
***In Conjunction with the USC-Brookings Schaeffer Initiative for Health Policy***

TRANSCRIPT

# 22nd ANNUAL WALL STREET COMES TO WASHINGTON HEALTH POLICY ROUNDTABLE

Washington, D.C.

Wednesday, November 15, 2017

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PAUL GINSBURG: Good morning, and I want to welcome you to the 22nd Annual Wall Street Comes to Washington conference. I'm Paul Ginsburg, director of the USC-Brookings Schaeffer Initiative for Health Policy, which is a co-sponsor of this conference. Many years ago, shortly after beginning the Center for Studying Health System Changes site visit studies on changes in the financing and delivery of health care, I perceived how poorly federal policy makers were informed about what was happening on the ground, in local healthcare markets. I also perceived that Wall Street analysts were conducting their own research on these issues to inform their investor clients, and that policy makers could also benefit from the analysts' broad market perspectives. After convening a meeting with analysists in New York to discuss market developments, I invited them to come to Washington the following year, and have these discussions in front of a policy audience, initiating what has been an annual event that many people inside the Beltway, value for its outside the Beltway perspective.

I'm delighted that the Jayne Koskinas Ted Giovanis Foundation for Health and Policy recognizes the value of this conference by funding the event for the fifth year. Through research and projects like this conference, the JKTG Foundation hopes to foster discussions about cost reduction, expanding access to care, and improving quality. The conference's main purpose is to give Washington health policy community insights about market developments that are relevant to policy, through a different source of information—equity analysts who advise investors about which publicly traded companies in healthcare will do well, and which ones will not. With a thorough understanding of healthcare markets, and the companies they follow, all three of our analysts today closely follow public policy, because the implications for publicly traded companies are so large.

The format of this meeting will be a roundtable discussion based on questions that have been shared with the analysts in advance. We will have two opportunities for audience Q&A's. The first before we take a break at 10:30, and the second before we adjourn at noon. Note that the analysts are not permitted by their employers to answer questions about the outlook, or their views for specific companies. A transcript and webcast of the conference will be available through the JKTG Foundation website later this week or early next. Before you leave today, we would appreciate it if you would take a moment to fill out the evaluation. It's the pink paper in your folder.

I want to introduce the panelists. These are all veterans of previous Wall Street conferences -- in fact, the exact same three people were here last year, and they did a phenomenal job. Matt Borsch of BMO Capital Markets, Ana Gupte of Leerink Partners, and Sheryl Skolnick of Mizuho Securities USA.

It's been quite a year in healthcare policy, perhaps dominated by repeated efforts to repeal major elements of the Affordable Care Act, so we are going to begin with a broad question about the impact of this policy uncertainty on healthcare financing and delivery. So, the question is: The election of Donald Trump was a surprise, and likely has introduced elements of policy uncertainty into healthcare financing and delivery. Most prominent has been the implications for individual insurance market and Medicaid related to attempts to repeal and replace the ACA, which we will delve into shortly. But ACA policy affects providers, particurly hospitals, as well as insurers, and other federal health policies may change. So, the question is: What has been the

reaction in the healthcare industry to this changed environment? What are insurers, providers, and others, doing differently, or thinking about dong differently in response to the new environments?

MATT BORSCH: One part of this is that contrary to sometimes the way the media treats the situation, the large public managed care companies have really only a very limited intersection with the individual market and the ACA exchanges that get sometimes the majority of attention, and that's even more true than it was a couple more years ago, as probably most of you know, the large companies have mostly pulled out of the exchanges, and even Anthem/Blue Cross, which runs 14 Blue Cross plans in 14 states, has reduced their exposure. Now, having said that, Medicaid remains as a source of revenue and earnings, significantly more important to the publicly traded companies. And again, that's about half of the industry. The other half of the non-publicly traded companies have a more significant presence in the individual market in ACA exchanges, but actually less presence in the Medicaid markets. Now, in terms of what they are doing, that's on the managed care side, you see an acceleration of their reduction and exposure to the ACA exchanges, although most of that was underway prior to the election. And recently there has been some pickup of interest in things like less regulated short-term policies that may be getting -- is getting the green light from the Trump Administration. Perhaps a little bit more aggressive pursuit of Medicare Advantage with a view that there is a slightly more favorable regulatory overlay from the Trump Administration, although quite frankly it had a pretty favorable regulatory overlay from the Obama Administration. So, not that much has changed.

On the provider side, I wouldn't say much has changed at all. Partly because there is not really that much that the hospitals and providers can change right now in response to what's happened. And again, the degree of change in volumes and reimbursement has not been that big. So, that's what I would say as an intro.

ANA GUPTE: [inaudible] on the managed care side. So, yes, absolutely, on the exchanges, and I will just put some specificity around it. United, Humana, and Aetna had been pretty much planned their exits even before the Trump Administration came into Washington. I would say that the uncertainty around the cost sharing reductions and the subsidies, the CSRs, have exhilarated the exits and the level of presence by Anthem and by Molina. I think that had all of this uncertainty not being there perhaps for 2018, we would have seen more presence, but Anthem is officially now said, in the third quarter, that they are expecting 70% of their membership to be gone in 2018. And Molina has now priced up their policies, I think, and especially because there is no clarity on CSRs. Somewhere in the 50 to 55% increase, and they're fairly convinced that with the pricing model and the narrow network model, that their presence will be in a very, very minimal in '18. So, you have Centene, which is like this bastion sitting there, and we all marvel at them because they have made a lot of money in 2017 as well, and continue to expand their presence, and CIGNA to a very small extent. CIGNA has never really been a big individual player, has been very cautious about it to start with, but they've continued with the knowledge that it was never meant to be a super profitable market, but they wanted to have a foot in the door if and when this ever took off. Medicaid, absolutely, as Matt says, there is a strong presence there, and names like Anthem are 35% of their revenue in Medicaid, so it's very difficult to kind of walk away. Medicaid expansion is a different source of growth than Medicaid privatization. So far, privatization, we have about, I think, 40% of revenue

and 75% of the membership is private, but there is still a huge amount of runway for growth. So, it's not just current exposure, but it's the future growth as well. So, they definitely want to stick with that. United, Centene, Anthem, are the leaders here. I mean, across public and private regionals, and then Molina and Well Care have a very obviously sizable presence, perhaps not leaders, but heavily exposed to it. I did quite a bit of work looking at the various incarnations of repeal and replace. I think Graham-Cassidy was probably fairly Draconian. They had cut down the funding in total, it was somewhere between 8 to 10%. But there was the shift and mix from the expansion states to the non-expansion states. So, on balance, when I looked at companies' specific exposure, it was flat to even slightly up post the implementation. But that interim transition was very unclear. What would happen in 2018-19, and I think the companies were pretty much looking at analysts like me to tell them what was going to happen, because it was all coming at them so quickly. So, certainly in terms of Paul's question on how did they respond, they were just hoping for the best, and hoping that it would die in the Senate, which it did.

The other piece, I think, that's been huge for Wall Street, and part of why repeal and replace's failure has hurt the publicly traded insurers, is that the health insurer provider fee, that was a moratorium this year. But in the repeal and replace bills -- at least, I don't think it was in Graham- Cassidy, but in the previous versions in the House and the Senate, it was intended to be repealed permanently, and that is a gigantic take for these companies. And now, we aren't seeing that. It wasn't in the final version of the bill. They have been hoping against hope it will come back in tax reform, but it doesn't look like it is going to do that. So, for 2018, they are all dealing with a very significant headwind, and how particularly they will price and design the benefits for Medicare Advantage, because it is a headwind, no matter how well you try to plan for it. And it's resulting in a bit of conservatism on the forecast, more so than we had perhaps expected, but not anything outlandish, so the stocks did quite well, a relief rally, if you will.

Then on the executive order, I had a couple of points --

PAUL GINSBURG: Excuse me, remind people what percent is the health insurance tax?

ANA GUPTE: Yes, the insurance tax can be as much as a 15% tailwind. It's about one and a half percent of premiums or fully insured premiums. And so, it can be 15 to 20%, depending on how much Medicare exposure you have. Medicaid; it was passed on to the states. Employers largely passed on to the employees, but there is a timing effect on when they can raise the premiums. But it's like 1.8%, I believe. I think that's what it is.

PAUL GINSBURG: Yes, so given the margins as a percent aren't that high. That's what I see by being substantial.

ANA GUPTE: It's massive. I mean, there are like, what, 5% margins on a plan year basis?

SHERYL SKOLNICK: Well, for United next year, it's a 76 cent a share headwind on a billion shares. So, figure that one out --$760 million -- I mean, you know, I could do something with that.

ANN GUPTE: Maybe I will stop and let Sheryl say something.

SHERYL SKOLNICK: Thank you, Ana.

PAUL GINSBURG: Tell us about hospitals.

SHERYL SKOLNICK: I will. But first of all, thank you very much, it's always a pleasure to once a year the opportunity to see two really terrific colleagues/competitors trying to figure out what's going on in this business. I always learn a lot. But thank you, Paul, and I appreciate being here.

Let's talk a little bit about the hospitals. I think Matt sort of hinted at this, that the hospitals -- the scenario actually played to the historical strength of the hospitals, which is being some of the most reactive managements we've ever seen on Wall Street. They actually like to sit back and react to things, rather than push forward and innovate. Things have been done to them for a long time, and one of the things that's being done to them is the potential that for a lot of reasons, they may see attrition in what is effectively a high margin managed care patient and exchange admission. And so, hospitals are being assaulted by adverse payer mix right now, meaning that their high margin managed care patients are disappearing. They are disappearing from the emergency room -- 60% of their heads in hospital beds, come from an emergency room admission. 25% of the patients who roll through the door nationally of an ER end up in a hospital bed, so if they are not coming in your front door, they are not staying overnight in your bedroom. That's become a real problem for the hospitals, even though it's lower acuity cases they are losing. That's one of the aspects of it, that they are losing it on their highest margin patients. And as exchange volumes are anticipated to moderate and certainly to have slow in growth, but also moderate, the hospitals don't seem really to be preparing too terribly much for a coming change and not only continued declining and pressure on volumes, but also declining payer mix margin revenue -- EBITDA [earnings before interest, tax, depreciation and amortization], dying cash flow, which is the lifeblood of their business.

Now, in terms of policy, I think that they were doing what I think also the health plans were, by and large, not all of them, they were kind of stepping back to the side and as suggested, you know, hoping that the Senate would be the thing that kept them all from disaster. And apart from lobbying a bit on trying to keep coverage, especially on Medicaid, which I think was the most positive impact on the hospitals in the Medicaid expansion, but also the woodwork effect was very positive for them; that there has been some certainly -- you all who are on the Hill would know how much lobbying they've done, but it seemed to me that the lobbying effort was very intense for very short duration, and then stepped back, and that might well have been very effective. That at that moment where you needed to count votes, it was very effective. But by and large, they kept their mouth shut. Publicly traded companies on their conference calls, you know, they will not touch health policy or politics other than to say, we think this is a good thing, we would like to see it improved, and that's that. And that is in stark contrast to the discussion around the ACA, and whether or not companies, especially providers, were for it or against it. Again, mostly reactive, lots of bad things are being done to hospitals right now, some of which is their own making, some of which is policy, some of which was just sort of natural evolution of patient health and utilization rates. And some of it is, I think, activism on the part of managed

care to try to keep cost trends down, which means reducing the utilization of this very high cost setting, wherever it's medically appropriate.

So, lots of things happening; hospitals are doing what they do, they are reacting. Very few of them are changing. And very few of them seem to be running to Congress to try to get any kind of help. I think they understand that that's pretty much futile, so why waste the breath?

ANA GUPTE: I make one point on hospitals on the behavioral health side, because with this latest executive order that the president put out, it's a weakening of essential health benefits, and you did have a better enforcement of mental health parity and coverage of substance abuse, and mental health. I cover two behavioral health hospital providers -- one of which was mixed acute behavioral -- Universal Health Services, and another one, which is a pure behavioral. I think my sense is that they are a little nervous. They are not super nervous, because there is a lot of supply and capacity constraints in behavioral health, so they haven't cut down on their capital expenditure and the construction of new beds in existing hospitals, and all, as a result of this. But it doesn't help their case, and they are seeing managed Medicaid players, and as I said, you know, you are seeing a lot of privatization of managed Medicaid. They are seeing pressure on their length of stay, they are being asked to discharge patients earlier, and so on. So, they have been saying they could use mental health parity from a legal standpoint to threaten lawsuits with insurers who refuse to cover patients for an extended or a clinically appropriate length of time. But if mental health parity gets weakened by the executive order, then that's a downside for them. But it's not -- like Sheryl and Matt said, as bad as it is for acute, where you are seeing ER volumes surgery volumes start to weaken because you have no more new patients there. Even a little bit of the uncompensated care you are beginning to see an uptick, and it's hard to say how much of it is because of high deductible plans and collectability of the deductibles from consumers, versus a little bit of maybe even attrition happening on exchanges at this point. They are all sort of impacted to the downside.

SHERYL SKOLNICK: I will try to wrap up my comments a little bit more quickly, but one of the reactions that I had when Paul gave us these questions, was a lot of this is almost irrelevant. If you look at the behavior of the publicly traded companies, be they managed care companies or be they hospitals, what Washington is doing in terms of repeal or replace the ACA, and almost even tax reform -- it's almost irrelevant, because the managed care companies have reduced their exposure to the risky part of this. They are still engaged with Medicaid, and they don't think that Medicaid -- I mean, I may be putting words in their mouth, but I don't think that repealing the expansion of Medicaid is yet really likely to be passed in the Senate. So, they are just going about their business. We don't talk about reform on conference calls anymore. We barely talk about politics. We talk about, how is it that everybody is going to have double digit Medicare Advantage growth rates, and that's going to be true for everyone? We talk about things like, well, what's happening with your cost trend? How are you pricing your premiums? Is there a cycle? Although, credit to Matt, he didn't ask that question on the last United call -- good job. That is a running discussion.

