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WEBINAR

WALL STREET COMES TO WASHINGTON HEALTH CARE ROUNDTABLE

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PARTICIPANTS:

PAUL B. GINSBURG, Moderator
Professor of Health Policy
University of Southern California
Nonresident Senior Fellow
The Brookings Institution
Senior Fellow
USC Schaeffer Center for Health Policy & Economics

RICKY GOLDWASSER
Managing Director
Morgan Stanley

GEORGE HILL
Managing Director
Deutsche Bank

ANN HYNES
Senior Healthcare Services Equity Research Analyst
Mizuho Americas

GINSBURG: Hello. I want to welcome you to 26th Wall Street Comes to Washington Healthcare Roundtable. I'm Paul Ginsburg and I'll moderate the discussion today. 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 healthcare companies along with a thorough understanding of healthcare markets and the companies they follow. All of our analysts closely follow public policy because of the implications for the companies they follow. I want to thank Arnold Ventures for supporting this event and recognizing the value of providing a forum for outside of the beltway perspectives on healthcare.

Our format will be a roundtable discussion based on questions that have

been shared in advance with the panelists. We'll have two opportunities for audience question and answers to first round at 2:45 and the second before we end at 3:30. You can either send questions by email to events@brookings.edu or via Twitter at #WallStHealthPolicy. We have staff monitoring the email and Twitter to make sure that we get as many questions as possible. Also, please note that the analysts cannot answer questions about the outlook for specific companies. A transcript and webcast of the conference will be available through the Brookings' website next week. I want to introduce the panelists. We have an excellent panel today. Two panelists, Ricky Goldwasser of Morgan Stanley and George Hill of Deutsche Bank are veterans of previous Wall Street roundtables, while Ann Hynes of Mizuho Americas is joining us for the first time.

The COVID pandemic has profoundly disrupted American society and U.S. healthcare. Since January 2020 nearly a million people have died from COVID in the United States, and the evidence is incontrovertible that people of color have disproportionately borne both greater health harms and economic hardships during the pandemic, highlighting longstanding systematic inequalities especially in healthcare. At the same time, the pandemic has spurred innovations in healthcare delivery, particularly telehealth and remote patient monitoring and other digital applications. So going into the third year of COVID, cautiously optimistic as we move towards a more manageable new normal, what are the big questions learned and what are the impacts likely to be going forward? Now, I'm going to start my questions with some on the pandemic. And the first one is what's been the financial impact on various types of providers and health plans? So, could you characterize the current financial standing of key provider and insurer types? And are there any long-term implications?

HILL: Ricky, should I jump in first? As we joked about before the panel? First, Paul, I say thank you for having us all here and having us all back. I'm going to give a very brief disclaimer which I think probably applies to Ricky and Ann too, which is that the three of us all do investment research for investment banks. You can assume that the

banks that we work for seek to do business with any individual companies that may be mentioned here. Although, I know I have no individual conflicts to report. And I can't imagine Ricky or Ann have any conflicts to report, but I won't pretend to speak for them.

I guess as we go into year three and we're now rolling from what we hope is pandemic to endemic, the endemic phase of this, I think from our perspective we're generally watching the insurers and various provider organizations as it relates to what have they learned of benefit from COVID. I do feel like this is a very wide-open topic which we could talk about for, we could probably spend an hour and a half on this.

I would probably focus on my areas of coverage which are managed care and the drug supply chain where managed care largely has seen COVID as an opportunity where they've collected revenue in the form of premiums and payments from plan sponsors and other beneficiaries. They tended to see at the earlier stages of the pandemic a lot of volatility in utilization, a lot of volatility in medical cost. And medical costs volatility to the downside. Not necessarily volatility of the upside where you saw earnings positively surprising and started to see the reading on the utilization.

I think one of the more interesting parts of the channel that we've watched is the pharmacy chains, the Walgreens and the CVSs and the Rite Aids of the world where they were getting pretty generous reimbursement for the administration of the vaccines. They had pretty high market shares in administration of the vaccine deliveries. And you had the in-store testing and the at home test sales, which are pretty significant economic contributors to (inaudible) over the last 12 to 18 months.

And then from a provider perspective, you saw generally whether it's doc's offices or physician's or the -- or whatever you call it -- the various flavors of the retail clinic model saw demand for services fall and then start to rebound. But, I think for most of healthcare we've seen COVID be a positive financial experience at least as of recent. And I think a lot of the learnings have been around readiness, around supply chain and around the ability to deliver care in what has evolved in a highly uncertain environment. But we can

spend like an hour and a half on this topic but I want to be sure that we keep moving and give Ricky and Ann time to opine.

GOLDWASSER: So, from my perspective -- and, Paul, thank you for having us with you again. It's always a pleasure to have that sort of discussion and dialogue. From our perspective, when we think about the financial standing of key providers in insurance, I think that large insurance and large provider groups have weathered the storm. And when I say weathered the storm, I think earlier in the pandemic there was this anticipation that the large insurers are going to see windfall, right? Because just less core demand. And over the last couple of years, I think the market has realized, right, that was not the case, right? And there are kind of a lot of things in play here. But overall, right, with all the puts and takes, we think 2022 is going to be easier comparisons for them financially versus 2021. But really the question is like what happens with the smaller players? With the regional players where potential losses sort of impact their profits? Impact their cashflow? And if you take that, and you combine it with the fact that we're in a really tight capital market right now. We're in a tight capital market which is more difficult for smaller players to raise money. We are in a very tight labor market. And these are all things that we're going to talk about later, which means the cost of doing business is increasing, and that's more of a burden for the smaller guys. And I think that is to me sort of the broader question, right? So being well funded, at scale is even more important than pre-pandemic. And I think that we have to ask ourselves the question, does this mean that longer term there's actually less competition? And does this mean that we're going to see more M&A in the future?

HYNES: Maybe I'll just add from a provider perspective, especially hospitals, since I cover that sector I would say that the main takeaway at first there was a lot of uncertainty of what would happen, but I think what came through was really the resilience of the American people because even though there was a big blip in utilization, it really did come back stronger than people expected and faster than people expected.

Obviously, it varies between which payer. Younger people, commercially

insured people tending to come back faster than Medicare or Medicaid. Medicaid is still really not back to pre-pandemic levels. But there definitely was a resilience. And I think for me going forward, the biggest question is what Ricky said, the cost of business will be increasing. And especially for providers, nursing, and we will address those later. Nursing is a big factor that has COVID structurally, negatively impacted that industry. And I think it's too early to tell because we still have these COVID waves and dips. But once that settles out, we'll really figure out if it's structural or not.

GINSBURG: Now, Ann, that's interesting what you said about Medicaid not coming back because there's so many more Medicaid eligibles now. That's really striking.

HYNES: Yeah, I think that sociodemographic got hit hard with COVID so they're probably less likely to get care at hospitals because they're afraid of COVID.

GINSBURG: Sure. Thank you. So presumably what you've all talked about may have implications for consolidation. Is this likely to mean that we're going to see more consolidation? Or is the financial stress of the smaller organizations going to be a barrier? And, how will the more vigorous promises of antitrust enforcement play in here?

