THE BROOKINGS INSTITUTION

WALL STREET COMES TO WASHINGTON
HEALTH CARE ROUNDTABLE

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SCHAEFFER INITIATIVE FOR HEALTH POLICY

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PARTICIPANTS:

Welcome and Introduction:

PAUL B. GINSBURG
Senior Fellow and Director, USC-Brookings
Schaeffer Initiative for Health Policy
Leonard D. Schaeffer Chair in Health Policy
Studies
The Brookings Institution

Panel Discussion:

PAUL B. GINSBURG, Moderator
Senior Fellow and Director, USC-Brookings
Schaeffer Initiative for Health Policy
Leonard D. Schaeffer Chair in Health Policy
Studies
The Brookings Institution

MATTHEW BORSCH
Managing Director
BMO Capital Markets

RICKY GOLDWASSER
Managing Director
Morgan Stanley

GEORGE HILL
Managing Director
Deutsche Bank

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MR. GINSBURG: Good morning, and welcome to the 24th annual Wall Street Comes to Washington Health Care Roundtable.

I'm Paul Ginsburg, Director of the USC-Brookings Schaeffer Initiative for Health Policy. Almost 25 years ago, shortly after beginning the Center for Studying Health Systems Change community site visits to study changes in the financing, organization and delivery of care over time, I realized how little Federal policy makers knew about what was happening on the ground in healthcare markets.

I also knew that Wall Street analysts conducted their own research on emerging market trends, often drawing on their access to top executives and healthcare companies to inform their investor clients, and believed that policy makers could benefit from the analysts' broader market perspective.

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 analyst who advise investors about which publicly traded companies will do well and which will not.

So, before we start, I want to thank Arnold Ventures for supporting this event, which many people inside the beltway value for its outside the beltway perspectives. Our format will be a roundtable discussion based on questions that have been shared in advance with the panelists. We'll have two opportunities for audience questions-and-answers. The first before we take a 15-minute break around 11:45, and the second before we adjourn at 1 o'clock. You can either ask questions through the webinar Q&A tab, or via Twitter at #WallStHealthPolicy. When you compose questions, emphasize ones that these equity analysts are best positioned to provide informed answers to. Also note that the analysts are not permitted to answer questions about the outlook for specific healthcare companies. Please send in your questions throughout the morning. We have staff monitoring the Q&A box, as well as Twitter, to make sure that we get to as many questions as possible. A transcript and webcast of the conference will be available through the Brookings website later this week or early next.

We have an excellent panel today. One analyst is a veteran of many Wall Street Comes to Washington discussions. He's Matt Borsch of BMO Capital Markets. And our two new analysts are Ricky Goldwasser of Morgan Stanley and George Hill of Deutsche Bank. The analyst bios and today's agenda are posted on the Brookings events website.

While the overwhelming issue facing the country generally, and the healthcare system specifically, is the coronavirus and the COVID-19 pandemic, we still face underlying and age-old challenges related to healthcare quality, costs, and access.

We will begin with a brief discussion of pandemic-related financial stresses to the healthcare system, both near and longer term, and then move into merger and acquisition trends, especially the push for vertical integration, the role of private equity and healthcare, provider payment reform, and as many other issues that we can fit in.

So, let's jump to the discussion and we'll do the COVID-19 questions first. I'll begin with, over the weekend the New York Times ran a story on predictions from Covered California's actuary that COVID-19 would lead to substantially increased insurer claims costs, meaning the premiums would have to rise substantially next year. But I've also been seeing stories of hospitals having to deal with sharp declines in revenues due to putting a hold on elective procedures to reserve medical equipment and supplies for COVID-19 patients…. And, some specialty societies have urged members to limit their practices to urgent problems to protect their health and the health of their patients as well as preserve scarce supplies. How do you square these two developments? Matt, you may want to start on this one.

MR. BORSCH: Okay, let me just give a quick high-level answer on this, just to -- I suppose -- state the obvious. When we're thinking about the healthcare insurers and the health providers, unlike other industries, we have to think about two things; we have to think about both the direct impact on healthcare costs and volumes of COVID-19, but then also the downstream indirect impact on the economy, which is the thing that most other analysts are focused on in other industries.

Having said that, as it relates to the potential for high premium increases coming out of this, I think certainly that's a possible outcome. I think right now the issue is that we just don't know. There's a wide range of scenarios along which this may play out, and we're running only very high-level analysis on what that could look like.

For example, it could be a scenario where the costs of COVID-19 overall are more than offset by the reductions in volumes from all of the disruption to the healthcare system that's occurred. I'm not saying that's likely, but that's a possibility. And then you range the scenarios all the way up to a very high level of costs, you know, that might for example, at the upper end of the range, wipeout the earnings

of the health insurers this year, in that scenario.

The one last thing I'll say on this, though, is that I think in some of the analyses, those who might be thinking about high premium increases -- and certainly that could come out of this -- it's not a given that the health insurers necessarily pass along the costs that they have already incurred, say in 2020, to recoup them in 2021. They might do that, but this is a very extraordinary situation, so we don't know how they necessarily will react.

MR. GINSBURG: Okay, any thoughts from Ricky or George?

MS. GOLDWASSER: Yes, there are a couple of things to think about. So, first of all, on Matt's last point, we really have to think about the impact of COVID-19 on 2021, because some of the deferred procedures that are benefitting the health plans early on will likely come back, and might not all come back because there's just a capacity issue in 2020; they might spill over to 2021. So that's one thing to think about. But I think more importantly as we think about premium increases and how likely they are, there are a number of things to consider.

First of all, if we think about MLR [medical loss ratio] minimums, that's something that the health plans should be thinking about. So, if the deferred procedures, we trip them on minimum MLRs, MLR on average three years, how do they manage it into next year as they think about the premium increases.

Another thing to consider that I think is going to be very interesting, that from what we're seeing with COVID-19 right now, the impact is very different based on different regions. We're not even talking state level; we're talking counties level. So that means that if you are a regional health plan in a specific area that's more hit by COVID-19, you might have to face very different realities and have to treat premium in one way, versus a health plan that's more diversified and can cross-subsidize different regions.

So, I think that it's very, very early to come up with these blanket statements of what premiums will look like in that their reality is going to vary depending on the plans' membership mix, acuity level, and regional mixes.

MR. GINSBURG: Thank you. George?

MR. HILL: Let me add just a couple of comments to what Ricky said. I just checked the

numbers, I guess as of last night or this morning there were about 400,000 diagnosed cases in the United States. While treating COVID is more expensive than the flu, to put that into perspective, there were about 30 million cases of diagnosed flu in the United States last year.

So, from an absolutely direct cost perspective, I don't think we're at the point yet of calling the impact of COVID "material" as it relates to health plan players. And kind of as Matt alluded to, we're talking about the direct costs -- what it costs to treat COVID-19 patients.

Building on what Ricky said, looking downstream, the indirect costs, what rolls from 2020 into 2021, and what we're paying a lot of attention to is the employment figures and coverage. I think a lot of these health plans right now need to be looking at themselves wondering, what does membership and enrollment look like as we come through the end of '20 into 2021.

You see a lot of people on television, and a lot of market strategists, and economists talking about what the shape of the economic recovery will look like. I think we need to track that because the other side of the cost equation for the MCOs [managed care organizations] is the revenue equation. How many people are on the membership rolls? How many people per month are they collecting for?

So, I think the other part of this equation is just, what happens to membership, particularly as it relates to MCOs that are exposed to employer sponsors as opposed to other payer books. And how does employment re-ring it once we get through this situation.

MR. GINSBURG: Okay, thank you very much. The pandemic appears to be presenting major challenges throughout the United States healthcare delivery system. While most visible are challenges in hotspots like New York city in addressing substantial numbers of COVID-19, health providers in many other areas of the country are being impacted in many ways, such as in revenue loss from putting elective procedures on hold, taking extra steps to treat patients who may or may not have an infection, and dealing with extreme shortages in equipment and supplies. What do you see are the most significant pressures on providers from this pandemic, both in the immediate term and the longer term?

MR. HILL: I guess I'll start. We'll go in reverse order this time around. I mean, the pressure on providers -- and Matt alluded to it earlier -- is your seeing almost all high-dollar revenue, high-dollar margin elective procedures being delayed or deferred to some uncertain date.

We have done a handful of calls with heads of health systems and chief clinical officer types, and CMIO types at health systems over the last week. And I would say, aside from the -- you've got the pressure of negative mix as it relates to the organizations -- which I don't even think a lot of organizations are focusing on right now -- they're focusing on their first priority of treating patients.

They're focused on the logistics of PPE [personal protective equipment]. How do I get enough masks? How do I get enough gowns? How do I get enough caps? How do I keep my providers safe? How do I keep my providers from getting infected? I've spoken to health system executives, how do I keep my provider in just continuing to come to work, given this environment? It's interesting, I think, in this situation, what is facing providers in the moment are the very real blocking and tackling, and logistics issues of how do I do my job and keep people safe on a day-to-day basis? I think the economic issues are largely taking a back seat at this point. You know, issues like how do I get enough tests? What is the false-negative rate on this test, on the early COVID-19 tests that have been as high as 30 percent or more? How do I know if I'm even testing people or treating people accurately? How am I not letting sick patients back out into the population?

I think the pressure on providers right now is much more around -- it's the face-to-face interaction, it's the personal risk, it's the how do I keep people, with economic issues and policy issues taking a back seat at this point.

MR. GINSBURG: Thank you, anyone else?

MS. GOLDWASSER: Yes, if you think about the dynamics, and you think about both mid-term and long-term, we would have to pay attention also to the stimulus package, that I think did a nice job of addressing the issues that hospitals and providers are seeing.

Whether it is some reimbursement for lost elective procedures, whether it's the 20 percent increases for COVID patients, greater DRG payments -- so I think that the stimulus bill has done a good job in it.

We also have to think longer term into the future and given all the focus on the hospitals and all the good work that they're doing, is how likely that we're going to see hospital reimbursement rate cuts in the future. I think it's going to be very, very difficult for that to pass in the years, kind of like, post-post COVID.

MR. GINSBURG: Yes, that's a good point. I've been thinking, many people have been saying that all the discussions about regulation of hospital prices, and I guess they have to take a back seat for some time now because of this crisis. Matt, were you going to say something?

MR. BORSCH: Yes, two things. I think it is early to understand -- and it's pure speculation -- whether this is going to lead to any changes on the provider side that are permanent, rather than obviously there's a lot of temporary disruption that's going on oriented around the crisis.

I think -- and I'm sorry if I'm jumping to a later question, Paul -- I'll just say very briefly, again, pretty much on the obvious, that telemedicine is a clear beneficiary of this situation, and there's an expectation that a substantial amount of that temporary conversion will outlast this crisis.

