WALL STREET COMES TO WASHINGTON HEALTH CARE ROUNDTABLE

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MR. GINSBURG: Welcome to the 28th Wall Street Comes to Washington Healthcare Roundtable. I'm Paul Ginsburg and I'll moderate the discussion today. The goal of this event is to give the Washington Health Policy community insights into the 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, these analysts closely follow public policy because of the implications for the publicly traded companies.

Before we get started, I want to thank Arnold Ventures for supporting this Brookings Center on Health Policy event and recognizing the value of a forum for Wall Street perspectives on healthcare. Our format will be a roundtable discussion based on questions that I've shared in advance with the analysts. We'll have two opportunities for audience Q and A's. The first, at around 1:15 pm. That's eastern and the second before we end at 02:00 p.m. You can either send questions by email to events@brookings.edu or via x at #WallStHealth Policy. 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 later this week or early next week.

I want to introduce the panelists. We have a terrific panel today, all veterans of previous Wall Street roundtables, Ricky Goldwasser, an independent nalyst, most recently with Morgan Stanley; George Hill of Deutsche Bank; Ann Hynes of Mizuho America; and Jailendra Singh of Truist Securities. We have a lot of ground to cover in a short time, so let's jump into the discussion.

Nearly a year after the end of the COVID public health emergency, the U.S. healthcare system continues to adjust and adapt to changes in the organization, financing, and delivery of care. Hospitals appear to be rebounding financially, with wage and supply cost increases easing somewhat. Volumes are up, especially outpatient care. And construction is booming with lots of outpatient capacity expansion. The outpatient boom appears to include two components, capacity at the hospital for procedures and ambulatory centers off campus. So, I'm going to start the question now.

The first one is what's driving the heavy emphasis on outpatient care expansion? Did the COVID experience strengthen patient preferences for outpatient, or is it reflecting technology advances, or there are some other factors? Okay, who would like to begin on this?

MS. HYNES: I can jump in.

MR. HILL: Go for it, Ann.

MS. HYNES: So, I would say it's a combination of things. First, it really depends on what procedure you're looking at. I would say the one area where COVID really drove an acceleration from inpatient to outpatient is orthopedic. Before the COVID pandemic. I would say now that about 80 percent of all

orthopedic surgeons' procedures are done in outpatient. Before the pandemic, that was probably 30 or 40 percent, and it's probably now at – 80 is a good percent because there's some people that are older who have various comorbidities that will never really shift to the outpatient. But that was the big thing. Also, what's really driving outpatient recently is a lot of outpatients are run by gastroenterology, and there was a recommendation for colonoscopies to be reduced to the age of 45. That's had a huge positive impact, at least for my companies, on outpatient trends.

But in general, it is part technology. And I'm a huge believer that it's really technology that's the big driver of the shift from inpatient to outpatient. And a lot of the things that probably are going to shift have happened. Maybe you have other areas like urology. There's some debate about cardiology, which I'm a little bit more pessimistic about, but I would say, it's all of the above.

MR. GINSBURG: Oh, thanks.

MR. HILL: Paul, I'd probably tackle it a little bit. And first of all, thank you for having me back again this year. And you've known from doing this with me for a few years that I take a kind of a light approach to the answer to these questions. So as it relates to the outpatient orthopedic stuff, I like to quip with part of the winding down of COVID, Grandma has been locked in her house for the last three years. She's ready to go on a cruise. She wants that new hip. She needs that new knee, which has resulted in a surge in the outpatient orthopedic procedures that we've seen, particularly among seniors, particularly impacting the Medicare Advantage books of business, though we've seen utilization spike across all kinds, I'd say across many different books of business. I generally look at it by payer type as well as by procedure type.

But I think one of the things that we look at, and I think one of the debates that's going on right now amongst investors is there's two schools of thought as it relates to the utilization trend. And this relates to both inpatient and outpatient – there's one school of thought that there's this kind of bubble that is working its way through the healthcare system as it relates to utilization. Kind of a short catch-up period. And then the other school of thought is, are we seeing because of COVID have we run the, if you had a normalized trend line of what utilization would look like over a five-to-ten-year period, we saw that trend line severely depressed during COVID. Do we now have a multi-year reversion period where we're trying to get back to that trend line to get back to like what we would expect normalized utilization to run like? We spend a lot of time talking to hospitals and health systems where we did a couple of these calls last week. Everybody continuing to see very, very strong volumes as it relates to procedure volumes. Again, this is both inpatient and outpatient, when we talk to health systems. But like what we just see here is this kind of from our perspective, it looks like there's this multi-year utilization catch up that we seem to kind of be in the middle innings of.

MR. GINSBURG: Go ahead, Ricky. Actually, let me just go back to George. That's so in a sense, given this very cyclical-- not cyclical, but one time really

suppression and then increase, it'll probably be very many years before we could detect whether the overall trend has accelerated or decelerated. Ricky, you were going to say something?

MS. GOLDWASSER: I think one of the things to think about, if we just think about those trends between inpatient and outpatient. I think that the trend is a trend that we've seen before COVID. It might have accelerated post COVID, but really, to me, the question then ultimately in the longer term is what's the role of the inpatient hospital? Right? And what is it ultimately a decade from now. And this is something that I heard heads of hospitals talk about ten years ago. We're not there yet, but ultimately, is this sort of the path that in the hospital is going to be a place where you have the intensive care unit and everything else is outside the four walls of the hospitals for multiple reasons. One is cost, it's just less costly. Convenience, and then sort of the emergence of technology. But I think that we are now finally sort of starting to see that acceleration of that movement.

MR. SINGH: If I can add, Paul, this is Jailendra. Thanks for giving me this opportunity. One thing I want to add is that also it's a function of the quality of care being provided in the outpatient setting. Right? It's a testament to technology, but also the investment hospitals are making and also like different provider groups and. All right. So, I think as patients getting more comfortable that they don't need to be in four walls of hospitals, they are more comfortable getting care in that outpatient setting. So it definitely matters. And also, if you think about hospitals are using outpatient as a way to extend their reach to patients which probably were not accessible. Right? So, I think those two factors are also driving more outpatient care as well.

MS. HYNES: And if I can add one thing, physician preference actually is a big part of what shifts from inpatient to outpatient. So, for example, a big debate is whether you get a cardiology shift inpatient to outpatient, and when you speak to cardiologists and anesthesiologist, that shift’s likely not going to happen or happen anytime soon. One, because the patient's much sicker, especially from the anesthesiologist side, if the patient is overweight, has different comorbidities, have high risk, they want to be right by the emergency room if the patient needs a blood transfusion. So, I really believe a lot of it has to do with the acuity of the patient and how sick they are.

MR. GINSBURG: Thanks. So, any sense about the implications of this construction boom for spending?

MR. HILL: I mean, I think one has to assume that if the provider organizations are making the investment and putting the capital to work around the construction boom, they must expect the volume to continue to increase. They, like us, are not immune from making bad investments which may or may not come to fruition. So we'll see what happens as it relates to volumes. I think we, I don't want to speak for the rest of the group here, but I think we feel pretty comfortable that outpatient volumes and ambulatory volumes will likely continue to see increased

utilization, both just as medical trend continues and as case-mix shift continues to occur. But I think an interesting thing as it relates to hospitals building and their capital expansion cycle is to what degree does that let them have some pricing power as well around technology utilization? Kind of getting to the point that Jailendra made.

