

THE BROOKINGS INSTITUTION  
WALL STREET COMES TO WASHINGTON  
HEALTH CARE ROUNDTABLE  
*An Event From the USC-Brookings Schaeffer  
Initiative for Health Policy*

Washington, D.C.

Friday, April 9, 2021

**PARTICIPANTS:**

**Introduction and Moderator:**

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MR. GINSBURG: Hello, this is Paul Ginsburg, and I want to welcome you to the 25th Wall Street Comes to Washington health care roundtable. I'm director of the USC-Brookings Schaeffer Initiative for Health Policy, and 25 years ago, shortly after beginning of the Center for Studying Health System Changes community site visits, I realized how little federal policymakers knew about what was happening on the ground in health care markets. I also knew that Wall Street analysts conducted their own research on emerging market trends to inform their investor clients, and that policymakers could benefit from the analysts' broader market perspectives. That was the genesis for this event. Today, I think the policy world and Wall Street know each other a lot better. Wall Street stays up -- quite up to speed on policy research, and policymakers pay a lot more attention to market developments. So, the purpose of this event is to give the Washington health policy community insights into market developments that are relevant to policy, through

the eyes of equity analysts who advise investors about the likely performance of publicly traded companies. Along with a thorough understanding of health care markets and the companies they follow, all of our analysts today closely follow public policy because of its key implications for publicly traded companies.

I want to thank Arnold Ventures for supporting this event, which many people inside the Beltway continue to value for its outside-the-Beltway perspectives. And this is the second time that we've held the event as a webinar. And after the first time, in March 2020, we realized that we now also have many viewers outside of the Beltway, and I'm very pleased about that. Our format will be a roundtable discussion, based on questions that I have shared in advance with the panelists, and we'll have two opportunities for audience questions and answers, the first at around 2:50, and the second, before we adjourn at 3:45. You can either send questions by email to [events@brookings.edu](mailto:events@brookings.edu), or via Twitter at [#WallStHealthPolicy](https://twitter.com/WallStHealthPolicy). We have staff monitoring email and Twitter to make sure we get as many of these questions as possible. Also, please note that the analysts cannot answer questions about the outlook for specific companies. And a transcript and webcast of the conference will be available, through the Brookings website, next week.

We have a great panel today. All are veterans of previous Wall Street Comes to Washington events, but Matt Borsch of BMO Capital Markets, I think, is the dean of these analysts. I went back and checked, and he participated for the first time in 2006. Our two other outstanding analysts are Ricky Goldwasser of Morgan Stanley and George Hill of Deutsche Bank, who both participated last year. , this is our 25th edition of this conference, and I thought it would be interesting to start off with a few comparisons between 1996 and 2021 in terms of health care spending. All of these figures come from the National Health Expenditure Accounts, although the 2021 figures are projected.

Total U.S. health care spending in 1996 was slightly less than \$1.1 trillion, and spending has almost quadrupled, reaching a projected \$4.2 trillion this year, and the share of GDP has gone from 13.3% in 1996 to a projected 18.2% this year. So, with that historical context in mind, and the health care system today still dealing with the most serious public health emergency in a century, let's jump into the discussion.

And the first question is to talk about the experience with the pandemic, and, first, what has been the near-term financial impacts, on various types of providers and health plans, and what are the possible long-term impacts on them? And, George, do you want to take the first crack at that?

MR. HILL: Sure, and I'll say first, thank you, again, for having me, again, this year. Thank you to everybody in the audience for participating and listening. And I think what we saw, as a result of the pandemic, and I remember when we did this event last year, I think we were just first starting to hear about

the coronavirus, and we were first starting to wonder what the impact was going to be. I think we were just first going into lockdowns, which was why the event went virtual.

And, I think from our perspective, we saw the pandemic as an accelerator of a lot of trends that we were already seeing in health care. We were already starting to see the rise of telemedicine, and we saw the explosion and the rapid adoption of telemedicine. I think we were seeing -- we were at the early stages of seeing what I would call the marginalization of the low value add -- likely differentiated provider or provider organization. We were seeing the increased responsibility of managed care companies, in driving and steering the care of beneficiaries under their care, particularly in Medicare, in plans like Medicare Advantage, and I mean, really putting the managing, in managed care.

And one of the things that we saw during the pandemic was an increased responsibility, particularly for managed care companies, as they tend to be the wallet of the health care system, whether they come from the government, or whether we're talking about the commercial space, in making sure that the health care system was sustained and sustainable through the crisis, through the disruption. Again, I know that Ricky and Matt can follow me and talk about all of these topics, where we saw managed care companies providing payments to hospitals, and health systems, and provider organizations, that might not have been seeing patients because of COVID. So, think about the disruption to the physician practice model or the hospital model.

We're enabling telemedicine visits and other types of deliveries of care. We're moving restrictions and access to care, but, I guess, really what we've seen is, and it's interesting, and I know we talked about this in one of our pre-calls, COVID has really served as a catalyst for a lot of the trends that were existing in the background, things like the move to value-based care, and I know we'll spend some time talking about emerging business models, as it relates to the value-based care space. But I think we really saw COVID as a catalyst accelerating a lot of trends that we were already seeing, kind of making weaker parts of the health care delivery system even weaker or potentially disadvantaged, and strengthening burgeoning parts of the care delivery system, particularly telemedicine -- like, the telemedicine genie is clearly out of the bottle now. And I would even extend telemedicine to almost every type of remote monitoring or remote care delivery interaction system, and kind of as a facilitator and an accelerant of trends that were already happening in the background.

MR. GINSBURG: Good. Anyone else who would like to comment? Okay, let me go on to the next question. I want to talk about the --

MR. BORSCH: Paul? Paul, could I -- I'm sorry. I just lost my mute button for a second, there.

Could I comment?

MR. GINSBURG: Yes, please do.

MR. BORSCH: Okay, I just wanted to add, in terms of the financial impact, that it has, in some ways, been different, depending on the line of business. For example, in managed Medicaid, when we're talking about health plans here, and in managed Medicaid, the states have been rather aggressive, partly, of course, because of their fiscal situation, coming back to the table in terms of the reimbursement rates to the health plans, and clawing back either real or perceived excess earnings, coming out of the disruption of utilization patterns. So, and I think, in some cases maybe that's even gone further than going back to normal profitability and cut a little deeper than that.

By contrast, I'd say in Medicare Advantage and commercial, while there's been a range of activity the plans have engaged in to sort of give back money, in the form of relief and that sort of thing, by and large, there haven't been any claw back mechanisms, that commercial customers have been able to use, or that the federal government has used, as part of its normal process. Medicare Advantage does, of course, as you well know, have a process for recouping the actual cost, as we experience it that has a very long lag.

MR. GINSBURG: Good. Let me move onto another question, alternative payments. What effect has the pandemic had on providers' and plans' appetite for alternative payments? So, will the pandemic experience, which forced many providers to shutter or stop elective procedures, increase the attraction of alternative payment approaches to fee-for-service because they reduced the reliance on volume, or will the pandemic experience make the risk involved with models that have both upside and downside risk just more daunting and delay adoption? Go ahead, George.

MR. HILL: Okay, that -- that's back to me, again?

MR. GINSBURG: Yes.

MR. HILL: I think, again, I think the answer to your question there, Paul, is a very vociferous yes, and again, as I alluded to in the answer in the last question.

MR. GINSBURG: I asked you the first question, high rapid -- high rapid sight for telehealth.

MR. HILL: Well, okay, well, so, telehealth is one part, but also as you think in terms of --

MR. GINSBURG: I'm sorry. Sorry about the telehealth, my mistake. I meant - I asked a kind of a rhetorical. Will the appetite increase or decrease, and you're saying it's going to increase for alternative?

MR. HILL: For alternative payment models, I would say absolutely. And, again, we're seeing -- I feel

like now is such an interesting time in health care, and it's interesting, you talked about the first one of these that occurred, I think it was back in 1996, and, I feel like we're seeing -- I'm seeing flashbacks of 1996 right now, when you see the rise and fall in that period of a lot of physician practice management companies, and a lot of services to physician practices, where you had an increased amount of risk taking by provider organizations that were probably not ready yet, for the provider -- the provider organizations, back then, were not good at taking risks, and the companies that were helping them were probably not well educated on the part of taking risk.

If you think about what we saw during the COVID crisis, we alluded to the hospital environment, and I would talk about the fee-for-service ambulatory environment, and if we went from April maybe through August of last year, you saw a very sharp fall in discretionary hospital procedures, discretionary surgical procedures. From some of the channel checks that we were doing with hospital organizations, we were seeing emergency department utilization down 30%, 35%, 40%. I mean, telemedicine exploded thousands of percents, and I'm going slow here because I want to make sure I phrase these things in the right order.