And the one thing that you mentioned on the provider reimbursement and the stimulus package, I'll just say there have been some stories in the media -- I think it was in the New York Times about surprise billing emerging as an issue, even with COVID-19 testing.

And that was to have been a provision in the stimulus package, but my understanding is that lobbyists were able to successfully block that from being part of the final legislation. So, we'll see if that comes back.

MR. GINSBURG: Yes, good point. You know, hospitals -- I guess you started getting into this, are hospitals likely to demand higher prices in future negotiations with insurers as a result of the financial pressures on them now?

MR. HILL: I think the answer is clearly yes, and I think that one of the things that this crisis is going to be tactical; is it's going to give the hospitals the artillery to go back and demand higher prices -- that they've been put under too much pressure for too long; that the infrastructure was not readily available when it was needed. I'm sure we've all been tracking the ventilator shortage and the ICU bed shortage, and the stories around that the infrastructure was not there when it was needed when this type of crisis struck. The providers need to be appropriately compensated for the risk that they take in dealing with infectious disease patients. It's going to be very difficult -- I don't think the war between the payers and the providers ever stops or slows down.

Matt made the point about telemedicine, which I'm sure we're going to spend a lot of time on later. But you're going to see high-acuity providers try to build a wall around the prices that they

charge and the value that they think that they provide. And as we come out of a crisis like this, it's going to be hard for payer organizations, whether we're talking about the government, whether we're talking about commercial payers, to push back, as you know, particularly as I think the providers are looking pretty good in this situation right now, doing the best they can taking on all personal risk and providing service to these patients.

MR. GINSBURG: I guess one issue we may have to start talking about is that for true standby costs, like having a lot of ventilators around, should that be funded through providers getting higher prices for other services? Or should that be directly subsidized by the government? I don't know the answer, but that really is the question it brings up.

MR. BORSCH: Paul, I was going to mention that. I mean, it's, of course, not clear yet to the extent the crisis infrastructure has been inadequate. And of course, even on that question, we don't know how that's going to play out yet. What will be the mechanism for building that infrastructure; Rates could be impacted but it could be through direct Federal investing or something like that.

MR. GINSBURG: Good. A question I have is, to what extent will these pandemic-related challenges faced by providers put on hold their ability to make progress under payment reform? So, their alternative payment mechanisms. Is that going to have to be put on hold for a while?

MR. BORSCH: Yes. I think so. A lot of things are being put on hold right now. Now, I'm not directly involved in that. It could be that there is some activity going forward. People are trying to do their jobs I this environment as best they can. But clearly, executive attention to get these deals done, difficult negotiation, efforts are being refocused right now; I expect most of that is delayed.

MR. HILL: And kind of to build on Matt's point a little bit, I think when we talk about payment reform -- at least from a research analyst perspective -- in big picture terms, what that sounds like is providers taking risk, financial risk, or beneficiaries increasingly taking financial risk. And this is kind of the Black Swan event where, "Hey the risk showed up, look what you're stuck with," from a cost perspective and from a capacity perspective.

And from an individual perspective, particularly in the commercial market, I joke with people, you know, you talk about risk-sharing arrangements, the most popular risk-sharing arrangement is your employer taking your deductible from $1,000 to $4,000 going, "Hey how about we share some

risk?"

This is the other side of risk-sharing, is that -- I don't necessarily want to call this the Black Swan event, but when the outlier event shows up, that drives high costs, particularly for a small number of patients. And I think what we're going to wind up seeing is the people who are going to wind up being most impacted are going to be the people with the least ability to shoulder the consequences of being impacted. There's going to be a lot of rethinking of the model in these risk-sharing arrangements.

MR. GINSBURG: Yes, really good points. Let's think two years down the road, and let's be optimistic. Let's say that this virus issue gets resolved, presumably through vaccinations -- and maybe cures -- I think more likely vaccinations, but we're two years down the road, and how does the way healthcare is delivered look different than it looks today, or that it looked yesterday?

MR. HILL: I'll say, Matt & Ricky, how much time do we want to spend talking about telemedicine here (laughter), because I think that's the answer.

MS. GOLDWASSER: Yeah, I think to, George points obviously, telemedicine is front and center. Today we have to think about some of the news that came out of CMS where nurse practitioners can now write prescriptions. So, I think we're going to see a real change, in a leap forward in some of the trends that we were looking for, but that otherwise might have taken five years to a decade. I think now, once this is out of the box, you can't fold it back in.

So, I do think that we're going to see more localized care, nurse practitioners taking more responsibility. I would even say that that concept of health hubs might take that leap forward because of that.

MR. BORSCH: Ricky, that's an excellent point on the nurse practitioners and, of course, dovetails with what's already a shortage that's getting worse and worse in terms of primary care physicians in this country with the demographic wave expected to drive higher volumes and that same demographic wave driving a lot of retirement amongst physicians.

MR. HILL: I guess if I were just piling on at the end, I would follow up on Matt's point on telemedicine earlier. From the provider organizations that I've spoken with, this have really been telemedicine's time to shine. We've seen a relaxation of the HIPAA regulations around privacy such that providers can engage with beneficiaries on the modality that makes the most sense for them.

So, whether they're using a commercial vendor, like a Teladoc, or an American Well, are probably the most well-known -- to a Skype, a Zoom, a Facetime; you know, putting the tools in the beneficiaries' hand and the providers hand to engage the beneficiary on their terms.

It's interesting Paul, you led into this conversation talking about what I've always characterized as the three competing priorities in healthcare, which are cost, quality, and access. I think there's a new one I walked past today. So, you've got cost, quality, and access; the new one that goes on here is risk. Telemedicine is now the answer to providers who don't want to engage and be part of the risk profile of spreading disease between themselves and other beneficiaries or taking any disease risk themselves.

Again, I'm just reflecting on the handful of conversations I've had with health system executives over the last week. But everybody has basically said this is telemedicine's time to shine; using their words, not mine, "This is telemedicine's time to shine. The genie is out of the bottle. We're not going back to the way things were." I think telemedicine would be a big part of the new normal in how beneficiaries engage with providers because it improves access, it improves outcomes, it reduces cost, and now it minimizes provider risk.

MR. GINSBURG: Yes, will telemedicine takes its shape -- I've seen two examples, just my personal experience, where the practice I go to, for the first time, is offering telemedicine. I also see the insurer that I have has a telemedicine benefit, but only through their contract provider, telemedicine.

You know, which model is going to become important as telemedicine grows?

MR. HILL: I mean, I think I can start off with the market is so big for telemedicine that multiple models can wind up being successful.

You can have a payer driven model that is successful. You can have a model that is driven by selling technology to providers that will be successful. You can have people put a hodge podge of technology together and use Zoom or Skype, and doctors try to drop bills the old school way. They can continue to have some success.

I think part of the promise of telemedicine -- besides it's increasing the convenience for the beneficiary -- you continue to mix down from a cost perspective. Most telemedicine visits are going to wind up being less expensive dollar for dollar than any type of inpatient physician visit.

And, again, while a lot of the outcome data has been sponsored by telemedicine companies, you're not seeing a steep or sharp decline in quality as it relates to treating beneficiaries. I think you're also likely to see a demographic change with beneficiaries as younger beneficiaries become our age.

Unless you're polychronic, or you have a long-term disease state that you think you need first contact with a specific provider, I think people are going to increasingly become provider agnostic of the idea of "my doctor" is eventually going to diminish and you're going to need the doctor who serves you on your terms, when you're ready, because that is the type of consumer experience that people have grown up the last 10 or 15 years are used to having with technology.

They want to be served in their manner, on their terms, in a way that suits them, as opposed to walking to a primary care office, potentially waiting in the lobby for an hour, to an hour and a half, to spend $200 - $250 for the six and a half minutes they got with their overworked primary care provider who's trying to see 50 patients a day.

MR. GINSBURG: Yes, really good points. Let's move on to other topics, and we'll start with vertical integration. A year ago, when we had our last conference, which Matt was at, we had a very long and fruitful discussion on that. Now we have different panelists, the world has changed somewhat, so let me pose some questions on this. In recent years, we've seen many transactions seeking to achieve vertical integration among healthcare companies. What do you think are the main drivers and strategies behind these combinations?

Public policies, either implemented or anticipated, they're a potential motivator of some of these transactions. And a better understanding of what's driving transactions could provide meaningful insights for policy makers.

And I'm going to organize this by focusing you on a number of transactions that we've seen, and ask you to explain what's really going on, what's the potential for it?

And the first I want to talk about is integration of large pharmacy benefits managers [PBMs] into insurers. Examples are Optum, CIGNA with Express Scripts, and Anthem starting its own PBM, Aetna merging with CVS. Ricky you had indicated that you might want to be the first to answer this question.

MS. GOLDWASSER: I think first of all, if we just step back, before we even dive into the PBM question, I think the overall arching theme around vertical integration is the idea of lowering cost of care, right? Because we know that, obviously, healthcare costs have been going up meaningfully. Health plans have been raising their premiums for the last decade and this is not sustainable. So, I think that there is an increased focus to shift to how to we lower the cost of care in order to maintain, kind of, like, their economic value.

Now, the vertical integration obviously comes from the vantage point of each company and what asset base they have. On the PBM side, I think what's interesting is that you really see across the board PBM functionalities are being integrated into, whether it's United, CVS to retail, and Aetna, or CIGNA. And when you think about PBM integration we have to talk about specialty, right? Specialty is the fastest area of growth in terms of pharma spend, it's been -- it's passed 50 percent of spend, and there is real relationship between specialty in medical cost.

So, from a health plan perspective, if you can control for specialty pharmacy on the front end, that overall is going to lead to lower medical cost, the back end, on the health plan side. So, I think that's an important part of it.

The other thing to remember, if you think about it, kind of like, United, when United first bought Optum, part of it is also expanding into areas that are not regulated, thereby diversifying your profit stream. So that's also part of that equation.

MR. GINSBURG: Yes, really good point. Let me go to the next think, which you started getting into, of acquisition of medical practices, and free-standing outpatient facilities by insurers, or joint ventures with providers. Initially I perceived these acquisitions as motivated by insurers' desire to keep practices from being acquired by hospitals. But now, I'm starting to perceive it as really some companies are really serious about that they can do it well. And I guess Optum would be the biggest example. Matt, and George, any thoughts on this?

MR. BORSCH: Maybe I could just offer that … as I worked in the physician practice management industry back in the late '90s, of course, the focus often was on taking risks for the entire medical budget, and one of the reasons there was that you needed a physician practice to be able to capture the savings that they were generating by investing in point of care technology, and other

infrastructure, aimed at cost efficiency. And that way of doing it, which is sort of a California model, was really hard to export to other areas of the country. In fact, at that time, really, you could say it failed.

The approach that United is leading, certainly among the managed care companies, it's being done at the payer end, and the economics are going to make sense for United probably even if the physician practice is only one-third United patients, that whatever United invests in point of care technology that's saving on the medical budget, they'll be able to capture all of those economics. And they'll probably be able to do some of that or non-United payers as well.