My point is that the publicly traded companies on Wall Street have essentially moved on from this issue. And not because it's not important what happens here, it's because they know they are helpless as they stand back and watch this chaos, in my view. Because if you have an

unpredictable system, the only thing you can do by getting involved is potentially make it worse for yourself. So, stand back, observe and move on to your other aspects of your business that you can control. And that's my observation about what they are doing.

PAUL GINSBURG: Is part of this bifurcation between the publicly traded parts of insurance and hospitals and the non-profit part, who I think are probably more impacted by this, and maybe have more [unintelligible] when it comes to lobbying?

SHERYL SKOLNICK: So, I can't speak to the managed care plans directly, but I can speak to the not-for-profit hospitals, because I have been speaking at conferences for the not-for-profit hospital leadership, managed care negotiators, or actual hospital leadership over the last month and a half or so. And they're much more worried about how they are going to put heads in their beds and whether or not their market share growth at any cost model is correct, then they are worried about what Washington is doing. Now, that changed dramatically, and my email lit up like a Christmas tree, when the House limited the ability of hospitals to use tax exempt financing. That would be, I think, incredibly devastating to many of the not-for-profit hospitals who are facing all of these same issues, the existing pressure on volumes, the adverse payer mix shift, the potential for Medicare and Medicaid to be cut by a trillion and a half dollars combined to fund part of tax reform, which was in the House budget resolution. They didn't even know that was there. They are beginning to understand it's there, whether it's relevant or not, it remains to be seen, but it's there. So, they are looking at all of these negatives, and then you take away their cheap source of financing and their entire capital structures are potentially much more expensive to maintain, and potentially at risk. So, that caught their attention. But apart from that, their concerns are pretty much the same as the hospital's concerns, which was, how do I grow volume, and how do I get out from under a mountain of debt?

PAUL GINSBURG: Let me move on to a couple of questions about the individual insurance market. I should say, and you've heard this, but it's important, that when the analysts reacted to the first draft of the questions, they said, you are spending too much time on the individual market, it's not that big a deal in the health insurance industry. And that it's something that is probably more of a deal in the Blue Cross/Blue Shield world outside of Anthem. Actually, I guess Anthem is novel, because it was a big deal for Anthem, and Anthem is departing it. I think the non-profit Blues, it's a big deal for them, and so most of them are staying, and I guess experiencing this uncertainty. The answer you might have given to my question about what kind of enrollment would you expect next year compared to this year, is probably affected by the possibility that the individual mandate might be overturned in the tax reform legislation. Any thoughts about what we might see?

MATT BORSCH: If I could just start out, and somebody in this room actually made an interesting observation to be looking at what the CBO wrote most recently, and I just hadn't caught this, that the CBO had said, regarding the impact of the individual mandate, potentially being repealed. But they are unsure. They don't know what the impact really is going to be, and I think that we are in some ways in uncharted territory. If you want to look at a test case, and I will have to admit, I haven't examined this too closely, but you could look at New York State, which for quite a few years operated in a market that had guaranteed issue, but of course no individual mandate. So I'm going to punt on it a little bit. Obviously, we would expect the enrollment to be

lower than it would be otherwise if the individual mandate were to stay in place. That said, you know, and again, this is probably common knowledge to everyone here, that the initial burst of sign-ups and we only have data, unless it's come out more recently since then, on the first four days of open enrollment, surprisingly strong.

ANA GUPTE: Yeah, I guess in terms of the impact, I think it's 37 states, maybe it's more now. My last count was that it was 37 states that were allowing a with and without CSR [cost sharing reduction] rate increase, and its somewhere between 15 and 20% higher. Now, for the subsidized -- very highly subsidized membership, you know, that 10 ish million, I think it's 57% that I believe are eligible to get the cost sharing subsidy benefit. They don't see that fall to their bottom line, or their out-of-pocket, because it is a percentage of income. However, if you take the entire silver plan, and spread that rate increase across all of the policies that are purchasing silver, you do have a meaningful percentage of folk that do not get as much subsidy either in a premium or a cost basis. So, I think there will be some reduction probably -- and I can only guess, and you know I haven't seen S&P and the other forecasts. I would say it's probably up to a million, maybe even a million and a half or so, that might move out of the exchange marketplaces, possibly into off-exchange, possibly get uninsured. I don't think the regulations are out on the executive order yet for some of these folks to be able to buy a shorter-term policy, but I wouldn't be surprised if we end up seeing like, an eight and a half million-ish kind of number. And I think the first couple of weeks, you usually get renewals as opposed to new folks. So, let's see how it goes. But it's not without impact, I don't think.

PAUL GINSBURG: As far as the insurers that have remained in the exchanges, do you have any sense of -- are they just hunkering down or do they see possibility of light at the end of the tunnel?

MATT BORSCH: I would just say, I think if you take the example of Centene, clearly, they see light at the end of the tunnel, and so --

ANA GUPTE: They haven't seen a tunnel, I guess.

MATT BORSCH: Right, right.

SHERYL SKOLNICK: Doesn't it make you nervous though, that if you are all wondering what's going on, that maybe there is something going on that you wouldn't want to wonder about?

MATT BORSCH: So, here is the thing that is different about Centene, which is that they build networks and have an orientation around what we might call the "near-Medicaid populations," so that is the population that is almost entirely subsidized, or very, very highly subsidized. In theory, you shouldn't have as much adverse selection there, and in fact, the profitability for Centene, at least so it appears, has held up pretty well throughout this whole period when a number of plans, particularly in 2015, which I guess would sort of be the trough year, we are losing large amounts of money. Now, whether those assumptions can continue for Centene since it's taken on a larger presence and is more frequently going to be the only plan available in a

number of regions as we go into 2018, although that was true for some regions in 2017. It's going to be a really interesting story to watch as it unfolds.

ANA GUPTE: I think one more point I would make on the individual piece of it -- there are two aspects to profitability, and I haven't quite figured out how Centene is nailing it so well. Nonetheless, they do have Medicaid networks, and so does Molina, and they chose to use lower cost networks on their exchange policies. Even Molina has had decent, what we call medical loss ratio, which is the percentage of the premiums that you are spending on medical cost. It's the other piece that's been the wild card, and that's the last R that is remaining -- the risk adjustors. And the Blues have a certain model and as a result, attract a certain type of health risk, because they have richer networks, they don't have the Medicaid narrow networks, and so on, and they are going much more with less-subsidized populations. Then you've got the Centenes and the Molinas who have the better health risk, because these are highly subsidized, and so they are not exposed to the out-of-pocket premiums and cost sharing and all of that. And Centene, year after year after year, seems to be coding very well, or doing something right, and they are not missing it on those risk adjustors. But Molina is just getting screwed. And Anthem and the Blues, up until 2016, they did really well on these risk adjustors. In fact, Mario Molina, who was the CEO of Molina, constantly would say to the Blue Cross/Blue Shield of Florida, who was very happy with exchanges of [unintelligible], now, you need to send me a Christmas present, because every year I have to write you a big check. But this year, Anthem didn't do as well. They don't disclose much, but they didn't do as well on their risk adjustors as they had in the past, and I think there was some tweak in the methodology by CMS. So, it's both those pieces that you have to think about. So, Centene is making six plus percent pre-tax margins on exchanges. Next year, if there is one piece I would say is more at risk, actually, it's this risk adjuster aspect, when all of these plans have left and now you have Centene and as the solo plan in some cases, and maybe with these Blues in other cases. How anyone can predict where that nets out, is hard to say. And they do it, by my estimate, about 15% of their earnings come from exchanges? This is nontrivial for them.

SHERYL SKOLNICK: And there was an article on apropos of the three R's, on Modern Healthcare this morning, was reporting that CMS is a little behind in its payments of risk corridors and the number is now up to $12.3 billion that is owed to the health plans for policy year risk corridor payments for '14, '15 and '16, and the $3.95 billion of that alone are for losses in 2016. So, you know, none of this was helped by starving the health plans for the cash that the law promised that they would get. So, there is enough blame to go around on why they had such big losses, but one of them was that the feds didn't pay the bills.

ANA GUPTE: Can I make one final comment on the individual mandate? My view has always been it's the carrot, not the stick that's making the difference. I know there is no way to 100% prove this. Maybe New York is one example that you can kind of try to say with and without, but subsidies are the carrot, and subsidies will keep that market at least relatively stable. The mandate -- the CBO projections to me, are hard to fathom, because they have, I think, 13 million fewer people insured. And I know it's in the future, down the road, but if you only have 10 million in exchanges today, it's kind of hard to see what they -- they look at it based on the original forecasts on Obamacare, which never fully materialized, so I think the CBO is a bit of a mystery, but ideologically, the Republicans would vote for this tax reform bill if they repeal the

mandate, and it gives them a nice little, you know, thing to offset three to four hundred billion dollars of tax rate reductions. I don't know that if that is repealed, that next year that's going to be the driver of the issues. It will be to some degree. I think CSRs and rate increases for those people that don't get the protection on income.

SHERYL SKOLNICK: Let's just take this down to the local level of politics, when the open enrollment started, you got that raft of news reports coming out of markets that especially from Trump voters -- oh no, I don't have to worry about signing up for that, that's been repealed. So, it's not really a surprise, and first of all, they didn't know the difference between Obamacare and the ACA, that the difference was equal to zero. Second, now they don't know that the ACA or Obamacare, neither one has been repealed or replaced. It might have been defunded along the way, moderately or extensively, but it's still there on the books. So, I think it's not at all surprising that in the individual markets, you are going to see the people who have made it their business to stay informed, because this is how they get their insurance, to be the ones to sign up before it gets yanked away at midnight by some act of Congress and the stroke of a pen. And they want to make sure that they are signed up and in, and that sort of thing. But it's that incremental group, that elusive extra number of uninsured that's out there, that sustained their status of uninsured, that was in the original CBO number, and I actually agree with Ana that those numbers are -- come from a completely different perspective. They are not necessarily flawed within their own system, but they are probably not relevant. That's that group that didn't respond to the mandate to begin with. They resisted that to begin with. And some only signed up reluctantly. Why should their behavior change now that they think that reform has been repealed or replaced?

PAUL GINSBURG: If the Trump Administration and Congress really wanted to stabilize the marketplaces, what are the most important things they should do?

ANA GUPTE: I kind of tried to -- I sort of give my bias in my earlier response, maybe I jumped the gun a little bit, but what the Affordable Care Act did, and in an insurance market, it's all about risk reward. They try to decouple the risk and reward, and then said the mandate is the way to kind of keep you guys whole, you know? You have to guarantee issue, there's community rating. You cannot medically underwrite, but we will make sure everybody is in there, because we will hit them with a stick if they don't. And I don't think the stick works. So, if it's already decoupled risk and reward -- so, if the carrot were there, and of course ideologically and from a budget perspective, that would be hard. The market that worked was the market that had CSRs and very rich policies, platinum plans and gold plans that there was no impact on their out-of-pocket and their income. So, you had a pretty healthy group. And so, Centene has done okay. Then if you kind of had the risk adjustor formula stop being such a mystery, I think that would help. But there were proposals in the past around the 300 to 400 percent federal poverty level. Should you even have that cohort aggregated as a -- in the same risk pool as the people from 100% to 300%? If you could segregate that and maybe put them either in a high-risk pool, or if there is enough money, just give them also adequate subsidies, so you can get the healthy people to come in. Because if I'm a family of four making $60,000, and it's costing me several thousand to insure this family, I'm going to buy gas or do groceries instead. So, you are just creating adverse selection by trying to aggregate that risk pool.

MATT BORSCH: Yeah, Ana, if I could just add to your point. I think that one of the sort of original sins of the way that the ACA and the exchanges were constructed, was the idea that you would take a large number of uninsurable people and put them in a risk pool, and have that subsidized by a larger, but still limited number of individuals needing coverage from the individual market. The individual market wasn't well functioning to begin with, but you are trying to force a bad economic deal down the throats of a fairly modestly sized population, rather than saying, okay, we've got all of these uninsurables, this is something that is a broader obligation to pay for. So, I guess to answer your question, getting to some of the provisions that frankly you had in the original legislation that weren't -- that Sheryl alluded to the risk corridors in particular, probably needed to be permanent and they needed to be funded.

PAUL GINSBURG: I guess a lot of your comments talk about the fact that this is not a homogeneous market out there that the lower income and the higher income people that -- this has provided opportunities for companies like Centene to seize a more profitable segment and cater to them, but it sounds like that's at the heart of some of the challenges.

SHERYL SKOLNICK: There is one other thing, I think, from a policy perspective that was deeply flawed. Do you all remember when the Supreme Court surprised us and said, you can't browbeat states into expanding Medicaid? Do you remember what happened after that? A lot of states like Texas and Florida and others decided not to expan Medicaid. Well, those subsides that we are talking about -- those CSRs do not apply to the population at or below 100% of federal poverty. The poorest of the poor were never covered by any kind of coverage expansion. So, if you want to talk about this from a policy perspective, and you want to cover the uninsured; that's your goal as a policy objective, take liberal or conservative out of it, just say that's your policy objective. You've now failed, because you need to go back and fix the law that provides for subsidies for that portion of the population at or below 100% of federal poverty, and put them on the exchanges. They don't qualify for Medicaid unless they are in an expansion state, and they don't qualify for subsidies, because the crafters of the law thought that they would be part of the Medicaid expansion. So, that is one thing that I might think about doing, because yes, it might make the risk pool at the beginning more adversely selected, but you know, some of these people who have been in the pool, have been in the pool, have been in the pool now for '14, '15, '16, '17 -- they are five years. And those very acute or chronic long-term issues that need to be addressed, may well have been addressed already. And the population itself may be becoming healthier, older, but a better fundamental health status, more appropriate to their age, given that they have been insured for now five years. Or going on it. So, some of the adverse selection may be addressed just by people getting the healthcare and having it paid for, and not being afraid to access. But you have to fix that problem.