GOLDWASSER: So, we think that we're definitely going to see more consolidation. And, in our 2022 outlook that was one of the things that we talked about. And I think that we're going to see small scale players merging with others to create scale. We're going to see the larger stakeholders, whether they're healthcare companies or tech companies in some areas or large consumer companies, we see them kind of like looking at healthcare. Opportunistically, looking at M&A. And we haven't necessarily seen it yet at scale. But I do think that we are going to see more of it in the second half of the year because the thing we're watching for is what's happening with those companies? They need to go back and raise money next year, especially given all the volatility. They're just going to be, I think, more pressure to go ahead and do something that's strategic. I think it's going to depend on their boards, depends on the C suite. I think they're still kind of like hanging in and hoping that the market is going to return and that multiples are going to

go up. But I do think that that is going catalyze that kind of like step up in M&A.

HILL: Yeah. If I can dovetail on that? I think Ricky kind of hit on this very well in the first part of the last question. And now, I think we all probably looked pretty closely at the value-based care space and you've seen multiples in that space kind of implode. A lot of the companies that have become public in the last year whether they came public through the traditional method or through the SPAC method which is a word we don't hear a lot. SPAC is a four-letter word now. But, these are companies that are now trading below their last private round in some cases. So even the private investors are under water. It's amazing how what's old is new again. I almost called this like WE WORK 2.0 where these were companies that used to be rewarded for growth in their KPIs and their stock price, whether their growth was membership, premiums, lives. However, it was being characterized. And the goal posts got moved on these companies as the risk profile of the market moved and the risk profile of the market changed.

And all of a sudden, we used to -- I say we used to cover companies that had lofty multiples that were considered expensive stocks on the promise of earning's delivery in 2025 or 2026 that are now, I say, , I thought they were expensive stocks before based on the earnings profile in 2026. And now, the market has heavily discounted their ability to deliver earnings and now years in stocks have kind of imploded. And valuations have imploded.

To Ricky's point, the need for capital is going to force them into making strategic decisions either around raising capital at unattractive terms or will they be pushed into the loving arms of the consolidators as opposed to looking for that extra round of capital. Whether it's the United Healths, the Anthems, the Aetnas, the Humanas that will be out there with the waiting arms with the large provider organizations. I think it remains to be seen. But what's interesting is there are so many factors at play here. There's the changes in the capital markets. There's employment. There's wages. There's interest rates. Like a lot of these decisions right now are driven as much by the macro as they're being driven by

the micro.

HYNES: And I would agree that I think it really is sector specific as well. Like for example, like how the clinic lab sector. And if you talk to some of these smaller labs. If they weren't doing COVID testing, which is very elevated pricing right now, they might have to close or sell because the cost of their business has increased so much that a lot of these benefits that some healthcare service companies are getting to the public health emergency is probably masking some of really the trouble going on beneath the business.

GINSBURG: That's really interesting. I want to switch now because it was mentioned to value-based payments. And my question is are we seeing just more value-based payment contracting between private insurers and providers than we've seen before?

HYNES: Maybe I'll start with that. I think maybe to a degree, but it's going to be slow. That's just how I view it. A lot of the companies are talking about it more as a big strategy like United Healthcare or some of the managed care companies especially with their Medicare Advantage population, really trying to shift people into providers they own to just to save cost and things like that. And again, I'm believer of it. It's just more timing. I think it's very difficult to change the traditional fee schedule. Hospital companies, they'll say we have some value-based contracts but it's really still like five percent. So again, I think it's happening. I just think it's going to happen slower than some people think.

GINSBURG: And it seems though this is a story that if you are here in four or five years ago. You might have said that as well.

HYNES: Yeah.

GINSBURG: And I just want to point out that change has really been very slow. And, unless one or the other panelists thinks it's -- sees something happening more rapidly maybe that's the takeaway.

HILL: Well, I guess I would put just a slightly different spin on it. I wouldn't say that I necessarily see it differently from Ann. And I think Ann is very, very right on what you're seeing on the hospital side. But I think on the outpatient side and on the ambulatory

side, you're seeing things move much faster. We've seen a tremendous amount of capital formation in that segment of the market over the last two to three years. This is where, I'd hop on my soapbox for all the Washington people on the line and be like I think I said this last year. Like, regulation, rules to some degree drive behavior. And your participants in the market are going to look at rules and change behavior to solve for outcome. So I always focus on is your policy decision well aligned with what you want to see? And the example, I would use here is we see all these subcap arrangements in the primary care space. Where you see managed care companies essentially shifting the risk from managing parts of the patient population away from the Medicare Advantage entity and into primary care entities that are then managing patient populations. And they're effectively taking the risk for these patient populations in what would seem to be a more lightly regulated environment from a care delivery perspective and from a cost management perspective.

So you are seeing tremendous growth in the number of participants in this space. You're seeing tremendous growth in the number of lives that are going to catch under these arrangements. Kind of to Ann's point, it's just a very small percentage of the total pie, but you're putting up 25, 35, 45 percent year over year growth rates projected to grow at that rate for those handful of years. I think I'm piggybacking what Ann said. The hospital organizations given the consolidation in the hospital market tends to look different than the consolidation in the primary care market. So you've got a different competitive dynamic. So they're not -- to Ann's point, they're not incentivized to move off the fee schedule. They're not incentivized to kind of take risk because they're getting paid well under the fee schedule. But I would just kind of -- we're kind of seeing different degrees of movement in different parts of the market. I'll kick it to Ricky.

GOLDWASSER: So first of all, we need to think about what the end market is, right? Because value based clearly is a good solution, right, ultimately for Medicare Advantage. And we're seeing more full risk, right, value based in that market. Not necessarily, right, at least for now the right solution for commercial. And even when we think

about sort of what type of arrangement we see, right? We see more full risk on the Medicare Advantage side because there are incentives there to George's point. We see participating in an upside arrangement on the commercial. So I think when we think about the market opportunity and the addressable market, we really have to think about it by end market and that's part of it.

But more than that when you think about what's the limiting factor. To me, value based is kind of like similar to how people always talk about what are the big trends, right? Demographics are the big trends. Value based is one of them. But providers, hospitals, health systems don't have the tools to take on risk. So I think that when you kind of like what is it? It's kind of like you tie the horse to the carriage. We need to make sure that there are tools that can help providers and health systems take risk and allow for it, right? And there's connectivity between all of them, before you really get to that massive shift. And I know that later we're going to talk about digital and healthcare technology, but to me that is kind of like where we have to think about what is happening in this space right now because that is sort of the foundation for later on. Kind of like acceleration and kind of like these value-based treatment models.

HILL: Well, if I could have one more point? Ricky makes a great point about healthcare in this country is not one market. Healthcare is thousands of markets based upon which region you're in, which competitive environment you're in, what your payer structure looks like, what your risk arrangement is. I mean your big divisions are going to be geographic and then Medicare, Medicaid and commercial. And like again, you basically multiply the three by the regions you come up with hundreds if not thousands of healthcare markets in the United States. So the idea that like why can't we fix the healthcare system? Or why the healthcare system is broken? It's like, well, which healthcare system are you participating in? Which healthcare product are you participating in when you're talking?

