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WEBINAR

WALL STREET COMES TO WASHINGTON HEALTH CARE ROUNDTABLE

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Panelists:
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George Hill, Managing Director, Deutsche Bank
Ann Hynes, Managing Director, Mizuho Americas
Jailendra Singh, Managing Director, Truist Securities

GINSBURG: Good afternoon. I'm Paul Ginsburg, and this is the 27th Wall Street Comes to Washington conference. 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 health care companies. Along with a thorough understanding of health care markets and the companies they follow, all of our analysts closely follow public policy because of the implications for publicly traded companies. Before we get started, I'd like to thank Arnold Ventures for supporting this event and recognizing the value of providing a forum for Wall Street perspectives on health care for policymakers.

Our format will be a roundtable discussion based on questions that I have made up and have shared in advance with the panelists. We will have two opportunities for audience Q&A. The first at 2:45 p.m. and the second before we end at 3:30. You can either send questions via email to events@ Brookings.edu or via Twitter at #WallStHealthPolicy. Also, please note that the analysts are not permitted by their employers to answer questions about the outlook for specific companies. A transcript and webcast of the conference will be available through Brookings next. Early next week. We have a great panel today. We have three veterans of previous Wall Street roundtables. Ricky Goldwasser of Morgan Stanley. I need to note that while she's still a managing director at Morgan Stanley, she's no longer with the research department. George Hill of Deutsche Bank and Ann Hynes of Mizuho Americas. And joining us for the first time is Jailendra Singh of Truist Securities.

Let me begin. As the end of the COVID 19 public health emergency nears, the health care industry faces a broad array of challenges, some new and many that predate the pandemic. For example, unexpected rapid inflation has compounded ongoing labor shortages, and many health care systems reported major losses in 2022. What are the biggest factors driving these losses? And let me turn to Ann Hynes to kick us off.

HYNES: Great. Thanks, Paul. So, I would say there are two major factors driving this. One, baseline utilization—meaning utilization trends versus 2019 pre-pandemic levels—are not back to historic levels. And second, it's the nurse staffing issues. And this has been a major issue for hospital systems around the country because during COVID—COVID has really driven an unsustainable supply and demand dynamic and given nursing burnout. During COVID, there was a lot of government funding provided to hospitals, which really helped fuel a rise in temporary labor pay. Just as an example, pre-pandemic a cost for a nurse was around $75 per hour. I mean, this is a temporary nurse versus a permanent nurse, which makes about 35 to $40 an hour below the height of pandemic. That $75 rose to about $250 per hour. And this resulted in a

lot of morale issues at hospitals. And you had longtime nurses resigning and becoming travel nurses. So, for a hospital, you had one and you had a lot of burnout. So you had some retirements and people leave the field. So now more of your staffing, Nurse staffing is made of temporary labor versus pre-pandemic. The cost of that temporary labor is higher. And also base wages have risen 10 to 15%. There are signs that that's stabilizing or slowing. But again, it's definitely been a difficult year and a half for hospitals.

GINSBURG: Oh, thanks, Ann. Any comments or follow ups, too?

HILL: I guess I would just build on what Ann said and I think hit on the labor part. You know, as we cover a lot of the companies in the drug supply chain, wages, interest rates, energy, commodities, supplies [up], and the flip side is reimbursement tends to have kind of fixed levels of reimbursement where a large health system contracts with big managed care plans tend to be renegotiated every 2 to 4 years, let's call it 3 years. So, you're locked into pricing on one end of the business, so you can't push price increases downstream if you're seeing these rises in labor costs today—rising mask costs, gown costs, glove costs. I know Ann talked about utilization being low—mix has not necessarily been great either. So, your more profitable discretionary procedures kind of took a backseat for a couple of years. Higher profitability emergency department procedures, from our perspective, that's the volume we really haven't seen come back yet. Yeah. I mean, I would just build on Ann's comments and say it's kind of been health systems tems…and interest rates, right. Most of these … large not for profit health systems are financed with municipal debt. You know the Fed taking rates from sub one to a number that looks more like five for anybody who's trying to refinance municipal bonds has had the below the line impact of financing costs as well. So I would say from a health system perspective, they've kind of been hit on all sides as it relates to their ability to generate profits.

GINSBURG: And George, something I've picked up from what you're saying, it's not just the higher prices of all types of items and labor, but it's also, you know, the shortages mean that, you know, prices aside, it's going to be less efficient to do your usual delivery of services because of this -- that kind of compounds it.

GOLDWASSER: Paul, I think that to your point and to George's point, this is a really, really important thing to stress, because if we think about utilization, even about supply costs, these are things that we can say are transitional in nature. The nursing shortages, right, we have to ask ourselves the question, is this structural? And this is something that now the industry has to step back and say, how do we do things differently? Because this is really ultimately not changing. And even to George's point around, sort of the mix, right, are E.R. visits. Right, because the pandemic changed something very fundamental that you don't use the ER as much. And what does that mean structurally to a hospital? How does the hospital think about sort of kind of – like allocation, the budgets, the real estate? So, to me, it's really about the sort of the near-term issues, and then there are the long-term structural issues that I think are very, very important for hospitals and hospital boards to think about. And also, as we think about, and I think that that's going to come later in the discussion, sort of what's the role of technology. Right. And are these sort of structural issues going to ultimately lend themselves to just a real sort of push into integrating technology to bringing the efficiencies?

GINSBURG: These are good points. One thing that George mentioned is that these negotiations between hospitals, physician organizations and insurers are not done every year. So that, you know, there's some rates that were negotiated long before this rapid inflation started. So, the question is how contentious do you perceive the upcoming negotiations between payers and providers will be? Will there be many clashes that force patients to change providers either temporarily or over a longer period of time or will, given the broad understanding of what's going on, will these be resolved amicably?

HYNES: I can take that one. I actually think we're going to be paying more through our premiums. I think managed care companies have been very successful in getting 50 to 100 basis point extra pricing from their customers to pass on to providers, and that will be a multiyear process like that that was highlighted.

GINSBURG: In a sense, the providers understand that the managed care companies are going to be passing a lot through because of they've alerted their customers.

HYNES: So, I mean, managed care companies are successfully receiving higher increases from their customers, whether it's large employer groups like large union groups, and they have specific increases within their increase to pass on directly to providers.

GINSBURG: Maybe, one thing that's facilitated that is the fact that with utilization being slow and in a sense there's been less pressure on premiums that there might otherwise have been, has kind of given insurers more scope to deliver to the providers.

HILL: Yeah, I think this is a question, Paul, that I always think it's important to look at regional issues as well. Health care is such a local business where local market strengths, and local market power matter so much. We recently were with a bunch of investors in Philadelphia, which is a locale that's near and dear to my heart. But it's a pretty highly fragmented provider environment with pretty strong concentration from the payer perspective. So, you almost see the provider organizations -- big provider organizations that are at a disadvantage versus Independence. Blue Cross and, Aetna's a big player in the market versus if you were to compare that to western Pennsylvania, you know, a really unique health care market with the battle between Highmark and UPMC-- to compare like the California market with Kaiser with an integrated model so I think I think provider organizations nationally speaking probably feel disadvantaged versus the payers, but I feel like it's very important to call out regional differences as it relates to these relationships.