I think the other thing that you need to do is, hospitals have gotten a very raw deal, especially if you are going to pull back on all of the subsidies and all of the mechanisms that were designed to expand the number of uninsured. They paid $155 billion over ten years in cuts, and they have not earned back $155 billion over ten years in income. Not hardly. Not at all. The health insurers have also had a lousy deal. They get to pay out-of-pocket when it comes to Medicare, the health insurance industry fee that Ana was talking about earlier. There are other cuts. They got the ACA imposed the 85% minimum medical loss ratio. They've got a lot of regulation in premium. They haven't exactly -- and certainly the publicly traded companies haven't exactly gotten a good

deal, so there are a lot of parts of the ACA that made for a very bad deal. You can't go back and rectify, but at least you can stabilize.

Finally, tightening up the rules around -- we've talked about this before, trust but verify. When people had a special election period, they were gaming the system. They would get sick, they would come in, they would buy insurance, they would get treated and go home. So, you have a 500% medical loss ratio and everybody loses money. And CMS didn't exactly validate that that actually had that special election period eligibility. There are rules that need to be tightened, there is population that needs to be addressed, and then there is also just the general understanding of, if you really want people to be insured, sometimes you just have to provide it for them.

MATT BORSCH: Sheryl, just one element of that I just take a little bit of issue with, which is, was it bad deal for the public managed care companies? I think from an investor stand-point, as you well know, the stocks have obviously done tremendously well, reflecting that by and large investors don't mind the environment that the publicly traded insurers are in, because it's one in which of course they can pick and choose which government markets or commercial markets for that matter, they want to be in. And some of these regulations, which have limited their profits, have also had other side effects, which by and large have been viewed positively, and maybe even viewed more positively than whatever profits the publicly traded companies gave up. I'm referring -- and we will get to this in a little bit, but I'm referring particularly to the minimum medical loss ratio rules, essentially gross profit margin caps, and how that appears to have smoothed out the profit margin volatility or smoothed out the underwriting cycle in the industry, and that in turn has certainly helped lead to higher valuations. And also on Medicare, of course, there it's a story of how it was regulated in the end, versus what was written into the legislation.

PAUL GINSBURG: Yes, so you might want to elaborate on that for a second about the -- how the regulation has been very favorable.

MATT BORSCH: Sure. So, if you go back to 2010, Richard Foster, who was the Chief Actuary at CMS, projected that the Medicare Advantage enrollment was going to decline by 30% by the time we got to 2016. And in fact, what we see instead, it's expanded by I think, more than 30%. What happened at the level of the regulation was, I think the Obama Administration recognized that they were going to be in a very difficult situation politically if they allowed the kind of damage to happen to the Medicare Advantage population in terms of benefit reductions, if the ACA were put into effect exactly as sort of described in law. So, they really did everything they could to really to circumvent the provisions in their own law, if you will, such things as the STAR demonstration program that went into effect for 2012, '13, '14. It gave an enormous amount of money to the Medicare Advantage program that otherwise wouldn't have been available. And the effect of all of those things that they did, made a huge difference. I'm not making any policy judgment here, but it made a huge difference in the impact of Medicare Advantage.

SHERYL SKOLNICK: I'm going to say, yes, Matt is correct. I absolutely agree that the minimum medical loss ratio, which by the way, wasn't intended to be a penalizing control, has turned out to be an incredibly stabilizing influence, if not an opportunity to actually gain market

share rationally in this market. But I'm more thrilled and delighted to hear Matt say that, because I don't think you always believed that to be the case. I think it took you a while to become convinced that we might actually see some smoothing in the cycle. And so, I don't want to lose my debating partner on that. I will take the other side of it. One should always be respectful of the cycle, because these companies don't always do the smartest thing in the world or what's in the long term, rational. But I do think for some of these companies, it was -- I'm remember how much it cost them in earnings, and I'm remembering how much they had to offset in Medicare rate cuts… if they've succeeded in getting more benefit than cost, as a result of this, then it's either by luck, or incredible foresight to innovate around it.

PAUL GINSBURG: Before you answer, I just want to say that I've had the perspective before the MLR regulation, that the underwriting cycle had become very dampened over time. I don't know, but you're saying there was still enough left of it?

MATT BORSCH: That's exactly, I think, the point. Just one distinction that -- and I agree with you, Sheryl, but I think if you look at the absolute amount of earnings that the managed care companies might have gotten in this period absent the ACA, it would have been higher. But I think from the standpoint of the stock valuation, I would argue, and we can't prove this, but I would argue it's higher now in aggregate than it otherwise would have been without the ACA, because I think investors like an environment where there is more smoothing effect on margins and the --

SHERYL SKOLNICK: Do you really think they understand that?

MATT BORSCH: Not necessarily, other than in the outcome that they see.

SHERYL SKOLNICK: Yeah, they know that they are doing really well, I'm not sure they understand why.

MATT BORSCH: Well, maybe not.

ANA GUPTE: If I could just come back to the consumer again, I guess. I like Sheryl's point, I think, around states like Alabama and all, where people make $3,000-$5,000 a year and they don't have anything from the ACA. And folk that are doing between, I don't know, $22,000 and $33,000 are getting these Cadillac benefits, because they happen to be in the little sweet spot that the ACA is supporting. This is a great one. I believe at least the Graham Cassidy bill, and I think some of the earlier bills as well, did change the threshold on the federal poverty level to a lower threshold for Medicaid. Maybe I misunderstood, but I thought your point was about exchanges, but they lowered the threshold for Medicaid, because a big reason why the red states did not expand Medicaid, was because it wasn't conducive to their problem, and where their income tax receipts were in their population. So that is one point.

The other point I would make is, again, back to kind of the intersect between whether we want Wall Street and these companies to do well, and the stock market to do well, versus the consumer to benefit from an entitlement. It's not an either/or, and I don't think one should get stuck in ideology, but I did hear the former CMS Administrator Andy Slavitt talk at one of our

conferences, and the pitch was: It doesn't matter what happens to these insurance companies. We are reforming healthcare, we are not reforming health insurance. We are just going to flood the market with subsidies.

SHERYL SKOLNICK:What law was he enforcing?

ANA GUPTE: Whatever he was doing with the ACA. And I look at the analogy, and I say, you have a bunch of consumers with their wallets and wads full of cash, and they are walking into a mall. But no merchant in that mall is making any money, no one is selling anything. How does it matter how much money you gave? You have to do a bit of both. And then you have the President today talking about, I don't want CSRs because they are bailing out these insurers. Firstly, they are not a bailout. Secondly -- because they go directly to the providers, and it's a pass through. But it's not an either/or. I think the whole failure is -- I'm not saying the ACA was ever perfectly designed, but the ideology, and this partisan divide has made it so much worse for people who are struggling in this country. Right? I'm glad about the MLR floors smoothing the cycle into [unintelligible] managed care has worked beautifully, but it's a pity in what else is going on.

PAUL GINSBURG: Let me move on to the next topic. Sheryl, could you explain to us in the short term and in the long term, how the Medicaid expansion impacts the hospitals in those states? As far as getting often additional patients at very low payment rates, but some of them would have been uncompensated care.

SHERYL SKOLNICK: So, on the thesis that something is better than nothing, especially when nothing costs you money, Medicaid expansion was a good thing. So, let's just start there in very simple terms. We had hospitals as the insurers of last resort have to take emergent patients who come through their emergency room doors. They have to treat them, they have to stabilize them, and then if there is a place that will be able to treat them appropriately, they may transfer them. But an absolute matter of practice, most hospitals, be they for profit or not-for-profit, end up treating a substantial number of the uninsured in their population, for both the emergency and the near emergency events. What they do with them when it's a little less emergent, that's why they did fast tracks in some of these other things. They ended up taking care of them then as well. And at some point, that hospital has to make a decision whether they are going to try to collect from the individual if they are working poor, if they are completely unemployed and uninsured, do they want to put them in a charity bucket? But the cost of treating that patient, the negative cash flow event associated with the uncompensated care, is the cost advert to the hospital, whenever an uninsured patient must be seen and treated in a hospital through the emergency room. So, when the Medicaid expansion went into effect in these states, and it reached all the way down into the single adult population, because remember, you know, CHIP did kids and Medicaid did the elderly and pregnant women, but the single adult male…and the single adult female in some cases who wasn't pregnant, didn't have an option if they were poor, to be able to buy health insurance or afford it. Or in some cases they didn't -- some people didn't even know they were eligible even without the expansion, which is what we call the woodwork effect. That people applying for Obamacare found out that they were eligible for Medicaid even in non-expansion states. So, what ended up happening for the hospital was the very simple thing that in Medicaid expansion states, a larger percent of that uninsured population got insured. That means,

they got a card by the second quarter of 2014, they showed up at the hospital door, and they said, "Treat me." And the hospital said, well, if you are an emergency, go left, if you are not an emergency, here is a doctor who is in our network, go for it. And that not only creates an initial encounter, but then because the patient now becomes concerned about their health, they are going to get treated, it's going to create a series of encounters, not just inpatient, not just surgical, but clinical in the physician's office, in diagnostic testing and outpatient procedures, and in some cases, we even saw Medicaid expansion patients in LTACs [long-term acute care hospital], in in-patient rehab facilities, because some of them had strokes. So, that's how it benefitted the entire provider community. It's not just the hospital. It's the doctor, it's the outpatient, it's the in-patient, it's the post-acute. That entire community, when people have insurance, they get -- they are going to use it. They get treated. Now, in the non-Medicaid expansion states, the difference was, that you had what I like to call that Medicaid gap. The poorest of the poor remained uninsured, which means that you weren't going to be able to collect much for the cost of their care. There is just nothing to collect. And you are unable to get them qualified for Medicaid. So, that meant the hospital became the insurer of the last resort, had to bear the cost. For the patient, it means discrete treatments. That emergent event gets treated. Until they are stabilized, they are treated. But there is no diagnostic, there is not preventative, there is no physical assessment and clinical assessment of, here is your health status, these are the things you need. So, you miss that entire tale of utilization throughout the system that brought that patient from an acute or chronic state at the beginning, to a healthier state at the end. So, you lost all of that. That's one of the things that, for the lowest income part of the population. That meant that for the most part, companies who were over-represented in their hospital portfolio in Medicaid expansion states, did relatively better -- had faster growth rates, so more improvement in cash flows than hospital companies who had less exposure to the Medicaid expansion states. The volume growth was big. I mean, we are talking admission growth of six or seven percent. I mean, this was pretty significant for the publicly traded companies.

PAUL GINSBURG: If you want to continue, you raised a number of concerns about the financial stability of hospitals with all of the policies that either have hit or might hit them. Are hospitals doing anything about it?

SHERYL SKOLNICK: I suspect some of them are praying every night. I know I would be. So, here is the situation. Publicly traded hospital companies have something called consolidation plays, or rollup plays, at their fundamental heart. So, what does that mean? They buy it, they fix it, they grow it, they do it again. And when that works, it works like a charm. You are buying at a low price, you are fixing it up, you are growing in volume by recruiting physicians, adding services. Your margins grow, your cash flows grow, you stabilize it, it generates cash flow, so you can go. It's like fixer-upper. You are using one fixer-upper to fund the next one, once it gets fixed. After a while though, when the generalized environment is less supportive of volume growth, then it becomes much more difficult to make that work. And you know, after 30 years on Wall Street, it's really clear to me that consolidation plays fundamentally always hit a wall. No matter what industry they are in. You just can't grow that fast indefinitely by acquiring. You have to at some point stop, consolidate, and generate internal growth and really operate what you're doing. So, the companies by and large, either failed to do that, or did it unsuccessfully, and also, we now have this greater environment of compressed utilization, declining what they call weakened volume. What we have seen first in Medicare Advantage, whether it be with

mandates to close gaps in care, and STAR scores and the like, we've seen the development -- I don't know if you are a believer yet, Matt, my friend at the end of the table, but we've seen the development of what I like to call sort of an activist managed care plan, in the sense that they know that they have to get their cost trends to be stable, if not down. And they know that they have to increase their patient satisfaction. And the way that you do that, is keep them out of the hospital, send them to the right place for the right reasons, the right cost, the right time, and that way you get a better outcome, you get lower cost, you get moderating cost trend, and you have a happy patient. You also have a happier doctor, because doctors I think fundamentally actually like to make their patients healthier. What you have is a very unhappy operator of facilities, because you are pulling out of the high cost. So, if this sounds like value-based care, it sounds a little like mixed up with bundling, because you are pulling for in-patient and putting it in out-patient. All of this gets wrapped up, and the way you execute on this, is by developing relationships with physicians, and you put them in these high-performing platinum, platinum plus, premier, whatever you want to call it, network. And these are the doctors who are using data and understanding what needs to be done to a patient, and understanding that nine times out of ten, if you send an elderly patient to the hospital, they will come home with some sort of infection. You might as well keep them out of the hospital, send them some place where no harm will be done, good will be done, and costs will be lower. Those are the kinds of things that are happening. So, right now, hospitals are facing this generalized weak environment. And if you actually look at the data; same hospitals, 4400 roughly of them in the U.S. from pre-reform in '13, to post-reform, first post reform year was '15 and into '16, you saw about a seven and a half percent decline in managed care in patient volume. The reason you saw that was because managed care was saying that short stay admission of that one day stay that is really nicely profitable, that's not an admission, that's an observation. So, you are going to get paid $5,000 instead of $15,000, or $3,000 instead of $10,000 for the same service. So, it's not just volume, it's rate. You've got volume down, you have payment compressing, because you are switching them from inpatient to outpatient, you have margin compressing, you have cash flow compressing, and you are getting what's called adverse payer mix -- when your highest margin patient goes away, and your overall demand declines. Government is a less good payer than private sector, and those private sector patients that they are seeing. However, the one saving grace is that complexity is rising. When complexity of patient care is rising -- more stroke, more trauma, more cardiac, more oncology -- as that rises for a hospital, it offsets some of the margin and cash flow pressures of all the other declines. So, where they are, is they load it up with debt to buy all of these assets, to grow volume, which they failed to do internally, and externally the world changed, and now they are not as generous in providing patients to the hospital industry; they can't carry their debt. Or, not without great difficulty. So, we have Community Health Systems facing maturity walls, which are quite significant right now. What does that mean? Starting in November of 2019, they have about $4.2 billion in debt due in total. And right now, they only have availability to borrow another billion, and plus some refinancing capabilities, so it's going to be really, really tight. Really tight for them to get that done. And they've had very material declines in their performance for lots of reasons, but the earnings are going this way, their debt requirement and financing load is going this way, and that's not a good thing for Community. So, they are going to figure that out, or they are not, but that's one example. Tenent is another example -- overloaded balance sheet, underpowered EBIDTA. Quorum was a spin-off from Community. That was blessed at birth with an overloaded balance sheet and an under blessed EBIDTA. So, the only one who is sort of out there, hanging out there right now that is

doing okay is HCA, but even there, they are struggling to get more than one percent EBIDTA growth. Then you have Life Point, who everybody thinks is cheap until they miss their numbers again. And until they start thinking about how much in capital spending commitment they committed, in addition to the debt that they incurred in order to make those acquisitions grow. They brought it on themselves in part; buy it, fix it, grow it, do it again, didn't work, because they didn't fix it and they didn't grow it. Now the market is unwilling to let them do it again. What do they do? Sell assets, raise cash, hope like hell they can grow their volumes and pray that Congress doesn't do anything to whack the Medicare and Medicaid rates, because if it does, this is a very delicate balance right now.