MR. HILL: I think, you know, we started down a topic that me, you, Ricky and Matt can probably each spend an hour talking about, and I guess I start to look at this from a top/down perspective of payers of all stripes, whether it's the government, or commercial payers, or state Medicaid agencies, are looking to reduce healthcare costs.

If you look at the provider business in most concentrated population regions of the country, you've seen increased merger and acquisition activity by hospitals and health systems as they've merged and they've bought ambulatory practices, which has given them pricing power in local markets, which payers of all stripes -- either the government has to eat it, or managed care organizations have to pass it along to their customers. One of the ways in which you can try to challenge the rise of these healthcare costs, you know, the buzz word that I use is, "vertical integrated, consumer directed, value-based care."

And what the payers are starting to realize is whether it's the integration of the pharmacy benefit, or the integration of the core medical benefit or the provider benefit, you can use the steerage tools that come with plan design, and through influencing beneficiaries and incentivizing beneficiaries economically, whether it's through high deductibles, whether it's through network decisions, whether it's through copays, to try to bend this cost curve. And I think that is the road that we're starting to go down right now.

And that is if your United with the Optum strategy, you're looking at where you are in 2025 and 2030, or if you're CVS post the acquisition of Aetna, you know, the communication with investors, it's the CVS, Aetna deals and about making their EPS [earning per share] numbers in 2020. It's is it a combined competitive company in the year 2030.

And with those, I keep kind of filling it upstream, what those companies need to do to continue to grow is to be competitive, and to win, and to take business and to take market share from each other.

The way that they do that is delivering on the promise on their ability to contain healthcare costs, cover beneficiaries and provide a robust benefit. One of the ways in which they get there is through the integration of benefit design and care delivery as a way to bend the cost curve, which is a phrase we hear bandied about all the time. How do you bend the cost curve?

So, if you're a United, you can steer beneficiaries to your own primary care facility, you can steer them to your own ASCs [ambulatory surgery centers], you can steer them through your own pharmacy benefit designed to pharmacies of your choice.

And a United executive once used this phrase to me, which was, the current U.S. healthcare system -- system might even be too strong a word -- but the way the U.S. current healthcare system operates, there's enough inefficiency that's small improvements create so much economic oxygen for the company, they create so much room to grow, where they can -- if you can eliminate the friction, you can deliver better care at a lower cost with better outcomes, while improving financial performance, both for the beneficiary and for the company.

And I think if we're hitting all those boxes, like everybody is doing everything right. The problem with that, of course, is that requires choices to be made. Again, cost, quality and access: what level of care are we giving to how many people, and at what amount do we want to pay for that? There are choices and tradeoffs on all these decisions that need to be made.

MR. GINSBURG: Yes, you really said a very interesting -- a lot of things interesting -- but the one about how big the potential margin is if you actually can create more efficiencies. And I guess it maybe comes down to, can the insurer owner of said practices be more successful in creating efficiencies in the practices, than say, hospitals can be, or that independent ownership can do.

MR. HILL: Well, I guess I would answer that with that it's like, in my mind, it's a pretty simple analysis of their incentives in the alignment. So, a hospital system, or a self-employed physician practice, is focused on maximizing their profits in practice, and maximizing their profits in the cost of delivering care, where practices that tend to be owned by a health plan are employed physicians, so

those doctors are incentivized to deliver the highest quality care at the lowest cost, probably with a more, a better focus on cost. Such that the managed care company can be competitive in its goal to win lives and cover more lives. And, you know, and both organizations want to generate higher profits, but the alignment at the care delivery level, and the incentives at the care delivery level would be different.

MR. GINSBURG: Thank you. Let me move on to, although not vertical integration, I've been struck by the degree to which physician practices are being acquired by private equity partnerships or funded by venture capital.

Some have become publicly traded companies, and examples that I'm aware of are Care More Health, IORA (phonetic) Health, Chen Med, Team Health, Envision Health, and the question is what opportunities does private equity perceive to make more money than the practices that they are acquiring are making today? Ricky, would you like to start?

MS. GOLDWASSER: When I think about primary care, and the investments that private equities are doing, but just in general the role of primary care, first of all, I think that we can just (inaudible) primary care becomes kind of like the hub of all things healthcare because that's where your individuals are going to have the connectivity. But what's really interesting about primary care, is that they really have the data.

So, the primary care practitioner knows the individual, has the data on the individual, and with the right tools, comes the right investments, and you can actually leverage on those tools to better understand the patient, to manage that patient better, and therefore, to lower costs in the future. So, I think this is a lot of what we're kind of seeing in terms of the investments around that.

We're also seeing a lot of investments in provider or primary care that are focused on specific populations, i.e. if we think about the MA [Medicare Advantage] population. Think about the dual eligible populations, or populations where primary care has a real opportunity to lower costs in these cost-sharing types of environments, or risk-sharing type of environments.

MR. GINSBURG: Thank you. Moving on to the next, which is hospital systems creating insurance plans focused on Medicare Advantage and ACA exchange markets, and partnerships between hospital systems and insurers to offer such products. Matt, did you have some thoughts about that?

MR. BORSCH: Well, I mean obviously, that's an area that has tremendous potential to

the extent that you can get individuals, or individual families, to have a mechanism for picking a narrow network of hospitals and physicians which is going to take responsibility for that families' healthcare needs, or at least, almost all of those healthcare needs, and along with that medical budget. If you can do that in a way where you avoid the complications of trying to force a geographically and otherwise diverse workforce into a single narrow network, that holds a lot of promise. But we've gotten excited by this concept before, and we really still don't see it happening on a broad scale. But, you know, this is where I think things are headed given the imperatives around cost effectiveness.

MR. GINSBURG: Thank you. It's a good point about this potentially can work well in markets where individuals choose their own insurance plan as opposed to the much, much larger group insurance from employers, where I guess these partnerships have not gone to that area. They're just focused on Medicare Advantage and ACA exchanges.

MR. HILL: Yes, and I think simplistically speaking, you're always seeing companies, whether that company is a hospital or whether that company is a health plan chasing growth, Medicare Advantage is probably one of the higher growth markets in all of healthcare with the beneficiary growth in Medicare Advantage growing almost 10 percent per year.

You talked about the provider-based plans that continue to come to market. You know, we continue to see just venture capital-based, and private-equity based health plans that continue to come to market focused on serving the Medicare Advantage population.

I believe the last stat I saw on this was from 2017 through 2020, the number of Medicare Advantage plans in the United States increased almost 50 percent on a plan basis.

MR. BORSCH: Wow.

MR. HILL: From just about 2,000 plans to almost 3,000 plans. I'm sure Ricky and Matt have seen the same numbers, I'm probably off by a little bit. But you do -- there are not a lot of markets in healthcare where your fundamental KPI [key performance indicator], which is your number of members, is growing in the high single digit rate, which is going to attract a lot of business interest in the form of capital.

MR. GINSBURG: Yes. Well, George, even though the number of plans is very high, I gather that major organizations that own Medicare Advantage plans, like United Health Group and

Humana, etc., account for a for large part, are you suggesting that with all this new entry by private equity and other initiatives, that the managed care market, as it's growing rapidly, maybe becoming less concentrated and more competitive?

MR. HILL: I don't know that I would call it less concentrated, but there's not a lot of markets in healthcare where you can grow your membership 9 percent per year, and you're treading water from a market share perspective.

MR. BORSCH: If I could just, sorry.

MR. HILL: No go ahead.

MR. BORSCH: I'm sorry, I was just going to say that it's going to take a lot to stem or reverse the trend toward greater concentration in Medicare Advantage. We've seen over the last decade the big four companies, if you want to look at them that way, United, Humana, CVS, and Anthem, have gone from about 40 percent to over 60 percent market share just among those four firms. So, what we're seeing so far is that the concentration trend is continuing. Now, maybe that will change, but it hasn't started changing yet.

MR. GINSBURG: Good, integration of insurance and retail pharmacies, of which CVS/Aetna is the example, any thoughts on whether they'll be able to get enough benefits from integration?

MR. HILL: I guess I'm happy to jump in on this one because I think it's one we've done a lot of work on.

MR. GINSBURG: Sure.

MR. HILL: And what I did here is I kind of contrast CVS/Aetna with United Optum, with Cigna and Express Scripts, and I think me, Matt and Ricky would all concede that pharmacy business in the United States is kind of a challenged industry and a challenged business. It's got a lot of structural factors that really make it a very difficult business to operate in.

Everybody is seeing that kind of vertical integration is going to be a path to the future from a growth perspective, both form a dollars perspective and from an earnings perspective, is around the ability to shake out synergies. That includes the integration of the insurance piece, the pharmacy piece, the care delivery piece, and I think that we should think even more broadly.

When you think of those pieces, it's how far does each company want to go in each direction? The phrase that I've used is, “Do you want to own the higher growth, higher value, lower cost, lower acuity assets, which will drive better returns in health plans based.”

CVS and Aetna, I think are a little bit of a different animal versus a United Optum and Cigna Express Scripts, where CVS knew that it wanted to vertically integrate its business with a managed care business. CVS didn’t have the luxury of coming to the transaction not owning 10,000 pharmacies, the way United did and the way ESI did.

But what they did see was an opportunity to use their footprint through the many clinics and through the health hubs to expand how they think about primary care and expand the way they want to bring primary care to market. Remember, CVS also has a big homecare business called Coram which they want to expand beyond oncology care and into other types of homecare.

So, I think of that less as the integration of a retail pharmacy business and a managed care business, than I do as CVS trying to be creative in how it engages the primary care model, that it works with its managed care assets on.

And to that end, if we were to compare CVS to United, United doesn’t own a bunch of pharmacies, but they have pharmacy partnerships, they have ambulatory surgery centers, and they have a bunch of primary care docs. So, CVS has not made any commitment around doctors, where United has made a commitment around doctors, and wanting to own and influence providers.

And maybe by the last contrast, Cigna and ESI have gotten together, to some degree e) they still preserve a lot of optionality around how they engage in the care delivery model because I think we’re still pretty early in the industry life cycle of this vertically integrated evolution, of what these businesses are going to look like 10 years from now and what the most successful model looks like.

And I add this last point for everybody in the audience because healthcare may be the best example of a market in the United States where business models can go from advantaged to disadvantaged at the stroke of a pen. And that stroke of the pen typically takes place in Washington.

So, while these companies are building businesses based upon a regulatory environment that they operate in now, they need to have some degree of flexibility in the businesses they build, understanding that the operating environment could change in the future from a regulatory perspective.

So, typically, whenever I talk to people in D.C. what I tell them to focus on is, what is the outcome that you seek to achieve as it relates to healthcare reform and policy change, and not, what is the point thing that you see wrong. And I think maybe the rebate rule in the PBM market, might have been a good example where people are like, “We don’t like the rebate rule. We don’t like the incentives that it creates.” I would agree that the rebate rule is clumsy, but the rebate rule does a pretty good job of lowering brand prices.