GINSBURG: Good point. How have the major insurers fared in this environment? Any perspective on what premium increases might look like for next year?

HYNES: I would say that they're successfully passing it on. So, I would assume premium increases of anywhere from 5 to 7%, maybe even 6 to 7%, because you have to include some of those labor cost.

GINSBURG: Thanks. Let me move on to another topic.

HILL: It seems like the payers got lucky kind of coming into 23 with good rate increases ahead of what they had to pass downstream to provider organizations to Ann's point. The managed care companies are getting ready to go into the market right now to price effectively for 24. So, I don't think we know yet. have a great sense yet for what the 24 pricing here will look like, but to Ann's point, they will have great back stream visibility on what costs look like.

GINSBURG: The next question is about implications of the upcoming end to the public health emergency. Curing the public health emergency as a result of waivers, Medicare beneficiaries had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply. Many Medicare telehealth flexibilities have been extended through the end of 2024. Many private insurers also expanded coverage of telehealth services. Similarly, CMS has extended the Medicare Hospital at Home Initiative through the end of 2024. Any insights into the thinking of private payers on their e coverage rules for telehealth after the public health emergency? Jailendra, do you want to start us off on this yet?

SINGH: Thanks, Paul, thanks for the opportunity. So, I would say a lot of depends on what states do on the payment parity laws, which is essentially that telehealth visits are reimbursed at the same level as the in-person visit for the same condition. And a lot of commercial insurers are regulated by states. So, I mean, at this point, almost half of the states in the country have passed some kind of payment parity law. In the other half, commercial plans vary widely regarding what they will cover and the rate at which they will reimburse. I think that's likely to continue a push for more and more states adopting payment parity law and that will drive what's covered by them. Other trends to watch will be like what CMS does with these telehealth waivers beyond 2024 in Medicare, as often private commercial insurance, and of course, George, Ricky and d Ann can comment on that, tend to follow the policies implemented in Medicare. So, I think that's something to watch for, but for now, it looks like we are going to see a lot of payment parity laws being adopted in several states.

GINSBURG: And that's interesting, these payment parity laws, would you say this is the first time that states have ever gotten involved in these issues of how insurers pay providers?

SINGH: There were payment parity laws even before COVID, actually, but not many states had adopted -- more like in the last two to three years, we have seen a big push and more and more states have passed this law. But yes, I mean, that has always been the case because providers have been have been pushing for it, and although, I mean, not every insurance company actually warns providers that and we can talk about that like what's the argument between providers and insurance companies like why they think that payment parity makes or does not make sense. But yes, these have been there for some time, but the increase in number of states adopting these have actually, you know, we have seen in the last couple of years.

GINSBURG: Thank you.

HILL: I would just dovetail on what Jailendra said from the payer perspective. I don't think the managed care plans like the idea of payer parity laws. I don't know that they see the telehealth visit as the same as the in-person visit, and I can't imagine that they want to pay the same either.

SINGH: I was going to say that I think it goes back to point of the way a lot of these reimbursement rates are structured. I think roughly half of the cost is driven by facility cost, right? And insurance companies argue that if a patient is not within the four walls of the clinic, four walls of the hospital, why am I reimbursing that facility cost? So, it should be at least half of the total reimbursement. But the providers will argue that yes, patient is not there, but I'm still there. I have to still take orders, all those administrative burdens. I'm still going through the same process, same steps in terms of meters and logistics. Why should I not be reimbursed at the same level? I mean, we'll see, it maybe settle down somewhere in the middle. But I agree with George's argument that insurance companies probably are saying, look, what's the point of telehealth if it doesn't drive savings for us from reimbursement point of view.

GOLDWASSER: It's a really interesting point, though, right, because when we think about telehealth and I agree that probably a year and a half ago, sort of when we were kind of like moving sort of to a new normal, that was very much how the health plans kind of thought about it. I mean, the question now is, after starting to think about it more from a long-term perspective, we're seeing a lot of plans having sort of kind of like the telehealth first type of programs, because ultimately telehealth might be there's an initial investment in terms of the parity, but ultimately it also means in some ways, sort of closer networks and more control over the patients that over time will lead to savings. So, I think part of it is that there is an acknowledgment that the industry is in transition and things are changing. And I think that some of the health plans, right, are starting to think about things differently than what they have in the past. So, I think we're kind of in a period where to your points, there f understand that they might have to pay more for more utilization on telehealth, but from a 2 to 3-year perspective, there's there will be sort of an increased benefit and ultimately higher savings. It also ties to value-based care, in essence. Because if we think about value-based care, closer interaction, and access to care ultimately is going to drive the savings. It's just going to take some time. And telehealth is such an important tool to get there.

HILL: Well, and to some degree, Paul, what's interesting is I think when you put all these pieces together, it becomes a little bit of a circular argument, right? If you have payment parity on telehealth laws, and if it costs $150 for your telehealth visit and it costs $150 for your primary care visit, as the patient, what you want to do? You probably want to go see your doctor and sit in front of your doctor. So, at one end of the spectrum, we've got telemedicine as a tool to drive down costs through lower cost mix and utilization. But the payment parity rules almost offset that benefit because, you know, some 20% of situations there's probably a situation where a patient would rather see a doctor via telemedicine as opposed to sit in front of a provider at the same cost.
We're going to wind up in this chicken and the egg argument when we think about payment parity.

GINSBURG: One thing from a patient perspective is, I always think about is this the type of visit or a problem where telehealth would really work or might the physician want to examine me and I won't be there. So, if it's going to cost me the same, it becomes much more uncertain. I had a question about, it seemed as though a couple of years ago, we had two very distinct approaches to telehealth. You have these telehealth companies contracting with employers or insurers, which actually would make the service available for free. But that was kind of in another world than patients' regular bricks and mortar primary care providers. Are

these two worlds separate or of the scale of companies been able to do things to foster integration with the rest of a person's provider network?

SINGH: So, you're right. I think, even before COVID, we had employers and insurance companies offering telehealth benefit for their employees, although awareness and utilization was not that high. And the idea for them was urgent care telehealth, where you are connecting with a doctor, not necessarily your doctor. So. when time is of essence and you need some quick health care access those telehealth services work perfect. And I believe there will always be a place for those kinds of services. So even if your primary care doctor can do telehealth visit, it doesn't mean that you can immediately get access to him in like next 30 minutes or 15 minutes. So that's what this urgent care telehealth can offer. But, you know, as Ricky was mentioning earlier, that there are several employers and insurance companies are now coming up with the solutions around virtual primary care…. where you are interacting with the same designated primary care, but more on a virtual basis. So, to answer your question directly, Paul, I think there will be place for all of these kind of solutions because they all offer different kind of services and there's different appeal for those. So, I think there's a placeholder for everything.