GINSBURG: Good. Yeah, I would like to move us to telehealth now. And

just to open this my sense of we all know that we will clearly have much more telehealth after the pandemic or during the endemic than we did beforehand. And it seems as though the federal policy for Medicare, as reflected in the latest appropriations omnibus, is kind of moving cautiously following the advice that MedPAC has been making to Congress of doing more now rather than locking in the program for the long time to kind of unlimited telehealth. Really looking at what types of services actually have a positive impact and which parts are problematic. What's your sense of what the private insurers are doing as far as their coverage of telehealth going forward?

HILL: Ricky, I'll let you kick this one first.

GOLDWASSER: Sure. So I mean when we think of what the private insurers are doing. I mean overall clearly in the last two and a half years we've seen that telehealth insurance parity. And I think for over a year now that question has been a very relevant question in terms of when are insurers going to scale back? And is a telehealth visit truly an equivalent for an in person?

I think that each payer that we speak with has different philosophy, right? There are some that want to scale back very quickly. And others that have different approaches. But to me, I always kind of like think about let's follow the workflows of what is actually happening in the marketplace? And today, when one area where we're being told that telehealth makes a lot of sense, right? Pre-op, post-op, kind of like full op services. Today, when I go to a physician and I pay that physician, if it's a fee-for-service model, the payment is for the procedure, right? For the operation. I actually don't pay for that first appointment and I don't pay for the post-op appointment. So to me, here's an example where telehealth is an add-on. It makes it easier, but you shouldn't really be paying for it, right? Because we wouldn't pay for it in kind of like an in-person environment into it. So I do think that insurers have to be and will be very thoughtful on where parity matters and where it does not.

So for example, behavioral health. There's clearly very, very acute issue of

supply and demand. And it lends itself very well for telehealth. So that is where you're going to see parity. So even if we see headlines that say that maybe reimbursement is lower. We have to kind of like really peel that onion because sometimes it makes sense and sometimes it's not different in how things have been done in the past.

HYNES: And just to add. I actually think physicians will have a say. I do a quarterly survey of about 250 physicians, and when I asked that question depending on the physician's specialty, I get very different answers. Where some will say, it depends on the reimbursement because obviously the reimbursement is elevated via the public health emergency. Some say I prefer to see the patients in person. It's not the same. So I think they all have a big say in how they want to practice medicine because ultimately the physicians are the ones practicing the medicine. So it makes sense for some. Like behavioral? Definitely. Especially in rural areas. And I also think geography will play a part in this as well. Because in some rural areas, there's a severe physician shortage. But I think physicians, their voice will matter as well.

HILL: Yeah. I think the only thing I would dovetail in here is again depending upon where you sit. It's like even as a payer organization are you seeing telemedicine either as a revenue opportunity or a cost center?

HYNES: Yeah.

HILL: And if, right, if you own your own telemedicine capability -- again, we kind of come back to this fragmented delivery system. If you're an ASO provider of services and you have an integrated telemedicine model and you can charge for it, you're going to steer patients in that direction. And if you're a risk-bearing provider, you're going to see this as something that hits your costs of goods sold. And you're basically going to want to contain costs against your medical cost, and you might discourage it. We are starting to see a little bit. There's been rumblings inside the federal government, Ann, I think you alluded to this, like will the federal government in Medicare fee-for-service pull back the easy access to telemedicine that's been granted during the pandemic? We are seeing some of those

initiatives at the state level wherein about two -- in the Medicaid populations has access to telemedicine kind of been too readily available. And then I know Ann talked about behavioral -- and we'll probably hop into this -- it does become very disease-state specific.

And I would say, , in general like in what I would call like either way like acuity care like going to a telemedicine doctor as opposed to going to the ER or the primary care space. We're starting to see utilization there come down. Not quite approaching pre-pandemic levels but normalizing at a number under 10 percent total visits.

GINSBURG: Yeah. Let me ask about payments. I guess, what we don't know is when the public health emergency has ended, will the parity between payment for telehealth and bricks and mortar care be over? Will telehealth be paid less? And, are the private insurers thinking that they might follow whatever Medicare does? Or do they have their own ideas as to how they're planning to proceed?

HILL: I guess I'll hop in first on this one and I'll go. And again, I think it depends on where you fit on the food chain. And if telemedicine is a cost center for you, you are going to try to pay less. You think about the health plans that are trying to start virtual first care offerings or virtual first delivery models as it relates to benefit design, right? They're starting with virtual first because they're expecting it is going to be the easiest access and the lowest cost. And then you'll work I'd say just like in benefit design almost any other category. You're going to work through your lowest cost care delivery options before you work into your higher cost care delivery options. And then if you're a revenue generating, if you're using telemedicine as a revenue generator, you're going to try to preserve reimbursement around it. I think over the long term, it's hard to imagine that telemedicine reimbursement is going to remain at parity for in-person reimbursement.

HYNES: I agree. I think it obviously depends but I think it's unlikely it stays.

GOLDWASSER: It's interesting just going back to I think that it will require study and analysis --

HYNES: Yeah.

GOLDWASSER: -- to take time because there are areas where I think about it. You go to a physician visit in office, there's a lot of code stacking that's happening, right? That means that the total cost of that visit might be meaningfully higher than the telehealth visits despite the fact that you have kind of like reimbursement parity. So I do think that from the private insurer side, there's going to be a lot of sort of analysis until we get to kind of like the true answer. But I would say that -- I mean it's again, if we think about this holistically, what is telehealth? And if we think about telehealth just like we think about in-person, right, it's just another method of providing care. Is it really it should -- it should be reimbursed as a telehealth code or should the reimbursement be more around what is that particular service? How this particular service apply to sort of that other services that a patient is getting?

GINSBURG: Okay. Any thoughts about how integration between virtual-only telehealth providers and bricks and mortar providers that people see in person some of the time. Is that going to be a source of real fragmentation? Or they finding ways to share information, et cetera?

GOLDWASSER: I mean, I can take it. So first of all, I think that digital first, which you kind of I think you're referring to because you referring to digital first in sort of that integration between digital and in-person. Digital first are basically narrow networks, right? I mean you control the environment. You control the leakage. You can very easily refer to sort of kind of like a specialist. So I do believe that digital first actually is going to encourage -- is an integrated approach. It will mean that there's just kind of like more collaboration, more cooperation between, and I think that that's something that's going to -- it's here to stay. And it's going to be -- have an increasingly more important. It's sort of step therapy also in a sense. So we talk a lot about step therapy on the drug side. This is what this is.

HILL: That's how I was thinking about it when I talked about it as part of the benefits factor because I was thinking about it as a step therapy edit or a prior auth or

however you wanted to think about that process.

GINSBURG: Well, thanks. Yeah, that's good. Let's turn to mental healthcare. And, we know that the pandemic has, , really increased the need for mental healthcare and there are a lot of shortages in both inpatient capacity and for mental health clinicians. So how are the payers likely to handle this imbalance? They perceive the need for more mental health services. The services are in short supply. And let me ask one other thing is that as the ability to get mental health services through telehealth makes it more attractive, I think for many patients, unless they will want to demand more.

But is this going to even exacerbate the shortages? And, we start wondering about who is going to get those services? Or on the other hand, are providers able to actually deliver more since they can do it from home?