MR. GINSBURG: Thanks. Let me talk about insurer-provider standoffs. Becker's Hospital Review recently reported that 21 standoffs—that's Becker's term—in the third quarter of 2023, a 90 percent increase from the year earlier quarter, year ago quarter. It doesn't surprise me that these standoffs are way up since we've been through a period where hospitals experienced higher inflation than was expected at the time their last contract with insurers was signed. And there's a new factor today, price transparency. Insurers have long had ways of gauging what their competitors were paying hospitals through coordination of benefits. But access to machine readable data on allowed charges provides new information for some hospitals.

What is your sense of the reasons for the increasing degree of standoffs? I used to call them showdowns at the Center for Studying Health System Change. Is this likely to continue or will a new equilibrium be reached soon, and the standoffs decline?

MS. HYNES: I can start. I think there will always be some type of standoffs between managed care and hospitals. I would say from the labor cost, hospitals are successful at getting price increases for the increased labor. They might not get all the price increases year one, it might be a multi-year benefit for them. I think the standoffs really come from hospitals expanding into tertiary markets to get higher managed care pricing. For example, I live in Boston and something Mass General has done is they brought up a lot of little hospitals in the towns surrounding Boston. And once that's in the Mass General network, pricing and reimbursement can go up 10 or 20 percent. And I think that's where managed care has a lot of the issues more than anything. And it may be it decreases because maybe a lot of that consolidation is behind us. But that's, I would say that's probably been the biggest trend over the past three to four years of hospital consolidation.

MS. GOLDWASSER: I think what's interesting, I mean it also depends on the market, right? So, if we look, for example at the New York market, super competitive market, and we saw earlier this year sort of the standoff between Mount Sinai and United, I think that was really, really interesting, right? Because sort of the reason it started goes, Paul, I think you kind talked about in the question is sort of the increased transparency. And in the past, I think increased transparency could have come from mergers because when there's a merger, you can see what pricing is and now it's coming from sort of the regulatory side.

But ultimately, what was interesting here that this was resolved in Mount Sinai and I talked about it as sort of a victory for them, right. They were able to get in their case of those price increases they were asking from United. So, I think what's interesting here is also as we think about sort of that power play, right? Who

has the power here? Is it a hospital or is it the payer? And it's really market dependent and it's also dependent on the patient mixes, right? Because if you think about New York and what we saw here, there's a lot of large employers and commercial in I think from a United side, right. it wouldn't have looked really good if patients now have to, employees have to change their providers because that could mean loss of contracts twelve to 18 months out.

So, I think it really depends on market by market. But it's also testing grounds, right. Because we've seen, and I know we talk about later about sort of vertical integration and these sort of kind of like entities that could be sort of standalone entities. So is this also a testing ground to see? Can we really not include a hospital, or can we not include a payer and still be able to deliver sort of that standalone business model? So, which is sort of kind of like Kaiser-like. So, I think that it's going to take and I don't think that this is sort of one and done. I think it's we're going to see more of these in the future.

MR. GINSBURG: Okay, thanks. You know, the Becker's report also indicated that over a longer period of time, a majority of these disputes have concerned Medicare Advantage. And researchers have shown over a number of years that hospital and physician payment rates and Medicare Advantage are very close to rates in traditional Medicare. So what are these disputes about? And I think Jailendra should start.

MR. SINGH: I mean, of course, we have managed care experts here. They can share more details there. But from our experience point of view, given we do cover some revenue cycle management companies, mostly it's always about rates. I mean, hospitals have been ending contracts with MA plans due to payment disputes. I mean, some of these have happened as hospital claims that MA plans don't reimburse at the same level as Medicare, and that can delay or deny care through prior authorization and impose other limitations.

So, I think it's mostly about rate differences and opinions there. And I know we are going to cover telehealth later in the discussion, but I'll give you this example, given that's one of the focus areas -- payers and providers are not on same page when it comes to telehealth reimbursement. I mean, it's one example, like, where payers still believe it should be way cheaper than when you provide care in four walls of clinic. They keep saying we are spending same amount of time and resources. We should be paid very close to the level. So, one example. But that's what we are seeing right now in terms of where we see these kind of standoffs.

MR. HILL: Paul, if I could just tack on at the end there first. I don't think Ricky's point about regional strength and regional market power can be understated. And Ricky talked about New York and Mount Sinai. Ann and I are up in Boston, so we understand the Boston market very well. I'm originally from Philadelphia, hyper competitive market from a hospital perspective. But independence Blue Cross has like 70 percent of the market. So, one payer kind of dominates the market. Right. California's got it's, you know, California's got five different flavors of what regional

healthcare markets look like depending upon what city you're in. So one of my favorite markets to always look at has been western Pennsylvania, where Highmark had 80 percent of the lives from a coverage perspective. UPMC had 80 percent of the patients from a volume perspective. And like Highmark's answer was to go buy a health system. UPMC's answer was to start a health plan because the two couldn't figure out how to get along.

I think, like, maybe to look forward a little bit. I think these conflicts that you're talking about are going to increase, and I think you're going to see more large provider organizations threaten to opt out of networks, particularly as it relates to MA. I'm trying to remember. Maybe one of you guys can help me out. Is it John Muir in California that opted out of MA? Like one of the big, one of the big health systems out west recently opted out? I think it was John Muir. Right? Prior auths are the problem. Claims denials are a huge problem. Just kind of barriers and access to care in all varieties are the problem. Delayed payments rates are the problem.

And again, I talked about on the calls that we do with provider organizations. Nobody that we've spoken to is like, nobody's there yet, but they're also talking about, like, I wouldn't think about it as all or not. There's like a lot of intermediate steps. Maybe there's a flagship hospital that can't be used by an MA patient. Maybe there's some type of clinic or some type of service that can't be used by an MA patient. Maybe there's some type of steer, other type of steerage that goes on, some type of procedural step edit that happens. But I actually, I think given the pressure that the Medicare Advantage plans feel like they were under in 2023-- are going to be under in 2024. Expect to be under in 2025. Given the rate notice. I don't think this is a problem that goes, this is a problem that gets worse before it gets better as it relates to beneficiaries having access, the conflict between provider organizations and the payers. It gets worse before it gets better.

MR. GINSBURG: Thanks. As an economist, the perspective I have on these standoffs is that when power balances change and everybody's aware of it, well, then they can make a deal, but they're not always aware of it. And sometimes that's why in this transition period, you have these showdowns until each party can figure out, well, who really does have more power and have our reimbursement agreements reflect that. Good. I've got some questions about cross-market mergers. Are we going to see more cross-market mergers? And will this be dominated by large systems in different parts of the country merging with each other, or large systems acquiring independent hospitals in adjacent markets? And just another part of the question, is there a rush to merge before the Federal Trade Commission develops its policies in this area?

MS. HYNES: I can take that. I would say potentially on your last question. Yes. Even though the current Washington environment is not great for any type of approval. So, I think that's, I'm not sure about that. But when you think of cross-market mergers, it would really be -- I don't foresee like a not-for-profit system going into another state trying to find, buy another not-for-profit system, maybe a large corporation like HCA buying a large not-for-profit system. But those, those

deals are very rare. I mean, I've been covering the sector 25 years and I've seen that four times. So, it really depends. I think healthcare is local, so you mostly see local deals, and I expect that to continue.

MR. GINSBURG: Thanks. On horizontal mergers in the same market, do you see FTC scrutiny restraining that trend?

MS. HYNES: Well, I think we see FTC scrutiny now because I think the FTC has figured out what hospitals are trying to do. Buy smaller hospitals, expand, get them, get those hospitals into the managed care network. So there has been multiple studies on what that's done to pricing and the healthcare costs in local markets. But again, I think it's going to continue. You see it every day now. Like, for instance, I cover Tenet and they've been able to sell hospitals at great valuations. And the companies buying the hospitals are major not for profits in their areas that are probably going to immediately increase the reimbursement for those hospitals. So even though Tenet's got a huge valuation for the acquirer, it probably makes sense because they're going to get better pricing. So, I expect that to continue.