GINSBURG: Thank you. To what extent are hospital labor and capacity constraints accelerating the use of hospital care at home? Will this trend be important enough to alleviate some hospital struggles with having an adequate nursing force, or are opportunities for hospital at home to grow limited?

HYNES: I actually think the tight labor is actually accelerating, not to home, but to the outpatient setting because a lot of nurses were burnt out during COVID and they actually prefer to work in an outpatient setting instead of an inpatient setting. And there are some procedures moving. So, like orthopedic is the big one. That was a big structural shift during COVID. Now, probably 80% of orthopedic procedures are done in outpatient versus, I don't know the exact stat pre-COVID, but it was probably only 40%. But I don't know. I'm a huge believer if you have to be in the hospital, you have to be in the hospital. Maybe there's a transition home earlier, but I don't think care actually is transferring. I mean, maybe over time, but I don't see it in the near future.

GOLDWASSER: So, I agree with Ann that maybe not in the near future, because maybe the technology might not be all there, but I tend to think that in the future well have – and again this might not be in the next three years, maybe it's 5 to 10 years. But it's sort of that idea that I mean sometimes, right, the sickest patients are at home. How do you take care of them? You have to think of the hospital as an extension. And so, I do think about that and I wonder and it's kind of like what are hospitals doing now as they think long term and strategically and what type of initiatives do they have to incorporate that? -- if they're doing anything.

HILL: Paul, I might split the difference with an answer and say it's almost like an asset utilization question. If you think about airlines, the whole idea of the airline is you want to keep the plane moving and filled with passengers and turning, turning it as fast as you can. Hospitals -- I mean, the problem is we have way excess capacity with hospitals, so hospitals don't have the luxury of turning beds that fast. But in the ideal world, you'd have somebody in for an acute procedure and get them back in their house as quickly as possible, so that you can get the next person in the bed to do the next procedure to keep spinning the bed so that you can continue generating revenue. I don't know that I want my surgery done in my bedroom, but I'm sure I'd much prefer my convalescence at my house than in a hospital bed.

GINSBURG: Certainly, surgery in outpatient centers, surgery centers is the equivalent of that turning the bed that you don't use the bed at all for something that can be done in another part of your facility. Good, let me turn to provider and plan consolidation. And the question is, despite the evidence that hospital mergers lead to higher prices, or perhaps because of it, health care merger mania is continuing and shifting somewhat from mergers of local competitors to cross market deals with across multiple states and broad geographic regions. And a recent example of the latter is the proposed 40 plus hospital merger between Albuquerque-based Presbyterian Health and Iowa based Unity Point. The federal antitrust officials have signaled greater concerns about mergers and have blocked some recent ones and vertical mergers, you know, those where hospitals acquire physician practices are getting greater scrutiny. Is tougher enforcement having an impact on consolidation?

HILL: Can I just say no? No. I mean, I don't know that it's having an impact on consolidation. And I know we're going to run down this rabbit hole, but I think I know where we're running with Paul. And I'm going to I'm going to channel my inner Ricky, which is to like, I think we need to think a lot about where this is going, whether we're talking about these hospital organization mergers or whether we're talking about what UnitedHealth buys in the provider space or CVS' pending acquisition of Oak Tree Health or Amazon's acquisition of One Medical? It looks like we're slowly moving down the path of a future where care delivery is delivered by companies as opposed to by your local hospital organization or your local doctor group and you will be a United patient or an Amazon patient or an Ascension health care patient if you want to go the nonprofit route. I think s that is the bigger framework that regulators need to think about, which is what does the future of care delivery look like and who owns care delivery, who owns the tools of care delivery? What is the framework by which you want to govern for-profit organizations and not-for-profit organizations that are involved in the care delivery process, such that you have the correct alignment of incentives such that companies make money and patients…

GINSBURG: So, George, you're saying the big thing in consolidation is really the vertical aspect of it -- the movement to vertical organizations that take care of all aspects of people's medical care. And perhaps you're saying that some of the cross-market mergers of hospitals are really initial steps in this direction. Or is that something separate that we should discuss separately?

HILL: I think they are defensive steps in that direction. Hospital consolidation is the way to eliminate regional costs and consolidate scale and negotiate with payer organizations. If you're trying to get more money from payers through consolidation, through increasing your regional scale, you want to reduce your operating costs. But, also you may be worried about is United buying the biggest practice organization inside of your local region such that they're not only your No. 1 one payer but they're also your No. 1 competitor as it relates to providing care. And I think this future map is what both sides are trying to navigate.

GINSBURG: Now let me clarify something. I was under the impression that say when United say when Optum is buying practices that those practices are still contracting with multiple payers as opposed to just United. And I remember being at a conference where it was clear that employers wouldn't want that -- because many people don't want this situation, oh, I changed jobs and I have to change all my providers, not just my insurer.

HILL: Personal story -- I found out I was a UnitedHealth patient member because they bought my local practice, but I'm an Aetna [managed care organization] MCO customer. So, all those pieces have to fit together, and I think the managed care companies are very comfortable in that sandbox of playing together. The big managed care companies also don't want to own big hospitals, but the big hospitals have historically owned primary care practices. So, it's kind of this multilevel chess that's going on where everybody is going to figure out where everybody wants to play.

SINGH: Just one comment. I clearly agree with George. I think vertical integration merger is that's where a lot of people are focused on. I mean we have seen horizontal mergers in the insurance space and provider space getting blocked. I think that those we are going to see less and less, but vertical mergers, for sure. But one example, I'll just say, like when United bought Change Health Care, one of the industry feedback was that, Oh, United can misuse all the data they would have access to from Change Health Care; they can use that data to jack up prices and everything. I mean, my argument, my reaction back was, let's accept it. I mean health care, the data is still not being properly used, I mean forget the misuse We're re not even at the stage where we are properly using the data to effectively reduce cost and improve clinical outcomes. We have to reach that stage and then talk about misuse. So, I just think that I think we are nowhere close to where really a strong case can be made against these vertical mergers and especially when these companies talk about overall improving outcomes and cost reduction.

GOLDWASSER: It's interesting because when you think about vertical integration and clearly everybody's talking about payer agnostic, and that has been the narrative. But we were kind of in a vertically integrated sort of movement for the last four or five years, if not more, at his point. The question is, again, over time, thinking about data, in thinking about interoperability, it's a really, really big task to have all this data

connected. So, is it simpler to have it vertically integrated -- entities that can really share data that ultimately does deliver better outcomes, at least it's kind of like more sort of initial phases before we then have a world where it's all integrated. I kind of think about it in pieces. So that's where I think that payer agnostic clearly is a narrative we're hearing today, but as we think about data, about outcomes, about sharing information, ultimately, is this really sort of the ideal construct?