PAUL GINSBURG: The point that was Sheryl was making about what managed care was doing to limit hospital admissions and stays -- are you seeing this a greater use of analytics as opposed to alternative payment arrangements? First, do you see it and what's your sense of what's responsible?

MATT BORCSH: Well, I mean I think there's certainly -- you know there has been advancement in analytics and the use of analytics and that's not surprising that these companies have made bigger investments in technology. Technology has advanced and their larger companies are more consolidated. So, I think that's probably played a role. Another role I think has been played by the fact that they've been somewhat more aggressive in pursuing the opportunity that they see to pay differently for different types of hospital stays. And I guess just to touch on one other issue, which is we look at the cost trends in general as they have affected the managed care companies, I think one of things that has been surprising is that trends have stayed so low for so long. I know we're going to get into that topic, so I'll save that. I'll save that for now. But you know, that certainly is a big thing in the back drop here.

PAUL GINSBURG: Let me go to the audience for questions on the stuff we've covered so far. And then we'll take a break. We have cards? I don't have cards. Why don't we just do it by a show of hands?

AUDIENCE MEMBER: Mike Miller. I've got sort of a global question. The one thing you haven't talked about is the current and expanding crisis on opioids, and how that's going to impact any of these sectors. How they are responding or not responding? It may also be a question for the second session too. I don't know.

PAUL GINSBURG: It's not a question for the second session. So, if anyone has something to say about it they can.

MATT BORSCH: Well, yeah. I mean I'll just say it obviously is something that's taken a great human toll. And it's a national emergency. At the level of impacting health care costs, and utilization, it just hasn't been that much of a mover of anything of a fundamental level for either the providers or the insurers. And so that's why it's gotten less attention from investors in those sectors.

ANA GUPTE: In the 21st Century Cures Act I think had some funding. But when you kind of translated it down to what it did for the behavioral health providers, it was not enough to move

the needle. And those would be the most impacted at all to the upside. I don't know if any of you watched the 60 Minutes expose, I'm sure you did, The Washington Post, expose as well. But it was mainly around, I think it's hurting the drug distributors. And what they were doing or not doing to try to not stop that epidemic. And how they promulgated it kind of you know the underlying thesis.

AUDIENCE MEMBER: PAUL HUGHES-CROMWICK: Weren't we getting to the point where the mandate penalties were going to rise to sort of save the day? And the part about all the woes of the hospital sector I don't get, is that aren't overall operation margins at or near historic highs?

SHERYL SKOLNICK: So, I'll take that. So, for-profit hospital sector, absolutely not. This is one of the times where you see the bifurcation -- margins have been compressing over the last four years. No question. Even as soon as they got through 2015, into the first quarter of '16, that was that. Benefit of reform loop was now a higher comp that they had to be and it was a head wind, not a tail wind. And there hasn't been anything to replace it; the accelerating affect hasn't been there. That's the first thing. The not -or-profits on the other hand, have been having phenomenal years -- year after year, after year. So, there's definitely something cooking either in the markets that are you know the for-profit are in, may have different dynamics than the non-for-profits. Or it may be something at corporate and behaviors at corporate or management thereof. And I'm sure, again, when you're integrating acquisitions, you're often times not paying attention to your bread and butter facilities.

PAUL GINSBURG: That's fascinating, because one obvious possible difference is that when you think about hospitals with clouts, the must-have hospitals. Very few of them are investor-owned. So in a sense to the degree that the hospital market is becoming more consolidated, that it's benefiting- actually there's a separate thing. But to the degree that it's becoming more consolidated- this could be the source of a bifurcation. You know you have the non-for-profit sector, lots of hospitals are struggling. Some of them are being acquired by dominant hospitals. Others are perhaps just passing from the scene.

SHERYL SKOLNICK: Yep, we are seeing some of that. And I think that the point of being must have hospitals in network is very well taken. HCA is sort of the one that is keeping its head in place, on its shoulders, more so than the others among the publicly traded companies with the exception of Universal, who has done exceedingly well because they have Las Vegas. But --

AUDIENCE MEMBER: [inaudible]

SHERYL SKOLNICK: Yeah, this is the year that the mandate penalties were going to bite. That it was going to matter. Up through now it's kind of been a toothless dragon.

PAUL GINSBURG: Yeah, and I guess up till yesterday, I mean probably even today, there was still this enormous uncertainly whether the mandates will be enforced.

AUDIENCE MEMBER: Thank you very much, I would like to ask you about two trends, at least in major metropolitan areas: One is hospitals buying up private practices and incorporating them. And then being able to bill at a hospitals rate, as opposed to the old practitioner rate. And then

secondly, sort of the Walgreens effect of -- that one is a vertical integration, but there's also horizontal effects by things like Wal-Mart and CVS offering more sort of patient care. And I wonder if you can comment on those how those trends --

PAUL GINSBURG: They shouldn't comment on the second one, because that's going to be a question they're prepared to be asked by me - In the second half. Any more questions on the first --

AUDIENCE MEMBER: JAN HEINRICK with George Washington University School of Public Health. As you talked about activists very strong managed care coordinated care, have you also seen more of the plans really investing in social determents of health? And those services not in the health care sector that impact utilization?

SHERYL SKOLNICK: I have a data point -- One data point which was fascinating to me. And I believe it was in Indiana. United Health Care's Medicaid plan wanted to make a go of the privatization of Medicaid in that state. And it was a very challenged population. So, they did a study of what the challenges were in that population that were impeding a better health status. In other words, how do they get the risk in their pool to go down? And what they realized is that the vast majority of their to-be-insured Medicaid beneficiaries in that state were homeless. So, they built homes. They actually built a housing development for the community, but low-income, heavily subsidized, and you can bet your bottom dollar, it was cheaper for them to build, house, in safe, clean environments, giving a healthy backdrop for a standard of living, the social determinant issue, than it was to have these women and men and children be in adverse living conditions -- terrible living conditions. It was cheaper to build it and maintain it, and supervise it and manage it, than it was to just pay their claims. That's how bad the claims risk would have been.

PAUL GINSBURG: So it sounds like this would mostly be in Medicaid managed care. And I ask Matt and Ana if they see other companies investing that way?

ANA GUPTE: It's home and community health. You know, we started with the dual eligible program, which I think you didn't really cover. But it didn't turn out to be as successful because there was the option for these members to opt out. And they exercised that option because they didn't really see any improvement to their bottom line or their caregivers didn't see any of that to them. But Medicaid long term support services is increasingly becoming a very attractive market area for the United Health's of the world, but also Centene, and Anthem, Well Care, Molina, and all of those as well. And as you point out, it's not just about healthcare utilization, it's really about moving those members out of an assisted living setting, and bringing them home, and that's kind of your ultimate goal -- to help them with the daily living, bathing, eating, all of those activities. And the way the managed care companies have been investing in that, is partly through housing projects that are made wheelchair accessible and so on. United has done it in 12 markets. I think they see a lot of privatization coming their way. But then they are also integrating their own home and community health workers with social workers within the community. And you know all of that it's part of their effort. So, it's not just purely out of goodness of heart, but it is an investment that they are making. And they are seeing much more impact on their top line, because there's huge unit volume growth. And maybe the margins aren't

huge, but even if you have a 3 percent pretax margin on a very large dollar amount, which could be as much as $15,000 to $20,000 a year for very disadvantage complex member like that it can be quite profitable.

MATT BORSCH: I agree with those comments. I would just add that the thing that we don't have is a good way of measuring it. So certainly, the companies and managements are talking about it a lot more. There are real life examples that Sheryl and Ana spoke to, but aside from those examples, and those are certainly worthwhile to highlight, it's a difficult thing for us to measure and say they are investing X amount, because we don't really have hard numbers around it.

SHERYL SKOLNICK: Let me step back again and try and frame this in a policy perspective. So, what does this say? There's a reason that I brought it up, right? Hard to answer your question. What is says is that all the data --I mean these companies don't just do this because it sounds like a good idea. Okay? And whether or not it's out of the goodness of their own heart, it's not hurtful to them that it's good for people to help them. But yes, they have to responsible for their shareholders and make money. But if you think about it, the private sector is stepping in to do what the public sector used to. It's a creeping privatization. So, if you're saying, well you're privatizing Medicaid -- you're not just privatizing Medicaid, you're privatizing social income policy. You're privatizing social housing policy. And you're putting that burden on the private sector. That's what has to happen.

ANA GUPTE: It's about $100 billion in premiums. There's a pipeline of $100 billion out of the $535 billion spent in Medicaid, that is Medicaid long term support services. And as I said, it's somewhere in the 3 to 4 percent pre-tax margin. So, you're talking you know the potential profit pool is as much as $4 billion or so. That's pretty measurable.

SHERYL SKOLNICK: That's on Medicaid or Medicare?

ANA GUPTE: The duals got de-coupled, because duals were not very successful as a three-way contract between CMS, the state, and the managed care company for two reasons -- CMS and the states had conflicts on the shared savings. And also, the opt-out issue. But privatization has continued. You have in Medicare dual special needs plans and those continue to be quite successful. And on the Medicaid side, you have long term support services. Some states have been less successful than others. Some states the companies in the early years have had to lose a lot of money. So, they are putting their balance sheets -- not only are they investing in projects and all of that of course, you know that is a small piece of it actually. When you're talking about $100 billion in premiums that you're underwriting and you're capitated against that underwriting burden, it's about a $10-billion balance sheet liability that you have to [unintelligible] And so for a small regional Medicaid player, they cannot swallow those losses for 18 months or so before they become profitable and finally earn that 3 percent margin. It doesn't happen overnight. And just another insurance sort of tactic that they've all become to employ, to make sure that stock analyst doesn't penalize them for those losses in the early years, is they take what we call a premium deficiency reserve upfront. So, they tell you they expect to lose money over the next 18 months to the tune of X, Y, Z. And then if it comes in better, we can chew it up in a positive way. And that helps kind of smooth the stock market volatility.

MATT BORSCH: Let me just clear up one point though, is to make in terms of quantification, I wasn't referring to the earnings quantification, but rather to the amount of investment in social determinacy of health. I think that aspect of it is difficult for us as outsiders to measure how much that has increased.

PAUL GINSBURG: Good. I actually started the questions a little too early. Mixed up something about our agenda. So, I would like to return to the prepared questions. And then we'll take our break. We have had years now of relatively low spending trends in healthcare, particularly in Medicare. And this you know for years we've had debates about the relative importance of the recession, and its slow recovery on spending, versus other factors that may prove more durable. At this point in time, what's your perspective on where we are and what might be in the near term?

MATT BORSCH: If I could start on this one, because this is something -- well, we've all spent a lot of time on this. And it's important for both providers and payers. And I will share my own frustration, which is that we followed a model that Milliman originally developed going back several decades, looking at the relationship between the economic cycle and healthcare utilization demand if you will. And basically, what it shows is that there has been in past economic cycles about a three to five-year lag between the beginning of an economic recovery, and when healthcare trend has bottomed out and started to pick back up again. Admittedly, that's only through a limited number of data points. But it goes back statistically as far as the 1960s, 1970s, although I think it's probably best illustrated by looking at the 1980s, or the 1990s, you know the 1982 recession, and the recovery started at that point and then you had a trough and then reacceleration in trend in 1986-87. The same thing really even in the stronger fashion perhaps in the 1990s with the slowdown in the earlier part of decade, and then when you got to the middle of the 1990s, trend bottomed out and started to pick back up again. And part of the theory behind this, and I will keep this limited, but part of the theory behind this is the idea that when you're going into recession -- in a recession that employers are focusing on tamping down every source of cost that they possibly can with a lot more attention maybe than they have when times were good, and as it relates to employee benefits in healthcare, they put into effect measures that usually don't have effect immediately, that affect when you're already in a recovery stage, and have multiyear impacts. But eventually, the employers, as they see their bottom line recover, as they see the labor market tightening, start to take their foot off the accelerator on those cost control mechanisms as trend comes down, and their profitability increases. Now the point is, moving forward, we did see some of this cycle recur again in the 2000s in a more moderate fashion. But it was there. In the current decade, that pattern is arguably still there in the data, but it's been very, very muted. And trend really has not seen any significant acceleration -- at least not yet, and we are well past the three to five-year point, which would put you around 2014. Now I will say, if you talk to United Health, they will say trend bottomed in 2013. Which is about when we would have expected it to and picked up from there. But the pickup has been very moderated. Certainly, people have pointed to the effect of the increased penetration of cost sharing generally, and high deductible health plans specifically. The increased penetration of managed care, and Medicaid and Medicare. That's maybe some of the reasons why you've seen it in other areas. But it is still a bit of a mystery that that trend has stayed as moderate as it has for as long as it has despite economic recovery.