HYNES: Maybe I can start with this one. I think this is actually a very interesting topic because the Washington environment, there's just no consensus among, I want to say Democrats and Republicans. And there's so much consensus around increasing mental health parity. And I actually think there might be a standalone bill. If one bill gets through Congress this year, it could be a standalone mental health parity bill that really addresses the mental health parity law in 2007 because there's a lot of the view in Washington among Congress is that health insurance is a problem in that law.

So I actually think that congressional action will force all those insurance companies to cover benefits more. Because mental health, it's especially when you get to the inpatient side, it's very managed by every payer besides Medicare. Commercial is overly managed. Managed Medicare is overly managed. In the scenario that the government is looking at. And because of the shortage on both the nursing side and the physician side, I think telehealth has to play a big part of any type of legislation that goes to Congress. And it probably will include some increased telehealth benefits once that bill goes through. But I actually think that increased coverage would be dictated by Congress.

HILL: I would take a little bit of a big picture approach to this. And Ann, I'd

be interested if you have like I don't know the numbers off the top of my head for the inpatient mental health component. But we've looked closely at the outpatient mental health component.

HYNES: Yeah.

HILL: And what I would say is like again from the -- so like I completely agree with Ann where things are going on mental health parity. But what we see from a big picture perspective is that if you look at the healthcare dollar writ large, where dollars go in big slices. Hospital payments, outpatient payments, labs, drugs, stuff like that. Mental health is not a big slice of the dollar. It's a very, very small slice of the dollar. So there is lots of room for mental health to grow inside of the health dollar. I'd say without changing the size of the pie so to speak. So I think that we could kind of achieve the goals that Ann is talking to around parity and not necessarily moving the needle on what the macro health costs are. And the good news raised, right, you can increase access through telemedicine while you mix down on price per visit at the same time. So I think, don't mean to make light of this, we're all going nuts. Two and a half years into the COVID crisis, we probably all need a therapist. And, the healthcare dollar writ large says there's money in the budget for each of us to see one. So again, I think the labor shortage in mental healthcare is the issue. I don't know that cost and its place in the budget is the issue from the work that we've done.

GINSBURG: Yeah. Well, let me push further about this labor shortage. About, , won't that be a big constraint? And what might be done longer term to alleviate that?

GOLDWASSER: So and I think that that's something that we talked about a couple of years ago when we had this discussion in the very early days with COVID. And that is practicing medicine, right, across states. It was allowed for a brief period of time then was pulled out. If you think about mental health here's such a way, right? Where you bring technology in sort of telehealth services and you can solve for this supply demand issues that we're seeing.

Training therapists across states, right? You have someone in California that is three hours behind. They can work with people on the east coast. There are easy solutions that require tweaks. And that's where I see the opportunities. Opportunity that is going to come out of need.

HILL: Ricky said it. Using technology to better utilize capacity.

GOLDWASSER: Yep.

GINSBURG: All right. Thank you very much. As far as the other digital technologies. As far as monitoring chronic conditions, hospital at home. Are either of those going to be more significant going forward?

HILL: I mean I can lead it. On every payer organization trying to drive every inpatient care delivery opportunity that they see into a lower cost of care setting, ideally, into the home has been – a trend. It's been going on for I'd say, at least 20 years now. I guess the, right, and where we're getting to now is just what level of acuity can you drive out of the inpatient setting and into the home just becomes the question? I feel like this is kind of Ann's bailiwick because she's the hospital analyst and I'm not the hospital's analyst. But like I know coming at it from the payer angle that that's what everybody wants to do. We could kind of UnitedHealthcare announced another \$4 billion acquisition the other week of a homecare company. Again, just building the capacity now to be in a position to provide care delivery in the home for people.

GINSBURG: And how are the hospitals thinking about this?

HYNES: I mean if a hospital's goal is actually to get the patient out of the hospital because have you been in a hospital lately? But the patients there are very sick. I mean to be in a hospital and their goal is to get the patient out into a good setting. And sometimes, it's the availability of a good setting. Like inpatient rehab for example. And you have to look at capacity utilization is a very high-capacity utilization. So there's not enough supply for the demand. But home is very important and it's ultimately where the patient wants to be. It's where the family wants the patient to be but they need the patient to come

back not too soon because hospitals do not want the patient to be readmitted. Like that's a big thing for the government, readmission rates. So I think payers, hospitals. You saw HCA actually invest in it's first home health business, a small regional one. Everyone is trying to increase their access to some type of home health or whether it's digital. Some type of capability because that is where the care is shifting if the acuity of the patient allows it.

And again, with the aging of the population, I always joke that I've been in this business for 25 years. And people were talking about the baby boomers 25 years ago. But they're actually here now and we will have -- and people turning 72 are growing five to six percent. So that is going to be a big focus for I would say every single part of the healthcare system whether it's provider or payer.

GINSBURG: Okay. Great. This might be a good time to turn to questions from the audience. And I've got some here. One is circling back to an earlier analyst comment. Can you please explain why value-based care is not a solution for the commercial healthcare market?

HILL: Can I hop in on this just because I did a call on this this week with a benefits consultant? And it just kind of cracked me up where the benefits consultant, one of the large benefits consulting firms is working with one of his self-insured employer clients. And like it's kind of the -- it's like the self-insured employers sponsor wants the provider to take more risk and put more skin in the game, but they don't want to buy risk and they don't want to pay a premium to the insurance company.

I guess I just I feel like there's simplistically speaking when you ask someone to take risk, you are asking them to commit some type of capital which they then charge you a premium for, which nobody seems to want to buy or pay for. So why are we not seeing more initiative on kind of commercial plans moving towards risk, right? The hospitals that Ann covers are getting paid very well right now while not taking risk. And these self-insured employer sponsors think that they are paying very low benefits cost without paying risk. And the insurance companies are being paid nicely to sit in the middle

from an ASO perspective and adjudicate claims and leverage their network contracts and leverage their discounts and leverage their rebates while not taking any risk. So everybody feels like they're doing great right now without taking a bunch of risk and without paying for a bunch of risk. But everybody wants somebody else to put more risk in the game without paying for it. So we're kind of stuck with this circle of people who would -- Paul I want you to take all the risk for this presentation going well without me preparing for it. So you kind of walk into this. Everybody has got to kick in their share for value-based care to take off in the commercial space.

GINSBURG: Yeah. That's a really interesting insight. I'm glad you brought that forward.

HYNES: Can I add one point to that?

GINSBURG: Sure.

HYNES: I would say also in the commercial market, we're in a very tight labor market. And when it comes to those value-based arrangements, you would have narrower networks. Employees wouldn't have as much access as they probably would want. And health insurances is very important to offer employees. So I think the tight labor market is probably impacting those as well from an employer desire to do it.

GOLDWASSER: Right. And I would say one other thing when you think about commercial. You have to think about the population. How sick the population is, right? Value based works when you're treating individuals that are sick, right, and have chronic diseases. Medicare population, Medicare Advantage where people are over the age of 65. That is sort of the near term, right, market opportunity. You talk with MA markets and they said even with that population, right, it's basically 20 percent of the members. It's about stratifying and identifying 20 percent of the members that account for 80 percent of the medical cost and managing them under value-based arrangements.

