they've had for their own operations have been mixed, but that's going to be an interesting story to watch.

MS. GUPTE: The other -- the other example of the consolidation in this ED space -- well, ED and anesthesia is pretty fragmented and you're seeing a lot of rollup. The two players are Team, as Sheryl mentioned, and Envision. And so you're seeing rollup within each of those as far as staffing of hospital physicians, and for all the reasons Sheryl mentioned.

There's another company, AMSURG, which is the ambulatory surgery player that bought an anesthesia company called Sheridan, and they recently made a deal now to merge with Envision, who is the ED, you know, consolidator, if you will, and the CEO there has the vision of this conglomerate that will offer one-stop shopping across all hospital physician staffing services -- ED, anesthesia, radiology, neonatal, and with their ambulatory surgery capability all rolled in. So I think, you know, that's ways for them to try to create value by offering better rates and one-stop shopping, physician training and recruitment under a corporate umbrella.

Team had enormous issues though when they bought -- they went out of their ED and anesthesia mode, into buying a company called IPC, which is a hospitalist company, and have over paid for it, have seen tremendous physician attrition in the hospitalist piece of that acquisition. And that, combined with the fact that they rejected a bid from AMSURG at 50 percent, you know, higher stock price not that long ago, then drove them into the arms of Blackstone, which is a private equity company, and they're hoping to turn all this around and bring stability to the hospitalist organization. Hopefully -- I think they're hopeful that the bundling story with CJR and all that will also play out favorably for Team, you know, but in a private setting so that all of us analysts and investors aren't breathing down their neck. I think the CEO, as Sheryl pointed out, was very strongly incented to sell, and his employment contract, it was pretty obvious he was going to sell very quickly.

MR. GINSBURG: You know, both of you have mentioned various what I call efficiency things, value propositions. But what about the potential for just pure leverage? You know, consolidating nationally the ED docs is going to give them great leverage negotiating contracts with hospitals. Is this something that policymakers should be concerned about?

MR. BORSCH: It's still very fragmented. I think if you look at the numbers, they're not easy numbers to come by, but I think you find that we're not -- I don't think we're close to there yet. Clearly, at a certain point the answer to that is going to be a yes, but that's -- from the numbers I've seen, would seem to be quite -- still quite a few years away and a lot of consolidation away.

MS. GUPTE: And ED has seen so much, you know, so many secular pressures. I think with the Affordable Care Act tapering off, if not even being unraveled. Medicaid expansion -- you may see more of a steerage from Medicaid plans away from the ED to primary care. Now, that might be kind of a golden scenario, but there's a headwind as well in ED. And then the freestanding ED story though. That one it's hard to really sort of say whether that is bad. But all of them, in the third quarter you saw HCA talking about freestanding ED pressures and then Team Health missed yet again, and so the stocks had really tanked for a while and all these worries.

MR. GINSBURG: Good, thanks.

I'm going to be moving to questions from the audience soon, but before I do that I want to give each of the analysts an opportunity to either answer some question that I didn't get to that they really had something to say on, or just, you know, give other thoughts of reflecting on the discussion so far as to what the audience should take away.

MS. GUPTE: I think talking about the small group market. You know, we talked a ton about the individual market but the small group market has been seen facing enormous headwinds. Not to say it was ever completely functional, and then you had all these employers who were slowly dropping their rates, offer rates and all of that. But I think we're now to the point where the under-50 market, you have this ACA compliant market where the companies are losing a lot of money and this is going to keep what you have, ACA noncompliant market, which is expected to be phased out by the end of next year, but the worry that Aetna and Anthem have, and they're probably the most exposed here, is that as these two risk pools are merged between the ACA compliant and noncompliant books of business, that the currently noncompliant small groups who are possibly healthier and more likely healthier will not be able to withstand that risk pooling. And so you have each of them now talking about how they're going, you know, Anthem is openly, I think, pretty much saying in their earnings call that they will compromise on margin to try to retain those groups but there's an enormous worry about what that pool risk looks like, and Aetna talking about, you know, sort of obliquely that they would be willing to lose membership to try to recover their small group margin because their efforts to keep margins intact this year did not play out very well for Aetna. And I think it was one of the, you know, one of the two drivers that led to them not beating numbers that as I think they had expected and perhaps analysts had expected at the early part of this year. The other being the individual market, which turned, you know, worse than they had hoped.