MR. GINSBURG: Thanks.

MS. GOLDWASSER: I guess one thing to look at as we think about sort of the FTC is the size of transactions because the FTC has been looking to now change sort of the thresholds of transactions. So, I think now they're looking at thresholds that are beyond $100 million. So, if that sort of goes through, that means that we could see sort of increase of scrutiny of deals that are smaller, that tend to be in the regional markets. So just something to watch for.

MR. GINSBURG: Thanks. Some questions on care innovation. What has been the experience with hospital at home programs? Provide us some more context. Medicare has a hospital at home waiver that runs through 2024, and it's 300 participating hospitals, and there's been a lot of advocacy to extend it. So, what is driving this trend? Is it hospital capacity problems, clinician shortages, or patient preferences? Jailendra, do you want to start on that?

MR. SINGH: I can start on that. I mean, I think the drivers you mentioned, capacity problems, clinical shortage, patient preference, I think all of them, I mean, it's probably not one specific item. It's probably all those items are driving the growth there. And as you kind of flag like, these are the programs where provide patients kind of ability to receive more acute care in the comfort of their home as opposed to going to a hospital. There have been some companies we track more in the private world, like Dispatch Health, which has been talking about doing partnership with health system to participate in these type of programs. And the idea is that you're seeing kind of better reimbursement for the vendor as they're doing more high-acuity work. And from the health system perspective, it's a way of their kind of, as I was saying earlier, the way of expanding their reach just to get more patients in their reach, which probably won't show up at the hospital settings. So, I think this is likely to continue. And there are several, kind of like a better word, like

it's an innovative approach to expand the reach and provide better care and patient health.

MR. GINSBURG: Good. Thank you. Let me move on to insurance trends. Recent research indicates that Medicare Advantage overpayments are even larger than previously believed. And it's often based on aggressive coding, selection of lower spending enrollees, and a quality bonus system where almost all are above average, as they say. MedPAC says that MA plans will get $88 billion more this year than if their enrollees had remained in traditional Medicare coverage. So, the question -- is the risk that Congress and or CMS will take more aggressive steps to reduce overpayment, slowing insurer entry into the segments? Or is the segment still so profitable that substantial entry is continuing or even accelerating?

MR. HILL: I'm happy to kick that one off. I don't know, as I look at the stats on the plan, stats and stuff like that, I don't know that we continue to see a ton of new entrants. And I think what you would see from a lot of the plans, again, end of ‘23 into ‘24, looking into ‘25, we're getting at what looks like a net rate reduction for the plans on 2025, x the risk adjustment. We actually just published some interesting work on this recently where we might contest some of the data. I don't know if I can contest the overpayments, but the idea that the aggressive risk coding, one of the things you've seen, as you would expect to see is you see the average risk score per Medicare beneficiary increase as the number of dual eligibles that participate in Medicare Advantage has increased over the last six or seven years. Paul, Medicare Advantage and Medicare Part D are like as a product, it's a very complex product to sell if you think of it as like something that a company sells to an individual.

So I would look at both the risk scores and I would look at the penetration of dual eligibles who are much sicker, who are much more expensive per beneficiary to care for. I would also look at the benefit design and the benefit structure of people that are in MA versus Legacy A plus B plus N plus D, where they're getting a much more robust benefit that does cost more money. But one of the stats that I saw recently was that on a like for like basis, the Medicare Advantage plans are delivering the A plus B benefit for 83 percent of what Medicare fee for service delivers it for. And basically the spread between the Medicare Advantage spend per beneficiary versus the legacy Medicare spend per beneficiary is all these other supplemental benefits that the Medicare Advantage beneficiary receives that don't necessarily exist in the standalone program. So I think the government's getting great, like, I think they're getting great value for their dollar. I think kind of the question that you're getting at here is do we want to reevaluate what the government is paying for when it's.

MR. GINSBURG: That's right. In a sense, I say the beneficiaries are doing very well because they're getting extra benefits. It's just that’s as much of that because the government's paying the plans too much and the plans use some of that for their profits, but a lot of it for beneficiary enhancements.

You had mentioned the increasing enrollment by dual eligibles and Medicare Advantage. Now that's a risk thing that I think has long been adequately accounted for. That's a risk adjuster. Is this person dual eligible or not? And I think what the controversy is about is really the use of the diagnostic information.

MR. HILL: Right. Well, I guess one of the big pieces of pushback that we've seen there, and I know that MedPAC and CMS has pushed back on this, is you'll see a lot of the diagnostic coding that goes into these beneficiaries that then doesn't show up as treatment. And I think that's a big part of that, is the move. Like a lot of that's the changes to the V-28 risk model where they basically pulled back on 2200 diagnostic codes that were used to diagnose patients. And basically CMS said, look, for these 2200 codes, there isn't a correlation between the diagnostic code and the care delivery or what patients are treated for the cost of care. So, to your point, I think CMS recognizes that and is working on that now. And I guess like if I'm looking forward, like we've had conversations and we've heard conversations with CMS where CMS is cognizant of the idea that as Medicare Advantage becomes greater than 50 percent of the beneficiaries, CMS transitions from an organization that is in the care delivery business to an organization that is in the contract management business and the vendor management business. And we would expect going forward that they get better at vendor management and contract management.

MS. GOLDWASSER: I think that one thing to add here, because George talked about V-28 and I think that this is one of the most important thing as we think about the dynamics and impact of the Medicare Advantage market. I would argue you heard different views. Some are saying CMS is really kind of like it's destroying the industry. On the other hand, I think what they showed us is real sophistication and understanding what the payment system are. So, I think what they're doing with V 28, they're actually saying they're shifting the spend. We're going to move transition from coding to actually thinking how do we deliver care in a more truly value based. Right? Because value based is not coding, which is what we've seen in the last five to ten years.

Value based is about sort of managing the health, managing sort of the cost. And I think that now through this kind of like maybe V28, there is now finally an economic incentive for industry participants to start behaving in this way that sort of aligned with the goals. But I do think that we're going to see, I mean, this is kind of like year one, this is a three-year process. I think that we could continue to see players exiting the market or forced to exit the market, both in the provider and in the payer side until we get to some more stability. As far as the benefits go, and this is going to be really interesting, right, because we just saw the rate announcement, it came in same as the proposed, right. So lower than what the industry expected. This should mean that in 2025 the services that are offered, all these wraparounds to the beneficiary are probably going to come under pressure. So how does that impact sort of the entire ecosystem in some of the companies? Jailendra, you kind of like spoke about before.

MR. SINGH: Ricky mentioned the final rule. Just want to flag one thing that I thought there was very interesting back and forth from some of the industry participants and CMS in the rule was that how everybody was complaining that if you look at recent trends, utilization has been running much higher than expectations. So clearly the rate should reflect that. But CMS responded saying that that's true. But what we expected the utilization for 2023 in back pre COVID, we're still seeing the trends below that level. So, I think that was very interesting argument, like how they're comparing with their projections three years back, not kind of, not kind of overemphasizing what we're seeing in the past six to nine months. That was kind of interesting feedback there.

MR. GINSBURG: These are all really good points. I'm glad I asked that question. Let me move on to a Medicaid question -- how has the impact of the Medicaid unwinding been playing out? Have most of those losing Medicaid coverage obtained private insurance either through employment or through marketplace exchanges? And how daunting has it been to figure out or implement adjustments in Medicaid capitation rates on the basis of the pattern of types of people losing their Medicaid coverage?