GINSBURG: Yes, that's interesting. I want go back to the first thing George said in response to that question, that he didn't think that the in stepped up antitrust efforts were going to have much impact. And is that because they're just going to be overwhelmed -- that the limited resources available for the FTC and the Justice Department and some states attorneys general to contest mergers is just going to be overwhelmed by the sheer mass of mergers. Or, of course, in the vertical area, it's really it's a lack of a knowledge base as to what difference vertical mergers make.

HILL: The merger and acquisition game to me feels -- it's almost zero sum, right? It's always done in competitive response, right? The provider organizations merge in response to the increasing strength in the payer organizations. The payer organizations will look for a new tool or a new widget. And I think from the business sense, this is the continued concept of creative disruption. Or these companies will continue to aggregate up to the point until they achieve a diseconomy of scale, or you will have a contra-synergy effect from what almost looks like a health care conglomeration…. Companies love conglomeration because it's places to either hide problems or hide profits or hide issues, where investors don't necessarily like consolidation and conglomeration because of those same things. If we want to make invested bets in a place in the market, we can't do it if a company becomes too big, it has too many assets. So, to me, it to me it always feels like you're getting in the middle of a process that's naturally going to figure itself out. I'd say there are exceptions around monopoly and abuse of power and stuff like that. I'm trying to think of the last time I've seen the FTC step in on a merger process… that really made a ton of sense as opposed to there have been times where they have not stepped in, where I've been that was a case of a missed opportunity to limit market power and to limit market consolidation.

GINSBURG: Actually, I don't have as much confidence as you might have that in a sense we're going to get to the point where mergers aren't pursued because of diseconomies of scale. I think just the excessive pricing will come long before that.

HILL: Probably, but you're seeing, whether or not they are great examples, but like the breakup of Alibaba into six companies, the breakup of GE selling off of health care assets by 3m. It does happen these diseconomies of scale do occur.

GINSBURG: Given the increasing degree of consolidation in many markets, are you perceiving that price regulation is becoming more inevitable? And if so, how far in the future is this?

HYNES: I mean, I don't have a strong opinion either way. I don't. Just on a private side, on private payers, I don't expect it to become more regulated, but someone else might have a different opinion.

HILL: I would tend to go back to Jailendra's commentary earlier on everything kind of flows from the fountain of Medicare. And if Medicare is in the market effectively setting prices and setting the rate for price increases, that becomes the benchmark for everything.

GINSBURG: You know, this might be a good point to take some questions from the audience. The successful incorporation of artificial intelligence into health financing and delivery requires substantial changes in payment approaches. So, in a sense, if there's potential for AI, is the payment system going to get in the way of taking advantage of promising aspects of it?

SINGH: On AI and payment, it remains to be seen. Use of A.I. is still in very early stages, and AI itself is a very loose term because… it can take different forms, different shapes. But I would say that more and more companies are trying to leverage AI in different ways. And, could that impact payment mechanism? Could that impact reimbursement? We'll see how it evolves. But I think it's still, I will probably still characterize that

as an early inning of in terms of having a wider adoption and wider impact, if that's the question the audience is asking.

GOLDWASSER: It seems that AI, at least the early stages that we are, is about improving efficiencies and lowering cost and maybe allowing sort of hospitals to do more with their time due to these savings. So to me, when I think about sort of the questions around reimbursement, I think about CPT codes versus value-based care. And I think that I would probably be very much aligned with value-based care. As we think about efficiency and even with those like reimbursement with CPT codes, to me, I actually don't see any tension there, at least in the near term, in how we think about care and usages because it's really more of an efficiency tool.

SINGH: You know, it's funny, I was at a conference a few days back and one speaker or a moderator made a statement that, hey, our health care system is broken. And then one of the panelists said, well, our healthcare system is not broken; it works perfect for what it is designed for -- it is designed for a fee-for-service model. So, complaining about reimbursement and fee for service and prices goes going higher and the tension between payers and providers, this will continue until we really make this transition to value based care. Providers have to be incentivized based on outcomes, and that's the future. I mean, I still think that this time it's very different… than what we have seen five, ten years back. This value-based care shift is in this situation, it's more a lot more aligned-- like all payers, providers, payvider, we call them, and patients, everyone is aligned for the outcome here. So, I think the future is more transition to value-based care and move away from fee for service – AI will play a role in that for sure. So, I don't see A.I. playing a role in improving the reimbursement inn fee-for-service environment, but I can see AI playing a role in helping the ecosystem transition away from fee for service to value-based care, if that makes sense.

GINSBURG: Thanks. That's really helpful. Now one more question that came in from the audience in advance of the conference on the nursing shortage. Will this be resolved the usual way, meaning, with higher pay leading to higher labor force participation by existing nurses? Or are the training barriers we have now really going to cause this to be a different situation?

HYNES: I think, one, obviously higher pay. Two, the issue is the average age of nurse is 50 to 55 and there was a lot of burn out during the pandemic. A lot of nurses maybe went part time, they left the industry, they left the acute care setting to go to a more pleasant setting that wasn't as intense during COVID. So, one thing that could help that is just the bad economy, like in past economic downturns and periods of high inflation, nurses who maybe went down to two or three shifts went back to full time. Again, that will help on the margin. But I think it's time trying to recruit, educate younger people to become nurses. And it will take time, so I think it's structural and I think it's a combination of both. I think it's a problem that it's not going away in the 2023 or probably 2024.

And it depends on the field, too. In some instances, like behavioral health, I know is our next question, but in some states, the nursing shortage has really hurt the behavioral sector. In some states, states are relaxing the regulations of what nurses actually have to do in a behavioral setting. So, they are trying to help the crisis. But again, I think this will take a while because there was a structural shift in nursing.

GINSBURG: Okay, thanks. Let's move back to the questions you've had in advance on behavioral health. The pandemic has fueled demand for mental health and substance abuse disorder care, with existing shortages growing for inpatient psychiatric capacity and for behavioral health clinicians generally. For example, hospitals are reporting that shortages of inpatient psychiatric beds and other services are forcing them to board mental health patients in emergency departments until they can find placements. So, are payers, including Medicaid, and the delivery system trying to manage these needs? And, with mental health clinicians historically being less likely to accept insurance, are private insurers taking steps to address this? Do you want to start us off then?

HYNES: So, states are allowing, again, the states definitely have to get involved because it is a crisis. So, there's definitely a lot of states that allow telehealth on the physician side, I cover one company who operates a behavioral facility in an unattractive part of the United States. They don't even have a physician live on staff-- everything is telehealth, and that has to be allowed by the states. The nursing crisis is a big issue, so some of these providers are working with the states to allow a little bit more relaxation of who can

admit a patient and what nurse does within the facility. But I would say the biggest barrier to treat the demand is actually the nursing shortage because with telehealth, even though the psychiatrist shortage is real, it's not as bad as the nursing shortage. And that was just really driven by the acute care setting, really trying to recruit nurses out of any setting they could to get nurses in the inpatient to treat the COVID patients. So, that's one, and two, one thing that's really helped expand the access to care for behavioral is just the public health emergency. Because during the public health emergency, states were not allowed to redetermine Medicaid members and Medicaid rolls increased, I think, by 13 million across the country. That really has increased access to care for Medicaid providers, or I should say, people who need those benefits. And, you know, that's at risk going forward because Medicaid redetermination started April 1. But I think a lot of the access issue really has to do with nursing.