On the commercial side, we just have less of that. So I think the dollar opportunity is smaller and that's why in the (inaudible) we're so early in penetration, they're

just kind of like markets that present a bigger opportunity.

HILL: And Ricky, you make such a great point on Medicare Advantage because when you look at Medicare Advantage versus almost every other market like because of Medicare Advantage through the regulatory process of the government, you have this broadly developed risk framework that does not exist in any other market so to speak. So like the framework for how risk get attributed and paid for exists in a way that it doesn't exist in other places. And I would like to drop in one of my euphemisms here is that you have to remember that we're always solving for three things. We're solving for high quality of care, low cost and broad access. I tell people you get to pick two and the third one is kind of something that falls out of picking which tree you choose to prioritize.

GINSBURG: Yeah. Good. I've got a question here that came in before we started, but it looks really good to me. Why is Wall Street convinced that startups can manage primary care and save money? Are they right?

GOLDWASSER: So I think that it's an interesting question, right? Because if you think about what are those startups, right? They're just kind of like they are -- we're seeing a lot of kind of like capital investment information in order to develop sort of new models that can help, right, solutions to close gap in care. And that is what these startups are about. So to me it's less about are can they ultimately -- I mean some of them might ultimately become bigger organizations. Some of them might be part of already large organizations. But it's about innovation. It's about where those startups, George talked about taking risk, right? Those startups can take on a risk in order to help solve these gaps in care. And that's a purpose just like in tech world where we're seeing tech startups taking risk and coming with innovating products. That's what we're seeing in healthcare.

GINSBURG: Yeah. So I guess a lot comes down to will they be effective at changing how primary care physicians behave. Or is it just a matter of providing primary care physicians with the right supports? And this will cause a bit sort of it very differently.

HILL: I mean I think you need to experiment at the margins. Like you need

to test and experiment at the margins. And one of the interesting things about primary care and I'd say about healthcare delivery in general in this country from the provider perspective is there's no kind of new uniform handbook around that either. It's like I'm here in Cambridge, Massachusetts and the doctor coming out of Harvard Medical School right now learns how to practice medicine from the doctor that trained him who learned from the doctor who trained him, which might be slightly different from the doctor who is coming out of NYU, close to where Ricky is. Like there are variances in care delivery that result from how doctors were trained and how medicine is delivered in regions. And I'd say, you should think about like again I've got to come back like this fragmentation of the healthcare system. Like we have these very variances and nuances that exist everywhere. But I think what's important is that you continue to test and experiment around the margins. So, these startups like they're going to try new models, new incentives, new procedures to try to create some opportunities and some savings there.

GOLDWASSER: And I would say that's the dirty secret of healthcare, right? Healthcare and we always talk about healthcare innovation. But it's not a very innovative industry, right? And it's because it's a very regulated industry. It takes years to make changes. You need these types of innovators to drive the industry forward.

GINSBURG: So next I would like to talk about workforce issues. And, workforce shortages especially for nurses in hospitals. Obviously, everyone is concerned about that. And maybe you could start, Ann. What are hospitals' plans going forward to address the nursing shortage they're experiencing now? And expect to continue I gather.

HYNES: Sure. I think hospitals hope that some of it naturally eases because what's happening during COVID is obviously we've had very elevated COVID hospitalizations and they've had to recruit other nurses. So they had to use a lot of temporary per diem nurses when they had elevated COVID cases. They had to do a lot of travel nurses, which at 13-week contracts on much higher pay. So now that hospitalizations are decreasing, they do hope there's just some ease in that nursing costs going forward.

But there probably is some structural change. It's similar to teachers.

There's like this great retirement of teachers because the average of a teacher in the U.S., I believe is over 50 and that is similar to the U.S. So there are nurses retiring, but I don't think it's 20 percent of the nurses. But it's enough that causes some of the hospital companies that I cover to be concerned. And I think what they're doing initially this year is realizing and appreciating that these nurses are burnt out. So they'll probably get more bonuses, more vacation, maybe less hours per week when the COVID demand ends and really doing what they usually don't do. And giving them a lot of love and things that they need to recoup and resolve the burnout. I know that sounds silly, but that's what they're doing.

But going forward in a hospital situation, and it depends on the state. You might have staff regulations or there's industry accepted nurse staff ratios. It will be an issue if there is some type of structural shift going forward. So I think permanently pay will be increased. Increased benefits. Pay for education. You just really have to want that nurse to work at your hospital. So even though it was always competitive to find a nurse, it will be more competitive. I know the U.S. government is doing some things to attract our system outside the company. So there are some visas happening this summer so they can do some international nurses. But again, it is an issue. Hopefully, it's not going to be an issue as we fear once the whole COVID hospitalization fixes itself. I think we'll really see how bad it is. It's probably not as bad as people think, but it will be an elevated pressure point going forward. And for hospitals, they can pay more. So I am actually more concerned about the non-hospital provides, home health, behavioral, for example. Because a behavioral nurse might make like \$85,000 a year, but hospitals should be paying \$120,000 a year. So they might leave a setting and shift to an acute care setting for a hospital if a margin impact. But for home health and behavioral, it's actually a revenue impact and a margin impact. So if you don't have the nurses, you can't admit patients. So I'm more worried about just the non-hospital assets more than anything.

GINSBURG: Well, that's interesting. And I guess the big question which

we can't know the answer to is a few years out past the pandemic, is there going to be some structural change in people's willingness to become a nurse? Particularly in a hospital because of what nurses went through during the intense COVID time? And, I'm sure there would be a long time before we can answer that question.

HYNES: Yeah. I think time will tell.

GOLDWASSER: So I'll take a different approach here. I mean clearly, we're seeing there are shortages and clearly there is this fatigue, right, of being in healthcare. But what we have also seen over the last couple of years, we've seen greater acceptance for a bigger role for nurse practitioners, right? For physician assistants. I mean for pharmacists. So I think that it would be actually very interesting to see how the industry evolves because if now you're being empowered and you can do more. And I think there are 23 states where it allowed for that. Does this mean that if we are making this into a more interesting field? And we potentially could see new people kind of like coming into it. So again, it's going to take time. It's long, but I think that we also need to think about what their role is and how the role is evolving. And is it going to change?

HILL: I'm seeing the question, Paul, in my head as a completely different place thinking about like have all the managed care companies appropriately priced for medical cost inflation for calendar '22? And, what are the numbers going to look like for calendar '23? Because when we think about the labor shortage, I think we think about healthcare as a generally better educated part of the workforce and a generally more expensive part of the workforce. Having said that, with inflation at running at 8.5 percent, almost nine percent. People who are not getting wage increases that match that or seeing their purchasing power increase. Historically, you have seen healthcare costs appreciate faster than inflation as opposed to slower than inflation.

So at some point do we have a healthcare cost catch up that we need to be concerned about? Is that a back half? And because healthcare on an annual basis probably looking at calendar '23 then as opposed calendar '22 event. I'm seeing, Ricky, I'm

seeing great recession. I'm seeing inflation. I'm seeing ballooning healthcare costs.