MS. HYNES: I can start with that. I would say more Medicaid beneficiaries lost their coverage than expected. And I think I read a stat with Kaiser this week and that 80 percent was likely due to administration reasons. So, as you continue, as the months go on, I expect that number to actually be reduced. But people are getting health insurance, exchange growth is very strong this year. So, a lot of them are getting through their exchanges. I would also wouldn't be surprised as the major companies report earnings, you see an uptick in just regular commercial growth because I'm sure in some instances it was much more economic for a person to get insurance through an exchange rather they were, especially if they worked for a small employer, their employer based insurance. So, we haven't seen a huge uptick in the uninsured. So, I think it is settling out.

And for your question about reimbursement rates, that's still playing out, I think companies will say most states have been giving some acuity adjustments and we're still going through that process. So, I think we'll have full clarity by August how that plays out. So, it's still not the final, we still don't know the final game, but I think if you asked any Medicaid managed player, it's probably going better than expected.

MR. HILL: Paul, I would probably just piggyback on Ann's comments cause I was down at the AHIP conference in Baltimore a couple weeks ago where we got kind of a lot of color on this from the companies that provide services as well as the state agencies down there. And, again, like just dovetailing with Ann's comments, the redeterminations have been largely administrative. What I think is interesting about that comment is that when you peel back the onion on that comment a little bit, like, what does that mean? Right?

Like people get mailed these forms and they get sent like a packet of stuff in the mail that says that you need to, you know, you're getting redetermined for Medicaid. You need to provide proof of address, provide proof of income, probably have to re-provide proof of citizenship. And it was interesting to hear the state administrators and the state people talk about like, nobody opens their mail anymore, like the quote was, mail's dead. So, like, it's interesting that you have this process where you can't get the engagement of the beneficiary because people aren't opening their mail if they have an address. People aren't answering phone calls from people they don't know. So, if the state Medicaid agency is calling you, what does that mean? And it's typically, what we've seen is you've definitely seen your younger, healthier people get redetermined out, so they're off, because your older, sicker people are going to pay much closer attention to their healthcare. This kind of dovetails on Ann's points where, so the acuity mix for the Medicaid managed care organizations is increased. The acuity adjustments are coming through. But again, our conversations let us believe that the prospects are probably lagging by six to eight months. So you'll continue to see the managed Medicaid plans get acuity adjustments in the back half of this year and through the first half of '25.

And like, what I thought is just interesting is Medicaid, like, is a unique population. Everybody seems to be struggling for what is the right way to engage with these beneficiaries, to keep them engaged as it relates to redeterminations. People don't want to respond to mail. People aren't answering phone calls from numbers they don't understand. They may or may not be reading text messages. I sat through a whole presentation on what is a signature and what counts as a signature in Medicaid as you're trying to redetermine people. I thought the color commentary in those meetings was actually more interesting and more instructive. Like, the color commentary is more substantive than just the, like, people telling us that. What are the numbers on redetermination? Kind of the process, I thought was really the interesting part.

MR. GINSBURG: It just shows the challenges in so many administrative things in this country. When you think of many countries abroad have auto enrollments in their insurance plan, and there's a lot of interest among policy wonks that are both conservative and liberal here, but the administrative challenges of doing it in this country are just amazing.

MR. SINGH: And if I can add one point. Oh, go ahead.

MR. HILL: The one point I want to add to that, Paul, is like, you also can't underestimate the politics of this. And again, talking to the state administrators, because Medicaid, you're typically dealing with a poorer population. You've got a lot of behavioral health issues. And one state Medicaid administrator recalled a story for me where he was dealing with the local sheriff and he basically looked at the guy and was like, dude, you can't arrest your way out of the mental health crisis. Like, it doesn't work like that. But like, again, like, kind of like. Again, like these touching, practical stories about, like, what we're dealing with there. But such a -- I'm sorry, Jailendra, I didn't mean to pop a little bit.

MR. GINSBURG: No, no, thanks.

MR. SINGH: No, no. I was just going to add the point that we talk about, okay, we might have good color on how enrollment is shaking out, but for the acuity point of view, I mean, some companies talk about they haven't seen any concerns. They all have seen concerns which probably are taken care by state. I still think it's too early. I mean, the way this Medicaid population, lack of engagement, they're not using the healthcare system as probably Medicare population is. You just cannot come to conclusion at this point that we have good color on how acuity is shaking out. So, I think it's still early. This process could easily take six to nine months. I mean, before we have good clarity, like how actual Medicaid acuity looks like.

MR. GINSBURG: No, thank you. Got a question on employer sponsored insurance coverage, recalling how take up of Sovaldi and other hepatitis C treatments impacted spending trends. The GLP-1 weight loss drugs appear to have the potential to have a much larger and longer lasting impact. Unlike Hep C treatments, which cure the disease in a matter of months, weight loss from GLP drugs requires continued use. So how are employers responding to this situation? And is enough known to determine how employer type influences the response?

MR. HILL: Did you say they're freaking out? Can that be an appropriate answer. This stuff's really expensive and they're freaking out because, remember, GLP-1 is also for diabetes. I don't know if you saw the stats. There was an article, academic article that floated last weekend. The GLP-1s also slowing the progression in Parkinson's disease to which, as you can imagine, there's a healthcare team at Deutsche bank where we have a round robin email where I'm like, well, if it works in Alzheimer's, then the whole country's going broke because that'll be it. Seems like the GLP-1s are fixing everything. They make everything better. But I think -- we spend a lot of time talking to benefits consultants. Everybody is struggling with what is the appropriate way to cover GLP-1s. How do you deal with the GLP-1 cost explosion? We know that some of the PBMs have tried to come up with GLP-1 cost programs and management programs. I mean, it seems like where like self-insured employer sponsors kind of want to cover it around a retention issue. At-risk plans are much more tentative about covering it. The data that we hear from insurance plans is like 40 percent to 45 percent of plan sponsors are covering it. And what's interesting is the 40 percent to 45 percent that covered it in 2023 won't be the same 40 percent to 45 percent that covered it in 2024. And the group in 2025 will be a little bit different as everybody's having their own cost experience and their own outcomes experience with GLP-1s. And then we're going to have the debate around to what degree should Medicare cover it, given that Medicare doesn't cover weight loss drugs -- freaking out.

MS. HYNES: I'll also add in 2024 and 2025 I don't see a significant expense expansion and employer-based coverage. But over time you have more sophisticated buyers of healthcare insurance. Probably the larger companies who I've spoken to, they're willing to do almost like a test group for employees like, for example, older corporations like autos or electric companies, they tend to have

people who work with them. Ten to 20 years, people like Facebook might have -- so why guess you have to look at your employee turnover or your employee longevity? Because I would say employers who tend to have an employee who stays at the company longer term, I think they're more willing to do like a carve out and a test to see if that group of employees, over time, the cost to treat them from a healthcare benefit is less than the, than the other group. And maybe you could do expansion that way. But again, I think it's not one solution for each employer. I think the size matters, the cost matters, your population matters. So, it will vary and price is the big one, obviously.

MS. GOLDWASSER: And it's interesting. Right. So to Ann's point, there are so many variables and seems that it requires sort of a multi-factored approach. Right. On the one hand, the PBMs are very familiar with Step therapy, but step therapy here looks different. It's really not necessarily the impact of the drug but the population and the population need. How do you craft step therapy around that? And what component and how do you manage weight? That's sort of what's behavioral versus therapeutic. So, I think that we're going to see a more involved role. I also think that it's going to be really interesting to, to see, because this is, I mean in the past we've seen sort of HCV drugs and we've seen all these different drugs, but the populations that were the addressable populations, it's so much smaller and now we're seeing it just across broad populations. But I think it's also going to be really interesting to see what the ultimate way to manage it will be and what it means to other drugs that are coming down the pipeline and even sort of kind of like gene therapy. Right. I mean, we're starting to hear sort of -- even employers, right, the more sophisticated employers talking about it.