MR. GINSBURG: Matt or Sheryl?

MS. SKOLNICK: Go ahead, Matt.

MR. BORSCH: No, I don't have one.

MS. SKOLNICK: You don't have one? Okay.

So first thing, yesterday when I was meeting with some of my hospital companies they asked me to sort of sit up here among all my managed care friendly colleagues to sort of defend the hospital sector. It's a little hard to do that right now because I'll start by saying what I said before, we honestly do not know -- let me remind you -- we do not know what is going to happen. So all of the things that we've been saying here are predicated either on the continuation

of the markets as we know them today, or some vision of what could happen in the future. But, you know, we come here and we're hoping through your questions to learn a little bit, or at least I am, to understand and get better insight as to what is likely to happen because there are a couple of things the market does not tolerate well, as I mentioned. One of them is uncertainty, and the other is negative surprise, being uncertainty. And we are -- so yes, they are the same thing. And we are in a position now of perhaps, you know, we're on a great precipice of great change so that perhaps Congress can lead us in a direction where we fix the things that are wrong with the ACA because there are many, and preserve what is good, but you know, from where I sit, I think it's a very risky bet.

So a couple thoughts. First of all, a very simple strategy with respect to hospitals. If reform was good for hospitals and reform is going away even before the election, it's still going away, so therefore, a lack of reform is bad for hospitals. The hospitals that I think will ultimately succeed in all of this are the ones that will be able to consolidate. And I don't mean by acquire; I mean by rationalizing the capacity that they have, because no matter what's going to happen with the ACA, you're either going to have no-pay patients coming back or you're going to have activist-managed care companies who are working to manage their margin at the expense of the hospitals. One of those two things I think is likely to happen irrespective of the politics because it's the economic equation at work. And if that happens, then we're going to see exits of hospitals from the marketplace. So that's the concern -- right care, right time, right place. That the economic incentives and the technology and the innovations in care management, the quality metrics, the readmission policy, all of these things are training primary care and other physicians to keep their patients out of the hospitals as long as they can. And the ones who will survive are the ones who have to survive, not the ones who want to survive. So we could be on the precipice of very, very great change, and it might not all be bad, but very great change for the hospital sector in particular. For the post-acute sector, I think I was here last year sounding the warning bell, and I hate to be Cassandra in this and I hate to be the one always being the voice of doom here, but maybe it's genetic and maybe it's just the 29 years in the business of just seeing things that we said, you know, bundling is going to be very dangerous for these post-acute settings. And in fact, it's even more dangerous than we thought, even before it fully kicks in in the sense that the skilled nursing facilities that were getting paid several hundred dollars per day are now no longer seeing those heads in the beds. It doesn't matter how low cost you are if the patient doesn't show up.

And now when you contemplate what might happen with Medicare block grants and what might happen with Medicaid funding overall, long-term care facilities where your moms and dads are maybe one day, or where I might be one day -- if I'm nice to my kids it'll be a good one -- they may be in very dire straits. But watch there hospitals, watch the ER admissions, watch for signs of the real changes that we could possibly see on that score.

And then finally, the best thing that I think could happen out of this whole policy mess that we've gotten ourselves into, not to mention the whole electoral mess, would be very a very rapid conclusion to the uncertainty, but also for the folks to just look at the ACA with more objective eyes, to understand that it is not wholly bad and it is far from wholly good, but that if we focus on some of these innovations in payment for value we could actually address what the ACA perhaps should have addressed all the way along, which was getting rid of the barriers for actually providing the right care at the right time in the right place for the right reason at the right

cost, which is where the healthcare system, I think, needs to go.