GINSBURG: Yeah. I'm glad you brought that up particularly because my Brookings' colleague, Matt Fiedler, has recently published something about explaining why the healthcare pricing numbers have been increasing so slowly. And that a lot of that is temporary. And there's even the possibility of some kind of bounce back as a result of that. Because so much has been really based on projections certainly in Medicare. And, the projections obviously were not accurate. And, it could mean that the next projections err on the high side, say.

GOLDWASSER: And it's also interesting, right, because at least from a Wall Street perspective, the investment community was really favorably surprised by the MA rate increases that they were so high and there was expectation of the low. What are they really based on? They're based on sort of these projections that we're going to see medical spend going up. And there is inflation and if you have to raise it not necessarily because you are giving the MA players just kind of like more dollars. It's because these are dollars that have to be used to offset this increase cost of inflation.

HILL: Yeah. I'm going to start say, I'll jab at Ricky and say that's kind of a sticky wicket though because from an individual company perspective like we're talking about this creative destructive cycle of new entrance that come to market and industry consolidation that occurs that gets rid of sort of the new entrants or gobbles up some of the new entrants and creates stable competitive environments for the remaining companies that participate in the environment. I think while the rate increase is a great thing for the companies that participate in this space, as somebody looking at individual companies, I question that we've helped subsidized some of the inflation that we expect, but we've also, were subsidizing marginal competition in the market with these great rate increases.

And I like to look at the corollaries through the history of this space where you had just -- what tends to happen is that in spaces where there's rapid growth in an industry and the rapid growth of capital towards an issue creates excess competition which

forces companies to not be lean and disciplined and kind of forces an irrational competitive environment to some degree which then needs to shake out later. I wonder if we're doing that in the Medicare Advantage space where we're just these great rate increases are subsidizing marginal competitors who might not be able to survive X without at 8.5 or nine percent rate increase.

GINSBURG: Yeah. And actually, just while we're on that topic do you see continued entry into the Medicare Advantage space? Or is that, -- I know some of the recent entrance have run into some problems.

HILL: I mean we'll wait to see, kind of a next go around of the number of approved plans. But we continue to see growth in the number, growth of the number of products in the space, yeah.

GINSBURG: Okay. Thanks. Let me ask a question about long-term care facilities. And, we know the huge impacts of COVID on nursing homes. And, will there be a long-term impact of institutional long-term care providers playing a smaller role in the system relating to various things of services at home for those that need long-term care services?

HYNES: I can take that. I think longer term if you're discharged from a hospital and you need rehabilitation, you can go to a couple of places. You can go at a home which a nursing home might be the person's home or you could get it at a patient rehab facility or home health. It really depends on the acuity of the patient. I do think after COVID more people will probably be hesitant going into like a SNF or a nursing home environment to get rehab. So maybe they choose to go into an inpatient rehab hospital. What's really if you look at the government data, they have very good statistics. Like the readmission rates for an inpatient rehab back into an acute care system is only about around seven to eight percent versus if you get care at a nursing home, it's more like 15 to 18 percent. So that's a big divergence and we have readmission rates.

So again, I think there will always be the drive to take people out of nursing homes, but some families don't have the options. So I think nursing homes will always be

around, but I think over the next decade just as folks on home health and improving things and offering more services in the home setting which will alleviate what the family has to do to help the patient. You'll see more shift back to the home. But again, I think it's investment into a lot of services. A lot of capability by both providers and the commercial payers for the ability to do that. But I was reading your question like there was no -- none of the hospitals ever talk about wanting to own a nursing home or get back into that business.

GINSBURG: Okay. I'm glad you answered that. Next question. Let's talk about the future of independent physician practice. And, we know physicians are leaving independent practices. And what would have been the most important destinations? I gather there are three. There's larger independent groups, private equity ownership or hospital ownership or insurer ownership. And, which type of -- any perceptions on which types of ownership might, prove to be most viable?

HYNES: I mean when I look at what type of practices private equity or these private equity-based companies, they tend to focus on emergency room physicians. They tend to focus on anesthesiologist. They tend to focus on maybe neurology a little bit. But I really, I have to think it really depends on the facility. Like for cardiologists, they tend to like to be owned by hospitals. And again, when a physician decides to -- we want to not be alone anymore, there's also other factors that might determine that. Whether their medical malpractice premiums are very high. So like, for example, emergency room doctors, medical malpractice is very high. It's very difficult for them to be independent. Obstetricians was the third one. There was a big either hospital owned or publicly traded hospital owned, they tend to go into that type because of the medical malpractice insurance.

Anesthesiologists, there was a big trend over the past, say, five years for them to really go into not ownership anymore. A lot of that had to do with the reporting data. They just didn't have the money. They would have had to invest a lot of dollars into technology to report data back to the government, and they just didn't have the money. And that really led anesthesiologists giving up ownership of their practices. So again, I really

think it depends on the environment, the type of physician, things like that.

GOLDWASSER: I think it's also a matter, I mean at the end of the day, right, private equity is buying those not to own it forever. So ultimately where they're going, right? And I think it all ties back to where we were before, insurer ownership. If you have a large Medicare Advantage book, right? You want to own a provider and you want to own a provider because that's going to create that stickiness with the membership which is going to be increasingly important as the market becomes more competitive and is ultimately growth in MA is going to slow down at some point. The same with hospitals, right? We talk about like the move from the four walls of the hospitals, more into the home to stay relevant, right? Do you need to own these groups? So I think the end game is that private equity does sell those to the health plan and to health systems.

GINSBURG: Good. With the No Surprises Act having been enacted and implemented, and private equity owning the specialties, emergency medicine and anesthesiology, where surprise billing was so important. Do you think this really undercuts the rationale for private equity that own those specialties? Or are there enough other reasons like what Ann mentioned, the malpractice insurance that it will still be a significant thing for private equity?

HYNES: It probably decreases their urge to buy it because that was a big strategy. And not all private equities would do this, but some would. They would acquire these physician practices and specifically make them out of network to get higher reimbursement. I would say that has stopped though over the past few years. Obviously, because the government initiatives to stop those type of things. So I would say yes to a degree. But I would still continue. I don't think it ends it. I just think it probably slows the growth.

GINSBURG: Okay. Yeah. And also, another reason that the consolidation was part of a private equity strategy and consolidation won't result in increases in fees to so much because of the No Surprise Act.

HYNES: Yeah. And also, I think it depends on the specialty -- like primary care that's the hot thing right now. Several companies want to get into it. So you might see a big uptake in private equity-based companies with PCPs and things like that. So I really think it depends on the specialty.

GINSBURG: Okay. Thanks. Actually, are there important insurers other than UnitedHealth Group through its Optum subsidiary or Humana that are making large investments in physician practices today? In a sense, what I was wondering is it that United and Optum and Humana are kind of outliers. They're doing their own thing, but nobody else is doing that. Or are others engaging in significant activity as well to own physician practices?