MR. SINGH: Few points if I can share. I would say like, I think probably a distinction worth making is that covering GLP-1 drugs versus responding to a trend where employees are a lot more aware about weight loss and the more on weight loss, I think a lot of employees are responding to that and think, okay, we need to have more weight loss programs in place. We need to at least, at least respond to that trend. We are seeing among employee base. And as George and Ricky and pointed out, I mean, we are seeing employers putting gatekeepers for GLP-1 prescription step therapy. As Ricky mentioned, we are seeing that. We're seeing employers partnering with vendors to act as gatekeepers as a way to curtail costs. Several weight management offerings.

We actually did survey and we saw guys like Varta Wonder and those companies seeing some good traction where they at least putting guardrails to put in place. Like not everybody is trying to get those GLP-1, try something out. And even, even when you put people on GLP-1 drug, there are certain other lifestyle changes you got to make to have full impact from GLP-1. There's one data point one employer pointed out to us was that more than half of the employees who went on GLP-1 drug did not even complete the program. I mean, they just opted out pretty quickly. So, in that case, actually the result could be not what you desire. So I think that we'll see how that evolves. I still think last year was probably too quick,

too short notice kind of for employers, because these guys, these employers have very long benefit season, selling season, and GLP-1 really started picking up the noise and update around that in mid of last year. I think we'll see, I mean, how it plays out this year. They said probably they had more time to prepare for it, but I think that's something all employees are really focused on.

MR. HILL: Maybe just one last comment. Paul, too. This seems to be a disease category and a drug category where plan sponsors are asking for like an unprecedented level of beneficiary engagement, whether it's prior auths, BMI tests, you know, in year, kind of prior auth renewals, almost like patient pledges around adherence to the drugs. I feel like we're kind of ushering to some degree it's a new era of patient responsibility. It's like, hey, if you want to be on this drug that costs 15 grand a year, you're going to have to make promises to us and assurances to us and be participatory in kind of the lifestyle and the therapy programs in addition to just filling the script at the store.

MR. GINSBURG: Oh, good. Well, we had a really good discussion of this question. It's time to go to questions from the audience. I'm just going to get them up on my screen. Okay. Actually, we just had a question about what will be the impact of GLP drugs on healthcare spending and insurance premiums. So any, after you all explains how this is very much evolving. It'll take a long time to evolve. Do you think this is going to have a noticeable impact on spending and insurance premiums, the rolling out of these drugs?

MR. HILL: Yes. Yes. However, one of the funny things about this, and Ricky made this point was, I feel like it's rare that anyone ever gets to say this, but could this be a case of PBMs to the rescue? Like, is it going to be PBMs that save us from, like, the rapidly rising? Like, the only people in a position to blunt the impact of the high cost of GLP-1 drugs are probably the PBMs. And it's rare that anyone ever says, thank God Caremark was there. Thank God that ESI was there when the GLP-1 thing happened. But, we might wind up saying, and I mean, like, to your point, looking back, Paul, on the HCV drugs, like again, if not for the PBMs, right. I mean, those drugs are basically free now, as opposed to drugs that came to market at a $90,000 list price for script.

MR. GINSBURG: That's right. That's a really good point. Going to another question, given the surge in outpatient capacity expansion, how do you foresee these trends affecting healthcare spending in the long term? Actually, we may have covered that, particularly in terms of cost containment efforts and access to care for underserved populations. Additionally, what measures can be implemented to ensure that the benefits of outpatient expansion are equitably distributed across communities? And how can healthcare organizations leverage technology and innovative care delivery models to enhance sustainability while addressing disparities in access to care? That's a lot of questions.

MR. HILL: Jailendra, you can take that one. I'll come back in an hour.

MR. GINSBURG: You can take a piece of them if you find something.

MR. SINGH: I often, I mean, I'll just start, I mean, again, this is probably more into George and Ricky or Ann. I would say, look, I sometimes feel like people focus too much on if there's a certain shift happening or innovation happening, how much it saves on medical costs, how much it brings down medical costs, and that's a very, I think it's very short-sighted approach.

It's sometimes okay to invest more in medical cost or spending if it drives better outcomes down the road longer term. So just because, like, a lot of employers talk about, like, hey, I mean, same thing, payers, like, hey, we invested all these things, but we are not seeing my medical cost trend and go down. It's not something, it's not a kind of a sprint. It's a marathon. Right. So, I think that focus on shift of outpatient care from inpatient, how will it drive down medical spending ultimately? I mean, think about the ER or wait time in hospitals or capacity concerns, physician burnout. There are a lot of issues going on. We got to address those first. If that means that we shift dollars in the short term before we see long term outcome, positive outcome, I don't know if I'll say that we're going to see some dramatic shift or drop in healthcare spending in the near term, but longer term, you know, that's definitely, if we are successful, we should see some decline.

MR. GINSBURG: Thank you. I'm going to go back to the questions that we've shared in advance with the analysts, and at the end of our meeting, towards 2:00 p.m. we'll go to the audience again. And I'd like to start with having talked so much about GLP. Are there other new drugs or technologies that are both very expensive and potentially high volume being introduced or expected soon, that will also impact costs dramatically. So, has anyone been following something that's coming that they think might have a really big impact?

MR. HILL: I mean, from my perspective, a lot of the really high cost stuff that's coming is low volume versus high volume.

MR. GINSBURG: That's right.

MR. HILL: Ricky brought up things like gene therapy, which are almost like one offs. I think, like the things that we worry about are like Alzheimer's and anything, should there be anything groundbreaking in oncology? Like that would be -- those are the two that you'd be like, oh, like here, these create big plus problems very quickly. Ann, Ricky, Jailendra, I don't know if anything else jumps out to you guys.

MS. GOLDWASSER: I mean, to me, it's really going to -- we're going to see how gene therapy develops because be, if it really lives to its promise, that it could really touch a lot of many different disease categories. A preventive measure, to me, that's the one comes to mind. Clearly not in the very near term. I think we have some time to deal with the implications of GLP-1s, but I think that's sort of the one that is next to come and really touches both the pharmacy and the medical because to George pointed before, the PBMs come to rescue. It's interesting here because it's so tied together, pharmacy spend and the implications on medical spend, and we need

to see both the two entities working together, PBMs, health plans, and employers or government, to get it to the right place.

MR. GINSBURG: Thank you. I want to move on to vertical integration now. Specifically, employment of physicians by hospitals, insurers, private equity and pharmacies. So, is there evidence emerging about which type of ownership of medical practices has been the most successful and will ultimately emerge as the dominant form of physician practice ownership?

MS. HYNES: I would say none have been really successful, to be frank. So obviously, there's been a big trend of acquiring primary care physicians and taking risk. And obviously with the V-28 risk coding, that has not gone well for these companies. So, we'll see how that develops in the years to come. But I would just say from a hospital perspective, a hospital would prefer not to employee physicians. With an employer or physician, it's more defensive than anything.

Like, for example, and this kind of goes to your next question about anesthesiologists or emergency room doctors sometimes right now there's a big trend now that they have to employ emergency room doctors because a lot of the companies who employ them are going bankrupt, and a hospital needs an emergency room doctor. So they are forced to pay them more and, or employ them. So the emergency doctor stays. I mean, they need stability with that group. So again, a hospital would prefer not to employ doctors if they don't need to. But some, some areas, some doctors have preference, and if the physician has preference, then the hospital has to do it.