GINSBURG: How big a role is telehealth playing in behavioral health care, and will it continue after the public health emergency by making mental health services more private and more convenient for patients? Will the increased demand just overwhelm the supply of clinicians?

SINGH: I agree with Ann that mental health has been one of the areas which has benefited most from consumers' acceptance of telehealth during COVID. And if you look at some data around how telehealth penetration has declined in a lot of various other conditions, in behavioral health, it has remained pretty steady even in a post-COVID environment. In other areas, people are seeing the value of seeing their doctors in person where a physical exam can be administered. But with mental health, a significant majority of the number of visits can convert into a virtual care setting because you don't need a physical examination in most cases to diagnose and treat most of the patients. And one other area in mental health, which has taken a lot of growth opportunity, is the asynchronous telemedicine, where patients and providers are only communicating via text-based chat. And the reason it's important because it allows consumers to take more time in putting together a thoughtful response when they're communicating with the providers through text compared to when you're put on spot and somebody is asking, hey, how do you feel? Sometimes they're not able to really respond in a more synchronous manner. So, I think there's a lot of value in asynchronous telemedicine in behavioral health, and I think that probably is going to continue. And from the provider point of view, to answer the question around the supply demand issue, I think that if they are able to do more visits and reach more patients, if they are managing, patients through this asynchronous telemedicine. So telebehavioral, telepsychiatrist, I think these are the areas which probably even after public health emergency is over, we think the demand for this probably does continue.

GOLDWASSER: We've talked before about utilization--other areas of utilization have decreased and haven't gone back up to pre-pandemic level. Behavioral health is one of these areas and we're just seeing utilization increase. It's sort of behavioral health is a …new pandemic. I think we're really seeing outsized demand that doesn't match with the supply of clinicians. And when we think about behavioral health and how it can be utilized over telehealth, we also have to think about cross state sort of care and companies that are certifying therapists and clinicians that can work across states. And then you have someone sitting in in the West Coast and work East Coast sort of time, and that increases the capacity. And I think that really lends itself to telehealth because of that sort of supply demand mismatch.

GINSBURG: Thank you. Let me go to digital health. The companies are focusing on technologies to strengthen health delivery. Coordination and measuring cost and health outcomes are facing strong headwinds as investors begin to demand profitability. And a lot of investment capital has flowed into digital health companies, particularly focusing on care management for chronic conditions. Do you perceive these initiatives as having a lot of potential to improve care or lower costs? And Jailendra, do you want to speak first on that?

SINGH: it's not surprising. I mean, if you think about almost like 60% of adults in the country have at least one chronic disease. 40% have multiple chronic conditions, and I think data is around 80 to 90% of U.S. health care spending is driven by people with chronic and mental health conditions. So, I mean, clearly these data points are the reason why employers and payers are focused on controlling costs related to these conditions. In fact, people who show up in the ER or people who are in hospital are mostly the guys with these chronic conditions. Most of these events are preventable, if patients had better access to proper care, even those that are not preventable can be better managed with something called remote patient monitoring.

And we have seen that adoption continuing as well among hospitals, among payers and among employers. So, I think the point is that this focus of chronic condition, early intervention, managing through remote patient monitoring, that probably does continue. And I think there's still a lot of demand for these solutions, although we can talk about what employers are demanding is a lot more engagement, a lot more driving awareness among people who are using it and using data more effectively. But I don't think there's going to be any slow down in focus on managing these chronic conditions from employers' point of view, from companies' point of view, because this is where majority of medical costs is being spent today.

HILL: The only point I might tack on to is that I think a lot of these companies now need to sharpen their value proposition. Two or three years ago this might have been going into the pandemic, a lot of these chronic disease state, disease management companies and there's a bunch of things—there's fertility, musculoskeletal, physical therapy, a lot of benefits navigation solutions. When we were at peak labor market, the lowest levels of unemployment, the highest levels of wage inflation, a lot of employer sponsors were looking at tools like this as new things to push in front of beneficiaries, as we used to talk about how good our benefits are, we're going to use these to attract and retain employees. We're going to have a thin sliced benefit solution that is carved out just for you, whereas the labor market is starting to loosen a little bit, things have got a little softer. The value of some of these solutions, I think, has come into question a little bit, which is probably softened their sales cycle, it probably made their funding backers, ask themselves some hard questions about whether or not they want to continue writing out serial C round, D round checks for companies to continue to lose money.

SINGH: One thing which has actually changed in …the last couple of years is that we are seeing a pickup in adoption among providers. If I go and see my doctor, if my doctor, my hospital has some kind of remote patient monitoring arrangement with a diabetes company or a diabetes management company or hypertension management company, they send me home with a cellular-connected blood pressure monitor, I am probably more likely to comply to using those devices. So, I think clearly, we all can agree on this that most of us probably trust our doctors more than our insurance companies and employers for our health care needs. So, any time any change in health care based on digital health adoption is driven by providers, we're going to see a lot more adoption and payer interest. That is slightly different this time, and I would say probably something to watch for.

GINSBURG: Thank you. Let me move on to private equity ownership of physician practices. Has the federal surprise billing law affected private equity investments? Are investors less interested in specialties where surprise billing, such as emergency medicine and anesthesiology, is important? Or are deals on hold pending resolution of some of the lawsuits by provider trade groups on implementation of the No Surprises Act? And will further consolidation of these specialties in local markets have less impact on payment rates given the law that would have otherwise have been the case?

HILL: That one's a little outside of my wheelhouse.

HYNES: I would just assume naturally they would be less interested in some of these specialties because I think the goal before was to buy physician practices, and if they didn't like payment rates, they would go out of network for higher payments. So, I'm assuming there's just less interest. But again, out of my wheelhouse, too, a little bit.

GINSBURG: Sure. Let me go on … reportedly some private equity firms that do staffing of emergency departments are using more mid-level practitioners to cut costs. Critics say the quest to save money results in treatment by clinicians with far less training than a physician, leaving patients vulnerable to misdiagnoses, excessive diagnostic testing and inadequate care. How significant is this trend towards changing the workforce of emergency departments?

HYNES: I honestly have not heard that. I know that these staffing companies who own ER departments, if anything, they're really going back to hospitals because they are struggling because of the No Surprise Act. And what they're trying to do is get more payments from hospitals, which they are receiving, because hospitals need the ER doctors, it's the gateway to a hospital. I think they're trying to get it out of their contracts and trying to look for new vendors, but it's going to take time. And so in the meantime, I really

haven't heard about going to less clinicians, because I'm sure some hospitals won't allow that. But they are going back to the hospitals and they're getting subsidies from hospitals because of everything with what's happening. And they're basically threatening to leave the hospital within two or three months if they don't get the subsidies and the hospitals have to give in. And that's another pressure point hospitals are really facing in 2023.