GOLDWASSER: Yeah. Cigna is, I understand, in December actually a little bit before that in early December really talked about publicly through a press about their intent to invest in primary care and into group primary care. I would say again because if you think about why United? Because they have 25 percent MA market share. Why Humana? Although, I don't think Humana necessarily is really follows through an ownership model that they're starting now. I think a little small and a little late because they have 20 percent of MA market, right? And it's 70 percent of their business. CVS is the third largest MA player. So again, I go back to let's think about strategic investment that they are making. And think how they're tied to what markets they're serving. So I think that you will see that, these investments for insurers. It serves market or it makes sense to own. So do I necessarily think that Cigna should own primary care of ownership? No, right? Because they are not in the MA market. But it's follow the lives.

GINSBURG: Yeah. That really makes sense to me. Yeah, thanks for bringing that up.

HILL: And maybe just to dovetail on that. It also goes to like again we're really talking about all this going on in MA and the focusing being on MA because there's the risk infrastructure there. And there's the ability to kind of shift cost and shift risk around, shift

earnings around. And in segments of healthcare where that is less obvious, you're going to have a lower degree of capability to do that. It's just less attractive to do.

GINSBURG: Yes, I can see it also plays into the fact that we're likely to see a very different story for different specialties. In that we've been talking about the story for primary care and I think Ann had mentioned that hospitals like to employ cardiologists in particular. And, yeah, I could see how this market is sorting out according to the opportunities for different owners by specialty.

HYNES: Yeah. I would say hospitals really don't like to own doctors. They will do it if they need to in specific markets because once a doctor takes ownership, they tend to work a little less.

GINSBURG: Yeah.

HYNES: Out of need.

GINSBURG: Good. Okay. Let's talk about the insurance industry now, which segments are seen as the most attractive for expansion at this point? Is it Medicare Advantage? Medicaid? Individual market or somewhere else?

HILL: I mean I think we'd all agree, MA is clearly --

HYNES: MA, yeah.

HILL: Yeah, like MA is clearly number one. And then, I think there might be some debate whether the individual market has increasingly sustainable attractiveness? And is poised for growth off of a very small base? Medicaid probably from a growth profile, number two. Except for we're going to go through this redetermination period as we exit the public health emergency. It kind of resets the bar there. And then commercial just kind of lumbers on. Is that the consensus? Did I say anything anybody wants to disagree with?

GOLDWASSER: A consensus. And I think that it also important to kind of address the why, right? If you think about it, it is just -- first of all, it's a faster growing market with membership growth. And we are in environment where price increases, rate increases are not necessarily, right, a foregone conclusion. For now, it is, but maybe not next year.

Maybe not the year after. So you really have to think about where the membership growth opportunity. And then there's also the predictability and the stickiness of that member. I mean the exchange market, if you look at it, right? There's 25 percent turnover. When you're in the risk-taking business, 25 percent turnover means that you really don't know 25 percent of your population every year. And it's difficult to manage risk. And I think that is why people really gravitate towards a MA marketplace.

GINSBURG: Yeah. The MA marketplace, I mean not only is this very stable enrollment but you can even invest in people's health since they are going to stay with your plan for many years.

GOLDWASSER: Yeah.

GINSBURG: Yeah. What about tech companies getting into the insurance industry? In a sense, are there real opportunities for them? Or is it really just to, , establish a foothold and then get bought by an insurer?

HILL: Can the answer be TBD? TBD, to be determined, right? I think if you were to ask the tech companies, they've got this shiny new bubble that is technology that they're going to apply to the insurance industry and do it different. And if you talk to older line insurance companies, they would tell you that they're blocking and tackling in dealing with the regulatory industry of the U.S. insurance market is hard work and there's real value in the long-term understanding and execution of those businesses right now. And I put it like this. I say, everybody's business in healthcare these days requires technology. You can't execute your business and operate your business without technology. That does not make every healthcare company a tech company.

GINSBURG: Yeah.

HILL: And understanding that bifurcation, I think is important. And just the idea that you're going to -- right? You can be -- just because you're a tech company doesn't mean you have the ability to rewrite the rules of how the U.S. healthcare system works or the insurance system works. Again, as Ricky made the point earlier. Like this is a market

that is inherently resistant to change. And is inherently slow to change.

GINSBURG: Yeah. Good point. This could be an analogue to the pharmaceutical industry where the development of new drugs shifted over time to biotech startups. But, they didn't run into the rest of the pharma's business, which is gaining regulatory approval and marketing drugs. So I wonder if it is really a matter of tech companies will come up? And if they have a tool that is very attractive to insurers, they will be bought. And then the next challenge will be, how effectively can an insurer integrate what they've bought into their organization?

GOLDWASSER: Yeah. And, Paul, that analogue is right on. I mean we actually used that same analogue in our 2022 outlook where we said, if you think about sort of biotechs, right? Biotechs are innovators. They are coming up with the new drugs. The large pharma companies are making them into products that can be used in the marketplace. So I think that that's an important differentiation not just for the tech-enabled MCOs, right? For all the other innovators that we are seeing in the marketplace. I think where tech is going to play an extremely important role is kind of like how do you use the data? Because traditional managed care companies, they have the data somewhere there, right? But they really haven't done anything with that data. And here you have companies that are very focused on that. So how do you stratify risk? How do you engage? Because to me without tech how can we get really to value-based care into risk taking? So they have an enormous role both in the backend which a lot of healthcare systems, but as well as on the frontend, right, in the digital. And how do you engage members? So I think their role is critical. It's important. And we're starting to hear kind of like the large guys talking about it, right? These have become sort of like buzz words that they're kind of like using. And I think that ultimately, they will work together because there's really no other way to move this market forward.

GINSBURG: I almost wonder if in a sense maybe we shouldn't be looking that much at the tech companies appearing to try to enter the insurance business. But it

may be an order of magnitude more as far as technology companies that are just selling their services as suppliers to the mainstream insurance companies. And that's maybe how new technology enters the insurance industry.

HILL: In the dovetail of what Ricky was saying. Like there's using the data and then like are you using it on the frontend or the backend? Which has tremendous implications for outcomes and cost. Like are you using the data to keep people healthier? To keep them out of the hospital? To better engage with them and get them more involved with their health? In thinking more about their health before they wind up having an acute care event as opposed to -- then there's using them on the backend after the acute care event for outcomes management, for disease management. I just kind of wanted to highlight the upstream and downstream implications of how you look at the data and how you use the data.

GINSBURG: Okay. No, thank you. And I actually have -- have insurers been making progress in using big data to constructively intervene in the delivery process for the patients to identify?

HYNES: I can take that one. It's not really evidence. And I think where we really need big data is on specialty drugs because specialty drugs are obviously a huge cost. And there's no type of plan design or tier in specialty drugs because they don't have the data. When I talk to consultants and when I ask them, they say employers just are not comfortable really tiering. Especially oncology drugs and things like that until they have the data. And they've always said whatever PBM comes up with that first will be the key winner. And we just haven't seen it. So obviously, data is important, but I think where I look at it what is the biggest cost right now? Especially drugs, we don't have it for that specific thing. Other things we do, but that's the one thing that stands out to me that's missing when it comes to data.

GOLDWASSER: To me data, I know we talked before about behavioral health, right? How do you take that behavior health data, right? And how do you use that to

understand which patient is more or less likely to utilize the drugs? Or to be compliant with certain treatments? So again, I do think that it is going to be increasingly important. I do think that some of the tech startups like, for example, (inaudible) is starting to show some evidence, right, in how the data that they have is starting to have an impact on MMR. Still early days, but we're starting to see some sort of hints of proof points.