And so, think about the policy goal that you seek to achieve, and reverse engineer from that how to get there, as opposed to looking at point pieces of policy that you like or don’t like and trying to tweak them without thinking of the unintended consequences and the downstream consequences of policy change.

MR. GINSBURG: Thanks for the thoughts. One more integration before we move on to the next topic, which is, insurance and post-acute care. I think, Ricky, you wanted to say some things about that.

MS. GOLDWASSER: So, I guess that there are a few things. And just, when we think, I want to first make one comment on the CVS Aetna, because I think, Paul, your question was, do you think that they're going to be longer term successful. And I think it's interesting that we see in the sea here is actually Walmart coming with their better healthcare/pay strategy, which I think is the way, if you think about it, as validating the model. And another interesting anecdote or data point is, we hosted back in February a summit with many CEOs of private digital health companies, and we also had large tech there and large retailers.

And we did kind of like a simple survey but one of the questions that we asked is, who’s really going to make the most impact on healthcare over the long term? And this is the second year we've asked this question. And this time most of the respondents said CVS and Walmart.

So, I thought that it was very, very interesting in how thinking is evolving -- and the year before, more people responded that health plans and large tech are going to have this impact. So, I think it's very interesting how this thinking has fairly quickly evolved, to understanding the value in this system.

In terms of post-acute in health plans, I think we’re really all addressing the same theme, which is the theme of how do we best manage the population, lower the cost, lower the risk.

I also think that the post-acute trends are going to be very different six months from now from what we've thought in the past, bringing back the COVID conversation and discussion, where lot of focusing on what happens in the hospital setting, and what happens after, and after you're being discharged. So, I think we're going to see some of the thinking evolving over time. But I think that overall, this is around making sure that you manage a population in all different settings in order to lower those costs.

MR. GINSBURG: Thank you.

MR. HILL: Maybe one point to add to that. It's interesting, there isn't consensus on which model is going to be successful because as we're seeing CVS and Walmart increase their exposure to care delivery, we're seeing Walgreens retrench and pull away from that. So, again, kind of TBD -- there isn't a consensus on companies thinking which model is going to be the one that wins.

MR. GINSBURG: Yes, well, the interesting thing is that I guess the virtue of the private sector is that companies can do this. They can make big bets. Some of them are going to fail. And they don't have to spend five years doing an experiment before they can decide whether to move forward.

So, let me move on to Medicare Advantage and alternative payment and Medicare has always been seen as attempting to achieve more value for beneficiaries who want to remain in a traditional program, than enroll in Medicare Advantage. How are Medicare Advantage plans evolving in their management and coordination? Are they using advanced analytics to coordinate care? Are they narrowing provider networks to those that their analytics suggest higher efficiency? You know, what are Medicare Advantage plans doing to actually manage the care more efficiently than fee-for-for service is? I think, George, you were the one who volunteered for this one.

MR. HILL: Okay. I mean I think the short answer is yes, they're doing all those things. They are restricting networks. They're integrating benefits, they're offering more services. Think about things that are around nutrition, food, and health, anything that they can do to increase beneficiaries' convenience. I think just about all Medicare Advantage plans as we get into fiscal '20 and '21 will provide telemedicine benefits, whether or not they'll all adopt it is something else.

You know, stratification of different plan designs to appeal to different beneficiaries, including vision/dental. So, I think you framed it well in the way you asked the question, is, Medicare

Advantage plans are trying to do everything that they can to attract beneficiaries from traditional Medicare and deliver more value and kind of provide better service, and kind of retain those numbers over a long life.

MR. GINSBURG: Yeah. That's interesting because 10 or 15 years ago, it didn't look like that. It looked more like an arbitrage game of trying to get healthier beneficiaries use the same fee for service model. And what led to real change there?

MR. HILL: I mean, I think in my opinion what led to some change there is the MCOs ability to control aggregate cost as it relates to Medicare Advantage and you see kind of continued cost creep in traditional Medicare.

MR. BORSCH: I would just add another impetus for change was the reimbursement pressure brought on by the Affordable Care Act provisions, and that whole reimbursement change that took place between 2012 and 2017.

MR. GINSBURG: That's a really good point, Matt. So, basically the arbitrage model didn't work anymore when reimbursements were tighter.

MR. BORSCH: Yes. Not as well, in effect.

MR. GINSBURG: Not as well. Okay, between coding issues and equality bonus systems that yields bonuses for most and does not include penalties for any plans, Medicare is continuing to pay more for Medicare Advantage than in the traditional program. Since some cutbacks in Medicare payments lead to fewer extra benefits and higher premiums to enrollees, has the program stepped into a trap in which continuing growth in MA makes it even more difficult for the program to correct the overpayments because of the political advocacy of the beneficiaries?

MR. BORSCH: If I can take a quick run at that?

MR. GINSBURG: Sure.

MR. BORSCH: I think the setup of that question, it fails to take into account the important dimension that you can't compare traditional Medicare and Medicare Advantage entirely on an apples to apples basis, because in Medicare Advantage you're getting additional benefits, principally through more costs, more comprehensive coverage and less cost-sharing. And if you didn't have those additional benefits, if that same population were back in traditional Medicare, they would be more economically

squeezed, either because they would need Medicare Supplemental Coverage, or because of the cost-sharing they would face in traditional Medicare. And that, in turn, would come out economically as greater inequality to some degree.

Now, I think the line of questioning that is a better one is, is this the most efficient way to deliver the cost of traditional Medicare and the extra benefits that MA is providing when you compare it on that basis. And I think opinions differ on that question.

MR. GINSBURG: Yes, thanks Matt. Let me move on to large employer health benefit strategies, which you were all interested in talking about.

So, with the Cadillac tax now repealed, I would expect a slowing of the growth of deductibles in employer plans and be the kinds of family foundations employer survey for 2019 appears to show this. And very tight labor markets are also likely to have an effect, but the uncertain economic outlook that we see today may also come into play.

And how employers are thinking about rising premiums and what is showing up more in large employer RFPs to insurers, the self-insured plans? And any of you can take a first crack at this.

MR. HILL: I guess to jump right in, as part of what's going on with COVID recently, I've touched base with a lot of health benefits consultants. Again, one of the themes that's going to resonate here again is whether it's telemedicine or whether it's a virtualized care delivery, we are not yet seeing employer sponsors want to push more cost, or push more risk from where we already are onto beneficiaries. I'd say particularly in response to the crisis, I think employer sponsors and health plans, they look politically unpalatable trying to do that right now.

The trend that I continue to hear from health benefits consultants is around beneficiaries engagement, how do you empower the beneficiaries with tools such that they can do a better job of engaging with their own care, engaging with their own benefits, you know, getting better consumption reducing costs and getting better outcomes that way.

I don't think you're going to see another step-up in deductible rates. I don't think you're going to see a big jump in high deductible plans or firms that move solely to high deductible plans without offering PPO plans.I think the general feedback that I'm getting from benefits consultants these days is it's about beneficiary engagement. And they feel that you've cost-shifted as far -- I believe there's some

Kaiser data on this too -- that you've cost-shifted to the point where you've gone beyond incentivizing good behavior and started to drive adverse outcomes, and now we want to come back a little bit from cost-shifting and figure out what is the way that we can keep the incentive alignment where it is, but continue to improve outcomes. And that's through engagement, that's not through piling on more restrictions on --

MR. GINSBURG: Good point, so in a sense, the move to higher deductibles probably was expiring on its own because of concerns that maybe it had gone too far. But now that we have a COVID-19 crisis, that's just going to accelerate the turnabout.

MR. HILL: Well, and I also think benefit design is a many headed animal. Where there's a lot of levels that you pull on as you create a health benefit for people in the commercial markets, again, if you think about things like, do you put somebody's drug payments into the deductible part of the plan and then do you incentivize pill splitting, and people skipping their scripts, and script abandonment when you're trying to encourage better health outcomes. It can be a very tricky and a very slippery slope trying to figure out if the behavior that you've incentivized is good behavior or bad behavior as it relates to health outcomes, and do you wind up costing yourself more money from a benefits perspective by a plan design that you've put in versus another plan design.

MR. GINSBURG: Thank you, George.

MS. GOLDWASSER: You know, Paul, one of the things to think about as well, because you were asking about would employers care about within the RFP, but we also have to think about the trend that we're starting to see where employers are looking at benefits that are outside the traditional RFPs and are contracting outside of the plans.

So, if we think about behavioral health benefit, if we think about digital diabetes, just kind of like all these ancillary wraparound benefits that are a way for the employers to, you know, the premiums have gone up so much, we now have to supplement the coverage with things that we don't necessarily want to do through our plan. So that's one thing.

The other thing that we are starting to see, it's still in its infancy, but we're starting to see large employers looking at it, is they're going back to the plans and they're saying, "We want you to give us the data. We want to do our analysis and to better understand our population and try to think about

solutions, and then we might contract with you for those solutions or not."

So, as an example, for example, here at Morgan Stanley, we now have a chief medical officer who is a data scientist, and we go to and we're kind of are looking at our data. And I think that is a real change where in the past the health plans perceived themselves the custodians of the data, and I think at times even told employers, you don't want the data because the data means that now you have kind of like, you're taking that risk that you have that data, and you need to do something about it.

And I think that that's something that's a fundamental change that is starting to happen in the market. And I know that in the earlier conversation, you had some questions about whether JP Morgan, Berkshire, and Amazon consortium and how that could change healthcare and how it can change benefits. But I think it's starting to happen already, even outside the consortium of these where large employers are taking a stance in looking at the that.

MR. GINSBURG: Well, that's fascinating in how --

MR. HILL: Think about organizations that push HTA [Health Transformation Alliance].

MR. GINSBURG: Go ahead, George, about HTA.

MR. HILL: I was going to build on Ricky's plan. I was thinking about organizations like HTA, a group of the largest self-insured employer sponsors --

MR. GINSBURG: Oh, the Health Transformation --

MR. HILL: Yeah, trying to work together to lower costs, and kind of vet some of these technologies that Ricky's talking about, and almost kind of work their own -- I would call it a "digital menu" of things that make sense to spread out to their employers and their employer group members.

MR. GINSBURG: Yes, so what you're both saying is that even though managing healthcare isn't what these companies are about, that's not their core, they feel that they just can't hand that off to insurers, they need to get involved themselves.

MR. HILL: When I talk to benefits consultants, it's interesting because a lot of these digital technologies that are coming to market now are pretty novel. Whether we're talking about the diabetes companies, or fertility is a big market, musculoskeletal is a big market, behavioral is a big market.