GINSBURG: I'm really glad you brought that up. And because I remember back when policy was being debated on surprise bills and some economists had this idea that the ideal solution would be that for physicians who practice hospitals, that the hospitals would be paid for their services and they would then that pay the clinicians in a sense, kind of like nurses that hospitals pay the nurses. And I don't know that it was ever politically feasible to do, but I can see, given the payments that hospitals make to staff their emergency rooms, I could see some of the merits in having a much more streamlined system.

HYNES: Yep.

GINSBURG: There appears to be a growing private equity interest at primary care practices, especially for those enrolled in Medicare Advantage and cardiology practices. How important are these shifts and are there other specialties that are likely acquisition targets? Is the prospect of doing well under risk- based payments something that is attracting PE or are PE entities more focused on driving volumes?

HILL: I mean, this is this is this is the big thing, right? This is the big trend. You guys please disagree, if you see the world in different way. This is the true north of the health care services industry right now is that provider organizations have recognized that it's become harder to pull the price lever, given what we discussed earlier in negotiations with managed care and what goes on with Medicare and Medicaid. And if you can't increase prices, your next goal is to increase spread--the difference between your cost basis and how you generate revenue. And the way to do that in health care slash primary care in particular, is risk. So, whether it is any of the big managed care companies that we've mentioned that own risk bearing primary care practices, some of the primary care businesses that have gone public over the last few years, either the traditional route or through the SPAC route, or technology enabled companies which help legacy provider organizations contract and take on risk in the Medicare Advantage space. I'm even starting to see a little bit in the Medicaid space--people who want to do risk in Medicaid, which you know seems to be pretty cutting edge It's not just private equity, it's venture equity, it's public equity, it's entrepreneurial equity. This is the trend that everyone is pursuing right now given that Medicare Advantage is kind of the unit growth engine of the health care space, growing members high single digits percent per year. I mean, if you think about it from an investment perspective, growth generally speaking masks a lot of ills and masks a lot of failure. And if you're operating in an industry that has high single digit unit growth, plus, oh, by the way, it's 2023, Medicare Advantage gave everybody a seven and a half percent or an 8% gross rate increase, so you're looking at 16, 17% market growth. It's like if you're not growing 17% this year--you should grow 17% not losing share. You don't have to gain any market share to grow 17% on a gross basis, not on a net basis, well, lots of puts and takes there. remember were going to get 3.3 next year for 2024 from our rate perspective. And what always happens is everybody is chasing growth, and Medicare Advantage is the engine of growth in health care services, and the sharpest tip of that spear is risk in primary care in MA and everybody's going after it.

SINGH: But one data point, if I can just add to that, is that it's not only, I mean, clearly Medicare Advantage is a growth driver, but even broadly just Medicare. CMS has put this deadline that every single Medicare individual has to be in some kind of value-based care arrangement by 2030. I mean, all providers are you, I know it's 7 years out, but I'm sure the majority of providers still don't understand what value-based care even means. So, they need these payvider companies, these insurance companies, who can help them make that transition to value-based care. So that's why we seeing the interest from private equity guys, because that's where the growth is.

GINSBURG: Yes. So, both of your answers to my last question about [PE] taking risk and reducing volume rather than driving volume in fee for service, if that's where the market is, private equity will learn how to do that. And this won't be a barrier to its participating.

GOLDWASSER: If you think about it, how can you take risk if you don't have data?

HILL: Good point. It's what can stop this cycle from being like the mid-nineties risk bearing cycle for the provider organizations where they didn't have the technology and they didn't have the tools, they didn't have the data. Now a bunch of the practice management companies pull themselves up.

GINSBURG: So, here's a question. Who is going to own the primary care practices of the future? Is this going to be payers, private equity, hospitals? How is that evolving?

SINGH: My view, and George, Ricky and Ann you can add or disagree, I think there'll be a place for all kinds of arrangements. There'll be some doctors who would be comfortable being part of health systems. Some doctors would be comfortable being part of United, Humana. Some doctors might say, you know what, I want to maintain my independence. They would prefer to work with entities like Agilent, Privia. Some doctors might be okay being part of clinic models like Oak Street and GenMed. So, I think it will vary a lot by primary care providers' preference. So, I don't know if there'll be one single winner to call out at this point. … I think there'll be all kind of ownerships down the road. Which particular arrangement will drive better outcomes; that remains to be seen, as some guys argue that ownership model, a clinic model, is the better model from that point of view. But I think at this point it is still too early to say. And all of these guys, I know the market opportunity is so big that all these arrangements have a role to play at this point.

GINSBURG: So, in a sense, your perspective is it's not really clear who's going to be better at running it. Primary care practices and physicians clearly do have their preferences. And unless something happens where, you know, one type of entity is just much, much better at it, meaning that physicians can earn a lot more working for them, then we're going to have this this substantial variation that we have today.

SINGH: Exactly. If you think about a primary care practice, a group which has been in the business for five, ten years, and they just need some help with the data and make this transition to value based care for them, I don't know if a clinic-based model is the right model because they already have that presence they can really leverage, they can take advantage of their market presence so that for them the partnership model makes more sense. But somebody like a doctor, which is in early state of his career, trying to build his practice, trying to make a reputation, trying to learn things, for them joining a skilled operator, becoming an employee, it might make sense. So, I think it will vary a lot depending on primary care providers' preference and see how it rolls.

GOLDWASSER: I think there's a lot of debate--is it going to be sort of large retail or is it going to be large payers? But ultimately, I think that owning these primary care meetings creates stickiness with members and consumers. So, we need to think about the incentives, right, that these large entities have and what their needs are and how much they're willing to invest in it in order to get there. So, I mean, my bias is that large payers are a really, really good fit because they have the data and it is going to provide them a competitive advantage in terms of member stickiness. And we know that the longer that you have a relationship with the member, right, the more profitable that member is. The other part of it is also as we think about that whole interaction is who can offer the best specialty networks because there is increased focus and importance on having that feed and relationship between the primary care physician and the specialty network. I think that that's something that's going to be increasingly important for members and consumers as they choose sort of for primary care. So again, you need scale in order to have that sort of ability and offering and relationships.

GINSBURG: As far as a specialty network, if it's an insurer in primary care practices, at least they have this current information on which specialists are in that insurer's network to focus on.

HILL: I might also just tack on a piece at the end. I'd come back to the regional component. Right, like what metro San Fran or metro L.A. looks like with Kaiser is going to look different than what Metro Boston looks like, which is going to look different from Western Pennsylvania, which is going to look different from Texas. They're going to be different models that have varying degrees of success in different regions.

GINSBURG: Excellent. Let's talk about the insurance industry for a bit. So, the first question is about value-based payments. And, what is the state of value-based payment contracting between private insurers and providers? Is this growing in importance, or are we still in early experimental stages?