HILL: My last point to that is so much of healthcare data is unstructured data. How do you use that? Like how do you take the unstructured data and turn it into something that's quantifiable and structurable and that you can point to a kernel of it? It's just it's hard. It's very hard.

GINSBURG: Yeah. I guess that's why it's been slow to make that useful. Let's change topics again. Social determinants of health and equity. And are insurers or large self-insured employers taking concrete steps to address social determinants of health and racial and ethnic disparities and access to care?

GOLDWASSER: So, this is probably the biggest, right? Social determinants of healthcare and health inequity with behavioral health I think those are kind of the two biggest issues that have emerged out of the pandemic. I think interesting there was a question before about some of those primary care models and innovators. We're seeing some of these primary care value-based models that are concentrated, right, around kind of like areas of certain populations where they help, right, kind of like close this gap in care. And health populations that in the past have been marginalized to get the care that they need. We are also starting to see some plans, and again these are more so the startups, that are looking at plan design, right? And different plans that are more focused on ethnic groups because there are different needs. So very early days but we're starting to see more of it. And I think that again when you think about what are the longer-term trends post-pandemic, I think that's a very important one.

GINSBURG: All right. Okay. Medicaid managed care. How are the various state demonstrations that have relied on private plans to serve beneficiaries dually

eligible for Medicare and Medicaid working out? Has anyone been following that?

HILL: I have not followed it as closely as I should. I know it is a very high pressure point because they are your hardest to treat and most expensive and kind of least - that's your hardest to treat, most expensive and least responsive patient population. And like I feel like as long as I've been looking at managed care, the idea of getting to the duals has been a challenge. I kind of like what Ann said on the (inaudible). I don't think anyone has cracked the code yet given the nature of the dual population looks like.

GINSBURG: Yeah.

GOLDWASSER: Yeah, and clearly, it's a large opportunity. What? There are like 12 million duals. Maybe three million are managed opportunities there. But the one thing that we have to remember when we're asking are there proof points? Is what? The MMP program started in 2013, it takes time for these things to keep momentum and then COVID happened. And that kind of like put a stop to everything. And so, I do think that has put us for now in the third year. That has put us at least two to three years behind in really kind of like understanding what's the impact in moving forward. And I think that's true not just for this but for a lot of other demo programs. A lot of other projects that whether it's CMS, CMII, have been kind of like looking at.

GINSBURG: Good. Thank you. Question about PBMs, it seems though, over a bunch of years most of the major PBMs have been acquired by insurers. Any perspectives on how the vertical integration that's been of PBMs and insurers has progressed? Has this turned out to be valuable or not?

HYNES: I can take it. I think it actually depends on the company. Like, for example, CVS was the first one to do it I mean over 10 years ago. And I do believe that they've gained market share because of their vertical integration into the PBM and not the health insurance. Because if you look at Walgreens, you look at CVS, you take out all the COVID noise. Walgreens' scripts are flat-ish where CVS is still growing with single digits. And that to me is evidence of their strategy to acquire payers and move market share and

shift them to the retail setting. So I would say for CVS, definitely yes. I'm less skeptical right now of Cigna and UNH. I mean it's not -- it doesn't hurt them but has it benefited them like they have for CVS? I would argue not as much.

GOLDWASSER: So I would say, CVS has been at it the longest, right? They have kind of like owned Caremark for a very long time. The others this is more recent. But if you really think about where it makes sense? Where it adds value? It adds value and make sense in specialty. Specialty management, right, that is where the cost is on the medical side. And I think that if you think about what kind of like what United talked about in their analyst day, right? They want to be in the PBM side and Optum Rx in the area of where they add value. Not where they act as a claim processor or are transactional. And that's where the tie with the insurance is. And I think that we're actually going to start to see more impact to the bottom line in '23 and '24 because that's when we're going to see the Humira biosimilar introduction. We're going to see a bio equivalent. And all of a sudden these -- because these PBMs just aside from just being a PBM, they have another function, right? They're specialty pharmacies. And I think that probably 12 to 18 months from now is going to be the first time in which you're going to see meaningful impact to operating income to growth rates. And then longer term, it's how well are you integrating really kind of like the managing the medical? In managing the specialty? How do you use big data to do it? How do you use technology, right? It all comes together.

GINSBURG: Yeah. Since only the largest insurers are integrated with PBMs now, what are the implications for the other insurers is this going to in a sense put them at a significant disadvantage? And kind of lead to further consolidation in the insurance market?

HILL: I guess I'd hop in here and I'd say like I think of a PBM -- like most people. I think if you've spoken to most people who aren't on this call and aren't listening, they wouldn't know who their PBM is or what a PBM does. And PBM generally is a business that operates in the back office of healthcare. And I'd say a business that benefits from

uphill station. It's kind of a business that benefits from being in the dark. I think that you're seeing -- you've seen Anthem effectively build its own PBM. Centene has been public about wanting to rework to some degree its PBM partnership. Whether it stays with CVS or whether it picks a new partner. I guess what I've been looking at most recently as it relates to PBM is there are a lot of state legislative initiatives that could have negative regulatory impacts on the PBMs. You're not necessarily seeing anything at the federal level, but there are about 15 to 25 states that want to drive increasing transparency into the PBM space, change the price models, change the reimbursement models. Turn some of the PBMs into fiduciary. So I guess I think that PBM historically is a business that has benefited from scale. And you've seen consolidation into three large PBMs, which have found homes inside of three large insurance companies. And the only way it seems to dislodge that scale or reverse that scale -- and I kind of say this from the perspective of like kind-- whenever normally functioning markets seem to get out of balance a little bit, sometimes, there's a regulatory course correct. And are we seeking it, the beginnings of a regulatory course correct at the state level? So I think it's been a benefit to the MCOs. I think it's been a benefit to the PBM I think there are industries that are concerned that there needs to be a course correction that has to occur at the regulatory level, particularly at the state level. Particularly in talking about those state boards of pharmacy and state pharmacy lobbies, they're trying to push this. I guess while I think there has been a big opportunity and a big benefit to the MCOs. I worry the competitive balance may have gotten a little bit out of whack. And, I'm seeing risk in that market as opposed to seeing tremendous opportunity in that market.

GINSBURG: I see. Thank you. Our time is running out. Let me just get to a question from the audience as we finish up. Given the evidence emerging about interference from outside investors in clinical decision making in primary care and other physician practices or hospitals. Do you appreciate greater regulation effecting the role of management services of organizations or related structures?

HILL: I don't know if I agree with the premise, Paul.

HYNES: Yeah.

GINSBURG: Okay. That should be the take home for the audience. Yeah, I think we're let me wrap this up now because I want to thank you. Because I think each of you have done a magnificent job today in contributing to this discussion. I think it's been really rich. I hope our audience feels that way too. I want to thank Arnold Ventures again for providing support for this event. And thank the audience for staying so long. So I guess we'll end it right now. One minute early.

HILL: Until next year.

GINSBURG: Until next year, yes.

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