And if you were the provider organization, either on the hospital side or on the ambulatory side, I think what you were struck by was how quickly the business you had could erode, and the impact that could have on financial statements. So, then, again, thinking about COVID as a catalyst for trends that were already occurring, you already had demonstration programs that were going on in CMS around bundled payments, like you said. You already have, in the ambulatory space, a lot of what I would call risk syndication business models. So, managed care organizations partnering with physician organizations, paying physicians organizations either basically a subscription to manage patients, so, giving them revenue visibility, or upside and downside risk related arrangements, and if you think about this from the providers' perspective, principally on the ambulatory side, you would be giving these provider organizations revenue visibility and revenue certainty in a market where it might not otherwise exist.

Also, you continue to see the growth through acquisitions of managed care organizations that want to own provider organizations, basically accelerating the trend of the verticalization of the health care staff, more physicians going from a self-employed model to an employed model. Again, think about it both from the practice level and from the individual level, that you're taking these people from having a lot of revenue uncertainty to a lot of revenue certainty. I think that shock to the system that happened during the COVID crisis is going to continue to pursue people to want to pursue these -- to go after these alternative payment models, particularly in situations where they either imply the option for revenue upside or greater revenue

visibility.

Again, I continue to refer to it as risk syndication -- the managed care companies basically want to share their risk with the provider organizations. I think, they'd ideally like to share the risk with the beneficiaries, as well, to the degree to which they can. But we continue to see this trend of people who want to adopt these alternative payment models, for two reasons. Number one, it continues to increase what the revenue visibility looks like for the provider organization, it increases what the cost certainty looks like for the payer organization, and it also would seem to enhance the margin opportunity for providers that want to participate.

When I look at a lot of treatment categories, historically, a lot of payers, particularly the government payers, the only lever that they've, historically, been able to pull well is the price lever. It's been very hard for the government to pull a utilization lever, historically. So, if you think about categories, like lab services or diagnostic radiology, I remember watching those spaces for years, where the government would just come out at the end of the year, and CMS is cutting reimbursement in this category. And, basically, the participation in these alternative payment models, on bundles or other avenues, I think, is going to continue to accelerate because it's going to continue to either enhance the provider organizations, revenue visibility, or their margin expansion opportunity.

MS. GOLDWASSER: Well, Paul, I think one of the things that, as we think about how the market has evolved, is always to think about the word dollars, and what's the dollar flow, because, really, the dollar is in the reimbursement. The payment is what shapes providers' behavior. And I think that, ultimately, the pace of that changed, from fee-for-service to value based, is going to depend on that. And I think that one of the things that we should all be watching for, and we don't have the crystal ball, but what we should look for is what is going to be the second derivative impact from the greater adoption of telehealth.

And what do I mean by second derivative impact? I mean, we're all now focused on telehealth and telehealth adoption. But how does telehealth adoption change how providers practice care? Does it mean when we think about a supply- demand curve, does it mean that now there's going to be less demand for lab testing? Are physicians using more of empirical tools when they're having those interactions, via a telehealth visit. And if that's the case, does that mean that even -- that if you're in a fee-for-service model, you're being paid less? Because fee-for-service models are about code stacking. So, I do think that, as we see how these sort of trends evolve and shape, and how the use of technology is impacting standard of care, and I'm not saying quality of care, but standard of care, I think, that's going to be very relevant to what's going to be

sort of that shape of adoption that we're going to see in the move to these alternative payment models.

MR. GINSBURG: I'm really glad you brought that up, Ricky, because I've been thinking that when -- and we'll get to telehealth in a minute -- that should telehealth become an important part of medical care, it just not so consistent as you say, with the fee for service model; it's halfway into the more capitated model, so to really get the fruits of it, and to make it more livable for providers, you're going to have to move further.

MR. HILL: And Paul, if I could just add one more comment there. I think Ricky makes a very astute and observant point about code stacking. And, it's interesting, because as you change some of these business models, in which you engage providers, to some degree, you change the incentive structure, which arguably is going to change, ideally it would not change the way in which providers deliver care, but, as Ricky, smartly pointed out, like the fee service structure incentivizes code stacking, what are the intended consequences and what would be the unintended consequences of changing to the bundled model, or the capitated model, as it relates to care delivery and services that are consumed, in kind of a method in which the services are consumed as well.

MR. GINSBURG: Thanks.

MR. BORSCH: Paul, maybe I could just one -- offer one comment.

MR. GINSBURG: Sure.

MR. BORSCH: Really, it's a question in my mind, that because bundled payments and capitated type payments, do rely to a certain extent, on predictability of the volume that is going to be provided or at least some level of predictability. I guess the contrarian argument would be what we've seen is the ultimate in unpredictability in terms of the volumes. Obviously looking back, a population-based health payment would certainly have been preferable to fee for service. We're going to go through a period fairly soon, when maybe to some degree, volumes will be above normal levels, so we'll have to take that into account, in terms of how provider reacts to all of this. I'm inclined to agree, by the way. I think, that this is going to accelerate the adoption of alternate payment methodologies. I'm just pointing out that other dynamic to watch for.

MR. GINSBURG: Yeah, thanks. I take it that probably it's a predictability of revenue, which is more important to providers, then the predictability of volume?

MR. HILL: Paul, I think that's fair, and I'm jumping in here, and it's funny, we've been having a lot of these conversations with investors recently about kind of the impact to the businesses on these changes and behaviors, and I try to keep it very simple, one of the analogies that I use with investors is, like, if I told you how much money you are going to make exactly for the next 10 or 15 years, you would probably run your life

a little bit differently. You might buy a bigger house. You might buy a smaller house. You might spend money on different things. You shouldn't think about a company or corporation as having these simplistic mind sets that's any different.

So, if you're a managed care company, or that the idea, that you can generate -- to some degree, a higher level of cost certainty, in parts of your book, are going to impact how you finance those businesses, how you think about fixed cost versus discretionary costs. What types of partnerships that you want to take on? How you reinvest capital in the business. Again, just tacking on to the end of Matt's comments, that I think, there are a lot of downstream consequences to how the permutation of the changes in the business models kind of roll out through the market.

MR. GINSBURG: Good. Let's move on to telehealth now. The experience with telehealth, before the pandemic convinced many that it has an important role. Actually, I'm sorry, it was during the pandemic, you were expecting it's to play an important role, but before the pandemic, both private and public payers were proceeding very cautiously in allowing coverage for video visits and telephone calls. I'd like to get your insights into the thinking of private payers on coverage rules for those technologies after the public health emergency ends. So, what will be covered, and how will payment rates compare to in person visits, and will payers differentiate between coverage with virtual only providers that they contract with versus bricks and mortar providers in their plan networks that also offer telehealth services. Ricky, would you like to speak first?

MS. GOLDWASSER: Sure. So, I think that we are probably going to see a number of things, and we're starting to see it already. I mean this year we started to see health plans offering benefit designs that if it's virtual only, that comes with lower premiums. And, when you think about those type of offering, and they're very early in the marketplace, but those are also offerings that provide the health plan, with a lot more control, because in essence here you have your ultimate narrow network, and lower savings.

But I think the question is even broader than that, right, because if we think about what will really help acceleration off telehealth -- one, there is really no other alternative during the early days of the pandemic, but there are also the changes, the very quick adjustments to the payment model, going from meaningfully below in person to parity. I don't think that that is sustainable, on, sort of an apples-to-apples comparison. And I don't think, that even when you talk with the providers, that they think that it is reasonable that that's going to be sustainable, because at the end of the day, an in person visit, is not equivalent to a telehealth visit.



The question is really -- what are we going to use telehealth visits for. Are we going to use telehealth visits to prescreen patients? Sort of pre an in person visit? Are we going to use it as a follow up? And, I think, that's how the payers will think about reimbursement. That said, I don't think that reimbursement is going back to pre-COVID levels, because those were clearly too low. It's sort of finding what's kind of like the right balance. The other thing that we're saying, because when we think about pricing, there are two factors that are impacting pricing. One is the actual price, but then there is also the mix. And, I think that that relates to the question that you asked about -- what can we use telehealth for? So, as we are going to see a greater adoption of telehealth by specialists, that would suggest, right, that we are going to see higher pricing. So, it's a combination of mix and actual price increases. There is also the question of, when is it going to happen? And, I think that there is something there, where with the payers, who's going to blink first? Because we are still under, sort of kind of like an emergency state, and you don't want to be the first one, who's going to come back, and say, well we're now lowering the payment.

So, I think it's going to take a while. I think that we're probably going to wait until 2022, it's sort of, kind of like the balance of what is my public perception and how do I look publicly, versus when do I think that I should do it as it impacts the P&L. And, we've seen it last year, with managed care, right? Early in the pandemic, investors were very excited and enthusiastic about the fact that managed care medical cost is going to meaningfully come down, because of the lower utilization.

But the health plans had to very quickly, made it very clear, to the public, to Washington, that they are trying to kind of like help here, and there was a lot of premium holidays, and giving back to the community. So, I'm thinking about, sort of, that adjustment to reimbursement and pricing of telehealth -- using that same lens.

MR. GINSBURG: Okay. Thank you. Matt or George?