So I'm encouraged from that perspective that perhaps a republican leadership can get us in that direction now that they're talking about preserving at least some of the ACA, only because that is the part of the ACA that I think actually has the opportunity to get us to a long-term better healthcare system.

MR. GINSBURG: Thank you. I've got time for a couple of questions.

Oh, yes, Shawn?

MS. BISHOP: Hi, Shawn Bishop with the Commonwealth Fund.

I was wondering if any of you have been looking at United Health Group's paper that they are talking to folks about. It's sort of their vision of all the things that they like -- that they would like to see happen. One of the things that's in that paper is their sort of commitment to having what they're calling, I guess, entitled subsidized health insurance for the uninsured. And what they are looking for -- now, maybe this paper was written before the election so maybe it's potentially mute, but we met with them after the election so they were still talking about -- but that they want to build on the Medicaid program as a way to insure the uninsured. They don't think the exchanges function in their current form. I was wondering if you could comment on that vision.

MS. SKOLNICK: I'll give it a crack.

MR. BORSCH: Go ahead, Sheryl.

MS. SKOLNICK: So first of all, how much simpler would it be? Okay. You're uninsured. You're low income. Forget the mechanisms and the structures of the subsidies. Put everybody in a Medicaid expansion plan. You know, ideally, that was part of what was supposed to happen when all 50 states were supposed to participate but, you know, from their perspective, from a social perspective, the mechanism from doing that, you don't have to build a whole new exchange mechanism. It would have been much simpler. Okay? So as one democratic staffer once said at a conference I attended, you know, if this was really a government takeover of healthcare, if this was really single-payer, it would have been so much easier. As of January 1, 2014, you'll all be covered by Medicare. Done. Finished. By the way, your taxes go up. That would have been very simple. But don't forget, this is a for-profit company with a very significant portion of its business coming from Medicaid managed care. So when you do block grants or when you do an expansion of Medicaid, the Medicaid managed care companies benefit. So should they be talking their own book? If I were a shareholder, you betcha I would want them to do that. It doesn't mean it's wrong, but just remember they will benefit from this. And I do think it would be much simpler to administer.

MR. BORSCH: Okay. One more question? Oh, Paul? Yes.

SPEAKER: Despite the fact that we've heard for months how terrible our economy is, in a few months it'll be the third longest economic expansion in U.S. history. And when it ends, that will give all of these players opportunities to make changes that they can't make when things are going well. What kind of changes do you see happening when we get to the next recession?

MR. BORSCH: Well, one thing to watch for, just if we go back to that cyclical model that we were talking about, is that historically anyway, trends usually spike or peak into a recession and, you know, that combined with the pressure on the bottom-line is what then has tipped the scales for employer-purchasers to take action in terms of healthcare cost containment. Or at least to step on the accelerator where maybe they weren't before.

I guess it's a little hard to envision, you know, what is the next step in healthcare cost containment when that becomes more urgent? More shifting into high-deductible plans. Narrow networks. But narrow networks aren't going to work unless there's broad -- unless you have -- employees have a broad choice of plans to pick the one that's appropriate for them and their family. So I think, you know, it's probably going to be something around the evolution of private exchanges that is what you would see occur when we get the next, you know, urgency call around healthcare cost containment brought on by a recession.

MS. SKOLNICK: I think the one thing that you omitted there is thinning of the benefit. Okay, it's not just the copay and the deductible; it's what's being covered. And if you get rid of the medals as, you know, think about do we get rid of the medals plans as a -- are they providing a floor for the benefits in some way, shape, or form? You know, if you're an employer and you're looking at medals, do you have to do better than that? Or can you do just that? Or can you do less than that? But you could also see the thinning of the benefits.

MR. GINSBURG: Okay. Well, this is a good time to close the meeting because we're approaching noon.

This room has to turn over quickly for another meeting, so I'd ask you to do two things. If you have cups, please take them out with you, and if you want to continue discussions with other people, please do it outside the door.

I want to thank the analysts for a really terrific job.

(Applause)

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