Again, kind of coming back to industry life cycle, I think these companies will have three

or four sales cycles where they can go direct to employer sponsors before the MCOs are going to need to find a way to integrate this into their offering, both because that is the job of the MCO, and historically, what you'll see is, if the cost of vertical that you're going after is not big enough, like either core medical or drugs, you're heads of health benefits wind up turning around and saying to their benefits consultants and to their MCO plans, "Can't I just get this through you?"

The executives get vendor fatigue. They don't want to manage 30 sub-vendors across 30 different disease states, each of which have a couple of employees in them.

So, you kind of see this path of creative destruction where you'll see a bunch of these new companies and new ideas that come to market, but to some degree they'll either get folded or integrated into the MCO offerings. I think one of the things that you see start to develop, which is very interesting, is Cigna and Express Scripts now having digital formulary. So, what they're offering to do -- and they seem to be ahead of the curve on this -- is they're curating these digital offerings already for their own beneficiaries and their employer sponsor clients.

And when we talk to smaller companies in this space right now, we tell them pick a partner, pick a partner on the MCO side because if you don't, you're going to wind up becoming the gatekeepers two or three sales cycles from now, when that head of health and benefits, either at Deutsche, or at Morgan Stanley, or BMO, is like, you know, "I don't want to be in the business of buying an obesity disease management app anymore. I just want my managed care plan to pull this together for me?"

MR. GINSBURG: Yes, that's a really good point. Before we get to questions, let's just finish this thing up, asking about your assessment of the potential of the partnership between Amazon, Berkshire Hathaway, and JP Morgan Chase, if you could talk both about what it would do for the three companies, and what might it do beyond the three companies.

MR. BORSCH: I can, Paul, maybe, from the standpoint of myself, and I don't want to say necessarily all the other analysts, but the three-way venture has so far been a bit of a fizzle. Now, I don't want to sell short what they may accomplish. And we could be surprised by what they come out with in a year or two. But the thing is the press release, or I should say, the public letter that introduced this was very broad and sweeping calling for a transformation of healthcare away from the for-profit model, and of

course, garnered a huge amount of attention coming from three of the most prominent business leaders in the United States. But the level of activity and traction for Haven, which is the venture they started, so far, has been -- we just really haven't seen any concrete results. So, again, it may be that things take time and we will see that, but so far, it's a lot of noise accompanying the initial idea, but not much follow through.

MR. GINSBURG: Thanks. Any other thoughts on this?

MS. GOLDWASSER: I think one of the things that we also need to remember is at times we get people put together, you know, what Amazon is doing with healthcare to the Amazon, Berkshire, JP Morgan consortium, and I think that we need to separate those two. These things take time. I think that, again, going back to one of the original questions that you asked in long-term, how is what we're seeing now with this COVID situation going to change healthcare delivery longer term. I think that kind of feeds into this question on how quickly can we see results from either what the consortium is, or even kind of like what Amazon can do in healthcare. We're looking at care delivery tools that are lower cost. So, to me, we might actually, from everything that is happening now, we might see an acceleration and seeing more coming out of those partnerships and of Amazon, than we've seen in the last 12 months.

MR. GINSBURG: Thank you. And George, what did you want to say.

MR. HILL: Paul, I love this question. It's one of my favorites. I would pile on to Matt's -- what we've seen thus far is a big goose egg. I think the model has limited scalability. I find it very hard to believe that BMO, Deutsche Bank, and Morgan Stanley, and Goldman Sachs are going to buy health benefits from JP Morgan. I've always believed that the organization that changes healthcare is in Washington, it's not in Seattle.

If we want to pull this apart, if you look at the characteristics of what has driven Amazon's historic success, they've been successful in fragmented end markets that are low or lightly regulated, have direct customer participation, focused on convenient selling, have an ability to provide a place discovery or transparency function, markets with inefficient supply chains or logistics, and the legacy advantage have been taxed advantaged buying. None of these things are healthcare.

Healthcare is an immensely regulated -- in some parts of the market fragmented, but in some parts, like Matt talked about in Medicare Advantage -- increasingly concentrated market. It is

heavily regulated both at the Federal and at the state level. I would pull apart -- I guess a question I would ask is, how long do we want to give Amazon and Haven to do this? I do not think the Haven organization will make meaningful impact on healthcare in -- I'm going to call it my professional career, so long as I've been doing this.

They are just so many barriers to every segment of the business that they go after, where there are entrenched relationships that will be hard to break down. Where there will be indirect customer participation, where the value proposition will not be immediately relevant, where it's hard to see what they're doing better than the companies that participate in the market are doing now.

I think we've been fretting about Amazon in the drug supply chain now since 2016 and it looks like they've won one contract, which is not even a -- they've gotten into one payer network, as a potential mail pharmacy. Healthcare is not an industry that is fast. Healthcare is risk of verse by its nature, it is slow. I mean, if we're asking does Amazon, does Haven make an impact in 50 years, maybe. Can they make an impact in five? Extremely unlikely.

MR. GINSBURG: Okay, very good point.

MS. GOLDWASSER: I have to jump into this one. I have a little bit of a different view.

Again, healthcare is very regulated but what we're seeing in these unprecedented times, we've seen relaxation of regulation, right. We've seen things happening very fast, CMS, FDA. And again, the question, are these things going to stick? Because if they are, we might see some new developments insurance that before we thought would take a decade to make an impact, could move things faster. So, I think these next 12 to 18 months are going to be very, very interesting for the healthcare system in terms of kind of rethinking the pace of change.

MR. HILL: That's a fair point and I would fall back on my comment where the stroke of the pen rests. Where business models can go from advantaged to disadvantaged very quickly, and opportunities can change very quickly based upon the regulatory environment. But that's a very fair point.

MR. GINSBURG: Okay, let me move on to some -- we got some questions. We've got one from Janet Heinrich. How do insurance organizations using integration strategies manage very complex costly patient populations that also need considerable health-related social needs? Oh, actually, this is not from -- this is from an anonymous attendee. Anyone want to take a crack at that?

MR. BORSCH: I guess I'll just jump in here. That's a work in progress. The evidence that we see is, I think, the success in the traction that the insurers have had taking on the higher acuity populations, you know, whether we're talking about dual-eligibles or other special categories of the Medicaid subpopulations. Because, of course, as I'm sure you know, Paul, that the -- it's pretty close to an 80/20 rule in Medicaid where 20 percent -- well, it's not 80/20, you know, maybe it's 70/30. But it's a small concentration of the high acuity patient base that drives the majority of costs in Medicaid. And that's been slow to shift to managed care, but it's been happening particularly in the last few years, whether that leads to sustained success, it's probably too early to say.

MR. GINSBURG: Okay, let me go to another question. Commercial insurers will need to make decisions about 2021 premiums before all of the COVID costs are known. Do you think they will lean towards the worst-case scenarios, much higher premiums, or attempt to keep the magnitude of the premium increases lower in 2021 and potentially increase premiums more in 2022 to deal with these costs?

MR. BORSCH: Ricky, I can see you want to answer this one. You're smiling.

MR. GINSBURG: It's a good question.

MR. HILL: Yeah, I'm --

MR. GINSBURG: Okay.

MR. HILL: I'm okay.

MR. GINSBURG: Let's go to Ricky.

MS. GOLDWASSER: Sure, of course. So, again, the timing here is very tricky. And, obviously, we don't have the crystal ball. I don't think the plans themselves have even enough information to have a clear view on this right now. We also have to think about just the political backdrop. You know, only a few months ago, there was -- we were talking about, you know, Medicare for all and kind of like the insurance companies were kind of like in the spotlight. Obviously, that has eased with now Joe Biden in being kind of like the frontrunner. But I think the point here really is that the premium decision, again, could vary by region, and has to be thought about within the backdrop of just the political landscape and publicity associated with higher premiums.

MR. GINSBURG: Thank you. Let me go on to another question. What are your views

on too big to fail scenarios for health care value chain? More consolidation or federal government steps in? What conditions would drive the greatest risk for insolvency?

MR. BORSCH: Well, I mean, let me just start by saying I think the obvious scenario that we could sort of plot out is if you unfortunately had a close to worst case scenario for COVID-19. We ran the Imperial College range from, you know, 10 days ago, which is changing, but, you know, 2 million to 20 million hospitalizations in the United States from COVID-19. And at the upper end of the range, that would imply, even with a lot of offsetting admissions that don't happen, something like 30 percent -- a 30 percent increase to the level of hospital admissions if you thought about it in terms of calendar year 2020. And maybe that would spill over to a 20 to 25 percent increase in health care spending at least as it relates to hospital and physician inpatient and outpatient. Then the question is how much of that flows down onto the books of the insurers?

And if you took that magnitude of medical cost increase, and put that on the books of insurers, a 20 to 25 percent jump -- not to say that that's likely to any extent or that that flow through is correct, you would be getting borderline insolvencies. You would be getting some insolvencies in the health insurance industry for sure.

But the problem with the math that I just outlined is it's also true that in a worst-case scenario or near worst case scenario, you're going to have a lot of care that's provided directly by emergency mechanisms directly funded by the government. So, I think the interesting question is if you had a scenario where health care costs were up by 20, 25 percent for 2020, how much of that would have to be borne by the health insurers?

MR. GINSBURG: Good point.

MR. HILL: Payer mix becomes a huge deal.

MR. GINSBURG: That's right. A very good point. The shedding of hospital beds has occurred with consolidation, closures, and shifts away from traditional inpatient facilities. How will the pandemic change thinking about hospitals of the future?

MS. GOLDWASSER: So, you know, it's a really interesting question and, obviously, there's no clear answer. But if we just -- if we step back within -- before this, obviously, there was a lot of discussion about overcapacity of hospital beds. And that idea that the hospital in the future should just

have, you know, an ICU unit. Interestingly enough here we're seeing -- obviously, we are the midst of this crisis where capacity issues in certain regions. But if we really kind of like think about where the capacity issue is, it is within the ICU, right? It is with the ventilators. And to me that is going to be the thing to solve for in the future, right? It's not just hospital capacity. Because all the other trends that we have been talking about, telemedicine, virtual health, that would actually suggest that we would need to some extent less beds, right? And we will need less physical capacity. But the capacity that we really need to focus on and better understand is really that critical care area. So, again, when we think about acceleration of certain shifts in the marketplace, here's another one that could happen.

MR. GINSBURG: Yes, that's a good point. You know, I guess we've always recognized that hospitals do have standby capacity. They have burn units. And it's always been a rationale for some of the hospital overhead being loaded onto outpatient services because of that. So, the need for standby capacity is not a new issue. But it's just, I guess this is different because of the magnitude of the spike in demands which, you know, maybe won't happen for another 10 years. Good point.