MR. HILL: I think, I'll jump in. Like, I think, Ricky had a pretty comprehensive there. The mix, I think, she's right on the mix point. She's right on the price point. I think the disease states in which you see telemedicine continuing to see a rapid uptake in adoption -- I would kind of call out behavioral. Telehealth is not great for everything, but you will -- you see kind of the -- you've seen a rapid uptake in behavioral, and you can almost see where behavioral is kind of a perfect disease state. It is clearly not the same as an in person visit.

I think there are also -- there are things that we are continuing to see a rapid uptake in telemedicine, that people might not instinctively think of as telemedicine. When I think about like remote ICU monitoring,

given the shortage of intensivists, like I think of that, as contributing to the growth of telemedicine. There is actually an inpatient component to telemedicine, so there are segments of the telemedicine market, that might not be obvious to a lot of people. Yeah, I agree with Ricky, the telemedicine genie is out of the bottle. Prices on telemedicine, if you think about the average price per primary care telemedicine visit is now, it's coming down, like, and it's funny like Ricky said nobody wants to be the bad guy from a managed care perspective. I'll be cynical, and say well, I think, I know who the bad guys going to be, come 2022, and I would say that, because we've started to have conversations with a lot of the pharmacy companies, around - - I'm going to use the analogy of the COVID-19 vaccinations, to telemedicine. And, CMS has come out and basically said that a COVID vaccinations gets reimbursed at \$40 a shot, and the government pay books of business, and then how are the managed care companies -- which managed care companies are matching that in commercial books of business, or other books of business and in their Medicare Advantage books.

I feel like, that makes a great precursor and a great case study for -- if I'm a multi-line MCO, and I know that I have to pay \$40 a stab for a COVID vaccine in my Medicare Advantage book, but I've got flexibility in what I want to pay people in my commercial book, that probably becomes the road map for the same approach that these payers take to telemedicine -- by end of '21 or '22 or '23, but again, like, you're going to see -- the numbers are going to come down -- that is the short answer, the numbers are going to come down.

MR. GINSBURG: Okay, Matt?

MR. BORSCH: I'll just add a little bit to that. It will be interesting to see how this dovetails with the adoption of alternate payment methodologies, that the faster and greater degree to which we go to that providers are willing to go, and are pushed to go towards capitation. The more, certainly, the payers are going to be perhaps more agnostic about whether it's done in telemedicine format or physical. And, it also, it might just surprise us that this doesn't slow down at all, in terms of the -- and I'm not suggesting that anybody said that it would slow down, but that there will be more resistance to going back on any front, given what we've experienced thus far, and that in fact things are going to push forward, rather than walk back, in any sense, when this is over.

MR. GINSBURG: Thanks. Now how do you think the virtual only providers of telehealth services, are going to seek to intergrade their services, with patients' regular bricks and mortar providers. Are there payers, paying attention to this issue?

MR. HILL: Is that question for me Paul?

MR. BORSCH: I guess --

MR. GINSBURG: It's for anyone.

MR. BORSCH: I honestly don't have a strong opinion on that one. Although, clearly payers are -- this is something that is going to be on their radar screen -- it's on their radar screen now. I'm not sure, although, it hasn't been really been shared with investors at this point what their thinking is. So, I think that -- I just think this one is wide open. I don't think we know how this is going to work out yet.

MR. GINSBURG: Yeah.

MS. GOLDWASSER: So, Paul, I think the -- in sort of my perspective, and maybe I'm taking it a little bit from a different angle, from the payer, sort of more thinking about, how are we going to see, sort of your point, a telehealth-only provider working with the brick-and-mortar provider. And, that takes me to the conversation, also to the idea of, how will telehealth be intergraded, into more conventional ways of delivering care, providing care. In that -- in that part of the biggest changes, I think, that happen in telehealth, are from pre-pandemic to now, is that before telehealth was a point solution, and now telehealth is becoming part of an integrated system. So, I think, that those telehealth solutions are point solutions, probably five years down the road, not going to have a significant place in the system, and it's really going to be all about integrating the two, and having sort of telehealth and in person providers combined. And, I think, that we are going see over time, consolidation because of that. Because you really have to provide those two modalities together now in order to provide the care that people need.

MR. GINSBURG: Okay.

MR. HILL: Paul, yeah, I don't know if I could follow up there quickly? I guess I would just say, the framework that we use to think about this, is to what degree does telemedicine, or any care delivery modality affect share of wallet, from the payer's perspective, and kind the ability to tell -- of telemedicine to continue to exist as a standalone line of business, versus, being integrated inside of the payer organization, will depend on how big of a share of wallet of that payer book and business, does it become. Ricky said it earlier, follow the money. But like if telemedicine grows too much, you will see more moves like Cigna's acquisition of MD Live, where the payers are going to work to vertically integrate these more lightly integrated revenue streams as a way to diversify their business away from their core business, and also, capture more of that -- that share of wallet spend, that they can kind of get their arms around and get control over.

MR. BORSCH: Paul, if I could just make one more point on this, which is, the other area to watch, is obviously going to be globalization, and this isn't something that's getting a lot of attention right now, but to

the extent that the rules start getting changed, maybe, around who can participate in telemedicine. And so, you have some providers overseas who maybe are as well trained but available for significantly lower prices, wanting -- I'm sure they do today -- wanting to be part of this, and that's something that's going to take longer to unfold, but that's going to be an area to watch.

MR. GINSBURG: Yeah, that's a really good point. Nurse practitioners and physician assistants -- will the pandemic experience lead to an increased role for these clinicians?

MS. GOLDWASSER: Absolutely -- that is something that we talked about last year. I think, that was one of the big, sort of, changes where all of a sudden, nurse practitioners had to take on some responsibilities that they didn't have before. And, I think, that that is something that is just going to continue. Even if we think about where care is going to be delivered, we are seeing an increased move toward care that is delivered at home. And, I think, at that setting is where we're going to see even a greater emphasis on that role that a nurse practitioner provides.

I think, it also validates some of the business models that we are seeing in the marketplace. We can't talk about specific companies, but if we talk about company strategy, right, so CVS and the health hub strategy, it's one -- it's a business that really kind of like anchored around nurse practitioners. And the nurse practitioners now have -- can take on that more responsibilities, and frankly, that is something that, Matt has talked about, globalization, that is something that has been -- that's how care is being delivered, worldwide, and I think that we're finally -- we're finally getting there. And, I think there is no going back.

MR. HILL: Yeah, Paul, I just kind of want to add one last comment. I agree with what Ricky said, and Matt said. Matt introduced what is probably the terrifying concept of global price competition in health care, which is not something that exists right now, right? Health care is very much a local business in the United States. Telemedicine enables the possibility for kind of global price competition in primary care. I mean, there's a regulatory mountain that needs to be climbed before that's enabled.

But I'm sure, if there are any doctors that are participating in this session right -- again the idea of competing with a doctor in any other region of the world, on a like for like service basis on price, is not something that has historically existed in health care, and would be terrifying for local doctors, and would have an incredible price compression component or effect on care delivery in the United States. I don't think it is something that any of us -- I think, it is anything we regularly contemplate. I mean, medical tourism is kind of a very small thing in the United States, right now. But technology does have the ability to, kind of, empower that next level of competition.

MR. GINSBURG: That's interesting, as it becomes more feasible, more attractive -- probably the battles between physicians trying to maintain their guilds and these forces for efficiency are going to get more intense.

MR. BORSCH: If I could just -- one more on this, which of course, is as we're all aware, and this isn't tied to the pandemic, per se, but it's coincidentally come along and around the same time it came out -- came with strategy was unveiled before the pandemic. But that is, not that they are alone, but looking at CVS's strategy of building a delivery system around their stores, that at least the initial picking is going to be entirely staffed by non-physicians, nurse practitioners, physicians' assistants, and the pharmacists, to the extent, somehow, they can make time for them. So that is going to be something to watch too.

MR. GINSBURG: Thanks. And, final question I have, on this topic is about long-term care facilities. In the pandemic, about 25% to 30% of all COVID deaths, were in nursing homes, and will this reduce the degree to which these facilities are used for post-acute care, or for custodial care in the future? And if that's the case, what non-institutional services might be used instead?

MR. HILL: I mean, Paul, simple answer is yes. And Ricky said it earlier, home care. A lot of this is going to get moved -- a lot of this -- a lot of these services are going to be moved to the lower cost home care setting, staffed with nurse practitioners, or orderlies, or physicians' assistants. I think I think we were seeing that before the pandemic. We're seeing that now.

It was a week or two ago, that me and my team were looking at occupancy rates inside of long-term skilled nursing facilities. Make sure I do this right for the -- for the audience. The trend line, kind of looks like this -- down and to the right, so that would seem to be the -- this was a business segment that was challenged before COVID, and COVID really did a number on it.

MR. GINSBURG: Yeah, thanks.

MR. BORSCH: George, you got your trend wrong there.

MR. HILL: It looks right on my screen. But you guys can tell me if I -- whatever, it's going the wrong way.