ANA GUPTE: What I would say is that incentive alignment is, I think, at the heart of it. And services companies in general are very adaptable, and they are very innovative,I think, particularly managed care. So, its incentive alignment along all three axes, the patient has seen all the way from just co-pays, to co-insurance, just basic buy downs to high deductible health plans with very -- a big impact on their out-of-pocket expense. So, they're more motivated to stay healthy or use lower cost sites of service, or whatever the different options are offered to them by the providers and the plans. The plans in the old days, and I remember 10 years ago when I first started covering, and I used to work at Aetna before that; they were not incented really to manage costs. They used to predict the costs, and they would price for the cost. And they could price quite well without any kind of rate review or anything. It was largely a commercial market. The top line was levered to pricing and even if there wasn't a whole lot of unit volume growth, you had pricing in the high single digits, to the low double digits -- your top line was merrily growing. You don't have that today. You have to earn your keep. So, they are becoming far more innovative around chronic care management programs, embedding analytics, and integrating clinical data with claims data, and the EHRs and their personal health records, and making sure that they have partnerships on the ground with primary care physicians where there's incentive alignment, and shared risk with health systems. So that axis is working as well as well. And then you have on the provider side, I think during the ACA, didn't they have the penalties for readmissions. You know, there was this consistent admissions and readmissions and then after discharged; no one was really coordinating the care of that patient post discharge. Now you have the managed care company, and there's home health providers and so that's part of the reason the hospital companies that Sheryl is talking about, and painting this very bleak picture, it's becoming -- it's a result of all of that incentive alignment. It's easiest with the primary care physician access in Medicare Advantage, which I think is the perfect value base care model. And in some ways, CMS has been trying to play catch up with Medicare shared savings plans, and other various alternate payment models. But Medicare Advantage with a fully captivated primary care doc. And the plan is getting $,12,000s a year. The physician is told -- I don't know what kind of -- it can be any kind of models, but it's a shared savings model. If you can cut your medical loss ratio by 10 percent, and you get 5 percent of the spoils, wow. I mean you're golden. As the primary care doc, as where your incentives had been getting worse and worse, I think it's kind of the resurrection of primary care. I've talked to startup companies who contract now with United and Well Care, and Humana and others like [Company] Health, who said their medical loss ratio is in the mid-60s. I mean that's shocking. You know, it's shocking. The managed care company has got maybe an 85% medical loss ratio. So, they're doing somewhere on our gap income statements, 80 to 85%. But there is a huge incentive for that primary care doc to keep that patient pool healthy. And that's why you're seeing spending in Medicare going down, and CMS is emulating that, not as well, but they're trying to play catch up with MSSP and other -- bundling in other pilots, which have had mixed success in my view. But it's because they're emulating the private sector really.

PAUL GINSBURG: So, one implication of what both of you said, is that this modest cost trend may continue for some time. Because this is not cyclical -- it's a basic thing.

ANA GUPTE: It's a structural change.

PAUL GINSBURG: Structural changes.

SHERYL SKOLNICK: There's one other aspect. It's called technology. So, when a patient needs care, they're going to look -- they have their app on their phone. It's tied to their health plan; it's going to say here are the covered places where you can go for what happened to you. What do you need? OK, you need urgent care. You need emergency room. First, it's going to send you to urgent care. And then it's going to send you to the one that's most cost effective in its network. And it's all on your phone. And I don't know about people in this room, but I mean I'm not a millennium; I do almost everything on my phone. But millennial do everything on their phone. And they don't pick up a phone unless they're going to do something that requires pushing it, rather than talking into it. So, this phone is going to determine where healthcare, at least at the potential non-emergent level, where it's going to get delivered. And if you're tied into your health plan on your phone, that health plan has an opportunity to send you to the right place, at the right time, for the right care. And it's not going to be a hospital-based outpatient unit that charges twice as much as a free-standing outpatient for half the quality. It's going to be the opposite. It's going to be the higher quality, lower cost ones. So, don't discount the revolution that technology has finally made in healthcare. I mean we're no longer celebrating hospitals getting their first fax machines. Which didn't happen that long ago. We now really should be thinking about when a consumer is making a healthcare choice, and they're using technology, what is that system? What analytics are tied to it? What are the behaviors that are going to dictate who and where -- who they go see, and where they go see it, how much they use and how much it's going to cost? You cannot underestimate it.

MATT BORSCH: If you look at -- there's also been slowing in traditional Medicare and in traditional Medicaid, which are unmanaged. And so, a little bit of a mystery there. I think maybe there's some part explanation in the fact that we've reached a saturation point or had reached a saturation point on certain kinds of utilization. But I will say that the sentinel effect of managed care having reached a tipping point, if you will, in terms of penetration in both Medicare with Medicare Advantage growth and also in managed Medicaid -- that's a theory.

PAUL GINSBURG: Yes, in a sense the economists call that the spillover effect. That so much of your work is in managed care that you're going to practice the same way as the unmanaged sector.

SHERYL SKOLNICK: Medicare fee for service is still probably dominant in a lot of sectors. Just remember, if you subtract 85 from where we are today, it's 1932. 1932 was a low-birth number year. So, we have another year or two to go through from the Great Depression before the 85 plus generation starts growing again, where most of your healthcare utilization comes from. So, if you want to just throw in a graying of America, the number of old-old, this is absolutely affecting nursing home admissions right now. They are at 100 percent --- operators are seeing this. So, just remember population dictates utilization as much as anything else. It's an important variable you have to consider. And right now, the old-old population is at a lower point than it will be two to three years from now. Does that mean the trend is accelerating? I don't think so. I think you know, trend you have to be careful how you measure it.

MATT BORSCH: Sorry, I was just going to jump in to throw in a number to your argument. 2027. That's when the leading edge of the baby boom population turns 74…

ANA GUPTE: And can I throw in a couple more numbers? No discussion on spending would be complete without a talk -- at least some acknowledgement of what optimists said as the vision optimist, part of United Health. They have targeted 75 markets, 30 markets they say are now pretty well populated. They are buying up all of these large multi interspecialty, largely primary care practices in those markets. Building out an ambulatory platform, which they call Optum Care across -- to some of Sheryl's points of the urgent care, where they bought a company called Med Express, and ambulatory surgery centers, where they are building off a format called Surgery Care Affiliates, which was a public company that they just bought. And then they have Optum Insights, where they are connecting that patient record across all of these various care delivery points seamlessly. You know, integrating electronic health records, clinical data with claims data. And the two numbers they put out, which are staggering I think is they're seeing for United Health Care insured patients, 50 percent lower bed utilization in the Optum care optum populated markets. And they also have the pharmacy benefits manager, and we'll talk more about all of that -- that's happening. But the Optum RX business is saving 20 percent pharmacy cost. So, they are lowering pharmacy spending per month, per member by 11 to 16 dollars. And this was last year's number. And they are doing an investor day in a week, so we'll see as they update us. But that has become the model that I think -- and we'll talk more about the CVS, Aetna and others are starting to lose share and are beginning to see, as they were trying to kind of execute on these big horizontal megamergers that went south, here you had Optum, that is truly bending cost strength. And it is just amazing.

SHERYL SKOLNICK: So, if there's one organization that's doing a job of implementing health policy, as in we need to get our health care cost down, we need to straighten out what's broken, we need to make sure that incentives are correctly aligned when you have a contract -- so break the old ones and redo them where necessary. The only one that I see has being capable of doing it and having any scale right now is Optum. They've done a lot, but if they stop where they are now, they're not nearly done. There's a lot more to do, because the health care system is still incredibly broken.

PAUL GINSBURG: Well it's been a fascinating discussion. Let's take a 10-minute break now. We'll start at say 10:50.

***BREAK***

PAUL GINSBURG: Let me continue this discussion of spending trends by focusing briefly on specialty drugs and the question is what role does growth in specialty drug spending have in your forecast of overall spending, and what percent of the overall spending gains now are coming from growing spending for specialty drugs?

ANA GUPTA: So, technically, what was it, 27% of the total, about close to $500 billion in pharmaceutical spend was specialty in 2015. It's probably somewhere in the low 30s now, but rate of increase, though, the specialty drug trend increase is running in the high teens to over 20%, I think, whereas the traditional drugs are running in the low single digits. So, the

expectation is, I think, by 2020, close to half of total prescription drug spend will be specialty spend. And I mean, then we can keep going into, Paul has the whole set of questions, but you know, that's where I think managed care and their pharmacy benefits management business relative to a standalone PBM that does not have a medical insurance underwriting business model and doesn't have – ultimately does not have provider networks, they do not have specialist networks and they do not have health system networks where these drugs are administered. They might have a smattering of infusion clinics. You know, I think, CVS has 73 infusion clinics, but they cannot influence utilization of drugs that are administered and injectable or in an infused setting, and that is going to become the largest part of the prescription drug market.

So, up until now, we've had, you know, managed care has huge cost pool. For every 100% of the $100 of spend, in the old days, only 10 to 15 was pharmaceutical and growing at a very low single-digit increase because the generics cabinet had taken over and the innovation s-curve was weak. They paid attention to the hospitals and, my God, they really handed the hospitals a very difficult, you know, deal. But now they are looking at it and saying, gee, now we've got to do something on the pharmaceutical side and where is this increase? It's in specialty. That's where some of these strategies we'll talk about – I don't want to deliver a monologue here, but it will become apparent.

PAUL GINSBURG: So later on I'll ask you about – because I think you were implying that there is a strong reason now, as far as management reason, for the PBMs to become much more closely aligned—

ANA GUPTE: Yes.

PAUL GINSBURG: —with the insurers than they've historically been.

MATT BORSCH: Just one point to add onto that, which is that one reason may be that we have room for specialty pharma trend to be as high as it is, is it, until recently, hasn't been that large of a percentage of the total but also because everything else has been so moderate. And so specialty pharma is really the one thing, in particular, that is increasing, but it's happening in the context of overall slow trend and, therefore, hasn't been treated as much as sort of a crisis as it might otherwise be.

SHERYL SKOLNICK: So let me just make an observation. So the flip side of this is, a couple of things that have happened that may impact trend going forward, and that is, one, you have uncovered or discovered and, for the publicly traded specialty pharmaceutical companies, have eliminated most of the opportunity to reprice old drugs at outrageous rates, so even though that might have been a very small part, it was nevertheless a very troublesome, annoying part of setting up these specialty pharmacy networks that would then get people onto these drugs and try to negotiate a way for the health plans to cover it, you know, super pricing a lot of these drugs. So, if you look at the stocks of Valiant, or Horizon, or some of the other companies that have been doing these sorts of things of buying up drugs and then making money just simply by slapping a new price on that, that game's done. So at least you're getting some mitigation of that small amount of the gaming of the system and the pressure that it's putting on the pharmacy trend.

The second point that I'll make is that I think it's the horse being already out of the gate, that, you know, some of the contract wins from OptumRX were precisely because they were able to do this integration, what they called the synchronization of the health event as well as the pharmacy event and the data around it, and as well as the management of the patient around those two events and the data. So it doesn't matter if it was seen at a physician office or at a hospital or whatever, that what you're no longer doing, and again, this is very similar to what the health insurance companies did in medical care, you're not just trying to price the treatment, you're trying to price the episode of care efficiently. So what does that mean? It means you're looking at the patient in totality—, sound like patient-centered medicine?—look at the patient in totality and see what services need to be delivered, where they need to be delivered, and what is the appropriate price to pay for that. In some cases it's going to mean give more. Give more up front. In some cases it's going to mean, when you're discharged from the hospital, you're going to get a call if you don't fill your post-discharge script within 24 hours, why didn't you do it? Your doctor wants you to do that -- wants you to be healthy. How can we help you get the script filled? So there's going to be some increases. As the approach to managing healthcare changes, there's going to be some increases in spend in some area, and there's going to be greater scrutiny and decline in others.

And the final thing that I'll mention is, you know, some of these drugs that were repriced or that had relatively high prices were generics -- sort of this notion of a branded generic, which is kind of interesting. And, they were able to have some pretty good periods of exclusivity, monopoly driving price higher, so one hopes that with an FDA leadership that is more focused on expediting approvals of lower cost generics that competition will begin to abate some of the price pressure as opposed to the unit growth pressure, but the price pressure.

And then, the final thing is, that as we're not talking specifically about things like Solvaldi or some of the other just completely innovative drugs that actually are cures, even though they're high-price spends on the drug, A) they've moderated substantially as more drugs in that class come on; and B) they actually cure patients. So part of what we're paying for in the specialty drug area may be oncology drugs that actually offer, if not a cure, than substantially a cure, such a great improvement in quality of life for a longer period of time, that they are, in some cases, justified as either financially worth it, or socially worth it. And so there's a lot of inputs into this pharmacy cost trend issue that are sticky, that are complicated, and some are going to help it to abate and others are going to cause it to increase, but it has got to be, and I couldn't agree with Ana more, it has to be integrated into the view of the patient as a whole, meaning the medical underwriting as well as the pharmacy underwriting has to be integrated.

MATT BORSCH: If I could make one point there on, not to get into a debate on Optum, yes. OptumRX, their account wins have mostly been the type of sort of carve out pharmacy PBM accounts, so those are some very prestigious ones that they have won. I guess the point I'm making is, it isn't clear that large employer purchasers have necessarily yet embraced the model of, okay, we want everything in one basket where -- we want one carrier to be managing both the medical and the pharmacy side. Now, that could very much be where we're going. It makes sense that elements of that are where we're going, but I don't think we've seen the evidence yet that that's resonating in the marketplace – yet.

ANA GUPTE: Well, I think there have been four accounts, right? It was GE, CalPERS – and these are all thought-leading accounts -- Texas Retirement System and State of New Jersey. I think there's a difference between fully insured versus self insured because when you're talking about a fully insured employer count, they're going to want to go with one provider because they can, you know, see the immediate impact on their medical costs versus what it would be if they had a separate pharmacy benefits manager that's doing the pharmacy benefits management. So there's more, you know, more likelihood that they'll go with the cap, you know, so called OptumRX, like pharmacy benefits manager under an insurance umbrella.