I think this is a good time for us to take our 15-minute break

MR. GINSBURG: Yeah. Okay, well, let's continue. Got some questions on narrow networks. And the first question is to discuss the influence of narrow network plans are having or will have on the marketplace plans and the employer-based coverage. To what extent are these networks being built on lower unit prices versus broader measures of spending such as per episode or total cost of care per year? And how does the quality of care enter into the process for selecting providers for narrow networks? I think, Matt, you were going to answer this?

MR. BORSCH: Yeah, if I could. I mean, I think this is a really important question. I think it in some ways, to the extent that integrated care has been identified as, you know, the most proven area for achieving health care cost efficiencies without sacrificing quality, figuring out how to penetrate, particularly, the employer-based coverage universe with narrow network plans is something that I've got to believe it's going to happen this decade.

And just to explain, I mean, to the extent that an individual or a family is able to select a narrow panel of providers that will take responsibility for population-based reimbursement, that should drive a lot of savings. There is a chicken and an egg problem here in that you referred to unit cost

discounts I would think about it more as, again, population-based level reimbursement. But the narrow network plans aren't going to be there until there is a critical mass of people, you know, willing to go to those plans and in turn, purchasers aren't going to be as attracted to them until the cost-effective options and providers are organized around those plans to provide them.

MR. GINSBURG: Yes, good point. And it seems, though, there are so many barriers to an employer doing this whose workforce lives all over the place, who has very different preferences. And, of course, the federal tax system is subsidizing employer coverage so heavily. So, I've just never seen how it breaks into the employer market.

MR. BORSCH: That's the question. Private exchanges were supposed to be the mechanism for doing that. But, again, I think partly the chicken and the egg problem, you know, they haven't prospered in the way that we expected a few years ago.

MR. GINSBURG: Yes. Well, you know, I guess the model will develop in the individual market for a while. But I guess it may stay there, or it may somehow maybe someone will figure something out in the employer world to do what private exchanges failed to do.

MS. GOLDWASSER: You know, you raise a really interesting point where you talk about the large employers and really the parity of the benefit. And how do you create a narrow network when you have employees across the nation? And we really have to think again about the role of the larger more diversified companies. I think we're going -- it sends me back to the whole vertical integration discussion. Are the players that are really going to be longer term winners are the ones that can create narrow networks but nationwide?

Going back to your initial question about the health plans and the fact that health plans now own physicians, they do have kind of like that national reach, and they have the ability to create narrow networks that will satisfy large employers' needs and demands on a -- but also on a local level. So, I do think that it brings a really, really interesting dynamic in a health care world that's very localized and regional where you have to be also able to scale and provide things across the country, which I think could lead to just more partnerships also in the future.

MR. GINSBURG: Yes, a good point.

MR. HILL: Ricky, you kind of touched on exactly what I was thinking, which was if we

can't kind of seem to make the narrow network thing take hold on the employer sponsor side, what you start doing is you start steering -- you do your best to economically steer beneficiaries to where they seek coverage as opposed to -- you're steering for channel as opposed to steering for doctors. So, you're steering towards telemedicine or towards retail clinics and away from primary care and away from the emergency department. That's the steerage you start to see as opposed if you can't get the narrow network thing to take root.

MR. GINSBURG: Yes, good points. Let's talk about Medicaid expansions and how are insurers thinking about their existing and future investments in Medicaid managed care markets?

MR. HILL: Paul, I missed the last part of that. Can you say that last part of that again?

MR. GINSBURG: Oh, sure. Yeah, discuss how are insurers thinking about their existing and future investments in the Medicaid managed care markets?

MR. HILL: I guess I can start with that one. I mean, I think most of the MCOs right now that are exposed to the managed Medicaid markets generally view them to be I'll call those markets somewhat attractive. They're obviously not as profitable as commercial markets. I don't believe they're as profitable as Medicare Advantage. That is a market that tends to be a little counter cyclical economically. When employment rises, you see Medicaid rolls fall. So, you have a little bit -- it's not necessarily aberrational for us, but if people are coming off Medicaid and going onto commercial rolls, the health plan would probably rather see that if they're picking up the beneficiaries.

You know, it's probably -- it's not a good thing for anybody if managed Medicaid becomes a rapid growth market again. It means the economy is going the wrong way. But I think most MCOs look at the managed Medicaid product as something that they want to have in their quiver as an offering. Few look at it as a core strategic growth product, in my opinion, except for the companies that are obviously focused on managed Medicaid.

MR. BORSCH: I guess maybe I would just differ in degree with you, George, in the sense that, you know, if you look at the managed Medicaid market from a revenue perspective, it's growing about as fast. It depends, albeit not in the last year, but and, again, because of some of the counter cyclicality, but if you look at it over a multi-year basis, it's growing about as fast as Medicare Advantage from the increased penetration of private sector managed care. You know, I think you will see

as you've seen recently some shifts in investor preference for growth from that program, which has been lumpier. We have less visibility on it versus its sort of regular growth that you have high visibility on in Medicare Advantage.

MR. HILL: Yeah, I think that's fair. I think -- and I think you made a good point about we've gone through a big period of coverage expansion in Medicaid, managed Medicaid. And I think the last that I saw it's about 82 or 84 percent of Medicaid beneficiaries in the U.S. are eligible for some type of managed Medicaid product based upon the state they live in. So, yeah, I don't disagree on it. I guess, my -- I would agree that the best years of managed Medicaid growth seem to be behind where we are now as opposed to ahead of where we are given the amount of managed Medicaid that's available.

MR. BORSCH: Yeah, but remember the spending penetration, as I think you know, is substantially less than the population enrollment penetration. It's, you know, you mention 85 percent, the spending penetration is thought to be somewhere between 50 and 55 percent.

MR. HILL: Fair point.

MR. GINSBURG: Okay. Let me go on to health IT. Collecting, analyzing, and using patient data will be a key element in providers taking on and successfully managing delivery of care. Right now, to some degree, EHR interoperability is still an important barrier. Then we just had new rules from the Office of the National Coordinator about mandating open APIs. And the question is might this substantially reduce the barrier to using data more effectively to coordinate delivery? And how might greater interoperability change the competitive landscape in health care delivery? I think all of you indicated you had something to say on this one. Well, George, you're on the screen, so --

MR. HILL: Yes.

MR. GINSBURG: -- maybe you should start.

MR. HILL: So, I think every health system would claim that having access to good data at the point of care is critical as it relates to their ability to take risk and manage risk. I think where we are post the implementation of the High Tech Act from 2009 through 2015 means that most large hospitals and health systems have a relatively current generation EMR system in place. I think of the technology and the data as kind of cable stakes so I think now it's -- the question isn't access to data. The question is the ability of health systems and health hospital organizations to make sense of the data and make

good decisions with the data as it relates to their ability to kind of take risk either on a commercial risk sharing basis or whether or not they want to own their own plan in any particular market.

MS. GOLDWASSER: So, Paul, you, I think one of the things that you are really asking is about how is sharing the data is going impact the competitive environment? And I think that out of a old school thought process that if you are operating in a closed environment, right, you are protecting your competitive advantage. And to your point, one of the things that this administration is being very proactive, and I think put the emphasis in the right place is the making sure that we don't have these data barriers. And I think that long term, we could see pretty meaningful changes in terms of the competitiveness. And I want to bring in another part of it because this is not just interoperability between hospitals. This is also sharing the data with the individuals and with the consumers.

And being able to -- for us to have our health records on the palm of our hands and on our phones. And that changes the supply demand curve in our view. That means that for me as an individual, I now can take my data and go to another hospital or another provider and share that information. It also means significantly lower cost burden for the system because you don't have to repeat tests to get results. So, I think that this will create very meaningful changes over time and will make the health care system more like a true marketplace.

MR. GINSBURG: Yes, good -- do you have any sense of how many years it might take before this has a noticeable impact? In a sense, how long do we have to go before people can -- the data actually does become interoperable and people figure out how to do something with it?

MS. GOLDWASSER: So, I'll go back to that survey that I quoted before where we asked private companies and some of also the largest enterprises, what are their thoughts there? And it seemed that I would say about 50 percent said that this is going to take somewhere between 5 to 10 years where we're going to see more of that kind of like seamless interoperability.

MR. GINSBURG: Good.

MR. HILL: I think you make a really good point though about the data portability reducing the switching cost that consumers have between provider organizations.

MR. GINSBURG: Yeah. You know, so that was -- what about -- we focused a lot about competition. What about how long is it going to take providers to be able to do better when they instantly

know, which of their patients have gone through emergency rooms that they didn't know about or make it easier to direct patients to suitable specialists. Is this another 5 to 10-year process or do you think that providers will be able to make effective use of the data much faster?

MR. BORSCH: Well, I guess I would just say I, you know, -- this is a very hard question to answer, but there is tremendous focus on, harnessing and using data. Obviously, health care has typically been a laggard, but that focus is across the entire economy, and so I'd be surprised if the pace of innovation there isn't accelerated over the next few years.

MR. HILL: Matt makes a great point that this has actually been kind of a promise of health care IT I think since the early '90s. I believe it was in '92 or '93, the Institute of Medicine published that report *To Err is Human*. It talked about 100,000 people dying annually as a result of preventable medical errors. Their prescription was that decision support tools and information technology at the point of care would help alleviate this problem. It's something that we're still talking about 30 years later.

And then I think kind of bringing all the points together is that the provider organizations aren't necessarily incentivized to better use the data because to some degree, the better delivery of care winds up picking their pocket. Either data transparency and data liquidity increases a patient's ability to go to another provider or the delivery of better care particularly in fee for service models, eliminates future revenue streams for the provider.

MR. GINSBURG: Yeah, that's a good point. To the extent the providers are still in the fee for service worlds, then these data don't have much opportunity for them. Good.

Hospital employment of physicians. The question is, you know, this has been a dramatic trend as far as the increasing proportion of physicians employed by hospitals. How much further will this go? And will most physicians in most communities be employed by hospitals in 5 or 10 years? Or will there be developments that are going reverse this trend?

MR. BORSCH: Well, I guess I, you know, I would just say you, yourself, Paul, made the comment that you sometimes attribute the motivation of United Healthcare and other payors in acquiring physician practices is actually to -- in part, to mitigate or prevent the hospital systems from taking over as it were. The jury's still out on, you know, what exactly is being achieved through the acquisition of all these physician practices? You know, is it -- is that, you know, really part of forming cost-efficient

accountable care organizations, or is it more oriented around controlling the market and controlling the flow of volumes? And, I mean, I guess the answer is it's a little bit of both. But I think what we've seen heretofore, a little bit more of the latter than the former.

So, you know, what stops, this trend from sort of continuing ad infinitum? I mean, historically, when the hospitals have gone through a number of years where they have done heavy acquisitions of physician practices, the results have not been economically sustainable. That may not be the case this time, but that certainly was the case in the late 1990s.

MR. GINSBURG: Good point.