MR. BORSCH: Right. I think, the point was clear though. Yeah, I mean, this is happening at a time when George, as you pointed out, this was already a trend under way, and the generational turnover, of course, just happens. Now it's sort of accelerated with the baby boomer population entering that age range for these sorts of services in earnest -- the first group turning 75, this year. Exhibiting a pretty strong preference within that younger generation away from SNFs. So, it's all coming together here, but then again,

those facilities play a role, that to a certain extent, you can't entirely just replace with other settings, and with the home setting.

MR. GINSBURG: Thanks. Got some questions about the surprise billing legislation. The first one, is whether you perceive, that The No Surprises Act was a win for employers/insurers, or for providers? Or neither?

MR. BORSCH: Well, I'll just say, I think when we say providers, we have to be careful about who we are talking about. Those providers who had built some degree of their business around leveraging, exploiting maybe in some cases, the system that allowed them to opportunistically stay out of the network, and then to bill very high rates for their services, clearly in my mind, they were the biggest losers here.

Although perhaps many of them saw the writing on the wall, and knew that this was not far away from coming. So, that would be number one, and on the other side, clearly in my mind, the biggest winners, were consumers and patients, and then the other parties in between somewhere.

MR. GINSBURG: Yeah. Will the -- will -- oh, go ahead, George.

MR. HILL: Previously, as someone who once got a ridiculous, \$16,000.00 surprise bill, for my little daughters, like, hospital visit for like a sprained knee. Amen, Matt, amen.

MR. GINSBURG: Yeah, so will the capital that went into the staffing companies for emergency physicians and anesthesiologists, will they kind of leave and do something else? Is this no longer a meaningful business opportunity for them?

MR. HILL: I mean, since I made the last comment, I guess I would say, it -- I'm not intimate with a lot of those companies, but one would assume that that business got a little less attractive at the margin.

MR. GINSBURG: Yeah.

MR. BORSCH: Yeah, we would -- I think -- I think, George, I think it's too early to tell, because we don't -- at least I don't have visibility on what their tipping point is. So, that's going to be something to watch.

MR. GINSBURG: Okay. Good point. Let me turn to the future of independent physician practice. And, the pandemic seems likely to further diminish the role of small or independent practices. And, do you have a sense of what shares of these physicians will be going to private equity owners, hospital ownership, or insurer ownership? In a sense, who can do the best job as far as delivering value in physician services?

MR. HILL: Ricky, do you want to go or do you. I guess I'd start off with, I think, it's kind of a mixed bag. I think the last stats that I saw showed something like 84% of doctor's that were coming out of med school right now were going into employed practice, as opposed to independent practice. Down - that

number might have been inverted, 30 years ago. And I, again, coming back to the aspect of health care being local. When you say private equity, corporate ownership, venture something or other, I really look at kind of the regional opportunities, and I think, it really is going to depend where that provider practices, and if it's -- right? -- if you are a Northern California doc, you might wind up at Kaiser. If you're a Boston doc, you might wind up at MGH, which I consider just employed practice. If you were at Research Triangle Park, there is a bunch of what I would call, corporate looking health systems, like Sentara, that are down there. So, again, I think that -- I mean, you could, is -- and it's the way these things change, of one person's private equity owned practice is bought by United Health Group, two years later, and then becomes something else. So, I think the regional component probably plays a bigger aspect in the near term of what the business looks like than what I would call like the capital formation component.

But I think the trend towards employed practice continues, and I think there's regional trends, also like indicate who your likely buyers are in each region. I think in each region, you need to focus on what are the provider competitive dynamics and you need focus on what is the payer concentration dynamics in each region to figure out what the most attractive opportunities and exits are.

MR. GINSBURG: Yeah, thanks. And maybe an implication of what you're saying, is that none of the three forms really stand out as being particularly stronger than the others in delivering a higher value situation, so it's going to be influenced a lot by what's already there in the region, as you were saying.

MS. GOLDWASSER: Yes, I think, so, here's another perspective of it. We also have to think about who can do that -- so, you talk about private equity, you talk about managed care, and you talk about providers. Let's think about managed care, I mean, owning providers by managed care, makes theoretical sense. Here's a way to control medical costs. The question is, do they have the balance sheet to do that? We're really seeing United pursuing that strategy because United has the best balance sheet. Other health plans are opting to partner, and they are being transparent by why they are partnering. They're saying that the investment community is not going to be really happy about seeing them investing a billion dollars into -- and limiting other things -- into buying a provider group, and in the relationship for now, can work at an arm length. So, I do think, that the payers don't necessarily not all -- most of them don't have the ability, especially on a regional basis to make that.

Let's think about the providers in the large hospital systems. Arguably, you might say that they don't necessarily all of them have the deep pockets, but do they have any other choice? I think, we have to think about the earlier conversation, which is telehealth. And, what does telehealth mean for hospitals? The

emergency room visit has been sort of the front door to the hospital. If because of telehealth, where you're not going to see emergency department visits, going back to, kind of, like historical base, the hospital now has to kind of like rethink the strategy, the sources of revenues, and how do we really kind of like preserve these revenue streams?

And, that goes back to sort of owning a provider, or owning an urgent care, and then private equity, they clearly have the capital, and I think that we will continue to see private equity buying these groups, and sort of consolidating these groups, with the idea that they could, either these days, and I think we talk about it later, sort of then take these models public or sell to strategic buyers.

MR. HILL: And, Ricky, kind of one more point. I think she started to touch on it. You also have to be aware of like, business model conflict, and customer vendor conflict. So, United buying practices and buying medical groups in regions where it has a very strong presence as a payer makes a lot of sense. You would have to question, does it make sense for United to buy a medical groups in an immensely fragmented payer environment, because why -- it can be hard to execute that multi-payer strategy, when the owner of the clinic, or the owner of the practice is Optum? Like why is Aetna going to want to business with you? Why is Anthem going to want to do business with you? Maybe the Blues are going to want to -- the nonprofits Blues are going to want to do business with you. But I think, everybody is very sensitive to, kind of that are you the customer? Are you the vendor? Are you a competitor alignment, and trying to make business decisions, which makes sense around that, and you see those conflicted business models fall on hard times very quickly? I would call out -- we haven't talked about Haven yet, the Amazon, Berkshire, JP Morgan intuitive. It's interesting when Haven fell apart, I felt like a lot of those of us, in the know, kind of snickered and walked away. Every health care services analyst was like, I called it. That wasn't going to work. Because if you were in the channel, you knew it wasn't going to work, because I'm -- Ricky, I and Matt, all know that, Deutsche Bank, Morgan Stanley and BMO are not buying health benefits from JP Morgan, right? Google and Microsoft are not buying health benefits from Amazon. It would be like; this was a business model -- like this was a business model and a structure that was never set up to be successful. The old expression; every billionaire needs a hobby. So, you get three of them together, and you get let's all fix health care.

But again, for people who have been in health care a long time, kind of, the obvious conflicts that existed on the face of that business were pretty clear, and I just bring that all the way back to when you think about, who buys providers or who owns providers, and what segment, or what market? I do really think it



winds up being local and you need to look at the competitive environment, in all these regions to figure out what makes sense, right? Health care in California is very different from health care in New York or health care in the Southeast.

MR. GINSBURG: Yeah, good point.

MR. BORSCH: One more point, is it's going to depend a little bit on what the imperative is as we move forward. Is it more on cost control, or how important is choice of provider, relative to the imperative for cost containment, because if it's really weighs more heavily on the cost containment side, it's probably going to favor planned ownership of physician practices in the way that tight vertical organizations can be the most cost-efficient. I think that's not true in every case, but more often it would make sense, that it would be more cost efficient. So, some of it, is going to depend on that.

MS. GOLDWASSER: Choice is an interesting thing, and maybe on taking this conversation to a whole different place. But, if we think about that idea of choice, which being an area, I think, that five, 10 plus years ago, was very much invoked. But as we are integrating digital tools, to me, we are going to satisfaction, and why do you need choice? You need choice, because you're not satisfied with the provider, with the network. But if we're moving into an era where patient, member, consumer satisfaction is sort of really that holy grail. How do we achieve that consumer satisfaction? Is it by giving choice, or is it by basically doing things in this certain level of quality and accessibility, and just an easier -- it's something that is easier for us to use, which might, I think, change sort of that paradigm that it's about choice. It's really about just getting access to a physician that listens to me, that I can interact with at 24/7, and just get what I need.

MR. HILL: Last point I'd like to throw on there is something that I always say is the three competing priorities in health care are cost, quality, and access. To dovetail on Ricky's comment about choices, you get to pick two. You can't solve for all three. And then the third, always winds up being the output of the choices that you make around the other two. But, you get to choose two, and you effectively wind up solving for the third one.

MR. GINSBURG: Yeah, although, another possibility is that choice is what people use to protect themselves against the cost being too high, or the quality being too low, or the access being deficient. In a sense, if all three are at an acceptable level, then perhaps there's less emphasis on choice. Good -- let me see. Oh, I see. I'm going to ask you another question, I just -- actually the audience questions just showed up, let me ask. Let's take a pause from my questions and go to the audience questions. So, Paul Nelson, a

physician, asks: how would you reduce health spending to a portion of our economy, as a proportion of our economy, the 13% or less, and reduce the nation's annual maternity mortality incidence by 70%, both within 10 years?