MR. SINGH: I'll add that, I mean, generally, like, I think when I used to cover hospitals back then, I felt like there was a rush from hospitals to own these doctors provider group. I think there is some slowdown there, and some of that, in our view, is likely driven by the fact that you have some decent funding dollar flowing in for physician groups. You have emergence of companies like these payer companies like Agile or Village MD, Oak Street, who are willing to work with these providers, either employ them or provide them administrative support so that they can operate at a more efficient level.

So, I think that probably has impacted in terms of these providers willing to give up their practice and join a hospital system. But, but still, like, more than half of the doctors are still employed by health systems and, but I think I agree with Ann. It's still early to say, like, which kind of ownership structure is probably most successful longer term.

MR. GINSBURG: That's interesting. I recall having the sense that a lot of insurer acquisitions of medical practices has been defensive in a sense of, well, let's keep them away from the hospitals. But then you have Optum, which that's clearly way beyond the defensive initiative that they really are seeming to go whole hog into creating that as a profit center. Any thoughts about why Optum is proceeding so differently from the other insurers?

MR. HILL: Oh, I'll have fun with this one. It's money. The answer's money.

MS. GOLDWASSER: You mean they can. They have the balance sheet.

MR. HILL: First, they can. Second, you'll see a lot of their provider consolidation tends to be focused in areas where they have significant Medicare Advantage footprints, their ability to steer Medicare. Or, and what you'll see is like, they can evaluate their Medicare Advantage footprint to see which practices that they use to target acquisitions. If I were to throw some rough numbers and some rough estimates around this, if you think about the pre-tax margin on a Medicare Advantage life of being normalized, because they're all kind of under what you're all under earning right now, call it three and three quarter to four and three quarter percent. Plus the capitated margin on a life in a health plan in a provider group can probably be as high as Optum targets, eight to 10 percent. CVS Oak Street targets a number that looks like 15 percent -- you can conceptually having United, monetizing the Medicare advantage life to an aggregated consolidated margin of a number that could probably look as high as 15,16, 17 percent on a PMPM life. That could be $12,000 to $15,000 per year in our regular individual MA life versus some of these dual eligible lives, you know, risk code of three, inclusive of the Medicaid payment stub, $40,000 a year in per member revenue. I mean, we're talking about pretty lucrative business here, hypothetical. But like that's the math.

MS. GOLDWASSER: And then there's another element because it's lucrative, but the reimbursement is coming down, right. Or whether it's direct reimbursing or through the risk code. So, it's not going to be as lucrative. But I think that part of it is also it's influence and control because ultimately, especially with MA members, right. You can switch plan every year. So how do you influence how you create stickiness with the member? If you have both sort of that provider and the payer, then you really just have more control over the member.

And I take Paul, you said, why United more than the others? I think because they can. I think everybody else in the industry always looks up to United and saying they really have been, in a way, visionaries and thinking about sort of what's the next thing that we need to do. So, it's a combination of that sort of strategic thought process that started early and over time gave them an advantage in the marketplace.

MR. GINSBURG: Oh, thanks. Still on this integration topic, between the extensive closing of clinics at Walgreens Village MD. And recent news that Walmart is slowing its building of retail clinics, is this simply a slowing down from what had been breakneck pace or an indication that pharmacy's vertical integration into physician practices is achieving less than had been expected?

MS. GOLDWASSER: I wouldn't say necessarily that it's achieving less than expected. The question is really sort of what is the KPI [key performance indicator] that a Walgreen or Walmart are kind of like measuring their success by? So if Walgreens KPI, by owning a provider group is to increase traffic to their stores, then that's the wrong KPI, right. That's the wrong incentive and that's not going to drive

sort of success. But if you are a CVS, for example, right. And you own a payer and a provider in sort of a pharmacy, and you are thinking about sort of your strategy is more holistic in nature, then that ultimately longer term could be successful. Right. It's still kind of like wait and see.

But I think ultimately it really goes to, we need to ask sort of the executive team and the board how do you measure success and incentives have to be aligned. And I really think that just these two retailers that you mentioned haven't necessarily. Right, sort of in line, sort of success with just longer term reduced improving healthcare outcomes and reducing costs.

MR. SINGH: Let's not forget the valuation at which the deal was done. Peak of value-based care valuation time period compared to like where we are right now.

MR. GINSBURG: I see. Thinking of vertical integration in healthcare financing and delivery more broadly, which combination do you perceive as most likely to create value in a sense? And which types of integration raise the greatest concerns about being anti-competitive?

MR. HILL: I mean, I would think the payer-provider integration generates the potential for the most type of value, as opposed to the provider with a pharmacy or the provider with any other kind of down community. And really what it's about is, I think it's about effectively using the steerage tools in benefit design as a way to drive value inside of the captive provider network. And basically, I've got a slide somewhere that like if the old Venn diagram was like the providers with the payers and the pharmacies with the beneficiary in the middle, it's kind of changed to a concentric circle diagram with the player on the outside, like rings of the provider organization with the beneficiary on the inside. That's kind of how I visualize it. But I think you really want the payer on the outside of that circle. And I mean, I really like, I just like what you want is a responsible payer. And this is where we had kind of started this conversation of talking about the New York Times article this weekend. Like, the structure of the payer environment, the regulation around the payer environment is really -- it's kind of hugely important such that that structure makes a little sense.

MR. SINGH: I might have slightly different view, and I hope George doesn't mind that. I mean, look, I completely agree that I think the payers have scale and balance sheet to do these transactions, be a lot more successful than small scale operators. I mean, I cover digital health companies, and maybe I come across as biased, but there are a lot of companies in my coverage which are trying to innovate and improve patient experience, improve the accessibility, because payers historically have not done so. And it's not like they have not improved. But clearly these health care disruptors exist because traditional healthcare delivery has not really worked. Right?

So, they had to really up their game. I personally feel like a pair -- again, I'm not talking about Optum, they're a completely different animal I believe. But

insurers owning these assets I feel like sometimes could be value destruction. But again, are we taking two steps back if somebody buys one of these healthcare disruptors or we are really adding value? I just feel like that's probably a longer term. I think the best outcome will be these payers really improve on what they've been doing for last several years in terms of accessibility, affordability and patient experience. Because still, I mean we all can agree that we are not calling our insurance companies and having very good experience. I mean except few cases. I still like experience customer. I mean what the NPS score is still not good. I mean so things might change in five years. Things have improved for sure, but I don't think we're there yet.

MR. GINSBURG: Thank you.

MR. SINGH: Sorry to disagree with you.

MR. HILL: Jailendra, it's more fun if we debate, right? Let's just, let's disagree. No, but like I agree with you're saying but I also think that's a much better world. Like I think that's a great scenario in a world where the consumer has great price transparency and value transparency which doesn't exist right now. And like I even think about like we know about like all the companies that do benefits navigation and stuff like that and like I guess they're kind of helping. But like so you almost make me want to couch my answer a little bit. Like the best experience is the one where the consumer has the ability to perceive cost and value and make those decisions appropriately.

Unfortunately, that's not really the healthcare environment that we operate in. And I confess I was kind of thinking about this still coming from the MA perspective, but when we talk about the employer sponsor book like that, it's a different animal, it's a different way of thinking about it. But I think I would just say U.S. healthcare is not a system, right? It wasn't kind of organized this way. It just kind of evolved haphazardly into this hopscotch of hoops we all jump through now and try to figure out how to get our care delivered without getting ripped off.

MR. GINSBURG: And it probably will never be something that's planned.

MR. HILL: I don't know that we want that either. I don't know that I want anybody in Washington making my healthcare decision.

MR. GINSBURG: Okay. Private equity. I've noticed how many different segments of healthcare private equity is involved in now. And which segments do you see private equity? Maybe not at the moment, but in a few years being the most important, is it nursing homes or hospitals or physicians?