HYNES: It is growing. And it's still early, but it's growing, and I think it will actually become much bigger over the next decade because Medicare is starting to focus on value-based payments. And they're not there yet, but by 2025 they want to… introduce some type of framework that Medicare pays on some type of value-based arrangement by 2030. We don't have that framework yet, and I think everyone defines value based differently, but it will continue to become a growing important driver of payment model going forward, especially if CMS leads the way.

GINSBURG: So actually, I was going to ask you about that. Initially, it seemed as though the models used by CMS and private insurers were somewhat different. Do you imagine -- there's already convergence over time and in particular their way of doing say an accountable care organization or a bundled payment approach. Or is are there very distinct ways, and this is going to be a barrier for providers, particularly, of having different players who are using very different approaches to get to value-based care?

HYNES: Well, I think value-based care, everyone defines it differently. So, some, taking risk is a fancy word for value-based care. Some define it as having the patient transfer home earlier. So, it really depends on what the organization defines it as.

HILL: Can we call it the same outcome for less money? It that value-based care?

GINSBURG: Well, that's what it should be.

HILL: Ann alluded to this -- value-based care in commercial is different from value-based care in Medicare are different from value-based care in Medicaid. So, there's going to be a lot of payer influence. From what we see, we don't see a ton of downside risk value-based care in commercial books of business, but we see some downside based, value-based care in Medicare, which is kind of what these capitated risk models look like. And we see performance based, cost plus or performance plus value-based care in Medicaid and commercial. So, it seems to vary by type of book of business.

GINSBURG: Ann, given the comment you made earlier about Medicare's getting into this area in a big way is helpful for private payers. You think the key thing is that if Medicare starts using more downside risk, as well as upside risk, would that be a signal that commercial payers could do that as well and thus have more effective models?

HYNES: Well, I think it's more that if Medicare eventually starts to reimburse on the value type arrangements over the next decade, providers will have to join the ball game, if that makes sense. I cover hospital companies who will say two of their contracts are value-based care; they don't want to take on risk, but I think that will accelerate it, if Medicare does it, the providers will have to join in.

GINSBURG: Efforts by policymakers are escalating to reduce overpayments to Medicare Advantage, responding perhaps to the increasing amount of research and analysis showing that overpayments are larger than previously believed and growing over time. The recently released final risk adjustment….we have a new rule on risk adjustments… I think the key thing is removing many diagnoses that were not shown to be predictive of future expenditures. We have tightening up the quality bonus system, so it's not as easy to earn bonuses…..how significant are these potential policy changes and are Medicare Advantage plans assuming a more challenging payment environment in the near future?

HILL: I would say the changes to the risk model are meaningful, but they're being phased in such that it can be managed. So, it's meaningful but not draconian? It's meaningful, but manageable. So how's that for an answer? I think that and I'll say, Paul, my life is so exciting that I remember sitting here one of those afternoons reading that 200-page report from it was either CBO or HHS or, you know, some three letters that put the report to CMS. You've got an interesting conundrum with MA, right? Because I think when I was reading that it was either the CBO report or it might have been the MedPAC report that was talking about how, right the problem is that Medicare Advantage has not turned out to be cheaper than fee for service, which had been hoped. But the Medicare Advantage benefit is a much more robust and much richer benefit, which is kind of one of the things the administration was trying to solve for, and I if I'm interpreting what I

read, it was basically like the people who are involved in Med Part A and Part B may be are getting a raw deal versus the people who participate in Med C because the people on Med C are basically getting a 4 or 5% richer benefit with a bunch of other bells and whistles with some trade-offs around network design and stuff. I mean, that's a long-winded answer saying, yes, I'm sure CMS is going to increasingly try to clamp down on the cost creep that goes on in MA. But the flip side is that, like the government is spending more for MA, but the beneficiaries are getting a richer benefit--it generates real value. And it seems like the MA people could probably point to better outcomes, too. It almost strikes me as it's becoming an apples and oranges comparison between fee for service and MA.

SINGH: If I can jump in with a little bit more broader level about risk coding. I cover these so-called payvider value-based care companies, and when they talk about making money on their contracts in terms of margin expansion… at least in early years, it's driven by better risk coding. Now, better risk coding is not a bad thing because, I mean, if Agilent, Privia and these payvider companies are doing a better job of engaging with patients, better understanding that, okay, this patient has I mean, on average Medicare patients have like six or seven chronic conditions. So better understanding, okay, this guy has diabetes and hypertension and… issues. If they're able to appropriately code for that patient population and documentation, actually, that is a good approach in long term because even if it's driving higher costs for CMS because they have to pay them, pay these guys more, but ultimately the goal is to drive more engagement, which drives better outcomes down the road and lower the cost in general. So, that's something CMS is actually trying to focus on, like where are the bad actors who are doing more aggressive coding and try to scale down on that versus just saying, hey, the risk coding itself is a bad thing. I think that probably will always be part of the model.

GOLDWASSER: The other question also it's a matter of better outcome but are we also seeing improved efficiencies? And it doesn't seem that the reimbursement the way it is now necessarily incentivize them. I mean, ultimately, it's a matter of resources, right? So, at some point, I think that it's fair to assume that the Medicare Advantage reimbursement will come down. And is this going to be ultimately the catalyst to really drive efficiencies? Because if your Medicare reimbursement comes down, which, today sort of some of these care delivery organizations say, well, you know, if reimbursement is going to come down, then we're going to offer less services. But ultimately, if this is a competitive marketplace and I think it is a competitive marketplace because there are many of them, that means that there is always going to be someone there that will offer additional services. And that's where really sort of like efficiencies, and again, technology and we talked before about digital will really, really matter, and we'll have both providers and payers just a lot more vigilant about implementing them. So, I don't necessarily think that from an industry perspective that low reimbursement rates on Medicare Advantage, and maybe that will be really controversial right into people that are listening to us are not going to like it. But I don't think necessarily it's going to be a bad thing for the system because I think ultimately it will force organizations to be more efficient.

GINSBURG: And that's a good point, because ultimately, I think there's a lot of evidence that managed care is very efficient. It's just because of the payment system not working the way it was supposed to -- basically as a result of coding generating a lot higher payments, this efficient system is just producing besides higher profits, more benefits for beneficiaries, but benefits that government wasn't particularly inclined to be asking taxpayers to take care of. So, I don't know if it's so much about efficiency or a matter of, you know, is there really a compelling reason to broaden the Medicare benefits and are people willing to pay for it? Or is this really a technical problem that is in the process of being fixed? The program is already efficient, and this way the government will achieve some of the savings that, or at least, you know, stop losing so much, stops paying so much more money than for traditional Medicare beneficiaries. I guess our time is getting limited. So let me ask some questions on some more topics. Medicaid managed care-- as many as 14 million people could lose Medicaid coverage as states began begin removing enrollees who no longer qualify but retained benefits during the public health emergency. How successful will efforts be to move people to other sources of coverage, such as employer plans or marketplaces? And how will the net loss of insurance by low-income people impact providers and insurers?