I'll make one more point, though on Matt's assertion about have large employers embraced this. We still have, and I feel – it feels to me that they have diminishing power as we've had more consolidation in the health insurance industry, but we still have the Aon view of the world of benefits consultants. And as the Uniteds of the world get more power and Optum and United become a one-stop shop for the employers, [benefit consultants'] role is getting increasingly marginalized, and so I do think there's some last vestiges of that that we're seeing in the self-insured markets still, because, you know, when we were at Aetna, they were – I was at Aetna. They were extremely powerful. This was like 10, 12 years ago, 12, 15 years ago. And they used to prevent – they would want to do a standalone pharmacy and a standalone dental and just because then they became the aggregator of everything, and today you have a formal consolidated industry, and an industry that's evolved that business model to do all of that well.

I've also heard from investors who are long – you know, the CVS's and the Express Scripts of the world, you know, this whole Optum thing is smoke and mirrors because all, ultimately, they're doing is underpricing relative to CVS. Who cares? I mean, at the end, if they're underpricing and they can still keep the same margin it's because their business model is tied to medical underwriting and medical share gains. So they can upsell their pharmacy book of business up to medical and they're making more money that way, and they can price lower than CVS, more power to them. An employer is going to pick them ultimately. CVS had to tie it to the front store up until now but, you know, the front store sales are getting eroded by Amazon. And over time, if Amazon comes into pharmacy, which we can talk about, you know, that's going to put a hell of a lot of pressure on CVS. So I just think that, you know, the employers need to go where the money is. I mean, why do they need complexity for no reason at all?

SHERYL SKOLNICK: I could not agree more with what Ana just said about the Aons, Hewitts and the rest of the benefit consultants out there that, you know, they should look to themselves as to whether they're actually promoting efficiency or inefficiency, improvements in patient care, and the cost to treat them, because I would argue that there are times, like now, where they may be preventing it rather than enhancing it, and not, therefore, helping their self-insured customers' bottom line, whose goal, overall, should be having healthier employees who come to work with lower healthcare costs as opposed to paying the margin of a middle man.

And then, you know, the one thing that I would just say is, it's possible that Optum has not substantially underpriced, so a couple of pennies difference doesn't seem like substantial underpricing to me, but rather that because of their scale in other areas, especially in technology, that perhaps they just simply have a better, more modernized business model. So there are some

aspects there where there may be a full competitive advantage. But be that as it may, sometimes the market, you know, is actually smartened where it puts the stock prices and CVS has had a rough time of it over the last couple of years whereas United, multi-pronged as it is, has not, along with the other health plans who have not. So there's something cooking in pharmacy and someone there, I think the bottom line here, is someone's going to get squeezed and, you know, you and I and everyone else in the room are hoping that it's not going to come – the funding for that is not going to come out of our pockets, but that whoever ends up winning is going to actually get us onto the right drugs at the right cost as opposed to something that would be a less good outcome.

MATT BORSCH: If I could just say one thing in defense of the large benefit consultants and, you know, we can argue all day—

SHERYL SKOLNICK: Why?

MATT BORSCH: It's pretty hard to, you know, to counsel employer purchasers on selection of vendors when you only have one or two, which is, you know, what we've gotten to with all the consolidation.

SHERYL SKOLNICK: Yeah, that's true. And again, why do you need them? If my choice is A or B, I'm not capable of making that choice? Then why am I sitting here as the decision maker in a benefits consulting suite. [Laughter]

PAUL GINSBURG: That's good. So, you know, we are talking a lot about integration of medical benefits and pharmacy. Any other activities, tools that either PBMs or health plans are using to address rising specialty pharma spend?

ANA GUPTE: It's tier 4 formularies is one. You know, it's co-insurance on a very large price drug per patient is, you know, it'll impact the choice, so that's one thing. I don't know that they are necessarily going to closed formularies or excluding coverage unless you have a substitutable option. I mean, with Solvaldi and, I guess, AbbVie came in with their drug, you know, they were considered – maybe there was the convenience element to the whole thing, but the companies managed to get amazing deals with Gilead on Sovaldi because there was an alternative, at least from an efficacy perspective, even if they might have to take the pill three times a day or whatever they had to do.

So I think the formulary design and co-insurance is one. And then we can talk about, I guess, you know, the oncology care model which CMS has had in place under the old Administration, Obama Administration, actually came out of an idea that Anthem had spawned to influence the choice of the treatment paradigm and the pathways for oncologists, and what they did was they put a certain fixed dollar amount per patient, per cancer patient, that was within a practice, and that was allowing the physician – the oncologist make all their money on what they call buy and bill. A lot of it is just being a distribution channel. But if they were given incentives to treat the patients in a way that made holistic clinical sense, rather than just do it to try to fill the bottom lines, if you will, that model then got adopted in the OCM, which I believe is still running, even under the new Administration. Right? And I think there are 3,000 oncologists in the pilot and,

you know, it's a pretty large pilot, and they are trying to influence utilization in this case, you know, again, by incentive alignment. The tier formularies are the patient and the OCM-type models are the physician, and that's how the payers are trained, you know, to steer patients to a certain therapy or not.

PAUL GINSBURG: Good. Well, let's talk about the insurer mergers now and, you know, specifically, I was going to ask about, you know, actually I'll still ask briefly, you know, the two years that the four insurers attempting to merge lost. Any sense of what they lost?

MATT BORSCH: Look, one thing they lost was hundreds of millions of dollars that got spent on, you know, not – not every penny of that was wasted because there were some insights that came out of that, but, you know, very heavy spending on transaction costs. Sheryl?

SHERYL SKOLNICK: So, strategically, so it's good we're not saying the same thing – so, strategically, I would say that, you know, they lost an awful lot of ground, and I think it's pretty clear now that you have the notion of Aetna perhaps merging with CVS, which will be our next topic, as perhaps a solution. You know, one of the things that was an investment thesis while the four of them were figuring out if they would get along, get a divorce, if the DOJ would intervene or not intervene because it really made for good sort of a gossip column kind of reading every day, if you like that sort of thing for healthcare, and you know, it was sort of like, at some point it just becomes too painful to see these deals done, but you do lose competitively and so United was kind of sitting there as the alternative company who wasn't engaged in any of these transactions or distractions, that was able to invest according to its strategic plan, that was able to execute on that strategic plan, and thus gain ground versus the competition. And, you know, during that period of time you saw stunning growth, not only in Optum but also in the United Healthcare Health Plan because there was distraction, or at least we'll call it stability, because you were kind of sort of, if you were one of the targets you were almost at a standstill. It was very hard to move ahead on a strategic plan, especially if the deal was not a friendly one, or, excuse me, was a friendly one. Where it was not a friendly one, you'd probably try to do whatever you want to do anyway. The point being that now you've got Anthem behind the 8-ball on its PBM because the Express Script contract was seemingly unsatisfactory to them, and I'm sure Ana and Matt can comment more on that. And then, you also have this whole notion of CVS and Aetna perhaps needing to get together to address what I think Ana was getting at, which is, if you're a PBM like CVS, then if you don't have that health plan integration and aspect of it you're really missing the boat on a large portion of the data and the synchronization and the risk that you need to manage, and the way in which you will gain market share by selling more because the market's moving towards a more integrated product, or at least one that talks to each other. But where's the technology investment that's behind that, and how many years away is that, and how many more hundreds of millions of dollars will that cost; whereas United already spent that money. So, from a competitive perspective, that time that they lost dithering around on this I think could be very damaging. And I'll just point out one other little thing that I found absolutely fascinating and I don't know if it's meaningful, and maybe my colleagues here can help me.

So when Anthem announced that they were going to go in and partner with CVS to build a PBM that was going to be their own, rather than give the contract to OptumRX or CVS or leave it with

Express Script or come up with some other solution, they called IngenioRX. I-N-G-E-N-I-O RX. So, looking at that, I'm thinking, gee. That word sounds kind of familiar. What does it remind me of? Well, United Optum Insight used to be called Ingenix. And Optum is called OptumRX, which I tend to abbreviate ORX, as opposed to Optum Care, which is OC, and Optum Health which is OH, and you get the drift, right? So we have In-genee-ORX [ph] [Laughter]. GenexRX. I mean, do you feel like, you know, it's the sincerest form of flattery here? [Laughter] And I mean that seriously. Because there's multiple years and millions upon millions of dollars that will need to be invested by 2020. And the irony is that United tends to be a seller when everyone else is a buyer. So by that time, 2020, you could already see the mail order and some of the fulfillment services being more than commoditized by who knows who, it might start with an A, might not, and United will be a seller when everybody else is a buyer. That's been the historic pattern in PBM because they sold the diversified pharmacy services long ago when everyone else was buying.

So, just an observation. They've lost a tremendous amount of time and competitive advantage, but it's a strategic advantage. It's a long-term advantage and it may – they may never catch up. So if you can't catch up, you'd better figure out how to leap frog.

PAUL GINSBURG: Well, let's talk about the merger between Aetna and CVS that may happen, and the real question is not so much, you know, analyzing the companies, but in a sense reflecting on it as, you know, what do you think they're trying to do and what does that mean for the way healthcare delivery and financing is changing?

ANA GUPTE: I think there's three big factors. You know, we talked a little, between the three of us, of all of them, but the first one is that everyone wants to be an Optum. So it's this Optum wannabe thing that's going on, and Anthem is doing it with Ingenio, and you know, and CVS and Aetna need to do it with each other. So it's, if you can't beat them you've got to join them and figure it out. That's one.

Second thing is, as I said, I mean, CVS's front store sales have been really, really challenging, and this is even examples—

PAUL GINSBURG: So the front store sales because they're [Cross talk].

ANA GUPTE: Front store is shampoo and, yeah, the greeting cards and all that. So that's been extremely challenging for them. That was the way that they were leveraging their pharmacy benefits managing model, and then CVS and Care Mark merged in 2007 or something, '06 or '07, it was all – the vertical integration was tied to bringing people to fill their scripts in the store and then shop, you know, and now you have Amazon Prime who's doing Amazon Prime Same Day in two hours, and they're going to give it to you, you know, they're giving it to you with free shipping. So why would you go pay those kind of hefty prices for your shampoo and, you know, anything else. So that's the other problem they're dealing with.

And then, the third one is the drug companies, I think, did a great job of pointing fingers at the middle man, and the retail pharmacy margins are in the high teens to 20%. I mean, how is that sustainable in, you know, a market where we're all saying that drug prices are just completely

unaffordable for the American consumer, and the drug manufacturers say, gee, you know, this is not about gross price increases, but it's net price increases of rebate. When you look at it, someone else is pocketing all of that. And the Hill, and all of you paid attention. So I mean, no one is really going after the drug companies anymore. So here's CVS sitting, you know, looking at all the customers, and now Anthem divorce Express. So what is that telling you? That your best customers are becoming your fiercest competitors. So it's not just that Anthem is, you know, maybe imitating Optum, but what power does Express Scripts have? They were literally making, and they disclosed this in an SEC filing, like $11 a script, or something, it's completely crazy, you know, down to now I would think, looking at the numbers that Anthem is projecting, which is $4 billion in savings starting 2020 when they switch. They're going to do $2 a script or less. I mean, all of a sudden, 80% of your margins are gone and no one's shopping for shampoo in your store. What are you going to do? I mean, that's just – it's a perfect storm right now for these guys.

SHERYL SKOLNICK: Do you think that Anthem will change its strategy terribly much once Gail sits in the seat?

ANA GUPTE: Once Gail sits in the seat? You know, we don't know—

SHERYL SKOLNICK: There's a change in CEO. Joe Swedish is retiring and Gail Boudreaux, who used to run the United Healthcare Health Plan and helped to turn it around in the post Bill Maguire days, is going – her non-compete is over and she's taking a CEO slot at Anthem.

ANA GUPTE: I really respect Gail, so I'm excited. You know, I think Anthem has certainly been slower at, you know, and as a stock analyst, we look at what's the next leg of growth, right, and so Optum is certainly on a tear, but Anthem looks like they have all the market share in the local markets. They've not been able to leverage their market share and their Blue Cross Blue Shield brand as well as they should have on the value-based care model, where control over your physician is your biggest power. And so now they can – I think they've kind of come out of some of the worst issues that they had under their previous CEO, not Swedish, Angela Braly, and you know, the four years of just challenges with Obama Care implementation and trying to fight Cigna legally in court and Express and all. Now they can kind of take the next move and build out Ingenio. She comes as CEO of United Healthcare and so while she didn't build out Optum, she was in the C suite as one of the three top leaders helping build out Optum, and so she can help, you know, drive that piece of it. And they've acknowledged that, I think, they wasted a lot of time with Cigna. If anyone has kind of said that openly, they've said that it was a mistake, you know, and it set them back. I don't think they're pursuing mega mergers anymore. They're doing roll up consolidation on Medicare Advantage. So I'm not sure if she needs to change strategy, she can certainly help execution, which is not perfect right now at Anthem.

PAUL GINSBURG: Let me talk about the Optum and the Ingenio and the possible combination of Aetna and CVS. You know, it seems as though only the really large insurers can do this, and the question is, I know United historically, through predecessors of Optum always, you know, had a business of servicing other insurers, and they still do. Is that going to be, in a sense, what happens with the rest of the insurance industry?

MATT BORSCH: I mean, it's certainly looking like that's where we're headed, and, you know, the interesting dynamic there is that, you know, you're correct that other plans, you know, regional plans, smaller plans, have been comfortable buying services from Optum, even though Optum is part of a very large competitor to them, but these are services and units within Optum that are really at an arm's length, or, you know, very separate from United Health Group. The point I'm making, though, is that as United bought Catamaran, a PBM which served a lot of different health plans, I think that's been more of a test case and maybe a difficult one because I've talked to a number of the smaller plans who've said they're not comfortable having their PBM business with one of their big competitors, but now, you know, and that's being tested with OptumRX and I think the jury's out. And it may be that the jury has no place to go because Aetna and CVS are combining, and if Anthem's out there with a model that takes market share from Express Scripts, you don't have much left other than to compete with one – or sorry, to contract with one of your largest competitors for PBM services. So that's something to watch.