MS. HYNES: I mean, private equity has always been involved in healthcare, and I don't anticipate that changing. Maybe some segments where they've been focused on over the past, say, five to ten years, there'll be less focus. What comes to mind is just physician ownerships like ER doctors or anesthesiologists, because the No Surprise Act has really made that business less profitable for them, because what they would do is in many cases, not all, but many cases go out of network, and

because that legislation really limits that. I just see investment in that type of ownership reducing, but behavioral is a big one. Private equity really likes hospitals. Anything, I would say anything post-acute related, especially like home health, because that's the trend, especially going over the next decade. Those are the areas where I continue to see continued investment with private equity.

MS. GOLDWASSER: I mean, Paul, in some ways your question is really where is growth in healthcare? Right. Where the trends are. Because if you think about private equity, right. That's where they, they are the ones that are financing future healthcare innovation, and they're doing it based as they think about it. What's the thesis? Right. Where are we seeing growth? And it was providers a decade ago, and they've done tremendously well on that. And now we're kind of like looking to what's next? I think we talked about it, right? We talked about sort of specialty medication. Right. We talked about specialty in general. Right. How do you manage specialty? Right. We started kind of like low hanging fruit, which was sort of primary care providers. Now it's about how do you manage sort of that world of specialty. How do you manage data? Or how do you manage to end point at home?

MR. GINSBURG: Good. Actually, I better move on -- our time is passing. I've got some questions on artificial intelligence and how will AI be used in healthcare delivery and by insurers? For delivery, will most of the early uses be focused on administrative tasks, or will there be important uses focused on improving clinical efficiency or quality?

MR. HILL: Can I make the quip that in the near term, artificial intelligence is going to occupy your time while you call your managed care plan and it eliminates a bunch of call center jobs and you're stuck talking with an AI tool that's trying to steer you to somebody for 30 minutes? That's probably the impact in the near term. As somebody who tried to call their managed care plan last week, I can't see AI like delivering care or steering care in the near term though, I know a lot of people want to try, Jailendra, I feel like this is your - like, you're the tech guy.

MR. SINGH: I mean, I think the early use cases will be on administrative functions and I think I feel like the whole rush on AI is a little bit overblown and like too much focus on that. But I'll give you an example. My own PCP did adopt some tool on this CHAT GPT on AI, whatever. And I was at his clinic last time like two months back and I was asking him that, how are you using ,leveraging AI? And he said, let me show you. And then once the visit was over, he said in his system, like send the visit summary to Jailendra and his phone number. And within like 1 second on my phone I had a summary of very easy to read and easy to digest format, like what exactly the visit was about, what next plan of action and, you know, anything. That's what I need. I don't need to go through my chart and all the details to figure out like what happened. It was right there. Quick snap of like second.

That's what we need. I mean, the patient experience for me was huge. Like, I mean, like that from starting. It's the small, small administrative stuff and I think we can probably leverage AI to improve patient experience, reduce the

administrative burden on physicians. I mean there was a presentation, I think from doxy.me. They talk about physicians to finish all their administrative burden and clinic visits, they need 27 hours in a day to finish everything. 27 hours. Clearly we don't have 27 hours. So, it shows you how much they are really getting burnt out. So, if AI can improve their, reduce the burden, I think that's the main focus right now from delivery point of view.

MS. GOLDWASSER: And listen, I think when thinking about it in healthcare, it's a really big bond. We have drug discovery, we have diagnosis where I think they're real sort of clear, even more near-term usages. But you make a fantastic point about sort of engagement. [Unintelligible] So, can you use AI for engagement?

It's interesting what you're saying that AI will not be used as a replacement of a physician, but can we see a future where AI -- and there was a question that I don't think we fully addressed because [Unintelligible]but about sort of health equity, which is such a big issue, societal issue. So, can you use AI to engage that type of population and potentially sort of offer them services that might be used by a nurse practitioner or a primary care provider just to kind of like screen and provide some rooting of basic healthcare?

MR. GINSBURG: And that's interesting that you bring that up about AI having the potential to improve the care of marginalized populations because there's so much as far as concern about, well, the AI tools aren't customized to them. Could they be harmed by it?

MS. GOLDWASSER: Right. So, a lot of thought is really being put into those algorithms. Right. To make sure. Right. That it is structured in a way, but once it is, there's actually an opportunity here for access and engagement and improve care on the long term.

MR. GINSBURG: Thanks. Now there's been pushback against AI being used inappropriately for prior authorization. To what extent has it been used and how are payer is responding to these concerns?

MR. SINGH: I mean, I haven't, I don't know if you guys have heard, but I haven't heard a lot about AI being used of prior authorization. I mean, yes, data and AI has been used to submit claims appropriately and doing proper checks in place so that the denials can be reduced. But I don't know, George, I don’t know if you’ve heard.

MR. HILL: I've heard a little bit about its use. And I know, like, again, I've seen a couple of news stories about it, like the accusations, I think, was it, I'm trying to remember if it was Cigna or United that was accused of kind of using it to -- it's like the article painted the picture that AI was being used to blanketly deny claims which did not seem to be a fair representation. But like, I mean, but like that kind of, to Jailendra’s point, like that's, that's the type of functionality where you can see the

implementation of AI making a lot of sense around the prior auth process and the claims process.

MR. SINGH: That's more on the payer side. Right. Not like providers are not like trying to leverage most payers.

MR. HILL: Exactly.

MR. SINGH: That makes sense.

MR. GINSBURG: Okay, let's move on to behavioral health care. Most Americans believe we have a mental health crisis. Early 2022 data indicated recent record numbers of suicides and drug overdose deaths. Despite this escalation, accessing treatment continues to be very difficult, as indicated by consumer surveys and national data. Factors like the decline in psychiatric beds, financing barriers, difficulty accessing outpatient treatment, and growing workforce shortages have led to more reports of unmet needs and psychiatric boarding in emergency departments. How is the financing and delivery system responding to what seems like a perfect storm? How much potential is there for market forces to address these needs? And are there policies that have the potential to be impactful?

MS. HYNES: I can start with this one. I mean, in general, I think the U.S. behavioral system is broken. If you compare it to, say, the UK, for instance, to get admitted to a behavior facility in the UK is very tough, but once they admit you, they want to rehabilitate you. So, the average length of stay is close to a year. In the U.S., the admission is not difficult. It's the length of stay issue, which varies by payer. So, for example, Medicare definitely has the most generous length of stay. So, if you're allowed to go into a behavior facility, length of stays, say ten to twelve days, commercial length of stay is typically five days, but again, it's very heavily managed by the managed care payer. Like, you have to get preapprovals on a daily basis.

Medicaid's the worst and it's become much worse with the increased penetration of managed Medicaid players. Average length of stay is two to three days. They just want to admit someone, get them on the right medication and discharge them as soon as possible. So, I guess one, that's a broken system. And could there be legislation passed someday that mandates a length of stay depending on what issue you have. I think that would help, but in general, I just think the system's broken. And that coupled with significant labor shortages.

MR. GINSBURG: As one follow-up, has telehealth, which has been used extensively for outpatient mental health care, has that actually had some benefits on the supply side as far as increasing the number of hours that mental health professionals are able to see patients?

MS. HYNES: On the physician side, but still being admitted to a facility, it's a nursing issue. That's the big issue because the industry accepted norm is six patients per nurse, and that has to be stretched now probably to seven or eight. And that's a lot for one nurse to take on. So, it's really, when I look at think of capacity

constraints and behavioral, I think it's more a nursing issue, which they have to be on location, where telehealth has definitely helped on the physician side because they prescribe, obviously, the medication.