MR. BORSCH: Can we? Is that the question? Can we do that? It might -- it might be possible if --

MR. GINSBURG: Yeah.

MR. BORSCH: -- there was the popular consensus to make some big structural changes and then to adhere to them, but that I don't see things going in that direction, at least particularly as it relates to the percentage of health care spending, as a proportion of GDP. I doubt that's going down, and I mean -- and I don't mean that necessarily in a bad way because, presumably, if we continue to get wealthier in society, we're absolutely going to put more and more money into health care versus other goods, it would seem to me. But then as it relates to the second question, it's a little tougher to answer.

MR. GINSBURG: Sure.

MR. HILL: Was -- wait -- I just want -- was that -- was that we want to -- was the short question we want to improve outcomes and reduce costs?

MR. GINSBURG: I think so.

MR. HILL: All right, well, then I'd say we'll start by taking what every doctor makes and we'll cut it in half, and that'll get us to the financial target, and then I -- that is not an answer as to whether or not we'll solve for the outcomes target.

MR. GINSBURG: Okay, I see that Allen Baumgarten, who -- hello, Allen, it's been a long time -- sent in an interesting question. Are hospital systems changing their capital investment strategies for post-pandemic, or are they changing their capital investment for a post-pandemic world? Perhaps fewer clinical sites because of more virtual visits and cost or more micro hospitals to expand geographic reach but at lower costs. Any thoughts on what hospitals might be doing that's different, post the pandemic?

MS. GOLDWASSER: Paul, can you repeat the first part of the question?

MR. GINSBURG: Sure. It's about how hospitals are changing their capital investment strategies. It might be -- go for fewer clinical sites because of more virtual visits and cost, or the second part was more micro hospitals to expand geographic reach but at lower costs.

MS. GOLDWASSER: So, it's an interesting question, in terms of will hospitals look smaller? I remember, five years ago, we hosted hospital executives who envisioned a hospital of the future. It was, I guess, that would mean it was 10 -- 10 years from -- it's five years from now, it would be only an ICU

because you won't need anything else. And maybe that's sort of the extreme, but I think that we would -- I would go back to one of the comments that George made earlier on, on sort of using telehealth as an extension of the hospital.

So, how does hospital change the footprint? Maybe you have an existing capacity, but that capacity is not all going to be captured by sort of the brick-and-mortar presence, but you expand it into the community. And I think that not just hospitals are kind of like facing it. We can argue that pharmacies are kind of like pulling through kind of like that same question and issues of what that pharmacy of the future would look like, and what's the balance between virtual and in-person. So, I'd say, in terms of early investment priorities, our early investment priorities are clearly on the virtual, but we have to think about why are they clearly on the virtual, and part of it is that if you're not going to do virtual, then you're really at risk that your footprint is going to be much smaller in the future.

MR. GINSBURG: Thanks. Let me go onto some questions about the insurance industry. I want to ask which segments are seen as most attractive, at this point? Is it Medicare Advantage, Medicaid, or something else? And will recent increases in subsidies for individual insurance under the ACA increase insurance industry interest in this market segment? And depending on the state, Medicaid managed care plans also are taking part in the marketplaces. Do you think this trend will grow? I think George and Ricky have an interest in asking -- in -- actually, I guess it was George, said that he'd be interested in speaking.

MR. HILL: I think it's pretty clear that Medicare Advantage is considered, at least by the investment community, the most attractive subsegment of the market, right now. What we always fall back to is kind of looking at what are the key growth metrics for each individual industry. The key growth metric for any of these industries would be unit growth or beneficiary growth, where MA continues to have high single digit growth. I'm sure me, Ricky, and Matt are all seeing tremendous capital formation activities around the end markets of this space. I think the commercial business probably tends to be the most profitable, but the growth is kind of stagnant, and you saw kind of commercial enrollment fall off through the COVID crisis and ideally starting to rebound right now.

Managed Medicaid is interesting because while we're not seeing the level of capital formation there, like we're seeing in Medicare Advantage, we are seeing interesting kind of new business models come to market that are trying to work with the managed Medicaid providers to try to do some of the services that I would say, like, the Oak Streets of the world are trying to provide in managed Medicare, kind of multi-payer partnership opportunities in Managed Medicaid. So, I think, historically, that's been a population that's been

harder to manage, but I think you're seeing people think that there's an opportunity there, and as it relates to the subsidies and the growth of kind of the ACA, and the exchange plans, and the managed Medicaid plans there, I think if the government kind of continues to subsidize those plans and make those -- make that a more attractive product, then you're going to continue to see insurers want to participate in that product.

Again, the question there, I think, longer-term, will be the government's commitment to the subsidies and the sustainability of that. But, at least in the near to medium term, that looks like that's going to be a more attractive product, and we've seen some of the large payer organizations kind of announce their intentions to reenter that market.

MR. GINSBURG: That's very interesting. What about in opportunities for tech companies to enter the insurance industries? Do you see that -- that happening in some way?

MR. BORSCH: Well, maybe I -- you're asking analysts who follow the incumbent companies. So, we may be a little bit biased, in that sense, but I also think a -- rightly skeptical, having seen new models sort of come and go and not really have much success, entering with some idea that it can be drawn on a napkin or that there's some easy shortcut to doing this business in a better way. It's just not clear what tech companies can necessarily bring to the table that the existing companies don't already have.

Now, you can get more competition because the profitability of, for example, Medicare Advantage and maybe now the exchanges again are attracting new entrants coming in, maybe not at big scale, but coming in with very localized provider partnership type models. They may not be scalable the way that on the other end of the spectrum, somebody, like Amazon, might want to come in with a giant amount of capitalization, but it's not clear where the real advantage is there.

MS. GOLDWASSER: So, even I mean, to me, Paul, you were asking the question, and we're already seeing a company in the marketplace that is coming in with a model that's sort of integrating technology in traditional managed care, as we call it, or the traditional stakeholder, right, and that's Oscar. And the market response was mixed. But I think that we have to ask ourselves the question, if we think about the health care industry, in general, it -- the health care industry tends to be a very conservative industry, and I'd say that that is a function also of just the fact that it's so heavily influenced by regulatory processes, right? Everything takes a long time, whether it's an FDA process, exchanges to reimbursement, and that's just how the industry sort of flows. But I do think that it's a really interesting question to ask because it's also about mindset, right, and it's about that idea that technology companies look at things a little bit differently. Historically, in health care, the focus has always been on a provider, for a very good

reason, right? That's where the cost is, and if you managed a provider and you managed the cost, then clearly you get to lower spend.

But I do think that it's going to be really interesting to see how technology companies can impact and influence the individual behavior because we're all talking about consumerism. It's a buzzword. The companies are talking about it. But the reality, there's still real skepticism, I think, both within the industry and among investors, on can consumerism really influence medical spend? And I think that -- I mean, I like to think that it does, because it's going to impact how we access health care. And I think that one of the biggest issues that we all have, and personally I have it's compliance, and if technology, on the front end, can help improve patient compliance and adherence, then I think that's a win, and that's going to help lower medical costs. And I think that's going to come from the tech side of the world, not from the health care side of the world.

MR. GINSBURG: Yeah, and I wonder if the tech side of the world initially got into things, just making it a more convenient experience for consumers. But that's kind of just the surface of what health care is about, and maybe in the future, they'll be able to delve into something like patient compliance, which is probably just far more important. That's good.

MS. GOLDWASSER: Right, but convenient gets you to compliance, in a way, right? Convenient makes it easier for us to do things, and if technology could actually do it on my behalf, even better.

MR. GINSBURG: Yeah.

MR. HILL: And I think Ricky -- Ricky said the all-important R word.

MR. BORSCH: But, Paul, one other thing to add. Just that telemedicine -- I'm sorry, George. I've said it was just one quick one --

MR. HILL: Go, do your point.

MR. BORSCH: -- which is telemedicine, obviously, is an area to watch. I mean, that is an example, in a sense. It may not be Amazon-led or by one of the largest tech companies, but by and large, that isn't something that the managed care companies had developed in-house -- that came from the outside, and then, of course, the pandemic accelerated it.

MR. HILL: Yeah, I was just going to add Ricky said what I consider to be the all-important R word, which is regulatory, and when I think of technology companies, I think of -- you hear the word displacement a lot. Can technology companies displace legacy companies? Very hard to displace the regulatory environment, or displace the regulatory hurdles, which I think serves as a great defensive moat for a lot of

the established players. I think you're going to see a lot of the technology players serve the purpose of pushing legacy industry kind of in the direction that it needs to go, particularly as it relates to compliance and patient convenience. All some of these smaller companies are going to wind up serving as kind of the acquisition pipeline for some of the larger companies, which I think we've already seen.