And just one other point on the Aetna-CVS. Well, it's still not been acknowledged by either company as something that they're actually pursuing although it's something we've heard Aetna management talk about in investor meetings going back – not a merger, per se, but what they might be able to do with combining with a retail pharmacy company, we don't know yet, though, fully what the articulated vision is going to be here, and I'm not talking about the PBM so much as what Aetna and CVS together would propose to do with the 10,000 retail stores that CVS has. Of those retail stores, by the way, something like 1500, I think, have—

ANA GUPTE: Minute clinics.

MATT BORSCH: —minute clinics. Not that that number's necessarily important for this, but, you know, is the vision there that Aetna would put, you know, a range of outpatient services into many of those stores and try to drive a revolution in where care is delivered to those sites being lower cost of care? That's something we're really interested in hearing from them, if and when this thing goes forward.

One other point to make on that, which is that Cigna has articulated somewhat of a different view where they've said we don't necessarily want to be tied into that kind of bricks and mortar approach, but because what we see is technology is leap-frogging that to a lot of things being done at home with remote monitoring and so forth. Now maybe their view will change if this merger happens, but that's what they've said.

ANA GUPTE: And I guess, you know, a couple points on that, I think, as Matt says, you know, I think the Aetna, CVS has been a little more open and vocal about the vision and if the front store model is starting to get threatened and with Amazon potentially getting into mail order pharmacy maybe that gets even worse, then they can repurpose those stores into community health centers. I know that's kind of their real estate, let's leverage our real estate answer to Optum, and then you kind of build out something more around the minute clinic model and you put telemedicine and, maybe you can get therapy and hearing aids, and they could wrap around a Medicare Advantage-like offering and that's kind of one way to go. It's going to be challenging to execute and probably will take multiple years for something like that to materialize because CVS still makes 25% of their retail sales from the front store and they lease stores, so they're

responsible for those leases on their P&L. But it sounded like the kind of vision I think that CVS and – I mean, CVS has never said anything openly, but Aetna has been painting, with the company, you know, like CVS and then the rumors break, so it feels like that's, you know, that's where they wanted to go.

PAUL GINSBURG: On the integration that we were talking about a few minutes ago with, in a sense, what Optum is doing with United. Do Optum, or Optum-like companies, have the ability to actually accomplish some of the integration with their other insured clients?

SHERYL SKOLNICK: That's the goal, and in some cases they're able to, but obviously, there are going to be some – they have an extremely flexible technology architecture that is designed to allow them to optimize the connectivity of their services to other payers, and even to hospitals and that part of their business. So the answer is that's the goal.

One of the things that is always a difficult choice, you know, why do hospitals choose to engage with Optum, why do health plans choose to engage with Optum, so I think their answer is often, so if you have the largest scale and the lowest cost, do you really want to go with someone else who's going to bring a cost disadvantage against you – who's going to bring a disadvantage to your cost rather than someone who brings an advantage. At the end of the day it's going to be an economic decision, and it often is. So long as Optum can demonstrate that they're not sharing strategic data or initiatives with the guys on the other side of Eden Prairie, because the buildings are now at least separate.

PAUL GINSBURG: We've picked up some of this before, but as far as large employer benefit strategies, you know, I'd always had a sense that some of the benefit buy-downs and other steps had been a response to the Cadillac tax, preparing for it. Cadillac tax is still on the books for 2020, but probably not expected to ever come into effect. Have you seen a difference as far as a backing off, or maybe a backing off just because, you know, how much larger can you make the deductible without starting to sacrifice the reason you offered health insurance in the first place?

MATT BORSCH: I think we haven't seen that yet. In fact, one of the things that has been surprising is the extent to which, at least from what we're hearing, that employers have been plowing ahead with, you know, when I talked about the sort of cyclical taking your foot off the accelerator in terms of cost control mechanisms, employers have really not taken their foot off the accelerator in terms of, particularly if you look at the penetration of high-deductible health plans. And it doesn't look like that's changing for 2018, either. I will say the prospect of the Cadillac tax, when it was to go into effect in 2018, certainly was a helpful thing to point to for many benefit managers in large companies. They could say, look, this is coming. We need to get ahead of where this is going to put us by changing our benefits now and, there were specific examples of where that led to employers adopting consumer-directed health plans for the first time. And I haven't really heard this, but it wouldn't surprise me if that's still being used now, the Cadillac tax has been kicked out to 2020, but it's still on the books.

ANA GUPTE: I think that anecdotally I have heard the push back or less appetite for a higher deductible. I think there is some sympathy for the worker and the pressures that they face on out of pocket. You pay all of this in premiums and unless you've been catastrophically ill you hardly

really get much benefit from what you're using, even if you get an ambulatory surgery procedure or whatever. But we still only have maybe about a third of the total, you know, high deductibles in the classic sense. It's about a third penetrated and maybe even less, depending upon the group sizes, so there's plenty of opportunity to increase the penetration rather than the deductible. Most employers will offer you a choice of a PPO plan versus a high-deductible plan and one has a slightly lower premium, but more up front deductibles. Then you have to make a choice and they kind of incenting the worker to make that choice, but there's a lot of head room still to go.

PAUL GINSBURG: Is there any sign of, in a sense, when you think of it, if deductibles are too large to increase further, seems as though the alternative way of still constraining your costs is to narrow the network.

ANA GUPTE: Yes.

PAUL GINSBURG: And, you know, I think large employers, particularly, had really not gone there for a long time. Do you see signs that that's changing?

ANA GUPTE: They haven't stopped. I mean, they were not there at all 10 years ago. At all. And that was the biggest constraint for a managed care company because, on the one hand, they were being tasked with being the stewards of bending trend, but then the employers used to say I want my worker to have access to Cedar Sinai, and UCLA, and every expensive provider system in the metro area. I mean, if your hands are tied like that you can't really negotiate with that provider in any way. And I think you had some, you know, questions later on, or maybe as part of this section, around how come? One of the factors, despite the hospital consolidation, we haven't seen pressure on contract rates for commercial contracts between health insurers and hospitals is because narrow networks give them the flexibility to just kick somebody out of the network, you know. And the employer is on their side, I think.

MATT BORSCH: If I could just add to that. You know, the real traction for narrow networks has been a lot more limited if you compare it to high deductible health plans. But let's remember how we got here. The other thing that happened in the last 15 plus years is that employers decided to move to models that were much more likely to be self insured, much more likely to want to consolidate their business with one or maybe two or three carriers. And if you're going to do that, it's really hard to not have a big network because you've got to take into account you've got a geographic and otherwise diverse workforce. But now the pendulum is maybe starting to swing the other direction. You hear of large employers doing what they call slice contracting, meaning that they're contracting, instead of just one or two or three carriers in local region, they may be, you know, giving employees a choice of five different regional carriers that have narrow networks and, therefore, lower prices and, on the margin, some of that's being done through private exchanges. So there is activity, but it's still on the margins.

SHERYL SKOLNICK: So the one thing I would point to is that, I would call it, the narrowing of networks as opposed to truly a narrow network, although I think there are high performing networks that are gaining traction with the most innovative and forward thinking employers, which is not the entire group, but the employers certainly do provide a drag on all of this, you know, a limiting factor on change.

As an example, United had this very embarrassing situation that despite being the parent company to Optum, United Health Group had some of the worst star scores of the big publicly traded companies, and when that happened they discovered that they had to narrow the network. They had to really assess the physicians and the quality of care that was being delivered through their physicians and their ability to have a span of control that was appropriate over those physicians to encourage them to follow the proper protocols, close the gaps in care, make sure that the patient satisfaction and outcomes were high. When they started to kick doctors out of their networks, do you know what doctors did?

PAUL GINSBURG: They went to the government.

SHERYL SKOLNICK: Sued.

PAUL GINSBURG: Yes.

SHERYL SKOLNICK: And they went to the government. They sued. So the push back on narrowing networks is a real issue in some cases. It's a real problem. Ultimately, you know, they were able to narrow the network a lot and their outcomes and metrics certainly did improve, maybe coincidentally, maybe not, but I would say that certainly on the Medicare Advantage side, they have had to do it because of the constraints they were facing on reimbursement and the need to increase star scores. On the commercial side, they are absolutely limited by what the self-insured employer will agree to, and that has been the case forever. And, in some cases, some of the things that they were trying to do with financial incentives that if you act in a more – a healthier way, if you do your numbers and you get your diabetic numbers down, or you become a non-smoker, they would provide a premium incentive for the good behavior, so a different way of getting cost trend down was by paying people to do smarter things for their health. In some states that's illegal, you can't do it.

So there's a lot of complicating factors. Narrowing the network addresses a lot of that because you'll end up with a better protocol that, where when physicians who get better engagement with their patients to get them to healthier status.

PAUL GINSBURG: You know, it seems what United was doing to narrow its Medicare Advantage network was far more challenging because they were basically booting people out who were willing to take the rates they offered.

SHERYL SKOLNICK: Yeah. It wasn't about rates. That's exactly right.

PAUL GINSBURG: Whereas, you know, in a sense, if you're going to take a very expensive hospital out of a network, that's a very different story.

SHERYL SKOLNICK: Well, I think, but then their whole concept of narrow networks, you bring up a great point, Paul. It's less about rate and more about quality and outcome that defines a premier provider. Rate's important, but a premier provider – and then there was one other point. I once asked someone in managed care, "Why do you still pay hospitals such high rates,

and 5% or 6% price increases every year?" And the answer is: "Because without us they'd go under and we still need them."

PAUL GINSBURG: Actually, I was going to ask about the degree to which narrowing a network is taking into account outcomes, quality, as opposed to being strictly a price thing. I don't know if anyone can respond to that.

ANA GUPTE: I can only speculate here, you know, but I think narrowing a network is turning into a more strategic partnership between the payer and the provider, so whether or not there is an outcome's metric that's being attached to it, at least it helps if the provider cares much more about the processes in disease management and care coordination approaches and quality star ratings and all of that and the objectives of the payer, because they're seeing far more patients coming through their doors that are attached to that particular payer. And so I would speculate that it'll drive more outcomes-focused care delivery from the provider as opposed to a much more transactional relationship that you might have with multiple payers when they resent the narrowing of the networks. And the payers, when they're taking on a strategic partnership with the provider, they look at risk – whether it's a large physician group or a health system, they're looking at risk readiness. How ready is this provider to be part of a strategic relationship that I have? And they use different algorithms to do that. Optum talks about this in some of their more flagship strategic relationships like Northwell and Dignity and so on, but there are many startups that just specialize in software that helps a payer determine do I want to invest in this particular provider system as part of my narrow network? Invest, perhaps not just in teaching them and giving them access to my programs and capabilities and systems, but, in some cases, they also offer them balance sheet strength to help them invest in what they need to do to become risk ready and become a preferred supplier to you.

PAUL GINSBURG: That's very interesting. Actually, speaking of Northwell, I gather that they shut down their plan.

SHERYL SKOLNICK: They did, after writing a big check to a large publicly traded managed care company for their risk adjuster payments. Close to $90 million, I believe.

PAUL GINSBURG: And the question is, do you see in our future, you know, any significant degree of health plans owned by health systems, or even the branded model where that's a partnership with an insurer with their brands, or is this kind of something that will pass?

MATT BORSCH: I mean, I think that it's understandable why your Northwell and some of the other provider-sponsor plan attempts have run into trouble, and the biggest reason, and Sheryl alluded to it, is because their natural focus was on the quote/unquote opportunity in the health insurance exchanges, and that turned out to be a terrible first place to do business as a health plan, at least thus far. But, you know, the one thing that I think we know can lower healthcare costs materially while improving quality is well-integrated care, and that's what provider-sponsor plans potentially offer, whether it's done on their own or whether it's done in partnership with the payer is pulling together an integrated care network and, you know, providing the outcome at a lower cost. But you need to have a purchasing structure that works with that model, meaning that these integrated care systems are, out of necessity, narrow networks and, therefore,

you really need to have retail individual selection of health plans rather than the sort of typically employer group model. And, in fact, there's a little bit of a chicken and egg dilemma here, which is that in some ways the integrated provider plans, or at least network offerings, aren't going to be there until you have the critical mass of retail purchasers, but we're not going to go to a retail purchasing type environment until employers can see that there are demonstrable cost savings, which doesn't happen until you have the lower cost integrated plan offerings.

ANA GUPTE: And, in Medicare Advantage, which is the other payer mix that provider-owned plans have tried to pursue. There is also a huge scale advantage, not just in the care coordination approaches and systems and processes, but I think it's underestimated as well and, you know, Kaiser says this, what the health plans need to do to sell the plans. It's around distribution and advertising and all of that. So, for a smaller regional health system to come in and brand themselves and develop the relationships with the brokers and pay those kinds of commissions becomes very challenging. And it's an underappreciated skill set, and maybe you have sometimes the Medicare Advantage plans who contract with primary care docs, you know, the docs say, "But Gee, I do everything. I'm dealing with all the patient care and all of that. What are they doing?" Well, they're firstly selling the plan. That's how you got the money to begin with, you know? And then they're helping to scale it up through systems and processes, and then there's balance sheet capacity, right? It's 10% to 15% of your premiums have to be ring fenced in the balance sheet against the provider claims that will have to be paid out. And if a hospital system is running at high debt ratios and their whole business model is tied to free cash flow generation and all this, there's just a conflict here. So a little bit of shared risk, yeah, provider-owned plans, I just don't think, you know, they will be as successful.

SHERYL SKOLNICK: Can I just make the whole concept very simple. The goal and exercise of any of these shared risk entities and any of these health plans is going to be to reduce heads in hospital beds. Whether it's going to be the acute bed or the post acute bed, that's what they're going to do. That's where their first and most obvious lowest hanging fruit is. So what hospital has the ability to get such shared savings and such a large share of shared savings from the population that they will insure through their provider partnership to take risk. Very few of them. Very few of them. Because the negative impact of losing heads in the beds cannot, at least in the early stages, be more than offset by their percentage of the profit that they just gave up. Right? Take 100, divide it in half. You still have 50 cents on a dollar. So that's one of the reasons why these hospital provider, or hospital physician plans, and hospital health plans tend to have an inherent conflict. I think if you go all the way back, it may be one of the reasons why Humana ultimately split off from its hospitals.