MR. HILL: Maybe looking at this from the supply side too, you don't see -- I thought one of the last stats I saw was that doctors graduating from medical school almost 90 percent of them are going into employed practice these days. Don't quote me perfectly on that stat, but I know the numbers have, you know, really high and up from the numbers that looked like 50 percent a little over a decade ago.

I think that primary care has become much less attractive of a business economically. I think standing up your own practice is hard work and unless you're a higher earning specialist, has become a much less attractive business economically. And I think if the idea is that you're going to come out of medical school $300,000 in debt looking to take a primary care job making 125,000 or $150,000 a year, standing up your own practice is probably not the best economic idea to do. It's probably to go work for your large health system that's nearby.

Paul, when you first asked the question, I was going to crack the joke, no, they're not all going to work for hospitals, they're going to work for health plans. Like I think employment -- I think the employee model particularly in primary care and the low earning specialties is just -- it's the decision that makes sense from the provider's perspective just because the individual practice is less attractive now.

MR. GINSBURG: Yeah, I mean, this is why it's happening so fast that, you know, there's interest in the hospitals in recruiting physicians, but there is -- but physicians, they don't want to run businesses. They don't want to be in small practices. And I guess that's why it's happening so fast. And I guess we will see in a few --

MR. HILL: Well,it's the answer to your private equity question earlier is that there's just a

supply of probably value -- attractive from a value perspective labor in the form of physicians where you can, you know, they -- the arbitrage in setting up the business opportunity is being taken on by the private equity firms and the venture firms that create the businesses. And we're arbitraging kind of the labor costs from what an independent provider would work -- would earn.

MR. GINSBURG: Yeah, so I guess the question is whether, in a sense, which is a more effective model, the hospital employment or the employment in private equity owned practices? Or insurer owned practices? Any perspective on whether the hospitals are doing well in managing this resource they've brought on board?

MR. BORSCH: You know, I mean, I think -- I've used this answer too many times, but I'll do it again. I think the jury is out on that to some extent. I do think that, despite the amount of tension that accountable care organizations have gotten and contracts with accountable care organizations, the shift of the medical budget responsibility to the extent, you know, that is ultimately where we go is still in pretty early days. And, so to the extent that that is the best place to get to, the insurer-owned practices are certainly accomplishing that more rapidly from what we've seen thus far.

MR. GINSBURG: Yeah, good point. I've got a question on hospital consolidation. While the pace of hospital mergers has slowed recently, there's still interest in scaling and combining operations among hospitals, often across distinct geographic areas. What is motivating these systems in different areas to combine? What do they see as the upside, and where is the FTC at in its potential to challenge these cross-market mergers? I think, Matt, if you want to start --

MR. BORSCH: Yeah, no, sure, I mean, --

MR. GINSBURG: -- for this one.

MR. BORSCH: I would just, you know, the attraction, of course, to the horizontal concentration of hospitals in a local market is very clear from the standpoint of pricing power and that's, of course, why the FTC has been paying a lot of attention to that. Definitely not as clear, you know, when you're moving across regions, but there are, of course, corporate level and some multi-region level economies of scale to be realized. It's not clear to me that some of the merging organizations are necessarily in a position to do that. I think some of the public hospital companies and maybe, you know, HCA in particular, are in the position to do that and they are, and it'll be interesting to see if that trend

accelerates over the next few years.

MR. GINSBURG: Good, thanks. Health plan provider pharmaceutical leverage. Is there a trend in whether plans or providers are gaining leverage now?

MR. HILL: I guess when you say pharmaceutical leverage, could you be a little more explicit in which part of the channel you mean? Like I said, if I were to start talking about the integration between the PBMs and the MCOs, the bringing of the lives together creates scale from the vertically integrated PBM's perspective. That scale gets executed in lowered brand drug prices by the ability to shift market share and earning higher levels of rebates. The higher level of lives that you manage turns into better retail pharmacy network discounts, so you're getting better prices on your ability to fill from retail pharmacies.

I think the technical back office synergies are probably not super high. I think there is probably on the managed care perspective, you can use what has historically been the higher returning PBM business if you want to, to subsidize market share gains across pricing in the managed care business. So, you know, are there savings being generated all the up through the MCO, the vertical integration, the PBM functionality, and to some degree, if you think about a PBM's cost of goods sold, the biggest portion of their cost of goods sold is what they pay to fill scripts at retail pharmacies. Those savings are definitely funneling all the way up through the channel.

MR. GINSBURG: Yes, good point.

MS. GOLDWASSER: I think another interesting point is when we think about the balance of power between drug companies and providers. Just last year, we had a group of hospitals, right, looking to create their own generic manufacturing sort of solution. So, I really do think that we are starting -- and, again, the jury is still out.

MR. GINSBURG: And that would be -- is that Civica? Is that the name?

MS. GOLDWASSER: Yeah. Yeah, and the jury's --

MR. GINSBURG: Yeah.

MS. GOLDWASSER: The jury's still out whether they're going to be successful or not. I know that a lot of eyebrows were raised when the announcement was made. But I think the point here is that we are starting to see these groups looking for creative solutions to help ease the issue of shortages,

of pricing. So, I think that -- as we see some success stories, we could see that balance of power starting to change.

MR. GINSBURG: Thank you. Any thoughts about providers and health plans? You know, I guess a lot is up in the air because of the coronavirus.

MR. BORSCH: Well, Paul, I mean, I guess I would just -- maybe this is at too basic a level, but the trend as far as we can discern it, seems to be gradually towards other plans emulating the model that United Health has pioneered. And I would predict you'll see more going in that direction even though, you know, some of the plans have just said we're not going to do that. We're not going to move in that direction. We think the virtual channels are just as effective or more effective than ownership.

MR. GINSBURG: Yeah, so when you say the United strategy, this is the owning lots of physicians' --

MR. BORSCH: Right, exactly.

MR. GINSBURG: -- practices? Okay.

MR. BORSCH: Yeah. But, again, the jury's out on that.

MS. GOLDWASSER: And, again, I think that even the health plans that are saying we don't need to own are starting to -- anecdotally, we're hearing, they're starting to partner. So, I do think that there is a greater appreciation of the value that's coming with between -- from that relationship with the provider. The question is really what is the business model going to look like?

MR. GINSBURG: Yes, that's a good point. There's been a lot of public policy discussion attention on drug distribution recently, especially concerning rebates, which have grown as a percentage of prices in recent years. The administration considered outlawing rebates, but pulled back. Some policymakers are considering having insurers credit something approximating rebates to patients who use the drugs, something that commercial insurers have been doing in employer coverage. What's your perspective on the value of rebates as a tool to obtain lower prices and the best approach to alleviate the burden on patients who use those drugs with particularly large rebates?

MR. HILL: I'm happy to start on this one, and just because I commented on rebates earlier. Like, I think rebates are effective but clumsy. And I think where we are with rebates now, kind of, you know, the point that Ricky made earlier is an unintended consequence of the rapid growth of

specialty drugs. Where you think about where a lot of the rebate dollars come from now, they come from very expensive brand drugs, which tend to be either specialty drugs or brand drugs which treat small patient populations. A lot of these people that we've discussed earlier might be on high deductible health plans. And, you know, another recurring theme in health care is there's only so many pockets of money to draw from. So, a lot of the employer sponsors in health plans are using significant rebate dollars. We've estimated that you could be subsidizing employer level total medical spend by up to 10 percent with the rebate dollars that are coming from brand drug manufacturers. So, if you think about where the money comes in to pay for benefits, you've got employer contributions, you've got employee premiums, and you've got drug rebate dollars. And on the other side, you've got the money spent for drugs and you've got the money spent for health care. If you were to redistribute those rebate dollars to the beneficiaries that are consuming the drugs, what you wind up doing is probably rising -- increasing premium dollars 5 to 10 percent to beneficiaries who are not on those drugs. And that's -- again, that's an issue that's really developed over the last decade, 15 years with the rapid growth in specialty drugs.

Again, the unintended consequence that has occurred is we're basically using our sickest, most vulnerable patients to subsidize 95 percent of your beneficiaries that are healthy. Again, not a planned consequence, but the flip side is now you have to turn around and go back and figure out how do you raise premium costs for your 95 percent of people who are not on these drugs?

So, I think that you could come up with a rule. You've seen health plans that will adjudicate these rebates at the point of care for beneficiaries from some of the self-insured employer sponsors that have implemented this that we've spoken to. What they have said is kind of in year one, we're going to eat this and see what it looks like. So, the employer will foot the cost. In year two, we've got to figure out what changes with the dynamic or what our PBM can do.

I don't think rebates are inherently bad. I think they are a clumsy mean that achieves the end of lower brand drug prices across a population. The problem in which they are administered and adjudicated is something that could probably stand some attention and some work.

MR. GINSBURG: Yeah, good point. In a sense, it's really like the drug benefit is being hollowed out in return for a lower premium because of the growth of rebates that aren't passed back to the patients that used those drugs. So, in a sense, the premium bump is often because, well, you're

restoring the comprehensiveness of the plan.

MR. HILL: Right, my plan --

MR. GINSBURG: I think Ricky was about to --

MR. HILL: My medical premium is artificially too low because anybody who's taking a multiple sclerosis drug who's generating 50 or $60,000 a year in drug rebates, those rebate dollars are being used to subsidize.

MR. GINSBURG: Yeah, exactly. Ricky, you were going say --

MS. GOLDWASSER: Yeah.

MR. GINSBURG: -- break in.

MS. GOLDWASSER: I mean, one of the things when we think about the rebate rule that didn't come to fruition, I think really fundamentally it was about aligning incentives. And we think about who's benefiting from the rebates right now, you know, a big chunk of the rebates are going to the sponsor. They're going to the employers. Some are kept within the channel whether it's mostly PBMs in the channel. But really mostly goes to those large sponsors. And that idea that if you now institute point of care rebates, the employer has to take a step back and think about, well, what do I -- what type of drugs should be on my formulary? Because I'm not getting the benefit of the rebate anymore, should I really go to that lowest cost drug? And that would, I think, if we would have seen it, would have actually incentivized also the manufacturers to start keeping price increases low, even lower prices.

So, I think this is really at the bottom of it, because I always kind of like ask the question, it might be a direct question, but at the end of the day, if we want to address the high cost of drug pricing here is as a manufacturer, why don't you just don't raise prices? Or why don't you just lower prices instead of giving that rebate? Of course, then they really have to compete. Then it's efficacy, right? Because then we're talking about kind of like volumes. But to me that's really the relevance of a drug rebate rule. It's just kind of like a first step to really change incentives in the system that will over time lead to different behaviors of all the different constituents.

MR. GINSBURG: Okay, thank you. Next question is the spending trend outlook. And spending trends have been moderate for many years, but still exceeding wage trends, and apparently, inching up. And the HCCI has been reporting that much of the spending increases, that's the Health Care

Cost Institute, it's been much of the spending increases in employer coverage has been due to price, but utilization has become a more important factor recently. What are your expectations for the next five years? And how might a upcoming recession affect the spending curve?