But just, again, the regulatory hurdles, and the space, and the experience, the regulatory hurdles, and, Ricky noted the drug development space. Whether it's managed care, whether it's drug development, whether it's care provision, I -- regulatory seems to be where all these companies wind up stumbling. Regulatory is what I'd call kind of the third-party payment process, the indirect payment process that exists in health care, also serves as another challenge. It's hard to -- it's hard to directly drive consumer behavior, when the consumer, so to speak, isn't necessarily the customer or the patient. It's the customer, but the patient isn't necessarily the consumer. The customer is the person who is paying the bill, and that's not always the same person.

MR. GINSBURG: Yeah, good point. What about big data? Have payers been making progress in using big data to deliver more value, as far as better steering, managing of really sick patients to get the services they need?

MR. BORSCH: I'm not sure that we necessarily know. I mean, we -- obviously, a lot has happened in the last 30 years, on that front, and new models have been developed. ActiveHealth, for example, bought long ago, by Aetna, now CVS. So, there is a lot that goes on there. I think what the question is, are they doing -- are they pushing the envelope far enough, or is there another, is there a whole other set of things that they could be doing that they're not doing? And that's -- I don't think we have visibility on that right now.

MR. GINSBURG: Okay. Thanks. Let me go onto some questions about pharmacy benefit managers, or PBMs. Most of the major ones have been acquired by insurers. And, how is this vertical integration working out? So, where are the areas where the integration has been most valuable. And what are the implications for insurers who are not vertically integrated with a PBM?

MR. HILL: Well, I guess I'll kick it off, and I would say I -- I think the vertical integration for the managed care companies that have bought PBMs, and I'd say kind of in the -- maybe in the case of United, and then PBMs that have bought managed care companies, maybe in the case of Express Scripts buying Cigna, given that Express Scripts was actually the larger cashflow generating entity, at the time, and CVS Caremark merging with Aetna. Again, I think it seems to have worked out well from a cross sales perspective and from a profitability perspective. I tend to think that -- again, I talked earlier a little bit about

wallet share and wallet and share inside of the payers and how much of the spend that you can address.

And the PBM was a business, historically, that kind of struggled to find a home, if you looked at the PBM industry kind of over the last 20 years. They've been owned by pharmacies. They've been owned by drug companies. They've been independent. But the pharmacy benefit, in my opinion, is really just part of the benefit stack, whether you're talking about primary care, you're talking about hospital care, you're talking about pharmacy care, you're talking about lab care, you're -- whatever. Like, this always seem -- this seems like it was the natural home. When I think -- like, every large insurer either owns a PBM or has a pharmacy relationship as it relates to PBM.

So, I don't know that anybody's -- I don't know that I see any risk there for the insurers that don't own PBMs. But, again, it kind of comes back to -- I don't -- I might almost come back to conflicted business models a little bit, and I think what you wind up seeing, at the margin, is companies maybe having to make decisions around who they really -- who those relationships are with and who they partner with, as the landscape evolves.

I might use the example of CVS when it merged with Aetna. We know it had relationships with the Caremark PBM had relationships with a bunch of Blue's plans that competed with Aetna in certain regions and certain markets, and then those Blue's plans that need to make decisions around do they basically want to maintain those relationships and kind of subsidize their competitors, or try to pick new relationships? So, again, as I think about it from an analyst perspective, I pay close attention to kind of what is the competitive alignment of those industries and those businesses, in certain markets and certain spaces? And I might just roll this into I think we're going to continue to see vertical integration around parts of the stack where dollar share continues to grow.

MR. GINSBURG: Okay. Ricky, do you have any thoughts on this?

MS. GOLDWASSER: I'd say that when I think about vertical integration, I mean, we've seen vertical integration clearly, and to George's point, it also impacts on customer relationships and alignments. But we have to ask ourselves a question, have you really seen vertical integration, i.e., have we seen the models truly being integrated, kind of like the payer and the pharmacy benefit manager? And that -- that is what I think is going to be critical in the evolution of these companies in the next five to 10 years.

And I throw this challenge on the payers or these enterprises because I think that, at some point, they have to combine the two. We have companies that report a PBM segment and report a managed care segment. And if we think about reporting lines, internally, within institutions, right, that drives behavior, that

drives culture, that drives alignment. If you really want an integrated offering, go ahead, merge the two. Make sure that the two have true incentives to work together, rather than compete as business segments for resources, etc. So, I think that that's yet to come. We haven't seen it yet. We've seen the first step, which is sort of kind of like preparing towards it, and I think that, ultimately, the marketplace is ready to it because when we think about the PBM, what do you follow? You follow the drug pipeline. And the drug pipeline is that specialty pipeline that has meaningful impact to medical cost. And if we think about the conversation that we have here, I do think that all the different dots tie together because it's about pharmacy spend and how it impacts medical cost. It's about the access that I get and the quality. So, it really all kind of like fits together, and I think for these enterprises to be successful in the future, they have to connect all these dots and truly integrate it in turn.

MR. HILL: Paul, I want to jump in on that point because, again, for everybody in the audience, Ricky and I are called -- we're co-op competitors. We, like, we compete in the market, but we're also looking at all the same stuff -- very prescient -- very important point that Ricky made about these companies should be going to end market by customer, maybe, or by business segment, as opposed to function, managed care versus PBM. I think what that winds up telling you is that kind of the unspoken truth here is that maybe they have different customers, and that managed care company serves a different group of clients necessarily than the PBMs do, that PBMs don't necessarily give us full transparency as to what percent of their operating earnings come from the serving of health plan clients versus come from the serving of drug companies, where, as analysts, we used to look at rebates, and rebate share, and how much of the rebate share was kept by the PBM, versus what was shared with the managed care company?

And they've kind of, now they tell us that 95% or 90% of rebates are shared with our clients, which is supposed to make us feel good about their alignment, and we trust that they are serving their health plan clients. But what they are not transparent about is to what degree there are still significant earning streams that come from drug manufacturers and other parts of the supply chain. And I might -- we talked about business conflict earlier. The PBMs have been masters of kind of managing this business conflict over the last couple decades, to their credit -- basically getting paid from drug manufacturers and drug developers, and getting paid by their commercial clients and the health plans. I would love to see them go in the direction that Ricky is talking about. I think it's essential for how they serve their health payer clients, but I think the current reporting structure is indicative that that conflict still exists. There are still significant earning streams coming from what we call non-health plan or non-cost containment related businesses, and I think



people who are deep in the weeds, in the PBM space, understand that that channel conflict still kind of continues to exist in that segment of business.

MR. BORSCH: Let me just throw one other point out here, which is if you look at the buying patterns of the most sophisticated customers, being the very large self-insured multistate employers, they haven't really bought into this, in the sense that, there's still the carveout model, where they'll contract with three or four or five different health plans, and then typically have a single contract, separately, with one PBM. It's still the dominant model, and they, to my knowledge, they really haven't moved away from that yet. Nothing has compelled them to say what, we really should be combining these functions, where we'll contract with three health plans, and they'll each have the PBM function embedded within what they provide. So, that's going to be an interesting area to watch, if that changes.

MR. GINSBURG: Yeah, so, in a sense, the employers, by continuing to carveout pharmacy benefits, are really not giving a vote of confidence about the degree to which insurers have integrated PBMs into their operations.

MR. BORSCH: In a way that's compelling, that they see as providing value, that -- not yet anyway.

MS. GOLDWASSER: And, compelling and providing value is the key word here. And the question is like, what is value and what's compelling, right? For some, value would be lower cost. But I don't think that the health plans, in some ways, earn that right yet. We haven't seen them yet coming to commercial employers and saying, look at our combined offer, look how we're making it easy to your members, your employees, for your members and employees, to manage their pharmacy, dispense their drugs, and how that flows in.

So, again, that all goes back to saying that we focus on consumer is not lip service. Saying that we are focusing on consumers is truly developing the tools that make this a reality, and I think that that -- when that's here, that could help kind of like that integration story come to life and make it a lot more compelling for employers.

MR. GINSBURG: That's a really good point. Let me ask about drug spending. I mean, drug spending is high and rising, and what are the recent or new steps that insurers are taking to control drug spending?

MR. HILL: So, what are -- was the question, what are the new steps?

MR. GINSBURG: Yeah. What's the newest, most greatest potential, as far as they can't control the prices, except when they're competing brand names, but the, is it more prior authorization, more step

therapy?

MR. HILL: Yeah, I mean prior auth, step edits, competitive markets, rebating. I mean, I saw one the other day, and I -- because I haven't had the chance to actually confirm this with Cigna yet. I saw Cigna was going to offer direct to patient rebates for drug switching, which would be -- again, that's kind of -- like I said, I saw it on LinkedIn, I haven't had the chance to run this by Cigna's IR team yet, which would be a whole new thing. And I would note that I've seen that -- I've seen that in other segments of the market. I've seen, in -- particularly in diagnostic radiology. If you want to go to the academic medical center and they want to charge you \$1,200 for an MRI, you're paying half of that out of pocket. If you want to go to the MRI around the corner that's charging \$350, we'll write you a check for \$100, and save both sides money. And that -- that is -- I think that you -- I think that -- I think that the current tool set that the PBMs have has been highly effective. You've seen net drug price increases in the aggregate kind of be close to zero or be very low single digits. So, there's gross drug pricing versus net drug pricing. Net drug pricing has been very well contained. There it has a small impact at this point, but, , we're seeing modest growth in our restricted pharmacy networks, in our primary restricted pharmacy utilization and commercial.