HYNES: That's the million-dollar question. I think that it'll be very different depending on the state. What happens in Texas is not what's going to happen in Massachusetts, because it really depends on the health of your exchanges so that states that did not expand Medicaid under Obamacare just don't have-- like their

exchanges are just not as healthy and robust as competitive as a state like Massachusetts. So, I really think it's state dependent. I think, one, the management companies who offer other services, the commercial, they can now directly reach out via text to these members and that will really help try to qualify them for other types of insurance. So there's going to be a lot of outreach by the managed care companies; there will be a lot of outreach by some states, depending on the state, and they'll also be a lot of outreach by hospitals. So, for example, if someone comes into a hospital right now and they don't have insurance, the hospital helps them apply for Medicaid. And I'm sure that might move to the extreme -- just next, especially since the subsidies will continue through 2025. So, again, I think it's a state-by-state issue. I think every state will have a different story, but I do think that there will be outreach in everyone's part to try to get these people insured somehow.

SINGH: I can add quick comment. I would say that it depends on what kind of timeline you're looking for, right. I mean, will this all be settled down in the next two years - for sure. But I mean, I'm a little bit more, maybe pessimistic or negative; I think there'll be a lot of disruptions. I don't think these Medicaid enrollees are going to be very easy to reach and try to engage them and try to get them signed up for other coverage. I think it's going to be a lot of confusion for next two, three, four, five months – 12, 18 months down the road, I'm sure things will settle down, but it's going to be a lot messier before we start seeing things stabilized. So, I'm little bit more negative on the impact of Medicaid redeterminations.

GINSBURG: Good. Let me ask a few questions on PBMs and drug spending. There's growing scrutiny of PBMs in both Washington and some states related to both rebates on brand name drugs and to generic drug pricing, especially claw backs from pharmacies. Is the industry expecting important policy changes that might lead to shifts in its business model? Or conversely, are there potential changes in their business model that might be pursued to head off the regulation?

HILL: I think the PBMs will be closely watching what goes on at both the federal level, and there's one of the things that we're seeing, is there's myriad state regulations that are going on as it relates to the PBMs with various degrees of sunshine laws, transparency laws. You talk about the pharmacy kickbacks, we call them BIR fees that are trying to limit PBM action in a lot of areas. I am somewhat pessimistic about federal government initiatives to have dramatic impacts on the PBM business model because I think over the last decade or so, the PBMs have done a good job of transitioning sources of earnings away from things like rebates to things like bona fide service fees and other fees that are collected from drug manufacturers. Also, when you we do work with people in Washington, we hear the PBM industry has a very, very powerful ally in the Congressional Budget Office, which is every time the federal government goes to tamper with the PBM business model, CBO kind of shows up and goes you're going to raise costs for beneficiaries, and all of a sudden that becomes politically unpalatable because for whether or not you like PBMs, they're very good and very efficient at what they do, which is create markets for the 88 or 89% of total drug spend that is focused on branded drugs and creating market-based models for competition for branded drug manufacturers, which drive rebates, the vast majority of which fall back to net payers, whether that be the federal government, state Medicaid agencies or commercial payers. I think the risk is around transparency and sunshine regulation, less around the business model. But you know, sunshine could be enough of a risk, sunshine and transparency into the business model could be disruptive enough. But I don't see any I guess I don't foresee any massive change to the PBM business model coming.

GOLDWASSER: I think George and I kind of see eye to eye on this. I also think that the PBMs are going to have a really important role on biosimilars, which we're in the very, very early stage of that transformation in the PBMs and large PBMS at least own specialty pharmacies, right. They will have a critical role there, and I think that that is probably going to help them sort of sustain and sort of maintain the business model that they've had and that the sort of influence that they have on the marketplace.

HYNES: And I would just add that the PBM legislation going through Congress now, I think there is bipartisan support. I do think it could be passed, not this year, I don't think there's a legislative vehicle, but maybe after the election. I think the important thing to note is this market is so competitive with the three big PBMs, a lot of the extra money they made five, six, seven years ago, they're just not over earning like they used to because the market is so competitive now.

GINSBURG: Those are fascinating comments, particularly the way George boiled it down, too -- you have the business practices with rebates, which can change and are changing, but then you have the transparency and you know the transparency, and I think, I'm actually pleased to hear that-- I am a CBO alumnus—and glad that they continue to influence policy with good, good work. But you know, it's long been accepted throughout the world in antitrust circles, that when there are large, buyers and sellers in a market, that transparency can lead, it's much more likely to lead to higher prices than to lower prices. And I guess I think that's what CBO is standing for, so in a sense, a lot of scope which is happening anyway to change some business practices that were bothering people, but if you force transparency, then you in a sense may have killed the goose that PBMs achieve for their clients.

HILL: Yes, that's fair.

GINSBURG: Okay, we just have 2 minutes left. Any final thoughts that you would like to put forward before we sign off?

HILL: I'm trying to think of what 23 is the year of? I'm hoping 2024 looks a lot like 2019. That's what I hope where we are from a health care perspective. I hope we are generally back to utilization running at 99% plus of baseline. I'll say Ricky and I did a panel a couple of months ago where I think we differing on biosimilars. I think I was right in short term. I think she might be right in the long run. I think we're going to need to see the back half of 23, early 24, to see what happens with the balance of the launches on Humira.

SINGH: From the digital health, health care IT, point of view, I'll say that access to free money is no longer there. I think gone are the days where employers are rolling out all these benefits, digital health benefits to their employees on a PMPM basis, and engagement is low and nobody cares. Things are changing, and employers are saying well, if you're not able to drive utilization, why am I even offering this benefit to my employees? So, I think you're going to see more and more a need for skin in the game. I mean, maybe it ties up to the whole shift to value-based care, which is happening in Medicare on the provider side, will in some form or fashion will happen in the employer market as well, I think. So, a digital health benefit may see good adoption, but time for them to deliver on more engagement and bring down the cost. So, we'll see how that evolves the next few years.

GOLDWASSER: And I would say in an optimistic note that this is just sort of the life cycle of things. So, we had sort of very early adoption of technology, where there is a lot of testing. We had the pandemic years where clearly all resources were directed into health care. And now we have a little bit -- I wouldn't say a setback, right? -- but we had a pull forward from demand. So, now employers are looking to spend on other things. But I think that importantly, when we think about the trend line, right from a five-year perspective, I think the trajectory will continue to be an upward trajectory. We're still in very early innings of a lot of really exciting things that are coming into our industry. And the fact that everybody in the industry is so involved in these conversations, I think really is a very, very positive indicator to the changes that's going to come and how informed the stakeholders are.

GINSBURG: Thank you very much. This has been a stimulating session and glad we had a chance to get your final thoughts. Thank you for participating. I want to thank the Brookings staff for its support during this conference and my colleague Alwyn Cassil for what she does, and Arnold Ventures for funding, I think of this very valuable event.