MR. BORSCH: I can take a stab there. I mean, you know, we've heard about this ad infinitum, but it bears repeating that the demographic trend is a strong one. And we're actually at a pretty important point I think, you know, to the extent we focused on the number of people turning 65. The vanguard of the baby boomers will start turning 75 next year and, you know, that while there's no, you know, cut off there, you know, we're really talking about peak utilization years. And in fact, the population of 75 and older is going to grow by 4 percent or more per year, for much of this current decade. And that's certainly going to be a driver of higher health care costs.

But, you know, to the extent it's -- I'm not sure that we know yet that there's going to be any broad-based utilization increase amongst the population if you adjust for age. That's going to depend to some degree on the degree of health care innovation that's out there. I think one of the things to bear in mind about where we are today is many of the expensive in-patient procedures that were underpenetrated in the '90s and early 2000s, are, you know, close to fully penetrated today. You know, hence, I point back to the pace of innovation and it may be that biotech and specialty drugs is what, so to speak, picks up the slack and the spending inflation starts to take off again.

MR. GINSBURG: Thank you. Do others have perspectives on spending trends?

MR. HILL: Yes, I think Matt kind of hit all the key points. Just the things to focus on is the launch of new technologies and the mix effect that has like kind of per capita utilization, age adjusted probably doesn't change a whole lot. But the introduction of new medical technologies, the introduction of new drugs, the introduction of new procedures, you get a positive mix effect that drives prices higher is probably what is worth paying closest attention to. And we're looking back five years from now to attribute where cost increases came from, the mix effect is probably more important than the utilization effect.

MR. GINSBURG: Good points. Okay, I've got one more question then we'll go to the audience for questions. This is about addressing rising drug spending. How much success are insurers achieving through their management tools, such as prior authorization and step therapy? And, I guess,

I've got a second piece of that.

MS. GOLDWASSER: That's a very short answer. I think they're achieving very high level of success. I think the question really is can you use these tools? These tools have been for years now, been successfully utilized on the pharmacy side. Can you use it now on the other side and on the medical side at the same level of effectiveness?

MR. GINSBURG: I see what you mean. Perhaps taking those tools and moving them into beyond pharmacy, beyond even physician administered drugs, and moving them on to procedures.

MR. HILL: Cost, quality, and access.

MR. GINSBURG: Okay, and what is Wall Street expecting as far as federal policy to constrain drug prices?

MR. BORSCH: I think that we are -- I mean, of course, you know, what happens next is probably not going to be until after, almost certainly, really, until after the November elections. So, to some extent, of course, it will depend on what the results of the election are.

I think, you know, at least from some of us analysts, there is some historical skepticism that we will see a whole lot of change because the pharmaceutical lobby is, of course, very strong protecting the current system. And, that's not to say that the current system doesn't have some strong positive features in encouraging innovation, which, you know, is something globally that is still led by the United States. But I think in terms of sweeping changes or big reform, I just don't think you're going to see it in at least the next few years.

MR. GINSBURG: Okay, and are there -- George was -- may have said something about this, but beyond specialty drugs, you know, beyond drugs period, are there other important medical technologies coming down the pike that might make a noticeable difference in spending trends, either raising them or lowering them that you're aware of?

MR. HILL: I'm trying to think if I can come up with an example in each category. Because, again, once you -- when you look at where macro health care costs are allocated in the country when you've done hospital procedures, primary care, and drugs, you've ticked about 70 percent of where the U.S. health care dollar goes. I'd say which both kind of creates an -- like if you want to do anything at the macro level to reduce health care costs, if you don't go after one of those three buckets, you're not

really moving the needle.

The other part is like I think about some of the expensive lab tests that might come to market like lipid biopsy, blood-based cancer detection, you know, continued growth of robotic surgical procedures. I'm much less the hospitals analyst I think than maybe anybody else on this call. So, I'm trying to think about what else jumps in here from a facilities-based perspective that drives the mix perspective. I mean, gene therapy, obviously, and kind of these rare disease drugs that are coming out at $2 million a treatment. They can be curative, but 2 million bucks is 2 million bucks. That's I think those are the buckets that we keep our eye on from a mix perspective.

MR. GINSBURG: Thanks. Thanks, let me -- actually before I go to the questions that we got from the audience, for any of you, is there any insight that you are looking forward to bring into our discuss that hasn't come into our discussion on any topic?

MR. BORSCH: Well, we've covered a lot of ground. Not from my perspective, Paul.

MR. GINSBURG: Okay, good. I've got a question from -- oh, I've got a whole bunch of questions. Okay, when are consumers ever going to have access to meaningful information about allowable costs and consequent copays and cost sharing, especially for high cost conditions like cancer, so that they can make informed decisions about health plan and provider selection?

MR. BORSCH: I mean, --

MR. HILL: That's a great question.

MR. BORSCH: Yeah, there's, obviously, if you compare where we are today versus 10 years ago, things have advanced a lot. But not to the point that, you know, they could or should in terms of providing the information that consumers really need and want at the point of care. And, you know, that's going to be contingent on upgrading and integrating the technology between hospitals and insurers and having the incentives to do that. And to some degree that has to be pushed by, you know, the end purchasers whether that's government or, you know, employers, particularly large employers. Otherwise it's going to take longer to see that get realized.

MS. GOLDWASSER: I would tie some of it back to one of the points that we discussed before, which is when we as individuals will have more control over where we decide to go to, i.e., when we're going to have all the information. I mean, we all -- the information is ours, right? But when are we

going to have access to the information? That's when you will start to see that happening more readily because when you talk about change incentives, then providers, hospitals, insurance plans, they'll all have that incentive to give us this information so we can make informed decisions.

MR. GINSBURG: Thank you. This from Henry Azowski (phonetic). How does the investment community evaluate the potential impacts of an adverse decision relative to the constitutionality of the Affordable Care Act?

MR. BORSCH: I'm not sure I understand that question, Paul.

MR. GINSBURG: I think they mean, you know, if somehow the Supreme Court, you know, struck down the constitutionality of the Affordable Care Act, if that enters the thinking of the investment community as to what do they perceive might happen after that?

MR. BORSCH: Well, I mean, it has, but I think I, you know, I think the pretty strong consensus is that ultimately the Supreme Court will rule to -- as they have already, two times in 2012 and again in 2015, despite changes in the composition of the Court, that they will highly likely uphold the law.

What happens if that's not the case? You know, I think there's an expectation that many of the popular provisions of the Affordable Care Act, including, you know, the ban on pre-existing condition exclusions, would somehow be retained by Congress. But I don't think anybody's really tried to plot out in detail how that might happen.

MS. GOLDWASSER: You know, another interesting thing to talk about when you think about the Affordable Care Act, again, putting on this COVID lens, is what the role of exchanges will be past this. And the idea of just more coverage, you know, it brings question, right? I wonder if, you know, the repeal or the replace of exchanges will even be a topic of conversation post this.

MR. GINSBURG: Yeah, good points. Got a question from Craig Lisk saying for physicians, will we see more movement of physicians into concierge practices? And what will be the implications for people to access to primary care physicians? And he goes on to give some examples of where it's impacted him. I've certainly heard lots of anecdotes about slow movement into concierge care. Has this been on your radar screen?

MR. HILL: There's a company that just came public that focuses on concierge care, so I think a lot of investors have focused on it. I think right now concierge care is kind of the niche offering in

the primary care space. You know, and I think it works for a lot of people. I think a lot of the market still doesn't even know a lot about concierge primary care or even what it is. Actually, I think it makes a lot of sense. And, you know, you kind of talk about risk sharing. If you're paying $2,000 or $3,000 a year for unlimited access to a primary care provider, that's basically then taking in a risk sharing arrangement on what your consumption looks like of their time.

I think concierge medicine has a role in the broader scheme of the health care system the way retail clinics and telemedicine have a role in the health care system. I don't know -- it's a long time before we're talking about concierge medicine displacing kind of the regular way primary care, anything like that, in my opinion.

MS. GOLDWASSER: You know, it's interesting because when I think about concierge medicine, I really think about access and coordination. And when we think about what's lacking in the U.S. health care system is access and coordination. So, you know, we can call it concierge medicine and there's, you know, some private docs that do concierge medicine for thousands of dollars, and then there are more accessible ways to deliver concierge medicine. It's really about making it a lot more easy for individuals to make the right health care decisions. And, you know, access is not just hypothetical access that I can go to a doctor. It's actually kind of like bringing it to me and making sure that sending me texts and reminding me. I think that's when we think about concierge medicine, that's all included in it.

So, again, to me this is about access and coordination. And I think that we will see more of that. You know, concierge medicine, it's just it's a label. But really when we think about what's behind that, I think that's something that should resonate more in the future.

MR. GINSBURG: Yeah, so, since what both of you are saying is that concierge medicine is a package of changes, and only one of the changes is, you know, being able to charge wealthier people more. It's a change in the risk sharing model. It's a change in the service model where concierge medicine is doing more coordination. They're making access easier. So, in a sense it's a bundle of all these things.

MR. HILL: I don't know if it's completely fair to characterize it as for wealthy people either because if you pay $3,000 a year for a concierge medical plan, and you have a $4,000 deductible through your employer sponsor and they do some matching into an HSA where there's the chance that they're

picking up half of it, I think it can wind up being relatively affordable to a good portion of the population.

MR. GINSBURG: I see what you mean. So, it's a way that a part of the population, you know, pays a premium to take some risk off the table for its large deductible by in a sense making a capitated payment for primary care.

MR. HILL: Yeah.

MR. GINSBURG: Good. Can do one last one. What impact do you think changing regulations allowing greater scope of practice for nurses -- I mean, with the nurse practitioners, increased use of other disciplines in the face of COVID will have on the future model of health care delivery and reduction of costs?

MR. BORSCH: Well, Ricky addressed this question earlier with, you know, the thought that we may see a permanent shift in the wake of COVID-19 towards greater usage of, you know, non-physician practitioners. I certainly would agree with that. And, of course, I think there's broad awareness that among the companies, CVS has been the most vocal on this topic given that they're implementing a model that is at least at this point entirely based on non-physician labor, which they contend -- and I'm not disputing this, because it was just that the implementation is still in the early stage. But they contend it will -- or can provide 80 percent of the services in health care needs that a primary care physician normally would. So, that's going to be certainly an area to watch.

MR. GINSBURG: Yeah, very interesting to watch. We've run out of time now. So, let me just take the minute we have to thank the three analysts. I think each of you have done a marvelous job. It's been fascinating to me. I also want to thank my colleagues, Alwyn Cassil and Abbey Durak for the support behind the scenes that made this Webinar go so smoothly. Thank Arnold Ventures for their support. And thank the participants, the audience, for hanging with us throughout the 2 ½ hours that we've been on. So, I'll close the Webinar now.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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