I think the PBMs have a pretty aggressive and effective tool set, right now. And then, the caveat I would kind of throw on the end of that is that, with a lot of the new and most expensive drugs you're seeing to come to market right now, you can use all those tools, but they target patient populations that are so small that if the drug works, it can be hard to escape the cost, I'd say, which is kind of a high-class problem of where we are, as it relates to drug development, but it's also a -- , it's kind of -- , when you're developing drugs for small patient populations, the cost of drug development kind of needs to be recouped, but the development doesn't make sense. Maybe the last point I'd throw in there is kind of having organizations, like ICER, that is out there, that basically is doing independent benchmarking of what they think the value of drugs is, to start as a leverage point in the drug price negotiations with manufacturers.

MR. GINSBURG: Good. Now, I'm glad you mentioned the point about Cigna sharing the rebates because that -- sharing the rebates with patients has become an interest of mine. I've written about it in Medicare Part D, where there it's really seen as a fairness issue. In a sense, the patient's using the highly rebated drugs and what they pay should be closer to the net cost to the carrier, and it's more difficult to do this in Medicare. I've become aware that UnitedHealthcare care was doing this very broadly, at least in its fully insured book, as far as -- and I'm not sure it was more motivated by the fairness issue or by the incentive issue to make it easier to steer patients to the rebated drugs that they've chosen. But it seems to

me that that's something that's really starting to change now. Good. Got some questions about behavioral health care. And with growth in the need for mental health care having increased with the pandemic and prior shortages of inpatient psychiatric capacity and many clinicians not accepting insurance, how are payers, including Medicaid, in the delivery system likely to manage these needs?

MR. BORSCH: I think you do see, actually -- the payers, to my knowledge, aren't doing much on this necessarily, but I think more of the innovation is on the provider side, and I think you are seeing some new models emerge, where they're looking to better leverage the different levels of mental health providers, in terms of psychiatrists, psychologists, clinical social workers, and so forth, maybe within the same organization, to some degree, and maybe, perhaps be more proactive about accepting in-network reimbursement. Although, that's a whole related area to this that's tricky, which is the, if you will, the inequity between the availability of in-network medical providers and in-network mental health providers, despite the mental health parity law, is something that I've sort of been expecting to see challenged in some major way, but that hasn't happened yet.

MR. GINSBURG: There's been a lot of enthusiasm about telehealth for mental health services. It seems to me that this doesn't really get at the very limited supply of mental health professionals willing to accept insurance to treat patients.

MR. HILL: Yeah. Matt hit on an interesting point about kind of what makes this a sticky wicket -- I think you're definitely seeing an increased focus from health plans and employer sponsors on providing mental health services or the mental health parity component to what I would just call regular physical care, but if, like, if there's no doctors in the network, , what do you want them to do? And then, I know that they're treating just a lot of out-network mental health claims, as they're out-of-network medical claims. That's just -- that's what they are. And, they might be covered at 40 cents on the dollar or 50 cents on the dollar, and these are real health care costs. I don't know how you quintuple the number of in-network mental health providers. And what would be interesting to see is, I'll come back to using the analogy that we used with the doctors in the minute clinics and the other clinic staffing, but, like, how far -- how far down the medical license can you go on the provision of mental health services? Like, does it need to be a psychiatrist? Does it need to be a psychologist? Can it be an MSW? Like, what is -- and I'm not even leaving it for anybody who might be on the -- like, I don't know enough about this space to even know what all the license classifications are in mental health, that kind of -- how can we better cover the services, and how can we better utilize people, according to their license, such that we provide the services to those who need them?

MS. GOLDWASSER: So, if we think about behavioral health, and I think that behavioral health, you talk about things that transpose COVID, I think behavioral health is a very big one because of the awareness, right, in the emphasis that is now being put on it, whether it's on Medicare, or Medicaid, or commercial. And, it's interesting because I do think the payers, if we listen to their sound bites, they'll talk a lot more about behavioral health, right, Centene and kind of like Magellan, and it is becoming more and more -- and United has been talking a lot about it, as they think about their Medicaid business.

The idea is, again, we're going back to adherence and compliance, and behavioral health is a limiting factor in achieving that. So, I do think that from the payer perspective, internally, there's really emphasis on behavioral health. I still think that there is a disconnect between what is going inside these organizations versus the perception, the Wall Street perception. And if we think about Wall Street perception, and we think about how investors are kind of like shaping this perception, it's all about what we know. We haven't seen, yet, these behavioral health companies coming to the capital markets, right, the public markets. And I think that that's partially why there isn't as much focus on it. But what we are seeing behind the scenes and what we're seeing if we look at sort of pipeline of private companies, that there are a lot of companies that are focusing and developing solutions on behavioral health. And, we're also -- the investors are very focused on the primary care models now. I won't be surprised if 12 months, 12 to 18 months, from now, behavioral health is going to be a greater area of focus of understanding. But I think a lot is happening behind the scenes.

MR. HILL: Yeah, and interesting kind of the -- to Ricky's point, too, is, like, getting the primary health business. I think a lot of the primary health businesses, as individual doc or small practice settings, so, how do you scale those? Like, how do you -- how do you take that and scale it as a business that makes sense, to either be rolled up by private equity or make sense in the public market? So, again, when you think about -- I -- like, it's been easier to do in primary care. I would question whether or not the same model works in behavioral.

MR. GINSBURG: Good point.

MS. GOLDWASSER: I think one -- one interesting thing is that also -- is the integration between primary and behavioral. So, can primary really be successful without the behavioral element? I had a conversation with a behavioral health organization, where I asked whether primary care doctors view them as competition. And they said that, initially, they do, but after a couple of weeks of experience, they realize that that behavioral health component actually makes them more effective as primary care physicians. So, I

do think that there is room for coexistence, and I wonder if in the future, especially with the large practices, do you have a large practice that has primary care, but also has the behavioral health element?

MR. HILL: Ricky's making the argument for vertically -- completely vertically integrated full capitation, where you should be getting the care that you need, kind of regardless of site of service. I like it.

MR. GINSBURG: Yeah. I've never actually thought about the degree to which multispecialty group practices and primary care practices are integrated at all with behavioral health, and I take it that they're usually not. So, yeah, that might be a real opportunity, down the road, to accomplish something there. Medicaid managed care and the -- does the insurance industry see major opportunities to provide value for dual eligibles?

MR. BORSCH: Short answer, yes. I mean, I think that the -- maybe the jury's still out as to how well they do it. I think, I mean, it should be -- play exactly to their value proposition, which is that dual eligibles often living in environments where their care is very fragmented and not well coordinated and there's a high volume of procedures, but it's not necessarily as rational as it could be. That's one of the areas where there's the greatest potential for both cost efficiency and also improvements in the quality of health that the -- that these duals are getting. So, you have seen, recently, the explosive growth in the Medicare Advantage Dual SNPs [special needs plans]. So, it's happening. I think the evidence that we do see is that -- so far, so good, but in terms of the penetration rate, it's still trailing, to my understanding, for example, if you look at how many of the Medicare duals are in Medicare Advantage versus how many the regular Medicare beneficiaries are, duals are still trailing, to my knowledge.

MR. GINSBURG: Yeah. And I'm glad you brought -- hasn't there often been an issue about -- is managed care coverage for duals -- is it going to be led by Medicare, Medicare Advantage plans, or by Medicaid managed care plans, who often are pretty different? And what you mentioned about the rapid growth of the Medicare Advantage SNPs for duals maybe giving some indication of that.

MR. BORSCH: I think maybe, but -- but it also depends on which, even within the dual universe, which ones you're talking about, and those served by the dual SNPs, the Medicare Advantage Dual SNPs, maybe a little bit more on the Medicare side. Typically, you do have one or the other coverage weighing more heavily in a dual situation. I'm not really sure, though.

MS. GOLDWASSER: And it's also about raising the question, and I don't know what the answer is, is who can do it better? So, is it the payer who managed because of the Medicaid population? So, is it -- is it easier to go from Medicaid to Medicare, or from Medicare to Medicaid, when we think about the type of the

populations and the complexities?

MR. HILL: And let me throw out a third option. The risk-adjusted capitated provider might be in the best position, right, because that's going to be the person who that beneficiary has the most interaction with. Right, the managed Medicaid or the managed Medicare plan is probably a light year away from that -- from a dual eligible beneficiary, right? I mean, unfortunately, the economic profile and the social determinants health profile of the dually eligible beneficiary is typically pretty dire. You're right, it's probably -- it's probably a provider whose best position to provide and manage that care and for better or for worse, that if that doc's taking Medicaid,, he's probably not -- he's probably not happy that he's taking Medicaid to start with. So, I mean, the duals are just a very difficult problem to get at.