MR. SINGH: If I can add something on telehealth and mental health, I think over the past three to five years, what at least result of COVID has been that the mental health and behavioral healthcare definition has broadened a little bit. I say a lot. I mean, like five years back, when people talk about mental health, they always thought about very acute mental health conditions. Today, things like having anxiety issues or having trouble getting sleep and those problems are also like mental health. And I think employers are realizing that some of those lower acuity issues can be managed through health. And I think a lot of mental health treatment are done over text messaging, I think, which is kind of where AI can be really handy as well. So that's what we are seeing, at least from employers' point of view, a lot of behavioral mental health care, telehealth programs being rolled out. And we haven't seen -- we've seen some consolidation happening, but not really a scale back of investment in those areas.

MR. GINSBURG: Okay, a question on prescription drugs with the Inflation Reduction Act, price negotiations, inflation caps, and discounts on drugs used by patients exceeding the out of pocket minimums affecting only Medicare pricing, are commercial insurers expecting any impacts on the prices they pay for drugs for the privately insured?

MR. HILL: I guess I would just have it like, I don't know that people in the private market know exactly what to expect yet. And from the conversations that we have, there's almost two schools of thought. The one school of thought is that if the federal government's getting a cheaper price on drugs, we can piggyback on this and get it, and get these lower prices for ourselves. And then the other school of thought is that, like, if the federal government is getting a better deal on these drugs, then somebody else has to pay for that, which is likely going to be the commercial market and the private market. I don't think anybody knows the answer yet, but I think people still expect there to be a range of outcomes, but I don't know if there's a set of shared expectations yet.

MR. GINSBURG: Okay. Although legislation on PBMs is on hold at the moment, the fact that it has such broad bipartisan support makes me wonder about how impactful either the House or the Senate versions might be on the industry. What's your sense of how significant these policy provisions being debated might be? Are they kind of just things that show your constituents you're doing something, or do they have potential to really change how the industry functions?

MR. HILL: Paul, you said that, not me.

MS. HYNES: I'll make one comment about the PBM legislation. There's some debate whether it comes back, and it could someday, but probably not until 2025, because the issue with this legislation is that you had the six, three key House, House, three kids, I'm sorry, three key House committees, three key Senate

committees, and the leaders of those committees negotiating this PBM legislation, and they couldn't get a deal done. So, for them to spend that amount of time with these key leaders and not be able to get a deal done, it's unlikely they come back to the table. But the big thing within that, a lot of what was proposed probably would have been increased administrative burden for the PBMs. But the one big thing that could have been proposed is the elimination of spread pricing in PBM contracts.

And again, that the industry probably would have been able to manage that if there was time to, meaning it wouldn't go into effect to 2026. They would have time to change their commercial contracting. But the issue is that their customers don't want that. The customers like spread pricing. They don't want to go to a cost plus drug model. So, it's one of the reasons why I think that it got stuck in Washington, because I think a lot of employer groups definitely came to the defense of the PBM industry saying, we don't want this. So that would be the big, the elimination of spread pricing and commercial contracts was the big thing.

MR. GINSBURG: Thanks. That's very useful to point out.

MR. HILL: I agree with you. It's just like reporting transparency and stuff that just basically raises costs for employer sponsors and plan sponsors. Nothing that's meaningfully changing the business model.

MR. GINSBURG: Thanks. Final topic, the upcoming elections. Tight race for president, slim majorities in the House and Senate in play. How does the healthcare industry view the elections? And maybe another way of saying it is what health policy changes from a possible Trump administration are various healthcare stakeholders eagerly anticipating or fearing?

MS. HYNES: I can start with that. I would say the two biggest things from healthcare services to watch for is the ACA subsidies expire at the end of 2025. They were expanded in the American Recovery Act during COVID-19 then further expanded in the IRA. Those are up in 2025, but apparently some key Trump taxes are also up at the end of 2025. So, the thought process would be, if Trump were to win, but does not have full control of Congress, that there would be some negotiation to try to at least save some of those subsidies.

And then the next big thing is just who wins the presidency and who controls CMS. Because for, and that's very important for Medicare Advantage plans, because the Biden administration obviously is not shy of changing things with Medicare Advantage. And if we get another Biden administration, I do think CMS will continue to go after Medicare Advantage plans. They've gone after coding, but they can go after utilization management is the big one. Star ratings is another big one. So that's something the industry does not want.

MR. GINSBURG: Anyone else with thoughts?

MR. HILL: I mean, I might piggyback on that a little bit. Like I was talking, I was recently down there, [provider directories] is a big one. I was surprised how big doc registries are and provider registries actually have risen to the legislative

agenda. The idea that Medicare Advantage beneficiaries have bought a plan and they think they're doctors in the network and then the doctor's not. And then it's like I bought a bill of goods that isn't what I thought either from a hospital or provider perspective. And then the other thing that I heard is that the, I was told the doc caucus is very strong right now. And like I was, again, I sat up through a political roundtable down in DC a couple of weeks ago. I was told, don't be surprised if the populist Republicans actually want to go after MA. And with the thesis being they don't like what supplemental benefits cover and they don't like the idea that Medicare is covering all this stuff that it was never intended to cover, and they come at it from a cost perspective. So, like, so, like, I like, I completely agree with Ann. Like, you've got to work. Like there's some risk if the Democrats maintain control. I don't think it's a riskless environment if the Republicans take control.

MS. GOLDWASSER: I agree with George. And it's also interesting because we've seen some headlines in the news that talk about these issues around sort of the Medicare Advantage plan. And I think that's sort of, kind of like there's a reason why they're being published. But it's interesting times where I think that there's not that much difference, right. Between what we're going to see under a Republican or Democratic, kind of like both sides of the aisle, I think, could be more critical of kind of like how things are done under the hood and MA and on the ACA side, I think the Democrats are probably more open to ACA now. That also sort of actually could be an opportunity of growing that. So, I would say, and usually I don't like to say that on elections, but I think it sort of kind of like would be benign for the healthcare industry. Not that we're not going to see impact, but there's not going to be that much difference between Democrats and Republicans.

MR. SINGH: Now, I'll just add one. I mean, clearly the point Ann made about focus on MA reimbursement environment, clearly from our coverage point of view, clearly that's given the shift to value-based cared MA, can we have a proper alignment on the utilization reimbursement environment. I think something will be focused on from the new administration.

MR. GINSBURG: Okay. Rather than go to audience questions. Again, we've only got two minutes. Any final thoughts from any of you? Something that you really want to say dawned on you during the discussion?

MR. HILL: I guess I'd have a final part. I feel like a topic we didn't discuss much at all, which I almost feel like is indicative, is pharmacy, and pharmacy just as a tremendously challenged industry. And I guess I don't -- that seems like it's an industry that's structurally disadvantaged. It feels like it's going the wrong way trying to find a way to right itself. Rite Aid declared bankruptcy this year. So, like, the fourth largest pharmacy chain in the country is going under. Other public pharmacy chains continue to kind of have reimbursement challenges. I don't know if it's in ‘24 or ‘25, but at some point, we're going to have to have a conversation on how we think about pharmacy and access and things like that.

MR. GINSBURG: That's a really good point. When we were talking about Walgreens closing Village MDs, the thought in my mind came to, well, pharmacy is so much less profitable today, and continues to get less. So, what's the big deal about attracting patients into the stores?

MR. HILL: Walgreens is closing more Walgreens than they're closing Village MDs.

MR. GINSBURG: Any other thoughts before we close? Actually, I think we've got to close now. So, I want to thank you all for great discussion. I want to thank Arnold Ventures for funding this event and for Brookings hosting it and the staff behind the scenes that helped get this to work. So, thank you all very much.

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