MATT BORSCH: You know, Sheryl, that's a good point. I would say that it's one reason why some of the large physician groups in California would argue, you know, you can't have hospitals running these plans.

SHERYL SKOLNICK: You can't. That's right.

MATT BORSCH: And they should be at the center of the ecosystem.

SHERYL SKOLNICK: They exist to fill beds.

MATT BORSCH: And the evidence from integrated care systems in California, at least some of it is, would perhaps back that up. The problem in many areas of the country, of course, is that hospitals are the only units on the provider side that have scale, that have organization, that have capital to pull those things together.

SHERYL SKOLNICK: Unless it's a health plan physician [partnership].

MATT BORSCH: Right.

PAUL GINSBURG: Yeah. Good. Let me ask you some questions about alternative payment models, you know, ACOs, bundled payments, and just tell us about the perspectives that both private insurers have, providers have on potential in these arrangements and the degree to which they're putting capital into expanding that.

SHERYL SKOLNICK: Can I just say ditto on the hospital side? So you don't want to put money into an ACO whose sole goal is to empty the patients out of your beds, if you're a hospital. So it's a fundamental conflict of interest and it's a serious one. It doesn't stop them from doing it and attempting it because they're sort of asked to do it, and it's the model and they want to try it and maybe they can make it work, but it's one of the reasons why you do not see the proliferation of hospital-based ACOs. You do see the proliferation of provider – physician provider health plan ACOs.

PAUL GINSBURG: Yes.

SHERYL SKOLNICK: Those are growing very rapidly, and they are generating meaningful savings.

MATT BORSCH: I don't have the numbers, but I think, I mean, there are quite a few hospital-centered ACOs, and I don't disagree with, Sheryl, with your take on that.

SHERYL SKOLNICK: No, all of the Medicare ones have to be because the health plans were excluded.

MATT BORSCH: Right. You know, but the separate point I wanted to make is the hospitals may very well, you know, only want to take it so far because they have this conflict of interest as it relates to bed-day utilization. But the ACO is also a cover, a partially safe harbor, for consolidation within their local market and, you know, that's often the first thing that happens, and regardless of where we go from there, that can be beneficial to the hospital system.

ANA GUPTE: I think it's going to be the primary care is the easiest axis to see so-called alternate payment models because there's incentive alignment across the payer and the provider. It's easiest for Medicare. You know, then maybe Medicaid. The adoption has been less for commercial because the payout is not as easy because it's not that quick to just say I'm going to cut, you know, X-number of hospital admissions and readmissions with more care coordination and save you more money and let's split the difference. But I feel like it's not just going to stop

at these contracting relationships. I mean, Optum has been going at it methodically in all of the markets that they're targeting and buying these docs, and for a while it was Humana who, you know, started some of this maybe in 2011, 2012 or so under the old CEO, Mike McCallister but it feels like they're resuming the purchase behavior as well, again, I felt that for the first time and they're -- after the third quarter -- that they're back in the Carolinas on the prowl and buying. So it's an arms race for primary care physicians across all of the plans. Still, to some degree, and you know, both of you should opine, but I feel like it's slowing down on physician employment on the hospital side but it's not dead yet by any means and maybe MACRA and these other things, you know, drive that to some degree again, accelerate it. And then, home health assets, I think are – everyone says they want to buy a home health company. I mean none of them have been sold yet, but there's not that many to begin with.

PAUL GINSBURG: But when you say everybody, who are the buyers of home health companies?

ANA GUPTE: So, United says that it's a huge priority, Humana says it's the absolute top priority. CVS is saying they want to buy home health and, I mean, if everyone wants to buy home health.

SHERYL SKOLNICK: There's only a handful of publicly traded companies and there are still some private, because I cover the home health companies, and, you know, gee, I hope they keep their word because that's the thesis, in part, but you know, home health isn't the easiest, nor is it the most efficient model in the world.

So, a couple of thoughts here, first of all. To tie this into premier networks, so if you think about what Optum Care has said that they are doing, and I do see them doing this, they're looking for a very specific kind of physician practice, one that is adaptable to the analytics informed, technology-driven delivery of best practice, patient-centered care – put every buzz word in it – value-based, everything, okay? Just load it up with buzz words, that's what they're going for. But behind the buzz word is there isn't a system out there that is either linked to a payer or not linked to a payer that can routinely and consistently, in a very patient-focused way, deliver the right outcome at the right cost. So if it doesn't exist and you've got scale, and money, and brains, you're going to build it and that's Optum Care in a nutshell. It's not a mystery. It's as narrow and prestigious a network as you will ever see and, if they're right, and if they can get to where they want to get to, because who starts the process of paying for healthcare? The primary care physician and his or her pad and pen. Okay? So, you've got to own that.

Now, as far as hospitals are concerned, as usual, hospitals have difficulties making money with doctor ownership -- practice ownership. And now it's become very clear that, you know, I think we all were kind of aware of what they were doing. When it was a free-standing doc practice and it could bill under Part B it got this much, and it became a hospital-based outpatient service and all of a sudden you repriced it and you got this much. And that game is pretty much called. I mean, it's become visible. Daylight's in on the magic. I think that margin goes away, whether it's immediate or whether it takes a little longer, it's done in steps or not, that's done. So the whole incentive of being able to reprice—remember like specialty pharma companies did, they

bought old drugs and they repriced—it's the same sort of thing applied to hospital. The ability to reprice, that loophole, I think, is basically going to be done.

Now, managed care has pushed back on that in the past. There was – I can remember where Texas Health Resources, I believe it was, bought a physician practice in the part of the state where they didn't have a whole lot of oomph, and they didn't have a whole lot of market share. The Blue Cross plan basically that was covering the Texas state employees at the time, said there is no way we're repricing those doctor practices. Absolutely not. And you had these two big behemoths fighting it out and guess what? The doctor practice didn't get repriced. So there's some precedent here for the health plan actually having some leverage not to reprice these services. If you can't reprice them, I don't think there's an opportunity for the hospitals to make an adequate return to continue to buy them other than, it's very well established in the data, that if you own the practice as a hospital, the primary care, the referral sources will refer more of their patients to the hospital who owns them than they will to any other hospital in the market.

PAUL GINSBURG: So it sounds like there's still potential for the hospital of employing physicians but it's lower because the repricing is going away?

SHERYL SKOLNICK: Yes.

PAUL GINSBURG: So they still can get the referrals, of course, this means they have to be able to actually effectively manage the practices.

SHERYL SKOLNICK: And they're frequently not able to do that so well.

MATT BORSCH: And there's a defensive element of it, too—

SHERYL SKOLNICK: That's right.

MATT BORSCH: —which is the extent you have Optum and others buying up physician practices in your market. You want to own some, too.

PAUL GINSBURG: Good. This will be a time to go for some questions in the audience.

AUDIENCE MEMBER: Many states have been working on innovations and alternative payment models and so you have places like Maryland that have global budgets, and that's now expanded to Vermont, and there's a new alternative payment model in Pennsylvania that's focused on small rural hospitals and critical access hospitals moving to global budgets. Can you say something about what you're seeing in those markets, because we all know Baltimore is a terribly competitive market, but they seem to like it?

SHERYL SKOLNICK: Who seems to like it? I'm sorry, I missed that.

AUDIENCE MEMBERS: Hospitals.

SHERYL SKOLNICK: Hospitals seem to like – well, again, that's more of a not for profit market, so I can't really speak to why the not for profits like Baltimore, but if the last I heard, isn't Maryland a Medicaid expansion state, so if you take away the expensive lower rung of uninsured and you give the hospitals a financial cushion, from that point forward, you now have a much better platform to run on. I do know that the home health business in Baltimore is growing by leaps and bounds and the one home health company that I cover that has business there can't hire what they call business development teams fast enough to be able to capture all of the referrals that are there. So I have to wonder whether there's not something in the demographic that's flipping that to be a demand growth market, and that may be supporting the business.

ANA GUPTE: What payer mix are we talking about? Is it long term care, is it age, blind, disabled, or when you say states are doing these global payment models, considering most of—

PAUL GINSBURG: This is for acute.

SHERYL SKOLNICK: It's acute care.

ANA GUPTE: On the hospital, but I mean, is the state doing it as the payer or, I'm not quite—

PAUL GINSBURG: No, as a regulator.

ANA GUPTE: —oh, as a regulator. Okay.

PAUL GINSBURG: Actually, you know, when you mention about the growth and demand for home health, you know, this is probably all part of the attempt to rationalize care.

SHERYL SKOLNICK: Absolutely.

PAUL GINSBURG: And especially in the elderly population, you know, a lot of Medicare Advantage activity, some of the alternative payment models, that's where the savings are for hospitals. You ask – they're going to lose some heads in beds, but to the degree that they can get the patient, you know, much more efficiently use the post acute care, don't put them in nursing facilities, use some home health. So in a sense, it's probably a healthy thing if it's growing so fast.

Deb?

DEB WILLIAMS: Thanks, Paul. But isn't it also true that if you don't control the home health and you get a referral and it's a very expensive referral like under Medicare rules, let's say they would pay that, then that can kibosh any of your savings, so if I were a plan or somebody else like that, of course, I'd want to do home health so I could keep the heads out of the beds but not get a lot of – get the right balance of referrals, let's just put it that way.

SHERYL SKOLNICK: So, yes. I mean, you want to make sure that there's not unnecessary utilization at any part of the spectrum of services, and there is a view about home health that, you

know, with the kind of error rates in billing that they have, that every single one of them commits fraud, so it's probably not the case that it's 100% fraudulent, but we certainly do have a generally very hard to supervise, very hard to limit benefit because it's being done in the privacy of the home. But, having said that, if you're still – if the average Medicare revenue per episode for the publicly traded companies of reasonable intensity of service is about $2,800 a month an episode.

ANA GUPTE: It's also into bundling, right? I mean, bundling is the other reason—

SHERYL SKOLNICK: Well, bundling is the thing that's driving a lot of that, and I get that, but, you know, if you're talking about the average Medicare – it's not actually driving that much volume growth, you'd be surprised, and that's a problem. It's not driving it. And it's $2820 per episode, on average, for Medicare. Okay, so you're going to spend $2820 but you're going to save $10,000 or $15,000 on a sub acute, so you're still ahead of the game. You want to talk about the other provider?

PAUL GINSBURG: Excuse me?

SHERYL SKOLNICK: No, go ahead. We can move on.

PAUL GINSBURG: I was just going to move on to the next question.

AUDIENCE MEMBER: I'd like to ask you to speculate a little bit. If this Administration is successful in essentially overriding state insurance rules by allowing plans to be sold across state lines, and we have been talking about competition and the impact, what do you see as potentially the impact on any trends that we're seeing is one question that I have.

MATT BORSCH: I'll just offer – I mean, you're essentially stripping away the state-level regulations on small insurers, in particular, because – sorry, not insurers. I meant small group because they're more heavily regulated, and you know, you get presumably where the insurers are domiciled for these multi-state plans is going to be in whatever jurisdiction has the least regulation so it'll be sort of a race to the bottom and one result you might expect to see from that is some bifurcation of – I'm sort of thinking that association health plans go along with this – but some bifurcation of underwriting risk in the small group going back to a more medically underwritten model.

PAUL GINSBURG: Bruce.

BRUCE: I'm Bruce Steinwald. I'm a member of the Physician-focused Payment Model Technical Advisory Committee. It took me six months to learn to say that – [Laughter] – that was created in MACRA to review and recommend proposals for alternative payment models, especially those that are developed by physician organizations and our focus is on Medicare. But I wonder if you are seeing models like that developed in the private sector? Certainly you're seeing some cancer models but other specialties and conditions are developing models as well, and I'm wondering if you think – if you're seeing it, and do they have much potential, do you think, to reform care and where care is delivered and how much it costs?

SHERYL SKOLNICK: So, I'll take a stab at that. So I am definitely seeing it and, as you suggest, mostly in the cancer models because that's the easiest place to 1) identify a difficulty or a challenge, shall we say, a problem with the existing incentives under the old model that, you know, as some were, you know, infamously quoted as saying you're paying doctors to be drug pushers instead of being physicians when you tie the reimbursement to how high a price drug they prescribe. So let's change that and let's think about what outcomes we want, so you change that. We've seen that. Where we've also begun to see some alternative payment models is where, especially on the gerontologist side, under sort of the Medicare Advantage, where the inclusion of, for example, hospice into the decision making can lead to a much lower cost with kind of improvement in quality of life, especially at the end stages of life. So I don't know that you call that an alternative payment model so much as it results in, in some cases I've seen where, in these limited studies, that the doctor choosing to make that choice even, you know, two or three weeks earlier when you know the patient is terminal, can have a dramatic impact on cost, and if you give the doctor some structure that rewards them for quality of life, not necessarily for cost savings, but quality of life, that you can achieve that outcome.

So, I've seen that being implemented in limited ways in a couple of practices, but by and large, when – I'm not seeing the health plans talk about certainly not very loudly or much out loud, how they're changing the physician payment models. Now part of that's going to be competitive and the other part of it is, that every time you change how you pay doctors they tend to yell and scream a lot. So you do your research and your modeling very intensively before you then select a group of forward thinking or interested physicians to pilot this with, and then you announce it when the pilot is done. So these pilots may be going on and we don't know it.

PAUL GINSBURG: This is a good time for us to end the conference because our time is up. We could've gone on for another few hours, otherwise, I want to thank the panelists for the extraordinary job they did.

[Applause]

PAUL GINSBURG: Also like to thank the JKTG Foundation for its funding of the event, and Alwyn Cassil and the JKTG staff for all they did to put this event on in a very seamless way. Thank you.