MR. GINSBURG: Yeah. Good point. And final topic is on large employer health benefit strategies. And is there anything noteworthy you're seeing on strategies being pursued by large employers to improve value in their health benefit offerings?

MR. BORSCH: I don't think you're seeing any dominant new trend emerge. I don't think you have seen that over the last several years. I mean, there has -- there has been some serious experimentation -- some large employers, Comcast, I'll name them, that have moved to a sort of health plan light model, engaging other entities to manage some of the front end, but -- but nothing like that is -- it's more -- that's more on an exception basis. I don't think we've seen a departure from the sort of traditional model in any major way, for quite a few years now, but -- but maybe I'm missing something.

MR. HILL: I'll jump in there and I'll say, Matt, I definitely don't think you are. And it's funny, I used the example earlier of risk syndication. And when I think of the last wave of risk syndication, I think everybody -- a lot of people on this call will get this analogy -- It's like, hey, would you like to share some risk? I'm going to take your deductible from \$500 to \$4,000. I've now syndicated some risk to you. So, there's some risk sharing between the payer and the beneficiary, and now we're seeing risk syndication to the provider perspective in MA. From our conversations, and we spent a bunch of time talking to health benefits consultants and, like, the big purchasing groups for health care. So, if you think about, like Northeastern Business Group on Health or National Business Group on Health, I do think what we've seen, over the last decade or so, is that the pendulum of risk sharing towards the beneficiary appears to have swung about as far as it can go, before you start to incentivize adverse outcomes, people not -- people not getting care, people not buying their drugs, stuff like that. It is what has enabled, I'd say, to some degree, it's what has enabled the rise of businesses and the success of businesses like GoodRx.

And now, I think you're seeing the health benefits consultants, the health plans, and the employer sponsors kind of look at benefit structure and be like, have we gone too far? And will we start to see -- but I don't know that I want to say that plans are going to get more generous. I don't think you're going to see employer sponsors go, well, we were putting in \$10,000 an employee before, now we're going to put in 12. But I think benefit design is always something where you're trimming the sails, and I think -- I think, to Matt's point, we're not seeing any -- we're not seeing any big changes, but we're seeing people trimming the sails.

MS. GOLDWASSER: So, to me, one area that's going to be really interesting to watch is customized benefit design, and to some level, benefit design has been sort of customized, right? When I -- I'd go to open enrollment, I have, like, three different options or three different levels. But I think that we -- it's going to be interesting to see if we move even deeper, in terms of customized, based on data. And before, Paul, you asked about big data, and I think that if you take big data, and we're seeing, Amazon Pharmacy, right? The first thing that they ask you, when you go on Amazon Pharmacy, is who is your insurer. That means that now they have the data. They know that I have, let's say, UnitedHealth or Express Scripts, and that I opt not to use my insurance to fill my generic script.

So, what can you do with the data? And can you use that big data, can you use that information, to better align the benefit design, in a way that's going to be more meaningful for them? So, I think it might take time because, again, it's an approach that puts the individual in the center, and that's an approach that, historically, hasn't been really sort of core to how health care stakeholders are thinking about things. But I do think that that's going to be a really interesting thing to watch, how it evolves.

MR. HILL: Yeah, Paul? Paul, one more thing just kind of jumped out at me, and I think about conversations that I've had, recently, with benefit consultants, and as you think about the health plan and you think about the employer sponsor market, the concept of equity and employee equity is coming up a lot, and I'll give you an example. It's -- I am married. My wife and I have three kids. There is a maternity benefit. There's a paternity time off. What about those employees that aren't going to have kids? What about them? There's a bereavement benefit, in some places. There's mental health benefits. You're seeing, at the -- at the margins, the development of a lot of other parts of the benefit stack to target what I would call thinner slicer, niche benefit components, to benefit smaller -- I'll call it -- smaller slices of the population, such that you can -- this comes back to when Ricky talked about benefit customization. It kind of led me down to this point. Whether it's LGBTQ benefits, trans benefits, you're seeing the -- you're seeing the development of new businesses at the margin, such that the provider of benefits can provide equity across the -- I'll call it

the entire population of employees or beneficiaries. And what we have found interesting, or at least what I have found interesting, is that when you -- when you take the benefit, you verticalize it, and you slice it thin, they can still be very big markets, from a total dollar value perspective, that still have pretty attractive business opportunities. And I think, again, like, from an employee's perspective, you're seeing, , it's a small slice of the number of employees, a number of beneficiaries, but I'm seeing -- that's where I feel like I'm seeing an explosion in the number of companies, companies going after that slice of the benefit stack.

I've got a pie chart that I use in one of my presentations that kind of shows, basically, issues start to thin slice all of these, I don't even want to call them -- disease states isn't even the right word, but these part - these benefit construction components, because -- because, before this, we might've called them cardiology, or maternity, or type 2 diabetes, or musculoskeletal. They're moving more into lifestyle and behavioral and other, where we're continuing to see people who are in the business of constructing benefits kind of slide these into the stack, as enabled as part of the benefit, already adjudicated. We know that Express Scripts, basically, they have a digital formulary, already, for digital solutions, the way that they have a formulary for drugs. I think that's a very interesting part of the market, right now.

MR. GINSBURG: Yeah, that's interesting -- actually, when you think of it, it's such a huge part of employees' compensation now, their health benefits, and identifying segments of your workforce that doesn't benefit from some very expensive parts that are used broadly, and the thinking about, well, giving them something, that I guess, seems natural to be occurring at this point. I'm going to ask, a question from the audience and then, give some thought to -- before we close, I'll go around to you, to get any final thoughts of wisdom that you'd like to tell our listeners about. I've got a question from Kay Meyer. About how much do anticompetitive contracting practices, such as exclusive, sole source, or bundled contracts play in the higher consumer prices, in the hospital supply chain?

MR. BORSCH: I'm going to offer the suggestion that it's not necessarily the anticompetitive, I mean, I think there is a -- there is a part played there, and so, I don't want to just come -- but I think the main thing is market concentration. And, that, above all else, whether you're talking about North Shore in Long Island, or Sutter in Northern California, everybody's favorite example, the degree of concentration. Now, concentration is very heavy on the payer side, too, but you have two industries, which are both now heavily concentrated, and I think that that is, by far, the biggest factor influencing price, making price higher.

MR. GINSBURG: Good. Yeah, let me just go around for any final thoughts that -- that you have on anything we've discussed today, something you've thought about since we've got to a segment.



MR. BORSCH: Well, let me just offer -- as we talked about the employer model, and I know this was something that maybe we were going to get to talking about. I'm just going to throw it out there. It is going to be interesting to watch the small employers and what they do vis-à-vis the exchanges, and if, in that very dysfunctional purchasing model, dysfunctional risk model in the small employer market, only 50% offering benefits to begin with, do we see them pull away from even providing that function or at least significant numbers, in a way that might dovetail with revitalization of the exchanges. And one of the other enabling factors, beyond the higher tax credits is also the ability for small employers to fund individuals paying for exchange premiums, or their shares, on a pre-taxed basis, they can do that now. I'm not saying that's going to happen, but if it does happen, it'll be -- it might start to set the stage for what ultimately could be some shift, real shift, away from the employer model.

MR. GINSBURG: Yeah, Matt, I'm so glad you brought that up because I just didn't get there, and if you'd like to have an opportunity to say something else besides that, it's totally up to you.

MR. BORSCH: No, I think I've said enough.

MR. GINSBURG: Great. Anything, Ricky or George?

MS. GOLDWASSER: Go ahead, George.

MR. HILL: Oh, okay. I'd just -- kind of a lot like how Matt's looking for a leading indicator of the disruption of the employer market, I'm paying very close attention to what's going on in Medicare and the Medicare Advantage market, particularly as it relates to the provision of care and kind of some of those contracting models that we talked about earlier. Does anything happen in the value-based care market that is also disruptive to the traditional fee-for-service style that benefits have been paid for historically, and in kind of anything that really kind of changes the economics of the provider model and the payment of care model.

MR. GINSBURG: Thank you. Ricky?

MS. GOLDWASSER: I think, on my end, it's -- again, it's sort of contract benefit design and how it's going to evolve. I do think that we are, as a health care industry, are in such exciting times. There is so much innovation in health care services. I think that we've always thought about innovation being sort of the privy of biopharma. There is so much innovation in services right now, and I do think that -- and it's a narrative we didn't focus on as much. For everybody, for the audience, follow what happens on the private side because the innovation that we're seeing there, I think can really sort of -- is something to follow, as we think about what's coming next, and as we think about whether the public companies need to adopt and how

they should -- should've shaped their behavior and business development, in order to get us so -- to the kind of like next step up function in delivering health care. So, these are such, such exciting times.

MR. GINSBURG: Yeah. Well, thank you all very much. You've all been outstanding, and at least I've been fascinated by the session, I could go on for another hour or two, -- but anyway, thank you very much for bringing your very wise, thoughtful perspectives to this. I'd also like to thank Arnold Ventures for its supports to put this on, and staff at the USC-Brookings Schaeffer Initiative, and others at the Brookings Institution for helping put this on. Take care, everyone.

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